Saving Faces: Art and Medicine
Iain Hutchison, Speaker Series, Friday, January 13, 2006 7:00pm

Ian Hutchinson – Pt 1

IH: I'm not running away from you. I'm going to stand in front of you, not behind the podium. Now, come and sit down everybody. I'm a very long-winded talker and you're going to get very painful legs if you stand up there for a length of time. Thank you very, very much indeed, Virginia, Veronica and Bill for organizing this exhibition and inviting me here to speak. I'm absolutely thrilled to be here. I've never been to the Midwest before. Omaha is stunningly beautiful. I'm slightly disappointed that there's no snow. I came slightly overdressed and I've dressed down for this evening. And it's wonderful to be here. The exhibition which you are about to see is beautifully hung. It's a wonderful hall. It's always great to see it in a fantastic environment, beautifully lit. Now, you, I assume most of you haven't seen the exhibition yet. I deliberately haven't shown any slides because the slides…you're going to see the paintings, so there's absolutely no point in seeing the slides because they don't really convey the absolute power of the paintings. As you heard, I'm a surgeon similar to Bill and to Dawn and to all the other people around…that I see around here going down and what…how this arose was that I had several ideas about what I wanted to do with the public, but it didn't quite grow like that. It also grew because you may not be familiar with St Bartholomew's Hospital. It's right in the center of London. I think Bart's probably exemplifies the fusion between art and medicine because Holgar, who you probably do know, was a governor of St Bartholomew's Hospital and he painted two walls, two huge walls in one of our grand old buildings with the pull of Bethesda, with patients with all sorts of diseases, with syphilis and so on. And so art and medicine have been embedded in Bart's since 200 years have elapsed.

Also, you may not be aware that if you're not from a medical background, that in the first world war, there was a fantastic project between two surgeons. One was Howard Gilles, who is the father of reconstructive surgery in the United Kingdom and the second was a surgeon called Henry Thomps who joined the Royal Army Medical Corps. Now Gilles kind of was practicing all sorts of new surgical techniques, which involved reconstructing the faces of first World War victims, which involved kind of taking bits of their leg and attaching them to their arm and then once it would take on the arm, attaching it to their face in operations and procedures that took several operations and many, many months to reconstruct faces. And Thomps, who joined the Royal Army Medical Corps as a surgeon rapidly realized that he wasn't going to be a surgeon. He just didn't have the stomach for it and ultimately, he became Professor of Arts of the Slade, which is one of our great art schools in the center of London and the Royal Academician and he honed his skills as an artist in the First World War, painting Howard Gilles patients who were going through this process. Now his paintings weren't designed for the general public. They were designed in an era when photography was in its infancy and when you know, a patient had to sit for hours and hours and hours to have a black and white photograph taken. His paintings were designed to inform surgeons about the revolutionary techniques that

Howard Gilles was introducing to reconstruct patients. But of course, they have become a lingua franca for what surgeons were doing in reconstruction in that period in the First World War. And they have been open to the public in art galleries. They're now in the Royal College of Surgeons in the Hunterian Museum, some of them and also some of them in archives and there were about 80 paintings produced. Now I wasn't aware of anything that had occurred from the First World War to the present day, which was paintings of patients undergoing facial surgery and I thought it was about time that we kind of brought the public up to date with what we do and so in my mind, I had this kind of ridiculous concept that we could, through art, show the public what we can do with modern facial surgery. For me, it's very frustrating, walking along the street or traveling in a London underground train and seeing a patient who has obvious need for facial surgery and it's all I can do not to go up to them and say, I know exactly what I can do for you. Here's my card. Why don't you come and see me. You know, I have to hold myself back. There are surgeons who do those kind of things, but fortunately I'm not one of them or maybe unfortunately, I'm not one of them. Uhm, and so, it is very frustrating for a surgeon to see somebody who obviously needs surgery and not to go up to them and say, there are things that can be done for you. Conversely, there are patients who have absolutely unrealistic expectations of what surgeons can do. They think we're miracle workers. You can see me here, you know. I'll turn around. I actually am three-dimensional. I'm a human being. I'm full of fallabilities. I am not superman. Bill and his colleagues are wonderful, but they're not supermen. We can't achieve perfection and for me to have a patient come along with a scar right across their face to say, "Can you remove this scar, doctor?" Well, no I can't. You know. There are things that I can do to try and make it better, but I can't remove it. And so it's very, very important or I thought it was very important that we should be educating the public about what we can do and what we can't do. So that was the first aim.

The second aim of the project was to talk about, to enter into a dialogue with the public about facial disfigurement. If we accept the fact that there are people born with disfigurement who we can make look absolutely normal or when we treat patients with cancer, of course with our modern reconstructive techniques, we sometimes….very often fortunately achieve terrific results, almost perfection, almost perfection. But there are patients where we don't achieve perfection and so they end up being disfigured and society has a big problem with that. I mean I'm sure that many of you here will have seen people with disfigurement and you either stare at them or you look away and you find it difficult to treat them as you would treat anybody else. And so what I wanted to do was to illustrate for the public how powerful people with disfigurement can be, that they can lead normal fulfilled lives, that they are just the same as you and me, that there's absolutely nothing wrong with them and so I felt that showing these images of patients in an acceptable way, in an accessible way, through painting rather than photography, we could achieve this.

The third reason was to allow a portrait artist access to these absolutely unique and extraordinary faces and these unique and extraordinary people and not just to portray them at one point in time, but portray them through this process of facial surgery, the before and after and the during, to capture the patient's physical transformation, but also their emotional transformation. So people say to me, well why not just use photographs? Well, the reason not to use photographs is because you take a photograph, one two hundred fiftieth of a second, the shutter snaps and you either capture the face in the appearance you want or you don't capture the face in the appearance you want. But the process of sitting for a portrait artist, means that you're going to capture the face smiling, miserable, grumpy, as the sitter sits there for several hours, sometimes in the freezing cold. And you're going to capture all those faces of the sitter and in this case, the patient and you're going to use all that information to inform the painting you produce and so you're going to capture not just the physical transformation of the patient as they go through this process, but also their emotional transformation and their emotional transformation, at the most dramatic moment of their lives. Now look, I've had ingrown toenails, God Almighty, ingrown toenails. I'm terrified of having an ingrown toenail. It is very, very painful, but facial surgery, imagine, you know, just having surgery on my ingrown toenail isn't very pleasant, but to subject yourself to facial surgery, the fears, the anxieties, the elation, if you're changing your face for the better. If you're deformed and having an operation which is going to transform your face into what you regard yourself as being. You know, this is undoubtedly the most dramatic moment of the patient's life and so, to capture that emotional transformation. You can't do it with photography but you can do it with art. So I wanted a portrait artist to have this opportunity to do that. And finally, I had this kind of mad concept in my head that if a patient who is undergoing this type of surgery, is sitting for an artist for several hours or even days or even weeks, where the artist is focused on their face and just looking at their face, this is an area of their body that is being the subject of ravages of surgeons picking up knives and doing horrible things to them, the type of things that we wouldn't be allowed to do on public transport. You know, if I went out with a knife and say, I'm just going to cut your face here and I'm going to take a little bit of your body there and you know, the things that surgeons are allowed to do are really quite dramatic and so, I thought that the simple process of sitting and having an artist look at them and capture them, would help with catharsis, would help them come to terms with all that had gone, help them go through the process in their mind to overcome all the anxieties they might have had and the fears that they had for the future. So those are my four ideas and I had these ideas. I suppose they started in the early 90's and I didn't really have an artist in mind. When my mother died….I should tell you a bit about my family, which explains perhaps a bit about myself. I'm a strange hybrid as many people in the UK are and probably even more in the states are because your country….I mean the UK is made up of immigrants. My mother was a Viennese Jew, who qualified as a doctor, worked as a doctor for several years in Vienna and then Hitler came along, marched into Austria in '39. She lost her job. She would have lost her life

