# THE SQUARE KNOT

The following are some guidelines for surgeons which I hope will be helpful to avoid malpractice lawsuits. Far more detailed and profound articles are available to those who are interested and should be consulted in given situations where you are concerned.

## How to Avoid a Lawsuit

***COMMUNICATE, COMMUNICATE, COMMUNICATE***

**By Alex K. Paterson, OC, QQ, QC**

In my own practice I have seen more actions instituted by patients irritated from a lack of communication by their doctor rather than as a result of evident malpractice.

*Alex K. Paterson*

And while everyone wants to win if sued, you should want to avoid the inconvenience, loss of time and harassment of a lawsuit at all, if you can.

In the early seventies, there was a general exodus of surgeons from Quebec following the advent of Medicare and the debate over the right to opt out of the plan. Patients woke up from their operations to find that their surgeons had left the Province and they were in the hands of another before their recovery or rehabilitation period ►

(please see **Lawsuit**, pg. 5)

**Inside**




DEPARTMENT OF SURGERY

NEWSLETTER

McGILL UNIVERSITY

SUMMER 1998

# Letters to The Editor

**Dear Editor,**

I thank you for your letter concerning the McGill Surgery Alumni & Friends. I like very much receiving the Square Knot, which helps maintain a bond and keeps me informed of the McGill Department of Surgery's tumultuous changes.

Talking about changes. I have recently moved my office from the Cleveland Clinic to the Mount-Sinai Hospital in New York. The Mount-Sinai Hospital will be merging with NYU making it one of the biggest and strongest institutions in the US with a hospital of 2,200 beds, and a network of 37 hospitals and 16,000 physicians. There is already a Department of Laparoscopic Surgery, which was previously under the Chairmanship of Dr. Barry Salky and was created by the former Chairman of the Department of Surgery, Dr. Arthur Aufses. I have accepted this new position and challenge. I want to create a state of the art Minimally Invasive Surgery Center for New York City.

I will continue my academic career with the Mount-Sinai School of Medicine where I hope to be a full professor of surgery with a chair. I will continue to proudly represent my McGill surgical heritage.

*Sincerely,*
*Michel Gagner, M.D,*
*New York, N.Y.*

**Dear Editor,**

Time flies since our seven years at McGill. Kathy and I started out spending three years on staff at Yale and then we moved to Seattle. Kathy retired from Pediatric Pathology and I have been in a hospital-based Pediatric Surgery practice at Swedish Hospital for the past five years. We think Seattle is great. Our 13 year old son gets to ski four days a week with his ski team as the Cascades are only 40 minutes away by interstate. Haven't missed the snow and ice of Montreal but certainly miss the culture. I thoroughly enjoy the Square Knot and I am always interested to hear of how politics are affecting McGill.

*Ian Neilson, M.D.*
*Seattle, Wash.*

**Dear Editor,**

The origin of medicine at McGill is slightly more complicated and bizarre than the report in the Square Knot (Fall '97).

McGill left land and money for the foundation of a college within ten years of his death, but his heirs, the Desrivieres, contested the will. The Royal Institution for the Advancement of Learning, a Quebec city body, had been granted the powers, land and money by the trustees of McGill's will, and they applied for and were granted a charter for a college and the power to grant degrees by King George IV in 1821. To counter the Desrivieres' claim that there was no college, the RI's lawyers argued that because the King granted the charter with the old Norman French phrase "Le Roy le veult" that therefore it existed from that day. The lawsuit dragged on from court to court, and finally the Judicial Committee of the Privy Council in the House of Lords Westminister decided in favour of the RI in regards to the land in 1828.

On Wednesday, June 24th, 1829, McGill was inaugurated at McGill's house, Burnside, which by that time was in a dilapidated state. The College had some land and five professors on paper, the RI was in Quebec city, there were no students and no money. Four of the five professors lived in Quebec.

Negotiations were started between the Montreal Medical Institution and McGill in order to merge so that the doctors trained by the MMI could receive a degree. This was finally achieved in 1832. Meanwhile, the second lawsuit between the Desrivieres and the RI was settled in the RI's favour in 1835 and they got the money. Thus, although McGill had officially been in existence for 15 years, the only activity other than rhetoric was in medicine where the first graduates were in the mid 30's. The first non-medical graduate was in 1843. Although Archdeacon Mountain said that the MMI was grafted onto McGill, it was in reality the other way round.

Reference:
McGill University for the Advancement of Learning, Stanley Frost, McGill-Queen's University Press, 1980.

*Harry J. Scott, M.D*

# Upcoming Events

**September 1-4, 1998**
Esophagus '98 VIIth World Congress
Montreal
Chairman: Dr. André Duranceau

**September 23-27, 1998**
International Conference on the Pelvic Floor, Montreal Convention Centre

**September 24-28, 1998**
Annual Meeting Royal College of Physicians & Surgeons of Canada
Toronto

**September 24-28, 1998**
Meeting of the Canadian Assocition of General Surgeons, Toronto

**October 5, 1998**
First Annual A.R.C. Dobell Visiting Professor of Congenital Cardiac Surgery, The Montreal Children's Hospital
Dr. Richard A. Jonas, William E. Ladd Professor of Surgery & Surgeon-in-Chief, Department of Cardiac Surgery, Children's Hospital, Boston

**October 25-30, 1998**
Clinical Congress of the American College of Surgeons Orlando, Florida

# WE NEED A P.R. PERSON ....

## Editorial

By E.D. Monaghan, M.D.

It is time that we in the Surgical Profession hired a Public Relations person, not only to improve our image, but also to explain our problems to the public and to our patients. When a government *spokesperson* maintains that there are too many useless operations being done, then this PR person, supported by data, could explain what we actually do. It seems that, recently, the media has placed medical happenings at the forefront of its agenda and we are frequently left with a hunger to intervene to explain things. A number of items come to mind.

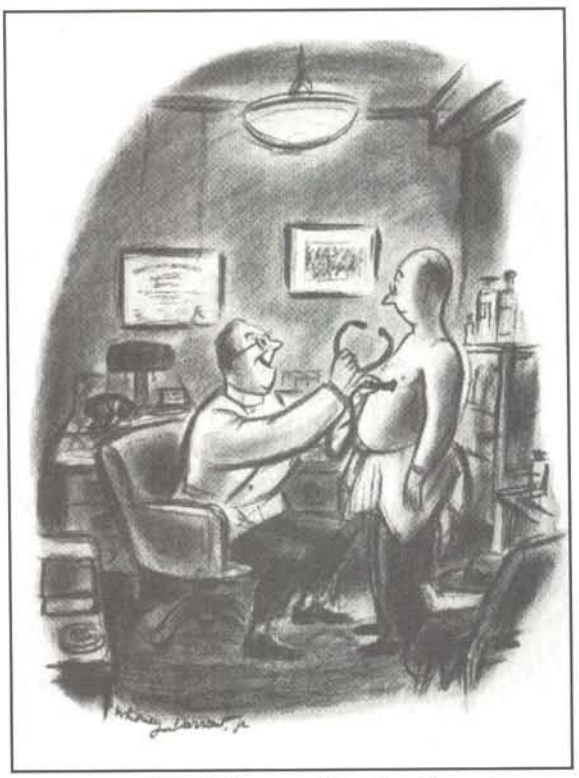
First of all, the media has become the beacon for developing technology. Almost every evening on the TV news, there is an item regarding a "new" finding or discovery viz. angiogenesis, taxol, tamoxiphen, PSA. We cannot stop this, but surely other matters could be explained to the public, particularly those issues relating to the government. The latter has its own "spokespersons" and the direction is one way. For example, too often, when discussing doctors' revenues, the figures given are those for Gross Income. The cap limit on a radiologist's growth income is $525,000 per year, but after expenses, the average radiologist takes home some $131,000 per annum. A Public Relations Agent could rectify any misunderstanding.

When the Quebec Government's Ministry of Health and Social Affairs developed its "plan de retrait" with the FMSQ, this "buy-out plan" mentioned the figure of $300,000. This was misleading in its presentation as readers assumed that retirees would receive $300,000 per annum. A PR person would explain that this $300,000 is to be divided amongst five years.

The public understands very little about capitation limits. A media agent could help in persuading our patients to interfere so that our Federations could be successful in negotiating with the government to scrap the limits imposed. Recently, the government in its dispute with GPs has, in negotiation, agreed to abolish the quota on the number of examinations per day among other things. Quebec's 7,200 General Practitioners earn an average of $150,000 a year and, as front line workers in our health care system, their numbers have dropped 200 over the past three years. Fewer than 30 new GPs have started up practice on the Island of Montreal in recent times because they have to take a cut in pay of 30% for ten years. All these problems cause an erosion in public confidence and we need good PR to circumvent this. FMOQ Vice President William Barakett maintains that the Ministry of Social Affairs is out of touch with the reality of health care. "Politicians and government bureaucrats have no idea what treating patients is all about". They need to be informed. Good communications could be improved by informed PR.

Another problem relates to *ceilings*. If a specialist's pay ceiling is $130,000 every six months (this may already be the lowest for his specialty in Canada), the government will make negative adjustments for any amount over this ceiling. Our patients generally either misunderstand this or they are completely unaware of this measure of cost control. Here again is where a PR person comes in.

A good press would improve our Health environment these days. Ms. Eva Ryten, former Director of Research for the Association of Canadian Medical Colleges, has reported recently in the CMAJ that there will be a shortage of doctors in the coming years. Enrollment in the medical schools was curbed in the early 1990's as a result of the Barrer-Stoddart report. She affirms that the 16 Canadian Medical Schools should be



*"Want to hear something funny?"*
*— The New Yorker*

producing around 2,000 new doctors annually. But in 1997, these same medical schools admitted only 1,513 Canadians and permanent Residents. Ms. Ryten said that it is obvious that Doctors are already coping with excessive workloads. "The Doctors who work in the hospitals and clinics, they ►

► know the situation is difficult. They are swamped. And when people go in (for care) they realize what the situation is. Are we to ignore all the evidence of our everyday experience?"

Doctors Sylvia and Richard Cruess in their lecture on "Professionalism" state that "Medicine's self-perception differs greatly from Society's view of the profession". We need to solve this. It will take more than good PR, but an ongoing method of communication would be a good start.

Perhaps this is all wishful thinking, but it would surely be satisfying to have someone to explain our side. ◆

*EDM*

## The MUHC Gets its Report Card

A survey team from the Canadian Council on Health Services Accreditation visited the new integrated McGill University Health Centre from November 16th to the 21st, 1997 and its report was very favorable and satisfactory to the MUHC leadership. This was the first time that the MUHC as a unified institution was accredited as one centre - a major undertaking given its many services and sites. The positive feedback was in the form of a "three year accreditation with report". ◆

*EDM*

## Attention!

***ALL GRADUATING RESIDENTS AND FELLOWS***

From McGill Post-Graduate Training Programs in General Surgery, Orthopedic Surgery, Cardiothoracic Surgery, Vascular Surgery, Plastic Surgery, Pediatric General Surgery, General Surgical Oncology, Neurosurgery and Urology.

**Please leave us your forwarding address**. We would like you to join the Alumni ($40.00) and we will send you "The Square Knot". ◆

Address: **Ms. Maria Bikas**
**McGill Surgery Alumni & Friends**
**The Montreal General Hospital**
1650 Cedar Avenue Room C9.169.2,
Montreal, Quebec, Canada H3G 1A4.
Tel.: (514) 937-6011 ext. 2028
Fax: (514) 934-8289

*EDM*

## Thank You Very Much To Our Contributors

Following the solicitation letter in our last "Square Knot", we have received over $7,500.00. We are sincerely grateful to our Surgical Alumni and Friends who help keep us in business.

The following colleagues donated $100.00 or more.

Dr. Basil R.S. Baeta
Dr. N. Belliveau
Dr. Sameh Barayan
Dr. David A. Cherry
Dr. Colin Cooper
Dr. K.S. Dhillon
Dr. Michael Gagner
Dr. R.B. Gledhill
Dr. A.E. Noelle Grace
Dr. Andrew Hill
Dr. Abdel-Raouf Ismail
Dr. Howard W. Klein
Dr. David Arthur Latter
Dr. Ramesh Lokanathan
Dr. Lloyd D. MacLean
Dr. Joel Steven Morris
Dr. Michael J. Morse
Dr. David S. Mulder
Dr. David Alton Murphy
Dr. Ian Neilson
Dr. J. Olak
Dr. Charles Omole
Dr. José Mijangos-Pelaez
Dr. A. Turnbull
Dr. Bryce Weir
Dr. Paul Wizman

*EDM*

## Colorectal Surgery Research Award

The McGill Division of Colorectal Surgery is offering an award for the best research paper in Colorectal Surgery by any resident in General Surgery effective immediately. Inquiries are to be directed to the undersigned. ◆

*Philip H. Gordon, M.D.*
*Tel.: 342-1772*

► was over. Many sued. Few won, but the lack of communication provoked the litigation.

Bound up in the issue of communication is of course the duty to give sufficient information to obtain an informed consent. It is not necessary to understand all the distinctions, directives of the Courts over the years in this regard. But at minimum, you should proceed in the following fashion to avoid litigation:

**Lawsuit**
(continued from pg. 1)

❶ Explain the procedure you are recommending, its seriousness, the material risks and advantages. Make sure they are understood and document your explanations. A good practice is to ask the patient in a general way what you have told him and document his affirmative answer. If he cannot repeat what you told him, probably go over it again. The following statement of the Supreme Court may be helpful:
**"No doubt, a surgeon has some leeway in assessing the emotional condition of the patient and how the prospect of an operation weighs upon him; the apprehension, if any, of the patient, which may require placating; his reluctance, if any, to submit to an operation, which, if the surgeon honestly believes that the operation is necessary for the preservation of the patient's life or health, may demand detailed explanation of why it is necessary."**

❷ If risks are only a possibility, they need not be divulged unless there are serious consequences such as death or paralysis or when the patient poses specific questions as to the risks. Ask the patient if he has any questions and document his negative answer;

❸ Insure that the patient is of an age and mental capacity to understand what is about to occur and therefore to give a valid consent. Try to understand the patient's personal situation to measure the effect of the occurrence of a risk (e.g. profession, status, education, etc...), especially for elective surgery;

❹ For non-therapeutic procedures, the standard of disclosure is far more exacting and the documentation should be more detailed. Even negligible risks should be explained and questions carefully answered.

❺ If the person is unable to understand or is mentally incapacitated or a minor, follow the same procedure with a member of a family or the appropriate representative as defined by the law of the jurisdiction in which you practice;

Where good relationships are created between a surgeon, a patient and their family, a lawsuit is far less likely to occur.

