QMR

QUEEN'S MEDICAL REVIEW

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BREAKING NEW GROUNDS TO BUILD ON PAST TRADITIONS

The "Patch" reaction, creating the space to question, the legacy and controversy of Medical Variety Night, a neurosurgeon reflects on Canadian and American healthcare, and more!

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From the Editors

As stated in Rohit Mohindra's article, "A New Year, A New Hope," the American presidential election, with its historical outcome and charismatic new leader, has left in its wake the promise of change. Whether this change is positive remains to be seen; however, the idea of looking towards the future and seeking change is at the very core of evidence-based medicine.

This term marks an exciting time of change for Queen's Medicine. This fall saw the groundbreaking of the new Medical School building for future Queen's medical students. This fall also welcomed many new changes to the medical curriculum, with the addition of professionalism seminars in the first year class, as well as the addition of a Global Health course. The move towards team-based learning has been a large source of contention amongst medical students, and is the topic of this edition's "Point/Counterpoint."

Queen's medical students have also been effectors of change themselves, through their continued contributions to research. Our medical program requires all students to complete a "Critical Enquiry" after their second year of training in order to provide us with exposure to clinical research. The diversity of projects undertaken by students each year is remarkable, as is evident from the "Critical Enquiry" feature in this issue. We hope to showcase more summaries of our colleagues' research in future issues.

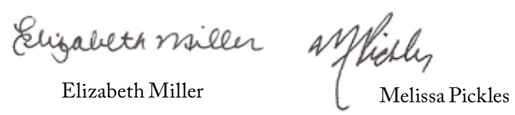
This issue reflects the progress and change that are occurring and also pays tribute to the present and past. Queen's is indisputably a school that values its traditions. While this can at times be frustrating (e.g., the continued retention of the "Honours" category), it also provides us with a sense of community identity, and a source of memories and nostalgia for years to come. Medical Variety Night, or MVN, is a current favourite tradition among medical students. This year's show, *Back to the Suture*, is reviewed from a first-year medical student's perspective, and "The History and Controversy of Medical Variety Night" outlines the challenges and accomplishments that our beloved variety show has experienced over the past century.

At the H.G. Kelly lecture, Patch Adams enlightened us with his very unique perspective of the present medical system. First and foremost, he considers himself a political activist, advocating for drastic changes in healthcare delivery. This sparked great debate amongst the medical students in attendance for weeks to come. Payam Yazdan-Ashoori writes about his experience getting Patch Adams to speak at Queen's, while four medical students provide their take on Patch's message.

In "A New Year, A New Hope," Rohit also encourages us to get involved and advocate for causes that we feel passionate about. "Notes from Tanzania" and "Matangwe" reflect upon the travels and adventures experienced by a group of students volunteering in clinics abroad. The Tunaweza and Matangwe programs, both of which are affiliated with Queen's Medicine, attempt to effect positive change in East Africa through community-based projects.

As always, QMR is also undergoing change with the addition of many new editors and writers with the incoming class of 2013. We would like to thank all of our new and returning staff for all of the hard work they have put into this issue, as well as welcome back Dr. Jacalyn Duffin as our faculty adviser. QMR was originally started by the class of 2011 in our first year of medical school, and we are excited that so many talented students in the 2012 and 2013 class will be continuing this project as we begin clerkship next term.

We hope that you enjoy this issue!



Elizabeth Miller Melissa Pickles

Editors in Chief

Internal News

BY JENNIFER LEE & RENEE PANG

QUEEN'S SCHOOL OF MEDICINE WELCOMES CLASS OF 2013

One hundred new first year medical students were welcomed to the School of Medicine during Orientation Week (September 2-5). Throughout the four day event, the class of 2013 engaged in various fun and exciting activities, such as attending the Dean's barbeque and the Thousand Islands boat cruise. Organized by upper year medical students and faculty, the week proved to be an unforgettable experience and a warm welcome.

PATCH ADAMS COMES FOR H.G. KELLY LECTURE

On September 10, the twenty-fifth annual H.G. Kelly lecture invited Dr. Patch Adams – a very well-known medical doctor, clown, and social advocate. The event was packed with students and faculty members from the School of Medicine, as well as other health care professionals and community members. Dr. Patch Adams presented on the topic of "the joy of caring." His talk encompassed his personal philosophy on compassion, service, and the power of caring.

HEALTH AND HUMAN RIGHTS CONFERENCE 2009

Queen's medical students and students from other faculties successfully organized this year's annual Health and Human Rights Conference. Held from October 2 to 3, the conference invited diverse speakers to share their unique perspectives on key health and human rights issues. The conference, entitled "Creating a Space to Question", provided the opportunity for attendees to challenge each other's assumptions and perspectives on critical global health issues.

ONTARIO MEDICAL STUDENT WEEKEND 2009 AT QUEEN'S

Queen's School of Medicine hosted this year's Ontario Medical Student Weekend from October 16 to 18. Roughly 500 medical students from six Ontario medical schools and the Canadian College of Naturopathic Medicine came to Kingston for the event. Students had the opportunity to participate in a wide variety of interesting workshops and lectures, from learning how to take a spinal tap to assessing the implications of practicing medicine during times of economic turmoil. Students were also able to enjoy a feast of interactive social events.

GROUND BREAKING FOR NEW BUILDING

The beginning of construction for the new home of Queen's School of Medicine took place on October 23 at the corner of Arch and Stuart. This exciting new addition to campus infrastructure will be among one of the most technologically advanced facilities in the country. Along with significant contributions from alumni and faculty, the project has been funded by the Government of Ontario and the Government of Canada's Knowledge Infrastructure Program. Construction is projected to be completed by spring 2011.

CHIAROSCURO 2009

Amidst the refinement of art, wine and cheese, the second annual edition of Chiaroscuro opened its doors to art-lovers and charity supporters alike on October 14 at the Agnes Etherington Art Center. The silent auction featured artists including Allison Chow, Cedric Gabilondo, Meiqi Guo, Oren Levin, Andrew Hurst, Jonathan Lee and Yong-Li Zhang, and included live music by DJ Romo and the Matchmakers. Over 6,000 dollars in ticket and art sales were raised from the event supporting the Juvenile Diabetes Research Foundation. For more information about Chiaroscuro, please see:

chiaroscuro.fr3.ca

BOYS AND GIRLS' NIGHT

On October 23, the Aesculapean Society hosted Boys' and Girls' Night at the Alehouse. Boys and Girls' Night is an annual school-wide fundraiser for Big Brothers Big Sisters of Kingston, Frontenac, Lennox and Addington, a local mentorship organization for at-risk youth. This year, over 500 dollars were raised through t-shirt and ticket sales. For more information about the charity, please visit their website at:

www.bigbrothersbigsisterskingston.com

News in Medicine

A LOOK AT MEDICINE OUTSIDE OF QUEEN'S

BY JACQUELINE WILLINSKY AND ZAINAB KHAN

MCMASTER'S SATELLITE CAMPUS GETTING UPGRADED

A new medical teaching centre, the Niagara Health and Bioscience Research Complex, is being built on Brock University campus. It will house McMaster's satellite medical school, which has been open for two years and currently runs out of St. Catherines General Hospital. The facility will be fully connected to McMaster's Hamilton campus. Over 170 have joined this new medical faculty with the hopes to recruit new physicians and advance health care in the Niagara region.

TORN ABOUT THE H1N1 VACCINE

Canada is currently in its second wave of the H1N1 pandemic. While the specialized immunization for this virus was recently approved and is now being distributed, polls reveal that 48 percent of Canadians do not plan on becoming vaccinated. Why is there this split down the middle? The reluctance stems mostly from several myths about the risks associated with the vaccine. Public health officials are working to reassure the population, and to educate people about H1N1.

DARWIN MAKES A COMEBACK

The World Health Summit, which recently took place in Berlin, revealed an upcoming field of medical research that is based on Charles Darwin's 150-year-old theory of evolution. Researchers feel that many modern diseases, such as asthma and obesity, can be traced back to natural selection. It is felt that this work will inform public health care and prevention measures.

AIDS VACCINE UPDATE

16,000 people in Thailand recently participated in a placebo-controlled study testing the efficacy of a new HIV vaccine. Although results were encouraging, showing that a series of vaccinations cuts the risk of acquiring HIV by 31 percent, experts say that they do not warrant widespread use of the vaccine. Efforts are being made to improve the current formulation.

CFMS - MCGRAW-HILL'S USMLEASY TRIAL

USMLEasy.com is a 8000+ question database for the USMLE Step 1, 2CK and 3 which simulates the real USMLE and provides other resources for medical students as well.

CFMS members receive an exclusive full-access trial account to USMLEasy.com which expired NOVEMBER 30, 2009.

PARKINSON'S LINK COULD LEAD TO NEW TREATMENTS

An Ottawa neurologist is part of an international research team that has uncovered a link between the genetics of blood cells and the brain cells that cause Parkinson's disease, opening the door to research that could lead to new treatments.

U OF T BODY DONOR PROGRAM PROFILED ON CBC'S SUNDAY EDITION

The University of Toronto Faculty of Medicine's funeral service to honor those who have donated their bodies for medical research was profiled in a radio documentary on CBC's Sunday Edition.

To listen to the documentary, entitled "That's Where I Want To Go," go to this link:
www.cbc.ca/thesundayedition/listen_stream.html

Select the October 11th edition of the program. The documentary begins at the 49 minute mark.

SIX MEDICAL PIONEERS NAMED CANADA'S 2010 HALL OF FAME INDUCTEES

The Canadian Medical Hall of has announced the 2010 inductees. The six inductees are:

Dr. Alan C. Burton MBE
Dr. William A. Cochrane OC
Dr. Phil Gold CC OQ
Dr. James C. Hogg OC
Dr. Vera Peters OC
Dr. Calvin R. Stiller CM OOnt

The Canadian Medical Hall of Fame is dedicated to creating a tribute to Canada's medical pioneers. Biographies of the inductees are available at
www.cdnmedhall.org/induction/

POTENTIAL CURE FOR MS

Dr. Paolo Zamboni, of Italy, has formulated a new model for multiple sclerosis: he defines the disease as a hereditary chronic cerebrospinal venous insufficiency due to iron buildup. The model is in its early stages of scrutiny. It is quickly growing in popularity because it led to a novel surgical treatment that was proven beneficial in a trial with 65 patients. Dr. Zamboni's research efforts were grounded in hope and love for his wife, an MS patient who has been free of signs and symptoms since undergoing his surgery three years ago.

"The introduction of Team-Based Learning is a positive development in medical education."

// For BY ANDREW GILES

We have all cajoled, criticized, and enjoyed various aspects of team-based learning (TBL) here at Queen's Medical School. Despite the difficult transition, I believe that in the pursuit of becoming lifelong learners and doctors with strong foundations, TBL is a change for the better.

Let me begin by saying that this issue runs deeper than simply maintaining our accredited status. Medicine is evidence-based, and it is important that our educational model follow suit. We are departing from the "old style" of didactic lecture followed by methodical review. This encourages a narrowly focused learning style that is disparate from the applied nature of medical practice.

In contrast, research shows that TBL results in deeper learning and helps develop such crucial skills as problem solving. Students prepare by learning directed material, and then interact with classmates and professors in the classroom around clinical cases. Professors can now elaborate on relevant concepts and instill high-level thinking strategies, rather than having to rehash what we could easily read on our own.