I suppose if she had stayed there and she and her sister both of whom were doctors, thanks to the Krakow's in the UK were able to come over to England and they had menial jobs, these young women who had been brought up in the early part of the century in Vienna, which was a center of cultural excellence and medical and artistic excellence. They were astute in the arts. They loved painting. They loved going to the opera. They felt very comfortable in that society. They never cooked for themselves. They had servants who looked after them and then they came over to the UK and they had to work as chambermaids and parlor maids and cookery assistants and things, but towards the end of the Second World War, their degrees were recognized and they ended up being general medical practitioners in the center ring in around Burma. My aunt never married. She had a kind of tragic love affair with a guy who ended up marrying the daughter of the leader of the Nazi party. My aunt was a very beautiful woman and she was kind of obsessed with this relationship. My mother, on the other hand, enjoyed walking and met my father in a walking holding in "Scotland. He was a Presbyterian Scot, very handsome man. I could see why she fell in love with him, but she was then 39 and she…unfortunately she's dead now, but if you met my mother, you'd see why the relationship never worked. She was a very powerful, very strong woman. He wasn't used to having somebody who, when she married, refused to say the I obey clause, which was in 1948 or 1947, was a pretty powerful thing, so the marriage didn't last long and I was the issue of it and I was essentially brought up by my mother by this very strange Viennese Jewish woman who was an agnostic at that stage, so I have no religion really. We lived above the general medical practice in a working class area. At first when I went to school, they said, oh, your mother's the Nazi because she spoke with a German accent and so I had this strange upbringing, but I mean, the reason I mention my mother is because I'm incredibly proud of her. I think she's made me what I am today, a slightly wild person, who has crazy ideas and when she died in '89, I put some of the money from her legacy, I put it into a research fund and I used it for bits and pieces to buy bits of equipment that the hospital couldn't fund and stuff like that and then I thought, well she was keen on art and she was a great doctor. Why don't I try and fund an artist in residence to do these things from her legacy? And I thought you know, every so often, every few months, every six months, every year, I'd think about this idea, but I never really thought about an artist until I was standing in Glasgow Central Station and I'm married to a Glasgow Catholic woman, so we go up to Glasgow quite a bit, and I was standing in Glasgow Central Station and then I saw Mark Gilbert. Now I had known Mark Gilbert because Mark Gilbert went out with my niece-in-law, the niece of my wife. And he'd actually painted my mother-in-law. We commissioned him to paint my mother-in-law. Now my mother-in-law is a wee Scots woman who is delightful, but when you see this painting that it took him six months to complete and she had to go three times a week into his dirty, filthy studio, which was freezing cold, you'll see that he hasn't captured her joy, her joie de vivre at all. She's sitting there because she's bloody cold and you know..but he's captured her strength, but I didn't actually think of using him at all. But the relationship with our niece had broken up some time before, maybe two

years before, but seeing him in Glasgow Central, I suddenly had a kind of road to Damascus experience where I thought, Mark Gilbert, and I said to him, "What are you doing at the moment, Mark?" And he said, "Well, I'm teaching at a school in the south of England" and I said, "When you get back down to London, give me a ring. We should get together because I've got an idea that you might be interested in." And so, he got back in touch with me and I showed him photographs of patients and I said, "Do you think that you could do this?" And he started to talk later on so I shouldn't steal his thunder and what's happened to him as a result of the project. But essentially, he did have some anxieties about it and he'll explain what his anxieties were because it's quite dramatic, you know, to see patients with their faces peeled off and for an artist who has never seen that before, to contemplate being involved in that project, obviously caused some anxiety. But to cut a long story short, in relation to Mark, he agreed to participate in the project. Now I had already approached…once I had approached Mark, I had approached the senior people in my hospital. I had spoken to the Chief Executive of the hospital and the Chair of the hospital trust and the Chief Executive of the Hospital, who is an ex-army man, said, "Oh, wonderful stuff, wonderful stuff. I really think art is very important. I love art in hospitals. Great, We must go ahead with it." So I got Mark down to London. I got the funding all sorted out. He said, "Just have a word with Visual Arts. They run the arts in the hospital. You have a word with them." So I had a word with Visual Arts and they said, "Well, you need to sign a contract with the artist. Who do the paintings belong to?" And then we entered into all this kind of stuff over, which I had never really thought about and it all got very, very complicated and then the Visual Arts would meet with the management of the hospital, the Chief Executive. I wasn't invited and they'd have these discussions about the art project and one of the managers was asked to represent my views without talking to me about it at all at these meetings and after about a couple of months, the manager said to me, "Right. I managed to get hold of him" and I said, "What's happening about this project?" And he said, "Well, we're coming to the final meeting today. I'll come back and tell you later on about what happens." So he came back down, and he said, "I'm sorry. It's not going ahead." I said, "What? It's not going ahead?" I said, "But it was going ahead. The guy said, "You know, it's a great idea. We've got to do it" and I said, "I'm going straight upstairs." And so I ran upstairs and I went into the Chief Executive's office, kind of pinned him against the wall. I said, "What's going on? You said this project is going to go ahead. Why do you say it can't go ahead? What's the matter?" He said, "Well, what if the patients think that they're being coerced into having this done and you're saying you'll only operate on them if they have the paintings done. What if we get bad publicity about it. You know, what if people think it's voyeuristic? What if people think this?"

And I said, "Look, the whole point of this project is about publicity. It's all about being open with the public." And he said, "Well, you know, what about the Royal College of Surgeons and that scandal a couple of years ago?" Well what happened a couple of years earlier was that a technician at the Royal College of

Surgeons had stolen body parts, arms and legs, and given them to an artist to cast and the artist had then exhibited these arms and legs that had been stolen, a kind of PlastiCast representations of them and there was a whole scandal about it. But of course, that was a secretive project. That was, you know, not telling people that the body parts were stolen. Ours was an open project, saying, this is the whole point of it. It is a public information project and I said, "Look, okay, what about if I deal with the Professor of Medical Ethics." That's the place and I lectured on the Medical Ethics course and so I knew the Professor of Medical Ethics and I said, "What about if I sorted out with him and he's happy with it. Would that be okay?" He said, "Yes, that's fine." So I got in touch with Len Doyle, who is our Professor of Medical Ethics and I said, "Len, we've got to get this project going." He said, "Umm, okay, fine. Well, I'll help you with it." He said, "Let's look at the information book that you're giving to the patients." So we generated an information booklet. Now over a period of time, which it actually was about five months. Len, unfortunately, was ill. He had general surgery problems. I won't go into the great details. But the point is that he wasn't always there and so we were corresponding on the phone or by e-mail. And I would send him e-mail documents of the information sheet that I had gotten, which talked about Thomps and Gilles which talks about Holgar which kind of illustrated for the patients why art is important and so on and so forth. And then at the end, it got them to sign a disclaimer saying, we're happy to participate in the project or not as the case may be.