### *THE OFFICE AND MEDICAL RECORDS*

Many practitioners are unaware when a lawsuit is taken how the lawyer has obtained the information on which to proceed. Many experienced practitioners will not sue until they have had a medical expert review the hospital record and advise them if there are omissions or acts of negligence apparent from the record alone.

The expert will analyse the record and particularly review the history; investigate what the patient has said beyond the mere signature on the formal consent; whether the medication orders have been noted and signed; if the operative note and discharge summary are complete, if visits of doctors have occurred and been recorded by the nurses or by his own note.

A complete record creates a good impression on the Court if action is taken. But if all the appropriate information is recorded, it often persuades the expert that there is no case and he so recommends to the Plaintiff's lawyer.

For example, the doctor may have visited the patient regularly, post-operatively, but there is no record of such visits. The expert concludes that the doctor abandoned his patient and recommends the institution of the lawsuit. Only later is the proof made and (with luck) the action dismissed. An unnecessary lawsuit that could have been avoided is taken because of the state of the record.

I have seen records with contradictions, and even written acerbic debates between attending staff, as to the appropriate diagnosis and treatment; others with a total void of notes by physicians during several shifts or notes erased and changed without explanation. Times that events occurred are often not charted or erroneously charted, and often there are simply gaps of information that allow speculation by experts and the Courts that are difficult to refute.

I have even seen records where entries relating to patients, other than the patient whose chart it is, have found their way in. Such a record gives a bad impression to the Plaintiff's expert and ultimately to the Courts.

The hospital record is the bible that forms the basis of both the claim and a complete defence. It is the only contemporaneous recording of what transpired and therefore becomes crucial when an action comes to trial many years later. It is important both in the doctor's interest and in his patient's interest to have a complete and accurate chart.

I appreciate that as a surgeon you often read a history prepared by someone else, rely on nurses' notes and ►

► those of consultants that are prepared outside of your presence. But at the end of the day, you are presumed to have acted on the basis of those notes and it is therefore worth the extra time to train all those who will work with you, on the importance of a complete record and to verify as far as you can the accuracy of those records before proceeding on the basis of the information they contain.

Your own office record will come second. But rest assured that it will be brought into play if an untoward event occurs.

It is of course often in the office, that the information required to obtain an informed consent is given. The notes of this explanation should therefore appear.

It is also in the office that you may discuss the follow-up, the recommendations for convalescing, rehabilitation, physiotherapy and post-operative medication. While often the hospital record will contain notes of this advice, if the hospital record does not, it should appear in your office record.

### *KEEP UP-TO-DATE*

Many malpractice cases turn on medical and scientific information available to the treating doctor at the time he diagnosed and treated the patient. If the doctor falls short of using the standard methods known and accepted by professionals, of the same qualifications, in the same milieu, or of informing the patient of available choices, he may run into difficulty.

Different courts faced with different factual solutions may come to different conclusions. Experts may give the court contradictory advice. You can never have too much information available and in the age of speedy Internet and web site sources of information, the standards are becoming more rather than less difficult to meet every day.

### *WRONG LIMB, WRONG OPERATION, WRONG PATIENT*

You probably, having read this chapter heading, will turn away and say: "That could never happen to me."

And yet, it has happened and in the best of medical circumstances, in teaching hospitals with distinguished surgeons of high repute.

Once it occurs, there is no way to avoid a lawsuit. So take the necessary precautions because while another's mistake may lead to the error, it is the surgeon that most often will be sued and blamed.

Why was the wrong eye removed, the wrong leg amputated or the wrong operation performed? Clearly, the operative site was chosen by someone else without verification by the surgeon or a change in the order of patients, scheduled for the operating room that day, caused an operation destined for another patient to be performed on the one that was replaced.

There are frequently changes in the operating room schedule. Beware of changes when one patient moves into the place of another.

These errors are inexplicable and unforgivable and rarely can the blame be shifted.

As the lawyer who fails to take an action within the delay prescribed by law cannot blame the secretary who keeps his diary, so the surgeon who makes this type of mistake cannot blame his intern, resident or operating room nurse.

If you retain nothing else from these comments, it is that it has happened before and it can happen to you.

So check, check and check again before you operate. Explain the presence of a surgical team and the roles of the various participants. You must tell the patient and obtain consent if someone other than the treating surgeon is going to do a major procedure during the operation. Experts may debate what comprises a major procedure so it is safer to explain more rather than less the roles the various participants will play.

There sometimes is a defence when a poor result is obtained that it was an inherent risk of the operation and not due to any reduction of surgical standards. But if a patient can argue that he or she expected his attending staff surgeon to perform his operation and it was performed by another, the defence of inherent risk may fail.

It is therefore worth spending the extra time to give the patient a general explanation of how the operation will proceed and that interns, residents, nurses and others all have a role to play during the procedure.

### *REVEAL ERRORS IMMEDIATELY AND PROVIDE FULL EXPLANATIONS*

If an error occurs during surgery that is explicable or even difficult to explain, it is best to reveal the error and give the explanation if possible. Often an immediate explanation with recommendations for corrective procedure, if they exist, are appreciated and accepted. The discovery weeks or months later that a mishap has occurred and has not been revealed raises the ire of the most complaisant patient or family. When in doubt, come clean. ►

► ***A FINAL WORD***

If, despite all precautions and following of all the best practices, a claim is threatened, a letter received or a lawsuit instituted, notify the CMPA, or whatever other insurance carrier you may have, immediately. For it is they who now have the responsibility to guide you through a series of legal procedures. Anything you say or do before consulting your insurers can only compromise the likelihood of a successful resolution.

***Editor's Note:***

**Alex K. Paterson** has acted as legal counsel to the McGill Teaching Hospitals since 1957 when he was first admitted to the Bar of Quebec. He also at one time was an adjoint-professor in medical jurisprudence at the McGill Medical Faculty (1973-1979) and chaired a joint-committee of the Canadian Medical/Canadian Bar Association to review and make recommendations to the two associations on matters of common interest. More recently, he chaired the Steering Committee that recommended the restructuring of four of McGill's Teaching Hospitals and chaired the interim board of the McGill University Health Centre. We congratulate Mr. Paterson on being named *A Great Montrealer.*◆

# Shortage of Anesthetists

Over recent weeks, the media has reported on the shortage of anesthetists at the McGill University Health Centre (MUHC). Although most of the information circulated on this subject focused on hospitals of the MUHC, specifically the Montreal Children's Hospital and the Montreal General Hospital, it is important to understand that the problem of recruiting and retaining anesthetists is not unique to the MUHC. It is being experienced in all major health care centres, particularly those in Montreal.

Although recruiting problems have existed for the past two to three years (the economic and political situation and the regulations concerning medical staff being the main causes), the situation has deteriorated since the fall of 1997 because of retirements and departures to other provinces and the United States.

For the past several months, active recruiting measures have been undertaken to avoid the inevitable repercussions of a shortage of anesthetists, such as operating room closures and postponements of elective surgery. Salary is the primary factor behind these difficulties in recruiting and retaining anesthetists. In Quebec, anesthetists, particularly in pediatrics, are less well-paid than anywhere else. Among other reasons most often mentioned by specialists are the financial penalties imposed on young doctors during their first four years of practice if they decide to remain in Montreal; they receive only 70% of salary in their first two years of practice, 80% in the following two years, attaining full remuneration only in the fifth year. Quebec also requires doctors who want to practice in a university teaching hospital to have an additional year of training abroad, which is not funded by the RAMQ. Moreover, the Collège des médecins du Québec imposes its own restrictions on the number of licences awarded to doctors trained abroad or in other provinces. It also requires a certification examination in professional competency as well as a French language proficiency test.

Faced with the set-backs in recruiting, a task force chaired by Eric Maldoff, a member of the MUHC Board of Directors, was set up several weeks ago to work with hospital professionals on studying the situation and the causes of the problem. It will also develop an action plan for the coming months and examine innovative methods of recruiting. In the meantime, hospitals are looking into temporary solutions to minimize the impact of the lack of anesthetists on patient care.

The current picture is as follows:

- At the Montreal Children's Hospital, 9 anesthetists are available for the operating rooms and other sectors (intensive care, pain clinic, radiology, oncology day centre, etc.), and we expect this number to drop to 5 in July 1998. The team normally has a total of 11 anesthetists to cover surgery and all other sectors (such as pain control, unit interventions...). Temporary collaborations have been established and more will be developed with the hospitals in the coming days to ensure provision of essential care during the summer period, and until the situation has been resolved.

- At the Montreal General Hospital, current operating room needs are covered by 13 anesthetists, several of whom also work in other sectors (such as the pain clinic, trauma ICU, teaching and research). The team currently needs an additional 4 ►

► anesthetists to be able to use all 12 operating rooms.

◆ At the Royal Victoria Hospital, the situation is not as precarious. So far, none of the 12 operating rooms has had to be closed as the 9-10 anesthetists affected to surgery have been sufficient to meet the needs. Of the remaining 8 out of a total of 18 anesthetists, 4 are full-time researchers and the others are assigned to the birthing centre, pain control and intensive care.

◆ At the Montreal Neurological Hospital, the problem has not presented itself in the same way. The 3 anesthetists meet the needs of the operating room and intensive care.

Although the situation is evolving, the MUHC Management is looking for a medium-term solution. The task force is pursuing its activities and care is being taken in each hospital to ensure that the best possible use is made of available resources.

The members of the task force appreciate the support they are receiving from the MUHC Board of Directors and Management who recognize the precariousness of the situation and say they are confident that a meeting will soon take place between designated members of the Board, the Director General of the MUHC, Dr. Hugh Scott, and the Minister of Health and Social Services, Jean Rochon. ◆

May 1998
Dr. Françoise Chagnon, DPS, MGH
Dr. Claire Dupont, DPS, MCH
Dr. Denis Roy, DPS, RVH
Dr. Ivan Woods, DPS, MNH

## Nick Auf de Maur Fund

***HUMANITARIAN SUPPORT***

Last April 7th, well known Montreal journalist **Nick Auf de Maur** passed away from cancer of the pharynx. It was Nick's desire that after his death, a fund be established at the MUHC. The purpose of this fund would be to provide humanitarian support for patients undergoing cancer treatment. This fund would help with taxi tickets, hotel accommodation, daycare, etc. The fund was established by Mr. Steven Phizicky, Nick's daughter Melissa and Roger Tabah. Already a substantial amount of money has been collected. A retrospective of Nick's work is to be published in the Fall of 1998. The proceeds from the sale of this book will be donated to the Nick Auf de Maur Fund. ◆

*Roger Tabah, M.D.*

## Were You There ? 1969

Left to right: Dr. Igor Bitenc, Dr. H.F. Moseley, Mrs. Moseley, Dr. John Duff, Mr. W.H. Norman, President of Johnson & Johnson, Miss Ernestine McLeod, photographed at dinner in honour of Dr. Moseley. It will be recalled that Johnson & Johnson Co. of Canada gave a large donation towards the support of the RVH Accident Service.

# Canadiana

***QUESTIONS***

❶ Everyone knows that Major General James Wolfe defeated General Louis de Montcalm on the Heights of Abraham on September 13, 1759. Who was General Wolfe's military colleague whose name should share the victory?

❷ Which famous naval person assisted greatly in the endeavors mentioned in item No. 1 above?

❸ True or False? The Battle of the Plains of Abraham allowed the British to occupy Quebec and therefore resulted in the surrender of French Canada.

❹ Which poem did James Wolfe read before his final day on the battlefield?

❺ Who called Canada "Our Lady of the Snows"?

❻ Who called Canada "Quelques arpents de neige"?

❼ Which British novelist in 1842 called Toronto "appallingly wild and rabidly Tory"?

❽ Which British author in 1882 is quoted as affirming that "Niagara Falls must be the second major disappointment of American married life".

❾ Who is the British poet who spoke lovingly of a North American Indian native girl".

❿ Adreno-Cortico-Tropic Hormone (ACTH) was first isolated and named at McGill by whom?

*(answers on page 19)*

# McGill Centre for Laparascopic Surgery

**By Gerald M. Fried, M.D.**

The McGill Centre for Laparoscopic Surgery has been active for approximately 18 months. It is located at The Montreal General Hospital, on 10 west and consists of a dry lab/conference room and an office/library. The laparoscopy research group meets weekly, usually Friday mornings at 8 A.M., and laparoscopy journal club is held monthly.

The Centre has a full-time nurse-coordinator, Maureen Antoniuk, and a completely equipped inanimate laparoscopy facility where residents and practicing surgeons can practice and develop their technical skills. We also have a large library of videotapes demonstrating a variety of surgical procedures. Data on laparoscopic cholecystectomy and Nissen fundoplication are being accrued in a computerized database located in the laparoscopy centre. These data have been the source of a variety of publications and presentations.

Our first fellow, Dr. **Anna Derossis** will be completing her year June 30, 1998. She has carried out research in education and evaluation of laparoscopic skills and has had an extremely productive year with 3 presentations at SAGES annual meeting in Seattle, and 3 accepted for the 6th World Congress of Endoscopic Surgery in Rome. **Drs. Kent MacKenzie** and **Craig Baldry** have worked in the laparoscopy centre during their general surgery residency, and have also been very productive.

Funding for the McGill Centre for Laparoscopic Surgery and fellowships has come from the Center of Excellence Program sponsored by United States Surgical Corporation (Auto Suture, Canada). Equipment for the Centre has been generously donated by Storz Endoscopy and Auto Suture, Canada.

A reception and open house was held in the McGill Centre for Laparoscopic Surgery on March 12. Food was served and a tour of the facilities given. It was well attended by residents and faculty.

The centre is open for the use of residents and staff. It is a valuable resource, and anyone wishing to use the facilities should contact Maureen Antoniuk at 937-6011, ext 2745, or by email at **czma@musica.mcgill.ca** to arrange a time. ◆

*Gerald M. Fried, M.D.*
*Professor of Surgery, McGill University*
*Head, Section of Videoendoscopic Surgery*

# Very Important Personage

Whether at the forefront of battle during World War II as Captain of the Royal Canadian Army Medical Core, or pioneering the first Oncology Day Centre at the RVH, **Dr. Edward J. Tabah** has always been there for patients. A senior surgeon for more than 40 years, Dr. Tabah has made extensive academic contributions while on the Faculty of McGill University, establishing himself as a leader in the treatment of cancer.

*Edward J. Tabah, M.D.*

Dr. Tabah began his career as an intern at the Montreal General Hospital, before joining the Royal Canadian Army Medical Corp where he served as Captain from 1943 to 1946. He became the regimental medical officer for the 17th Hussars Reconnaissance Regiment in the 3rd Canadian Division, whose job was mainly to find out where the enemy was and wire back information to the troops.