TBL provides a real-world forum for learning medicine, introducing us to the case-based approach that we will use for the rest of our careers. Furthermore, it puts our education in context of the interpersonal nature of our profession. Our days as physicians will not be spent in lectures or reading textbooks, but rather collaborating with patients and colleagues. Team-based learning is the best method for acquiring these habits and skills.

While our new curriculum is still rough around the edges, we are in the midst of a healthy and necessary refining process. I have had the privilege of curriculum representation, and have been amazed by the responsiveness of the administration to receiving and addressing our concerns. Together we are sowing seeds that will reap rewards for our own education and for that of future generations of medical students.

// Against BY WAJI KHAN

There are many sacred rules in strategic consulting. One such rule is that strategy and structure must match and support one another in order for things to work effectively. The introduction of team-based learning (TBL) can be both positive and negative in this light. I am of the opinion that it has been mostly negative at Queen's University Medical School, as a result of inappropriate implementation of the structure.

Firstly, most students in medical school are the best-of-the-best in terms of learning in a traditional lecture/reading format and then writing a multiple choice exam. This is the structure of the system that gets us into medical school, and this is the system in which we function best. I am not debating the merits of learning outcomes from other teaching methods. I am simply stating that asking us to do team-based learning is like asking the finalists of the Olympic Track 100m race to compete for the gold medal in a pool. Changing the rules and moving the cheese is not something that medical students are trained for.

Second, the use of this method is contingent upon the development of a valid curriculum that has both content and facilitators who can implement the learning style effectively. There is no doubt that team-based learning requires more of both the educator and the student, and that the outcome is superior. However, I feel that we have blindly adopted TBL without adequately preparing the student for these sessions and without preparing the instructor for proper implementation of this teaching method. As a result, our TBL sessions have either been glorified lectures with multiple attachments to read or vague learning sessions with students staring at the sky wondering what they've been doing for the past four hours.

Overall, although team-based learning has the potential to

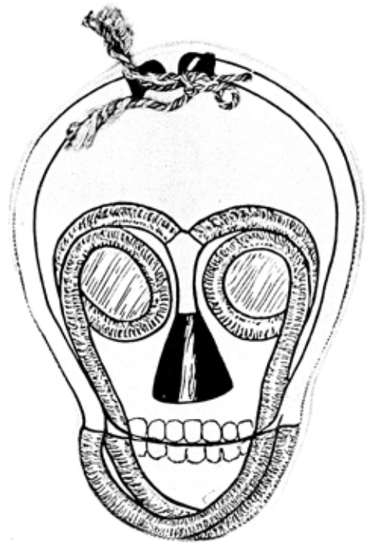
Against, continued on page 34.

The opinions expressed in the Point/Counterpoint articles are the views of the authors and do not represent the views of the QMR Staff.

The Legacy and Controversy of Queen's Medical Variety Night

BY ELIZABETH MILLER

A traditional variety show, like Queen's Medical Variety Night (MVN), is one of the few forms of entertainment that has truly stood the test of time. While MVN has seen minor changes over the years (ticket price, for example, has increased from 50¢ in 1965, to $5 in 1987 (1), to $10 in 2008 (2)), both current medical students and alumni alike have a similar reaction to the question, "what are your memories of MVN?" No matter how long it has been since graduation, every Queen's Medicine alumnus reacts with the same guilty laugh, a fond explanation of the poor acting, and a beaming sense of pride in the camaraderie and community that surrounded, and continues to surround, the show.



1920 Aesculapian Society Annual Dinner menu
Courtesy Queen's University Libraries / Archivist & the Aesculapian Society

Although MVN is ragingly popular among the medical students at Queen's, it was not always as well-received by members of the faculty or the Kingston community. The spicy details of the shows are rarely recorded, maybe for that very reason. Recollection of the show relies intensely upon the oral tradition of stories between generations of medical students and faculty members. With this year marking the 39th Anniversary of MVN, Queen's Medical Review would like to reflect upon, and pay tribute to, all of the remarkable individuals who throughout the history of the show have worked to fundraise, educate, entertain and pass on the traditions to future generations of students. It is also a wonderful excuse to plunge into the Archives and "pick the brains" of our esteemed faculty members for scandalous stories of MVN's past.

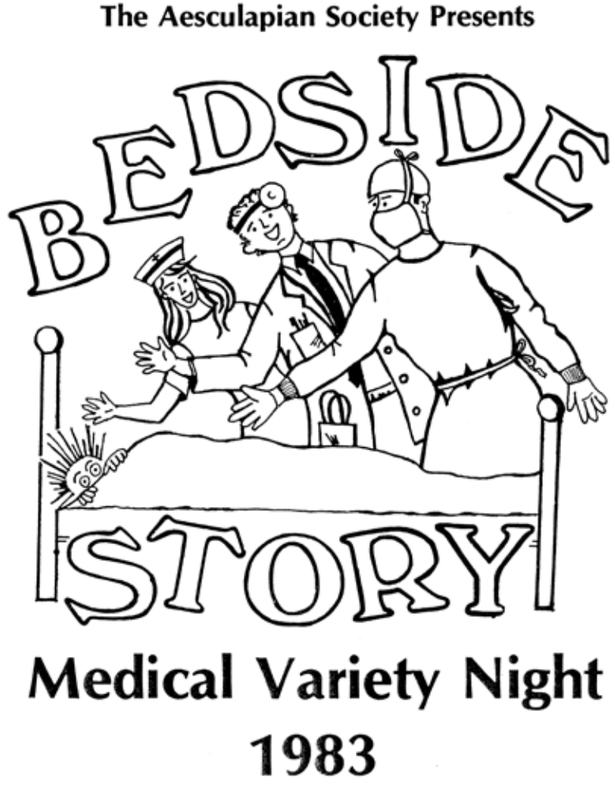
Before delving into the exciting past of Queen's MVN, it is important to understand the significance of the medical student show to medical student life, not just at Queen's, but worldwide. Dr. Charles Hayter, in his article "Medicine's Moment of Misrule: The Medical Student Show" (3), superbly places MVN in the context of the medical student experience and compares it to similar shows at other Medical schools: Pithotomy Show at Johns Hopkins, the Second Year Show at Harvard, the Smoker at the University of Michigan, Daffydil at the University of Toronto and Tachycardia at the University of Western Ontario. Hayter demonstrates the profound importance of these shows to the students that produce them, and the friends and faculty that enjoy them. "Although [the shows] seem to be irrelevant and irreverent frivolities, they are a rich and fascinating source of information about the experience of medical school" and are a "valuable resource in the study of medical student life and culture" (3). He suggests that carnival (a brief period of suspension of normal rules and boundaries involving such activities as role inversion, cross-dressing, sexual freedom, masquerades, profanity, and celebration of the bodily and physical) is deeply rooted in Western society; it is not unique to Queen's that carnival has a long-standing role in the education of medical students.

MVN was not the first of the medical student shows; Daffydil was founded in 1912 and the Pithomy Show began in 1905. Although the tradition of an annual show within the Medical School had begun much earlier, MVN formally debuted as a show AND fundraising event in 1970. Beginning by supporting a handful of charities in the early days, MVN supported four charities in 1988 (4), five charities in 1989 (5), nine in 1990 (6), thirteen charities in 1995 (7), and nine in 2008 (8). Some shows were particularly successful in the fund-raising effort: in 1988, $10,000 was raised for four charities (9) (in comparison, $9,000 was raised at last year's show). The programs indicate that many of the shows, until as recently as 1995, included all of the programs in the Faculty of Health Sciences, including Nursing, Occupational Therapy, Physical Therapy and Life Sciences. A review of the 1989 show in the Queen's Journal described the rivalry between the Meds, Physical Therapy, Occupational Therapy and Nursing students. However, there seemed to be a consensus about the superiority of the health science-oriented fields over "dumb plumbers" and "commies" (5). The rivalry eventually became an inter-class rivalry when the show was run by solely Medical students. The "Silver Syringe" award now exists for the best class skit of the show (and is awarded on closing night). The recent tradition has been that the third year class has won the award; students argue that the superior third year skit is due to a mix of experience and reduced class time in Phase IIE compared to other courses. The year 1983 marked the first time that MVN ran for three consecutive evenings (10), and 1987 was the year of the first official MVN photographer (1).

"Although [the shows] seem to be irrelevant and irreverent frivolities, they are a rich and fascinating source of information about the experience of medical school" and are a "valuable resource in the study of medical student life and culture"

MVN has a history at Queen's of giving generously to the charities within the Kingston community, and for creating a wonderful sense of unity among the Medical faculties. Dean Emeritus Duncan Sinclair said that MVN has "served better than any other curricular, administrative, or any other device to promote a common sense of purpose among students" (3). However, the successful history of the show is tainted by certain events that in the present day show directors and actors work very hard to avoid. The 1979 show entitled "On His Majesty's Secret Cervix" was attended by "2000 perverts" and was based mainly on Saturday Night Live skits. Reviewers described the show as "an assault on prudence,"– and many details that were unprintable "in lieu of an obscenity suit" (11). They gave "top marks to...[the] Aesculapian idiots for making the audiences forget they were ever decent human beings" (11).

It seems that few things changed over the next ten years in the history of the show. The review of the 1989 show was entitled "Sexism for Charity", and described the blatant sexism of the show as extremely ironic, considering some of the money raised by MVN went to Interval House (a service provided for female assault victims) (5). Although a letter to the editor of the Queen's Journal explained that there were some "quality" acts in the show, the content was blatantly racist, sexist, homophobic and culturally chauvinistic, and it mocked the "no means no" campaign; only white, upper-class males were left "unscathed" (12). Despite this very unfortunate occurrence, the Medical students clearly took these comments about their actions to heart, and the following year the Gender Issues Committee was involved in planning the show. It was suggested that the actors had attempted, for the most part, "to adopt a more responsible attitude" (6).



Before 1970, the structure of this annual show was somewhat different; however, it still seems to be encircled by the themes of Medical student camaraderie, faculty mockery, celebration, and still a hint of notoriety. The events in the early 1900's were characterized by a festive meal followed by a show and entertainment, although there were a few years where the celebration was withheld due to the war (1918-1920) (13). The beginning of an annual show most likely occurred as a part of the Medical student dinner. Among the Medical Archives is a beautiful collection of old menus from the Aesculapian Society Annual Dinners (dating back to 1908). The descriptions of the exquisite-sounding dishes are always followed by a witty or humorous quotation (from what appears to be Faculty members), and these are followed by a series of toasts, for example, one to the Medical Profession in Canada from 1920: "... two famous doctors came, And one was as poor as a rat—He had passed his life in studious toil, And never found time to grow fat. The other had never looked in a book; His patients gave him no trouble: If they recovered, they paid him well; If they died, their heirs paid double" (14). The menus suggest that a performance accompanied the annual formal dinner.

Although the presence of an entertainment component to the evening is not explicit in the menus, it seems that this secrecy was not associated with a scandalous evening, at least early on. A recollection from the Meds 1919 yearbook describes the post-dinner affairs: proverbial and non-proverbial sayings spoken by respected doctors and professors and skits about their respected instructors (13). Thus, although the fundraising affair did not occur until 1970, the presence of an annual "show" is deeply rooted in the history of Queen's Medicine. Travill recounts the medical dinner as one of the most significant social events of the year, hosted by the Aesculapian Society at one of Kingston's larger hotels,

Dean Emeritus Duncan Sinclair said that MVN has "served better than any other curricular, administrative, or any other device to promote a common sense of purpose among students"

Previous page: Medical Variety Night programme Courtesy Queen's University Libraries / Archivist & the Aesculapian Society

where "regularly the governor-general, the prime minister of Canada, the lieutenant-governor, and the premier of Ontario were invited, and just as regularly sent their regrets"; however, the mayor of Kingston and Principal Grant nearly always attended (15). The event seemed to lose esteem when the 1886 dinner degenerated into bun fights and excessive speech-making. The event became, for some years, a conversazione where Kingston's debutantes were presented, refreshments offered, and dancing lasting into the wee hours of the morning (14).

