QMR

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HUMAN RIGHTS LAW

Photo Contest, Health and the Federal Election, News from the CFMS, Health and Human Rights Conference

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From the Editors

The cover photo for this issue was selected by a panel of photographers from a multitude of submissions. The image, captivating in itself, is also allegorical to the content of our current issue: moving forward towards an unknown future. There is a common call for improvement; a desire for better. There is also the underlying acknowledgement of the interconnectedness of things – that health is a global phenomenon affected by nearly all aspects of life.

Two articles in this issue profile physician initiatives that step outside the biomedical aspects of medicine and focus on ecological well-being. Physicians for Global Survival (PGS) is dedicated to preventing the horrors of nuclear warfare both on the planet and on ourselves, while the Canadian Alliance of Physicians for the Environment (CAPE) recognizes the intimate link between the health of the environmental and that of the individual.

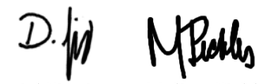
We see, from the review of Dr. Orbinski's talk, a need for optimism. He inspires us to appreciate that things can improve fundamentally if there is a drive to "not accept the unacceptable". The evolution of this concept is seen in Jessica Moe's discussion of the development of international human rights legislature. These principles have had a major impact on human health and on our perceptions of what is just. This theme is extended in the annual Queen's Health and Human Rights Conference, which exists and is flourishing because of our changing conceptions.

A call for improvement, however, is incomplete without introspection. Our medical education, as we are repeatedly told, changes us, and we owe it both to ourselves and to our future patients to critically appraise whether we are being adequately prepared for our careers. The value of mentorship is seen in an article relating the experience of working with a distinguished oncologist. This article also displays the ways in which our medical education can be tailored to suit our individual realms of practice.

Our relationships with our teachers however, can occasionally result in internal conflict. An anonymous letter received by the QMR brings to light the dilemmas frequently faced by students when the ideals they entered medical school with are challenged. Our education, as previously stated, changes us. This letter, however, asks the question: are there parts of us that should resist this change? Indeed, there would be a stagnation of progress if we who are entering the profession did not use our personal and moral judgments to guide our education.

An issue on improvement is hardly surprising in a publication written by medical students. Diverse as we are, we share a near-neurotic desire to be fitter, happier and more productive. We have all striven, and continue to strive, to better ourselves and achieve all that we can. Therefore, it's only fitting that we should project these values towards the world around us.

We are also excited about inducting the Queen's Medical Review into its second year of publication. We would like to extend our thanks to everyone who submitted photos and articles. We would also like to thank all of our returning staff, as well as our many new staff who have brought fresh perspectives and enthusiasm to QMR. Finally, we would like to thank our new faculty advisor, Dr. Hoey, for his guidance.



Daniel Finnigan Melissa Pickles
Editors in Chief

Internal News

BY MICHAEL SURKONT

NaHSSA Conference to be held at Queen's
The National Health Sciences Students' Association is a nation-wide interprofessional organization dedicated to linking students from a variety of healthcare professions. This organization will hold its 5th Annual National Interprofessional Healthcare Conference at Queen's on March 20-22. Queen's medical students participated in last year's conference, which took place at the University of Western Ontario.

Medical school in expansion mode
The Queen's School of Medicine is expanding. Plans have been put in motion for the construction of a new medical school building to replace Botterell Hall as the center of medical education. The new building is set to be located across from Botterell, on the corner of Stuart Street and Arch Street.

Alumni Golf Tournament held
The Annual Alumni Golf Tournament took place at Smuggler's Glen on Friday, September 26th. The event was well attended by numerous alumni, as well as a dedicated group of student volunteers. Faculty members and avid golfers such as Drs Walker and Sanfilippo teed off with student volunteers for a great round of golf. Many thanks to Dr. Reid and Jessica Bogach (Meds 2011) for organizing the tournament.

MVN: a resounding success
The annual Medical Variety Night has been a resounding annual success since its inception. The event is organized by the students of the Queen's School of Medicine. MVN is traditionally hosted in Grant Hall, where it attracts a large audience of faculty and students. Since all proceeds are donated to charity, MVN epitomizes the generous spirit of all the members of the Queen's community involved. This year, over nine thousand dollars was raised for charity.

Queen's medical students participate in the 2008 Run for the Cure
Top Row: Vivek Singh, Amandev Aulakh, Adrienne Li, Eric Dantzig
Bottom Row: Salina Chan, Darlene Lower, Iskra Todorova Peltekova, Oren Levine

Queen's Masters of Public Health Program Deferred
The much touted Masters of Public Health Program, scheduled to be offered in September 2008, has been postponed to next year. This delay is related to obtaining approval from the Ontario Council of Graduate Studies. The program will offer "interdisciplinary training grounded in real world experiences, with the goal of providing public health expertise both within Canada and internationally."

Queen's medical students partake in Run for the Cure
On the sunny Sunday morning of October 5th, Queen's medical students participated in the annual CIBC Run for the Cure. The course, either one or five kilometers, was no match for our athletic colleagues. Overall, the run raised $28.5 million across Canada, which will make a significant contribution towards the fight against breast cancer. Breast cancer is the second most common Cancer in Canada, affecting approximately one in nine women.

News in Medicine

BY ZAINAB KAHN AND JACQUI WILLINSKY

OMA Tentative Agreement: benefits for medical students
The OMA has reached a tentative agreement with the Ontario government after hard work lobbying and negotiating. A new program will allow medical students to defer payments on the principal of eligible debts during training, and the Ministry will pay the full interest on the debt through to the end of the residency program. The second key benefit is that the clerkship stipend will be increased to $750/month effective July 1, 2008. In addition, funding for clinical rotations will be made available for all training more than 100 km from the border of the student's home community within Ontario. Thank you to the OMA for making this possible!

University of Ottawa Faculty of Medicine hosts second annual Pow-wow
The University of Ottawa community and Aboriginal leaders gathered to celebrate Aboriginal culture at the second annual Faculty of Medicine Pow-wow on Wednesday, September 10. The Pow-wow celebrated the Faculty of Medicine's Aboriginal Program and the students admitted to the program since it was developed in 2005. Dr. Jacques Bradwejn, Dean of the Faculty of Medicine, hoped for this event to be a way to educate non-Aboriginal students and staff about the Aboriginal people's history, culture and health issues.

Schulich School of Medicine and Dentistry makes global health a priority
In the aftermath of a report issued by the Global Health Task Force in April, the Schulich School of Medicine and Dentistry is establishing a new Office of Global Health to develop resources for Global Health research and education.

Canadian study: new weapon against arteriosclerosis?
Researchers at McMaster University and University of Sherbrooke found that people vaccinated against pneumonia were 47 percent less likely to have had a heart attack. The vaccine may indirectly prevent the heart damage which can be caused by the pneumonia bacterial infection. It is possible, however, that the antibodies from the vaccine interfere with the hardening process of arteries. These novel ideas will give rise to a new area of research.

Nobel Prize in Medicine
The 2008 Nobel Prize in Medicine was given to three European scientists who all contributed to knowledge about viruses. Harald zur Hausen, who received half of the monetary award, discovered the role of the human papilloma virus in cervical cancer. Francoise Barre-Sinoussi and Luc Montagnier shared the other half of the prize based on their isolation of the retroviral enzyme reverse transcriptase, which led to the increased understanding of HIV and its treatment.

Simulated radiologist
Computer-aided detection technologies have been developed to flag suspicious areas on mammograms. British researchers found that a single radiologist with the help of this virtual aid is just as effective as two radiologists in detecting breast cancer. This technology may improve detection rates in centers where single readings of mammograms are the norm.

Markham schools focus on preventive health
A handful of Markham schools used their gymnasiums as multidisciplinary health care hubs. Nutritionists, dental hygienists, opticians and audiologists performed checkups on children, gave out tip sheets to parents, and made necessary referrals to dentists and doctors. Director of the York Region District School Board would like the project to expand, possibly throughout all of Ontario.

"Hands-on" learning in the University of Manitoba's Faculty of Medicine
The University of Manitoba's Faculty of Medicine opened the doors to their new multidisciplinary Clinical Learning and Simulation Facility. Students will now be able to practice medical diagnosis and treatment on five life-like robotic mannequins, which include two adults, a birthing mother, an infant, and a child.