Says Dr. Tabah, "I went over to Normandy after they had established the beach head, which was about the seventh day of the invasion. From there, I stayed with the regiment and we made our way into France, Belgium, Holland and into Germany. It was a long drive. There was a lot of action and, many casualties, — there were very limited facilities. I had a lot of different experiences. We got bombed. We got shelled. We were strafed by Germans out in the open fields. We were even bombed by our own airforce by mistake, the RAF, as we were setting up an attack near Caen and Falaise where nearly two hundred thousand Germans were taken prisoners.

After the war, Dr. Tabah met up with Dr. Gavin Miller, Chief of Surgery at the RVH and Dr. David MacKenzie who was in charge of research in surgery at McGill. During their talk, Dr. MacKenzie remarked that while they had very good new facilities at McGill, one of the things which was sorely lacking was surgical instruments.

Said Dr. Tabah, "I believe I have something which may be of use to you." During the war, Dr. Tabah had come across huge boxes of brand new German stainless steel surgical instruments still in the original wrappings which had never been used. Explains Dr. Tabah, "I helped myself to four boxes of equipment. I didn't know what I was going to do with them, but I put them in my 'half-track' and went through the rest of the war carting them around always thinking, what am I doing with these? All they are doing is taking up space. "When Dr. Miller opened the boxes and saw the new surgical equipment donated by Dr. Tabah and which was so badly needed, he was pleasantly amazed. Needless to say, it was quickly put to good use and Dr. Tabah was appointed to the residency program at McGill.

He worked as a surgical resident at the RVH for two years, 1946-1948, and then went to New York city, where he did a year in fellowship in Surgical Pathology at the Presbyterian Hospital. The next year he was accepted as a surgical fellow at the then world-renowned mecca for cancer surgery, the Memorial-Sloan Kettering Cancer Center. After four years of specialized training in radical operations for all kinds of cancers, he returned in 1953 to become a staff member at the RVH, as the first fully trained cancer surgeon, or surgical oncologist, as the specialty is called today.

During the 39 year period from 1953 to his semi-retirement in 1992, he served as senior surgeon at the RVH and Associate Professor of Surgery at McGill University. He also served as Director of the Central Cancer Registry, Chief Surgeon of the Green Surgical Service, Chairman of the Cancer Committee, a member of the Commission on Cancer of the American College of Surgeons, and numerous other national and international committees. He was also a Founding Member of the prestigious "Society of Head and Neck Surgeons" in 1955. In 1987, he was presented with the Distinguished Service Award by the Royal Victoria Hospital.

It was during this time that Dr. Tabah distinguished himself as a highly skilled and fearless surgeon, who was able to perform the most difficult and radical operations on patients with advanced head and neck cancers, but also in other anatomical sites. For this he was highly esteemed by his peers, as well as for his compassion and devotion to his many cancer patients.

In 1965, one of his patients, a young man in his twenties, died of cancer. As a result of this, together with this young man's father, the late Mr. Joseph Chamandy, a group of business associates, and others, Dr. Tabah helped found the Cedar's Cancer Institute which turned out to be an indispensable resource in the fight against cancer. Its primary purpose was, and is, to fund a variety of cancer-related activities at the RVH and McGill. Cedars has provided major funding for cancer research, education, patient care, and equipment. Their efforts over the years have touched virtually every area of the Royal Victoria Hospital. From much needed facilities to the im- ►

► provement of patient care, Cedars has always been there, and continues to be there.

In 1966, Dr. Tabah initiated what was truly the first Oncology Day Centre in Montreal at the RVH. This facility gradually evolved and expanded over the years. Two years ago, Cedars completed a massive renovation and expansion of the Edward J. Tabah Oncology Day Centre with the hospital, doubling the core of this facility. Doctor Tabah continues to practice at the RVH and was awarded the Order of Canada in 1993 in recognition of his outstanding work in the fight against cancer for more than 40 years.

Whether it was treating the wounded, escaping enemy fire, carting surgical equipment across two continents for the then unknown purpose of helping a surgical program at McGill, or pioneering new cancer treatments, it can certainly be said that Dr. Tabah "did his part." Some people, some "personas", some physicians have the ability to change other people's and patients' lives forever, by virtue of who they are. Dr. Edward J. Tabah, clearly, —- is one of those. ◆

***Editor's Note:***

Reprinted with kind permission from the MUHC Ensemble, March 1998 (Editor Diane McPeak).

## Surgical Infection Society Annual Meeting

**Dr. Nicolas Christou** attended the Annual Meeting of the Surgical Infection Society, April 30 - May 4, 1998 where he handed off his Immediate Past Presidency to Dr. Ori Rotstein from Toronto. At the same meeting, **Dr. Andrew Seely** presented a paper entitled *Neutrophils Shed their TNF Receptors Upon Transmigration: Implications for the regulation of Neutrophil Apoptosis* which won the prize for the Best Resident Presentation among a field of international competitors both from North America and Europe. At the same meeting, **Dr. Lorenzo Ferri** received a research fellowship from the Surgical Infection Society which will fund his research in the Surgical Scientist Program starting July 1, 1998. ◆

## Welcome Aboard

**Dr. Dominique Shum-Tim** has returned to McGill University as an Assistant Professor in the Division of Cardiothoracic Surgery primarily based at the Montreal Children's Hospital. Following completion of his training in Cardiothoracic Surgery at McGill University in 1995, Dominique spent two and a half years training at the Children's Hospital in Boston in the research laboratory under Dr. Richard Jonas. There he was part of extremely important research on Cerebral Protection during Pediatric Cardiac Surgery as well as in the area of Tissue Engineering. While in Boston, Dr. Shum-Tim also spent six months on the clinical service in pediatric cardiovascular surgery. This experience will undoubtedly be extremely valuable in fulfilling his main mandate at McGill University, namely developing a Pediatric Cardiac Surgery Lab at the Montreal Children's Hospital. We welcome Dominique at McGill and wish him a lot of success in the future. ◆

*Dr. Dominique Shum-Tim*

# The Chief Residents

***ACADEMIC YEAR 1998-1999***

### *PEDIATRIC GENERAL SURGERY*

**Dr. Pascale Prasil** begins a 2 year fellowship in Pediatric Surgery at the Montreal Children's Hospital. Pascale comes from the Quebec City area. She graduated from Laval University in 1993 and completed her General Surgery Residency in its affiliated hospitals. She is an expert in French grammar, is a classical pianist and enjoys horseback riding, scuba diving and travelling. We are happy to welcome her to the Children's.

### *DIVISION OF CARDIAC SURGERY*

**Dr. Stephen Tahta** was born in Montreal and graduated from the McGill Faculty of Medicine in 1993. Following two years of core surgery, he did research on heart transplantation immunology under Drs. Jean and Christo Tchervenkov, and was accepted into the new six year Cardiac Surgery Residency Program at McGill. His goal is to become a pediatric cardiac surgeon. Stephen and his wife, Claire, are proud of their 19 month old son, Tristan.

**Dr. John Tsang** was born in Hong Kong. In 1992, he graduated from McGill Medical School. Following two years of core surgery and one year of research in myocardial protection, he entered the new Cardiac Surgery Residency Program at McGill. He is married to Dr. Sylvie Jones, a geriatrician at McGill and they are the happy parents of a 15 month old daughter, Mattea.

### *DIVISION OF VASCULAR SURGERY*

**Dr. Shaun MacDonald** was born in Hanover, Ontario. Having received a Bachelor of Science Degree from the University of Western Ontario, he attended medical school at the University of Toronto, followed by a comprehensive surgical internship at St. Michael's Hospital, Toronto. Dr. MacDonald completed a residency in General Surgery at Queen's University before coming to McGill, where he is presently finishing his first year of Fellowship training in Vascular Surgery. His research interests include the effects of endogenous nitric oxide on human neutrophil function and surgical nutrition.

### *DIVISION OF ORTHOPEDIC SURGERY*

**Dr. Sharlene Bogusz** graduated from McGill Medicine in 1994. After her Orthopedic Surgery training, she will be working in an outlying area of Quebec as part of a contract position with the government.

**Dr. Jean Ouellet** was born and raised in Ottawa. He did his undergraduate education as well as his Medical Doctorate at the University of Ottawa. Throughout his residency, he was supported by his loving wife, Krista and their two children, Philippe and Sofia. He plans to pursue a career in pediatric orthopedics after his fellowship at Texas Scottish Right Hospital in Dallas.

**Dr. Susan Nasser-Sharif** was born in Great Britain, but was raised in Winnipeg, Manitoba. She obtained a B.Sc. from the University of Manitoba in 1990, and then headed to McGill University where she graduated with an M.D., C.M. in 1994. After completing her Orthopedic Residency, she has been accepted to do a Fellowship in Pediatric Orthopedic Surgery at the A.I. duPont Institute.

### *DIVISION OF PLASTIC SURGERY*

**Dr. Abdulelah Bassas** is a native of Saudi Arabia and a graduate of King Saud University. He came to McGill in 1994 and will complete the Plastic Surgery Residency Program in June 1999. He plans a one year Clinical Fellowship in esthetic surgery in Canada prior to returning to Saudi Arabia to practise. Abdul is married and his wife is completing her degree in Sociology at McGill. They have one child.

**Dr. Subhas Gupta** was born in Prince Edward Island. Suby has his M.D. from McGill and his Ph.D. in Medical Informatics from the University of Kentucky. On completion of Plastic Surgery training in June 1999, he plans one year of Fellowship training in basic research related to angiogenesis, then a second Clinical Fellowship in Hand and Microsurgery. His ambitions are directed toward academic plastic surgery. Suby is married and his wife is a successful performing artist.

**Dr. James Lacey** originally from South Africa, he and his family moved to Canada when he was a young child. A graduate of McGill's Faculty of Medicine, he will complete formal training in 1999, and then pursue a Fellowship in Hand and Microsurgery. James' wife works in the Social Service Department of The Montreal General Hospital.

### *DIVISION OF UROLOGY*

**Dr. Peter Chan** originally trained in the Royal College of Music and was once a concert pianist. Although these days Peter is more occupied with his research in Urology, he still ►

► finds time to explore other hobbies such as gourmet-cooking and close-up magic. He received his undergraduate medical training at McGill as a J.W. McConnell Faculty Scholar. After finishing his residency, Peter is going to the U.S. for a Fellowship in infertility and impotence.

### *GENERAL SURGERY ONCOLOGY*

**Dr. Francine Tremblay**, a general surgeon from Joliette, has entered the Surgical Oncology Fellowship starting June 1, 1998. We are very proud to have her since she is an experienced general surgeon who wants to re-enter academic medicine in the field of Surgical Oncology. She is now our third trainee since our fellowship became accredited by the Royal College. We already have a trainee for 1999 and he is Dr. Mohammed Al-Zahr.

### *DIVISION OF GENERAL SURGERY*

**Dr. Mohammed Al-Suwaidi** is a graduate of the Arabian Gulf University - Bahrain. He is planning to do a Fellowship in ERCP at McGill after graduation. At the end of this Fellowship, he will be going back to Bahrain to work in the Bahrain Defence Force Hospital in the General Surgery Department. He is single at present, and enjoys soccer.

**Dr. Talat Chughtai** is a native of Montreal and received his medical degree from McGill in 1994. During his residency, he has published papers in the journals Surgery and Annals of Thoracic Surgery, and co-authored a chapter in the textbook Advanced Therapy in Thoracic Surgery. He also enjoyed being a "flying doctor" for Skyservice Air Ambulance Lifeguard. He is actively involved in teaching medical students in patient examination skills and Advanced Trauma Life Support, and is a regular examiner for their core surgery exam. Highlights of his senior years included becoming engaged to Miss Ayesha Ajmal in Pakistan (where he also did an elective in Surgery), and operating with his father, Dr. M.S. Chughtai, at St. Mary's Hospital. During his spare time, he enjoys playing squash and frequently visits his home country Pakistan. After graduating next year, he hopes to continue his training in Cardiothoracic Surgery.

**Dr. Tariq Jaber** was born in Riyadh, Saudi Arabia in 1964. He is married to dentist Randa Shaker. They have two daughters, Nora and Sara. Tariq graduated from King Saud University Medical School in 1989 with an M.B.B.S. Between 1990 and 1994, he did four years of General Surgery in S.A. He successfully passed the Arab Board of General Surgery in 1997. His hobbies include reading, travelling and playing chess. His scientific interests have included *carcinosarcoma of the gallbladder, Hirschsprung's disease and Crohn's disease in children.* He intends to go to the USA for two years of Fellowship before returning to Saudi Arabia.

**Dr. Kent MacKenzie** is a native of the west coast, but after nine years in Montreal now considers Quebec home. In his limited spare time, Kent loves to play hockey and golf and to have barbeques. Kent and his wife, France Morin, will be moving to Chicago in July 1999 where he will be doing a Peripheral Vascular Surgery Fellowship at the University of Chicago.

**Dr. Louis-Philippe Palerme** graduated from the University of Ottawa in 1994. He has a B.Sc. in Molecular Biology (Ottawa). As part of his R-IV year, he carried out research projects in Vascular Surgery. His hobbies include skiing, outdoor activities such as back-packing. His ultimate career goal is to do a Fellowship in Peripheral Vascular Surgery.

**Dr. Steven Paraskevas** obtained his B.A. Biology (Honors) from Harvard University and his M.D.C.M. from McGill University. His one of the first graduates from the McGill Surgeon Scientist Program, and will be completing his Ph.D. this year. He was awarded the 1997 Scientific Trainee Award from the Canadian Diabetes Association. A former varsity rower (lightweight crew) and marathon runner, he now enjoys running for relaxation. He is married to McGill endocrinologist, Line Vautour. He plans to continue on as an academic surgeon after completing a Fellowship in Transplantation.

