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Welcome to the 60th Anniversary edition of the UWO Medical Journal. This year we hope to bring you a bigger, better, brighter, bolder (am I getting carried away?) Medical Journal. Sixty years in publication - that suggests a venerable tradition of publication...I delved into the archives to see how we compared...

The first issue of the Medical Journal was published in November 1930. The Journal was published in a book format for the first 49 years and contained articles of a scientific (or pseudo-scientific) nature. It had a staff of between 10 and 20 students. At that time the position of editor was an elected one, and Dr. Martin Inwood (Editor 1968) tells me that the competition was fierce.

When the Journal began publication, the medical school was located at the corner of Waterloo and Ottaway Avenue (now South Street). The class of 1969 was the first to study basic sciences in the current Medical School. Certain themes recur throughout the Medical Journal's history. Did you know that the issue of Honours/Pass/Fail first arose in the 1960s? Discussion on the merits of problem-based learning began when McMaster opened.

As I sit here writing, scattered memories of the past three months of clerkship run through my mind at warped speed. Nowadays we all seem so busy that a gathering of even your closest friends is difficult to arrange...“Let's get together Monday night...No, I'm on call...What about Tuesday?...No, then I'm on call...What about Wednesday?...Are you kidding, I'll be sleeping then...”Life becomes very simplified, consisting of only the basics, especially when on surgery, ob/gyn or internal medicine (of which the sleep part can sometimes be very questionable). We become obsessive-compulsive, sleep-craving creatures, sneaking off for little REM breaks or “absence” episodes whenever possible, whether in the back row at rounds, “studying” at the library, or during lulls between admissions. It's interesting to note that no one has yet to conduct an experimental study on the prevalence of narcolepsy among medical students, for which I would be more than happy to donate a few bucks towards a cure.

But in all seriousness, as the amount of responsibility given to us increases, productive use of what little time we have becomes of the essence. Rushing to fill the endless tasks of everyday, it's easy to lose perspective of what's really important, becoming minimalist in attitude. After all, the objective of clerkship is to develop skills in order to become competent doctors, but also to enjoy life. It's sometimes easy to forget this when plodding through the daily drudgery of being a clerk, especially when the highlight of your day consists of comments like —“Oh, don't bother asking him/her, s/he's only a clerk.” —Arrrrgh. Agreeably we don't know as much as our fellow consultants, as we have not had the fortune of their extra 10-50 years of experience, but being treated as stool softener is not exactly uplifting to anyone's morale.

But then there are those bright moments, when you actually get that good feeling that reminds you of why you went into medicine; when you feel that you've done something constructive and positive for someone. Whether it be one of your pediatric patients drawing you pictures and telling you that you are the best doctor in the whole world, or a patient thanking you for caring, it makes it all worthwhile in the end.

Until next time... 

Funding for the Journal has been a perpetual problem since the start. "At various times interest in the Medical journal ebbed so low that it seemed advisable to discontinue the publication. The Journal had been launched on the sea of publication for only a short time when it was cast on the financial rocks. But in one year an industrious staff, with careful planning, erased the large debt. The alumni were generous in their support and encouraged the undergraduates to continue the publication." Editorial 14(1), 1944. Until recently, some funding came from the Faculty of Medicine and some from the Hippocratic Council, occasionally supplemented by advertisements. Today our major source of income is advertising - and our budget is still on a shoestring.

The focus of advertisers has certainly varied over the years. During the 1950s the focus was on advertising baby formulas - "as good as mother's milk" and the new anti-hypertensives (a veritable cocktail). A typical treatment (1955), Nitrophenra contained dry extract rauwolfia, sodium nitrate, phenobarbital, dry extract hyoscyamus, digitalis pulvreta and nitroglycerin. During the 1960s the focus of ads shifted to contraceptives. An advertisement for Julius Schmidt stated, "Any husband or wife in your practice would most likely prefer a prescription for condoms and be saved the embarrassment of asking for them in public". In 1967 Ortho-Novum 2 mg was the leading oral contraceptive.