While current medical students cannot imagine MVN being displayed anywhere other than in the beautiful and historic Grant Hall, there were times in the past where the show occurred at other locations separate from Queen's campus. For example, in 1967 the show was held at the Steelworker's Hall on Concession Street (16). Although many of the Medical dinners were held at Grant Hall, many were also held off campus, for example at one of the large Kingston hotels (15). Although Grant Hall has been standing since 1905 (17), discussions with alumni have led me to believe that, at times, the show was held off campus in order to avoid disproval from the University. On the other hand, especially in the very early days, logistical reasons also probably played a role.

The media plays an interesting role in the history and present day of MVN. Although the Queen's Journal reviewed a number of the controversial shows, it has not been a regular reporter of the event. Perhaps there was a certain desire to keep the details of the show within the confines of the Medical School; after the 1988 show, the directors advised their successors, "Don't invite the Journal!" (8). Today it is impossible for the exuberance of MVN to remain within

the confines of Grant Hall. With the current ease of the internet and widespread obsessions with Facebook and YouTube, photographs, video and posts about MVN exist widely for the public to view on the World Wide Web. This is exciting for the Queen's Medical Community, since now alumni who are no longer in Kingston can still partake in the delight of the annual MVN show. Queen's Medicine hopes to increase the recent attendance of the show and raise awareness of the show and its purpose: bringing students, faculty, friends and family together, celebrating our talents, and fundraising for charities in the community. The attendance has been lower in recent years, probably a result of the shift from a show put on by the entire Faculty of Health Sciences, to one organized by only Medicine. The MVN directors, along with a fantastic group of individuals on the Organizing Committee, work hard to promote the event throughout the Kingston community and to other faculties. The show is also filmed and DVDs of the event are sold. On the other hand, the ease of the internet provides another challenge for the faculty and MVN directors. A show that could once be easily contained to oral recollection only can now be broadcast, potentially out of context, across the world. For example, a plethora of photographs from the event always appears on Facebook on the Sunday morning after the closing night. Students need to be cautious of what is posted on the internet, and be aware of the potential for misinterpretation. This is important since many of the videos displayed during the MVN show star many of our esteemed faculty members, in particular two videos from this year's show showed Dr. Sanfilippo dancing to Beyonce's "Single Ladies" with the 2011 girls, and Dr. Averns daydreaming during a patient interview.

Despite the increased potential audience of MVN due to digital photography, improved video technology and the internet, the faculty has not enforced censorship, but has left the full direction of the show up to the students. Although Hayter's article indicates that some schools have attempted to censor the medical shows, he argues that "the shows' most important function is to be deliberately offensive by challenging and destabilizing prevailing norms of student and professional identity. Those who question the appropriateness of the shows miss the essential value of a controlled episode of misrule in maintaining a vibrant intellectual culture and in preventing outbreaks of authentic sedition or violence. In other words, the shows provide a venue for the controlled release of sometimes hostile feelings about the process of getting doctored"(3). The concept of "controlled release" is important, since the student MVN directors put a great deal of effort into ensuring that the content of the show, although controversial, is only mildly irreverent and not derogatory. The faculty and the students trust them, and look to them for guidance when creating their skits and acts. They set the tone for the show, and others follow suit. Although much of the show is controlled acts, jokes and humour, there are always unexpected events that seem to occur. For example, during the 2007 show one actor sustained a tibia fracture while entering the stage by jumping from the balcony above. During the 2009 show, an oversized martini glass broke on stage in the scene right before 20 barefooted zombies were to perform Michael Jackson's Thriller. These uncontrolled scenarios required the actors, and especially the technical and backstage crew, to be reactive and creative to fix the situation seamlessly, as the show must go on!

The importance of MVN to the history and tradition of Queen's Medical School is significant. Although the details are not recorded well on paper, they are held strongly in the hearts and minds of many medical students who have passed through the school. From members of three previous generations of Queen's Medicine grads in my family, I have heard the wonderful and horrific stories of MVN's past, and understand the importance of oral history in cherishing the positive moments and recalling the mistakes from which we have learned. MVN is a clear display of the "Queen's Spirit". In the words of a student from Meds' 1919, "To none is it given to understand fully what that means until he has experienced it himself" (13). MVN has thus, despite its many controversies, proven to truly embody the generosity, community, diversity, talent, friendship, and sense of tradition that has exists at Queen's Medical School. We can continue to look forward to many more great shows in the years to come! Q

Thanks to the following individuals for their assistance in writing this article: Dr. Jacalyn Duffin, The Queen's University Archives, Paul Banfield, Deirdre Bryden, Dr. Donald Delahaye, Dr. Donald R. Miller, Dr. Charles R. R. Hayter, Dr. Frank Tindall, Dr. Tony Sanfilippo, Dr. David Walker, Ronish Gupta

CHARITIES SUPPORTED SINCE 1970:

Interval House, Hospice Kingston, Alternatives, Frontenac Food Sharing Group, Kingston Aids Project, Camp Outlook, KAIROS, Kingston and Area Senior Citizens' Council Inc., Katorokwi Native Friendship Centre, The Anorexia and Bulimia Association of Kingston, Independent Living Resource Centre, Ryandale House, Child Life Services at Hotel Dieu Hospital, Epilespy Kingston, Canadian Mental Health Association Kingston Branch, Canadian Council of the Blind Kingston Chapter, Queen's Medical Outreach, Kingston Literacy, The John Howard Society, Queen's Charities, Partners in Mission

A SPRINKLING OF PAST MVN THEMES:

1967 "Beyond the Syringe", 1983 "Bedside Story", 1987 "Steroids to Heaven", 1988 "The Sound of Mucus", 1989 "Little Shop of Hormones", 1990 "Stayin' Alive", 1991 "The Wonderful World of Dysentry", 1992 "The Academy of Wards: A Celebration of the Silver Spleen", 1994 "The Med Sullivan Show", 1995 "Medical eVolutioN" (25th Anniversary), 2008 "The Wizard of Gauze"

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3.Hayter CRR. Medicine's Moment of Misrule: The Medical Student Show. J Med Humanit 2006; 27: 215-229.

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Necessities - Brenda Law

Vibrancy - YL Zhang

Critical Summaries

Each summer, second year Queen's medical students (and some super-keen first years, ahem, 2011), are able to gain valuable research experience while completing the critical enquiry. One plus of this requirement is the degree of freedom granted to medical students: any topic remotely related to medicine, is up for grabs, providing one can find a supervisor. This can include basic science, clinical medicine, ethics, epidemiology, history and anthropology, etc, as it relates to virtually any specialty, in locations ranging from Toronto to Tanzania.

Although students are only required to spend ten weeks doing research, many continue on to submit their research for publication and/or present their findings at conferences. The class of 2011, whose reports are due this year, were asked to provide summaries of their projects. We have chosen five summaries to highlight in this issue, and hope to publish others in future issues. Many thanks to everyone who submitted! Q

Caregiver Satisfaction with Pediatric Pain Management in the Emergency Department:

A Survey

BY JANEVA KIRCHER

Email: 7jk16@queensu.ca

Supervisor: Dr. Samina Ali

Supervisor specialty: Pediatric Emergency Medicine

Location: Edmonton, Alberta

Objectives: Determine caregiver satisfaction with his or her child's pain management while in the emergency department, assess pain scores over the past 24 hour period, and determine agreement with several pain management myths.

Findings: Caregivers are satisfied with the care their child received in the emergency department despite reporting high levels of pain at discharge. Caregivers also believe in many myths surrounding pain management.

Reflections: This was a FABULOUS project as an introduction to the research process. If anyone is interested in working at the Stollery Children's Hospital for their critical inquiry project, contact me!

Detection of cerebral amyloid angiopathy in the elderly

BY ARUNDIP ASADUZZAMAN.

Email: 7aa11@queensu.ca

Supervisor: Dr. Angeles Garcia

Supervisor specialty: Dementia / Geriatrics

Location: Kingston, Ontario

Objectives: Cerebral amyloid angiopathy (CAA) is an age-related disease of small vessels in the brain, marked by numerous microhemorrhages in a cortical distribution. In this pilot project, we used a new research MRI method: susceptibility weighted imaging (SWI), to describe findings of early CAA in 13 cognitively normal volunteers above the age of 65.

Findings: We found radiological evidence of CAA in one individual, and found that the SWI method was useful for detecting microhemorrhages. The conventional method (Gradient recalled echo) was found to be useful for the detection of white matter disease, another manifestation of CAA. The results of this study justify the imaging of a larger population of normal elderly patients, to better understand the prevalence of CAA and elucidate the role of secondary prevention strategies (i.e. avoidance of anticoagulation therapy).

Reflections: This was a fun and enriching learning experience, as I had the opportunity to undertake a multitude of research tasks (planning, ethics, recruitment of subjects, interviewing and cognitive testing, developing an imaging protocol, and actually scanning the subjects). I had the privilege of attending dementia clinics where I learned and practiced cognitive testing methods. I also had a chance to work with radiologists at KGH to interpret the images.

Screening for sexual concerns and sexual dysfunction in rheumatic disease patients:

A survey of Canadian and British rheumatologists

BY FIONA AISTON

Email: 7fma1@queensu.ca

Supervisor: Dr. Henry Averns

Supervisor specialty: Rheumatology

Location: Kingston, Ontario

Objectives: Rheumatological diseases are associated with varying degrees of sexual dysfunction. This survey was aimed at Canadian and British rheumatologists to obtain information regarding screening, discussing and addressing patients' sexual concerns.

Findings: With 84 respondents, the results of the survey suggest that only 33.6 per cent (n = 30) of rheumatologists screen for sexual concerns of their patients. Among those who screen, the vast majority (90.0%) only screen a minority of their regular patients. Sexual concern and dysfunction screening was conducted most frequently by female rheumatologists and also by rheumatologists who were comfortable taking a sexual history. The majority of rheumatologists (90.4%, n = 75) believe that family physicians, in part, should be addressing the sexual concerns and sexual dysfunction of rheumatic disease patients.

Reflections: This project provided the opportunity for me to learn about survey design, implementation and data analysis. This was a project that was designed to be feasible in the short time frame available. The results suggest that this is an area of research that could be further explored.

Crossword found on page 35.

Global drug development in cancer:

A cross-sectional study of clinical trial registries

BY PAUL HERTZ

Email: paul.hertz@queensu.ca

Supervisor: Dr. Ian Tannock

Supervisor specialty: Medical Oncology

Location: Princess Margaret Hospital, Toronto

Objectives: I looked at all clinical trials registered in oncology that evaluated medical therapies (chemotherapy, hormone therapy, monoclonal antibodies, etc.) over a 6 month period in 2008. After assembling the list of approximately 200 eligible trials, I determined where the trials were being conducted, what types of cancers were being studied and who was providing the funding for the projects.