**Dr. Joe Tector** is the son of Wisconsin cardiac surgeon, Dr. Alfred Joseph Tector. Joe came to McGill in 1992. He and Kelly are proud parents of three children. Joe has done clinical research for three years in Xenograft Biology with Dr. Jean Tchervenkov and has submitted his Ph.D. Thesis on this subject. He is interested in a career in academic surgery and, after his Chief Residency at McGill, he intends to go to the University of Miami to do a Fellowship in Transplantation. ◆

# McGill Core Surgery & General Surgery Residency Training Program

***JULY 1, 1998 THROUGH JUNE 30, 1999***

### *R - 1*

Abu-Req, Hisham (PI)
Al-Hendal, Adnan (GS)
Al-Khaledi, Khaled (Ortho)
Al-Khaldi, Abdulaziz (CT)
Al-Taweel, Waleed (Uro)
Amar, Yannick (OTL)
Bittira, Bindu (CT)
Chaudhury, Prosanto (GS)
Draxinger, Kevin (Ortho)
Faizer, Rumi (GS)
Fakhri, Samer (OTL)
Hagaraty, Sarah (GS)
Hall, Jeff (NS)
Homoud, Mohammed (NS)
Irshad, Kashif (GS)
Iyer, Vikram (NS)
Kamal, Dhafer (GS)
Kassouf, Wassim (Uro)
Koumanis, Jim (till Sept 20) (GS)
Moola, Farhad (Ortho)
Morissette, Annie (till Oct 4) (Ortho)
Nahhas, Mohammed (Ortho)
Ordas, Nina (GS)
Otaky, Naim (GS)
Pickle, Andrew (GS)
Poirier, Madeleine (GS)
Roger, Eric (NS)
Sen, Milan (Ortho)
Steinberg, Jordan (Uro)
Ukani, Hanif (PI)
Volesky, Monika (Ortho)
Wan, Calvin (GS)

### *R - 2*

Al-Jabri, Badr (GS)
Al-Jassir, Fawzi (Ortho)
Al-Obaid, Abdulrazzaq (Ortho)
Andtbacka, Robert (GS)
Avery, Roger (NS)
Bui, Paul (GS)
Charlebois, Patrick (GS)
Chedrawy, Edgar (CT)
Cohen, Danny (Uro)
Ehrensperger, Eric (Ortho)
Hakim, Jonathan (Uro)
Hussain, Ali (till Nov 15/98) (PI)
Jamjoom, Hytham (PI)
Karsan, Naznin (GS)
Khan, Atif (GS)
Koumanis, Jim (from Sept 21) (GS)
Lo, Kirk (Uro)
Macelaru, Dragos (till May 2) (Ortho)
Medeiros, Lori (GS)
Mittal, Sandeep (NS)
Morissette, Annie (from Oct 5) (Ortho)
Parker, Wendy (PI)
Pascual, Jose (till Oct 18) (GS)
Rabah, Danny (Uro)
Steinitz, Daniel (Ortho)
Stephenson, Andrew (Uro)
Su, Jean (till Dec 13/98) (NS)
Tan, Michael (till Mar 7/99) (GS)

### *R - 3*

Bratu, Ioana
Chattopadhyay, Runi
DiCarlo, Antonio
Ferri, Lorenzo
Hayati, Hussein
Huang, Felicia
Mathew, Jane
Morin, Nancy
Nikolis, Andreas
Pascual, Jose (from Oct 19)
Robinson, Patrick
Tan, Michael (from Mar 8)

### *R - 4*

Al-Qahtani, Aayed
Behzadi, Abdollah
Chen, Margaret
Fridell, Jonathan
Kay, Saundra
Labelle, Eric
Linjawi, Ayman
Pires, Jose
Ramawamy, Archana
Ross, Alison
Seely, Andrew
Swartz, Dan

### *R - 5*

Al-Sowaidi, Mohammed
BinSaddiq, Wadi (till Dec 15)
Chughtai, Talat
Feldman, Liane (till Dec 15)
Ferdinand, Brett (till Dec 15/98)
Jaber, Tariq
Keyser, Eric
Legha, Prithvi (till Jan 11/99)
MacKenzie, Kent
Palerme, Louis-Phillip
Paraskevas, Steven
Tector, Joe

### *EMERGENCY MEDICINE*

Adjemian, Raffi
Chesser, Tracey
Haggar, Carine
Josephson, Tim
Kravitz, Joel
Poiier, Vincent
Rabuka, Curtis
Troquet, Jean Marc
Vaillancourt, Christian

### *DIAGNOSTIC RADIOLOGY*

Gilloteaux, Laurent
McKerlie, Ify
Mikhail, Miriam
Pressacco, Josee
Tsatoumas, Maria

### *OBS/GYN*

Al-Shangiti, Fatma
Jean, Catherine
Hargassner, Edward
McConville, Fiona

### *ORAL MAXILLOFACIAL SURGERY*

Amir, Ajar

# First Trauma Achievement Award in Canada

By Rea Brown, M.D.

On Thursday, April 16th, 1998 at Surgical Grand Rounds, the Trauma Center of the McGill University Health Centre at the MGH recognized the outstanding contributions made by **Suzanne Laplante-Edward** towards the development and passing of gun control laws in Canada. Mrs. Laplante-Edward's talk was entitled *Gun Control in Canada: A Must.*

Mrs. Laplante-Edward's daughter was one of the fourteen young women killed during the Montreal massacre at l'Ecole Polytechnique on December 6th, 1989 by a man with a legally acquired military assault weapon. She is the founder of the organization "Victims of December 6th Foundation Against Violence". She has relentlessly crusaded for gun control legislation in Canada and is committed to ensuring that this law is fully implemented.

The American Trauma Society yearly recognizes a lay person in the hospital community for outstanding contribution to the care of the trauma patient. Gun control is about saving lives and because of Mrs. Laplante-Edward's commitment, it is only fitting that she be the recipient of this First Trauma Achievement Award recognizing her outstanding contributions. ◆

*Rea Brown, M.D.*
*Coordinator of Trauma, MGH*

*Suzanne Laplante-Edward*

# Cathy Torchia

By Judith Trudel, M.D.

***THE DEPARTMENT OF SURGERY RECOGNIZES THE EXCELLENCE OF CATHY TORCHIA***

**Cathy Torchia**, Coordinator of the General Surgery and Orthopedic Training Programs, accepted the position of Coordinator of the McGill Radiology Training Program and Executive Secretary to the Acting Chair of Radiology in April 1998.

Cathy joined the McGill Department of Surgery in January 1983, as Coordinator for Undergraduate Surgical Education. In May 1991, she became Coordinator of the McGill General Surgery Training Program; in March 1997, the McGill Orthopedic Training Program was added to her responsibilities. In these various capacities, Cathy got to work closely with countless students, approximately 100 residents, and 4 program directors.

To the students and residents, Cathy was an advocate, a confidante, and a friend. She was there to help in times of difficulty, to listen to good and bad news alike, and to offer support, motherly advice, or a good "kick in the pants" when needed. To the program directors, Cathy was an invaluable assistant. Her masterful knowledge of various accreditation and licensing requirements, her ability to juggle several urgent tasks simultaneously made us look good even in times of pure mayhem. She looked at each new task as a challenge, and did not measure the time and effort needed to complete her work.

*Cathy Torchia*

The McGill Division of General Surgery wishes Cathy the best in her new job. She will be replaced by Andrea Pugliese, who filled in during Cathy's maternity leave in 1995. ◆

*Dr. Judith Trudel,*
*Program Director,*
*McGill Division of General Surgery*

# The Chughtai's at St. Mary's Hospital

By Talat Chughtai, M.D.

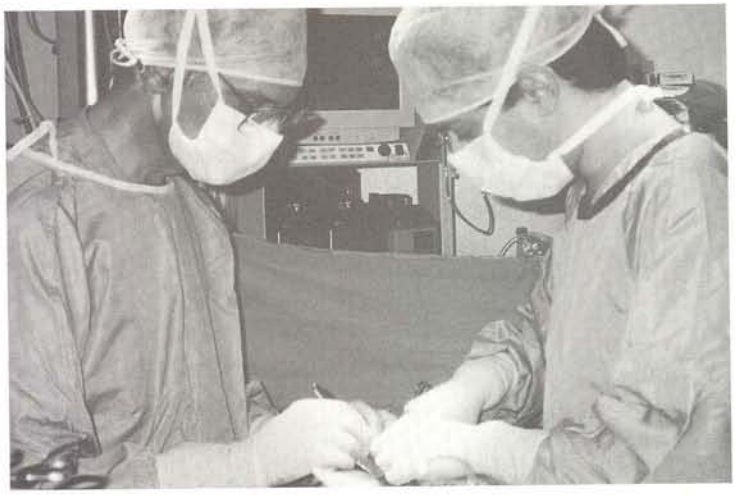
St. Mary's has always been a popular hospital for students and residents to rotate through. As a student and junior resident, however, I chose not to go there in order to avoid the possible 'conflicts' that may have arisen because of my father being one of the surgeons there. Finally this year, as a senior resident, I realized that I could not go through my entire residency without the experience of working as a resident on my father's surgical service. Thus, I requested a rotation at St. Mary's, and was granted what was to be a unique opportunity.

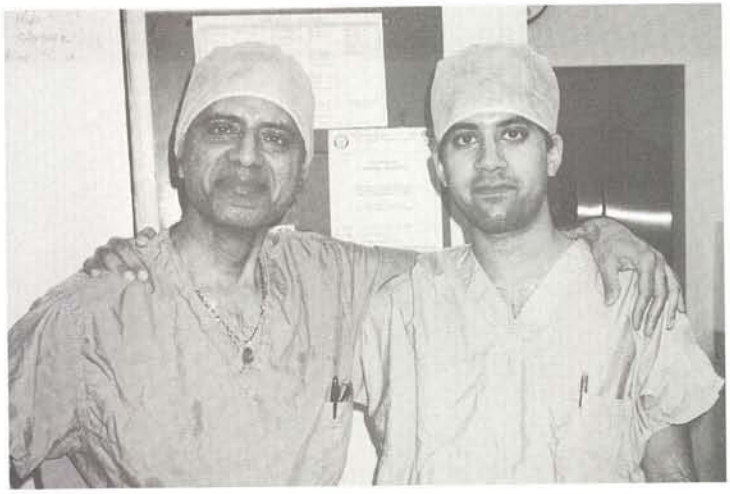
Needles to say, as much as I tried to treat it like any other rotation, I could not avoid the initial incredulous reaction on my first days, and the continuous references throughout my stay to my 'special status': From the nurses calling me 'baby Chughtai' (as they all remembered me coming to the hospital with my dad as a kid), to the medical staff whispering to each other "that's Chughtai's son" as I walked by on the wards.

As far as the operative experience went, it was even better than I had expected. I was initially afraid of scrubbing with my father, fearing 'not being good' ... but it turned out that it was as great a learning experience as I have had. He is truly a perfectionist in the OR, and a very patient teacher of surgery. I often felt during surgery as though he was giving me his usual 'fatherly advice' (on how to operate), that I have heard so often at home. You can imagine the intra-op 'discussions': "... that's the artery, dad ... I want to dissect it out ..." ... "... no. Talat, trust me, it is the duct ... don't touch it ...". The variety of cases we performed together (and thus from which I learnt from him) was also amazing; a true 'general surgical practice': from routine cases such as laparoscopic cholecystectomy and hernia repair, to colectomies, open common bile duct explorations, and thoracotomies for lung resection. On his non-operating days, I also finally witnessed what I had heard for so many years with respect to his being a 'master clinician', as he would clear out the emergency room in an 8 hour shift, which would include casting fractures, treating ocular emergencies, and diagnosing myocardial infarction (in addition to referring any good surgical cases to himself).

The best compliments however, do not have to come from me. As the patients uniformly told me on morning rounds (always after he had already rounded on them), he has a true care and respect for patients and their illnesses. I learnt a lot from him in every aspect of patient care, operating and otherwise, and he is one of my mentors. I am very fortunate to have had the unique experience of working with my father, whether operating, seeing patients, or discussing cases, and am proud to try and 'follow in his footsteps' (as I have heard ... many times), and graduate next year, 34 years after he graduated from the very same General Surgery program at McGill.

I would like to thank him, and especially the great staff at St. Mary's for being so kind to me and making my stay there so much fun. ◆





# Professionalism

*ST. MARY'S BULLETIN 1998*
*REPRINTED WITH PERMISSION FROM "THE BULLETIN", ST. MARY'S HOSPITAL.*

By James D. Sullivan, M.D.

What does the word "professional" mean when applied to members of the medical profession? Does it mean that we are members of a "profession", like lawyers or accountants, and that we earn our living being doctors? Does it mean that as "professionals" we are not "amateurs" who might play at healing the sick on weekends or holidays? Does if refer to our being "health professionals", under the thumb of the Ministry of Health by popular demand, lumped together with other "health professionals" such as the nursing profession, dentists, pharmacists, and physiotherapists, remunerated like them from the public purse in return for catering to the nation's health requirements? Whatever it means, some of the writing and rhetoric in the past 30 years tells us that too many of us in the profession have been guilty of not acting professionally enough, given the times and the change of attitude.

A taxi-driver the other day was telling me how impressed he was when he consulted a car mechanic at one of the auto-part sales stores downtown and came away with a fund of information, something he could really put to use. "That guy behind the counter was really something", he said. "He told me what I wanted to know in no time flat and when I asked him something he didn't know, he said he didn't know, but told me how I might find out. No bull, ya' know. Great guy, real professional".

Judging from this little vignette, the qualities that John Q. Public regard as professional might include: communicator, knowledgeable, honesty, altruism, generosity, teacher, member in good standing, moral, caring, transparent. Other examples may bring out some of the other qualities generally attributed to real professionals: ethical, just, defender of social justice, seeker of truth, proactive, leader, non-judgemental, responsible, accountable.

From reading the history of medicine through the years, we are struck with the natural highs and lows that characterize the rhythm of all human endeavour. We exult in the scientific breakthroughs wrought by our champions and decry the self-serving abominations served up by the charlatans. In the first part of the 20th century, the medical profession had much to be proud of: The improvements in surgical practice brought on following the two World Wards, most ably assisted by the emergence of nursing care and the birth of the rehabilitation services; the improved use of radiographs, the discoveries of penicillin and insulin; effective heart medications; and improvements in anaesthesia. The public at large was made aware of these happenings, expressed their gratitude, and everyone benefitted.

Despite these triumphs, beginning in the 1970's, criticism of the medical profession began to rear its head. Elliot Friedson, a critic of medicine in America, in a number of articles accused it of using its control over an exclusive body of knowledge to preserve its monopoly and to remain dominant. He noted the inherent conflict between altruism and self-interest, and that self-regulation was weak, being characterized by insufficiently rigorous rules inadequately applied. Medicine had created a mystique around itself that it had come to believe, a mystique that interfered with the proper appreciation of its own conduct. Accountability, it seemed, was not high on the list of the medical practitioner.