Over the years the Medical Journal has run the gamut from scientific in orientation to light-hearted. How did we compare? Quite well. We have tried to maintain a balance of the scientific as well as some of the lighter moments of medicine. Although we are forced by our financial constraints to keep the Medical Journal somewhat smaller than we would like, we have been able, for the first time in the three years that I have been a Co-Editor, to defer articles for publication...That is a very encouraging feeling, and it indicates to me that we are being read - which ultimately is really the reason that we keep on doing what we are doing.

Finally, found in Volume 38(1), 1967: "This space has been reserved for the flood of "Letters to the Editor" which are expected for the next issue. Letters of praise and adoration for the Editorial Staff will be particularly welcome."
Letters to the Editor

Quackery
Dear Editors:

"Naturopathic Medicine: A brief synopsis" by James Francis, Meds '93 appeared in the April 1990 issue of the journal. The article reads like an advertisement for Naturopathy. No attempt has been made to critique this alternative form of health care. I am appalled that such an article could appear in a medical school publication. The article contains false and unsubstantiated statements which may be misleading to medical students and other readers. It would be of considerable interest to know the source of Mr. Francis' information.

Contrary to the claim of the article, Naturopathy is not the practice of medicine which is specified by law and can only be practised by graduates of certified schools of medicine. Naturopathic schools are not certified or recognized in the province of Ontario. The article claims that Naturopathy augments natural healing processes. Unfortunately, even if the claim were valid, the capacity for natural healing is quite limited. Dependence on natural healing prior to the era of modern scientific medicine produced high infant mortality, short life expectancy, plagues and chronic untreatable diseases, many of which can be effectively prevented, treated or managed by modern scientific methods.

The article claims that naturopathic training is extensive and includes basic and clinical sciences. Interested parties should investigate these courses in depth to establish their true nature. The fact that Naturopathy has been practised for centuries, as the author suggests, is not a valid criterion for establishing validity or efficacy. The list of therapies used by naturopaths includes homeopathy, herbology and chiropractic, none of which have a scientific basis.

The philosophy, as stated, that guides the naturopath's treatment and style of practice is not different from that of a medical practitioner. However, unlike the physician, the naturopath is quite incapable of fulfilling these objectives. For example, treating the underlying source of illness, not just the symptoms, is specified. Naturopaths do not receive the same training as medical students. Consequently, they have little capacity to diagnose organic disease, to understand pathology, to utilize appropriate diagnostic procedures or to establish etiology or pathogenesis. They are philosophically opposed to and do not have training in pharmacologic agents or to perform surgery.

Most objectionable is the assertion that naturopaths are "quite successful in preventive medicine, pain management and in treating non-life-threatening acute problems and numerous chronic conditions." These claims are totally unsubstantiated. Naturopaths are not known to undertake appropriately controlled clinical investigations which would be necessary to confirm these assertions.

The article includes an appeal to the province of Ontario to include Naturopathy in the Ontario Medical system in order to decrease medical costs, reduce iatrogenic illness, and improve medical care. The Ontario government is currently developing legislation to regulate health disciplines (Health Disciplines Act). Naturopathy has not been included because, quite appropriately, the government recognizes that Naturopathy is unscientific, has no defined knowledge base, and may not utilize valid and safe methods of diagnosis and treatment.

The Dangers of Naturopathy are clearly indicated by the tragic case of Lori Atikian, a child in Toronto who died recently as a consequence of treatment by Gerhard Hanswille, a naturopath. Hanswille has a mail order doctoral degree in Naturopathy from "Bernadean University" of Los Vegas, Nevada. The parents of the child have been convicted and sentenced to jail for failing to provide the necessities of life for their baby daughter. Hanswille, to date, has not been charged with any crime. The case was heavily reported in the Canadian press in recent months. An excellent summary appeared in the Newsletter of the National Council Against Health Fraud, (Volume 13, July/ August 1990).

To balance the article by Mr. Francis, the information contained in this letter should be brought to your readers' attention. W.B. Chodirker, M.D.
Professor of Medicine
Chief, Clinical Immunology
and Allergy Service, U.H.

A Viable Alternative?
The Editors:

Thank you for the opportunity to defend my article on Naturopathy. Dr. Chodirker in his letter to the editor has questioned the sources of my information and the benefits of Naturopathy. In this response, I would like to challenge his claims.