Findings: Not surprisingly, most of the funding came from industry (pharmaceutical companies). Interestingly, the cancers for which there were the most number of clinical trials were those of high prevalence in the West (North America and Europe). These cancers, including breast, prostate and colon, already have many effective treatments. Cancers which are some of the most deadly worldwide (stomach, esophageal and liver), are being understudied and this is compounded by the fact that fewer treatments are available for these patients. In our opinion, the industry may be guiding research towards drugs for more "profitable" cancers (i.e. those where many people, with the means to afford the medication, will be able to purchase it).

Reflections: I had a great experience in Toronto and everyone I worked with was amazing. My work was presented at an international conference in Orlando, Florida and was recently published in a reputable cancer journal, Annals of Oncology. I was also able to learn a lot about oncology and participate in some clinics as well, keeping up with my clinical skills over the summer.

The history of rheumatoid arthritis and parallels to 19th century tuberculosis

BY DAN FINNIGAN

Email: danfinnigan@gmail.com

Supervisor: Jacalyn Duffin

Supervisor specialty: History of Medicine, Hematology

Location: Kingston, Ontario

Objectives: To review the historical formation of disease categories for chronic arthritic conditions, specifically focusing on those likely to have included patients who are diagnosed today with rheumatoid arthritis (RA).

To consider how theories of RA disease causation influenced the evolution of these disease categories.

To review the therapies applied to RA patients, based on theories of causation, their efficacy, and perpetuation through time.

To compare and contrast the evolution of RA and tuberculosis (TB) as diseases, with a specific focus on how, in the case of TB, movement from a symptom-based (i.e. nosological) definition to an organic (i.e. pathological) definition resulted in the unification of many diseases that had previously been considered as separate conditions.

Findings: Diseases for which the most effective modern treatments exist are usually pathologically defined.

Nosologically defined diseases like RA likely have multiple, distinct pathologies that have not been identified; this is a point which has been noted numerous times by renowned physicians from history.

RA should be taught not as a disease but as a disease spectrum. It should be renamed to reflect this status - another point which has already been proposed by eminent physicians.

Reflections: The area of research was far, far too large for a single summer to encompass.

It was surprising and humbling to learn about the insightful and discerning ideas of physicians from antiquity, specifically their ability to detect and describe subtle clinical patterns.

A full understanding of the patterns seen in the autoimmune diseases of today would require historical investigations of multiple sclerosis, systemic lupus erythematosus, psoriasis, ankylosing spondylitis, and many other conditions defined similarly to RA.

It is important in medical education and research to realize that our current disease categories are not definitive, and will likely evolve as the resolution of medical science progresses.

The application of RCTs and Koch's Postulates to disease-spectrum categories may be inappropriate, especially in relation to curative therapies, as opposed to symptomatic relief.

The Adventure that was Inviting Patch Adams

BY PAYAM YAZDAN-ASHOORI

When I ran for Vice-President Academic, I knew that one of my duties would be to invite a speaker for the H.G. Kelly Visiting Lectureship. I wanted to make this one as big as I could: something medical, memorable, popular and with the potential to stir up conversation. The first person who came to mind was Dr. Hunter "Patch" Adams. And so it began…

I began by trying to contact him. It was one of those generic forms – you know – the ones that you fill out in vain knowing that you won't get a response? The week after filling the form, I began to think of other speakers – and then his manager called me with interest. I was excited - so excited that the fee escaped me. My euphoria and idealism translated into a determination to make this happen, despite the fact that it was an expensive venture. I drafted a formal letter and attempted sponsorship opportunities from banks, industries, and pharmaceutical companies. All of this to no avail; all of them responded with a no, stating the reason of tough economic times - that is, if they responded. In the end, the economy worked in my favour – Patch, knowing the situation, miraculously decided to lower the fee, although it was still over double the budget.

I decided to doggedly pursue this, at the risk of missing deadlines for other "easier" speakers. This needed strategy to work. If I booked Patch, he would be available for the entire day. In order to capitalize on this, the idea of trying a partnership came to mind. Since trying to partner with nearby universities and colleges was unsuccessful, it turned out that the answer was right in front of me: the Department of Family Medicine. The Department would have Patch for a workshop earlier in the day and the H.G. Kelly lecture would happen later.

Now it was time to worry about how to raise money for travel and accommodations. This could not have been done without help! Clarissa Moodie from my class helped connect me with Ruth Wannemacher and David Young from Alumni Relations & Annual Giving. Through their help, complimentary accommodation was generously provided at the Four Points by Sheraton. Much of the travel costs were raised at a year-end post-exam BBQ. This was not possible without Medical House and its members, and their fantastic chef, Jack Francis. Another classmate, Elizabeth Miller, was very persuasive and creative in selling 50-50 tickets at the BBQ. Following this, I could think of no better place than Medical House to hold a public book signing with Patch after the lecture (the book signing turned out fantastically), and I would like to thank Medical House for being such a stellar host for these events.

As far as the H.G. Kelly Lecture – what a hit! I discovered that people started lining up over an hour in advance. In the end, there were an unprecedented number of audience members. What a scene - every single seat of the largest classroom auditorium at Queen's occupied, people sitting in the aisles and standing at an overflowing entranceway, and a large group sitting on-stage around Patch, breaking fire code. Special thanks to Alex Atfield from my class for filming the event!

Payam and Patch playfully picking probosci
Photo by Whitney Smith

Ultimately, I am glad that it all went smoothly. What Patch had to say had elements that everyone could agree on, while other things he said were controversial. Despite this, he was an engaging and interesting speaker, and I would prefer controversy over boredom. The best part of it all is that the bank was not broken, with ample opportunity to arrange for a great speaker next year! I can't wait to attend. Q

The "Patch" Reaction

PATCH ADAM'S LECTURE HAS BEEN WIDELY DEBATED BY THOSE WHO ATTENDED IT. HIS PASSION FOR WHAT HE DOES IS REMARKABLE, BUT HIS SELF-DESCRIBED "REVOLUTIONARY" IDEAS LEFT VARYING REACTIONS. FOUR STUDENTS DISCUSS THEIR OWN TAKE ON "PATCH":

THOUGHTS FROM A FIRST YEAR MEDICAL STUDENT

My classmates and I got together for dinner after the Patch Adams lecture to discuss our impressions. Many audience members seemed critical of him early on, disregarded many of the claims he made and passed him off as just a "clown". We, on the other hand, walked away from the talk inspired and touched by the videos in which he emphasized the importance of personal interaction and human touch in the healing process. Perhaps, being first-year medical students without much exposure to the real practice of medicine (or even the "real world" on the whole), we may seem too naive and sanguine in our reception of Patch Adams.

Sure, we agreed that he was an extreme socialist and his ideas were too radical and simply impractical for Western society. After all, the pervasive dominant ideology, which makes the acquisition of profits and power as the main driving force of policy decision-making, is in direct conflict to Patch Adam's idea of altruistic doctors providing free health care to all. Yet, at the end of the day, rather than trying to over-analyze all of his specific claims, we recognized him as a talented motivational speaker with a positive message of love and care.

Personally, I thought that Patch Adams' use of politically incorrect terms and concepts was a simply a ploy to grab the audience's attention. It was a way to get us out of our comfort zone and into thinking in novel ways. For example, he asked what it's like to be "hideously ugly" and declared that "snooping" through patients' "personal letters and journals" constitutes an acceptable part of the doctor-patient relationship. We gasped at and remembered those statements as proof of his preposterous persona. Yet, it seemed clear to me that he was not being literal here. Behind all the silliness, there was a simple message disguised. It was his plea for health professionals to throw out the "rule-books" once in a while and stop following prescribed formulas for doctor-patient relationships.

Patch Adams urged us to "people-watch," so-to-speak, and the point here was not to overstep privacy boundaries or professional distance. Instead, the reason for being extra attentive is simply for the personal reward one gains from observing and learning about people and their behaviours. After all, there is so much to learn outside the classroom, if only you open up your eyes to look closely at your surroundings and keep your ears perked to listen to people's stories.

- Katrin Dolganova, Class of 2013

ON THE DANGERS OF IGNORING BURNOUT

Hoping to alleviate human suffering is most likely one of the reasons many of us apply to various health-related professional schools such as medicine and nursing, and caring, kindness, and empathy are some of the traits we bring with us as we join our respective healthcare professions. Patch Adams described caring as a "dance of love between people", calling it an "ecstatic experience" and a "holy situation".

As a third-year medical student, I was struck by Patch Adams' seemingly unwavering enthusiasm for people. He denied ever feeling despair, saying "I never fear how much horror I see, because I know it won't hurt me; it will inspire me to work harder." While my travel experiences clearly don't even begin to compare to Patch Adams' work in numerous refugee camps and orphanages, I can't help but think that decrying despair and burnout is a dangerous denial of a very common experience that many health care students and professionals experience. Patch Adams argued that burnout results from how we choose to respond to caring, and that it's just as easy to "invite the glory that is in the act of care and go home hot, baby, ready to go, so thrilled that you got to care." Perhaps he's right, and the despair and burnout some of us feel from our experiences just require a change in perspective and maybe we're not fully appreciative of the privilege we have to care for people. However, I would suggest that sometimes despair and burnout can result from too much caring. Stating that "despair is never a useful instrument" can be discouraging for those of us that do go home exhausted.

Caring can be extremely meaningful, as Patch Adams demonstrated in his videos, but I would argue that it's important to recognize that despair and burnout can also be helpful in learning to re-focus our energy, reach out to our family and friends, and remember why we aspired to join the health care field in the first place.

-Adrienne Li, Class of 2011

THE WISDOM IN EXTREMES

Patch Adams' extreme remarks can be intimidating, even infuriating, but they are also enlightening. This is why I enjoyed his talk. He unabashedly makes broad-reaching statements crossing many disciplines, causing some offense. As just one person, he does not have the expertise and experience to be certain about all of the claims he makes. However, by possessing the audacity to make those claims and swatting the wasp's nest, he forces people to see new perspectives and seek answers to questions they may have ignored. He doesn't have to be right to make a difference.

He also presumes that everyone has the same emotional core as him, as a basis for the claim that if we all cared as much as he did, we would not burn out. He is a psychiatric aberration; one that does not require treatment, but rather who treats others. Each person has their own unique psychiatric environment, partly genetically and partly environmentally determined, and not all of us would thrive in the health care model Patch proposes. In effect, he has run a successful n of 1 experiment, but the uniqueness that is his greatest strength, may also be the downfall of his revolution. If you ask me, I feel confident saying that we could all be a little bit more like Patch. However, I also think the world is only big enough for one of him.

One of his controversial statements that really struck me was his approach for consoling "hideously ugly" patients. He said: "I would ask them, 'What is it like to be hideously ugly?' Now, I feel your nervousness. How can you not ask them? Probably there is nothing you'd rather be than hideously ugly. When I heard their stories they were always thankful [by the way], no one would ever ask them because no one would ever dare ask them. Because you know how nervous you are in the presence of someone hideously ugly."

In a world of political correctness, we are often afraid to make inquiries that could be construed as offensive. What if the person does not consider him/herself ugly? Yet, when someone is painfully aware of the altered behaviour one's appearance creates, how unfair is it for us to fail to create a forum where one can talk about how that makes them feel. Instead, we offer trite falsehoods, in the guise of compassion, implying that they must be misinterpreting the world around them. In effect, we are telling them that they are not only ugly, but they are also crazy. We are naive to believe that "hideously ugly" people are unaware of our reactions to them. That is like believing that a person who is missing a leg is unaware that some people take a second look. If we, as health care workers pretend ugly does not exist for our own comfort, we are failing our patients.