Many other professions came in for similar treatment by the public. The theory of deconstructionism, also known as post-modern thinking, dedicated to leave no "sacred cow" unturned, became popular and other established walks of life such as architecture, literature, big business and organized religion were likewise targeted in the various media. The revenge of the perceived disadvantaged was in full swing, not hindered in the least by the not infrequent report in the media of greed, misrepresentation, or poor judgement on the part of a member of the establishment. Society looked elsewhere for leadership while members of the medical profession, simultaneously put upon by ministries of health or "managed care" institutions, scrambled to re-assert their identity, their purpose, their calling, their resources, their rights, even their income. Not to be undone, medical schools with their eyes open and their ear on the ground instituted changes in their curriculum in keeping with current popular themes: medical ethics, medicine and the law, and the doctor as health manager have now become study options.

In spite of these inevitable attacks, pessimism about our profession will always remain inappropriate. Change is not inherently bad and allows for growth. The profession itself, as vital as any in existence, is not on trial, only some of the people practising in it. We should all collectively learn from periodic low periods and re-adjust our goals to aim at a better form of professionalism in our doctoring; not only clean up our act but use the impetus to take it to a higher level. Although the professional dominance of medicine may be decreasing, medicine remains the dominant health profession be- ►

► cause of the centrality of its knowledge base. Members of the profession, while still remaining healers, must be willing to make more representations outside their traditional base of operation and prepare themselves to enter the lesser known arenas of public education, health management, social reform, and medico-legal expertise where their contribution will not only be welcomed but is also sadly needed. ◆

## Canadian Association of General Surgeons

***POSITION STATEMENT ON RESOURCES FOR GENERAL SURGEONS***

General Surgeons across Canada provide essential core services including Emergency and Trauma care. General Surgery is a hospital-based specialty which requires access to hospital resources. The needs of individual surgeons will vary considerably depending on their type of practice, their special interests, academic duties, and the needs of the community they serve.

Hospital boards across the country are in the process of re-organization. These boards are committed to provide quality care in a cost efficient manner. Hospital boards are dependent upon General Surgeons amongst other specialists for the delivery of essential services.

General Surgeons and their respective hospital boards must recognize their mutual interdependence and appreciate each other's concerns in a rapidly changing environment. For their part the Board of CAGS, on behalf of General Surgeons of Canada, is committed to the provision of quality surgical care including emergency and trauma care. This requires adequate resources.

General Surgeons recognize the constraints under which boards operate and will work to achieve cost containment as long as surgical standards are not compromised.

For their part hospital boards must recognize:

1. The key role of General Surgeons in providing core services for the population.
2. The hospital dependent nature of general surgical practice.
3. The need to provide adequate resources for the General Surgeons to provide these emergency services.
4. General Surgeons must also have sufficient resources to conduct elective General Surgery practice. These resources include: in-patient beds, operating room time, endoscopic and laparoscopic equipment and time, clinic space, and access to other clinical specialties.
5. Surgeons must have appropriate access to laboratory, x-ray, anesthetic, and intensive care services commensurate with the needs of patients they serve. ◆

## Amazing But True Golf Facts

Making a hole in one may seem like a rare golf shot, but each year there are roughly forty thousand aces recorded in the United States alone. Amateurs have a 1 in 13,500 chance of getting one, while club pros drive from tee to cup about twice as often.

Meanwhile, on average, a touring pro hits a hole in one every 3,500 opportunities. The rarest scoring feat is the double eagle - a 2 on a par-5 hole. This elusive three-under-par feat happens maybe 250 times a year. ◆

*Dr. H.R. Shibata.*

# Canadiana

***ANSWERS (continued from pg. 9)***

❶ The British St. Lawrence expedition was under the joint command of Admiral Sir Edward Saunders whose fleet consisted of thirty-five ships-of-the-line, supported by another dozen smaller men o'war and numerous transports. This enormous Royal Navy armada had to inch its way through thick fog and innumerable shoals. Admiral Saunders was therefore responsible for these vessels and the men who manned them and the ten thousand soldiers on board the transports.

❷ James Cook, Master of His Majesty's Ship Pembroke had charted the St. Lawrence river and approaches to Quebec. Also, on the day of the Battle of September 13, Captain Cook and his ship made a divisionary attack down-river at Beauport.

❸ False. Fighting continued elsewhere and it was not until General Amherst advanced from New York and occupied Montreal that French Canada surrendered on September 7, 1760.

❹ Wolfe recited Gray's "Elegy Written in a Country Churchyard". According to popular historian Francis Parkman in *Montcalm and Wolfe* (1884), the general then turned to his officers and said "Gentlemen, I would rather have written those lines than take Quebec tomorrow".

❺ Rudyard Kipling visited Victorian Canada and in 1897 he published the poem "Our Lady of the Snows" in The London Times. He was awarded an honorary degree by McGill in 1907 and he won the Nobel Prize for Literature in 1908.

❻ This is how Voltaire dismissed Canada at the time.

❼ Charles Dickens.

❽ Oscar Wilde toured Canada and said this at a press conference in New York.

❾ Henry Wadsworth Longfellow "The Song of Hiawatha".

❿ Dr. James B. Collip, a brilliant biochemist from Belleville, Ontario, achieved this milestone. He was working in Montreal at the same time as Drs. Frederick Banting and Charles Best. He actually assisted them in purifying insulin, but though he did not share in the Nobel Prize for the discovery of insulin, he did share in the money portion of the Nobel. ◆

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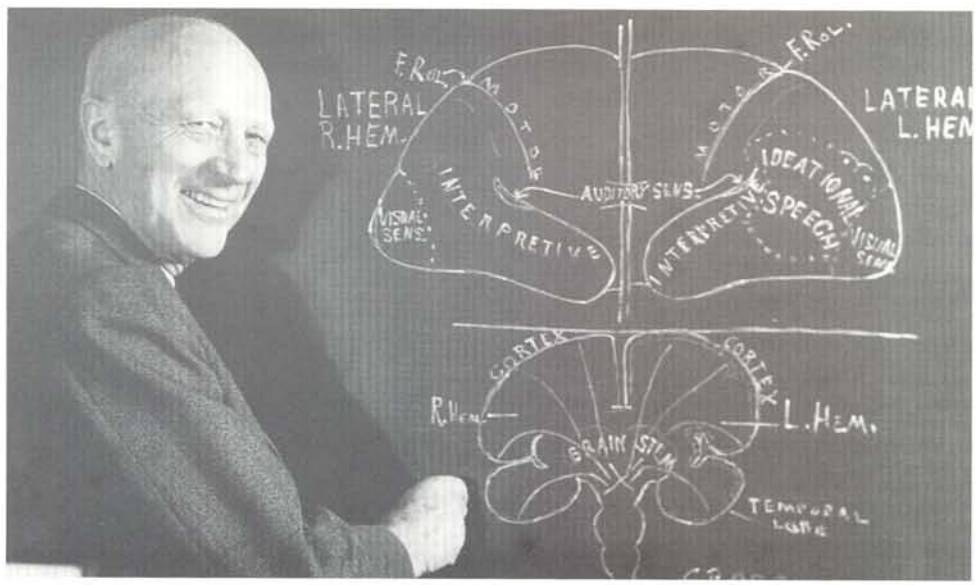
# Were You There? - 1963




***Dr. Wilder Penfield**, Founder and Director of the Montreal Neurological Institute, teaching medical students. **Dr. William Feindel**, curator of the Penfield Archives, gave us permission to use this photo and points out to us that Dr. Penfield did this drawing on the blackboard using both hands at once as he was perfectly ambidextrous.*

## KUDOS !!

**Dr. Paul Belliveau** completed a year of study of surgical education with the first group of Teaching Scholars of the Faculty of Medicine at McGill, and acted as a co-instructor in the McGill Center for University Teaching and Learning (CUTL) *Course Design and Teaching Workshop*, May 25-29, 1998. It was noteworthy that Paul was elected to the Executive Committee of the Montreal District of the Quebec Medical Association as Secretary-Treasurer and acts as Delegate of the Dean of the Faculty to the General Assembly. At the upcoming International Conference on the Pelvic Floor to be held in Montreal in September, Paul will moderate a panel entitled *Ileoanal Anastomoses and Ileostomies: Quality of Life Before and After Surgery.* He will also present two papers, one on *Electrostimulation of the Artificial Anal Sphincter* and the other on *Ileoanal Anastomosis: Indications and Techniques.*

**Dr. Gerald Brock** is to moderate a panel entitled *Approaches to Organic Impotence* at the meeting of the International Conference on the Pelvic Floor in Montreal in September. He will also be a moderator at a plenary evening session entitled *Sexual Dysfunction in the 21st Century.*

At the Annual Meeting of the Surgical Infection Society, April 30th to May 4th, **Dr. Nicolas Christou** handed the Presidency over to Dr. Ori Rotstein from Toronto. Dr. Christou is the co- author along with Dr. J.C. Marshall, M.F. Jimenez and Andrew Seely of a chapter entitled *Inflammation, Infection and Organ Failure* in the textbook **Crucial Controversies in Surgery 1998.**

**Dr. Mostafa Elhilali** will be the moderator of a panel on *Prostatic Cancer: Towards the Year 2000* at the meeting of the International Conference on the Pelvic Floor in September in Montreal.

**Dr. David Evans** married to his own anesthetist, **Danièle Matte**, are the proud parents of four daughters, Chloé a big sister to triplets Emilie, Caroline and Sophie born on May 9, 1997.

*The Evans'*

**Dr. David Fleiszer** and **Dr. Ruth Russell** have yet another reason to be proud of their son Tim who in April was signed as a defensive lineman by the Hamilton Tiger-Cats. There were 490 players eligible for the Canadian Football League college draft and Tim was the first choice among the 43 selected. Tim, who is 22 years old and who grew up in Westmount, until recently has been playing football for Harvard University. He has a rich athletic heritage since his mother ran track in high school and his father, a fullback with the McGill Redmen, captured the 1969 Hec Creighton Trophy as Canada's outstanding collegiate football player. His mother until recently was the Program Director in the McGill Postgraduate Training Program in Psychiatry.

**Dr. Claude Gagnon**, Director of Urology Research Laboratories, is chairing the 8th International Symposium on Spermatology to be held in Montreal, August 17-22, 1998. The topics selected to be addressed include most areas of spermatology from spermatogenesis to sperm functions, spermatozoa as a vehicle for HIV transmission and controversies on the most recent reproductive technologies will be discussed. The meeting also includes a workshop on *Structured Management of Male Infertility.*

**Dr. Philip H. Gordon** of the JGH is on the Executive of the International Conference on the Pelvic Floor which is be held in Montreal, September 23-27, 1998. He will present two papers, one on *Fistulae and Abscesses* and the other on *Sphincter Saving Rectal Resection.* He will also moderate a panel on *A Critical Evaluation of Surgically Implanted Anal Sphincters.*

**Dr. Frank Guttman** recently returned from Bulgaria, where he spent two and one half weeks as Visiting Professor, under the auspices of SACOW (Surgical Aid to Children of the World). He lectured on *Congenital Diaphragmatic Hernia; Anterior Saggital Approach to Imperforate Anus (the Mollard-Laberge procedure); Inflammatory Bowel Disease;* and *Bowel Transplantation* in two university centers, Sofia and Plovdiv. He also demonstrated our techniques for common pediatric surgical procedures, and a Soave pull-through for Hirschprung's disease.

**Dr. Jonathan L. Meakins** in March was a Visiting Professor to the University of Louisville Students Surgery Club. On April 25th, he gave the first Charles Tater Lecture to the Canadian Association of University Surgeons entitled *Surgical Research: Oxymoron or Career.* On May 6th, he travelled abroad to give the Turkish Surgical Society Lecture entitled *Immunoinoculation and Surgeons.* Dr. Meakins has been elected Vice-President of the International Federation of Surgical Colleges.

**Dr. Lawrence Rosenberg** was the recipient of the McMaster-Nebitt Award for Research Excellence in Surgery and Medicine. He also successfully renewed his Canadian Diabetes Association grant entitled *Determinants of Islet Cell Survival.* ►

► The Faculty of Medicine Selection Committee has named **Dr. Harvey Sigman** to the Faculty Honour List for Educational Excellence in recognition of his outstanding contributions to teaching and educational leadership in the Faculty of Medicine. The individuals named to the Honour List were honoured at a Symposium on Education in the Health Sciences on June 4, 1998. Dr. Sigman served as Assistant Dean, Medical Education and Student Affairs from 1993 to 1997, but his genuine interest and commitment to teaching at all levels has been evident throughout his career at the Jewish General Hospital and McGill University.

**Dr. Christo Tchervenkov** was a Visiting Professor in November 1998 at Mount Sinai Medical Center in New York. While there he gave two talks *Congenital Heart Disease with Aortic Arch Obstruction: The Single Stage Approach and Double Outlet Right Ventricle: Primary Repair in Early Life.* Dr. Tchervenkov also presented a paper entitled *Biventricular Repair in Neonatal Hypoplastic Left Heart Complex* at the 34th annual meeting at the Society of Thoracic Surgeons in New Orleans in February 1998; and *Single Stage Repair of Aortic Arch Obstruction and Associated Intracardiac Defects using Pulmonary Homograft Patch Aortoplasty* at the 78th annual meeting of the American Association for Thoracic Surgery in Boston in May 1998. Dr. Tchervenkov has been elected to active membership in the American Association for Thoracic Surgery. He is also currently the Vice Chairman of the Examination Committee in Cardiac Surgery for the Royal College of Physicians and Surgeosn of Canada.

**Dr. Jean Tchervenkov** has been appointed as Co-director of the Transplant Program at the MUHC along with Dr. Rolf Loertscher from the Department of Medicine. Drs. Tchervenkov and Loertscher have joint responsibility for the development, consolidation and coordination of patient care, research and teaching in solid organ transplantation at the MUHC. As part of the integration process, these activities are centered at the Royal Victoria Hospital (adult) and the Montreal Children's Hospital (pediatric).

**Dr. Fried Wiegand**, a staff surgeon at St. Mary's Hospital since the unfortunate closure of the Queen Elizabeth Hospital, recently returned from a month's tour of duty doing surgery for *Medecins Sans Frontieres/Doctors Without Borders* in Kayanza, Burundi. He worked at the Baptist Hospital in Jerkéssedongon, Côte d'Ivoire for 6 weeks in 1997, and for MSF in Jérémie, Haiti in 1996. MSF is looking for surgeons (Fred can be reached at 514-489-9574).

# Achievements, Residents and Fellows

For the second consecutive year, **Dr. Peter Chan** received the first prize of research presentation in the St. Lawrence Urological Group meeting at Quebec City in February 1998 for his recent work entitled *The Use of a Cytoprotective Lipid Peroxidation Inhibitor in Preservation of Penile Erectile Function Post-Prostatectomy in Rat.* The co-author of this work was **Dr. Gerald Brock** of the Department of Urology, with whom Peter is working on several projects aimed at minimizing erectile dysfunction after extensive pelvic surgery.