At one point, the author questions the quality of the Naturopathic training. From my experience as a student at the National College of Naturopathic Medicine, I have found the training in basic sciences to be similar to, and as thorough as those courses offered at Western. This was exemplified by the use of several identical texts, and professors who also taught at conventional medical schools.

The author also claims that "Naturopaths...have little capacity to diagnose organic disease, to understand pathology, or to utilize appropriate diagnostic procedures." In contrast, Naturopaths receive and utilize professional instruction in pathology, pharmacology, microscopy, ultrasound, radiology, minor surgery, natural antibiotics (e.g. penicillin) as well as training in non-traditional modalities.

Dr. Chodirker also calls into question the scientific basis of Naturopathy and claims that they are "not known to undertake appropriately controlled clinical investigations." In response, the U.S. Naturopathic colleges have been publishing results of controlled studies for over a decade. Many reputable journals report the efficacy of acupuncture proven through scientific methods. In "Acupuncture the W.H.O. View"; (World Health Organization, Dec. 1979) more than 40 diseases that lend themselves to acupuncture treatment are cited by the World Health Organization. In regards to Homeopathy, reference can be made to "Is Homeopathy a Placebo Response?" (Lancet, Oct. 1986)

The story of Lori Atikian is indeed a tragic one. However I believe that Dr. Chodirker has unjustly and inaccurately applied it in his letter. Mr. Hanswille bills himself as an "Herbalist", not a Naturopath. The N.C.A.H.E. article also refers to him as such. In any regulated province or state, Mr. Hanswille would not be able to practice under the incorrect title of Naturopathy. The Ontario Naturopathic College reports that Naturopaths have been for the last twenty-five years and still are, regulated in Ontario under the Drugless Practitioners Act. This act is currently under review.

In my opinion, it is oversimplistic to believe that one approach is inherently right and another totally without merit. It would seem reasonable to me that conventional medicine has both strengths and weaknesses as does Naturopathy. Since both have the same objective - to relieve human illness, they should not compete, but instead compliment each other.

by James Francis, Meds '93

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page 3
The Enhanced MCCQE: Will National Portability Be Guaranteed?

by Keya Hosseinzadeh, Meds ’92, VP Medical Education, CFMS

One of the difficulties students have faced with the above question has been to sort through the facts and rumours concerning the Medical Council of Canada Qualifying Examination (MCCQE), attempting to rationalize the reasons behind these changes. Every imaginable academic body, be it students, universities, the Colleges, and Provincial Medical Councils are involved with the enhanced MCCQE. Each organization has expressed a position reflecting concerns and possible suggestions to the new MCCQE, which may or may not overlap with the opinion of others. In this synopsis, I have stressed the academic and practical issues of licensure on which these examinations will have an impact, especially the issue of portability of general licensure across the country. This was the major goal of the MCC. I believe it is important to become familiar with the general concerns and outcome of the MCCQE, specifically the new Part II, as well as focusing on the examination format.

Problems with the present Licenti ate of the MCC (LMCC):

When Canadian Physicians have their names recorded in the Canadian Medical Registrar, they become Licentiates of the Medical Council of Canada (LMCC). Although, each province has the discretion under the Medical Council by-laws to grant a license to practice medicine, Provincial Licensing Authorities have agreed in the past (so it has been said) to use the MCCQE as the national standard to measure candidates’ competence. However, the present MCCQE assesses only cognitive knowledge and clinical reasoning skills at time of completion of the undergraduate medical curriculum. The Provincial Licensing Authorities have therefore identified the need for the assessment of more dimensions of clinical competence closer to the time of general licensure. This requirement introduces a fine point in student evaluation as assessing educational programs versus professional accountability. In educational programs, the timing of summative assessment is upon completion of the formal curriculum that is common to everyone being tested. In the case of professional accountability, assessment is made immediately prior to commencing independent practice. The latter requirement has been supported by the Federation of Medical Licensing Authorities of Canada (FMLAC) to the MCC, and has been the main basis for holding a clinical examination (MCCQE PartII) towards the end of post-graduate training. It seems clear that the viewpoint expressed by the FMLAC as related to professional accountability is primarily for the protection of the public, specifically in case of independently practicing physicians. Experience has shown that those physicians who are likely to generate complaints are those that lack communication skills, those trained outside an objective-based postgraduate education process, those unfamiliar with the provincial health care in which they practise, and those unaware of the medical-legal implications.