We do not have to be as frank about it as Patch, I think only a personality like his could pull off such a statement, but we should certainly consider approaching the topic. Perhaps: "Some people in your situation find they get a lot of negative attention when they go into public, do you ever find that to be the case?" By making future health care workers consider this issue, especially in his strikingly exaggerated way, Patch is increasing awareness of suffering that might be hidden inside some of our future patients.

-Dan Finnigan, Class of 2011

FRUSTRATINGLY MEMORABLE

I didn't know much about Patch Adams before his talk – I hadn't even done the usual Wikipedia search – and so my expectations were based on a movie that I saw long ago when I was in high school. I was surprised, then, to find that there was more to the talk than an inspiring story about a clown.

Throughout his talk, Patch described various aspects of his view of an ideal health care system. It provided free health care to all and allowed for doctors to spend hours with each patient. I found this discussion somewhat frustrating. It was hard to take these suggestions seriously as the outcomes didn't seem feasible, and Patch didn't provide me with any plausible steps that would lead me to this direction. Furthermore, I didn't agree with all of his goals: for instance, I don't think that this approach would suit all patients. Some patients prefer that health care is not a large part of their lives, and I think that physicians need to recognize those who want non-invasive care – physically or, sometimes, emotionally – and react accordingly.

As I write, I'm struck by the fact that I'm still thinking of this talk two months after I heard it. I found the talk frustrating, and I didn't come away with an inspired plan or the wish to be just like Patch. I disagree with some things he said. However, it definitely left me with something to reflect on, and perhaps that's important in itself. Maybe if instead of advocating a search through a patient's private journals, Patch had simply stated that doctors should try to put more effort into understanding their patients' lives, I would have thought: "Yes, that's a good idea," and not thought of it again.

-Julia Cameron-Vendrig, Class of 2011

“Creating the space to question”

QUEEN’S HEALTH AND HUMAN RIGHTS CONFERENCE 2009

BY KATRIN DOLGANOVA

The annual Queen’s Health and Human Rights Conference (HHRC), held on October 2 and 3, 2009, successfully created a space to question our ideas regarding health and human rights inequalities, both at home and abroad. The conference featured a number of local and distinguished speakers, who addressed a variety of controversial issues ranging from the widely discussed, (Canadian health care system; NGO work in Africa) to those that do not usually receive as much media attention (the African Ju/’hoansi tribe).

SELECTED HIGHLIGHTS:

PANEL ON “THE FUTURE OF HEALTHCARE”

The conference began on a high note with a discussion on the current and future states of the Canadian health care system. The discussion was led by a panel featuring Ana Johnson, Albert Schumancher and Jeff Turnbull. Although there were differing opinions as to what the “ideal” health care system is for Canada, all agreed that despite the pride we Canadians feel for it, our system of health care ranks only 6th of all OECD countries and it is not functionally sustainable.

Dr. Turnbull emphasized that the challenges go beyond an aging population or lack of access to care; rather, many problems are due to misguided public policy and the difficulty of delivering care in a large country with an unequally distributed population. Government policies of the early 1990s had an especially profound impact on the shortage of doctors in our country. During that time, the government cut medical school enrollment by 15% and residency spots by 20%, while the number of registered nurses was simultaneously cut in half – policies enacted with the belief that a rising standard of living and innovative technology would improve the wellness of society.

Dr. Schumacher, in turn, advocated for accessibility, universality, public administration, the possibility of private funding, and self-sufficiency in the Canadian health care system. He believed that policies should prioritize the training of health care workers in our own country, rather than relying on immigration to supply our health care providers. The government also needs to invest more in health care technology research and development, so that Canadians don’t have to leave the country to access novel treatments.

ATIF KUBURSI: THE GLOBALIZED VILLAGE

The morning of October 3 began with Atif Kubursi’s keynote address. This set the stage for the afternoon workshops by describing the context in which many health and human rights problems arise and the reason why we, as privileged citizens of a developed country, should care about what takes place in other parts of the world. As a result of widespread globalization and unprecedented growth of the economy and telecommunications, we now live in a “globalized village.” If there are 1000 citizens in this conceptual village, 150 of us live in the affluent area, 780 in a poverty-stricken area, and 70 in the transition zone. This concentrated village is characterized by a digital divide that grows deeper every day and allows the global financial superstructure to take on a life of its own. Deregulated money flows in and out of countries and fills the pockets of the few people in power while draining the rest of their basic resources. More importantly, it is time to realize that we cannot continue on this road for much longer; the exploitation is simply unsustainable. As Professor Kubursi reminded us in his closing, “Today, our own security is inextricably linked to security in other places.”

WORKSHOPS

The HHRC brought many workshop speakers to Queen’s from the Kingston community and from around the province. The conference was successful at providing sessions with thought provoking and new material for attendees with variable levels of expertise and multiple areas of interests. In fact, many people found it challenging to choose among workshops with a range of excellent topics and speakers, such as Adam Newman’s workshop on addiction in Kingston and Jacalyn Duffin’s exploration of the history of human rights abuses in medicine.

It was refreshing to see a balance of both uplifting and poignant lectures, because in discussions of health and human rights, it is all too easy to focus on extreme abuses of power, sentimental narratives, and negative criticisms. Fortunately, the HHRC provided a view of both human rights abuses and success stories.

One could attend Mimi Kashira’s workshop and hear a heart-wrenching account of the conflict in Congo and the extent of suffering experienced by women there. Yet, in the same afternoon, one could also listen to Richard Lee give an anthropological account of a small, isolated hunter-gatherer African tribe, the “Ju/’hoansi.” This group has not only successfully and rapidly integrated into the modern market economy society, but has also maintained the lowest rates of HIV/AIDS of any ethnic group in Africa, despite living in Namibia and Botswana, the two countries with the highest HIV rates.

For those interested in setting up or doing NGO work overseas, Dr. Carpenter and Dr. Yeates of Queen’s medical school spoke about their experience in Tanzania. They shared the challenges they face in providing ethically responsible and sustainable health care for marginalized populations in a developing country.

Other speakers included Udo Schuklenk, Chris Lowry, Abi Sriharan, Meridale Dewar, Andrew Pinto, and Alexandra Mihailovic. For more information about the individual speakers and contact information of the organizers, please visit the HHRC 2009 website (end of article).

COMMITMENT TO ENVIRONMENTAL SUSTAINABILITY

Acknowledging the link between environmental sustainability, health and social responsibility, the organizers of the HHRC made a commitment to reduce their impact on the environment. Both the health-conscious and environmentally minded attendees were pleased to find that the conference was powered on sustainable wind energy from Bullfrog, all food was locally sourced, the leftovers donated to the less fortunate in the Kingston community, and all remaining waste was either recyclable or compostable.

“Today, our own security is inextricably linked to security in other places.”

OVERALL IMPRESSIONS

At the end of the day, HHRC set out what it meant to do. Due to the nature of the workshops, Saturday was a long, mentally and emotionally-draining day, yet the majority of attendees stayed until the end - not solely because of the delicious food, but rather because of the inspirational speakers and a genuine desire to explore and learn more about human rights in the context of health care. The variety of issues addressed, and the controversial nature of the perspectives presented by the speakers allowed delegates to openly question, discuss and compare ideas on the intersection of human rights. Yet the real test of the impact of this conference is still to come. With the seeds of thought planted, the more crucial next step involves the transformation of ideas into action.

www.queenshhrc.ca

CFMS / OMSA - WTF ??

Our AS VP-External explains the mystery behind all of the (relevant) acronyms

BY CHRIS BROWN

As an undergraduate medical student, you have probably heard about OMSA or CFMS at some point, whether during O-week, a pizza lunch or one of the hundreds of updates you will see here during your time at Queen's. Yet what do these groups do for you and for your medical education in general?

OMSA

The Ontario Medical Students Association (OMSA) represents all medical students from the six medical schools in Ontario. Queen's has two representatives who act as our VP Externals – Christina Nowik (2011 and VP External Sr.) and myself, Chris Brown (2012 and VP External Jr.). Aside from this position, Christina has also been elected as the 2009-2010 OMSA Chair. What do we do? We are the provincial voice of medical students, liaising with the OMA, government officials and many committees and councils involved in medical education. What does this mean for you? This can probably be best illustrated by using examples of our recent achievements.

The most significant recent OMSA achievement was our involvement in the 2008 OMA-MOHLTC Agreement in which we negotiated two major benefits for students: an increase in the clerkship stipend from $500 to $750 in the last 12 months of your clerkship and a deferral of all interest on Provincial and Federal Student Loans for Ontario Residents who agree to practice in Ontario for 5 years after completing their residency. Although the final details and the implementation of the program are still in progress, current residents need not worry; when the program is started (likely February), retroactive payments will be made from July 1, 2009.

OMSA's most publicized and well-known annual event is the Ontario Medical Students' Weekend (OMSW), which was held here at Queen's this past October. Christina and I would personally like to thank all of the students, residents and faculty who gave their time and expertise to help us make the event a massive success. Next year's OMSW will be hosted at Western, so we hope to take a large and eager contingent westward to London.

Every year, OMSA holds a Leadership and Lobby Day. This is an event where medical students attend a day of leadership and communication skills seminars, and then go to Queen's Park to meet with MPP's and discuss issues that are affecting medical students. We are always looking for interested students to join us for this event, so please keep it in mind if you'd like to attend (you will receive an email in April!).

Other OMSA events and services that you may have taken part in are the Research Day held at U of T, the annual Equipment Sales at each medical school and the OMSA publication for medical students, "Scrub-In".

CFMS

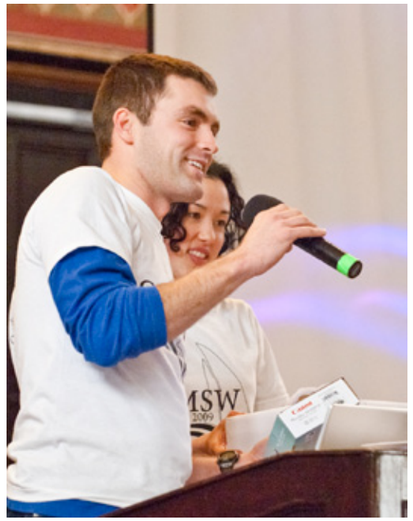
The Canadian Federation of Medical Students similarly represents all medical students in Canada (with the exception of the French Schools in Quebec). Many of the functions of the CFMS mirror those of the OMSA on the national level. The CFMS executives work with numerous academic committees to help shape the changes that are occurring in medical education. It publishes original research and position papers on relevant topics like Distributed Medical Education, International Medical Graduates & Canadians Studying Abroad, and Aboriginal health issues. The CFMS also has Global Health Representatives and a Political Advocacy Committee, to which Queen's sends representatives. Similar to the OMSA, the CFMS holds an annual Lobby Day at Parliament Hill, where students meet with MP's (likely in February).

In closing, the OMSA and CFMS are councils that advocate on your behalf, provide a venue for your opinions to be voiced and help improve the lives of medical students in Ontario and Canada. Whether your ambition is to become a VP External or Council Executive member, attend a Lobby Day or work on an upcoming position paper, or write an article for Scrub-In, there are many different ways to get involved in the OMSA or CFMS.