And he kept sending it back to me, saying, "I don't like this sentence and I don't like that sentence" and so I'd change it and then he'd say, "No I don't like this sentence" and we were having this dialogue. Meanwhile Mark was down in London not getting paid, staying in hospital accommodation free of charge admittedly, and we were kind of in abeyance. We were in a vacuum. Nothing was happening. And I had already sorted it out with all my colleagues, with all the nurses, with everybody who is going to be involved. It was just simply the hospital management that were blocking it. And bear in mind, this is 1997, 1998 and so what happened was, it became clear that Len, this medical ethicist, who is not a doctor, not medically qualified, not nursing, nothing, no scientific background at all, no legal background. He's a philosopher and he believes that patients are all powerful and should have ultimate control over everything that goes on in relation to their body, which is fair enough. But what he was concerned about with this one sentence, which said, "If you agree to participate, you can't pull out of the project." You can't leave the project and bear in mind that Mark took six months to paint individual paintings, single paintings. You know, the concept of Mark spending six months painting a painting and the patient saying, "No, I don't like it. I'm not interested" was anathema to me and the point about portrait artists is that people don't like their paintings. You know, the famous case is of Churchill, who had a painting done by Graham Sutherland, leading role academician at the time. Churchill didn't like it. Clementine Churchill, his wife, didn't like it. She destroyed it. And it's often the case that people who sit for portrait artists, don't like the final result. So I didn't want them

and also I didn't know how the paintings were going to turn out. I said to Mark, "I want you to paint the patients fairly realistically. I don't want you to do cubism or Picasso type stuff. I do want you to paint the patients as they look, but apart from that, you've got carte blanche to do what you want, do I didn't necessarily feel that the paintings were going to be absolutely accurate representations of the patients. I didn't know how they were going to turn out.

And so the concept of patients having a veto on the paintings once they'd agreed to participate in the project, was anathema to me. But it wasn't anathema to him and so at the end, I understood why he kept sending this document back to me with little gripes about various points. It was this one sentence, this only sentence and so I said to him, "Look, what's the deal here? Are you saying that if at the end of Mark's painting this particular patient, they don't like the painting, that the patient can withdraw from the project?" and he said, "Yeah, I'm saying exactly that." I said, "So what happens to the painting?" He said, "I don't know." I said, "Do you think it should be destroyed?" Now that was the key I was leading up. There was a sharp ray of light in my brain there. I said, "Do you think it should be destroyed?" He said, "Yes, I suppose so." I said, "Aha, you're a book burner." Now bear in mind, he's a philosopher and a liberal. The concept of being a book burner. I said, "This is art. This is going to live on long after you and me and the patient are dead. You know, this isn't for us. This is for future generations. This is art. It's a representation. You can't go around destroying that." And I won him over. That was it. That was when I got the winning stroke, the home run. So the project went ahead. Now what happened was, Mark first of all, started working from photographs and the very first thing he did was a sketch, a charcoal sketch. We had to find him a place to stay in the hospital where he could paint. And the only room I could find…we had lots and lots of empty rooms, but what happened was that the hospital was closing whole corridors to save money and if they had one room in the corridor occupied, then they would have to pay the local counsel rates for the whole of the corridor, so it wasn't enough to have lots and lots of rooms empty. I had to identify a room where the hospital didn't have to pay for it, so what I did was I kind of finagled with my colleagues and I got a little room in our department where all the secretaries had offices and where we had offices, so Mark was embedded within it. Now I only had one complaint from one of my senior colleagues who said, "I really don't like the smell of turps that we're getting now that Mark is here from all the painting and wiping it off and the like and cleaning his brushes."

But what happened was, the very first charcoal sketch he did, I realized immediately I'd struck gold with Mark. It was just wonderful. It just captured the sitter perfectly. And I ran out of his room and I ran into the first secretary's office I could find with a secretary in it and I grabbed her and dragged her through and I said, "Look at this." And what happened then was that from that moment on, Mark…and Mark will tell you this as well…that Mark had been used to working on his own. Artists work on their own. They don't work amongst people. They work in a ?? but here was Mark embedded in that department, surrounded by people

and so the nurses and the doctors and the secretaries all used to start coming in to watch his work and to see what he was doing, so we were learning about art. Art became part of our lives for the period that Mark was there. People were coming in and seeing what was going on. Then I had already decided how it would be run. I mean it's all very well saying to a patient who is about to undergo cancer that they do have cancer and they're going to have an operation. They're going to have radiotherapy, but I don't think it's appropriate to say to them, "Oh and by the way, I've got an artist here. Do you mind if you sit for the artist before the operation?" You know, the patient who is about to undergo this life transforming event, this warring event, isn't really going to be concerned about having a painting done." So we would take photographs of the patients beforehand, which we did anyway, but what I would say to the patients is, "I'm going to have an artist who is coming to theater to watch the operation. Do you mind if he is there, if he takes photographs of you, if he sketches you while you are asleep? And if they said no, that was fine. But not a single patient said no. They all said, "That's fine. I'm asleep. It doesn't bother me and by the way, what music are you playing while you're operating on me? That's more of a concern to me in case I wake up in the middle of the operation. I want to know that it's enjoyable music on."

So they all agreed to it and what I would then do, is if the patients, if I felt they were appropriate for the kind of text that we wanted to create of what we were doing, I would then ask them afterwards whether they would sit for Mark and not one patient refused to sit. What happened on about two or three occasions was that patients didn't respond to Mark's phone calls. They didn't ring him back and didn't sort it out, so I think those patients chose not to refuse me but refused by not participating. So we had a whole cohort of patients and we started to build up this huge body of work. We have about 100 works of art now produced by Mark and Mark will tell you how it changed his life both in terms of his technique, in terms of his attitude to sitters, and his attitude to working with other people and so on. But I'd really like to concentrate on how it changed my life and how it changed the patient's life and how it changed the public's life who saw it towards the end of this tour.

So what did it do for us? Well, for me, what happened was that it did have a dramatic impact on the patients. The patients did love sitting for Mark and it was so powerful, the impact on the patients, that we employed the psychologist, Paul Ferrant, to come in and study the impact on the patients. And so he's written extensively about that, about how the patients…we're using Mark as a counselor because while they were sitting for him, they were telling him about what they felt about things. Patients and I'm sure many of you here have been patients yourselves. Patients, on the whole, like their doctors and trust their doctors and they don't want to hurt the feelings of their doctors. They don't want to say to the doctor, you know, that operation you did for me, it's fine, but I've got a ugly pain down here and I've got a bit of numbness down here, down my leg. They don't want to hurt our feelings and so they don't tell us the whole story even if they are