"All physicians, regardless of postgraduate training, should be paid the same per unit time."

//For BY ADRIENNE LI

Regardless of postgraduate training, all physicians share the same purpose in treating patients: to prevent illness and disease and to promote and restore health and well-being. As colleagues, we depend on each other's knowledge and skills to provide appropriate care for our patients. By remunerating some physicians more than others, however, we endorse an implicit hierarchy of physicians. The remuneration system perpetuates our society and profession's judgments of the differential value of various specialties when there should be no hierarchy in medicine.

If all physicians were paid the same per unit time immediately upon starting a postgraduate training program, then perhaps medical students would be less inclined to seek the higher remuneration rates of some specialties and instead look to specialties where they might be truly interested and satisfied. We might have more family physicians, and family physicians might not be as rushed to see a certain number of patients per hour. Each specialty is integral to our healthcare system, and one is not worth more than another.

I do not deny that some postgraduate training programs are more rigorous and demanding than others, but I believe that so long as remuneration is based on time invested, residents and physicians will be compensated for their efforts accordingly. I am not proposing how much physicians should make per unit time, but rather, simply that we should value each other equally.

//Against BY AISLING CLANCY

Physician remuneration should not be measured by the impact on patient health or physician value, but should rather reflect the desirability of the position. My high school history teacher was paid more when he worked as a garbage collector than as a teacher. Why? Because refuse collection is a less desirable occupation to the general public and as such, a higher wage is required to retain the employees in this position to meet the need of the city.

Certain physicians make more sacrifices than others and should be rewarded for the additional time spent in training, for the poor hours, and for stressful or difficult work. The average trauma surgeon works more evenings and weekend hours than the average general surgeon and adjusts other areas of their life accordingly. The rheumatologist sacrifices years of pay to become more knowledgeable in his specialty. The rural physician sacrifices the amenities of the city to work in what are often more difficult conditions. I believe that people should be rewarded, in some way, for these sacrifices.

Given the competitiveness of applying to certain specialties (and assuming that monetary compensation can be a career motivation), it is clear that there is an inverse relationship between compensation and the desirability of specialties. There must be a balance between the stress and difficulty of a physician's job and the remuneration. The issue is not that some specialties are paid more than others, but that the highly desirable and competitive specialties are paid more than is necessary.

Orientation Week 2008

BY KEN COLLINS

I've got to say, it's more fun on the other side of the fence. Sure, I was waxing nostalgic as I watched all the new medical students make small talk, trying desperately to absorb it all: where are you from, what did you study, welcome to the profession, etc. But, seeing some forty of my 2011 classmates catching up on summer exploits, brought me back. Finally, the plans, the emails, the phone calls, and the meetings were all coming together, And Costco had enough canola oil…

The Medical School Olympics this year benefited from more money and some imaginative events to get the week started. Thanks go to Kathryn and Dan F. for their efforts during the summer. The Dinner Dance, held at everyone's favourite prison-adjacent restaurant, was a great success, thanks to the musical stylings of Rohit and the decorating panache of Morgan and Rachel.

After a day of rest, Brad W. and his crew staged the perennially epic Movie Night. A few trips to the LCBO and two broken jousting sticks later, it all ended with the baptism in Lake Ontario, followed by a bunch of oily frosh making their way to Elixir. It was a spectacle to be seen; the night of as well as the day after on the lawn of Meds House. A special thanks to the sober guardians who kept the drownings to a minimum.

Friday night came, much to the relief Morgan and Kirsten, who had been stopping at practically every bar in Kingston—planning the pub crawl…

"Team Helga," O-Week 2008
Back Row: Jonathon Wong, Jessica Moe, Tyler Law, Eric Mutter, Jovana Martinovic, Zale Mednick, Aisling Clancy, Jasmine Lamba, Adrienne Li, Paul Uy
Front Row: Jennifer Baxter, Karen Arcot, Amandev Aulakh, Natasha Datoo, Vivek Singh

I assume. A bunch of tired and weary people managed to drag themselves to the Grad Club for the beginning of another night of fun, hosted by a smattering of our favourite third years.

Finally, in an attempt of medical-legal interaction outside the courtroom, we gathered with the first year law students at Stages for a band night. With on-stage chemistry that could rival only that of a sober Cheech and Chong, Kevin and I hosted the medicine portion of the evening, handing it off to the lawyers-to-be to finish off the night.

Overseeing O-Week has been such an adventure. Thank you, Class of 2011, for giving me the opportunity to organize it. I've always loved new student orientation, and I had been looking forward to September nearly all summer. I felt as though I got an encore O-Week, but it seemed better this time with all of the awesome people I've gotten to know. Thanks to everyone who played a role in showing the first years a good time and welcoming them to our school.Q

Canadian Federation of Medical Students

BY CHRISTINA NOWIK

The Canadian Federation of Medical Students (CFMS) represents over 6500 medical students pursuing their medical careers from 14 Canadian medical schools across the country. The three pillars of the CFMS are "Services. Representation. Communication." The CFMS takes this mandate very seriously.

You might be aware of some of the many services provided to you. Some examples include:

- 10% off WestJet flights in January to ease the burden of travel to CaRMS interviews (but not limited to this function!)
- Great data and voice packages with Telus
- Specials on LASIK eye surgery
- Help with billeting when away on clerkship
- Tips for CaRMS interviewing

And that's just the tip of the iceberg! For years, the CFMS has been diligently campaigning the federal government for debt relief. Several provinces (including Ontario!) have come up with interest deferral programs and the CFMS plans to capitalise on developments at the provincial level and pressure the federal government to make similar changes.

Communication is about linking the opinions, initiatives, and issues at each school to the rest of the country. Recently, the CFMS had its Annual General Meeting in Halifax, where the CFMS execs, medical society reps, medical society presidents, and Global Health Liaisons met to discuss pressing issues for the upcoming year.

Very high on the agenda was equity in electives applications. This year, the CFMS will be working towards standardising the application process. This includes a common immunisation form, common applications, and working to make sure that all clerks have a minimum amount of notice for their elective schedules.

Also a big topic is that of Distributed Medical Education (DME). Queen's is the only school in Ontario not currently expanding class size, and the others are doing so by having distributed teaching sites (i.e. NOSM at Thunder Bay and Sudbury). This new strategy in education brings up issues of equitable access to resources and problems in technology used for communication, etc. The CFMS will undertake a student-centred review to ascertain student satisfaction and complaints with DME. This may not seem as relevant for you lucky Queen's students, but expanding sites around the region, even if not during pre-clerkship, will be something you will have to contend with as Ontario makes room for more doctors-in-training.

Something else that will likely cause your ears to perk – your Queen's VP Externals passed a resolution calling on the CFMS to undertake a student-centred review of grade reporting policies. Yep, that's the ol' H/P/F debate stirring again. Queen's students are not the only ones interested in finding out how other schools report their grades, how satisfied their students are with this, and how excellence is acknowledged amongst their student body. This will be of great value as Canadian medical schools seek to highlight their students while promoting fair and agreeable learning atmospheres.

Go to www.cfms.org for more information on the CFMS. And remember to keep in touch with your representatives, because something you bring up to one of us could end up as a big resolution...Q

"The CFMS will undertake a student-centred review to ascertain student satisfaction and complaints with DME."

COMMUNITY QMR

From Intentions to Actions: Perspectives on Global Health

Queen's Health & Human Rights Conference 2008 – October 4th-5th

BY F. DANIEL RAMIREZ

The Queen's Health and Human Rights Conference held on October 4th-5th was designed to be multidisciplinary and to address a broad scope of health and social issues. Of the thirty-five or so speakers invited, this article focuses on three, though many others are highly deserving of being mentioned and critically discussed.

Dr. Samantha Nutt, founder and executive director of War Child Canada, readily addressed the theme of the conference: from intentions to actions. She recounted her once "crippling cynicism" of fellow medical students interested in global health, referring to their international trips as "traveling vacations". She questioned then and asks us now to find significance in such endeavours. She described how her time in Somalia – arguably her first experience in the field – showed her that her ideas of "how to make a dent in the global health machine were naïve or at least totally incomplete" as she was faced with the realities of the failed state, including child soldiers and the amazingly abundant supply of Kalashnikov rifles.