In addition, because of variability in post-graduate training programmes available, provinces have found it increasingly difficult to define the content of post-graduate training programmes which...
would be acceptable for the purpose of licensure, as well as meeting the requirements of specialty programmes. For example, a present post-graduate trainee who successfully completes a one year general rotating internship in Ontario, may be refused a license in another province owing to deficiencies in Ontario training as viewed by the province issuing the license.

The need for a more global assessment of clinical competence on which to base licensure

There has been a growing consensus that Provincial Licensing Authorities will not so rigidly define the requirements for licensure, if a more global assessment of knowledge, clinical skills and attitudes is undertaken prior to completion of the pre-registration period. ERGO, the Enhanced Qualifying Examination, MCCQE Part I and MCCQE Part II, would no longer be intended for the 'validation' of the undergraduate medical curriculum, but would have as its objective the assessment of clinical competency for the provision of 'general medical care'.

MCCQE Part I (Q1-Q4): Essentially MCCQE Part I will remain similar to the current MCCQE, which has consisted of pencil and paper assessment of cognitive and clinical reasoning skills. Q4 will replace PMP (Patient Management Problems) or 'rubouts' as they are more commonly known. This will hopefully better sample domains and problems related to short clinical vignettes; short descriptions of clinical problems will be presented, and students will be expected to provide the 'key features' for diagnosis, management, etc. of the case in question. The examination will be first administered in May 1992.

MCCQE Part II (Q5): FORMAT: This new part will take the form of an objective structured clinical examination (OSCE), and will be aimed at testing clinical skills including: history taking; physical examination; communication; problem solving; management strategies and procedural skills. The OSCE will comprise two types of questions: 1) 10 minute patient encounter stations, where for example, the candidate's interviewing skills will be assessed; 2) couplet stations, comprising of a 5 minute focused patient encounter followed by a 5 minute post-encounter probe. All stations will employ standardized patients.

LOGISTICS: The examination will be administered centrally but delivered at 7 test sites across Canada (locations unknown).

CONTENT: MCC yielded a matrix of symptoms and causes each weighted for importance in terms of frequency of occurrence and urgency of the problem. The examination is domain referenced i.e. an index of importance and an index of difficulty is assigned to each item on the station's checklist or each post-encounter probe question.

COST: A final fee for Part II has not been decided as of yet, but will range between $500-600.

TIMING: MCCQE Part II will be administered November 1992.

For Ontario graduates, criteria for admission into MCCQE Part II includes successful completion of MCCQE Part I and satisfactory completion of 16 months of post-graduate training. The criteria for registration on the Canadian Medical Register and granting of the LMCC requires successful completion of MCCQE Part I and Part II, and satisfactory completion of 24 months of post-graduate training, or programs of the RCSC or CFPC. This 24 month period will probably require an 8 month core content for all graduates providing exposure to the major clinical disciplines (Medicine, Surgery, OB/Gyn, Pediatrics, Psychiatry and Family Medicine). The 2 year post-graduate training will come into effect in Ontario in July 1993 to replace the one year rotating internships.

Potential Problems

A) Presently, graduates of Ontario medical schools of '91 and '92 will have to complete one year of general rotating or comprehensive internship, and MCCQE (Part I for Meds '92) in order to obtain the LMCC and a general license for Ontario. Difficulty may arise following the granting of general licensure, when these candidates wish to practice or continue in specialty training in another province which already has a 2 year internship in place or to be implemented in 1992 or 1993. These provinces in question may require the candidate to successfully complete MCCQE Part II for eligibility for general licensure in their province. In addition, the MCC requires at least 16 months of post-graduate training prior to MCCQE Part II. The restrictions mentioned will not affect Meds '93, simply because all provinces (with possible exception of Manitoba in Canada will already have 2 year internship in place and the implementation of the new criteria for the enhanced LMCC.

Therefore, the following issues need to be resolved: will portability of general licensure for Meds '91 and '92 be assured without MCC Part II? This decision is in the hands of each Provincial Licensing Authority. A grandfather clause will remove potential complications and barriers to further education or practice in a different province. If not, what conditions prevail for general licensure in other provinces during the 1991-1992 transition phase, and how do these candidates go about fulfilling these requirements?