very fond of us, even if we do have close relationships with them, but what was happening with Mark and I do have great relationships with most of my patients. I adore my patients. They've given me immense strength and courage and you know, the great thing about being a cancer doctor, if you're successful is the patients live on and so you become almost like a GP because you see them regularly as they come to you and you know them as human beings and you know what their children are doing or what their parents are doing or what they're doing and you know, you become part of their lives. And admittedly, they like seeing you, you know, if you see a patient even five years after their cancer. When they come to see you, they've got a little bit of trepidation when they come in because they're worried you're going to say, "Aha, it's come back." But the moment you say, "No, no, it 's all clear", then the floodgate's open. They say, "Well, you know what I was doing this month? I've started a new job and my child has just done the examinations and they're just going off to university and so it's a great experience to have to work with patients. It's a great privilege. But even despite that, there were huge gaps in my knowledge, which were filled in by Mark, because the patient is using him as a counselor and telling him things. Certainly they didn't tell me, but also they never told their own families. So, as he engaged with them and he was helping them come to terms with it, it was an immensely cathartic effect. The other thing that the artist found was that they were using the paintings as a means of controlling their disease process, so the patient Roland, who was up there. Roland carries around photographs of the paintings, his operative paintings, his pre-operative paintings, his post-operative paintings and when people stop him on the street and say, what's that scar on your face? He says, Wait, hang on a moment. Let me show you. Or he's in the pub, you know, having a quiet drink and somebody comes up and says, what's that scar? Let me show you. And he says, "This is me before the operation. This is the scar on my face, you know, the cut they made on my face and this is me with my face peeled off and this is me…and there's the cancer. You can see the cancer there and this is the cancer removed and my eye socket removed and this is me after they've reconstructed me and put me back." And so he's able to use the paintings as a means of empowering him and saying, "I'm in control of this process. I'm in control of this disease and also I can talk to people about what's happened to me."

There's Chris up there who was beaten up with baseball bats and at the lowest moment of his life, there's a painting of him with the endotracheal tube in just about to go into surgery to save his eyesight and repair his broken skull fractures and facial bones and he has that blown up on his wall. He doesn't have the painting of him afterward where he looks normal, although grumpy. He doesn't have that up on his wall. He has the painting of him in his moment of extremist because it empowers him. He says, "If I've lived through that, I can live through anything." So the patients are using this art. It has become an important part of their lives. What happens is that when the paintings are shown, the patients now get very upset if their paintings aren't shown. They want the public to see their paintings. They want the world to know what's going on. Those are two

examples of how it's impacted on patients, but there have been all sorts of misunderstandings along this process and I've realized that actually when you have a good idea and I've had the good idea. I've funded the good idea. When my mother's money ran out, I paid Mark myself and when you have a good idea, you know it's a good idea because other people come along and do all sorts of things that you never dreamed of. So for instances, right at the beginning, I said to Mark, look, I'm only interested in the face. I only want you to paint faces. This is not about the whole body. I don't want extraneous stuff in the background. I don't want you to paint bookcases and all that sort of stuff in the background. This is about faces. Focus on the face. Focus on the face in profile as well as in full face. Now bear in mind that I never thought that an artist would have difficulty painting a profile. I thought it would be straightforward and Mark disobeyed me. I'm paying him and he disobeyed me and he disobeyed me with Mazeda and you'll see Mazeda upstairs and you know, it's very difficult for me to talk about Mazeda because the moment I start talking about Mazeda, I start thinking about Mazeda and I start thinking about the portrait. And when you go upstairs and see that portrait, you'll know exactly what I mean. This is a little Bangladeshi girl, who at the age of 1 ½-2, developed a malignant yolkcyte tumor of her face. She had chemotherapy. You'll see the portrait of her after chemotherapy when the tumor still stuck out here. Her eye is stuck out. She's blind in the eye because the tumor has compressed the optic nerve and then I operated to remove the tumor. Fortunately, she's still alive and well, eight years on and she's still smiling as you'll see in the portrait. But when she came along, she's a Muslim girl and just to provide a little anecdote about her mother, I was walking along the street one day and this woman in a burka comes up to me and says, hi Mr. Hutchison and I said, hello. You know, it's very difficult to know who's behind the burka and she said," I'm Mazeda's mother. I'm Mazeda's mother" and I said, Oh right. And it was a very relaxed and easygoing conversation with a person whose face you can't see, but you know, it was bizarre to think that should think that I knew who she was despite the fact that she was wearing a burka. She certainly knew who I was. But the London Hospital is situated…and you mentioned the Hometan Hospital as well. The London and the Hometan Hospital are situated in two of the most deprived areas of the UK. Bart's Hospital, which is two miles up the road, is situated in the heart of the City of London, which is where all the business empires are and is one of the wealthiest areas. The square mile is the wealthiest area of…more money per square inch than anywhere else in the UK. But the London Hospital is in this poor area because it's seen all these waves of immigrants that have come in to the UK. The one with the big wave of immigration is the Bangladeshi population and not the wealthy Bangladeshi population from Dacca, the capital, but from the rural area select and so we have a lot of Bangladeshi patients and a lot of mouth cancer as a result of that because of their pawn chewing habit. Anyway, Mazeda's parents were both Muslim, both Orthodox Muslim and they sent Mazeda along to have a postoperative portrait with a beautiful green velvet dress and a pink ribbon in her hair and Mark couldn't resist painting a full portrait. How dare he? How dare he? Anyway, I'm thrilled that he did because it transformed the whole project. It

changed it from being just the faces into much more than that. And what happened then was that patients started to dictate how they wanted to be portrayed. They would come along and they'd say, I want to be portrayed with my son. I want to be portrayed with my radiation mask. This radiation mask…the surgery was a doddle but the radiotherapy was a nightmare and I want to exorcize that beast. I want you to paint me in the radiotherapy mask. I want to get rid of it out of my mind. So patients started taking control of the project in a way. So that's the second odd thing that happened. The third odd thing that happened was that I started to say to the patients when we had a body of work and when I felt comfortable about Mark, I'd say to the patients, "Look, I've got an artist. Do you mind if he comes to theater? Why don't you go and say hello to him? Why don't you go and meet him beforehand, so you know he's a nice guy." And Mark misunderstood me, so the patient who is about to have a cancer operation would troop upstairs to see Mark, ostensibly, to say hello to him just to shake his hand. And Mark misunderstood me and thought that I wanted the patient to be shown paintings of the operation they were about to undergo.

So he started showing patients paintings of the operation they were about to undergo. Now, you know, that would have been the furthest thought from my mind, but bear in mind when you know. You have to be honest with patients don't you Bill? I mean you have to say to a patient….you can't say to a patient as we used to do, us surgeons used to do, oh, you've got a little touch of flu when they've got cancer. I'm just taking you in for a little operation and the patient wakes up and half their face is gone. And it's not appropriate. You have to be open with patients and so you have to explain to patients what they're about to undergo. You know, I'm going to make a cut along your leg. I'm going to take a bone and skin out of your leg. I'm going to peel off your neck and I'm going to take away your jaw and I'm going to put in the bone from your leg into your jaw. You're going to have a tracheostomy tube afterward and you know, for the patient to hear all this story, is very frightening and actually, when the patient saw the paintings of the surgery they were about to undergo and they saw the results afterwards, and what the patients looked like afterwards, they actually were reassured and felt better. So something that I would have thought of as being absolutely revolting, turned out to be very, very positive. So that was another way in which the project changed. Now what happened as a result of going into the art galleries was that schools would come along to visit and so, we would be invited to go and talk to schools about the project and I then thought, well hang on a moment. Instead of us going to the schools and hospitals are actually the resource of the population. They shouldn't be the resource of the doctors and nurses who work in them. They are the resource of you, everybody, you know, the whole environment around and we should try and make hospitals more friendly places. I know that nobody really likes to go to a hospital and I remember going for my interview. Now bear in mind I had lived about the surgery. I had seen patients come in with cuts and things and seen my mother treat people and give injections and stuff like that, but when I went to my medical school interview, when I was 16 or 17 and I walked into the hospital and I was