Drawing on stories from her time in the Democratic Republic of Congo, where the war and its aftermath claim the lives of 45,000 people monthly, she spoke of the disparity between its citizens' way of life and our own. Dr. Nutt also referred to the Western world's contribution to this divide as she stated, "Policies, economies, consumer practices at the very least facilitate the preconditions that enable such inequities to exist. And what inequities these are."

Underlying her talk were the notions that good intentions are not by themselves sufficient to bring about beneficial change, that concepts of charity need to change for global health to be meaningful, and that human health and human dignity are indivisible and necessary concepts.

Saturday's closing keynote speaker, Maj. Brent Beardsley – an Infantry Officer in the Royal Canadian Regiment, the previous Chief Instructor of the Canadian Forces Peacekeeping Training Centre, and co-author of *Shake Hands with the Devil: The Failure of Humanity in Rwanda* – spoke independently from any organization on issues of international security and the emerging and forecasted effects on the global community.

Maj. Beardsley described a world in which the dual nature of globalization is fuelling future (and perhaps current) conflicts. He argued that this is arising fundamentally from a growing frustration and lack of hope in third world countries due to an ever more visible and increasingly polarized distribution of wealth. He stated, "a world system based on the rich getting richer, fewer, and more regionally based, while the poor get poorer, more numerous, and more desperate will result in conflict."

He argued that the declining or stagnant population in the developed world, the youth population bulge in third world countries, the depletion of key resources (particularly water and petroleum), and climate changes are setting the stage for conflicts, natural disasters, poverty, famine, and disease. Compounding these issues, he argued, non-state actors, such as trans-national corporations and the privatization of military/security forces, are bypassing democratic institutions, leading to asymmetric intra-state wars with international consequences. Furthermore, more of these conflicts will be identity-based (racial, ethnic, religious, and national) and will thus more likely result in gross violations of human rights, war crimes, and genocides as in these conflicts the enemy is not a soldier, but rather the other group's civilian population.

He closed his talk by saying "Go out. Get your boots dirty. It will change you."

In a workshop on Sunday afternoon, Hon. David Kilgour and Mr. David Matas, co-authors of the Report into Allegations of Organ Harvesting of Falun Gong Practitioners in China, spoke on the findings of their investigation. Falun Gong, a spiritual practice introduced to the general Chinese public in 1992, rapidly gained acceptance and momentum until the Chinese government banned it in 1999. The country has since been accused of permitting organ harvesting particularly from Falun Gong practitioners.

Though thought-provoking, the strength of the talk was undeniably in the twenty minutes allotted to Lizhi He, a quiet and unassuming man not mentioned in the conference program.

In 2000, Mr. He was sentenced to three and half years in prison after mailing letters to friends and colleagues detailing his beliefs in the Falun Gong practice and the persecution that he and others were facing by the Chinese government. During his imprisonment he was forced into slave labour, was sleep deprived, and was violently beaten and electrocuted.

Calmly, Mr. He told of blood tests and physical exams for which no medical records were kept - the grisly significance of which he understood only in retrospect. He also told of the mysterious disappearance of prisoners who withheld their names and addresses in the hope of protecting loved ones and fellow Falun Gong practitioners.

Meanwhile, having successfully fled to Canada, Mr. He's wife had been lobbying on his behalf. He was deemed a prisoner of conscience by Amnesty International. Thousands of Canadians signed petitions demanding his release and with governmental assistance, Mr. He was freed and reunited with his wife in Canada.

Throughout the course of the conference, it became increasingly apparent that many well intentioned acts driven by humanitarian motives can be counterproductive or destructive to those we seek to help. Issues of sustainability and the promotion of dependence on foreign assistance come to mind. It is this transition from wishing well to doing well that is difficult – a reality Maj. Beardsley alluded to when discussing the multi-factorial underpinnings of current and future humanitarian crises. His encouragement to go out into the field seemed at odds with Dr. Nutt's 'cynicism' in medical school, but both refer to the same concept: we personally benefit greatly from traveling to areas in need of assistance, but we should ensure that the communities to which we travel stand to gain as much as possible from it as well. One must think critically of how to effectively and productively act on one's intentions, as the 'best' ways to act can often be challenging to determine.

Furthermore, both Dr. Nutt and Mr. He impressed the notion that 'global health' need not be synonymous with packing up and going to impoverished or war-torn areas – though there is an important yet delicate role for such assistance. Dr. Nutt referred to our consumer practices as driving inequities between us and third world countries while Mr. He thanked Canadians for signing petitions demanding his release. Though few of us will become Nutts, Dallaires, or Orbinksis, there are other effective ways to act on our intentions.Q

"Policies, economies, consumer practices at the very least facilitate the preconditions that enable such inequities to exist."

What I Wish I Knew...

Pointers from Upper Years

...IN PRECLERKSHIP

1. I wish I had known that you don't need most textbooks. There are maybe 4 textbooks I'm happy I bought in med school (anatomy, histology, ECGs, neuro). All the rest you can find the info you need online and save some cash. Or mooch off your friends.

2. I wish I had known that I would forget the details of a lot of the things I did in med school. Start keeping track of all the groups you've belonged to and random activities you took part in, including the dates you did them. This will save you some grief when you're doing CaRMS.

3. I wish I had known how much free time (and sleep) there was in 1st and 2nd year. Enjoy it now!

...IN PERI-MEDICAL LIFE

1. Find some extracurricular activities outside of medicine that you love doing and make these a priority in your life, even when school gets busy.

2. You definitely don't need a PDA for clerkship.

3. Get yourself a free subscription to UpToDate (ask someone who has it, ie. a 4th year medical student, resident or physician, to send you a free trial) and check it out. This is one resource I would have used over and over for PBL, etc...

4. Live with people. Once clerkship starts it can be pretty lonely to live on your own as you're often too busy and tired to go out. So the right company at home can be just enough to keep you feeling connected to other people.

Orbinski on Optimism

A Review of the H.G. Kelly Lecture

BY KAREN ARCOT

The atmosphere before the lecture was palpable – curiosity mingled with anxiety. We were curious to see Dr. James Orbinski, the famed co-founder of Médecins Sans Frontières Canada and author of the best-selling autobiography, *An Imperfect Offering*, yet we were anxious that a man who had seen the worst of humanity would not be able to inspire us after all. In his book, Dr. Orbinski details his evolution as a humanitarian doctor through anecdotes of his experiences in conflict-torn zones, including the Rwandan genocide. His frank documentation reveals that in medicine, even when we choose to help people regardless of ethnicity, religion, or wealth, we cannot be apolitical. Access to health care is a political choice. Although he initially resisted this conclusion, Orbinski eventually embraced it, and lives now as an advocate for his causes.

Following an introduction by Karmen Krol (Meds 2011), Aesculapian Society Vice-President of Academic Affairs, Dr. Orbinksi took the podium. His prepared speech occasionally involved verbatim recitations from his book; he recalled a story from his childhood, in which a young doctor illegally procured medicine in the middle of the night for Orbinski's brother's febrile seizure. He also recalled a young man asking him why Orbinski brought him only kindness when he needed medicine, and a nine-year old child explaining having seen her parents shot from a hole in a pit latrine. The facts, and the historical and contemporary context he outlined for us were not unfamiliar – 3.8 billion of us live on less than $2/day, and the average African has half the life expectancy of the average Canadian, partly because they have no access to essential life-saving medicines for diseases that receive no research attention (e.g. sleeping sickness). Yet many of us left the auditorium energized by his unfazed optimism in the face of the seemingly insurmountable failings of humanity, ranging from climate change to genocide.

His passion really came alive when he began fielding questions from the audience. When asked about how he stayed optimistic despite all that he had seen, Dr. Orbinski recast the question, astutely observing that "Should I be optimistic?" was a privileged question in itself, a luxury that half the world does not enjoy. He nonetheless replied, explaining how he finds hope in the beauty of life, like the changing colours of fall leaves on the drive to Kingston. He remarked that having children was an act of hope and profound optimism in itself. He shared how his experiences have educated him on his own smallness in the world when placed against the millennia of human civilization before him. In searching for and finding the beauty of life, he rallied the audience to a cry against apathy.