*Peter Chan*

**Dr. Tony DiCarlo**, R-II General Surgery, and Laura Panarello became engaged on February 8, 1998 and are planning their wedding for September 26, 1998.

**Dr. Julia Dorfman**, resident in Cardiac Surgery, was a finalist in the C. Walter Lillehei Forum Competition and presented her paper at the meeting of the prestigious American Association for Thoracic Surgery in Boston on May 5th, 1998. From more than 50 papers submitted by cardiothoracic residents from all over North America, 8 were selected for presentation. Her paper entitled *"Myocardial Tissue Engineering with Autologous Myoblast Implantation"* was well presented and well received.

**Dr. Lorenzo Ferri** received a research fellowship from the Surgical Infection Society which will fund his research in the Surgical Scientist Program which will begin on July 1st to qualify for a Master of Science.

**Dr. Felicia Huang** has received a Fellowship from the Research Institute of the Royal Victoria Hospital to pursue a second year of research (1998-99), with **Dr. Nicolas Christou** in *Neutrophil Activity in a Double-Hit Sepsis Model in Mice Involving Pneumonia and Peritonitis.*

Congratulations to **Dr. Saundra Kay**, R-3 in General Surgery, who tied for first prize in the category of Basic Science Presentations, at the MCH Annual Research Day on May 20th. Her presentation was on *The Use of Antenatal Steroids to Counteract the Negative Effects of Tracheal Occlusion in the Fetal Lamb Model.* She was supervised by **Drs. Hélène Flageole** and **Jean-Martin Laberge**.

**Dr. Nancy Morin** received a Fellowship from the Royal Victoria Hospital Research Institute to continue a second year of research (1998-99), with **Dr. Peter Metrakos** studying *The Development of an* ►

► *Immunosuppression Protocol for Small Bowel Transplantation to a Porcine Pre-Clinical Model.*

**Dr. Andrew Seely** presented a paper at the meeting of the Surgical Infection Society entitled *Neutrophils Shed their TNF Receptors upon Transmigration: Implications for the Regulation of Neutrophil Apoptosis.* The co-authors were Dr. D.E. Swartz and Dr. N.V. Christou. ◆

### *THE HENRY R. SHIBATA LECTURER OF THE CANADIAN SOCIETY OF SURGICAL ONCOLOGY*

*Dr. Henry Shibata, M.D.*

**Dr. Judah Folkman,** Professor of Surgery at Harvard University and Senior Surgeon at the Children's Hospital in Boston, Mass. was the Shibata Lecturer for 1998. The concept of *"angiogenesis"* was first proposed by Dr. Folkman almost 30 years ago. He has worked relentlessly to put forward his concept that by controlling the blood flow to tumours and shutting off the nutrients to the cancer cell, more effective control can be obtained than by concentrating on killing the cancer cells. In his lecture, he introduced two new chemical agents, *angiostatin* and *endostatin*, that in animal models have been able to completely eradicate rapidly multiplying cancer cells. This new discovery by Dr. Folkman and his colleagues in his research laboratory at the Sidney Farber Cancer Institute was heralded worldwide as one of the newest hopes in the fight against cancer. On May 2nd, Dr. Folkman presented his fascinating data not only to surgical oncologists, but to an interdisciplinary group of oncologists from across Canada. ◆

*EDM*

# Congratulations

***1998 MCGILL DEPARTMENT OF SURGERY GRADUATES***

***NEUROSURGERY***
Dr. Kamal Balkhoyor
Dr. Rachel Dureza
Dr. Cornelius Lam

***ORTHOPAEDICS***
Dr. Khalid Al-Quwayee
Dr. Abdullah Baslaim
Dr. Wojciech Bulczynski
Dr. Jennifer Fletcher
Dr. Rudy Reindl
Dr. Gonzalo Valdivia

***UROLOGY***
Dr. Ahmed Al Kandari
Dr. Roman Jednak
Dr. Franck Sajous
Dr. Wei Zheng

***CARDIOTHORACIC SURGERY***
Dr. Stephanie Helmer
Dr. Mackenzie Quantz

***PLASTIC SURGERY***
Dr. Shayne Burwell
Dr. Janet Mackenzie
Dr. Carlos Cordoba

***LAPAROSCOPIC SURGERY***
Dr. Anna Maria Derossis

***PAEDIATRIC GENERAL SURGERY***
Dr. John G. Gallucci

***GENERAL SURGERY***
Dr. Najma Ahmed
Dr. Abdulwahab Al-Jubab
Dr. Vinay Badhwar
Dr. Wadi Bin Saddiq
Dr. Jody Bothwell
Dr. Julio Faria
Dr. Liane Feldman
Dr. Bret Ferdinand
Dr. Prithvi Legha
Dr. Laurie Morrison
Dr. Tarek Razek

# Were You There? 1971

*Dr. Marvin Wexler and Dr. Anna Daniels at a reception marking the opening of the RVH Transplantation Service June 10.*

# Testimonials Awarded to Three Retiring McGill Surgeons Chairman - Dr. David S. Mulder

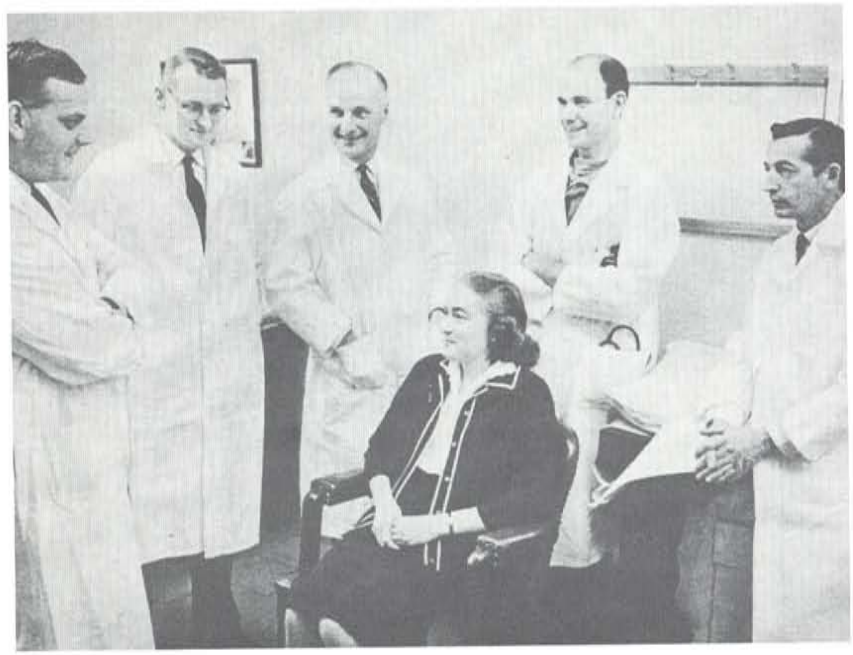
***Dr. Edmond Monaghan*** *presented by Drs. Jonathan L. Meakins and Sarkis Meterissian*

***Dr. Frank Guttman*** *presented by Drs. J.L. Meakins and Jean-Martin Laberge*

***Dr Peter Blundell*** *presented by Drs. Ray Chiu and Ron Lewis*

# Were You There? Kidney Transplant 1965 RVH

The recipient, Montrealer Mrs. Rose Shaper, and the transplant team.
Lt to Rt: Dr. John B. Dossetor, Dr. F.G. Inglis, Dr. J.A. Oliver, Dr. Lloyd D. MacLean and Dr. Kenneth J. MacKinnon



# Fraser Gurd Day Part I

*MAY 28, 1998*

The 1998 Fraser Gurd Visiting Professor was Dr. **Charles M. Balch** who is Professor of Surgery at the University of Southern California School of Medicine; and President and Chief Executive Officer of City of Hope National Medical Center and Beckman Research Institute.

Dr. Balch's lecture at Surgical Grand Rounds at the MGH was *Delivery of Cancer Care in a Managed Care Environment.* At the RVH Grand Rounds, his talk was *Management of Melanoma.* ◆

*Dr. Charles M. Balch*

## Awards ~

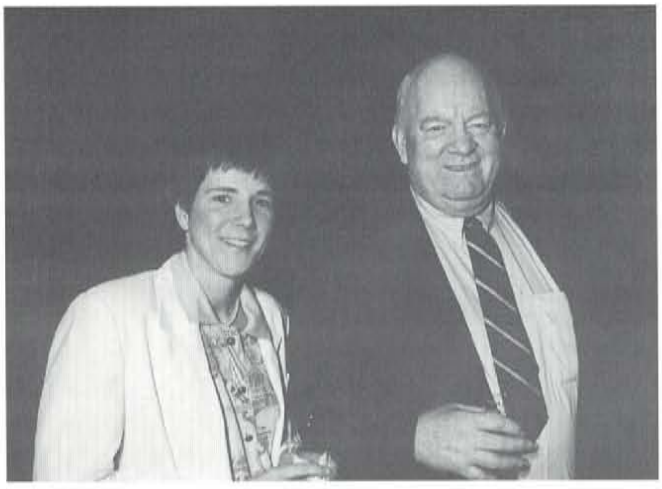
***TEACHING EXCELLENCE AWARD (STAFF)***
Dr. David Evans

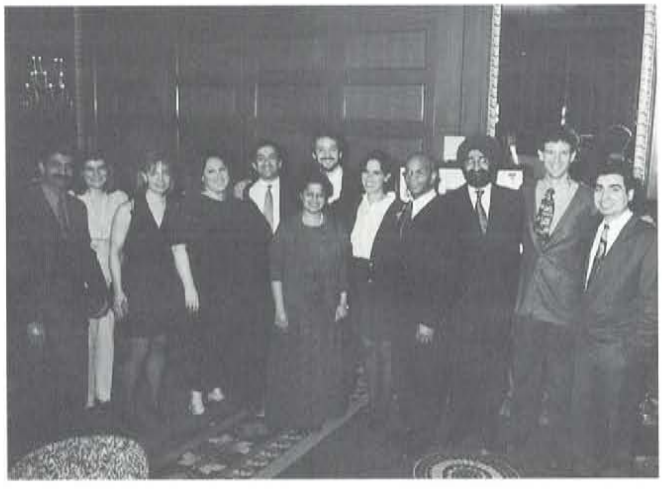
***TEACHING EXCELLENCE AWARD (RESIDENT)***
Dr. Vinay Badhwar

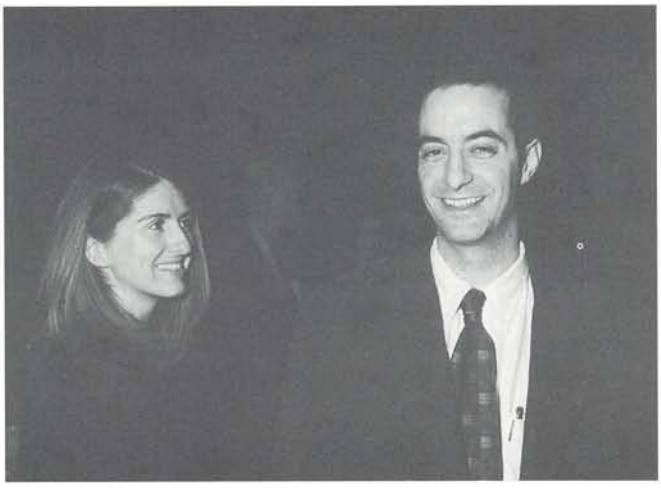
***EXCELLENCE IN RESEARCH***

| | |
|---|---|
| **First Prize** | **Dr. Joe Tector** |
| **Second Prize** | **Dr. Kayvan Taghipour-Khiabani** |
| | **Dr. Andrew Seely** |

***THE KATHRYN ROLPH AWARD***
Dr. Pnina Brodt







# Fraser Gurd Research Day Part II

*MAY 28, 1998*

This year's Fraser Gurd Research Day highlighted an exciting selection of research being conducted within the surgical labs at McGill/MUHC. As usual, the quality of the presentations was high and the award-winning papers reflect the outstanding calibre of work that we have come to expect over the years. The complete program is included for those unable to attend.

***PROGRAM***

9:00 am **Andrew Steinberg** (Urology)
Vascular Endothelial Growth Factor (VEGF) Expression In Renal Cell Carcinoma And Its Correlation With the Von Hippel-Lindau (VHL) Gene

9:15 am **Roksana Nasseri** (Urology)
Behavior And Transscriptional Activity Of Sex Chromosomes In The Oocytes Of The B6.Ytir Sex-Reversed Female Mouse

9:30 am **Kent MacKenzie** (Vascular)
Videoendoscopic Thoracic Aorta To Femoral Artery Bypass: A Feasibility Study In A Canine Model

9:45 am **Victor Chu** (Cardiac)
Comparison Of Angiogenesis Induced By Needle- Or Laser-Transmyocardial Revascularization In A Chronically Ischemic Porcine Model

10:30 am **Marc Pelletier** (Cardiac)
The Value Of Research In A Surgical Residency Program

10:45 am **Jonathan Fridell** (General Surgery)
The Dog-To-Pig Renal Xenograft: A Suitable Model To Study Discordant Pig-To-Human Xenografting.