Please contact your VP External Chris Brown (vpexternal@qmed.ca) if you have any questions, comments or want to get involved. For more information about the organizations, take a look at the homepages for the OMSA (www.oma.org/students/) and CFMS (www.cfms.org).

See you at our next Pizza Lunch!

Ontario Medical Students' Weekend 2009



Let the healing begin! Speakers and workshops at the Ontario Medical Students' Weekend were enthusiastically received. From top left: students learning the finer points of airway management from Nate Charach; Chris Brown and Christina Nowik announce door prize winners; advanced surgical reattachment of pigs' feet; keynote speaker Dr. Jeff Turnbull; Queen's Emergency Medicine resident Tim Chaplin supervises the immobilization and remobilization of a room full of left wrists. Photos by Alexandre Atfield

Chiaroscuro 2009

Left: Filgen Fung peruses the artwork

Below: End of the Day
by Allison Chow
Linocut on rice paper
allisonrchow@gmail.com

Queen's Health and Human Rights Conference

Left: Jonathon Lee and The Matchmakers

Below: Right: Cedric Gabilondo and Lindsey Lytle discuss the finer points of aesthetic theory In the background is Wednesday by Jonathan Lee (Giclee)

Right: A moment of collective self expression – the not-yet-complete paintings of the HHRC deligates

Below: Alex Florea

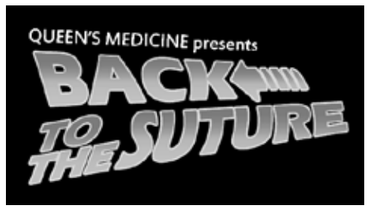
Right: Erik van Oosten and Renee Pang adding some colour to a quickly filling canvas.

Photos by Alexandre Atfield

Review of Medical Variety Night 2009: Back to the Suture

BY KATRIN DOLGANOVA AND IDARA EDEM

Medical Variety Night (MVN) is an annual three-night event put on by Queen's medical students to raise money for local charities in Kingston, including Epilepsy Kingston and Queen's Health Outreach. This year's theme was "Back to the Suture" and with the combined generosity of the faculty, sponsors, and attendees, the show raised $7550.



This year's MVN was once again a spectacular event, in line with the 39-year history of MVN (see article by Elizabeth Miller on MVN history in this issue). Each of the four classes created a skit, and the winner of the Silver Syringe, the award for best skit, was "A Potpourri from Phase IIE" by Meds 2011. Students and faculty alike immensely enjoyed the Meds 2011 final music video, "Seasons of Glove," a nostalgic rendition of pre-clerkship years spent at Queen's. The final words of wisdom from the 2011s were, "Wear your disposable, non-latex gloves." Even some of the faculty made memorable appearances during the MVN show; including Dr. Averns who showed us the joys of daydreaming during patient consults, and Dr. Sanfilippo who danced to Beyonce's "Single Ladies" alongside some of the 2011s.

The show also featured a number of talented singers and song-writers. Andrea Gauster from the 2013 class serenaded the audience with beautiful Indie songs. Although she has only been performing live since the summer of 2007, she has already signed on to a record label, recorded her first album entitled «Reverie», and is currently working on a second. From the 2010 class, the "self-defecating" Brian Liu, also known as Tactile Fremitus, gave a highly entertaining yet informative performance about clerkship, medical romance, and the CaRMS application process. Lyrics such as "page me to the extension of your heart" and "I'm a mixture of Gandhi and Scooby-Doo" exhibited the witty yet unassuming humour of medical students.

This year's show really displayed the multicultural assemblage of medical students at Queen's. For example, Huan Yu of the class of 2012 performed a wonderful Wei Er Wu Cultural Bowl Dance, twirling across the stage with three bowls balanced on her head. The audience, already on the edge of their seats, broke into roaring applause as she revealed the pinnacle of the performance: the bowls she had been carrying on her head were filled with water! Nachna Fusion Round 2 also amazed the audience with their colourful, energetic blend of modern and traditional dance moves to a remix of Hindi Bollywood and Bhangra music. Another amazing dance performance was that of the Meds 2013 Hip Hop Dance Crew, half of whom had no prior dance experience. Yet, after an astounding 35 hours of training, they could have passed for a professional dance crew, as they pulled off some hard-hitting moves with ample attitude, energy, and flair.

The legendary Dr. Duffin posing with the 2013 Dr. Duffin, Sarah Leonard.
Photo by Andrea Gauster

Unfortunately, while the Saturday night performance boasted a packed house filled with a large and energetic crowd, the Thursday and Friday performances, on the other hand, had significantly smaller attendance. Low attendance at the week-night shows is not surprising and seems to be a recent phenomenon; in fact, according to upper year students, the turnout this year was much higher than the past two years. While not a novel trend, it has not always been so. In the past, there used to be a more noticeable presence of undergraduate, nursing, and other health professional students in the audience and even on stage.

Perhaps, in the years to come, it may be worthwhile to advertise MVN more extensively to students outside of medicine and invite other health professional students (nursing, physiotherapy, occupational therapy) to participate in the show. Not only will that increase MVN's fundraising capacity, it may also help to foster true inter-professionalism spirit. Although there is a strong push within the faculty of medicine to emphasize inter-collegiality and teamwork, aside from one or two inter-professionalism classes and cafés per year, the various schools operate as independent institutions and the students have minimal interaction during their training. MVN may be the perfect opportunity to make what we discuss in the classroom a campus reality.

Yet overall, the emcee of the night, Taylor Lougheed, aptly summarized the essence of MVN this year as one filled with "good times, good fun." In the end, MVN accomplished its goals: to raise money for local charities, and to showcase the hidden talent and creativity among Queen's medical students. For this unforgettable event of the year, we would like to thank the committee involved in putting the show together: Directors Mike Steedman, Gita Raghavan, Marta Wais; Tech manager Emidio Tarulli; Stage manager Amy Wong; Fundraising director Philip Harvey; Set design/website manager Nan Gai; and House Managers Danyela Lee and Jennifer Lee.

The future fate of MVN now lies in the hands of the 2013s, who are faced with the task of organizing next year's 40th anniversary of MVN and expanding its audience and intercollegiate spirit. Q

MVN - QUOTES AND IMPRESSIONS

What a great MVN! I am always amazed at the level of talent; the students hide it so well for the rest of the year. I was astonished that students had spotted my 2 minute attention span, and my subtle use of the double entendre. My wife and children, however, can testify that the portrayal of a British rheumatologist was uncannily accurate...may I borrow the escort in her scanty union jack?

The highlight for me was the Indian dancing closely followed by class of 2011 song.

- Dr. Averns

My family and I have been attending MVN for 22 years -- with almost no misses. The show was fabulous--astonishing array of entertainment--as usual. Quiet, loud, wild, witty. Our medical students are amazingly talented--in so many directions. Choreography, dance, wit, acting, music, film -- and they seem to wear their gifts lightly -- without taking themselves too seriously. I was flattered to be imitated...my colleagues (all except Reifel, Morton and Averns) are probably jealous!

The show's content is much more politically correct, less scatalogical, less sexist, less chauvinistic in many ways. Those changes are for the better. We also miss having the input from nursing and rehab which used to be regular features. In any case, next year's show promises to be well up to the high standards judging by the talents we saw from the 2013 class.

We were a bit surprised by the small turnout on Friday night--people missed an excellent show and a chance to donate to good charities.

- Dr. Duffin

"It was amazing. Especially [the 2011 skit and music video]. So creative."

- Dan

"It's great. I'm not in MEDS, so I didn't get all the jokes, but it's great so far."

- Julia

"I loved Dr. Sanfilippo's cameo in the 'Single Ladies' video. All the performances were really great!"

- KGH staff.

"It is amazing to see the hidden talent at Queen's. It highlights the need for artistic expression as an outlet, especially in a demanding profession like medicine."

- Andrea Gauster

Matangwe

BY MEDINA G SARKAR

This past summer, some of the students from the 2011 and 2012 classes traveled to Kenya as volunteers with the organization, Caring Partners Global (CPG). CPG is a health and development network whose aim is to create sustainable community endeavours in the village and surrounding area of Matangwe, Western Kenya. The organization involves itself in a multitude of initiatives, many of which we were able to observe firsthand. These projects included a water sanitation program, where CPG delivers clean water to some remote areas by means of a tank pulled by a tractor, a sponsorship program for orphans to help them pursue secondary level education, and a feeding program that provides students at the Matangwe Primary School with daily lunches. During our stay, we saw the near-completion of a community centre that will generate a sustainable income through literacy programs and technical skills training for adults, and will also promote intergenerational mentoring between the youth and elderly members of the community.

The majority of our time, however, was spent in at the the Mantangwe clinic, which provides 24-hour primary and emergency care to the area. Our activities at the clinic were wide-ranging. We participated in the daily running of the clinic. For instance, we had the opportunity to help dispense medications such as antimalarials, antiretrovirals and antibiotics from the clinic pharmacy. We also performed antenatal physical examinations on expecting mothers and participated in "Well Baby Wednesdays" where mothers brought their babies in for growth measurements and vaccines. Furthermore, we were fortunate to be able to assist with emergency cases which included wound care and child-birth, and helped with the weekly HIV/AIDS clinics for counselling and testing.

Our involvement extended beyond the clinic. We also had the opportunity to get involved locally through CPG's outreach program. Every week, they CPG aimed to provide a rotating outdoor clinic in neighbouring villages as a resource for those who cannot travel to the Matangwe clinic. We also had the opportunity to spend time at the Bondo District Hospital, a government hospital located within the township of Bondo, (approximately 7km from the Matangwe clinic,) that provides an intermediate level of health care services. There, we observed caesarean-section surgeries as well as participated in rounds through the wards.

As I'm sitting here writing this, I cannot help but reflect on the people and experiences that made our trip so much more than just "volunteering in a clinic". Joyce, a caretaker at the clinic, is a soft and gentle woman who always has a

Matangwe, continued on page 34.

A well baby clinic offering vaccinations and growth monitoring for newborns and counselling for young mothers about HIV prevention and nutrition.
Matangwe Clinic, August 2009
Photo by Rebecca Grimes

Notes from Tanzania

BY SARAH KAWAGUCHI

The vacancy in his eyes was the first thing that I noticed. Eyes roving without purpose, eyes like marbles, eyes screaming in terror on behalf of an owner too ill to speak. He opened his mouth only to choke out a hoarse-sounding cough that rattled his entire body. I cringed as I palpated his abdomen; the skin was stretched so tightly over his drum-like belly that I half-convinced myself that the whole thing would burst like a blister under pressure. The grossly enlarged lymph nodes in the crooks of his arms were the size of small oranges. I looked at his chart: "Active tuberculosis, liver failure, lymphadenopathy, full-blown AIDS. Palliate."

The man that I have described is only one among many HIV positive patients being treated at this very moment at Kilema Hospital in Moshi, Tanzania. The hospital cares for the entire spectrum of patients with HIV/AIDS, ranging from asymptomatic stage I patients to those with severe stage IV disease. Local people travel from nearby villages to the newly-built care and treatment centre to obtain ARV regimens, medications for opportunistic infections, and counseling about symptom management. Kilema Hospital has certainly made great strides in the treatment of patients with HIV/AIDS in recent years. Sadly however, the lack of funding, persistence of stigma, and frequent loss of follow-up continue to make such severe cases as described above an ongoing reality.