Orbinski catalogued the dangers of disengagement, cynicism, and narcissism. He stirred us out of our bourgeois bubble, with its accompanying sense of entitlement. Finally, he challenged us: "We have the liberty to act and to pursue something better in the world. It is a duty to do so. Choose optimism." He stressed the importance of calling our politicians to account by voting in the federal general elections, highlighting the increasing danger of privatization of our current health care system. He encouraged us, most of all, to speak and not to be paralyzed by fear when we see injustice around us.

> "We came to the lecture wondering *if* we could make the world a better place, and we left asking *how* we could make the world better."

When the question period ended, a long queue of students formed – cynics, optimists, and people looking for answers, or at least, more words of wisdom. We came to the lecture wondering if we could make the world a better place, and we left asking how we could make the world better. Dr. Orbinski humbly lives up to his challenge. With his words and actions to inspire us, I hope that we will too. Q

Health Care and Election Campaign

The Lost Debate

BY FIONA AISTON

On Tuesday, October 14th, Canadians from Victoria, British Colombia to Gander, Newfoundland went to the polls for the third time in four years. There are 4-5 million Canadians without a family physician and yet, during the 2008 election campaign, there was barely a reference to the crisis facing the Canadian health care system. Canadians deserve to debate the issues surrounding health care services.

Under the direction of Stephen Harper, the Conservative Party stood on its election platform of being the best money manager to steer Canada through economic crisis. The Conservatives also promised to increase defense funding, create tougher immigration standards and develop more severe penalties for young offenders. Mr. Harper's prospective spending budget does not have room for healthcare. Many will remember that he broke his 2006 election promise of creating a wait-time guarantee along with shortening wait times. Furthermore, in his previous life as vice-president of the National Citizens Coalition, Harper suggested that the Canada Health Act should be completely abolished. In a recent Canadian Medical Association Journal editorial, Attaran et al. attack the Conservative government and noted that "government policy errors helped bring about [the recent epidemic of listeriosis]" that killed 19 people across Canada this past summer.

Healthcare is the number one or two issue on the agenda of most Canadians during election time. While the Conservative party failed to make new platform promises on issues pertaining to health, the other major parties all made major announcements. The Liberal Party of Canada listed its priorities under healthcare as: training more health professionals, working on closing the gap in the health status of Aboriginal peoples and creating a catastrophic drug coverage plan when the drug costs of an illness become too much for a family to handle. The New Democratic Party called for a 50% increase in the number of doctors and nurses trained in Canada. In addition, the NDP opposed privatization of services, promised an expansion of drug and alcohol addiction and prevention programs (including harm reduction programs) and investment in long-term strategies for the management of chronic diseases. Although the Green Party of Canada failed to elect a single member of parliament, they did garner 6.8% of the popular vote. The Greens' platform emphasized health promotion and prevention via recognition of determinants of health and working to reduce and overcome factors that harm health. Despite the presence of health in their platforms, health did not emerge as a key election issue and the coverage in the media of health related stories was minimal.

After the election results, we now know that Stephen Harper will be holding the reigns of another minority government in Ottawa. In addition, we also know that many major health issues will remain: shortages of health human resources, long wait times, a deficit of modern diagnostic equipment, underserviced rural areas and rising costs of prescription medications. Permeating all of this is the debate over public versus private funding.

Based on its past history, its philosophy of government and its platform, we can make some predictions about how the current Conservative minority government will steer the health care portfolio. There is little room left in Stephen Harper's fiscal framework given that existing tax revenues are already spent or promised, therefore in the present Conservative minority government there will likely be no major health initiatives.

One of the major post-election stories was the missed opportunity by the Conservatives to secure a majority government. Miscalculations and errors in judgment by the Conservatives in Quebec are the likely reasons Canadians returned a minority parliament. A Conservative majority government would have meant that much more emphasis would likely have been placed on the privatization of health care. We have no indication, however, whether this would have extended to private funding. That would, of course, require amendment to the Canada Heath Act and entail a major public policy debate. Only a government with a strong mandate and the insurance of a full four years in office would likely undertake such a fundamental change.

One thing that is certain is that as medical students, physicians and Canadians, we must continue to ask questions of those who are in power and who are directing health resources, both during an election campaign and afterwards. Health is too important to leave to politicians alone; we all have a stake in it. Q

This article has been peer-reviewed.

Humanity's Autoimmunity

The Threat of Nuclear Weapons

BY KRISTINA POWLES REPRESENTING PHYSICIANS FOR GLOBAL SURVIVAL, KINGSTON CHAPTER

The human adaptive immune system is a wondrous thing. Through a complex process it continuously matures and evolves to rigorously protect us from the noxious bacteria and viruses that invade our bodies. The wonder lies in the system's specificity - its ability to seek out, identify, imprison, and direct the complete destruction and removal of the organism that dared attempt assault on our body, and to do all of this without damaging our own tissue. However, as medical professionals we know this elegant system can break down, leading a well-trained defence mechanism to destroy the very thing it is meant to protect.

Likening the human immune system to a military is a commonly used analogy to help students understand how the system works. Even when the system fails the analogy still holds: just as antibodies may destroy innocuous, healthy cells and cause death, so may military strikes kill innocent human beings and now… may annihilate humankind.

In August of 1945 atomic bombs were dropped on the Japanese cities of Hiroshima and Nagasaki. At detonation a massive amount of energy was released causing intense heat (several million degrees Celsius!) (2), significant blast forces, and extreme local radiation exposure. Buildings, trees, and humans were vaporized on the spot, leaving only ash and smoke. Huge air pressures caused violent firestorms, crushed tens of thousands of buildings, and created hurricane-force winds. An estimated 110 000 civilians died when the two bombs were dropped; another 95 000 were severely injured (3). In the ensuing months approximately 36 000 died from the after-effects of acute radiation exposure (3). Symptoms included epilation, petechiae, oropharyngeal lesions, vomiting, bloody diarrhea, high fever, overwhelming infection, seizures, coma and ultimately death. For nine months following the explosion pregnant women that suffered heavy exposure were also plagued with birth deformities and stillbirths (2). Regions bordering both cities experienced a 'black rain' of radioactive materials which remained detectable in soil and farm products for years (2). There continues to be an increased rate of cancer of any organ among the survivors. The devastation caused by these two relatively minor bombs was non-specific, aggressive, massive and complete.

At present, nine countries harbour more than 30 000 nuclear weapons, of which more than 10 000 remain operational (1). As long as even one weapon exists there is a risk of nuclear weapon deployment and detonation by design, accident, miscalculation, or by terrorists. Unfortunately, the political power conferred by these weapons has severely hindered efforts to disarm and dismantle the world's stockpiles and has been incentive for several countries to begin new programs or strengthen old ones. It is no secret that nuclear bombs are the most powerful and destructive weapons known to humankind – and today's nuclear weapons are many times more powerful than the bombs dropped on Hiroshima and Nagasaki. The devastation is almost unimaginable. But the diagnosis is clear - we have an autoimmune disease. Hundreds of thousands of innocent people have already suffered and died. Tens of thousands of nuclear weapons still exist and many are armed and ready to be deployed at the push of a button. With the known destructive capacity of nuclear weapons there is no doubt that we are capable of destroying our entire existence. Every single one of us is vulnerable and at risk.

What can you do? Educate yourself. Help raise awareness. Become involved with one of the many strong initiatives currently working to achieve global abolition of nuclear weapons. One such group is Physicians for Global Survival (PGS) of Canada, which has recently helped to launch the International Campaign to Abolish Nuclear weapons (ICAN). You can learn about the Canadian and international goals for ICAN by visiting the campaign website at www.icanw.org to find out more about how you can become involved.Q

For more information please visit:
Physicians for Global Survival: www.pgs.ca
International Physicians for the Prevention of Nuclear War: www.ippnw.org

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PHOTO CONTEST: HONOURABLE MENTIONS

The following photos represent the honorable mentions in the recent QMR photo contest. There were no restrictions on submission content and style. We received a range interesting and beautiful photos and the difficult job of judging fell to the Queen's Medicine Photography Club. The winning photo, submitted by Alex Atfield, is featured on this issue's cover. The QMR would like to thank everyone who participated in the contest, and we extend our congratulations to the winners.

