

# QMR

QUEEN'S MEDICAL REVIEW

VOLUME 1  
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FEBRUARY  
2008



## WILL WE SUSTAIN OUR HEALTHCARE SYSTEM?

MOVEMBER, CRITICAL ENQUIRY 101,  
STENT REMOVAL, HEALTH  
SURVEILLANCE, DARFUR, AND MORE

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*Derek Tsang, Diana Popescu, Amy Wong, and Aisling Clancy in Frontenac Provincial Park, September 2007.  
- Julia Cameron-Vendrig*

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## FROM THE AS

First off, we would like to say congratulations to the QMR staff on their premier issue! We wish you all success. To the rest of the student body: here are a few events coming soon about which you may wish to know!

**The Annual Travill Debate** – Monday February 11th

Is the feminization of Medicine a hazard to the Public's health? The implications of this controversial question were hashed out by some of our very own faculty and students. Dr. Lindsay Davidson (ORTHO) and Adam Szulewski (Class of 2010) supported the "YEA" side of the argument while Dr. Peter O'Neill (OB/GYN) and Emily Austin (Class of 2011) supported "NAY". If you missed this exciting and humourous night, you will have to wait until next year to see the ever-entertaining AA Travill debate!

**Mentor Trivia Night** – Date and Location TBA

Join your mentor group (that you met during the mentorship dinner at KGH) as you face off against all the other mentor groups for a riveting game of Trivia at one of Kingston's many fine licensed establishments. This trivia night is held annually, is well-attended, and lets you see a different side of your future colleagues (be it desirable or not)! Keep an eye out for this event coming at the end of February/beginning of March!

**Interview Weekend** – March 1-2 and 29-30, Queen's University

Hundreds of promising men and women from across the country will be flocking to Kingston in March in the hopes of becoming a member of the class of 2012. Our very own 1st year class is facilitating the interview process as well as organizing social events, tours, and presentations. This is a great way to show the applicants (and the world) how great Queen's Medicine is and how much we love being here, so come on out and share your wisdom while adding to the enthusiasm!!

**AS Council Meetings** – Every 2nd Wednesday, 5:30-7:00

Do you want to know more about the issues affecting your class and medical students in general? Do you want to have your voice heard? Then come out to the AS council meetings in the CEC. Everyone is invited!! This is a great way to become familiar with the exciting behind-the-scenes activity of Queen's Medicine, and to participate in discussions that may affect your education. Check out QMed for the specific dates.

Cheers,

Aesculapian Society Council

**T**OWARDS THE END of Phase 1, one of our teachers said that medical school changes you. And it does change you, but I've realized that this does not occur in a vacuum. The changes take place within the context of our peers, mentors, and teachers. By the end of September, I was impressed by many of my classmates and the upper year students in our School. Listening to their experiences, it became clear to me that there was much to learn from these bright and promising individuals. With the help of the Aesculapian Society and the School of Medicine, the Queen's Medical Review staff has created the first issue of what we hope will be a force in creating synergy in our community. By stimulating discussion about important healthcare issues, distributing news from the AS, and publishing students' experiences in research and electives, we hope to enhance communication between all members of our community. Jong Kim's enquiry into the sustainability of our healthcare system leads us to reflect upon our willingness to continue paying in spite of increasing cost, while Dan Finnigan's report of surveillance systems traces the history of epidemics and suggests how we, as healthcare professionals, might better react to the next one. Nicole Kozloff's review of the recent Health and Human Rights Conference demonstrates how students can begin effecting change on a global scale, and Kevin Leung's hilarious recap of the 2011 "Mo-Brothas" demonstrates how committed some of our colleagues are to fundraising for prostate cancer research. In Point/Counterpoint, important issues regarding the current curriculum are raised as students debate whether future applicants should have a health or life sciences background, in order to eliminate Phase I. Scott Bradshaw's summary of his critical enquiry about electrolytic stents demonstrates the immense potential of

innovative research in our School, while Alex Yeung provides some helpful tips about the research process and critical enquiries. Derek Tsang's discussion on the cost of his Habitat for Humanity trip to Ethiopia and Hanni Darwish's description of his medical elective in the Himalayas both contemplates the value of these personal journeys and describes how their perspectives and attitudes have changed as a result. Melissa Pickles and I had the pleasure of speaking with a past AMS member and AS president, Dr. Al Adler (Meds '65), and our interview presents a small but inspiring glimpse of how our alumni have contributed to society. Finally, Eric Dantzig's reflection on the roles of physicians asks us to consider how we might be socially engaged citizens. Medical school is not just about being in medical school, but about becoming physicians. As future physicians, let us not operate in the vacuum of biomedical sciences, but rather, let us be continually aware of the power and influence that we hold as members of this profession. We shape and mold each other, for better or for worse, and it is only by critically reflecting on our profession, our community, and our society that we can begin to effect positive change, whether it is locally or globally.

I would like to thank the writers and reviewers for their contributions to the Queen's Medical Review. I'd also like to thank Dr. Jackie Duffin for her invaluable advice in guiding us through the process of publishing our first issue, and the AS and the School of Medicine for their support. Finally, I'm deeply grateful to the Editorial staff for their time and tireless efforts in editing articles and communicating with the writers and reviewers, as well as for their eternal patience with me in our long meetings and many e-mail exchanges. I hope you enjoy the first issue of the Queen's Medical Review.

BY MICHAEL SURKONT

**University of Toronto to Open New Medical Academy**

The University of Toronto's Academic Board has agreed to the construction of a new medical academy at the Mississauga campus. The plan envisions the enrolment of the first students in 2010. Furthermore, students from U of T's downtown campus will also undertake some rotations at the site.

**Sometimes Even Doctors are Duped**

A recently published study in the British Medical Journal identified seven common medical myths that even many doctors believe. The study included such popular misconceptions perpetuated by many physicians as humans using only 10% of their brains or the belief that reading in dim light causes eyesight loss. To see where many of your colleagues get duped, link to: <http://www.bmj.com/cgi/content/full/335/7633/1288>.

**Chinese Doctors to be Evaluated on Medical Ethics**

At the end of 2007, China's Ministry of Health announced plans to set up a system of evaluating the country's doctors on medical ethics. An electronic filing system will allow the annual ratings to be used for promotion and remuneration considerations and to flag misbehavior. However, critics contend that the process fails to account for patient opinions, considering instead only the evaluations of hospital superiors.

**British Columbia to Change Malpractice Law**

British Columbia's Attorney General, Wally Oppal, plans to introduce legislation modifying the law dealing with wrongful death. Currently under the 1846 Family Compensation Act, only loss of income can be sought after a medical mistake. Claims for grief, lost care and companionship are not considered under the previous law.

**Extreme Competition Expected for British Version of CaRMS**

This year's upcoming British medical match has left many young doctors riled. British media report ferocious competition and an average of three applicants per residency spot. For the most popular specialties, there will be at least 20 applicants for each place - double the number last year. This is the first year that British medical students will be up against foreign medical graduates after a court ruled that British graduates could not be given priority over candidates from outside Europe.

**Canadian Medicare More Efficient than Previously Thought**

A study by the Centre for the Study of Living Standards Canadian Health reports that Statistics Canada analyses seriously underreport the output of the Medicare system. Released in December, the study urges the agency to adopt a new framework to better monitor productivity in healthcare. The study concludes the current input-based method is flawed when compared to data analyses methods used in the United States and several European countries.

**CMA President Contemplates Private Medical Schools**

In a speech given to the Economic Club of Toronto on January 15th, Dr. Brian Day acknowledged that the establishment of private medical schools may be the answer to the shortage of doctors. Dr. Day gave the example of private non-profit American schools like Harvard and Yale as potential models to follow. He cited the need to open up the healthcare system to Canadian medical students studying abroad to alleviate the shortage in physicians.

**Prince Edward Island Launches Family Medicine Residency Program**

Prince Edward Island, which does not have a medical school of its own, has signed a formal agreement in December 2007 with Dalhousie's Faculty of Medicine to begin training residents as early as July 2009. The blueprint calls for the training of five residents a year, based out of Queen Elizabeth Hospital in Charlottetown. It is hoped that this initiative will help address the province's doctor shortage.

**Recent Data Shows Decline in Hospitalization Rate**

According to information obtained from the Canadian Institute for Health Information, 2007 showed a 2.3% decline in inpatient hospitalizations after adjustments were made for sex, aging and population growth. This represents a 15% decline from 1996 hospitalizations.

**New CMA Study Shows Alarming Facts**

In early 2008, the Canadian Medical Association released the results of a study by the Centre for Spatial Economics. The report described the devastating effects of long wait times on Canada's economy. For example, long queues in four critical areas: joint replacement; sight restoration; cardiac bypass surgery; and MRI scans, cost Canada over \$15 billion last year.

**U of T Meds Contemplates Move to Pass/Fail**

Like us, U of T students overwhelmingly support moving from the Honours/Pass/Fail system to the Pass/Fail one. In early January 2008, a town-hall meeting of students with the U of T Vice-Dean in charge of Undergraduate Education supported moving to Pass/Fail. Will this lead to significant changes? More information in the next issue of the QMR. ■

DAN FINNIGAN, MEDS 2011

I contend this statement on two accounts. The first is Queen's School of Medicine only accepting students from the life or health sciences. This would eliminate the diversity of types of people in medicine, thus reducing the variety of ideas and inspiration. Louis Pasteur was a chemist, yet he helped found germ theory. Dr. Duffin stated in a history of pathology lecture that medicine is an applied technology that makes extensive use of science, not a science in itself. Our lesson from the past is that medicine has a propensity to trend on arrogant philosophy, stifling its growth. Forgetting history and limiting entry to only people trained in the current accepted standards of "science" dooms us to repeat it.

My second issue is related to the belief that Phase I can be eliminated. Components of Phase I may seem redundant, but the whole of it is not. Everyone has areas they need to develop in their basic science background for proper understanding allopathic medical theory. Even if it seems boring, it is more because some of the information lacks novelty, not because it is perfectly understood. It is not good enough to have heard it before; we need to understand it. Phase I didactic teaching methodology could use updating, but the material itself needs to be reviewed. Students should consider that most of the knowledge they are inheriting was generated from thousands of years of observation, experimentation, and inspiration. A few months at the beginning of medical school is a small respect.

## "QUEEN'S SCHOOL OF MEDICINE SHOULD ONLY ACCEPT STUDENTS WITH A LIFE SCIENCES OR HEALTH SCIENCES DEGREE, IN ORDER TO ELIMINATE PHASE 1."

CHRISTINA GRAVA, MEDS 2009

Phase I has to go. When I was in Phase I, I thought it was great but now that I am 95% of the way through Block 2, I realize that Phase I had very limited value. Undoubtedly, the anatomy and early clinical skills that we covered in Phase 1 should be included in the curriculum. The other lectures had content that most students either already knew from university or the information was so technical that it did not hold much practical value.