From its humble beginnings as a small dispensary in 1920, Kilema Hospital has grown to a 120-bed hospital with a catchment area of 228,000 people. The road to the hospital is a steep, unpaved collection of rocks and potholes that is almost impossible to traverse during the rainy season. Thirteen Queen's medical students in the class of 2012 and three in the class of 2011 traveled that road this summer. We spent two weeks at Kilema Hospital and two weeks at the Pamoja Tunaweza Women's Centre, that provides free medical care, counseling, loans, and business classes to women who have experienced every type of hardship imaginable. Nephrologist Dr. Karen Yeates and emergency physician Dr. Jennifer Carpenter founded and opened the Women's Centre in June 2007 and have been working to expand its initiatives ever since. Part of this expansion was to set up the month-long volunteer placement in which we, sixteen, participated this summer.

The hospital and Women's Centre are situated in rural Tanzania, on the foothills of Mount Kilimanjaro. The rural aspect meant two things. One, our surroundings were absolutely idyllic: there was no shortage of greenery,

Empowering female entrepreneurs in Tanzania through daily business classes
Pamoja Tunaweza Women's Centre in Moshi, Tanzania
Photo by by Sarah Kawaguchi

rows of big-leafed banana trees and red dirt roads, with the snow-covered peaks of Kilimanjaro as an ever-present backdrop. Two, being exposed to rural health care opened our eyes to some harsh truths. All too often, differences in the provision of care between our own medical system and theirs came down to a simple lack of resources. For instance,

Tanzania, continued next page

A New Year, a New Hope

BY ROHIT MOHINDRA

On a cold and dark night this past January, many of us were swept away by a bright sense of hope and optimism as we watched the inauguration of U.S. President Barack Obama. He projected a refreshing sense of change, and promised a better world ahead. I think for many of us, President Obama reminded us that we can do the right things, the right way. We can bring about the change we want to see and live: a change for the benefit of humanity that we can leave to future generations. A new year can bring new goals for all of us. Some goals may be academic, like doing well on an exam, while others may be personal, like training for a marathon. We can also set goals for ourselves as a profession, as a group of students, and as members of a community. I challenge my peers, our faculty and our fellow health care workers to take some small steps to start effecting change in the medical education and health care system. Specifically, I would encourage them to be engaged citizens, to question the status quo, and to embrace innovation.

What does it mean to be an engaged citizen? Philosopher Mark Kingswell has argued that citizenship (which is typically defined as membership of any group within society) should be defined by the act of participating. This, in turn, fosters an environment of mutual care and respect that can be the catalyst to move towards the just and moral world we seek (1). In other words, in order to make our world into the one we desire, we must be actively engaged to make the changes we want to see. Simply sitting back and allowing the world to take its course is not enough. The first step to creating a better hospital, medical school or health clinic is to take the effort to be engaged. Choose a cause that has meaning to you and join an organization that is advocating for this cause. For example, become a member of a hospital board, student advocacy group or a community organization. Actively immersing oneself in the process is the first step in bringing about a positive change.

Once engaged in a cause, ask yourself "what has made your particular cause a success so far"? Most likely you will find the roots of success buried in years of experience. Indeed, it is difficult to deny that trial and error have made certain aspects of our medical system better. However, there are aspects of things we do that are deeply steeped in tradition rather than evidence and this may detract from patient care. A seemingly trivial example is the instruction of medical students to only examine from the right side of the patient during physical examinations. This is a remnant of the ancient superstition against left dominance (hence left is often equated with the Latin root for sinister, sinestra). For the almost 15% of medical students who are left-handed, this is an additional impediment, which has no proven clinical benefit for most aspects of the clinical exam (2). While this in itself may not cause harm to the patient, an art such as medicine – built on a foundation of similar archaisms – may greatly benefit from strong conviction from any of us to question and remove these outdated and unnecessary conventions. This initiative can come from a junior medical clerk, from a professor emeritus or from the two working together; anyone can have a profound influence to shake off the status quo and create space for progress and innovation.

New ideas are fundamental for instituting change and bringing about the best within our field. Our success in health care has risen from generations of scientists asking how something can be done more effectively and more efficiently. Just think of the drastic changes that have evolved in the past 20 years: the global wealth of knowledge shared through the internet, the compact automatic insulin sensing pump or the emergence of non-invasive surgical procedures (3). Yet, there seems to be a general reluctance to accept change in much of what we do. A recent study published in the CMAJ demonstrated that experienced physicians were not as likely to prescribe the evidence-based regime of medications after discharging patients admitted with myocardial infarction compared to their younger colleagues (4). Since the medical training system is largely founded on mentor-student relationships, it is easy to see how a difference in proposed therapeutic management could arise in a teaching setting and could prove harmful to the patient. One patient may not live as long after discharge based simply on his or her physician's reluctance to prescribe the current evidence-based regime of medications, while another patient may benefit from the correct medications. Certainly, this is a situation that contradicts the ethical principles of justice and non-maleficence that are essential to the professional trust we have with our patients. Therefore, we must be able to evaluate new and innovative ideas critically and we must have the courage to change our standard of care to provide the best possible options for our patients.

Undoubtedly, this inherent hesitation ensures new medical knowledge is applied with caution and that patient safety is kept as a paramount priority; however, it is important to ask if our lack of enthusiasm for new ideas is based on carefully weighed evidence or if it is based on the perception of inconvenience that it might cause in the comfortable routine we have established. Even if we don't make any changes to the way we learn, practice or interact, asking ourselves why we are hesitant to accept innovative ideas can only help challenge us to improve our clinical abilities, our teaching skills and our medical knowledge. Ultimately, as a profession, we can strive for a better balance between innovation, tradition and optimal patient care.

At the end of the day, the world we live in is the world we make. I often turn to the infamous words of Margaret Mead for inspiration: "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has" (5). We always have a choice, whether it is to stay an extra ten minutes to comfort a patient, to make a lecture for students just a little better, or to help a fellow student who is struggling with a difficult procedure. We are the ones who can make a difference to our patients, to our profession and to our communities, and I challenge you to start now.

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Tanzania, continued from previous page

the hospital was not equipped or staffed to treat femoral fractures with internal fixation, making the outdated method of pin traction the only treatment option. Pin traction requires patients to be immobilized in bed for three months, during which time they are at risk of deep venous thromboses, pressure ulcers and pneumonia. These risks become realities with alarming frequency, turning fractures into death sentences.

At this point I should stress that to characterize Tanzanian medicine purely as a disquieting tragedy would be to wantonly disregard its positive feats. Each year at Kilema Hospital, hundreds of babies are delivered safely and their mothers are monitored carefully pre- and post-partum. These women are also offered a program for prevention of mother to child transmission (PMTCT) that has surely prevented HIV virus transmission from countless mothers to their infants during labor and delivery. Ultimately, the doctors work with what they have, and I am grateful for their warm welcome into the operating theatre, wards and clinics.

I will close with the admission that this article was the product of an internal struggle. Overall, my experience in Tanzania was very positive and I would highly recommend the trip to anyone interested in going. I do not, however, wish to make this a propaganda piece since the decision to travel is truly personal, and is whatever you make of it. All sixteen of us have our own recommendations and stories to tell, and thus anyone considering the trip would be wise to hear everyone's perspective. Details about this month-long placement as well as other international electives will be provided in the coming months.

Dr. Yeates and Dr. Carpenter plan to solicit feedback from the students who travelled to Tanzania and other locales this past summer. They will use this feedback to improve the student experience in both Tanzania and other placement locations. Their ultimate goal is to compile a database of worthwhile and appropriate Global health placements/ electives in which Queen's medical students can participate in the coming years. This database will then be updated annually as students return from abroad so that other students can benefit from the information.

Dr. Rees Cosgrove

On neurosurgery in Canadian and American contexts

BY ANA BRADI AND KATRIN DOLGANOVA

Dr. Rees Cosgrove was born in Montreal, Quebec, where his father had an established practice at the Montreal Neurological Institute. As he entered young adulthood, he decided to follow in his father's footsteps and pursued his undergraduate and medical education at Queen's. A graduate of the Queen's Medicine class of 1980, Dr. Cosgrove completed his neurosurgery residency at McGill in 1986. He moved to Boston, where he began his post at Beth Israel Hospital and started his teaching career at the Harvard Medical School. Currently, he is the Chair of the Department of Neurosurgery at the Lahey Clinic and is Professor at the Tufts University Medical School. Dr. Cosgrove's interests include brain tumors, epilepsy, radiosurgery and all aspects of stereotactic and functional neurosurgery.

Sailing
Photo courtesy Rees Cosgrove

1) What attracted you to Queen's and Kingston when you applied to university?

Queen's seemed the most natural place for me to go to university because it was close to Montreal where I grew up and was also where my mother, a Chown, had originated from. One of my first impressions at Queen's was that there were a lot of very smart people there. I quickly realized that I was of rather average intelligence and I would have to work very hard if I wanted to succeed. I also had tremendous fun and met extraordinary people; so much so, that when I had the opportunity to apply to medical school, I only applied to Queens because I wasn't interested in going anyplace else. Most pre-med students would recognize this as a seriously flawed strategy.

2) Can you tell us what Queen's medical school was like during your time here (1976-1980)?

I look back on medical school as one of the very best times of my life. We had one of the greatest groups of people I have ever met who enjoyed working hard, having fun, helping each other and playing sports. Several of these people remain my life-long friends. Your truest friends are made through shared experience under both adverse and agreeable circumstances. These friendships are what help you navigate through many of life's difficulties and challenges. I wish I had more of these close friends living in my neighbourhood or working down the hall.

The curriculum was relatively conservative with basic medical sciences in the first 2 years and clinical sciences and practical rotations in the last 2 years. The most exciting part was actually rotating on clinical services in the hospital and I remember well the very first night I was handed a beeper and told that I was on call. I thought I had died and gone to heaven! With 30 years of perspective, another seriously flawed impression.

3) When did you first realize you wanted to be a doctor? To what extent did your upbringing influence your decision to pursue medicine?

I realized I wanted to be a doctor while I was in high school. As a boy growing up, I had been introduced to medicine by my father, who was a neurologist at the Montreal Neurological Institute (MNI). He was a compassionate physician and dedicated researcher with two Master's degrees, one from Cambridge University in England. He was hired by Wilder Penfield to initiate a program for the investigation and treatment of multiple sclerosis at McGill. He would often take us in to the hospital for various functions and every Christmas morning, we would go around to every ward singing carols with the 'Cosgrove Choir' and help deliver presents to all the hospitalized patients. I then went on to be an orderly in the hospital over the summer months and Christmas vacation to earn enough money for school. This experience was invaluable because it allowed me to see the most basic elements that are required to care for another human being. Even though I was only an orderly, I also always made sure to try and attend every grand rounds and scientific lecture that was being given. It was so very exciting.

4) Were there specific moments in your life that sparked an interest in neurosurgery and academic research?

When I was about 10 years old, we had a dog who began to have seizures. Initially, we could control them with Dilantin, but eventually they got worse, and one morning I awoke and found the dog in status epilepticus. My father said that we had to put her down, and the only way of knowing what the cause of her seizures was would be to perform an autopsy. So we proceeded to wrap the dog in a blanket and took her down to the animal laboratories at the MNI where he skillfully euthanized the dog. He then proceeded with the removal of the brain which was performed somewhat less skillfully and with me as his assistant. It was a difficult emotional experience, and I somehow knew that the autopsy could have been performedbetter.