Above: *Alexandre Atfield;* ***Below:*** *Christopher Noss*

***Above and Right**: Alexandre Atfield; **Below:** Christopher Noss*

***Above:** Christopher Noss; **Below:** Jasmine Lambda*

Above: *Maurice Ennis;* ***Below Left:*** *Alexandre Atfield;* ***Below Right:*** *Christopher Noss*

An Introduction to Human Rights and the Human Right to Health

BY JESSICA MOE

There are few Canadians for whom the words "human rights" fail to evoke some vivid image. Perhaps it is of a brutal massacre, of men in uniform unleashing AK-47 rounds indiscriminately into a hysteric crowd. Or maybe it is of Western activists unfurling, for waiting cameras, a sensationalist banner screaming epic violation. Perhaps it is an image of starvation, of children with toothpick arms and distended swollen bellies listlessly wasting away. Or maybe even it is the image of a lone, brave soul caught in a timeless confrontation with an armoured tank.

Whatever the image, it is certain that human rights have woven themselves, in many ways, into our everyday discourse. We see them on the front pages of newspapers, on grocery store labels, in the bookstore, at the movies. Indeed, human rights are powerful – the idea that we, as human beings, have rights inherent to our very existence; that we are entitled to something, irrespective of the variability of our changing conditions. It is little wonder that the mere mention of human rights is often enough to evoke an emotional response.

But once the rage or euphoria of the emotional reaction has worn off, what are human rights after all? A journey through the winding corridors of international law provides some insight into the sources and meanings of human rights.

Origins of Human Rights

The concept of individual liberty was born during the Age of Enlightenment in 18th century Europe. Antecedents of fundamental human rights concepts can be seen in John Locke's elaboration of natural rights including life, liberty, and property, and in Rousseau's idea of the 'social contract' from which citizens derived their rights (i.e. things that they were entitled to) and sovereigns their powers. Human rights as such became codified for the first time at the turn of the 19th century, and, into the 20th century, developed internationally as labour standards.

Human rights definitively entered the forum of international law with the atrocities of the Second World War fresh in the collective international memory. The Charter of the United Nations (UN) was signed in 1945; it established as one of the main purposes of the UN to "achieve international cooperation... in promoting and encouraging respect for human rights and for fundamental freedoms." The Universal Declaration of Human Rights (UDHR), adopted by the UN General Assembly in 1948, is the earliest comprehensive international human rights instrument. The UDHR along with the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR), adopted in 1966, make up the 'International Bill of Human Rights'.

What are Human Rights?

Human rights are commonly understood to be rights accrued to all human beings by sole virtue of their humanity. However, schools of scholarship differ on whether these arise naturally or are social constructions. Some even challenge the premise of human rights altogether, dismissing them as a form of Western moral imperialism that has little sensitivity to cultural nuance. Human rights are certainly not absolutely accepted, and even when codified in law, they are cautiously limited. Section 1 of the Canadian Charter, for instance, guarantees rights and freedoms within " limits prescribed by law" and only when they can be "justified in a free and democratic society." Moral and philosophical debates notwithstanding, human rights are part of a web of factors that influence how individuals, countries, and the international community act and interact.

Basic human rights are premised on the need to protect the individual against the potentially arbitrary use of power by the State. Human rights also apply "horizontally" to prevent individuals from infringing the rights of others; however, there is no universal consensus on the extent to which private actors (like individuals, corporations, or paramilitary groups) can be held accountable for human rights violations. Importantly, at the least, human rights give rise to State obligations, both positive (i.e. the State must provide something) and negative (i.e. the State must refrain from doing something) in nature.

Human rights are commonly classified as civil and political, or economic, social, and cultural. Civil and political rights generally describe 'basic rights' and 'physical integrity rights'. These include such rights as the fundamental right to life; freedom from discrimination, torture, inhuman treatment, arbitrary arrest, and interference with one's privacy and

ownership; freedom of thought, conscience and religion; and freedom of expression, association and assembly. The ICCPR is the key international instrument codifying civil and political rights.

Economic, social and cultural rights may be described as rights that provide conditions for prosperity and wellbeing. These include rights to property, work, and a fair wage; to health, shelter, food, and education; and to participate in the cultural life of the community, as well as to share in scientific advancement. Economic, social and cultural rights are entrenched in the ICESCR.

While international treaties cannot be directly upheld in Canadian courts, they serve as important references for the interpretation of domestic law. To illustrate, between 1998 and 2003, the Canadian Supreme Court referred 27 times to international instruments and institutions in Charter decisions.

A Dichotomized View of Human Rights

Economic, social and cultural rights are widely perceived to be secondary to civil and political rights in weight, due to their alleged vagueness of definition and imposition of positive obligations on States. In contrast, civil and political rights are seen to be more precise, and to produce negative State obligations. As a consequence of these views, civil and political rights are considered to be more concrete and easier to uphold in judicial contexts.

"Rights only have meaning when they are considered to be intrinsically interconnected. For example, my right to vote has little value if I am too sick or hungry to be able to exercise it."

However, this polarized view is simplistic; both civil and political rights, as well as economic, social and cultural rights generate a range of positive and negative State obligations. Rights only have meaning when they are considered to be intrinsically interconnected. For example, my right to vote has little value if I am too sick or hungry to be able to exercise it.

The Human Right to Health

The essential aspects and complexities of human rights can be seen in the examination of the 'right to health'. The preamble of the World Health Organization Constitution in 1946 was the first to explicitly outline the right of every human being to the "enjoyment of the highest attainable standards of health," which is governments' responsibility to provide." The 'right to health' is enshrined in many international instruments, including the ICESCR (Article 12.1), the UDHR (Article 25.1), the Convention on the Elimination of Discrimination Against Women (Article 12), the Convention on the Rights of the Child (Article 24), and the Convention on the Elimination of All Forms of Racial Discrimination (Article 5).

(I) Obligations

The 'right to health' generates both negative and positive State obligations. The 'right to health' means that the State cannot obstruct equal access to basic health services, and cannot act in such a way that endangers peoples' health. Equally, it means that the State must protect people from third party infringements on their health. Furthermore, it creates the positive duty to provide basic health services and to create conditions conducive to adequate access to health services.

Human rights may be conceptualized as a minimum floor of acceptable standards necessary for the preservation of human dignity. Along these lines, the core content of a right comprises the essential elements without which the right is meaningless. The core obligations arising from the 'right to health' have been interpreted as the State's duties to ensure "the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups," and to basic shelter, minimum nutrition, sanitation, water, essential drugs, and to equitable distribution of health facilities.

(II) Enforceability

It follows that various aspects of the 'right to health' are enforceable to differing degrees. States have been found to have violated the 'right to health' for displacing people from their homes , causing adverse health consequences ; for failing to legally obligate that blood products be adequately screened by blood banks, leading to HIV transmission; and for failing to provide hospital services to critically injured persons. While it is challenging to uphold positive obligations for the provision of basic health services, importantly, the 'right to health' may be upheld under the umbrella of civil and political rights. This is most notable where health intersects with rights to life and to non-discrimination. The Eldridge Case in British Columbia illustrates this point: here, the Supreme Court ruled that B.C. must provide interpretation services for hearing-impaired individuals within hospitals, upholding the 'right to health' under the right to non-discrimination (Section 15.1 of the Canadian Charter of Rights and Freedoms).

Clearly, the 'right to health' is real and enforceable. Its codification in treaties and confirmation in judicial decisions symbolize international and national consensuses that health is of fundamental importance in the respect of human dignity.

The Added-Value of Human Rights

'Human rights' is one of many lenses through which one may view the world. As such, it is a useful analytical framework, adding terms of entitlements and obligations to our understanding of difficult situations. Human rights also set standards of permissible behaviour that add strength to advocacy and impetus to dialogue. As health advocates, human rights language gives us a tool to uphold the right of all peoples to equal access to basic health services and to the fundamental building blocks of health.

Human rights are conceptually interesting – somehow, the abstract notion that we are entitled to something by virtue of our humanity can lead to real policy and public health outcomes. Equally, however, human rights discourse can enter the realm of self-righteous moralizing, the "I'm better than you are because I believe in human rights" attitude that stops discussion before it begins. Human rights can become a sacred justification of action that precludes the necessity of any thought, and thus strips the action – whether well-intentioned or not – of any meaning.