B) Concerns arise for candidates of RCSC and CFPC programs since they will also be required to fulfill the MCC criteria for the enhanced LMCC and general licensure. The Royal College Programs with one year of straight internship contain core requirements specific to their specialty training. They have agreed in principle to accommodate the core content requirements for the enhanced LMCC without prolonging the duration of their already extended programs.

The College of Family Medicine will be less hindered to incorporate these new changes but they have stressed repeatedly that those holders of the general licensure, should and will be considered as family practitioners by the CFPC.

C) No provisions for remedial training were proposed by the MCC for candidates unsuccessfully completing MCCQE Part II. The need was strongly expressed by the Canadian Federation of Medical Students to the MCC. However, it appears the Council has separated itself from this important section of medical education, where clinical skills can only be rectified and improved through constant supervision. The post-graduate program directors especially those of
Class Reports

Casey at the Lab

by Justin Amann, Meds '94

Twas one September morning early in the fall,
A hundred or so students assembled in a hall.
They came from far and wide, from both the nation's shores,
And assembled all together, they became Meds 94.

A scavenger hunt, a BBQ, a picnic at Fanshawe Park,
Where the flesh did themselves proud in a boat race after dark.
They drank their beer with gusto, these new kids on the block,
And quickly realized their competition was a crock.

With orientation over, and classes starting soon,
It was time to choose an executive to lead them until June.
Mark Mensour became President, Chris Lindsay his V.P.,
B J and Amit social reps, and Ellen for Treasury.

For sports reps they elected Jill for girls and Jon for guys,
And Burke and Dana would get Tachycardia organized.
They all got shots for MNR, DPT and TB,
And Caroline warned them daily about Hepatitis B.

By then lectures had started, their courses had begun.
(If only they could stay awake in M341)
In that room of misery all the subjects looked the same,
The biggest thrill was trying to recall each other's name.

Naturally their class spirit could overcome this boredom,
And Ray and the Inebriate went boozing at the Forum.
To celebrate Ray's birthday was the idea of this bash,
But with Ray comatose by ten, the party was a crash.

Sean rode his bike for Research, and raised 200 bucks,
While the two softball teams did not have as much luck,
The A team was not filling the enemy with awe,
And on the B team Greg Sue-a-Quan incurred a broken jaw.

Other events followed, like Faisal's Pizza Hut,
The Homecoming Parade, and Thursday at Yuk Yuk's.
But let's not forget learning is what Med School is about,
And hope that unlike Casey, these young doctors won't strike out.

Christopher Robin leads an expedition to UH "B"

by Barry Love, Meds '93

One fine day, Pooh was sitting in the UH cafeteria humming a little bear song, for that was what bears were best at, when along came Christopher Robin.

"Good-morning, Christopher Robin," he called out.
"Hallo, Pooh Bear. Today, we're going on an Expedition!" said Christopher Robin.

"Going on an Expedition? Where are we going?"
"Expedition, silly old Bear. It's got an 'x' in it."
"Oh!" said Pooh. "I know." But Christopher Robin knew Pooh didn't really and thought it to be reminiscent of all those who say that they hear a diastolic murmur when the cardiologist says they should but they don't.

"We're going to discover UH B"
"Oh!" said Pooh again. "What is UH B?" he asked.

"It's just a thing you get sick of when you are in second-year medicine."
"And when we discover it, we will be sure and find out what is new with Meds '93"
And so off they went. Down the corridor. Through the doors.
Down the hall. UP the stairs. Into UH B. And who did they BUMP into first but David Hatcher and Lisa Fisher.

"Pooh, I would like you to meet two of my new friends," offered Christopher Robin excitedly. "They are from U of T and are new in our class!"

"Greetings and Salutations." said Pooh Bear a little shyly while trying to figure out what a "U of T" was, which it wasn't.

David and Lisa took their seats and got ready for another exciting microbiology class. Christopher Robin took a seat next to Pooh at the back of the room so he could quietly explain to Pooh about Meds '93.