I do not think that Queen's should only accept students with a life science or health science background. Personally I have an honours B.Sc. in immunology, and I recognize that my strong life science background has been beneficial. Yet, I still value my classmates with

English, Engineering, or other non-health backgrounds. In fact, my engineering friend invented and patented a medical device while working on his critical enquiry this summer. Some people believe that non-health/life science students will have problems in medical school if Phase I is eliminated, but I do not. There are already credit requirements for all students applying to medical school and, in theory, these should be sufficient. If the faculty is concerned about the knowledge of incoming students, it should recommend that students applying consider certain science courses instead of requiring a health science degree. In particular, a basic cell biology course would be a reasonable suggestion. I feel that understanding of the cell provides an understanding of some core concepts that come up time and time again in medicine.

**NEXT ISSUE'S TOPIC:**

**"THE GOVERNMENT SHOULD IMPOSE A TAX ON JUNK FOOD ITEMS."**

Send your response to [queensmedreview@gmail.com](mailto:queensmedreview@gmail.com).

# MO' MONEY MO' CHARITY

BY KEVIN LEUNG

**C**LINICAL PRESENTATIONS: ITCHINESS of the face. Awkward looks from others. Un-metrosexual dirtiness. With these three symptoms, what is your diagnosis?

Diagnosis: Why, this man is growing a Mo (slang for Moustache) and braving the elements of social acceptance to support the fight against prostate cancer, of course! Prostate cancer is the number one cancer threat among men. In fact, according to the Prostate Cancer Research Foundation of Canada, more than 22,300 men will be diagnosed this year alone and 4,300 will die.

This year, however, 26 men of the Queen's Meds 2011 class were passionate enough about men's health to step up to the plate and sacrifice their upper lips for the greater cause during the entire month of Movember (the month formerly known as November). Banding together to form the team, "Queen's Med '11s Bro-thas from different Mo-thas," the Mo Bros set a fundraising target of \$1100 in commemoration of their graduating year and went about sprouting their upper-lip nose-dusters and under-lip ticklers. Within two weeks, however, the Mo Bros smashed through this donation target with ease and agility, though it was admittedly tough work to fight against itch as well as the lucid summons of the razor. With the old target long past, a new bold target of \$2011 was set. It was also around this time that many a Mo Bro commented that they would get more "looks" as they strolled down the street;



*Movember campaign organizer Kevin Leung and Man of Movember Adam Gruszczynski*

simply awe-inspiring. Previously unkempt facial mops and stray whiskers miraculously metamorphosed as they were coiffed, trimmed, shaped, and sheared. In no time, the basement of Botterell was populated by more Tom Sellecks, Borats, and Burt Reynolds than you could shake a stick at. Joining the fray were trucker, and pornstar, and creep Mos (Oh My!). Indeed, it was time for the final trial: the glorious battle to the death for the "Man of Movember (Best Mo)" title and the other category titles to be waged. The battle was heated and intense and after all the dust

The real benefit is to the men and women who have been touched by prostate cancer. Every dollar raised is being used towards research on or awareness education about prostate cancer. Every penny of the donations that was raised by the Queen's Meds 2011 class went directly to the Prostate Cancer Research Foundation of Canada.

And what of that \$2011 second target you ask? Yours truly is very glad and especially humbled to announce that the final figure that the Queen's Meds 2011 class was able to

**"THE FINAL TOTAL RAISED WAS \$3009.00."** raise rocketed far beyond our original and second

the general consensus was, however, that they were likely not of the flattering kind. Interestingly enough, this was also the week of the Breast Exam practicum in clinical skills and while the thought of meeting the shocked standardized patients with fuzzy caterpillars under their noses rattled and racked the minds of our heroes, it provided only a taste of the trials that were soon to come. By the fourth week of growth, the Mo Bros had started to eye the coveted title of "Man of Movember"—the ensuing transformation was

settled with the casting of the final online ballot, many laughs were shared and many heads were held high. Among the notable winners were Brad Walker for The MoMo title (Most Money raised), Ephraim Tang for The Best "You call that a Mo?!" Mo title (The LaMo, aka The Encouragement Award) and, finally, Adam Gruszczynski for the Man of Movember title (Best Mo) just to name a few, though everyone who participated was truly and sincerely deserving of an award.

targets and is a testament to the event's smashing success. The final total raised was \$3009.00.

I would like to take this opportunity to thank everyone who was involved including Marc Elliot and Derek Tsang who were kind enough to set up the online voting, the 2010s, 2009s, and faculty who put up with my constant announcements, and finally a special thank you to all of the sponsors and Mo Bros who helped make this all happen. ■



# 2011s MEN OF MOVEMBER

KEVIN LEUNG



BRAD WALKER  
JONATHAN W. M. LAU  
PAUL HERTZ  
BRANDON GIRARDI  
CHRIS NOSS



CHRIS NEWCOMBE  
ALLEN GREENWALD  
JONATHAN C. LAU  
BRIAN SIU  
NATE CHARACH



ADAM GRUSZCZYNSKI  
CASS BENAY  
CHRIS LUSTY  
DAN FINNIGAN  
DAVID SKOGSTAD-STUBBS



ERIC DANTZIG  
KEN COLLINS  
PARAMBIR SINGH-KEILA  
ROHIT MOHINDRA  
ADIEL MAMUT



LOUIS FURTADO  
FEMI BAMMEKE  
MICHAEL SURKONT  
EPHRAIM TANG  
CHINMOY CHOWDHURY



INSPIRED BY:



*With the advent of a new year comes a new Aesculapian Society Council. To help us get to know the new council better, we issued a short survey to the newly elected members. Thanks again to all who participated!*

**Name: Hanni Darwish**  
**AS Position: President**

**What is the real reason you wanted to go to medical school?** For all of the free pizza lunches from the various banks. After the first 2 weeks of med school these free lunches seemed to disappear, but since I was already enrolled I decided to stick around and become a doctor.

**What is your favourite vice?** Wrestling lions, grizzly bears and starving raccoons all at once in a gladiator-esque arena located in rural Mexico. Either that or maybe those chocolate oranges that you smash on the table before opening. Those things are tasty!

**What Medgames event would you totally dominate should it exist?** Falling asleep on the train the fastest (I swear I have a rare type of mass transportation narcolepsy)

**Which member of the class/faculty would you most like to emulate?** The president of our class, of course. Eric Cole is a smart and funny man, he's irresistible to women and men alike, and he makes all of his MVN co-MC's look so sexy. Someday I'll be the president of something, just like Eric.

**Name: Brian J. Liu**  
**AS Position: Speaker**

**What is the real reason you wanted to go to medical school?** The same reason I told my interviewers - it looked like they were having so much sex on Grey's Anatomy.

**What is your favourite Kingston "establishment" and why?** Jimmy's Fry Truck across from Botterell. The man serves a killer poutine. The gravy is made with equal parts meat chunks and awesome.

**What Medgames event would you totally dominate should it exist?** Poutine eating (see question 2). Honestly, I've eaten this stuff for breakfast.

**Which member of the class/faculty would you most like to emulate?** Dr. MacSween. She's got moxy and sass. Also, Jack Bauer.

**Name: Karmen Krol**  
**AS Position: VP Academic**

**What is your favourite Kingston "establishment" and why?** The Toucan. Curried beef pie; Harp, Guinness, Bass, and Newkie Brown on tap; how can it be better? Living right above the joint doesn't hurt either.

**What is your favourite vice?** The Toucan. See above.

**What Medgames event would you totally dominate should it exist?** Pants removal. Theoretically.

**If you weren't pursuing medicine, what would you be doing?** Boreal forest conservation. Yes, you read that correctly.

**Name: Hannah Shoichet**  
**AS Position: VP Internal**

**What is the real reason you wanted to go to medical school?** To save puppies and kittens.

**If you could be anywhere in the world right now, where would you be?** South East Asia

**What Medgames event would you totally dominate should it exist?** Mario Kart showdown

**Which member of the class/faculty would you most like to emulate?** Dr. Jackie Duffin, because of her spirit and energy for her work.

**Name: Yelena Chorny**  
**AS Position: VP External**

**What is the real reason you wanted to go to**

**medical school?** To meet boys, of course.

**What is your favourite Kingston "establishment" and why?** The Merchant. Especially on a Friday night. Oh, and Ace's Top Card: cheap beer, local punk, & super sketch. Can't beat that.

**If you could be anywhere in the world right now, where would you be?** Copenhagen or Berlin. How about on a plane going from Copenhagen to Berlin. Yeah, that would be great.

**What is your favourite vice?** Do I have to pick just one??

**What Medgames event would you totally dominate should it exist?** The napping marathon. I can out-sleep anyone...except for maybe my roommate...

**If you weren't pursuing medicine, what would you be doing?** A lot more partying!

**Name: Christina Nowik**  
**AS Position: VP External Jr.**

**What is the real reason you wanted to go to medical school?** To look at kidneys all day long.

**What is your favourite Kingston "establishment" and why?** Sleepless Goat. I am addicted to breakfast burritos.

**What is your favourite vice?** Breakfast burritos

**If you weren't pursuing medicine, what would you be doing?** Pursuing my career in entertainment as the next Bill Nye the Science Guy (See "Nowik the Science Chick")

**Name: Sanjho "the Banjo" Srikandarajah**  
**AS Position: VP Finance**

**What is the real reason you wanted to go to medical school?** Money, Power and Girls (in that order, thank you Tony Montana)

**If you could be anywhere in the world right now, where would you be?** An island in the Caribbean with at least two of: Money, Power

and Girls.

**What Medgames event would you totally dominate should it exist?** Sleeping in.

**If you weren't pursuing medicine, what would you be doing?** Refer to: where would you be anywhere in the world.

**Name:** Laura Nguyen  
**AS Position:** Treasurer

**What is your favourite Kingston "establishment" and why?** While few things rival the line at Alehouse, the high-schoolers at Smijie's, and the bikini-clad beach-slammers at Stages, I'm going to go with Elixir on Wednesday nights.

**What is your favourite vice?** Definitely post-bar poutine from Pita Grill. Nothing like a couple thousand grams of fat before bed, all in a convenient handheld styrofoam container! They even do them up with onion rings and chicken if you ask.

**What Medgames event would you totally dominate should it exist?** The speed eating of copious amounts of eggs benedict event. There are few people who love a good hollandaise as much as I do.

**Name:** Dmitry Tsvetkov  
**AS Position:** TechRep/Webmaster

**What is your favourite Kingston "establishment" and why?** KGH cafeteria - rumour has it that every 10th burger comes with a free coronary bypass surgery

**If you could be anywhere in the world right now, where would you be?** Tokyo - it's like going into the future

**What is your favourite vice?** Eating KGH cafeteria burgers. I am only 4 burgers away from my free bypass!

**If you weren't pursuing medicine, what would you be doing?** Flying planes

**Name:** Adam Szulewski  
**AS Position:** Senator

**Name:** Raed Joundi  
**AS Position:** Information Officer

**What is your favourite Kingston "establishment" and why?** The Sleepless Goat! It's a great place to drink a hot beverage, relax, and read (non-medical stuff)!

**What is your favourite vice?** Eating gratuitous and rather unacceptable amounts of chocolate

**What Medgames event would you totally dominate should it exist?** Bear Blasting

**Which member of the class/faculty would you most like to emulate?** I think I would probably try to emulate bits from all over. If I had Karmen's anatomical knowledge, Kevin's resonating laugh, Dr. Duffin's passion, and of course Dr. Mackenzie's awe-inspiring facial hair, I would be a very happy man.