The truth is that human rights are not a sacred panacea; they are complex in their meaning, applicability, and enforceability. We must never stop to critically contemplate what it is that we are advocating for, because if we do, we risk being dangerously unconscious of our impact in this world. By never stopping to question, we become more conscious of ourselves and of our actions. Human rights should be used as a tool to stimulate dialogue, not to stifle it; as such, they will allow us to be stronger, more thoughtful advocates. By gaining a basic understanding of human rights, we become more educated, critical, and credible agents for the necessary confrontation of injustice. Q

This article has been peer-reviewed.

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MEDICINE@LARGE QMR

Health: A State of Physical, Mental, Social and *Ecological* Well-Being?

BY ELIZABETH MILLER

With gradually rising global temperatures and sea levels, a clearly visible increase in weather extremes coupled with ever-dwindling sources of potable water, the health of our environment is becoming a growing concern on a global scale. During the same time period in which we witness the effects of global warming, our reliance on pesticides and herbicides for both agricultural and cosmetic (gardening) use is compounding the threats on our ecosystem and human health. Recently, the attention surrounding poor air quality in Beijing during the 2008 Summer Olympic Games emphasized the impact of human beings on the environment. The menacingly low air quality indices were a major concern for the athletes, and these brought the severity of pollution's impact upon human health to the attention of the global community. Closer to home, many Ontarians, including the Ontario College of Family Physicians, are becoming increasingly concerned about the dangers of urban sprawl to our health in areas such as the Greater Toronto Area (GTA) and Ottawa's (1).

"CAPE has worked to inform the public about the health effects of pesticides and, with other groups, pushed for legislation that reduces the use of pesticides."

Although the exact nature of the link between environmental and human health is not always clear, a group of physicians is working to promote the importance of environmental health related to human health. The Canadian Association of Physicians for the Environment (CAPE) is "a group of physicians, allied health care practitioners and citizens committed to a healthy and sustainable environment" and "works to protect the environment in order to protect human health" (2). Since 1994, CAPE has been recognized as the Canadian affiliate of the International Society of Doctors for the Environment. CAPE's objectives include educating physicians about environmental issues, increasing awareness about the health implications of environmental issues, and advocating for certain courses of action (2).

CAPE is involved in protecting human health from harmful environments. One of CAPE's main concerns is children's health, and protecting our youth from environmental harm (2). Secondly, CAPE is concerned with the effects of climate change on human health. Their concerns include increases in insect-borne disease, injuries due to severe weather and raising sea levels, food shortages, the lifestyle of Canada's First Nations, and increased disease due to higher temperatures (2). A third priority is the risk of environmental toxins (2). Although pesticides are widely used in agriculture, landscaping, and on golf courses and soccer fields, their negative effects on human health are being increasingly recognized. For example, the Ontario College of Family Physicians' review of relevant literature found that there are associations between pesticides and the development of solid tumors and leukemia (3). CAPE has worked to inform the public about the health effects of pesticides and, with other groups, pushed for legislation that reduces the use of pesticides (2). Many cities are beginning to restrict cosmetic pesticide use (e.g., for lawn care), through by-law enactment, and Kingston recently passed a by-law regulating the use of cosmetic pesticides that will come into effect on October 15, 2008 (4).

CAPE is also involved with reducing the health care system's impact on the environment. One way to measure environmental impact is through calculation of an 'environmental footprint'. This is an area-based measure of an individual or population's demands for goods and services (5), and is defined as the "total area of productive land and water required on a continuous basis to produce the resources consumed and to assimilate the wastes produced by a specified population"(5). Did you know that the average environmental footprint for an individual is 7 ha of land (5)? Considering that there is only 1.5 ha/person available, this is unsustainable. Recently, Susan Germain (MD and Member of the Board of Directors of CAPE) calculated the environmental footprint of a mid-size hospital in Vancouver at 2,841. This is 719 times its physical footprint (5). The impact of hospitals on the environment is not surprising when we think about the waste, drugs, and chemicals they expel. For example, in Dr. Germain's study, 1.8 million pairs of gloves and over 6.4 tonnes of sterilization wrap were collected as waste (5). One of CAPE's initiatives is to promote the principle of primum non nocere – "first do no harm" (2) and works to promote green health care through, for example, conserving energy and minimizing waste.

"The impact of hospitals on the environment is not surprising when we think about the waste, drugs, and chemicals they expel."

As we continue to advance and to develop health care, physicians should not ignore the significant impact of environmental factors in both the diagnosis and treatment of a number of diseases, especially respiratory illnesses in pediatric and geriatric populations, and in oncology across all age groups. It is very important that organizations like CAPE exist, continue to grow, and promote a healthy environment for healthy living. I encourage physicians and medical students to consider the environmental impact of health care delivery, to advise patients about strategies that minimize personal risks of exposure to environmental toxins, and to collectively advocate for strong public policies that favor preventative medicine and a safer environment.

If you are interested, you can calculate your personal environmental footprint by visiting: http://www.myfootprint.org/en/.

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Dr. Peter Corbett

BY BRAD BIAGIONI

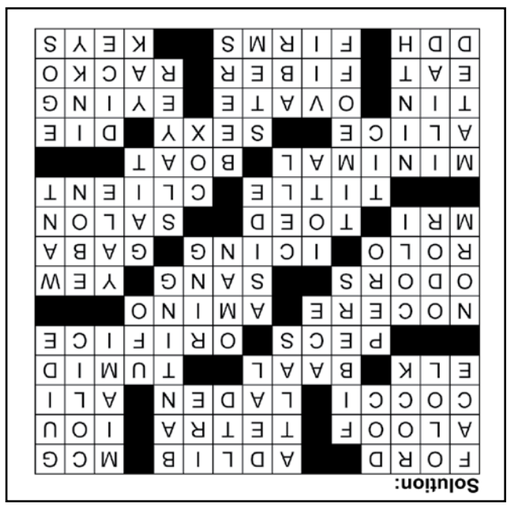
Dr. Peter Corbett is a British-trained radiation oncologist and the former head of radiation oncology at both the Tom Baker Cancer Center in Calgary, AB and the London Regional Cancer Center in London, ON.

Since 9:00 AM, I have been in the medical oncology clinic at the Tom Baker Cancer Center in Calgary. The typical organized chaos of clinic is occurring all around me. Charts are stacked and ready for review; a couple of patients are waiting as nurses, doctors and technicians rush about. Patrick, the internal medicine R2 who is showing me around, is new to this place as well. He asks the nurse how much time we have to see the first patient, and looks shocked to hear: "as long as it takes."

At noon, after seeing only two patients, I am off to meet Dr. Peter Corbett, the person responsible for setting me up with this particular observership. Peter is a family friend. My brother and sister went to high school with his kids, I have been to his home a number of times, and he's a regular attendee at my parents' annual Stampede party. I have never before met the Dr. Corbett, radiation oncologist and former head of radiation oncology at two major Canadian cancer centers, with who I am to talk to this afternoon.

I am shown to his office, where we have a quick chat, and then we're off. First on our agenda is a simulation: the planning of a treatment regimen for a breast cancer patient. After examining the real-time images generated by the simulation machine, Dr. Corbett draws up the treatment plan. I am treated to Corbett's Essentials of Oncology, which consists of two sigmoid lines on a graph, with dose on the x-axis. One line represents "tumor/disease control" and the other "ill-effects/death." Peter tells me, "All of oncology – and perhaps all of medicine – is concerned with tearing these two lines further apart."

"Medicine is human biology…it's the stories that are fascinating, and it's a privilege that we get to hear them."



Dr. Corbett's educational background has, at least in part, fostered his broad view. He started medical school at University College London in 1963, where instead of fast-tracking into clinical work, he took the time to finish a B.Sc. in neuroanatomy during his pre-clinical training. This allowed him to interact with basic and social scientists, such as the famous physical anthropologist Lewis Leakey. "True academics challenge everything," he tells me.