"...You see Pooh, Karen Lukasik and Brent Shulman are both in our class and they just announced that they are getting married this summer...and Meds '93 will probably go down in history for the class who had their second year Tachycorp ready and cast before the end of first year. Everyone is working very hard on it...and in October we all went to Seema and Nil's place for an ethnic pot-luck dinner and boy was it yummy."

Pooh thought about that and decided that 'pot-luck' must mean 'pots that are lucky' and if a pot is lucky then it must be because it full

continued on page 7

Ann Slanders

Dear Ann:

A couple of months ago, I started this thing called 'clerkship'. I had been so looking forward to it—no more classes, wearing pyjamas all day long and carrying around that cool little beeper. Now I find that I'd be getting more sleep if I had lectures to sleep in, that the novelty of that wonderful color—GREEN—has worn off, and that the little beeper goes 'beep!' at the most inopportune times. I'm sleep depraved, tired of dining out at Cafe de l'Hopital, and I feel like throwing the beeper into a fishtank.

Sincerely,

Lean, Green and Mean in London.

Dear Lean Green:

You forgot to mention a few reasons for your sleep deprivation. Barney has shown great hospitality towards your class throughout the summer, and it was so thoughtful of his neighbour, Joe, to con-

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MCCQE  Continued from page 4

Royal College Programs have indicated disfavour to allotting time and taking responsibility for retraining purposes. An official of the MCC pointed out that feedback will be offered to the students after each station, which although is necessary, will not be sufficient to prepare them for a future attempt.

The mandate of the MCC has always been at the crossroads between education and licensure. The MCC has worked towards a Canadian Mandate that will assure holders of the LMCC, in a more valid and reliable way, 'portability' in Canada. It is hoped the successful completion of these qualifying examinations should bring candidates up to the required level for licensure in every province. I hope that this synopsis has answered concerns or questions you may have had. At present of utmost importance is to voice students' concerns as future practitioners on the aforementioned problems.

Class Reports  Continued from page 6

...and we have a holiday semi-formal party in December...and we are going on a ski-trip to Collingwood in February...and everyone is very excited about the Ontario Medical Students Weekend in February here at Western...and we go to Ethics seminars with famous people like Dean Valberg and Dr. Linton and they are always interesting...

By the time Christopher Robin had explained all this, class was over.

“Everyone was very nice and it looks like they are having a lot of fun but all the same Christopher Robin, I would like to go back and see my friends at the Hundred Aker wood 'cause I'm sure that they miss me.”

“Silly old Bear,” said Christopher Robin and gave Pooh a little hug.

We’re Back

by Connie Nasello Paterson, Meds ’91

After 17 months out of the classroom it will be a welcome change to come back. Just think, no responsibilities, no 7 a.m. rounds, no beeper... Time to reacquaint ourselves with our classmates, 'you know, what's-his-name, I can picture his face...”

Several of our classmates were able to travel to exotic locales for electives. Jan R. and Kip checked out Emerg in Edinburgh, Iris caught the 'rays' in Hawaii, Bevin doctoring in the depths of the New Guinea wilderness, others ventured into the jungles of downtown Toronto...

Plans for the ATLS course are already underway, and the class is already full. For those who didn't get the course, hopefully another can be arranged later in the year. Tachy planning is underway, and Mark and Lydia promise an exciting script. All the required internship letters are done - Thank God - and most of us have had at least 1 or 2 interviews. Now, if we only knew where we were supposed to go.

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Medical Students for Social Responsibility

by Les Wasilewski, Meds '92

The Canadian Physicians for the Prevention of Nuclear War (CPPNW) consists of doctors and health care workers committed to the education of the Canadian public regarding the still present danger of nuclear war and the catastrophic damage resulting from an even limited nuclear exchange. Over the last few years the organization's focus has been on showing the loss of potential funding to health care, education, and environmental programs as a result of the continued military arms buildup throughout the world.

The local chapter of CPPNW had four successful projects over the past year. In the spring, the 3rd annual Healing Our Planet Contest was held for all London high schools, with the winning student receiving a free trip to the United Nations in New York (accompanied by 2 medical students). Medical students were very actively involved as they travelled to local high schools and helped interested students decide on topics and the appropriate media (posters, videos, music, essays, or projects) to express their ideas.