immediately assailed by that smell. Now I'm inured to it now and the surgeons around here won't recognize that smell, but I bet you, you who don't go into hospitals regularly, when you go into a hospital, you smell that kind of antiseptic smell that all hospitals have. And I went in, I thought, my God, am I going to be able to work in this environment with this smell the whole of my life and it is a very frightening smell because you associate it with pain. You associate it with all sorts of horrible thoughts and what I wanted to do was to change that and the reason I wanted to change it….now in Omaha, your hospitals are terrific, but certainly in the UK, in our deprived areas, the population around don't see the hospital as their resource. They don't realize that they're paying out of taxation for the hospital. They don't realize that actually, this hospital is there for them. They assault the staff. They break the car windows of the people who drive there. They damage the hospital and what I wanted to do was to change that attitude, to say look, this is yours. Come in. Come in. And in fact, what is happening now as an aside, in the London hospital with this Bangladeshi population, the young boys and girls aren't allowed to meet at home because of their religion, so what do they do? They come into the hospital and you see them in the bottom of the stairwells, kissing and cuddling and holding each other. The initial response is, this is a hospital. What do you think you're doing in here kissing and cuddling? But actually, they're transforming it into a place of joy for themselves. I'm not recommending sexual intercourse in the corridors, but you know, the point is, that they're making it into their resource and that's what hospitals should be. So what we've got is what we've done is we've started projects where we bring school children in, 16, 17 and 18-year-olds, science students, art students and they spend time with the artist, they spend time with the patients. They write poetry about them. They write plays about them. They paint them. They sculpt them and they spend time listening to the patients and so it becomes much more than just a horrible place to go. It becomes a place of joy for those students and they realize that the hospital doesn't need to be a therapeutic place. It could be a pleasant place as well.

So we've seen the way that the patients have used the project. We've seen the way that the project is developing and you realize that I have no notes, so I tend to forget loads and loads of things about the project because it's had an immense impact on me. It's had an immense impact on the artist. It's had an immense impact on the patients, but it's also had an immense impact on the public. Now I suppose I shouldn't really be telling you about the impact on the public because you're going up there to see it and I'm kind of foisting on you the opinions of other people before you and so ignore everything I say and just go in there and form your own opinion. But I want to tell you what the art galleries have told us. What they've said is that we didn't necessarily get more people coming than we normally get, but what we did find was the people who came stayed longer and they stayed longer because they were looking at it sometimes as art and then translating it into medicine, sometimes as medicine then translating it into art. So for the scientist going in there, it was an introduction to art. For the artist going in there, it was an introduction to medicine and what happened was, that there are

booklets which are the patient case histories, which tell you about the people, who they are, where they come from, what disease they had, what treatment they had to put a kind of perspective on it, so what people were doing was they were looking at the paintings, then going to read the patient cases and looking at the paintings again in a different light and maybe looking only at one painting of the patient and then looking at the whole panel of the paintings of the patient, so people were staying in a lot longer than they would normally stay. And the second difference in the galleries was the Comments books. Now what happened was that most Comments books say, very enjoyable show. Please let's have more of this, but these comments weren't like that at all. People were bearing their souls. Either people with disfigurement or people who had gone through the same disease or people who are perfectly healthy, who were bearing their souls and saying, I never realized that surgery could be like this. I never realized that people with disfigurement could be so powerful. And they were expressing themselves in a dramatic way and our record entry….I don't know whether you have A4…do you know what I mean when I say A4?. A4 is that size of paper. Our record entry is 4 pages of A4 from one person. One person writing 4 pages of A4 comment. But you know, it was very frequent to have people writing one page of A4, so when it got to the National Poetry Gallery in London, because it had been to several galleries before, I said how many Comments books are you going to have and they said, well one. We only have one. I said, well you're going to have a problem with that and sure enough, they did have a problem. There was a two-hour que for people filling out the Comments book, so then they had two and in the end, they ended up with five Comments books because people just needed to write things down and what was interesting when it was in the National Portrait Gallery is there was a juxtaposition because there was a photographic exhibition by one of our great fashion photographers, with pictures of all the famous people, Brad Pitt, Gweneth Paltrow, Naomi Campbell and model Kate Moss and so on and people would write in the Comments books, saying, I've just seen the Testina Exhibition and those are supposedly the beautiful people, but these are the beautiful people and what….I just want to tell you two anecdotes about the impact which really exemplified the whole project for me in terms of the general public. The first is, I was giving a lecture at the National Portrait Gallery and unusually for me, I was early and so I went upstairs to look at the exhibition and I saw two young women with their buggies and their babies in the buggies and they were standing in front of one of the huge operative paintings and they were looking at it and they were pointing at it and they were obviously describing for each other the anatomy that they were seeing. And to see these two young women, who obviously weren't medical at all, with their little babies, learning about the process, how the patient had got from A to B, what was going on or what the patient had to undergo to achieve the final results was absolutely fantastic. You know, it was exactly what I wanted to achieve.

And the second anecdote I want to say is when the paintings were pulled down from the National Portrait Gallery, Mark was there overseeing the removal and

the guys who stand in the galleries, the guys who click buttons to count how many people have gone through and seen it, and they stand around looking fairly bored, said to Mark, "I'm absolutely thrilled or we're absolutely thrilled that the exhibition was here. It's the best exhibition we've ever had at the National Portrait Gallery." Now bear in mind the National Portrait Gallery is three floors of portraits, some of the best artists in the world and for them to say that this was the best exhibition they've ever had, was just incredible. I had forgotten to say lots and lots of things, but I think I've kind of covered how it started, the difficulties in starting. I should mention that the reason it was difficult in starting was because there were no artists in residence projects like this before. But what's happened since then is that there have been a blossoming of artists in residence projects. We've had so many letters from people saying and we've had people come to visit us to see how we set it up and they've set up their own artists in residence projects, so it's led to a kind of…it's burst the dam and there are hundreds of artists in residence projects, not only in the UK but around the world. The paintings of the patients with disfigurement have been on the front covers of journals around the world and have empowered people around the world who are disfigured and who have written to us and said, you know, "I know I'm not alone now. I know seeing the portrait of Henry the barrister, that people that were great, that I am great, that you know, that my disfigurement is as of naught. I can lead a fulfilled life so his portrait alone has empowered people around the world. It's an absolutely wonderful project that I'm immensely proud of and I'm absolutely delighted that it's here in Omaha. I think it's a beautiful city. I think this is a beautiful gallery and I'm thrilled that Ginny and Bill and Veronica have made it happen and all the other people and I just hope that you enjoy it as much as I do and all the things that I've forgotten to tell you about. I'm going to be around in the gallery and you can ask me questions about things and I'm happy to do that. Thank you very much. (applause)

I'm happy to answer questions now if they want to.

Okay, this is your turn. I'm going to just turn the floor over to you to ask your questions or make comments to Iain Hutchinson and he is happy to take your questions or respond to you in whatever way.

IH: Yes. You're the brave first one.