As I progressed through medical school, I began working in research labs at the hospital and began seeing medicine at a different level. The realization that one could care for patients and, at the same time, advance clinical treatment and science was energizing and captivating. I began to see that neurosurgery was one of the most challenging fields in medicine, with exceptional clinical requirements and stimulating scientific possibilities. I knew early on that I wanted to be a surgeon, but also that I wanted to be challenged intellectually and be able to investigate the function of the human brain. Neurosurgery was the ideal opportunity, and I have loved it ever since.

Meds 1980 alumni 25 year reunion
Photo courtesy Rees Cosgrove

5) Did you find that your Canadian education prepared you well for working in the US?

Physicians and surgeons never really have to find a job, we just have to find a place to perform our work. Hospitals are hospitals, and are similar everywhere; the essential interaction between patient and physician is the same throughout the world. My first practice was at Beth Israel Hospital in Boston, and a major teaching facility for Harvard Medical School (which was a bit intimidating at first). I then realized that I was probably better trained clinically coming from Canada than most US trained doctors. Queen's trained us as medical students to be practical, organized and complete. We were also given exceptional opportunities to develop our clinical judgment, and I always felt that I was better prepared for clinical practice than most other medical students.

While we had more access to technology and equipment in the US, the expectations from patients and fellow physicians were extremely high. I remember diagnosing a woman with an acute non-traumatic third nerve palsy as having a posterior communicating artery aneurysm that needed to be clipped. I recall sitting in the Neuro ICU beside the patient waiting to take her to surgery when I got a call from her treating physician. He said that if anything happened to this woman, I had better get a plane ticket back to Montreal! Queen's and McGill had prepared me for the pressure of even these types of situations, and I felt completely confident and able to do what was needed. I clipped the aneurysm easily and phoned the physician later to inform him of the successful outcome.

6) You have recently spent two weeks in India, visiting two medical schools. Can you tell us a bit about your impressions from this trip?

I was the Honoured Guest of the Indian Society of Stereotactic and Functional Neurosurgery and was asked to give three lectures at their annual meeting which was held at the Christian Medical College in Vellore. This had particular significance for me because the 'Father of Neurosurgery in India', Jacob Chandy, was trained at the

Profile, continued on page 34.

Against, continued from page 5.

be used as a tool to reinforce certain concepts, it would be a very poor idea to adopt it as the sole teaching modality. Medical education comprises a great deal of core knowledge and tacit skill that need to be acquired in a short four years. Exclusive implementation of team-based learning, even if done effectively, would extend our medical education to eight years in length. This learning style might produce a better physician in the end, but the reality is that we need to learn and be able to implement knowledge in an efficient and timely manner. If we learn best though didactic lectures and clinical encounters in clerkship, perhaps that should remain the focus of curriculum development.

Matangwe, continued from page 28.

smile on her face. Pope, the medical officer who is willing to drive you anywhere you want to go. Julia, the administrative assistant, whose wisdom and knowledge of the community are beyond compare. Sam, the caretaker of the clinic grounds, and the jolliest guy you will ever meet. The nurses, Ingrid, Selomi Salome, Benter, Eunice and Lorna who are beyond amazing. Susan, the pharmacist, who makes counting pills the most entertaining activity. Jeremiah, the clinic driver, who took us to meet his in-laws and to have dinner at their home. There were so many countless individuals who opened their hearts and homes to us in Matangwe, I feel rather guilty for having taken away much more than I felt I gave, but perhaps one day my feet will touch the red clay soil of Matangwe again.

And yes…some of us did get to see Obama's grandmother!

Happy travels.

Profile, continued from page 33.

MNI and started a Neurosciences Institute in Vellore. Dr. Wilder Penfield went there in 1957 to open the institute, and very little has changed since that time. I had heard stories of the place and this man since I was a little boy, and being there in person was quite compelling. I rounded in the hospitals in Vellore and New Delhi, and I have developed great respect for the Indian neurosurgeons. They deal with an incredible burden of disease with limited resources and exceptional skill. We could all learn from their judgment and compassion.

7) Clinical and academic work can be demanding and challenging at times. What do you do to keep a balance?

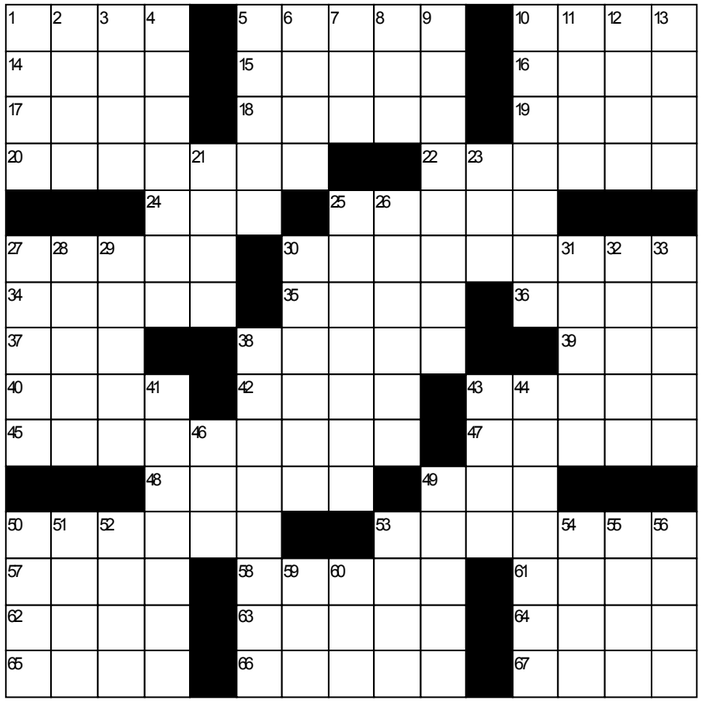
Teaching is not demanding or challenging for me. It is in fact, one of the most rewarding parts of my day and something I enjoy completely. The clinical responsibilities I face are always taxing, but so deeply satisfying that these too are welcome. Some of the administrative duties can be quite taxing at times and when it is a rough day, I always joke that I would love to escape to the OR and do a long, demanding, high-risk skull base procedure where everybody is doing exactly what I say! It is obvious that balance is the hardest thing to achieve in a life in which you are passionate about. In order to do neurosurgery well, you have to devote all of your concentration and abilities to it. This leaves less time than you would like for all the other important aspects of your lives. I try to leave most of my work issues at the hospital but this is increasingly difficult with the internet and ubiquitous cell phone coverage. It is very important to spend time with your family and friends, to exercise and restore your spirit, to listen to good music and good conversation, and to do anything else that can feed your soul.

8) The field of neurology and neurosurgery is evolving at a fast pace. What is, in your opinion, the most promising area of research in this field?

In terms of applied clinical research, the most promising area of research in the next 5 -10 years will be in the neuromodulation of brain function. This implicates the use of deep brain stimulation and other modalities in altering or improving neurological function. In terms of basic scientific research, the future rests in molecular biology to help understand the true substrates and pathophysiology of neurological disease. In terms of understanding the human condition and human behaviour, the future will be dominated by advanced brain imaging and the delineation of complex neural networks. We have been granted exceptional tools to better understand the human brain and we have a responsibility to continue to ask essential questions.

The Fifth Lobe

BY DANIEL FINNIGAN



www.CrosswordWeaver.com

ACROSS

1 House of God author, pseudonym
5 __ Stomach
10 Stack of paper
14 Beside, prefix
15 Easily taken advantage of
16 Lip
17 Like a wing
18 Egg __
19 Quarrel
20 Dependent upon (2 words)
22 Repents
24 Charged particle
25 Farcical
27 Humour
30 The boat bone
34 Brown
35 Kiln
36 Painful
37 Inhibitor for BP
38 Frighten
39 Worm type
40 Before a seizure, sometimes
42 Monk's room
43 Invited person
45 Good for UTIs
47 Chilean mountain range
48 Rabbit
49 National police
50 Run
53 Exciting
57 Burn treatment
58 Visualization
61 False god graven image
62 Stable gear
63 Taboos
64 Otherwise
65 Sodium
66 Grind together
67 Saw, in past tense

DOWN

1 Fight
2 Fit
3 Time periods
4 A form of EtOH
5 "The Jungle" author Sinclair
6 Common patient complaint
7 Short-term memory
8 Compass point
9 Aged wine attribute
10 Hone in again
11 Adam's garden
12 Malaria may present this way
13 Ward slang
21 Soybean
23 Perhaps a nervous one?
25 Combat troops on horses
26 Excessively
27 Jacob's father
28 Happen again
29 Musical production
30 Primun non _
31 Trotted
32 Get up
33 Doesn't own
38 Detect by smelling
41 Old
43 CNS inhibitor
44 Wholenesses
46 __ voyage
49 In the ___, person
50 Corona virus
51 Guilty or not
52 Churn
53 Self-esteems
54 Lazy
55 What snobby people look down
56 Dell (without keys)
59 Day of wk.
60 Lupus confirm

FOR SOLUTION, SEE PAGE 15.

On Violence

How medicine is a mirror that reflects our norms

Medicine is a rational science. A patient presents, and the doctor analyzes clinical symptoms and signs to generate a diagnosis. Doctors are reasonable people in society, the keepers of answers and pills.

However, to ignore that clinicians operate within a larger, influential structure that shapes our perspectives is to be blind to the historical and societal forces that determine how we think and make decisions. It is easy to become disconnected from this larger picture as we get caught up in the pressing tasks of the everyday. There are patients to be seen, diseases to be managed. But if we take the time to step back from the rush, it is evident that societal values and biases percolate through to the practice of medicine.

The goal of diagnosis, at its basis, is to differentiate between health and disease, or normal and abnormal states. As objective as this task may seem, in fact, medicine is a coloured lens through which we apply these definitions.

If someone were to present with sudden blindness, there is no doubt that something is wrong; normal function involves seeing, so not being able to see is abnormal. We treat the visual loss to preserve restore sight.

Now, consider an individual who presents to the emergency room bleeding profusely from the scalp, having been injured in a serious fight. We stop the bleeding, suture up the lacerations, but stop short of questioning why this individual engaged in and was hurt by a violent act. Implicitly, we accept violence as normal rather than questioning whether it should exist at all.

I was taken aback recently when, in our session on intimate partner violence, the statement was made that most people who commit violence against a partner are "normal," with no medical or psychiatric disease. Perhaps the absence of a physical or mental diagnosis is one way in which normalcy may be defined, but, in this case, it is an unacceptably narrow definition. If we, as physicians, accept that inflicting disabling or fatal harm on another human being is "normal," we compromise the principles and values of the medical profession. We denigrate the very tenets upon which our noble profession is built.

We must be keepers of individual and societal health, and it is our obligation to challenge the status quo when the circumstances suggest that there are positive changes to be made. Violence should not be the norm, even when society accepts it as such. As physicians, we must be on the front lines of a campaign to reclaim these values that seek to uphold health and prevent harm to patients, including emotional and physical abuse.

The objective of medicine is to treat disease. We identify problems, work them up, and apply solutions. Perhaps we cannot fix violence with a pill, but we can advocate for the safety of victims, and ensure that adequate supports are developed and available for perpetrators, who, although not "ill" in the traditional medical sense, could perhaps learn to recognize their violent tendencies and channel them in alternate ways. By refusing to accept the unacceptable, we will be important participants of a movement to de-normalize violence in our society. Q

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