Early evening on August 5, 1990, over 1000 Japanese lanterns were floated on the Thames River to commemorate the 45th anniversary of the bombing of Hiroshima and Nagasaki. Simultaneous demonstrations took place in cities throughout the world, including Europe, the Soviet Union, Japan, and the United States.

The UWO medical student chapter of the CPPNW is now known as Medical Students for Social Responsibility (MSSR). As well as contributing to the above-mentioned projects, MSSR had two very successful projects of their own. At the Lanterns for Peace Ceremony, a raffle was held and over $800 was finally raised for a Neonatal Resuscitation Teaching Unit. The much needed equipment was given to the training program working throughout community hospitals in Western Ontario in order to provide skills in newborn infant resuscitation. The draw was held to provide an example of how extremely important and needed health programs do not get adequate funding in contrast to the continued worldwide proliferation of nuclear weapons.

MSSR was also responsible for getting London’s City Council to send a resolution, passed unanimously, to the federal government in Ottawa demanding that they support an upcoming Comprehensive Test Ban Treaty Conference scheduled for the United Nations in January 1991. Canada currently opposes such a treaty on the grounds that this approach is too rapid and might possibly jeopardize existing treaties - treaties which have allowed the world’s nuclear stockpiles to increase six-fold since 1968. Interestingly, the United States also does not support this treaty, leading experts on foreign policy to wonder who is dictating Canadian policy on nuclear issues.

The Lanterns for Peace and Healing Our Planet projects will again take place this year and another fund-raising initiative is being planned by MSSR. All interested students can contact Gord Schacter (642-4763) or Les Wasilewski (433-3984).
“Whaddya mean, no clerks from July to November 1993 — who’s going to do our scut?!!”

Get the facts about the challenge and opportunity of the Canadian Forces Medical Officer Training Plan. Your new career could include a peacekeeping tour. Here’s how it works.

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Following graduation, you will combine your medical training with that of an officer in the Canadian Forces.
In the South of Nigeria

by Lea Babcock, Meds '93

The goal of MedOutreach is to promote understanding and awareness of third world issues - especially as they pertain to medicine. A major part of the MedOutreach effort is devoted to an annual trip to a third world nation. This past summer, eight health science students spent six weeks in Nigeria experiencing the country and participating in the delivery of health care. The eight students were Jen Andrade (Meds '92), Stephanie Windsor (Meds '93), Tanya Petrasko (Meds '93), Mark Rosati (Meds '93), Lea Babcock (Meds '93), Anne Zimak (Nursing '91), Michelle Robitaille (Nursing '91), and Juliet Pepper (Nursing '91). The following article is one student's perspective of the MedOutreach '90 summer program.

I'm sweating constantly! This evening when I got home I had to peel the clothes off my body. I spent the morning at a water sanitation project and primary health clinic just outside of Calabar. We then fought our way through the local Calabar market and bartered with the aggressive shopkeepers during the afternoon. I have already changed twice today and have taken two warm water bucket baths with the worm-infested well water. Won't someone turn down the heat?! It is so hot... it is always hot... such is the life in Africa.

This is a glimpse of my June 13 journal entry from my six week visit to the rain forests of Cross River State, Nigeria.

There were eight of us this year who stoically bent over for our Hep A inoculations, eagerly packed our backpacks, and kissed a summer's wages goodbye for our own personal adventures in a third world country.

When a fellow MedOutreach, Stephanie Windsor, coined the phrase "Taking a Reality Pill" in a London Free Press article earlier on in the year in reference to our upcoming trip, I thought that perhaps she had been listening to too many soap operas and was being overly dramatic. (This was before Tanya Petrasko came up with the "Life without Revlon" statement so I still had high expectations of a professional media image!)

I had very few preconceived notions about what awaited me in Africa. Sure it was going to be difficult at times and very different than here, but nothing could have prepared me for the whirlwind adventure that began that day in early June when we disembarked from the Sabena Airlines jet in Lagos - the capital of Nigeria. After we hyperventilated for an anxious hour onboard the plane (a lengthy delay in letting us leave the plane and then having us go out the tail exit had us all convinced that the plane had been hijacked), we stepped out into the sour, polluted air of Lagos, the home of 11 - 13 million Nigerians. For the next several hours, we were treated to a hair-raising introduction to bartering in the airport terminal. Here, Mark Rosati was eventually suckered out of $20 U.S. dollars - close to one month's salary for most Nigerians - by two persistent porters. (Sorry Mark, but how could I let you forget that one?)