R: I should say, do I really need it that badly. In the US, it's very popular on some of the cable networks to have a lot of medical programs now and I was wondering if there are any documentarians in England who have expressed interest in doing a documentary on this project or this process?

IH: There have been lots of little snippets. I would have loved to have a documentary about the whole project. We had….I didn't mention this, but I kind of did a sleight of hand, a bit of a sales job. What happened was that when the paintings….I'm going to go off on a tangent…you'll excuse me…I have realized I

have forgotten things….what happened was that Mark produced all these paintings and when we had dignitaries come round, I'd grab them and take them up to see Mark's studio and we'd show them the paintings, but the paintings were in a corridor about, you know, from there to there, so we couldn't really stand very far away to see them, but they could see them nonetheless and what I did do was I tried to persuade the National Portrait Gallery to come along. I wanted it to be shown in the National Portrait Gallery, so I persuaded the National Portrait Gallery to come along, send somebody along to look at the paintings and what I did do was I got two of my friends, John Snow, who is the Channel 4 News anchor, so one of our big news anchors to come along and also Jonathan Price, who is a well known actor in the UK, yes, to come along, who also studied art and who has also commissioned Mark to paint a few things for him. So I got them to come along and of course, the people from the National Portrait Gallery knew John Snow and Jonathan Price and so I kind of geed….I was geeing everybody up, so John Snow and Jonathan Price were saying, wonderful paintings, wonderful paintings…aren't they fantastic…and so how could the person from the National Portrait Gallery not say they were wonderful. So what John did was he then said, why don't I get a health correspondent to come along and do a piece for our national news and so what they did was they did about a 12-minute piece, which is a large piece on the project, which was on Channel 4 News and we then got lots of tapes of it and we sent it to art galleries around the UK to say, are you interested in showing it? And that led to us having a tour of eight art galleries. So that was the first bit of filming. Now I have been involved with a one-hour documentary, which I'm not particularly happy about, which is called, "What are you Staring At?" and I wasn't happy because the documentary makers misled me. They said, we're very interested in the Saving Faces art project. We're very interested in your research. We'd like to come along and film all that stuff, and actually what they were doing was, they were funded by the Disability section of the BBC and they were doing something on disfigurement and what they did do was create a debate between people who said if you have disfigurement, you shouldn't have surgery. You don't need to have surgery or a wild surgeon like me saying, "You must have surgery." So they kind of painted an extreme view of me, which wasn't quite me, which is a facet of me, you know, but now the whole me, so that they could have this debate, this artificial debate over whether surgery was a good thing for disfigurement or not. And unfortunately, what they did do was they, with the people who said you shouldn't have surgery, they got a young woman who actually had had five operations before, none of which had been successful and so she was saying, I'm not going to have any operations, but she had five operations before. And she was saying about the art exhibition, which she hadn't seen, saying that she thought it was a voyeuristic show and then they went to…when the exhibition opened in Bartha, Mark and I went down to open it, they went down and filmed it and they filmed me laughing like a hyena, which I do, but at an inappropriate time. So I was disappointed in that because they misled me. But we have lots and lots of little pieces, so German television, Swiss television, Swedish television, but we haven't had a whole documentary on the art project itself, which I think merits it.

It would be great to have a documentary on the art project, but it hasn't happened.

R: I was wondering what the clause that the medical ethicists recommended that you take out of the contract or something.

IH: We didn't have the contract. We never signed a contract. There were two things. One was the concept that we should sign a contract, that Mark and I should sign a contract together and we never actually signed a contract. I'm hopeless on law and what we said is this is not…although I've paid Mark and although Mark painted the paintings, but they don't belong to anybody. They're meant to be for the public. The aim is that they would always be on permanent show to the public. They're not for sale. They are a public resource, so that's the one thing, but in terms of the clause that you were going to ask me a question about that clause.

R: It's a counter factual question. Let's suppose a patient today came to you and said, I don't feel comfortable. I don't want my portrait shown. What would you do?

IH: I'd say….you mean the portrait had already been done [yes]. Now that we've got the body of work and now that I know that Mark doesn't take six months to paint one patient, we can do it much more quickly, I'd say fine, that's okay. But now we've got a hundred paintings. If somebody had said that to me then I would have been very disappointed but actually they don't say that. They say, why isn't it being exhibited? Why is my painting not up? I want my painting up. My Christmas card from Henry Egpei said… Henry is a Nigerian….I mean I haven't told you any of the patient case stories really, but I can tell you those up in the gallery if you want to ask me about them. I mean I don't mind walk you around and talk to you about each individual painting and who the people are. Henry Egpei was a…I think he was 26 when he came over to see me. He had been told he had a benign tumor and he had a myeltelectomy to have the whole of his upper jaw removed. He had had several other operations before he came over. It turned out it was a malignant tumor. He had never been out of Nigeria before. He found his way. He raised funds to come over to the UK because he obviously had to pay the hospital for treatment. I didn't charge, but he had to pay the hospital and he had to find a place to live and so on. He had never been out of Nigeria before, never been on an airplane before. He found his way to my department in my hospital with the money in his hand. He came over. He is still alive. He's got a malignant tumor. He had a 23-hour operation with my newest surgeon in 1991. That was the first operation he had. It was slightly longer than it should have been because my newest surgeon had only been working for a year and he was a bit slow. But I was slow at that time as well. And he sent me a Christmas card this year saying the usual things, you know. I love you…that's wonderful….how are you? Jeremiah is doing really well because he's now

gotten married. He's had a boy. You know. His life has developed. He works with a senior psychiatric nurse in a hospital in London now and he said, I just want to thank you for making me famous around the world. I mean, it's a kind of bizarre thing and I don't think he really means that, but his is a story that needs to be told. He's got a wonderful story to tell, an empowering story, a brilliant story and unfortunately, because his speech isn't clear. He's never appeared on any television thing, which is a real shame because he's got a…you know, his story is a story to write a book about. Now I've gone a long way from your saying about…oh yes, I know why I said that. It's because the patients all say I want to be shown. Not a single patient has said, I don't want to be shown. The patients have said. Sue Elfick says, "I look at this portrait of myself and for the first time, I see myself as I really am. You know, I previously….although I had the surgery, which transformed my face so it looks normal now, I never really appreciated it till I see the portrait of myself sitting and smiling, you know, beaming."

R: When you speak about the patients that have completed the process, the whole project seems to have given them a lot of validations, self-confidence, you know, faith in who they are and the ability to relate to others. How would you juxtapose that for example with having surgery of their own as you have presented it as opposed to like Nebraska Medical Center is a large transplant hospital. Validation of the cells or for example, with a facial transplant of some kind that would not have been from the cells?

IH: Right. Let me just see if I've got this right. Are you asking about the facial transplant?

R: Yes. How would you see that as a….

IH: Having a facial transplant.

GA: Can I ask…because you've got the microphone that you will try and restate the question. [All right. Okay] I think we're having some trouble hearing.

IH: Okay, fine. All right. So let me just….that's good. Thanks a lot, Ginny. So are you talking about the face transplants that have just gone on in France?

R: Yes, as opposed to the future…

IH: Okay. Aha, right. So the question is, let me see if I can…because I've got to speak into the microphone here. Let me see if I've got it right. That what you're talking about is, if somebody has a face transplant, where they have somebody else's face put on them, is that going to affect their personality, how they feel about themselves as opposed to having where we reconstruct them using bits of their own body?