**Name:** Stephanie Brule  
**AS Position:** Student Initiatives Liaison

**What is the real reason you wanted to go to medical school?** To be able to write "M.D." on my Facebook profile

**If you could be anywhere in the world right now, where would you be?** Somewhere hot. Surrounded by the Ottawa Senators.

**What Medgames event would you totally dominate should it exist?** Dodgeball, and it does exist, and we did dominate!

**Name:** Baldeep "Beepy" Paul  
**AS Position:** Social Coordinator

**What is the real reason you wanted to go to medical school?** I still don't know.

**What is your favourite vice?** Poutine... mmmm.

**What Medgames event you would totally dominate should it exist?** Cookie eating contest. I AM the cookie monster.

**If you weren't pursuing medicine, what would you be doing?** Pan-handling.

**Name:** Alan Tam  
**AS Position:** AMS Representative

**If you could be anywhere in the world right now, where would you be?** Japan

**What is your favourite vice?** Laziness

**What Medgames event would you totally dominate should it exist?** Random TV trivia from the last decade

**If you weren't pursuing medicine, what would you be doing?** Law school in Toronto, learning to be a cut-throat corporate lawyer.

**Name:** Ed Cheung  
**AS Position:** AMS Representative

**If you could be anywhere in the world right now, where would you be?** Somewhere other than Stauffer. Preferably somewhere warmer than Kingston. Florida sounds about right...

**What is your favourite vice?** Facebook

**If you weren't pursuing medicine, what would you be doing?** Probably not studying for 2B exams...

**Name:** Adrienne Li  
**AS Position:** Women's Athletic Representative

**What is your favourite Kingston "establishment" and why?** Curry Original, for its delicious butter chicken and sag paneer!

**If you could be anywhere in the world right now, where would you be?**

With family/friends, somewhere near mountains and/or ocean, relatively warm and sunny

**What Medgames event would you totally dominate should it exist?** I wouldn't dominate at ping pong, but I think I could be a contender

**If you weren't pursuing medicine, what would you be doing?** Immigration law, probably... maybe photojournalism.

BY ADRIENNE LI AND MELISSA PICKLES

*A member of the Queen's Medicine, class of 1965, Dr. Allan Adler is a well-respected psychiatrist based in San Diego. As the founder and medical director of the Alvarado Parkway Institute from 1975-1995, Dr Adler has been extensively involved in many organizations and committees, speaking at national conferences and clinical presentations. Dr Adler has also published articles on a wide range of topics such as burnout and eating disorders and is the author of the book "Divorce Recovery" (Bantam Books).*

*At Queen's, Dr Adler served as the Student President of Morris Hall in 1962 and as the Aesculapian Society President in 1965. We had the pleasure of interviewing Dr. Adler about his time at Queen's and his professional career.*

**What was it like serving as the AS President and being a member of the AMS? How has that experience helped you in your career?**

It helped me see how organizations are run. In the AMS, we'd start meetings at 6 pm and end at midnight, so there wasn't much

studying those nights. I learned how to deal with hot issues from one of my colleagues on the AMS. She would let people state their divergent points of view for half an hour and then summarize both sides and finish the discussion by showing the validity of her view. This colleague usually got what she wanted because both sides felt heard.

**What was your favorite aspect of Queen's?**

At Queen's, I loved the fact that most of the students were away from their homes. I loved that we were able to intermingle with people, and basically live there. We'd have these long talks, about how to solve the world's problems, hours and hours long. On a personal level, my years at Queen's were some of the best years of my life.

**What drew you to psychiatry?**

I always enjoyed the humanities, like political sciences. I was always primarily into psychiatry and the way to get there was through medical school.

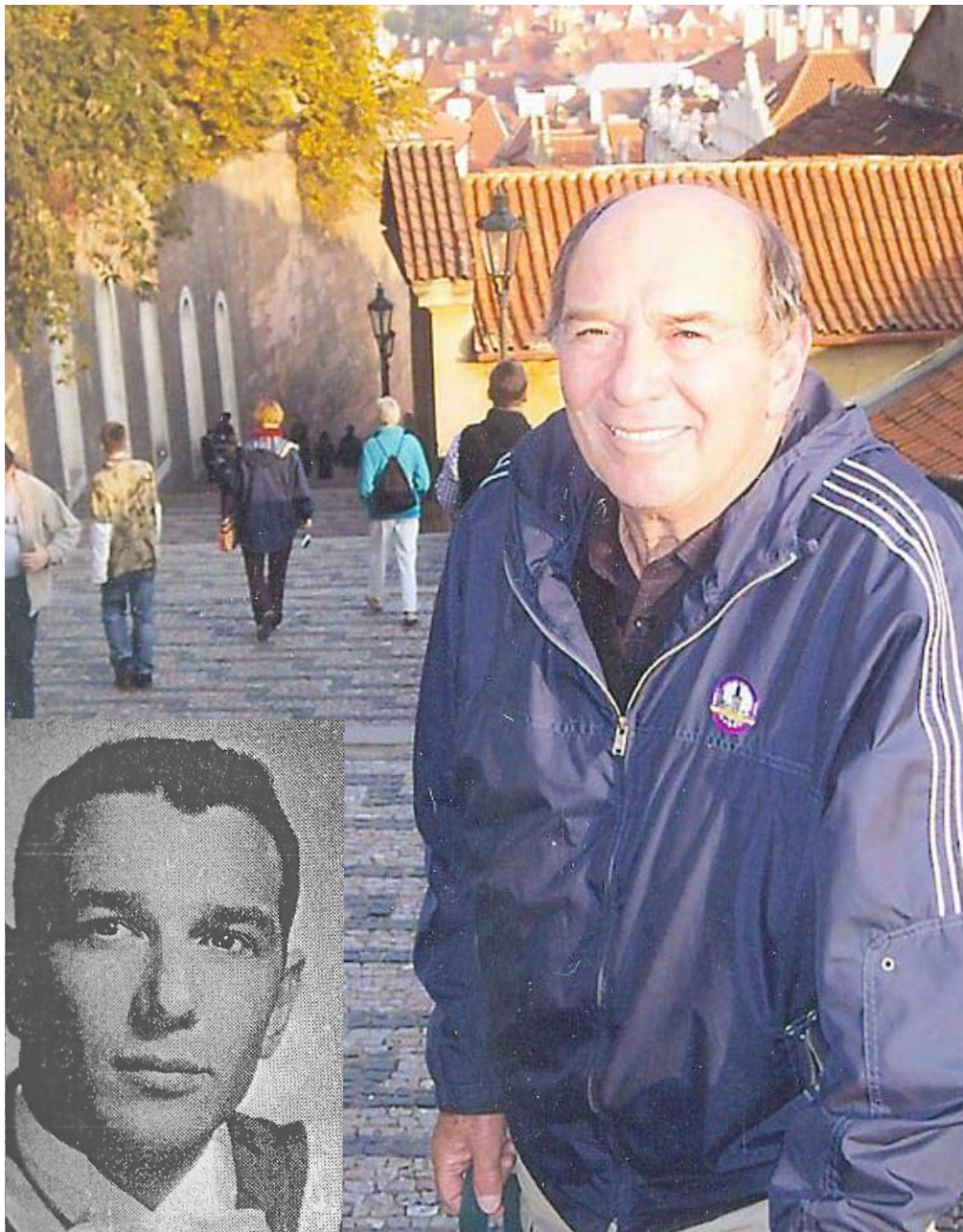
**Could you tell us more about your clinical work as a psychiatrist?**

For the first five years in clinical psychiatry, I worked in BC, where I basically combined work with hospitalized patients with outpatient psychiatry work, where we saw patients with all sorts of problems, from bipolar disorder to personality disorders. It was a nice combination.

Then I moved to San Diego, where I founded a psychiatry unit, which started off as an 11 bed unit which finally increased to a 100 bed hospital. Canadian hospitals are much larger than the American ones. In BC and in Montreal, chronic psychiatric hospitals would have a few thousand patients, but in San Diego, we ran a hundred bed hospital. The large hospitals house chronically mentally ill patients, whereas the small ones take care of acute episodes.

**What type of lifestyle did you lead as a psychiatrist?**

One of the advantages of being a psychiatrist is that you can have a reasonably normal life, combining a good family life with a good work life. With other specialties like those with acute patients and emergencies, it's really hard to combine a family life. Being



Dr. Allan Adler. Inset: Dr. Adler's graduation photo, 1965.

# DOLLER (MEDS '65)

with your family and children was much more important to me. Those are choices we have to make. I was able to keep my life balanced by making conscious decisions about my hours. For example, you stop at 4:30 pm when your kids have something at 4:30 pm, which costs you money, but hopefully someday your kids remember that you showed up at their Little League games. There are emergencies in psychiatry, but there is staff in hospitals that can help you with this. It also depends on your personality.

**You've done quite a bit of work related to addiction, from reviewing articles for practice guidelines for substance related disorders to working with the Mayor of San Diego in public health. In your opinion, how has the public perspective on addiction changed, if at all?**

I think it has changed. When I finished my training at Queen's, I knew very little about addiction, but that wasn't Queen's fault. I trained in psychiatry at McGill in the 60's, and we learned very little on addiction and alcoholism. In our hospital at San Diego, we had many units including an addiction unit, and I totally fell in love with the treatment of chemical dependencies. It's different from diseases like schizophrenia, where we can treat you with a not so perfect drug, but you'll still have the disease for the rest of your life and a lot of times our expectations are borderline functioning. What I loved about treating people with addictions was that if I took an alcoholic of 15 years, admitted him for a couple of weeks as an in-patient, he commits to AA, and then he can go back to being a normal human being. They're "cured," and there's very little outright curing in psychiatry.

**Some experts are proposing that not all alcoholics need to adhere to complete abstinence. Do you have any thoughts on this?**

Let's say you have 100 recovering alcoholics – if they all take a drink, 95 will relapse, but how do you figure out which 5% won't relapse? I don't think of alcoholism as addictive psychology, but rather as addictive physiology – they have different neurotransmitters. Let's say we have two people working at a plant: one is a recovering alcoholic and the other is not. Both are laid off, and they deal with

this by going to the bar to drink. The non-alcoholic wakes up with a hangover, and continues with his life while the recovering alcoholic will wake up and continue drinking pathologically until there is an intervention. That's the difference: same stresses, but different reactions.

**How has Alcoholics Anonymous affected the prevalence of substance abuse?**

The acceptance and treatment has been effective. You don't have to hide the fact that someone in your family is an alcoholic. If they've been treated properly, they won't be scared or feel guilty to refuse a drink at a party. There's so much positivity and reinforcement that it's acceptable to be a recovering addict without a sense of shame.

**What changes have you seen in the practice of medicine? What would be the most positive and the least positive?**

I can only speak from the perspective of the States, being here since 1975. Probably the least positive in the States is that medicine is run by insurance companies who decide how often and how much you can see the

as colonoscopies, which are wonderful things. If you think of acute surgery, operations that used to hospitalize you for a couple of weeks are now outpatient procedures. These have revolutionized medicine.