It makes sense, then, that after completing his training as a surgeon, Dr. Corbett would choose not to pursue further training at the University College Hospital. "I realized that with the medical unit I would have been on, I'd see every case of tertiary hyperparathyroidism in England, but never a patient with diabetes or a stroke, and I took myself off to another hospital where I would get more general medical experience." After completing this training in Nottingham, he moved to Cookridge Hospital in Leeds seeking a consultant, or staff job. This is where Dr. Corbett would develop his interest in oncology. "In about 1975, after doing surgery for about 4 years…I got into this oncology training with the idea of developing as a surgeon specializing in cancers," Peter says. "[Oncology] was interesting…we did both the radiation and chemotherapy, and offered lifestyle things I didn't know about, like nights off. So I stayed in it."

It was this search for professional fulfillment and lifestyle balance that led Dr. Corbett to Canada. His career was rewarding and cancer treatment was developing rapidly, but he found himself getting restless. "I told everyone I was going to London for a few days," he jokes, "it wasn't entirely untrue." His visit to London, Ontario led to a job offer as head of the radiation oncology department, just in time to move to a brand-new, purpose-built facility for cancer treatment. "It was an offer I couldn't refuse," he says. Dr. Corbett spent four years in London: "It was an exciting time, the work was good, and I enjoyed the challenge of building a whole new department from the ground up. Buying equipment, trying to see far enough into the future to make sure our patients' needs would be met." He would eventually move on to Alberta, where he helped guide the radiation oncology department in Calgary through major expansion and restructuring.

As with most doctors, Peter has struggled to find a work-life balance. "I think that you go through periods, in residency, the start of your first staff position, where you make sacrifices," Peter says after describing his grueling residency schedule. "There is this culture in medicine that…equates sacrifice [of your life] to dedication to patients, but you also have responsibility to dedicate yourself to yourself and your family." With this in mind, I ask him if he has any advice for those just starting a career in medicine. "Keep the perspective. Take a long-term view. If you don't take care of yourself, then you are not able to function well as a doctor."

As I drive home from my meeting with Peter, my mind drifts back to the first patient I saw at the Tom Baker Cancer Center. We weren't there to explain his symptoms, or to diagnose his disease, or even to talk about his bowel cancer. We were there to listen to his frustration with his chemotherapy, how it was hell on his digestion, how it makes him irritable, that he snaps at his wife and kids without knowing why. We spent over an hour with this one patient, simply listening to the story of his disease and treatment. Peter's words float back into my head, "Medicine is human biology…it's the stories that are fascinating, and it's a privilege that we get to hear them."

Dr. Tony Daicar

BY TYLER LAW

Dr. Tony Daicar was born in Zlin, Czech Republic, home of the prosperous Bata shoe factory, which employed his father. With the coming German invasion in 1939, the company sought to re-distribute its employees and their families to other production sites. For the Daicars and 180 other families, this meant immigrating to Frankford, Ontario. Dr. Daicar grew up in this tight-knit community composed of other Czech immigrants and the Frankford residents. It was the influence of his community that persuaded Dr. Daicar to pursue medicine over architecture, his initial career choice. After graduating with the Queen's Medicine class of 1957, Dr. Daicar specialized in Obstetrics and Gynaecology, eventually obtaining additional training in sexual medicine. Upon retirement, Dr. Daicar pursued training in sculpture. His former specialty has greatly influenced his sculptures, which frequently display images of mother and child.

What led you to choose a career in Medicine? Did you always want to be a doctor?
From the time I first began to think about what I wanted to be, I wanted to be an architect! Medicine was thrust upon me by well-meaning relatives and friends who felt that I would make a good doctor. This, of course, was very flattering and, not wanting to disappoint anyone, I applied to Medicine at Queen's and to Architecture at UBC. I was certain that I didn't have a hope of getting into Queen's.

Dr. Tony Daicar

I was interviewed by the Secretary of the Faculty, who logically asked why I wanted to be a doctor, and why he and his colleagues should spend six years of their precious time educating me to be one! I didn't think that I provided any adequate answer. Then came the 'coup-de-grace': "Well Daicar," he said, "your marks seem good enough, but can you catch a football?!" I had to admit that I couldn't. I explained that my high school had been too small to field a football team. The fact that I was pretty good at throwing the discus and javelin didn't seem to count.

Thus, I was in total shock and disbelief when I received word that I had been accepted to Medicine at Queen's, as well as to Architecture at UBC, with only 10 days to respond!

What did you enjoy most about Queen's? What would you have changed?
I did enjoy my medical school years at Queen's, but there were times that I felt that I had not made the right career choice. The early years were, to me, an endless round of lectures, furious note-taking, and memorizing of facts and figures, which then had to be regurgitated at exam time. Everything began to make sense when we were finally exposed to patients in our senior years. The current curriculum is far better, and several of my classmates, who returned to Queen's, have played important roles in making these changes.

What was important in your decision to specialize in Obs/Gyn?
I spent the summer prior to my final year of medical school at the Belleville General Hospital as a "Summer Externe". It was then that I first experienced what being a doctor was about, and when I first truly felt that I had made the right career choice. It was in Belleville that my classmate Wesley Boston and I delivered our first baby. Wesley became a Neonatologist and I became an Obstetrician/Gynecologist. We both returned to Queen's and,many times, shared the care of mother and baby in the delivery room. I have never lost the thrill and wonder of the ultimate act of creation: the birth of a baby! What a privilege to witness such an event!

What were some of the highlights and challenges of your career?
After graduating in 1957, and following a one year internship in Toronto, I did my postgraduate training in Obs/Gyn at KGH, in Oxford and Bradford, England, and in Albany, N.Y. I obtained my FRCSC in 1963. The following year, I joined the Department of Obstetrics and Gynecology at KGH and Queen's.

In 1958, the two Senior Residents at KGH were Stevan George (recently arrived from Glasgow) and I. We became lifelong friends, shared the same love for our chosen specialty, and decided very early in our careers that we would practice together. We were both invited to join the Faculty at Queen's, and established Kingston's first joint referral practice in Obs/Gyn. Our peers were sceptical, saying that women would object to having shared care. However, this proved not to be the case. Our patients were satisfied with their care, our families were happy to see more of us, and we enjoyed working in partnership.

Almost every day presented highlights and challenges. Obs/Gyn is, for the most part, a happy specialty. One deals with women of all ages, and learns to admire and respect them. The opportunity to work with my departmental colleagues and to teach medical students and residents was, of course, a highlight of my career.

What was your experience with sexual medicine (an often overlooked area of the specialty)?
My involvement in Sexual Medicine was the 'icing on the cake' of my career at Queen's. Following a sharp learning curve, beginning with three months at McMaster, I returned to KGH with forty referrals on my waiting list. In the subsequent fifteen years, the Sexual Medical Clinic filled an important role in patient care and the education of not only our Obs/Gyn Residents but also Family Medicine Residents and Senior Medical students. Every year I attended courses and meetings that improved my knowledge and confidence. It was a very interesting, but also demanding, experience, and caused me to delay my anticipated retirement. Unfortunately, when I did retire, despite very good candidates willing to take my place, the clinic has ceased to exist. However, the need for it still remains.

You must have seen some dramatic changes in medicine during your practice.
The practice of medicine has changed in many ways, mostly for the better. Technology has provided many tools, but some are being over-utilized at the expense of the most basic and important ingredients of good patient care: a proper history and physical examination. I was taught that, if after taking the history, I could not come up with a good differential diagnosis I should take the history all over again! Tests and investigations ought to be ordered only after a thorough physical examination, to support or confirm a working diagnosis. This was called the "Art of Medicine."

Mother and Child. Media: Alabaster
A sculpture by Dr. Daicar.

I fully support the team approach to medical care. I fail to understand and decry the long waiting times for appointments and treatment.