11:00 am **Joe Tector** (General Surgery)
Discordant Hepatic Xenotransplantation In Recipients With Liver Failure: A Window Of Opportunity For Clinical Trials

11:15 am **Subhas Gupta** (Plastic Surgery)
Microsurgery Without A Microscope: Evaluation Of Three-dimensional On-screen Microsurgery

11:30 am **Saundra Kay** (Pediatric Surgery)
The Effectiveness Of A Minimally Invasive Method Of Tracheal Occlusion And Tracheal Release In The Fetal Lamb Congenital Disphragmatic Hernia Model

11:45 am **Kayvan Khiabani** (Plastic Surgery)
The Role Of Constitutive And Inducible Nitric Oxide Synthase Isoforms In Ischemia Reperfusion Injured Cutaneous Flaps

1:15 pm **Fackson Mwale** (Shriners)
Chondrocytes Create An Extracellular Matrix Permissive For Matrix Mineralization: Assembly And Remodelling Of Collagen And Proteoglycan Associated With Expression Of The Hypertrophic Phenotype

1:30 pm **Jennifer Fletcher** (Orthopaedic Surgery)
Patient Satisfaction And Knee Stability After Anterior Cruciate Ligament Reconstruction Using A Patellar Tendon Autograft

1:45 pm **Philip Downer** (Orthopaedic Surgery)
Local Bone Graft Harvest In Anterior Spine Surgery

2:00 pm **Daniel Swartz** (General Surgery)
Alteration Of Neutrophil Kinetics In Sepsis: A Role For L-Selectin

2:15 pm **Andrew Seely** (General Surgery)
Neutrophils Shed Their TNF Receptors Upon Transmigration: Implications For The Regulation Of Neutrophil Apoptosis

The Executive of the Division of Surgical Research wishes to extend its congratulations to this year's recipients of the Sherwood Davis&Geck prizes for research excellence:

**First Prize:** **Dr. Joe Tector**
**Second Prize:** **Dr. Kayvan Taghipour-Khiabani**
**Dr. Andrew Seely**

*Dr. Lawrence Rosenberg,*
*Division of Surgical Research*

# Doing Rounds in Space

By Dave Williams, M.D.C.M., McGill 1983

"Close visors, turn oxygen on and have a great trip". This message from Mission Control brought us to the last items on our pre-launch checklist. It was now two minutes prior to ignition of the three main engines and two solid rocket boosters that would provide over seven million pounds of thrust to put the space shuttle Columbia into a final orbital altitude of 150 miles. I reached over to the panel beside me to turn on the ICOM recorder to provide an audio recording of all transmissions on the communications loops and settled into my seat waiting for the remaining 90 seconds to pass. At T –15 seconds I remember looking up at all of the computer displays which monitor each of the many shuttle systems and thought to myself, this is not a simulator run!! This would be the real thing, eight and a half minutes later I would be in space, floating freely in zero gravity as we orbited the earth at twenty-five times the speed of sound. By the time our launch guests were arriving back at their hotels, the STS-90 crew would have orbited the earth once providing us with a unique opportunity to look down at Kennedy Space Center as it passed by beneath us.

*Astronaut Dave Williams*

My first task after MECO (main engine cut-off) was to get out of my seat, fold the seat back forward, and position myself to take photographs of the external tank with a 400 mm lens on a Nikon F4 camera. The photographs provide documentation of the state of the tank before it enters the atmosphere again. The crew continued working closely together as we progressed into the post-insertion phase of flight, a very busy time when we get out of our spacesuits and configure the orbiter for the remaining mission activities. This was followed by activation of the Spacelab, the laboratory in which we would be conducting all of our experiments over the next sixteen days. Each of the payload crew members then participated in the SITE experiment, one of the Canadian experiments designed to assess changes in eye hand co-ordination that take place in space. It was quite amazing to me to fall asleep floating freely in my sleep station, after such a long and productive day, realizing that after all of the hard training and preparation our dreams were coming to fruition.

Prior to launch, it seemed that the sixteen-day mission would be quite long. Once in space however, the days flew past as the crew worked very hard to accomplish the many payload objectives as well as perform minor repairs on some of the shuttle systems. A typical day would start with a wake up call from Mission Control in Houston during which they would play the song of the day for us. The chosen music always had some space or "brain related" theme and, as on earth, we often found that the song would keep popping into our head throughout the day. Post-sleep activities were scheduled for 3 hours each day to provide time for eating, washing and cleaning but we found early on that our busy experiment schedule required us to use some of that time to reconfigure the Spacelab for the day's experiments. During the day there would often be two or more experiments taking place concurrently in the lab. On some occasions, there was so much hardware deployed that it was hard to see from one end of the lab to the other! Conducting the experiments kept us busy for at least ten to twelve hours each day with time in between experiments to eat and exercise. The pre-sleep time period always seemed to come faster than expected and never seemed long enough for all of the things we wanted to do. After a quick dinner, with food very similar to that used on camping trips, we would try to get a chance to look out the window at the spectacular sites below us. Whenever we had time, we were able to send e-mail notes through the Mission Control Center to friends and family at home to share our incredible experience.

Over the course of the mission we were able to complete all of the objectives for the four human experimentation teams. The investigators were thrilled with the quality and quantity of the data, which included the first microneurography signals obtained in space. Preliminary data from the Autonomic team has already been submitted as an abstract for publication attesting to the quality of the results downlinked from the orbiter. The data from the Sleep, Vestibular and Sensory Motor Performance teams is also very exciting with preliminary analysis revealing a number of interesting observations.

Overall, the animal experiments were also very successful despite losses of some of the neonatal rats from dehydration. While these losses affected the Mammalian Development team, the experiments with the adult rats as well as the neurobiology and aquatic experiments all provided excellent data. The first extracellular recordings obtained in space from multiple neurons revealed the existence of place cells within the hippocampus similar to those described on earth. These data will be analyzed to determine if the cells respond differently in the absence of gravity when the animals freely moved about in a 3-dimensional environment. As a graduate student at McGill over twenty years ago I had learned how to ►

► record extracellular potentials from individual brainstem neurons, I never thought that many years later I would be able to record similar activity from 40 – 50 neurons simultaneously in an electrophysiology laboratory in space!

Caring for the dehydrated rats provided me with a first hand exposure to veterinary medicine. Each day, we would transfer all twelve cages from the RAHF (research animal holding facility) to individually check each neonate and dam. Under the guidance of Rick Linnehan, our Payload Commander and on board veterinarian, each animal was individually cleaned, hand fed and given gatorade to drink. In a number of cases we administered subcutaneous fluids and antibiotics to the animals, which helped many survive. The initial assessment, made on orbit, was that some of the dams did not appear to be able to care for their pups as well as others. In one case, we intervened and transferred some of the neonates to another litter and the new dam nursed them successfully. There is no question that the clinical skills of the payload crew were instrumental in preventing further losses from maternal neglect.

There were many interesting clinical observations during the mission as well. On earth, I am sensitive to the adhesives used on tape and the EKG electrodes. During the mission, I noticed no reaction to the adhesives at all! Abrasions occurring in space healed well and showed no signs of infection. There were no major medical problems during the mission. Some of the common medical problems noted during our mission and others were back pain due to elongation of the vertebral column (I was two inches taller in space than on earth), facial fullness and congestion, nausea, fatigue and constipation.

As the mission drew to a close, the crew deactivated the lab and prepared the shuttle for entry. The day of landing we woke at 3:00 AM EDT, had a quick breakfast and completed the many tasks called for in the de-orbit checklist. Prior to strapping into my seat on the mid-deck, I was able to enjoy one last spectacular sunset as seem from space, as I helped the orbiter crew members strap in on the flight deck. Entry was very smooth as the shuttle streaked through the upper atmosphere. There was short period of vibration that occurred as we broke the sound barrier as the orbiter became subsonic near the Kennedy Space Center in Florida. After a smooth landing, we left Columbia on the runway as we were taken to the Baseline Data Collection Facility to finish the final phases of data collection.

It would be an understatement to say that space flight is a remarkable experience. There are moments when I find myself recalling the sensation of floating freely, unrestrained by the force of gravity. The feeling of excitement, knowing that we were breaking new scientific frontiers, was there throughout the mission as the crew worked hard to complete the most complex series of life science experiments ever performed in space. There is no question that human space exploration is part of our destiny, for only thus will we come to understand ourselves and the world in which we live. ◆

# RVH Cardiac Surgery Visiting Professor

***February 19-20, 1998***
***Dr. Eric Jamieson***

For the 4th consecutive year, the RVH welcomes one of the leading cardiac surgeons in Canada, Dr. Eric Jamieson from St. Paul's Hospital in Vancouver. Dr. Jamieson is well known internationally for his extensive clinical research on valve related issues.

On Thursday, Feb. 19, the subject of his presentation at Surgical Grand Rounds was *Cardiac Valve Surgery - Risk Stratification, Current Performance and Future Technology*. On Friday, Feb. 20, residents enrolled in the Cardiothoracic Surgery Training Program at McGill gave short presentations on clinical cases or research projects.

The purpose of such a visit is for our residents and our staff to meet cardiac surgery leaders in Canada. It also gives our visitors the opportunity to see our training program as well as visit our institution. ◆

*Benoit deVarennes*
*Director, Cardiothoracic Surgery,*
*Royal Victoria Hospital*

# General Surgery Day

***February 26, 1998***
***Dr. Stewart M. Hamilton***
***Walter Stirling Anderson Professor and Chair of Surgery***
***University of Alberta, Edmonton***


*Dr. Stewart M. Hamilton*

In February, the McGill Division of General Surgery had the pleasure of welcoming Dr. Stewart Hamilton as its guest of honour at its annual General Surgery Day.

Born in St Catharines, Ontario, Dr. Hamilton spent his formative years in Baie Comeau and Vancouver before coming to Montreal and McGill for a B.A. and M.D.C.M. Sadly for us, he left again for the West where he did his residency, M.Sc. and a year of Critical Care Fellowship at the University of Alberta. Following another year of fellowship in Toronto, this time in Experimental Pathology, in 1985 he returned to the University of Alberta Hospital where he quickly became Director of the Critical Care/Trauma Unit in the Division of Critical Care. The unit was a mixed medical-surgical one with a very significant academic, scholarly and administrative presence in Canada. All the while he was the Program Director in General Surgery and Head of the Trauma Service. In 1993 he assumed his present position as Chair of Surgery.

Dr. Hamilton has had a productive career in critical care and trauma research, focusing on resuscitation and delivery of trauma care in Alberta. With regionalization and the dramatic changes instituted in health care delivery, he has of necessity been caught up in the turmoil of delivering surgical care and managing a university department while dealing with the maelstrom of reorganization of services.

Dr. Hamilton initiated General Surgery Day with his presentation *"Regionalization of Surgery: The University of Alberta Experience"*. It stirred much discussion and universally the hope that we will not have to face the same challenges. If we do, his experiences and the excellent studies he has made of it will help us meet that challenge.

The morning's activities continued with a series of video presentations and discussion. The following videos were generously loaned by the American College of Surgeons Educational Library:

- Abdominal wall defects following sepsis and trauma: Acute management and definitive reconstruction
- Post-traumatic hemobilia
- Resuscitative thoracotomy - Procedural principles and surgical techniques
- Localization and resection of insulinoma
- The spectrum of disease and treatment of suppurative perianal Crohn's disease
- Laparoscopic Heller myotomy
- The avoidance and correction of complications secondary to Laparoscopic
- Nissen Fundoplication
- Interactive demonstration of technique and pitfalls of laparoscopic cholecystectomy

After a luncheon for staff and residents, the program resumed with presentations by staff members. These were:

| | |
|---|---|
| **Dr. P. Belliveau** | Teaching strategies in General Surgery - A teaching scholar's perspective |
| **Dr. P. Gordon** | Lateral internal sphincterotomy for fissure-in-ano - Revisited |
| **Dr. J. Barkun** | Randomized trial of laparoscopic hernia repairs |
| **Dr. L. Rosenberg** | Islet expansion technology |
| **Dr. B. Stein** | Gluteraldahyde-induced colitis |
| **Dr. J. Tchervenkov** | Dog to pig liver transplantation: A clinically relevant xenotransplantation model |
| **Dr. L.D. MacLean** | Bethune and Archiblad - Sung and unsung heroes |
| **Dr. H. Flageole** | Tracheal obstruction to treat diaphragmatic hernia |
| **Dr. N. Christou** | PMN-EC interactions in sepsis |
| **Dr. G. Fried** | The use of inanimate methods to enhance performance of laparoscopic skills |
| **Dr. F. Sampalis** | Advanced breast biopsy instrumentation (ABBI) |
| **Dr. C-A. Vasilevsky** | Fistula associated with complicated diverticular disease |

The next morning, Friday, Dr. Hamilton made rounds in the ICU at the RVH and adroitly handled case presentations.

*Sherwood Davis + Geck* have generously sponsored McGill General Surgery Day since 1996 when it was instituted as an annual event. Our previous guest speakers were Dr. Jerry Shuck (1996) and Dr. Bernard Langer (1997). The activities were held in the Osler Amphitheatre of the Montreal General Hospital. ◆

*Jonathan L. Meakins, M.D.*
*Head, McGill Division of General Surgery*

# The Edward J. Tabah Visiting Professor in Surgical Oncology for 1998

***MARCH 25-26, 1998***

By Henry Shibata, M.D.

**Dr. Douglas Scott Reintgen**, Professor of Surgery at the University of South Florida, Co-Director of the Comprehensive Breast Cancer Centre and Program Director of the Cutaneous Oncology Program at the Moffitt Cancer Centre in Tampa Florida, was our guest on March 25th and 26th of this year.

Dr. Reintgen is one of the leading experts in sentinel node mapping for the staging of melanoma and breast cancer. He is also a proponent for radioimmuno-guided surgery in the management of solid tumours. He gave 4 lectures during his visit, and the title for the E. J. Tabah lecture for Oncology Grand Rounds was *Lymphatic Mapping and Accurate Staging of Melanoma.*

*Dr. Douglas Scott Reintgen*

Our heartfelt gratitude to the Cedars Cancer Institute and **Dr. E. J. Tabah** for this great opportunity to invite prominent surgical oncologists to enlighten us with their expertise. ◆

# Annual McGill Urology Research Day

***MAY 6, 1998***

Research groups in the Division of Urology have been steadily growing since the current McGill Urology Research Laboratory opened 14 years ago. Residents, medical fellows, graduate students, postdoctoral fellows, and faculty members are now spread throughout four McGill affiliated hospitals: RVH, MGH, JGH and MCH. In order to encourage the interactions between the fellow members, the Annual McGill Urology Research Day is held every spring.

The 8th version of this event was held on Wednesday, May 6, 1998 at the J.S.L. Browne Amphitheatre in the Royal Victoria Hospital. The half day event began with a lecture by **Dr. Peter N. Schlegel**, urologist from the New York Hospital/Cornell Medical Center. In his lecture entitled *Genetics and Treatment of Testicular Failure*, he discussed the genetic causes of male infertility and recent developments in reproductive technology. As an example of such advancement, he reported that patients with XXY Klinefelter's syndrome can now become the biological fathers of healthy babies. A key to this success is the microdissection of rare seminiferous tubules in which some germ cells have completed spermatogenesis. The collected spermatozoa are then subjected to ICSI (Intracytoplasmic Sperm Injection). After successful fertilization, pre-implantation diagnosis is advisable since aneuploidy is common in the sperm of patients with genetic disorders.