**Having written a book about divorce, do you have any advice for medical students in relationships?**

Most people feel that physicians get divorced because their practice is so onerous and they don't have enough time for their family. However, the genesis of most divorces originates in someone's ambivalence regarding their marriage partner on your wedding day. One party is unsure that they are marrying the right person and that doesn't get verbalized.

**If you were to do it all over again, is there anything you would have done differently?**

No, I've had a very happy professional career, and it's fulfilled who I was. I love psychiatry. I retired when I was sixty and now I play golf. I still work a little bit, doing some drug research, and I chair the Impaired Physician Committee at our general hospital. I went through a divorce and that was a very unhappy part of my life, but I've been blessed with a

**“WE'D HAVE TALKS ABOUT HOW TO SOLVE THE WORLD'S PROBLEMS... MY YEARS AT QUEEN'S WERE SOME OF THE BEST OF MY LIFE.”**

patient. It's not as clinically driven as it should be. Advanced technology has also replaced good listening and a good review of systems. I find Canadian doctors are much better trained in terms of looking at clinical signs, listening to the patients, and doing proper physicals. In Canada though, there's no private insurance companies, but it is controlled by the government and it also isn't as clinically driven as it should be. It's more financially driven in both countries. However, in fairness, I feel that the physician would probably spend too much money if it was totally clinically driven.

In terms of positive changes, we might complain about the technology, but it really helps the diagnosis and the procedures such

second wife who has been very terrific.

**If you could offer one piece of advice to current Queen's medical students, what would it be?**

Have a balanced life and have balanced goals. I truly mean that. Some people rationalize that their work is their love and their play, and in my judgment, if you are a physician who wants to fall in love with medicine, that's who you are and you can spend 80-90 hours at work. You should also make the decision about whether you want to have a family. To be an absent parent is a dereliction of duty. It's been a good thing that our expectations have changed, making it okay for physicians to take more time off. ■

BY ALEX YEUNG

**How do I know what I'm interested in?**

Maybe you already do. Maybe you don't. Maybe you're iffy. Observerships are a good way of exposing yourself to a discipline's routine work, and are valuable sources of information and connections. Ask the staff and residents/students questions; they'll usually be very helpful, and may even let you do more than just stand there, if you show genuine interest. Read up on potential supervisors and their research to see what may make you tick.

**How do I pick a supervisor?**

Start early. Ask around...professors, friends, family. Be persistent. Most physicians in academic centres will readily welcome smart medical students like yourselves, volunteering your time to work for free\* for them! Although they may be slow to reply to e-mails, if you reasonably contact them via e-mail, phone, and/or in person (latter is best - just set up a meeting), your hard work will pay off. Many of them have projects that will readily accept students...especially medical students - they just need to be asked. Departmental secretaries can also be helpful in that they know of staff involved in research that requires extra help.

**\*Do I have to work for free?**

Stating that you want to conduct research with Dr. X because you are really interested in Dr. X's field (along with hopefully some other engaging reasons), will generate interest amongst potential supervisors. But, although you may think that you have to work without pay, Dr. X usually is aware that you would like some money for your efforts. Dr. X may not go out of her/his way to find funding for you, but there are certainly lots of funds available, if you dig deep enough. JD Hatcher Award (from Queen's), hospital-specific funding (e.g. Hospital X Summer Student Research Scholarships), general funding (e.g. cancer fellowship), discipline-specific funding (e.g. "Organ X" cancer fellowship) are available. Just keep your eyes open for postings, apply early (many of these apps can be time consuming) and ask around!

Sources: Queen's sends out an e-mail to you with a list of funding sources and research

opportunities. Some include:

- [fundingopps.cos.com/](http://fundingopps.cos.com/)
- [www.library.utoronto.ca/ims/programs/summer.htm](http://www.library.utoronto.ca/ims/programs/summer.htm)
- [www.fmd.uwo.ca/research/newwebsite04/medstudents\\_nonSRTP.html](http://www.fmd.uwo.ca/research/newwebsite04/medstudents_nonSRTP.html)
- [www.bloodservices.ca/CentreApps/Internet/UW\\_V502\\_MainEngine.nsf/page/E\\_SIP?OpenDocument](http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/E_SIP?OpenDocument)
- [www.rsna.org/Foundation/ResearchMedicalStudentGrant.cfm](http://www.rsna.org/Foundation/ResearchMedicalStudentGrant.cfm)

**Are the Critical Enquiry deadlines firm?**

Sure, rumours in the past and clear-cut hard evidence have indicated that as long as you submit your final report by graduation, you can graduate. Having said that, if you can complete your Critical Enquiry early, it's just one less thing hanging over your head. If you can't make the deadlines, e-mail the Phase IID director, who is usually pretty flexible. You can start, and even finish your critical enquiry during the school year if you buckle down and organize it that way, which will free up your summer! You may even be able to submit work that you did in the summer of first year, if you talk to the Phase IID director.

**What should my Critical Enquiry involve?**

This varies. Some people analyze questionnaires that were handed out during international medical exchanges. Many do chart reviews. There are others that organize clinical trials, some that involve literature reviews and then others that involve basic wet and/or dry lab experiments. Just double-check whatever you end up choosing with the Phase IID director. As long as you can provide evidence that your work "furthers our understanding" (often subjective) of some medical-related topic, it should pass.

**Will my Critical Enquiry determine my Residency fate?**

Unlikely. Although having conducted research in the area of medicine that your residency applications are targeted towards is a great benefit, your Critical Enquiry experience (from what I've heard) can also provide other indirect benefits that can enhance your residency application - it just depends on how you word it. Example: By conducting research in Area A, I learned a lot about the pros and

cons of A, and met lots of great people. This included meeting some residents in Area B, who exposed me to the close interactions between A and B. I did some observerships in B, and found that I really enjoyed B.

**Other points:**

Your Critical Enquiry will usually never work as planned, no matter how hard you prepare. You will run into obstacles. Sure, all you may have to do in your study is to get some patients to do a Romberg test...but did you get ethics approval? Do you have to compensate the patients? Do you need to involve nurses? Do you have workspace? Identification? Approved consent forms? Will the patient's doctors be available to supervise? Do you need access to patient records? Do you need training to access electronic patient records?

Prep early, and prep thoroughly. Even if all things screw up, other opportunities may present themselves: you may be able to report on negative findings, publish some interesting case reports, discuss your results on protocol feasibility studies, get involved with other research projects, get some other students to continue your work and so on.

Get Ethics approval EARLY! You don't want to be bumming around at work waiting for approvals for the first few weeks, then working 24 hour shifts for the remainder of your enquiry. Getting ethics approval through Queen's is generally faster than obtaining it at other locations. It may be possible for you to do this even if your project is occurring outside of Kingston, as long as it doesn't involve hospital patients. Check with the Queen's ethics approval board to confirm this, though.

Don't just do research. Set up observerships. Set up clerkship elective opportunities. Meet people. Attend special talks. Talk to staff, residents, and other medical students. TAKE ADVANTAGE of free (may even be daily) lunches and events sponsored by companies!!!

*This article has been peer-reviewed.* ■

# HEALTH & HUMAN RIGHTS CONFERENCE 2007

BY NICOLE KOZLOFF

**T**HIS YEAR, I had the honour of acting as the Speakers Coordinator for the Queen's Health & Human Rights Conference, held between October 26-28, 2007. Both multi-disciplinary and multi-faceted, the conference featured lectures and workshops by experts on health and human rights from various fields. Other highlights included a film screening, wine and cheese reception, photo contest, poster presentations, and an NGO fair. The conference brought together students and professionals from a variety of disciplines to learn about, discuss, and respond to issues related to health and human rights under the theme "Think Globally, Act Locally". Topics discussed included prison health, HIV treatment, female genital mutilation, organ harvesting in China, and the crisis in Darfur.

I had been involved in the planning of last year's conference, where I attended a lecture by Major Brent Beardsley. Major Beardsley has served for twenty-nine years as an Infantry Officer in the Royal Canadian Regiment of the Canadian Army. His presentation focused on his time as General Roméo Dallaire's personal staff officer and Operations Manager in the United Nations Assistance Mission for Rwanda (UNAMIR) before and during the Rwandan genocide. Having witnessed one of the greatest violations of human rights in the last century, Beardsley poignantly communicated the sense of frustration and tragedy that have become synonymous with the Rwandan genocide. By using human examples in addition to the sobering statistics, Beardsley established a personal connection between attendees and the victims of these tragedies. No Hollywood film or magazine article that I have encountered since the genocide has accomplished this so effectively. Beardsley analyzed the "formula" by which the genocide had been executed, and compared it to the (sadly still) current situation in Darfur, where



*Left to right: Dr. Torston Trey, speaker; Tiffany Van Slyke, Co-chair; Nicole Kozloff, Speakers Coordinator; Nicole Labrie, Co-chair; Hon. David Kilgour, speaker. Photo by Eddie Moss.*

government-backed militias have slaughtered and displaced millions over the past four years. Again, for the first time, I was truly incensed by the situation, and motivated to act.

Many of my peers were similarly inspired. In Major Beardsley's workshop that followed

started planning this year's Health & Human Rights Conference, I committed myself to making Darfur a priority on the agenda.

To get thoughtful minds reflecting, sharing ideas, and making plans for action are the best outcomes of a student conference like

**"BEARDSLEY POIGNANTLY COMMUNICATED THE SENSE OF FRUSTRATION AND TRAGEDY THAT HAVE BECOME SYNONYMOUS WITH THE RWANDAN GENOCIDE."**

the lecture, he offered practical ways to make a difference in the situation. With his suggestions, we channelled our frustration and rage into planned initiatives to raise awareness about the situation and lobby the Canadian government to take a more active role in the movement to end the genocide. We teamed up with Students Take Action Now: Darfur, the national student group created to respond to the genocide, and held an information session which culminated in forty of our fellow medical students participating in a letter writing campaign to the Prime Minister. We talked to experts on the situation who put us in touch with more experts on the situation. Finally, when I

the HHRC. Whereas other pleas for my compassion and efforts had largely failed, hearing an expert who had witnessed an enormous tragedy of human rights speak roused me to action. I can only hope that the important topics addressed at the 2007 conference similarly touched and inspired this year's attendees.

*To get involved in the planning of next year's Health & Human Rights Conference, please contact [queenshhrc@gmail.com](mailto:queenshhrc@gmail.com). For more information on the situation in Darfur, please see [www.standcanada.org](http://www.standcanada.org). ■*

# THE VALUE OF OVERSEAS MEDICAL ELECTIVES

BY HANNI DARWISH

**D**URING MY FIRST year of medical school, I heard many interesting stories about traveling around the world and participating in medical experiences through a myriad of programs. Upper year students generally presented these programs positively, and, although many of the stories were often followed by the statement “I didn’t get to do as much medicine as I did sightseeing or connecting with people from different cultures,” my interest was peaked. I thought that I could turn this type of trip into a more positive experience if I didn’t build up my expectations in a medical sense, but rather enjoyed the trip for what it was: a way to see a different part of the world and learn about another culture, people, and healthcare system while providing a bit of assistance to those in need.