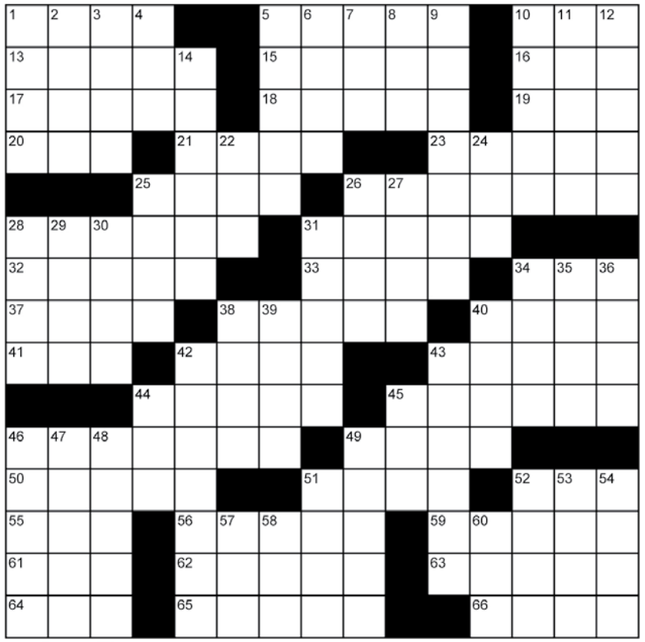
Since retiring, you have become interested in sculpture, which is not common among physician-retirees. Could you tell us how this interest came about?
I have always enjoyed creative visual art. However, during my medical career, there was simply not enough time to indulge in that interest. I was determined to follow another career in retirement, and sculpture seemed to fit the bill. I took my first course in drawing and sculpture at Queen's in 1989 and loved it. Thereafter, my family's winter holidays were spent in San Miguel Allende in Mexico, where I learned bronze casting. My current work is in stone carving: in marble, alabaster, limestone, and various soapstones. If you would like to see what I do, visit: www.daicarsculptures.com.

What thoughts do you have, or what advice can you give, about maintaining interest in activities outside of Medicine?
I found it very difficult to pursue many other interests during my clinical and academic work, in order to do my job well and not short-change my family. However, one thing that I found essential to include in my daily life was physical activity. From my earliest childhood, I was involved in sports (not including football) and I was able to remain active in tennis, squash, skiing, and sailboat racing. Together with a former Queen's Dean of Medicine, I have the historic distinction of colliding with an American sailboat during CORK (an international sailing regatta). We sunk the boat, and thus participated in the first sinking of an American boat by a Canadian boat since the war of 1812!

What advice would you like to share with the current medical class?
We all realize that time is our most precious commodity, and, in medicine, we must be willing to share a great deal of it with our patients. Give your patients the time that they require, and listen carefully to what they have to say. Do not neglect a thorough physical examination. Utilize the wonderful new technologies judiciously. You have chosen a wonderful career. Enjoy! Q

Medicalese

BY DANIEL FINNIGAN



www.CrosswordWeaver.com

ACROSS

1 Betty of drug and alcohol rehabilitation
5 Improvise a speech
10 Metric weight unit
13 Distant in manner
15 Having four, prefix
16 Acknowledgement of debt
17 Some bacteria
18 Heavy
19 Boxer Clay
20 Moose relative
21 Phoenician local deity
23 Swollen
25 Chest muscles
26 Mouth, e.g.
28 Primum non _
31 _ acid
32 Smells
33 Made music vocally
34 Taxol source
37 Rolled chocolate candy brand
38 Cake topping
40 CNS inhibitor
41 Definitive for diagnosis of meniscal tear
42 Pigeon _
43 Hair _
44 Dr, eg
45 Customer
46 Token value
49 Navicular shaped
50 Girl in Wonderland
51 Attractive
52 Doctor tries to avoid their pateint doing this
55 Composition of a man in need of a heart
56 Elliptic
59 Looking at
61 Dine
62 Muscle or nerve
63 Brand of Tile game
64 Risk for large first born female baby in breech position
65 Who lawyers work for
66 Maple, house, and sour

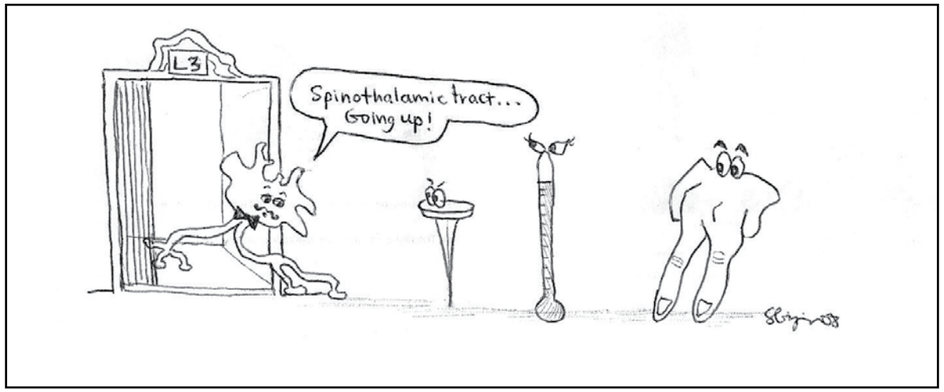
DOWN

1 To address, as a problem
2 Beta-blocker suffix
3 Lava, e.g.
4 Medical practitioner, short form
5 Prometheus' brother
6 Transaction
7 Limited (abbr.)
8 Anger
9 Discovered insulin
10 Florida City
11 Toddler disease
12 Usher
14 Muscle component, plural
22 Inhibitor for BP
24 Vehicle of ET
25 Brand of coffee alternative
26 Asian nation
27 Finger ornament
28 Average
29 Smell
30 E. _
31 Side note
34 Harvard rival
35 Black
36 Desire
38 Small particle
39 Monk's room
40 Walking style
42 Break (2 wds.)
43 Killer
44 Twitch
45 NSAID target
46 Paired sock
47 Book by Homer
48 Glossopharyngeal
49 Ales
51 Controversial cells
52 Game cubes
53 Murky
54 Self-esteems
57 It takes this to smile
58 Abridged (abbr.)
60 Wild ox

For solutions, see page 24

Blumenfunny

BY SANDRA GUIRGUIS



Dear QMR,

Please share this with my fellow medical students.

The following is an anonymous letter that was sent to QMR by a Queen's medical student. Efforts have been made to respect the privacy of all persons concerned.

A woman with a mental illness is brought to the hospital. She is dazed, clearly distraught by her strange and bewildering situation. She is escorted to an isolated room where her shouts are muffled behind the closed doors.

The attending physician, barely looking up from the chart, makes a callous joke. The laughter that follows from the surrounding staff echoes the same callousness.

Nobody so much as stops to ask who this woman is, nor to ask for her story.

This is something that I saw during my hours at the hospital, and it impacted me in a profound way. I couldn't help but wonder what this woman was thinking and feeling at that moment. I thought about the complexity of my own experience, about the times that I've felt fear or confusion, and how alone I was in the solitude of those feelings. I have no idea what must have been going through that woman's head, but what I do know is that she is as complex a human being as any one of us. She has a story, like any one of us. And, by so casually diminishing her condition, we – the medical establishment – failed her.

Our 'uniqueness' as medical students is constantly being driven into our heads. Indeed, we have the privilege of the incredibly formative experience of medical school that is bound to change us somehow. My hope is that we are aware enough of who we are – of the fact that we too can be vulnerable, scared, and alone – that we don't lose sight of being human. It is not okay to diminish people who are sick, scared, or different; it is not okay to make passing comments about people with debilitating illnesses, or conditions we may never have experienced or do not understand; it is not okay to perpetuate injustice by being passive when we know that something is not right.

I came home feeling horrible because I witnessed an injustice that I knew was wrong, and I did nothing. I was paralyzed by my inability to confront a doctor who is my superior; I felt disempowered in my own socialized position. It takes courage to stand up alone, and I failed to overcome my cowardice.

It would be unfair (and too easy) to blame this individual physician for the injustice of those remarks. Often, our indifference is a shell which we shrink behind to protect ourselves. But more importantly, insensitivity is a manifestation of the larger, structural inequalities in which we live and operate, that shape our thoughts and actions in ways we don't even recognize. Over months and years, we are conditioned to laugh at jokes that our gut tells us aren't funny, and to look down on the marginalized of society – the addicts, the prostitutes, the prisoners, the mentally ill – because it props up the pretence of our own self-importance.

We need to support each other collectively as we strive to be the change that we believe in. We need to bring each other back down to earth if, in becoming doctors, we ever forget to be human. By doing nothing while we bear witness to injustice around us, we become agents of that injustice. For my part, I pledge that next time, I will not be a silent spectator to discrimination. I hope that you will join me in this pledge.

Passiveness is not an excuse, and injustice is never right.

Sincerely,

A Human Being who is your classmate and colleague