Dr. Schlegel's lecture was followed by short presentations by 18 residents, medical fellows, and students. Afterwards, the four best papers were selected by four judges:

- Paracrine Role of Neuroendocrine Cells in Prostate Tissue Remodelling and Cancer Progression by **Isabelle Defoy**
- The Use of a Cytoprotective Lipid Peroxidation Inhibitor in Preservation of Penile Erectile Function after Prostatectomy: A Study in Animal Model by **Peter T.K. Chan**
- VEGF Expression in Renal Cell Carcinoma by **A.P. Steinberg**
- Expression and Behaviour of Sex Chromosomes in the Oocytes of the B6.YTIR Sex- reversed Female Mouse by **Roksana Nasseri**

McGill Urology Research Day was concluded by the presentation of awards and a buffet. All events were supported by generous contributions from fourteen pharmaceutical companies. ◆


*Lt. to Rt: Dr. Peter Chan, Dr. Mario Chevrette, Dr. Andrew Steinberg, Ms. Isabelle Defoy, Dr. Peter Schlegel (guest speaker), Ms. Roksana Nasseri, Dr. Teruko Taketo, Dr. Denise Arsenault, Dr. Mostafa M. Elhilali (Director, Division of Urology). Absent from photo is Dr. Claude Gagnon (Director of Urology Research).*

# New Surgical Residents Room Named for Dr. Rea Brown

By Vinay Bdhwar, M.D.

The construction of a long awaited residents room has been completed on the18th floor of the Montreal General Hospital. This has been made possible through the support of the general surgical patients of the MGH, Mr. Max Roehl - a governor of the MGH, and Dr. David Mulder. However none of this would have been possible without the tireless support, heart, and soul of Dr. Rea Brown who has been the driving force behind this project.

Dr. Brown's dedication to resident well-being is legendary. He leads by continuously promoting a collegial interactive atmosphere of honour and respect. Throughout the years, he has made it his personal priority to keep his finger always on the pulse of the residents. Uncle Rea's passionate dedication to the pursuit of academic, professional, and personal development of the residents has indeed left a lasting impact. The residents were asked to submit one word that they felt described him. Some of these were: HEARTFELT, CARING, SACRIFICE, KINDNESS, GENUINE, DEDICATED, HUMBLE, LOYAL, LEADER, MENTOR, and FRIEND.

There is no doubt that his profound respect for humanity has left an indelible mark on the lives of his patients and on his residents. He has been a role model to a generation. The word I would choose to describe how Dr. Brown has lead this department and the residents over the years would be COURAGE. Keshavan Nair once said,

*"With courage you will dare to take risks,*
*Have the strength to be compassionate,*
*And the wisdom to be humble.*
*This is the foundation of integrity".*

At the 1998 Fraser Gurd Banquet, as a surprise to him, the resident room was dedicated to Dr. Rea Arthur Brown. The "Brown Room" will serve as a place of education, collegiality, and comradery for the surgical residents for the years to come. ◆

## FROM THE ROYAL COLLEGE CREDENTIALS SECTION
### American Specialty Board Acceptance of Canadian Residency Training

| American Board of .. | Accepts Canadian Training |
|---|---|
| Allergy & Immunology | Yes |
| Anesthesia | No |
| Colon & Rectal Surgery | Yes |
| Dermatology | Yes |
| Emergency Medicine | Yes, but under review |
| Internal Medicine | Yes |
| Medical Genetics | On an individual basis |
| Neurological Surgery | No |
| Nuclear Medicine | Yes |
| Obstetrics & Gynecology | Yes, but under review |
| Ophthalmology | Yes, but under review |
| Orthopedic Surgery | Yes |

| American Board of .. | Accepts Canadian Training |
|---|---|
| Otolaryngology | No |
| Pathology | Yes, but not for subspecialties |
| Pediatrics | Yes |
| Physical Medicine & Rehabilitation | Yes, but under review |
| Plastic Surgery | Yes |
| Preventive Medicine | Yes |
| Psychiatry & Neurology | No, but under review |
| Radiology | No |
| Surgery | Yes |
| Thoracic Surgery | No, but under review |
| Urology | Yes |

# John McCrae (1872-1918) Doctor-Soldier-Poet

By E.D. Monaghan, M.D.

Dr. A.R.C. Dobell has drawn our attention to an article written in the Annals of Thoracic Surgery 1997;63:264-8. This interesting article written by Dr. Richard Carter of Indian Wells, California relates the biography of John McCrae who was born in Guelph, Ontario in 1872. He graduated from Toronto Medical School in 1898 with a gold medal for academic excellence. He trained in Pathology at McGill University under noted Professor John George Adami. He was a Lieutenant in the Canadian Field Artillery during the Boer War. Afterwards, he was Resident Pathologist at The Montreal General Hospital and later at the Royal Victoria Hospital. He was a member of the Montreal Shakespeare Club and became a close friend of the humorist Stephen Leacock.

In 1914, at the age of 42 he was appointed Brigade Surgeon to the Canadian Field Artillery and later became a Lieutenant Colonel in the Canadian Army Medical Corps. It is interesting to note that Sir William Osler's son, Lieutenant Revere Osler, lost his life in the Ypres section in 1917, but first had been triaged at the dressing station under the command of Major John McCrae.

Out of the ruins of World War I arose the poignant verse of the "Trench Poets". Lieutenant Colonel John McCrae, Canadian doctor, professor, and soldier, exemplified this verse in his haunting poem "In Flanders Fields". After establishing himself as a respected physician and university lecturer in Canada and the United States, he served in World War I as a physician and artillery commander. In 1918, after a gruelling tour of duty, McCrae witnessed one of the Great War's most horrific technological creations: chemical warfare. He suffered from asthma and probable chronic obstructive pulmonary disease all his life, dying at age 45 of cerebral meningitis. ◆

*Portrait of Lieutenant Colonel John McCrae by Evan McDonald*

***In Flanders fields the poppies blow***
*Between the crosses, row on row,*
*That mark our place; and in the sky*
*The larks, still bravely singing, fly*
*Scarce heard amid the guns below.*

*We are the Dead. Short days ago*
*We lived, felt dawn, saw sunset flow,*
*Loved, and were loved, and now we lie*
*In Flanders fields.*

# Some Thoughts From Work Overseas

By Fred Wiegand, M.D., F.R.C.S.C.

Médecins sans frontières/Doctors without Borders is the largest private emergency medical relief organization in the world. At any one time, there are approximately 2,000 delegates working in about 70 nations around the world - from Columbia to Cambodia, from Sierra Leone to Sri Lanka. It was founded by a group of young doctors who had worked with victims of the Biafran War and felt that the established medical and political hierarchies in western nations were too slow to respond to those in acute need from natural or man-made disasters like floods, famine, earthquakes or warfare. The organization, its central secretariat located in Brussels, celebrated its 25th anniversary in 1996 and has national divisions in numerous nations.

Canada's MSF headquarters is in Toronto and the Quebec division is here in Montreal at Carré St. Louis. Surprisingly, although many nations, where MSF workers are located, are ostensibly Francophone (Haiti, Côte d'Ivoire, Burundi, Benin, Cameroun, Rwanda), there are only two Quebec surgeons on their active list! MSF activities may include everything from vaccination to fighting cholera epidemics to treating those injured in armed conflicts.

Sanctions or embargoes invoked to bring military dictators or errant regimes into line may be assuaging to western consciences because they minimize the "messiness" of war. However, the victimization it produces for the common people of the sanctioned country can be impressive. For example, UNICEF has verified figures showing that 1.2 ►

► million children died from embargo-related causes between 1990 and 1997 in Iraq.

Sanctions or embargoes, whether induced by the U.S., the U.N. or a nation's neighbours usually start a predictable sequence of consequences consisting of soaring inflation and unemployment, the appearance of a vigorous black market, and a worsening of life for the poorest socio-economic brackets. Cases in point include Cuba, Haiti, Burundi and Iraq.

The U.N. Sub-Commission on Human Rights concluded in 1994 that blockades, sanctions and freezing of assets are "terrorist acts".

While Canada's federal government deserves praise for its support of the campaign against land mines, it is worth noting - as the Coalition to Oppose the Arms Trade (489 Metcalfe St., Ottawa, ON K1S 3N7, (613) 231-3076) recently pointed out - that Canada has not in fact exported antipersonnel land mines since 1987, or used them in battle since the Korean War. Canada, however, is still currently exporting a wide array of military hardware to countries engaged in wars and/or the repression of democracy and human rights, e.g. permits in Canada were given for military exports worth $498, 403, 415 in 1996 to 99 different countries world-wide.

In some cases, Canada is allowing military exports to both sides of an armed conflict, e.g. India and Pakistan, Greece and Turkey, Lebanon and Israel.

For any surgeon who has ever had to amputate one (never mind both) legs of a 17 year old "freedom fighter", the end of the antipersonnel mine scourge cannot possibly come soon enough. I had such an experience in Pakistan working for the International Red Cross.

Burundi is a small country almost in the centre of Africa and is virtually a carbon copy of Rwanda both geographically and sociologically. Tutsi herders came down from Ethiopia and Uganda almost 500 years ago and conquered the Hutus who lived there and the Tutsis have, broadly speaking, commanded the wealth, the army, and the political power more or less since.

Although located in equatorial Africa, much of Burundi is on a mountain range that gives freedom from oppressive heat and humidity. In Kayanza, where I was working, most days were like a sunny, summer day in Ste Agathe. Working there in February 1998 for MSF, I did everything from burr-holes to hysterectomy.

Inter-ethnic conflict between the minority Tutsis (about 15%) and the majority Hutus (about 80%) is nothing new in Burundi and massacres on each other have been perpetrated for 500 years. Since 1993, approximately 150,000 people have been killed in Burundi and in the recent attack by Hutu guerillas on the airport in the capital on New Year's Day 1998, a total of 284 deaths occurred. The airport terminus was shot up as well.

Controversy exists about the value of "foreign aid" and whether it actually helps the recipient nations. Developed nations pour over 50 billion U.S. dollars worth of aid into the poorer nations each year, so it's big business. Nevertheless, detailed studies over many years by Lord Peter Bauer and economist, Peter Boone - both of the London School of Economics - analyzing data from 97 countries that received aid revealed:

- ◆ no relationship exists between the levels of aid and rates of growth in recipient countries;
- ◆ aid levels have no impact on lowering tax rates or eliminating other policies that retard growth in poorer countries;
- ◆ aid flows have insignificant impacts on things like infant mortality and the percentage of youngsters in primary schools;
- ◆ 75% of aid flows are unfortunately used to raise public sector spending, increasing the patronage and power of politicos and civil servants, diverting entrepreneurial energy.

Everybody knows that the infamous Pol Pot instigated the era of the Killing Fields in Cambodia and a recent investigation by Yale University researchers put the total killed at about two million instead of the commonly accepted one million, but nobody seems to remember that President Nixon and Henry Kissinger made the illegal decision to bomb eastern Cambodia (without Congress being aware, never mind giving their permission) so ferociously during the Vietnam War that the populace turned to the Khmer Rouge (the Cambodian Communist Party) in desperation and that in turn led to the ascension of Pol Pot. Allegedly all references to the bombing have been eradicated from the computers in the Pentagon.

MSF/Doctors without Border, both in the U.S.A. and Canada, pride themselves on spending minor percentages (11%) of the donations they are given to run their organizations on office overhead, advertising and fund-raising, while funnelling most of their funds (89%) through to projects and workers in the field.

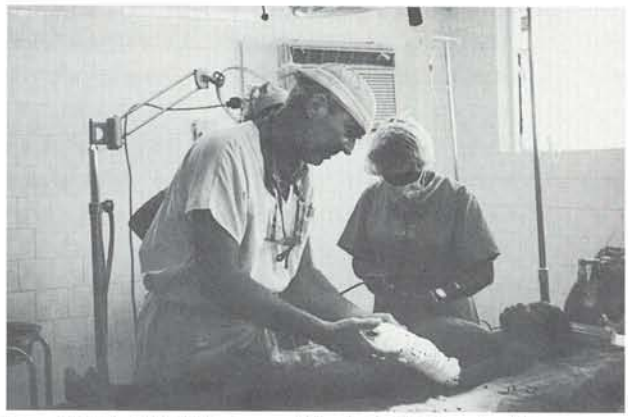
International medical/surgical aid can be and usually is quite different from international economic aid, and is usually characterized by help that is from grass roots to grass roots. Other organizations doing this besides MSF/Doctors ►

► without Borders include World Vision, the International Medical Corps, Médecins du Monde, and the International Red Cross.

The Quebec Division of Médecins sans frontières/Doctors without Borders holds an information meeting for anyone interested in its activities on the third Tuesday of each month. For information, call Laurence at 845-5621. MSF is looking to recruit surgeons as well as physicians. ◆

***Editor's Note:***

The opinions above are those of Dr. F.M. Wiegand - tel.: (514) 489-9574.



*Working with MSF - Haiti 1996. 9 year old boy had his left hand and forearm mangled in a sugar mill. After 3 reparative operations and/or skin grafts, final results fairly good.*

*Working on boy with fractures of femur, tibia and fibula - MSF - Haiti 1996.*

*Bilateral fractured femur in traction - Burundi - MSF Feb.'98.*

## Obituary

**Butler, Dr. Albert Alexander**, B.Sc., M.D.C.M., F.A.C.S., F.R.C.S.C. Orthopedic Surgeon on May 24 at St. Anne's Veteran's Hospital. Dr. "Monty" Butler, a graduate of McGill, served in the Royal Canadian Air Force as a Wing Commander during World War II. He is credited with having developed the use of the Pneumatic Tourniquet in Orthopedic Surgery. After the war, he returned to practice at the RVH. His specialty was in spinal disorders and he invented the Butler Compression Spring for spinal fusion. He was also affiliated with the Queen Mary's Veteran's Hospital, the Reddy Memorial Hospital and the Shriners Hospital. He was a fellow of the Royal Society of Medicine, the A.C.S. and a member of the Canadian and British Orthopaedic Associations. He is survived by his devoted wife Kay (Takamatsu), his daughters Trisha (Richards), Rosemary (Vollmer), six grandchildren and a great-grandchild Cameron. He was buried in The Field of Honour, Pointe Claire, Quebec. Donations in his memory may be made to the Dr. Albert A. Butler Fund, c/o McGill University, Rabinovitch House, 3640 de la Montagne, H3G 2A8 "A legacy of courage and devotion to mankind". ◆

*EDM*

# St. Mary's Surgical Staff - February 1998

*Back Row Lt. to Rt.:* Martin Girard, Dr. Carl Emond, Dr. Vinay Badhwar

*Standing Lt. to Rt:* Dr. C. Kwo, Kai Schoenhage, Dr. S. Skoryna, Dr. R Moralejo, Dr. P. Madore, Dr. Talat Chughtai, Dr. M.S. Chughtai, Dr. M. Orfaly, Dr. D. Tataryn, Dr. M. Sossoyan, Dr. J. Keyserlingk.

*Sitting Lt. to Rt:* Marlene Grenon, Dr. J. Rodriguez, Martin Kahle, Claudia Zubke, Erica Hasse, Jean-Sebastien Joyal