In choosing a trip, one organization stood out in my mind. This was the Himalayan Health Exchange (HHE, [www.himalayanhealth.com](http://www.himalayanhealth.com)) which offers several medical expeditions throughout the year. All of the trips take place in northern India and last about 3-4 weeks. The first week and last few days were spent getting acclimatized, learning some medical basics, and sightseeing at Buddhist temples, monasteries and other places, whereas the middle of the visit was spent practicing medicine. With the help of several residents and doctors, my fellow first year medical students and I got to take histories and do physical exams on patients in every village we visited. It was our responsibility to write up our findings, try to come up with a diagnosis, and write a prescription for the patient.

The experience was fantastic in the sense that I got to practice my clinical skills and learn about the typical causes of illness in another country. However, my impact on the health of the local populace was limited because I was only in that region for 1 day out of the entire year, and the prescriptions I gave were often limited to 2 weeks. As a result, it was difficult to make a difference in long-term illnesses such as diabetes, hypertension, or CHF. However, this is the nature and limitations of these programs. All in all, I found the experience to be a wonderful way to explore the culture and medical system of another country.

There has been substantial criticism of medically-oriented programs over the years. Some critics may tell you that if you want to promote international health, these “medical vacations” are not the way to do it. They believe that a much more effective way to enter this profession is to build up contacts and experience with global health organizations such as the Canadian International Development Agency (CIDA) or War Child Canada.

I agree with this opinion in the sense that these trips do not prepare you well for a career in international medicine. However, the majority of medical students do not plan to base their professional careers around global health. Students like these can benefit from medical trips such as HHE by having the opportunity to travel abroad while getting a better perspective on global health issues. So, if you are planning on going on a medical expedition this summer, make sure you have realistic expectations and that the trip offers the benefits and experiences that are in line with the goals you hope to achieve.





# THE DARFUR CONFLICT



BY RAED JOUNDI

**I**N ANY PRESENT day conversation of human rights and social justice, the word Darfur almost always emerges. However, for the most part, it seems we have become immune to the crisis in that part of the world. The images and discussion have become so familiar that we often cease to think of the situation as a relevant and urgent issue. But the problem in Sudan is more pressing than it has ever been.

Today's situation in Darfur is characterized by exceedingly high levels of violence, with severe and persistent violations of fundamental human rights. By some estimates, upwards of 400,000 people have been killed, with 500 more deaths every day (1). Two million individuals have been internally displaced, with at least 300,000 forced to leave the country as refugees (2). However, reports of some numbers actually span a wide range. In the case of death toll, the Sudanese government maintains that only 70,000 have been killed, whereas the official UN position is at over 400,000, with other sources reporting more or less). Some argue that there is insufficient

Justice and Equality Movement, attacked government installations in Darfur, citing a history of injustice, discrimination, and marginalization of their people by the government. The government of Sudan responded with a horrific counterinsurgency campaign, allowing a militia group known as the Janjaweed to engage in the destruction of villages, the mass killing of civilians, widespread looting, abductions, and rape. This has continued, with extensive government backing and logistical support, although this is publicly denied by the government (4). In the past few years, various negotiations were set in motion to initiate peace between the government and rebels. These attempts failed, exacerbating the situation, and allowing the widespread injustice and human rights violations to degenerate into what is now often without hesitation referred to as a genocide.

Arguably one of the more horrific strategies used has been sexual violence, which has often been used to characterized the horror in Darfur (5). Rape has been used to terrorize

**“TWO MILLION INDIVIDUALS HAVE BEEN INTERNALLY DISPLACED, WITH AT LEAST 300,000 FORCED TO LEAVE THE COUNTRY AS REFUGEES.”**

data to ever achieve a proper estimate, due to the application of site-specific surveys to the broader population, which does not account for the intensity, escalation, and variability of the conflict in different areas of the country, as well as any changes in these factors over time (3). However, while there is debate over some of the figures, it is undeniable that the numbers of deaths and displacements are well beyond what we should accept.

Darfur is an area to the west of Sudan about the size of France. The current crisis began in 2003, when two armed opposition groups, the Sudan Liberation Army and the

populations and break their will. Women who suffer from rape are often shunned by their own family, shamed for life, and are at increased risk for contracting HIV. Many women are too shamed to complain, which is why rape and its consequences did not initially get the attention it deserved, yet remains a routine atrocity that has had massive consequences for the individual and society.

Currently, approximately a dozen rebel factions are engaging in continuous fighting with the Sudanese government forces and sometimes between each other

(6). Civilian death and village eradication continue, creating an extremely chaotic and insecure environment. This has placed severe restrictions on humanitarian access, causing even more suffering in the form of famine and sickness, and lack of medication and sanitation, especially among internally displaced persons (IDPs) and refugees. As a result, Darfur presents one of the worst humanitarian disasters in the world. Even if the conflict were to be resolved tomorrow, it could take years to repair the damage to the economy, infrastructure, and people.

Canadian forces and dollars are playing an important role in Darfur. Since 2004, Canada has contributed \$286 million to support the African Union and resolve the conflict through peace building projects, diplomatic measures, and humanitarian assistance (7). However, many criticize Canada's limited role by saying that this merely treats the consequences as opposed to addressing the roots of the current conflict. Currently only about 7,000 African Union troops are deployed in Darfur, a number deemed by many as completely insufficient for the scale of the issue. More effort is required to upgrade the international presence in the area to provide protection to civilians and allow international relief efforts to fulfill their role in distributing aid (8).

On an individual basis, the most obvious and perhaps most effective response to genocide is to ask our governments and international bodies to apply pressure to end the crimes against humanity and take a more active role in negotiations and potential peace settlements. Refusing to act due to the complexity and horrifying nature of the situation will fail to resolve this humanitarian catastrophe.

Obviously, this issue is multifaceted, as there are many intertwined layers to the conflict that must be considered. However, learning about this issue and others on an individual basis is the first key step for progress. As future physicians and respected professionals in society, becoming aware of the severe human rights violations taking place around the world should be an important part of our self-education. We should advocate not only for health, but for human rights, as they are often mutually connected. In the past, many

genocides have not been given due weight, such as in Rwanda, Armenia, or Bosnia. Offering an apology or pleading ignorance afterwards will not suffice. This time we see the overwhelming evidence of a tragic genocide in Darfur unfolding in slow motion. We should not hesitate to take the opportunity and fulfill our obligations as members of society to act accordingly in protesting the gross injustices being committed in Darfur.

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*For more information about Darfur, here are some places to start:*

<http://www.eyesondarfur.org/index.html>  
<http://www.standcanada.org/>  
<http://news.bbc.co.uk/2/hi/africa/3496731.stm>

*Advocacy Section  
 Global Health Working Group  
 Queen's University School of Medicine ■*

# THE COST OF CHARITY

BY DEREK TSANG



IN MAY 2007, I had the privilege of joining a Habitat for Humanity Global Village team in Debre Berhan, Ethiopia. The Global Village program sends small groups of volunteers to communities in underdeveloped nations in need of decent, affordable housing. We spent two weeks in Debre Berhan and in that time, we worked on 23 houses and dedicated two dwellings. As a participant on the team, I saw first-hand the poverty in the community, the pressing needs of local villagers and the lack of modern infrastructure.

When friends and family heard that I was going on this trip, one of their first questions was whether expenses were paid as a volunteer. They all balked at the cost, but I now understand that it is simply impossible for any organization to provide an all-expenses-paid trip. But other questions were raised which were more difficult to answer, such as why not simply send money? The cost of the trip was \$1,500, of which only \$450 was a donation to the local Habitat affiliate. The remainder went towards our transportation, our accommodation, and our food. Wouldn't we be doing more if our project fee were instead used to build houses? A Habitat house costs \$2,000 from groundbreaking to dedication. How can we justify spending so much money on ourselves, when our two-week trip could have helped build a home for a family?



However, the trip was not a vacation. We helped construct homes, which involved digging trenches with rudimentary hand tools, laying giant rocks in the foundation, plastering walls with chika (mud) and painting interior walls. Yet for all of the sweat and blood that went into the twenty-three homes that we worked on, the entire team of ten volunteers saved the local Habitat affiliate about 120 birr per day, which works out to about \$13. Certainly, we would be deceiving ourselves if we could justify our \$1,500 extravagance with our manual labour.

We did, however, contribute to the local

economy, by spending money at local businesses when we were not working. Without foreigners visiting Ethiopia, the tourism industry that employs workers and generates incalculable spin-offs would collapse. Indeed, of the \$1,050 that was spent on us, all of it went towards the Ethiopian economy.

Yet, the cost of my trip exceeded \$1,500 because of the flight; I spent \$1,800 on transportation to Addis Ababa. That money was paid to airlines, not the Ethiopian economy. Would it have been better to send \$1,500 + \$1,800, an amount equivalent to more than one-and-a-half houses, directly to Habitat for Humanity, or to have partaken in the trip?

I struggled with this question, but I realized that the need for humanitarian aid in Ethiopia and beyond is overwhelming. Not only is there a dire need for decent shelter, but also for other basics such as water treatment and road infrastructure. In places like Darfur, the need for essentials like food and personal security are barely being met. No amount of money that I contribute will rectify this. Not

even a charity, with all of its donations and resources, can solve such immense problems. Boundaries must be drawn. If the cost of the trip was instead donated to Habitat, then what else should I donate? The need is almost infinite, but I have finite resources.

Instead, I believe that the Western strategy of giving handouts needs to be questioned. Economic prosperity in the developing nations cannot come in the form of blind foreign aid from individuals or governments. Habitat homes are not given to homeowners; they are merely subsidized. Locals must apply for a Habitat home through a competitive process, even though the homes come with a substantial mortgage. Prospective homeowners are assessed on the basis of need and ability to pay. It is through such a program, where locals are employed and are able to earn their home, that the community is strengthened and the homeowner is empowered. Habitat merely provides the helping hands that build a sustainable, dignified community.

So far, I have ignored one of the biggest strengths of the Global Village program,

which was the interaction it brought between us and those we were helping. I sensed their initial curiosity about the foreigners, their excitement and hospitality towards us, and their genuine and sincere gratitude for our help, even though we only provided labour worth 120 birr per day. There was no need for words – I could see the kindness and warmth radiate from their smiles. We loved the homeowners and their families, and they loved us right back. I could have sent a faceless cheque in the post, which would have built one-and-a-half homes, but it is my belief that our brief visit to the sun-charred land of Debre Berhan spoke a thousand more words than a cheque ever could. We gave homeowners and families a glimpse of the world beyond Debre Berhan. From a simple soccer game to working hand-in-hand erecting mud walls, we were the reason why the Global Village program is indeed global. We have broken the walls of political borders and shown the people of Debre Berhan what the rest of the world is about. We have shown that we care. For this reason, my trip to Debre Berhan was worth every penny, and I would do it all over again. ■



# WILL WE SUSTAIN OUR HEALTHCARE SYSTEM?

BY JONG WOAN KIM

Is our Canadian healthcare system sustainable? This seemingly simple question has been a hot topic of discussion in both public and academic societies, with many researchers arguing that it is not while others believe that it is (1, 2, 3, 4). In my opinion, there are two components in answering the question: first, whether we are going to spend more money; and second, whether we can afford to spend more money.