R: Exactly.

IH: Okay. Right. Well, that's a fascinating thing and I wrote a piece for one of our national newspapers, an off ad piece about it because I have quite strong views about it. I think it's very, very important that we have innovation. We need innovation. Otherwise, we don't move forward. But when innovation occurs, we have to, because innovation may be bad as well as being good. We have a mold imperative that we must study critically and carefully the impact of what we've done. You know, I know it's an extreme example, but thalidomide was a wonder drug until we discovered that it resulted in children being born without any limbs. Surgery is not something that you can reverse. You do the surgery. That's it. It's done. You can't go back and say, sorry I'd like to have it all taken back. So here we have a situation in which the patient has had a face transplant. Now I've spoken out against face transplants and urging caution. The dam has been breached now. The genie is out of the bottle and undoubtedly face transplants are going to go ahead. But there are serious physical risks for the patient who has a face transplant. In order to put the face transplant on, you have to remove the reconstruction you've already done. Now this woman had her injury six months before. They did not…they cannot have left her with a hole in her face for six months. They will have done conventional reconstruction which will involve several long operations to reconstruct her using the current goal standards. They would have had to remove all that and throw it in the bin to put on the face of the other person. Now the chances of immediate success are pretty good using microsurgery, joining up the blood vessels, doing plumbing basically under a microscope, but there is a five to ten percent failure rate of that thing and when it fails, it fails completely, so although the risks of failure are low, the results of failure are catastrophic because the woman is back to where she was when she had the accident. The second thing is that the immunosuppressant drugs may not suppress the immune response and the Royal College of Surgeons in England examined the possibility of face transplants because we've had surgeons in England who want to do them as well as in the states. And what they found was that there is a probably over five-year period….there is a 30 to 50 percent chance of rejection of the face transplant, so a failure. And then the people have to be on immunosuppressant drugs for the whole of their life, which means they have a greatly increased risk of cancer. So what is this woman going to feel ten years on if she gets a lethal cancer? Is she going to feel that her quality of life was great for ten years and so it was worthwhile having it done or is she going to regret having it done? So we don't know. We don't know what the impact is on the donor's family, the interference in the grieving process. No, I won't say because it's kind of frightening to say, the scenario that I'll say. I need to write it down very carefully so that I'm writing an editorial of the woman's life, so I won't say that scary thing. But the point is…but the donor's family…a lot of religions involve an open coffin. I know that when my mother died, that I raged and screamed and held her and I shouted at her and whispered to her and it was like I was still talking to her and I'm sure many other people have that experience with their loved ones and you can't do that if the face is removed, so we need to study the impact on the donor's family.

Now I haven't mentioned anything about the psyche and the psychological impact for this woman, or what she feels when she sees the face. But what's interesting is that Dubinow was one of the surgeons. He's not the facial surgeon. Devachal is the facial surgeon and he's an excellent facial surgeon. I know him a little bit, not hugely. But Dubinow was the guy who was involved in the first hand transplant and what was interesting when the media came to me immediately after the face transplant and asked me what my opinion was, I said, well, do you remember what happened to the hand transplant and of course there was a huge amount of publicity when the first hand transplant was done and they said no, no, no, I remember it being done but I don't know….I said the patient two years afterwards asked for the hand to be removed. Now we don't know why the patient asked for the hand to be removed. Was it that they couldn't cope with it? Was it that their expectations of the hand moving weren't fulfilled. Was it that they just….you know, it was hanging loose from the side and they found it an incumbrance. And so it's very, very important that the public understand because the concept of face transplants is titillating. It's exciting. It's dangerous. It's the stuff of movies like Faceoff. It is…are the FBI going to use it in their Witness Protection Programs? You know….I've got a few lines now. Actually, hang on a moment. You've got a nice face. Do you mind if you sign the Organ transplant thing that when you die, I can have your face. You know, the point is that the general public have all these images in their mind and it's very important that they understand that this is not going to be something that is a common transplant. It is not a life saving transplant. It is a quality of life transplant and therefore, there is a balance. If you're going to die of heart disease, then it's a no brainer. Yes, I want a heart transplant. I'm prepared to risk. If I live ten years, which I wouldn't have lived otherwise and I die of a cancer, it doesn't matter because I've had ten years extra. But if it's only about quality of life, is that….is the balance right and we don't know and that's why it's so vital to follow this up. I don't know the answer. My feeling is, it's not a good idea to do face transplants but now that it's going to happen, it must only happen in the very few centers. It must be very, very carefully controlled and it must be studied so that we know what happens, so that the media know what happens as well as the scientists and the doctors know what happens to patients with face transplants. Does that help a little bit? Okay.

R: Most of the patients that you talked about were patients with cancer. You talked about one that had injuries from an attack. I wonder if you had a sense that the reaction of the patients to the process or to the paintings were different for the cancer and non-cancer patients?

IH: The question is do different patients…now it's interesting, this business of responding to the questions. I heard Paul Nurse, who is head of our Imperial Cancer Research Fund and I heard him in India speaking to an audience of school children and what he did was he repeated the question, not because of the microphone but because it was useful for the audience and also possibly too useful for him to rephrase so, so it's a very useful technique to use. So the

question… excuse me, paraphrasing, but the question is, if a patient has a different disease process, do they have a different response to being painted? That's basically what it says, isn't it and the answer is no. They….I can't think…we've had patients with facial disfigurement having operations to make them look better. We've had patients with facial injuries and no, the response is always the same, it's that the paintings are empowering. Maybe the paintings at different times have a different thing, but actually, Henry Delabienier, the painting that he liked best, was the painting of him sitting there with his facial disfigurement. The same with Henry Egpeai, the same with Roland Scott. I think that they all, that they choose different paintings from the series that they love, but they all love having the paintings done. Does that answer your question?

R: You and the other surgeons now that have worked through the artist, does that make you kind of broader approached as a surgeon to think more towards kind of an end result or to….

IH: Right. Excuse me in paraphrasing again and if I get it wrong, tell me. The question is, has it changed me? Has having the artist working with me, the process of seeing the paintings, the process of seeing the effect on the patients, has it changed me? And the answer is, it has changed me. It has changed me profoundly. I've learned a huge amount. I couldn't put my finger on one thing and say that I'm a better person because of this, but I have no doubt that it has improved my understanding of what the patients go through. It's torment. Right, I can give you an example straightaway. Uum, it's obvious, but it wasn't obvious to me before. Henry Delabienier, the barrister, said, I don't mind being disfigured now. I've got a great job. I can play my sports still despite the fact that you removed one of my eyes. I can play criquet. I can wind surf. I've got two wonderful children. I've got a wonderful wife. I'm 40 years old. I'm happy. It doesn't bother me, whereas somebody who is 12 or 13 having that kind of surgery, it does bother me because of course, they're going through the most important development period of their life when they are being judged on the face. I mean, we judge people on faces the whole time. The point about the face is, you don't know that I've got a wooden leg, so I'll show you my wooden leg. You don't know whether I've had a testicle removed. You don't know anything about what's under my clothes, but you know what I look like and we judge people on faces. We've done research, psychological research on 18-year-olds and 19-year-olds, medical students and six from high school pupils and what. I'm glad I said about removing the testicle. That's raised a little tizzifag, good. The point is, levity is good. We've showed them a series of photographs and we asked them to judge them. What we did was we had 30 people who had normal faces. You know, you look at them and you say, that's a normal face and then we had 30 people with not gross disfigurements, but you know, jaws are very big or jaws are very small and I've done surgery to harmonize their face, so that their teeth meet better and so that they looked within the normal range as it were. And we jumbled up the pictures, so that the people didn't know that they were looking at the same people pre and post op. And we asked them to judge

them on attractiveness. Well, that's straightforward. But we also asked them to judge them on honesty, on violence, on intelligence, on all these facets that had nothing to do with how you look and of course, post operatively, the patients were all more honest. They were all lest violent. They were all more intelligent and the promiscuity hadn't changed. We asked them about promiscuity. And so, but all positive features psychologically after this, which illustrates that people who do have disfigurement, do have major problems because they're judged, particularly when they're teenagers. They're not only judged by their peers as being violent, God I don't want to see him, or somebody with a scar across their face, who happens to have got into, you know, been walking past a pub where somebody has come out and just slashed their face. They're not violent at all, but you know, they can't get jobs because people look at them and they say, I don't want him at work. He looks like a rough diamond, a rough character and so we judge people on faces the whole time. And so for teenagers, it's particularly difficult coming through this period and of course, it makes sense, but I hadn't really thought it through before Henry told me that, so there are lots and lots of ways that I've learned as a result of the process and that's just one of them. It's been great for me. It's been fantastic. It's also resulted in me coming to Omaha.

R: Sir, there's a follow-up question to that, but it seems like your project is a real classic bringing together of right brain thinkers and left brain thinkers, artists and scientists. Do you look at your patients now more than artists at all? How would Mark paint his patients or….?

IH: So have I changed the way I look at patients as potential subjects for Mark or how they would be painted or rather than just simply seeing them as patients with a disease process?

R: Yes. I guess artists kind of look at people and kind of see the story, you know, [Right] look at a patient and see what's unique about them. You mentioned the girl in the dress, things like that.

IH: Right. Well I think you're asking me when I see the patient first of all, do I think of them differently rather than when I see them afterwards, when I'm planning what I'm going to do. Do I see them differently? I don't think so, no. I think….I've always, when I'm teaching my juniors or medical undergraduates, I say to them, when you present a patient, the very first thing you do….now we have to do postgraduate exams in the United Kingdom, the Fellowship of the Royal College of Surgeons. One of the things we have to do is ….and we have it in our medical undergraduate course too….we have to examine patients and we have to diagnose them in an examination setting and we have to do it in 15 minutes, so we go in and we've got a patient and the horrible thing is that you go into a patient and they say…you go through the questions that you meant to ask them, the standard questions and they say, yes, I've got that, yes, I've got that, yes, I've got that and you don't get a chance. You're terrified you're going to have a patient who is never going to give you a chance to come to a diagnosis in

15 minutes and so you're going to have to go to the examiners and say, well, I didn't get anything done and I learned very early on, that the best way in this examination setting is to go into the patient and say look, "I'm really sorry. I'm probably going to be fairly brusk because I've only got a short period of time, but I hope you'll forgive me for that. I've got to find out what's wrong with you and so on to present to the examiner." And so the first question I then say is, "How old are you? Who do you live with. What do you work as?" And so the very first questions are asked aren't anything to do with their disease process at all. I'm getting to know them as people and actually, I find that when I do that, the patients in the exam situation and in life, immediately relax and think, this guy isn't thinking of me as a mobile hernia or a mobile varicose vein. He's interested in…you know, I was teaching one of my…talking about ingrown toenails, I've had other surgeries than ingrown toenails and actually, the surgeon to have surgery is very, very good. It helps you understand it from a different perspective, but most of my operations were when I was a teenager. But the classic example is, and I told this to a person who is applying for a job and she used it and she's told it to loads of other people applying for jobs and it is the story and it is a fictional story. I made it up. It's the business of an ingrown toenail. An ingrown toenail to a surgeon is not a disaster because I can sit down to operate. I don't need to move around too much. But an ingrown toenail to a postman who is going door to door means they can't work. They're off work because they can't…you know, they're walking ten miles a day and so the disease process depends on who the disease belongs to. It isn't..you know. …a hernia isn't a hernia isn't a hernia. A hernia in a fractured cheekbone in an African footballer, who has to play in the African nations cup next week, is different to a fractured cheekbone in me, you know, who doesn't have to play football. It depends who the disease is in and so for me, it's always been the case….and it's one of the joys. I don't want to be treating people as a mobile hernia. I don't want to be looking at your groin the whole time and addressing myself to your groin and saying that's very interesting. I like the hernia, the direct hernia and you know I'm going to do a besenia repair on that, you know, and never look at you. I want to know you as a human being. It's my joy. It's my privilege to get to know you and so, the story I told in the beginning of asking you, the age, what you do, who you live with, it breaks it down and in the examination situation, the patient has heard nothing I say. Actually, doctor, I'll tell you what's wrong with me. I've got a problem with one of my cartilages and I'm also schizophrenic and I carry knives around with me and I'm going to stab you in the heart. But the point is, that the patient has opened up in the exam situation because they saw millions of human beings as well. Okay? And so it is…I've always felt like that. I want to know the people's people. I don't want to just say…I don't know about the right brain and the left brain and I don't look at them as an artist would, because I'm not an artist. I can't compete with Mark on that front. I hope never be an artist.

R: Could you please share with us some of problems of the family members of the patients and how they felt with maybe a son or daughter?

IH: Okay. Well, I'll talk about Henry's spouse. So the question was, what do the families feel about the portraits? Well if I talk about Mazeda and Henry, every gallery in the UK that the portraits were in, little Mazeda would go along with her mother and father, mother and the burka and the father to the gallery opening to this kind of event and look around and talk to people and things and they were very proud and still are very proud. We've produced Christmas cards with portraits on them and things and they love those and they send them out to their friends and family. Anita Delobienier, the wife of Henry Delobienier, who died a couple of years ago, went to the gallery opening in Yale. She flew over to Yale. Henry Egpeai went over with his family when it opened in Stockholm, so the families go along. They love it. They think it's great. I think everybody is worn out now. Well, thank you very much indeed for coming along. (applause) There is drink and food upstairs as well as the portraits.

GA: Just a minute. They're waiting for us and I want you to get up there so you can enjoy the paintings and Iain has said that he would be there and wander around if you've got more questions, you can certainly ask him in the gallery. I want to thank Iain Hutchinson for coming to be with us. I already gave him a nice envelope. These are just some special things for him. [Oh that's lovely] This is a copy of the Powerpoint Program that we developed for our program and I hope you enjoy it [great, yes] with all the paintings. And this is something to remind you of our morning today.

IH: Okay. Thank you very much.

GA: I took Iain around and showed him some of my favorite places in Omaha.

IH: Yeah, it's beautiful place. Just one point I should say. There's something missing here which we will try and address which is, there's a beautiful film, a 15-minute film produced by Mitch McKenzie, a well-known filmmaker and it hasn't come from Boston on to Yale on to here, but we'll try and get it. It's a gallery installation film and it brings a tear to my eye when I see it. We'll try and do that. We'll try and get it to you on a DVD in the next week or so so that other people can see it. Okay. Thank you very much indeed. (applause)

GA: Thanks for everything.