With regards to the first question, the answer is yes, we are going to spend more money. However, this is not driven by something out of our control. The often-cited source of the hyped 'incoming, inevitable healthcare expenditure crisis' is the aging of population and demographic transformation, where less people will work and pay taxes while more people will be dependent on public welfare (5). For example, the percentage of the Canadian population over 65 years old, who use significantly more healthcare services, will increase from 13% now to 21% in 2025 (6). Moreover, keep in mind that this group requires 4.7 times more healthcare spending per capita than an average person in the population and already 40% of our healthcare expenditure is spent on them (7). Is this a sign of doom?

Not necessarily. Demography per se is not a major factor in the increase in healthcare cost. We might spend more money as we age, but this is due to proximity to death, not aging per se. We spend more than 80% of our lifetime's health expenditure in the last years of our lives (8, 9). This is the end-of-life-cost theory – the aging of population causes an increase in healthcare expenditure because as more people become older and are in the last years of their lives, they require more healthcare services. If this is true or has significant explanatory power, the aging of the population only changes the distribution of healthcare spending over time since everyone eventually dies. Ultimately, the aging of the population alone does not cause an overall increase in healthcare spending over time (10). In fact, this has been the case in Canada

in the last decade, even as our population continues to age (11).

In fact, the increase in healthcare spending in Canada can be attributed to technological changes. More technologies have become available for more diseases (including newly created ones) without serious concerns for cost. The majority of these technical changes occur in pharmaceutical companies, which spend the biggest portion of their expenditure on marketing – on the "new" diseases for which they found a cure (12, 13, 14). That explains the trend demonstrated in the 2004 report by the Canadian Institute for Health Information (CIHI) on healthcare spending in Canada. The report showed that the major impetus of the recent healthcare expenditure increase in Canada came from pharmaceutical expenditure, while public spending on physicians and hospitals remained largely fixed. The American healthcare system demonstrated a similar finding in technological changes and their impact on healthcare cost (15). As the advent of costly and new technologies shows no lag in its momentum, it seems very likely that we will be investing more money in our healthcare system (7, 11).

Indeed, many researchers question the value of our current technological innovations, taking into account benefits accrued for the high costs (11, 15). Putting the right pressure on technological development can alleviate the increase in healthcare expenditure, such



Andrew Mok

that there should be more emphasis on cost-saving technologies on top of our current emphasis on life-saving or life-improving technologies. After all, it is not our aging population or any other uncontrollable factors that have driven our healthcare spending to increase exponentially, but rather, our near-blinded focus on such technologies that is contributing to our own healthcare crisis.

Then, will we be able to pay for this crisis? Calculating future healthcare expenditure is complex. Even if we forego an elaborate formulation of future costs, we can do a far simpler calculation demonstrating that we can afford significant increases in healthcare spending while preserving our current lifestyle. This is due to economic growth – we will spend a greater proportion of our GDP on healthcare, but as the pie gets bigger, the slices also get bigger, in that there is now more money left for us to spend. Let's elaborate on Dhalla's calculation, which was included in the recent special edition of CMAJ concerning the sustainability of Canadian healthcare, with a focus on how economic growth allows us to pay more for healthcare (2). Imagine that we make \$100 per year and are spending 10% of our total income (\$10) on healthcare, and the rest (\$90) for other goods and services. The natural growth rate of the Canadian economy is about 1.3% year, accounting for inflation, so our economy will grow approximately two times larger over the next 50 years. Let's assume our healthcare spending goes through the roof and we spend four times more of our income on healthcare over the same period of time. Then, after 50 years, our income will be \$200, and we will spend 40% of our income on healthcare, which will be \$80. However, we will be left of \$120 to spend on other things, which is still more than what we had left to begin (\$90). Thus, we can spend more money on healthcare, and still have better quality of life, assuming that our spending on other goods and services and our minimal necessities are fixed.

However, just because our economy can accommodate the increase in healthcare expenditure does not mean that our budget

can afford it. Some public policy makers fretted that in Ontario, public healthcare expenditure has increased from 32% to 39% of the total government budget (excluding interest payments) between 1998 and 2003 (3). In Quebec, the healthcare expenditure has risen an average of 5.6% per year between 1997 to 2005, which is well above 4.4%, the average annual increase in government revenue during the same period of time (1). It has been argued that as of 2003, we are facing “future funding obligations for healthcare that exceeded expected future revenues by \$555 billion” (4). So, if we are not facing an economic sustainability crisis, are we facing a fiscal one (16)?

The simple answer is no, but with some reservations. If we increase taxes, we can preserve or even expand the public coverage of healthcare. In 2006, about 47% of the Canadian GDP was collected as tax revenue (17). Any more increases in tax will not only have a political impact, but also have an impact on the long-term prospects of our economy. This problem is complicated. If we trade future economic growth for the current healthcare expenditure, then we limit the scope on how much we can spend on healthcare (among all other things) in the future. However, it does not necessarily follow that if we increase taxes, then we will immediately experience a horrific recession and our economy will shrink every year for an extended period of time. Rather, it is more likely that increases in tax will result in slower, but still positive, economic growth. This is the balance we have to find – just as we considered the trade-off between consumption on healthcare and on other goods and services, we now have to consider the trade-off between healthcare and economic growth.

Then, what kind of trade-off are we going to make? Many forms of taxation are termed distortionary because they change people’s behaviour (18). Despite the negative nuances attached to the term, not all the distortionary taxes are bad. An example of good distortion is the tobacco tax, where the tax is used to increase the price of tobacco in order to decrease the consumption of the unhealthy product. However, if income tax is increased, it provides a disincentive for us to work more and produce greater output (18, 19). This might hinder the economic growth in future,

but the effect can be mitigated by several other factors, including increased productivity and investment. More importantly, if taxes laid on the factors of production, such as physical and human resources and technology, are increased, the return on capital and investment will decrease (19). We need to maintain a certain level of investment merely to keep our economy from moving backwards, as machines rust and people’s knowledge become outdated with time. Thus, the decrease in the investment will cause a decrease in long-term economic growth (18, 19, 20). Exactly how much it will decrease the economic growth is hard to say, given the large gap between theoretical models and empirical data and also between different countries (18, 19). As an illustration, one theoretical model estimates that if we increase all the taxes by 10%, our annual economic growth will drop by 1.5% in long term (21).

Having dealt with the sub-components of the sustainability, it is clear that it is not impossible to sustain our healthcare system. The sustainability crisis is not driven by the factors out of our control, but by the factors under our control. However, with so many trade-offs necessary, if there is a single factor that can make our healthcare system unsustainable, it will be the limitations we might place on how much we will spend on the healthcare. After all, the key issue in sustaining our healthcare system is not “can we”, but “are we willing”. Ultimately, the sustainability of our healthcare system is not actually an issue of sustainability of the system per se, but rather the sustainability of our values. As long as we prioritize our current philosophy of healthcare, we can and will have it. But will we? That is a question that economists and policy makers have not yet been able to answer, and indeed, the answer should and can only come from us, as members of Canadian society and future consumers and providers of healthcare.

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# ADAM

QMR

BY JON LEE



# BIRD WATCHING: EMERGENT DISEASES AND SENTINEL WATCHING

BY DANIEL FINNIGAN

**B**EFORE 2002, FEW people gave much regard to corona viruses. The term SARS, for sudden-acute respiratory syndrome, did not even exist. Then, for a short period of time, it dominated the media. The disease, emergent from the Guangdong province of China, furtively spread in the countryside for the first couple of months. It slipped silently into surrounding countries via tourism and business travel, with its non-alarming array of symptoms reminiscent of a cold or flu. Alarm bells began to ring when a business man, Johnny Chen, traveling from China to Singapore developed pneumonia-like symptoms, to which he succumbed in a Vietnamese hospital soon after. This was when SARS showed its proclivity for infecting healthcare workers: numerous staff at the hospital developed similar symptoms. An Italian doctor, Carlo Urbani, who later died of SARS, alerted the World Health Organization (WHO), which issued a global alert on March 12, 2003, five months after initial cases had been seen in China. SARS came close to home for Canadians with 241 cases and 43 deaths (1); it created an environment of fear for an invisible, indiscriminant disease. It also exposed weaknesses in our preparedness as a country to protect against large-scale pandemic threats from emergent diseases (2).

Epidemics are not new to human civilization; rather, they are a part of it. From ancient times populations of cities, countries, and entire continents have been subject to mass death from outbreak of disease. Plague, cholera, malaria, yellow fever, typhus, syphilis, smallpox, and influenza, just to name a few of the more infamous diseases, have shown a sinister capacity to spread through large civilized populations, unceremoniously dispatching huge numbers of individuals. The infamous 1347 plague of Europe killed an estimate of one-quarter to one-third of the world's population (3). It collapsed the infrastructure of society and had impacts on

social development that persist to this day. Particularly, it killed off mostly the working class and placed an increased demand on the survivors by the ruling class that had fled to the country during the plague. This was fertile ground for peasant empowerment and revolution, such as the English Peasant's Revolt led by Wat Tyler in 1381. The Spanish Flu after World War I killed more people than the war itself (4). In bitter irony, the Spanish flu was more likely to be fatal to young and healthy individuals. What is perhaps most disappointing is humanity's willingness to use disease as a weapon of war, such as the intentional infection of civilizations of the New World with smallpox (5). Recently, Ebola drew media attention, though it did not have as large an outbreak potential as first feared. However, the emergence of multiple-antibiotic resistant strains of bacteria such as methicillin-resistant *Staphylococcus aureus* (MRSA) is not something to be ignored. Neither is the development of biological weapons; followed by inoculation at multiple key airports in the international community. With business and tourism, the dissemination potential of a virulent disease is unprecedented. It would be foolish to believe that modern medical care and public health can effectively protect us from such ominous threats. It is more prudent not to wonder if there could be another potentially catastrophic epidemic, but rather when.

Currently there has been a lot of media attention given to a disease referred to as Avian Flu. This avian strain of flu (more accurately referred to as H5N1) is not highly infectious to humans, but if an infection does occur, the mortality rate is very high (6). The concern comes from the genetics of the influenza virus: it possesses a segmented genome supporting re-assortment in humans or animals co-infected simultaneously with different strains (7). The result, which has been the source of previous flu epidemics, can be a highly infectious version of the disease



with a high mortality rate. Researchers consider this consequence for H5N1 Avian Flu only a matter of time. This, and other recent disease threats, has initiated the development of national and international disease surveillance systems.

There are many surveillance systems in place around the world. Individual countries manage most surveillance systems, although larger systems are beginning to form, such as the Global Outbreak Alert and Response Network (GOARN) working synergistically with WHO. Another is the European Center for Disease Prevention and Control (ECDC), although this agency has less funding than the US Center for Disease Control (CDC), or even the UK or French public health agencies (8). Even so, this agency has been working on strengthening pandemic preparedness in Europe. Some countries, such as the UK, have developed primary care sentinel networks that are very promising (9). What is enticing about primary care sentinel networks is the amount of information available relating to individual cases: virtually their full electronic medical record (EMR). This type of system is not as efficient as a dedicated surveillance network for a particular disease, but it is more versatile. This is because investigators can search through the database of patient EMRs looking for symptom patterns, even if they do not have a particular diagnosis associated with them (9). Such a feature could prove useful in outbreaks of emergent disease where no specific surveillance exists. There is an initiative to establish a similar Canada-wide primary care sentinel network (10). Although it will take years before the system could be operational on a scale even remotely comparable to the systems currently used in other countries like the UK, it is an initiative that doctors should support and participate in. Ideally, more efficient integration of surveillance, medical records, and other healthcare information systems will result in a robust tool that could save countless

lives during the next major pandemic. In the mean time, it could be used for research of chronic disease managed in primary care settings, which is the growing majority of what healthcare in Canada manages. If the next potential outbreak is Avian Flu, then our FluWatch system will hopefully catch it. However, if it is a disease for which a surveillance network does not exist, days before detection could mean lives, thousands of them.

*This article has been peer-reviewed.*

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# ELECTROCHEMICAL REMOVAL STENTS FOR PATHOLOGICAL

BY SCOTT BRADSHAW

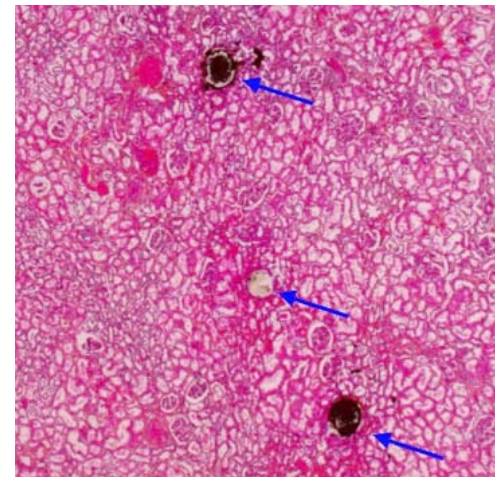
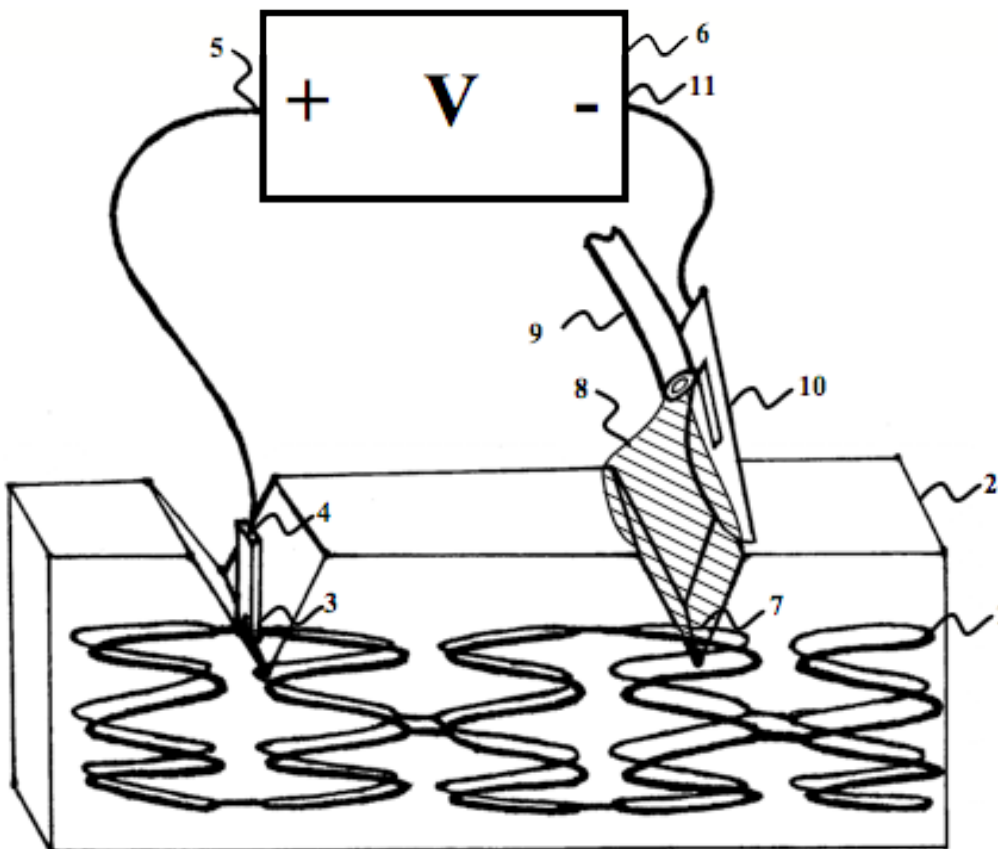
**B**IO-IMPLANTED METALLIC DEVICES such as coronary stents and surgical staples are becoming ubiquitous in the medical field. However, they present difficulty in surgically-resected specimen and post-mortem analysis. At autopsy, for example, it is frequently necessary to section through the major coronary arteries at intervals along their lengths to allow gross inspection and occasionally microscopic analysis. Because of its hardness, sectioning through a stent using conventional methods causes significant damage to and/or loss of native morphology of the underlying tissue. A review of the literature relating to this problem reveals

specialized methods for making thick and thin sections through metal implants suitable for gross and microscopic inspection respectively (1, 2). However these methods suffer several drawbacks: they are expensive, due to the requirement for specialized cutting and/or grinding tools and specialized acrylic for sample impregnation; they are time consuming, due to the extra processing steps involved; and the resulting tissue samples also suffer several technical deficiencies, including cutting artifacts, undesirably thick microscopic sections, and a reduction in the subset of chemical and immunological stains available for tissue analysis. Because of this, there is an interest in developing

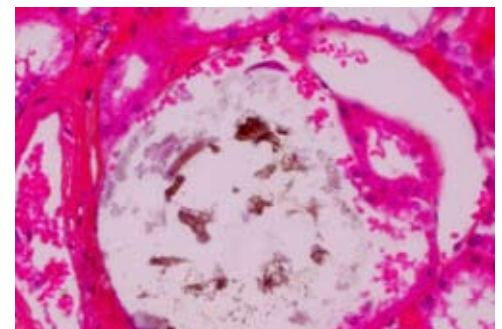
new techniques for the management of these tissues with metallic implants.

In this article, we review initial testing of a method involving dissolving stents using an electrochemical process, while leaving the underlying tissue minimally affected. The tissue is then amenable to conventional processing and analysis methods. The schematic representation of the apparatus used is illustrated in Figure 1 (3). Initial tests were conducted on metallic fibers inserted into kidney tissue. Electrical contact was made on one end of the wires, and the portion of each wire for dissolution (the other end of the same wire) was exposed to

*Fig. 1: The stent (1) and surrounding tissue (2) is removed from the artery, and the tissue is impregnated with wax. A portion of the stent is exposed (3) and attached by a metal clip (4) to the positive terminal (5) of a voltage source (6). A second portion of the stent is exposed (7), and immersed in a low pH and highly osmotic solution (8), which can be continually renewed by a plastic hose (9). The solution is in contact with a metallic surface (10), which is connected to the negative terminal (11) of the voltage source. The stent becomes the anode, donating positive ions, which will plate onto the grounded anode. In this way, the exposed portion of the stent (6) can be dissolved. The surrounding tissue is protected by the wax, which is both chemically inert to the acid, and electrically inert to the electric current.*



*Fig. 2: Low power microscopy (100X) of three dissolved wires (blue arrows) in the kidney tissue. Metal oxide marks the locations where two of the wires were dissolved. HPS stain.*



*Fig. 3: High power microscopy (400X) of one of the dissolved wires in the kidney tissue. The cells adjacent to the dissolved wire remain undamaged by the dissolving process. HPS stain.*

# OF ANALYSIS

solution at the base of the sample. After exposure to solution and electric current for 12 hours, approximately 3mm of the wires were dissolved. The portion of the sample from which the wire had been dissolved was re-mounted in three 1mm sections and sliced using conventional processing technology. The metal was successfully dissolved with minimal disruption to the surrounding tissue (see Figures 2, 3), suggestive of the potential application of this concept to metallic stents in coronary arteries.

Experiments are currently underway involving the electrochemical removal of coronary stents to provide a comparison of the histological results obtained from this method to that of the standard methods currently in use. These experiments are primarily aimed at optimizing the reaction rate and solution composition. Modifications are necessary to overcome difficulties with corrosion products and precipitates which coat the stent and interfere with electrical conduction. In addition, a compromise is needed between reducing the time of exposure to solution in order to minimize acidic tissue damage and reducing the electrical current density to avoid thermal damage. However, initial results of the application of this method of stent removal have shown promise, suggesting that electrochemical dissolution of coronary stents could become a viable option for analysis of samples which contain metallic implants in the near future.

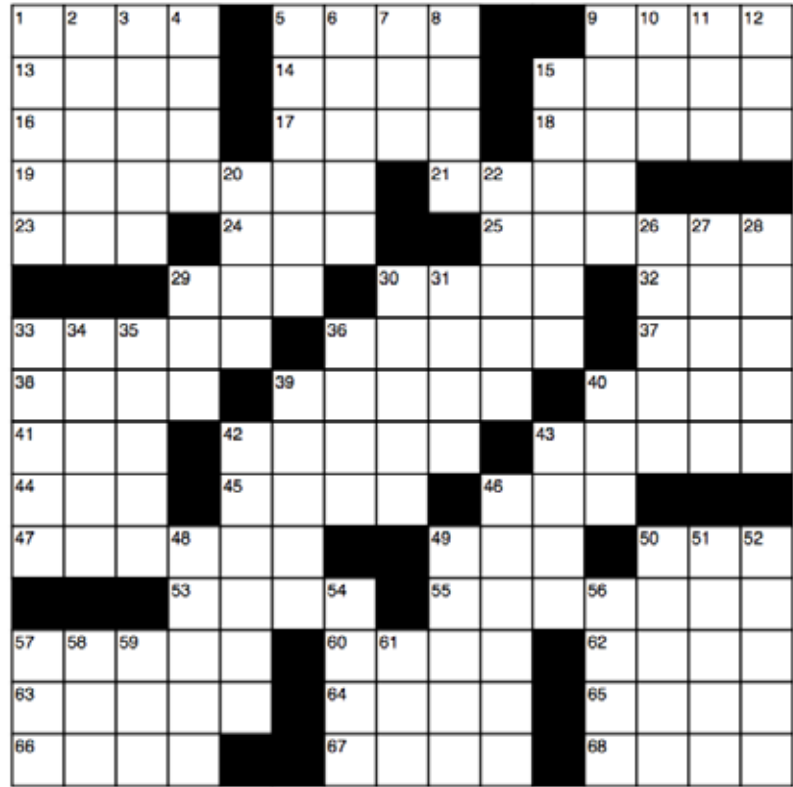
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# THE HUMORAL END

## MEDICAL MUMBO JUMBO



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### ACROSS

- To drain
- Black
- Make fun
- Found in hair
- CNS inhibitor
- Pope's governing organization
- Opera solo
- Clench you teeth
- Stomache sore
- Discovered insulin
- Giant
- Concord e.g.
- Part of a foot
- City in Italy
- Checks heart
- Open
- Extension (abbr.)
- Slow tree mammal
- First Canadian female doctor
- Day of the wk.
- After, prefix
- Sought on Boxing Day
- Medication form
- Consume
- Malaysia's Peninsula
- Governing group
- Street abbr.
- Efferents

- Chew the \_\_\_
- Look over the book, again
- Worm type
- Teaspoon (abbr.)
- Action in surgery
- Visible
- Detect
- Beta-blocker suffix
- Kid's mom
- Thorn
- Pre- and after-
- Negative (prefix)
- Ear secretions, e.g.
- \_\_\_ of function
- Cell phase

### DOWN

- Plasma product
- Can occur before migraines
- Finger, e.g.
- Louver
- Christmas drink
- Transport
- Kimono sash
- World organization
- Mixed drink
- Spark

- Pastry
- A part of hear
- Arrow poison
- Annoying, like a bug bite
- Chew like a rodent
- Induct (2 wds.)
- Jump for joy
- Inscribed pillar
- Airport abbr.
- Prometheus' brother
- Baby kangaroo
- Pap \_\_\_
- Depart
- Swimming mammal
- Plasma component
- \_\_\_ Arabia
- Position
- Patient in pain, possibly
- Unknown female patient
- Visual \_\_\_
- School assignment
- Tenderloin
- Cut of beef
- Thin flat strips
- Chromosome arm
- Count votes
- Seaweed substance
- Compass point
- Time period
- Nil
- Urine sample collection site

# CADUCEUS

BY JULIA CAMERON-VENDRIG

the two symbols are quite similar. The caduceus differs from the rod of Aesculapius in that it is topped with wings, and has two snakes instead of one encircling it. It is the symbol of Hermes, given to him by his father Apollo, the sun god, and since early Babylonia, has represented fertility, wisdom, healing, and sun gods. Greek heralds and ambassadors used the caduceus as a symbol of peace and neutrality. More recently, it has been used in commerce, postal service, and medicine – since 1902, it has been the symbol of the medical branch of the US Army.

The rod of Asclepius is currently used to represent many medical groups, including the Canadian Medical Association and the Canadian Federation of Medical Students. The wooden rod is encircled by a snake, which was sacred to Aesculapius. A legendary Greek physician, Aesculapius

Asked to describe the symbol of the medical profession, I suspect as many people would draw Hermes' caduceus as the rod of Aesculapius. Not surprising, as

was the son of Apollo. The myth tells that he became so skilled that he learned to revive the dead, at which point Zeus killed him. To recognize Aesculapius' skill, however, Apollo asked Zeus to make him the god of medicine. Worship of Aesculapius spread to Rome after a plague in 293 B.C.E., and temples to him were also locations to treat the sick with massages and baths.

This bit of tradition was likely known to Queen's medical students who, several years ago, decided to name their new publication "The Caduceus". Did they choose the caduceus because its history may be considered more colourful, and because it has been associated with many things outside of medicine? Was this a sign that they wished to cover a broader range of topics – or perhaps to link or contrast the paper to the Aesculapian Society? We have deliberately chosen a neutral title for this new publication (The Caduceus has not been published for many years), hoping that this will give us flexibility and easy recognition. But I can't help admiring the clever name our predecessors chose, and thinking that they must have known the coloured history of their symbol, and aspired to tell other colourful stories.

The Columbia Encyclopedia, 6th Ed., Lagassé, P. ed. Columbia University, USA. 2000

## K33NR1T15



Andrew Mok

A new syndrome has been recognized: Chronic Question Asking (CQA) syndrome.

The symptoms:

a predilection for students in post-secondary education; a proclivity for raising the hand; in some extreme cases the shoulder is actually locked into place; frequent vocalization; sometimes sufferers are found talking to themselves in bathroom mirrors; selective hearing loss; an abnormal affinity for the classroom setting; sexual arousal when within ten feet of a professor

Physical examination: normal

Treatment: symptomatic

Patients were told their diagnosis. When asked if they had any questions all raised their hands. Two were so agitated they accidentally hit the attending physician in the face. They suffered minor injuries as this agitation caused their shoulders to lock for several hours.

Currently, the cause of CQA is unknown. Some suggest a link to the geque gene, but contradicting evidence exists. One clinician hypothesizes a viral trigger, and suggests a strain of the avian flu, Influenza A (K33NR1T1S) virus. Until a cause of this syndrome is identified the prognosis cannot be determined. Among devices for therapy are mechanical restraints to prevent shoulder locking. Patients are being closely monitored to ensure their status does not deteriorate.

### SOLUTIONS:

#### WHO SAID THAT:

Mark Twain  
Benjamin Franklin,  
William Osler,

#### WORD JUMBLE:

Water on the knee.

### MEDICAL MUMBO JUMBO:

S	A	P	S		E	B	O	N		J	A	P	E		
C	U	R	L		G	A	B	A		C	U	R	I	A	
A	R	I	A		G	R	I	T		U	L	C	E	R	
B	A	N	T	I	N	G		O	G	R	E				
S	S	T	O	E		N	A	P	L	E	S				
			E	C	G		A	J	A	R		E	X	T	
S	L	O	T	H		S	T	O	W	E		T	U	E	
M	E	T	A		S	A	L	E	S		P	I	L	L	
E	A	T		M	A	L	A	L	Y		J	U	N	T	A
A	V	E		O	U	T	S		F	A	T				
R	E	R	E	A	D			P	I	N		T	S	P	
			S	N	I	P		S	E	E	A	B	L	E	
S	E	N	S	E		O	L	O	L		G	O	A	T	
B	R	I	A	R		L	O	A	D		A	N	T	I	
W	A	X	Y			L	O	S	S		R	E	S	T	

# WHO SAID THAT?

Unscramble the names beneath each of the famous quotes to identify the original speaker.

"In science the credit goes to the man who convinces the world, not to the man to whom the idea first occurs."

LIAMLIW ROSEL

"Nothing is more fatal for health than over-care of it."

JAMNEBIN LINKNARF

"The only way to keep your health is to eat what you don't want, drink what you don't like, and do what you'd rather not."

KARM WITAN

# WORD JUMBLE

FINEK



RODWAT



THEFY



NEREKE



"When the gentleman accidentally spilled his drink he developed this"



## QUEEN'S MEDICAL REVIEW ESSAY CONTEST:

# "WHAT IS MOST IMPORTANT FOR FUTURE PHYSICIANS TO LEARN?"

SEND YOUR ANSWER IN 600 WORDS OR LESS  
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THE WINNER AND OTHER NOTABLE ENTRIES WILL BE PUBLISHED IN THE QMR'S NEXT ISSUE.

## FIRST PRIZE: \$50 AT THE BOOKSTORE!

# WHAT'S UP, DOC?

## A COMMENTARY ON THE PHYSICIAN'S SOCIAL ROLE

BY ERIC DANTZIG

As medical students, we are entering quite a bizarre profession. While we are being trained to take care of patients, the roles expected of us after medical school will stretch far beyond patient-care and health. We will be placed on pillars that give us incredible power in many social, political and economic situations. It is fair to say that our patients and communities will expect a lot of us. Recognizing responsibility that comes with our power and influence, we must come to terms with what we believe the roles of the physician should be in society.

What, as medical students and physicians, do we do with society's weighty expectations? What must we do to merit the social influence with which we are endowed? How much should physicians have to 'give back'? Answering such questions is by no means simple. Amongst other things, answering such questions involves examining the way we educate medical students and thinking about whether our curriculum effectively trains doctors for what we consider their roles to be.

In defining the social role of a physician I like to use the words of Robin Williams in the movie *Patch Adams*, who describes a physician, at the end of the day, as a 'trusted and learned friend'. Educated with the knowledge and skills to serve others, the ultimate role of a physician is to do precisely that. We become doctors to serve the people and communities around us, with some expanding their services to global health.

This point of serving others, which to me is the most fundamental tenet of medicine, is too often lost in the North American medical establishment. While I am certain that most medical students and physicians ultimately wish to serve the common good, I think that too often medicine gets caught up in a capitalist system which makes us err in our social role. The fee-for-service system turns Canadian medical practice into a business, where stark inequities in the healthcare system, such as a lack of drug coverage for

some populations, a lack of access to family doctors, and a lack of resources leading to horrendous wait times persist, while medical salaries and the costs of healthcare keep rising. How can we say that we are serving others when there are so many Canadians who are not being adequately served?

I once heard a physician, speaking of the incredible demands an aging population will have on the Canadian healthcare system in the next fifteen years, suggest that soon his specialty would have the healthcare system "by the balls". His words, in my mind, were counter to the values that I see a physician holding and the social roles I see played by a physician. A physician, in my mind, must be humble. He or she must value the power bestowed upon them and must use this power to act in the interest of their patients and the public good. Even when confounding factors like money come into play, I would like to think that public good and not individual interest would win out. It is in improving the quality of our patients' lives, and in fighting for social justice and in fulfilling our obligations within the doctor-patient relationship where our interests should lie.

I asked earlier what the role of the physician should be in society, and suggested that it should be to serve the people and communities around us. I would like to further propose that the role of every physician should be to go beyond the duties of medical practice to give back. Not only must physicians serve society, but also, they must serve as catalysts for social, economic, and political change. Medical students and physicians, with the influence available to us, should make efforts, starting at the community grassroots, to address determinants of health and well being. We must advocate for safer communities, for increased green space and parks, for less pollution in our cities, and for increased access to healthcare. I am not encouraging every medical student and physician to run around saving the world. We are ultimately trained to be clinicians who care for the health of our patients. We cannot all go off

gallivanting to the developing world, for if we were to do so, we would be breaking our commitment to the health of our patients and our communities. For many of us, giving back might very well be in financial terms. We will use our relative social affluence to contribute to the causes and issues we believe in. And this is perfectly fine, so long as in some way we are giving back to the shaping of what we believe to be a better world.

I, therefore, commend Queen's Medical School for its efforts to incorporate public health and global health into its medical curriculum. Through the efforts of a socially conscious faculty, it is clear to me that Queen's is educating not just clinicians, but physicians that will serve as leaders in combating injustice both locally and abroad. I encourage Queen's, however, to keep doing even more to incorporate humanism and social advocacy into its curriculum. As a medical school, we must take more time to explore issues of poverty and inequities in our healthcare system. We must do more to change the status quo in a Canadian healthcare system that is struggling to meet the needs of its people, and must to more as a school to contribute to global issues like malnutrition, drug- and multidrug-resistant TB, and HIV.

As today's medical students, we can be the catalysts for local and global change. We will work with the nurses, lawyers, teachers and engineers, training now at Queen's like ourselves, to bring multidisciplinary perspectives to a variety of social, political, economic and healthcare issues. In my classmates, I see great potential for transformative change. A barbeque at the beginning of the year to raise money for earthquake victims in Peru and a moustache-growing campaign to raise money for prostate cancer are just two examples of the compassion and benevolence we have in our class and in our medical school. Let us do more of this. Let us meet the expectations society places upon us and seek to right wrongs. Let us be conscious students. Let us one day be humble physicians. Let us always be global citizens. ■