The eight of us were split into two groups. Two medical and two nursing students left for Michika in Congola state, and two other medical students, a nursing student and myself flew to Calabar in Cross River state. Within a week, I had been attacked by a "madman" with a gasoline can who stole my umbrella; I was hit on the backside by a stick-wielding youth in a painfully casual fashion as we were returning from the local market, and then I did a classic Maxwell Smart move into a disgusting five foot deep hole that was functioning nicely as a sewage/rain reservoir in the crowded Calabar street. These incidents, however, were more than compensated for by the high degree of respect and kindness that was extended to us by the Nigerian people.

The south of Nigeria is an area of incredible contrasts. On a free weekend, we went trekking in the grass plateaus of the Obudu mountains. This range is the highest in Nigeria and it is often shrouded in the clouds. This was a memorable weekend. One piece of advice: Never hire guides less than seven years old to take you on a hike through low hanging bush! Although we set out to see a "well-known" waterfall, we never arrived but spent eight hours crawling up and down steep slopes on our hands and knees. We felt lucky to have found our way back.

In the next breath, I found myself back in the polluted area surrounding Calabar. We spent the majority of our time traveling to health clinics throughout Cross River, Akwa, Ibom, Imo, and Benue states. During a posting to the outlying village of Inyama on the very northern aspect of Cross River State, I swallowed a full bottle of reality pills. The local government of Inyama serviced fifty to one hundred thousand people who lived in mud huts deep in the dense tropical bush. The entire area was the responsibility of one very elderly health care worker who had a dispensary set up in a small, open hut in the village. While I was there, a large group of women came by with their children or elderly parents for medical attention. At least nine out of ten of them were sent away untreated, with no advice...
or medication because they didn't have one or two Naira for payment (about 20 to 25 cents). This treatment would often have been the factor deciding if these patients would be around the next day. In consternation I watched as the women picked up their dying child, wrapped him/her up again, and headed back to the fields to work. Never again will I feel more useless than I did that day.

The access to medication is very limited and even if one could afford one of the four drugs available, three quarters of it was either expired or mislabeled. In this area, there had been a very serious outbreak of Guinea Worm disease (also called Draculoculiasis). This water-borne disease had left most of them sick and weak from an infestation of three to four foot long thread-like worms that burrowed out from beneath the skin. Their only water supply was a stagnant collection of rainwater a few minutes into the jungle - the source of the infection.

By virtue of some stroke of fate, I had fresh bottled water at my disposal, and the option to pack up my stuff and leave. These people held no grudge that I was drinking safe, clean water while they sufficed with their own dirty water, or that I had the money and power to leave and they did not. I will not forget them... they represent the majority of people in our world. We are the lucky ones.

The Nigerians doted on us, treating us like royalty. Over and over again, I asked myself why, by virtue of our skin colour and birthplace, are people so segregated? What special feature did the Nigerians think that I had that they lacked to warrant this distinction? I had the fortune of being born a Canadian and by that stroke of fate, I have had the opportunity to do anything with my life. This includes doing incredible things like MedOutreach. It is inconceivable to imagine that the average Nigerian will ever get the chance to go to university, let alone leave Nigeria.

In Canada, everything is placed at our feet and we have the choice of whether or not to pick up the opportunities presented to us and run with them. I now appreciate that this freedom is a very precious gift and I, for one, am going to grasp it in both hands and run with it!
So who in London cares about a little homecoming parade? I found out pretty quickly what homecoming means in this city, and Meds '94 was a part of it all. Headed by Gillian Buckley, Bill Manopoulos and Michael Taylor, the Meds '94 float "Club Meds" was a great success. Many thanks to Big V Drug Stores for their generous donation of a flatbed truck and a great driver. The Friday night before homecoming, Meds '94 was feverishly putting the masterpiece together. At first, the float didn't look like anything more than a flatbed truck and a pile of wood with other miscellaneous items strewn about. But in the freezing cold of the night, something happened... Not only did a float appear from the pile of rubble, but more importantly, a bond between future colleagues took place.

Saturday morning came quickly (not enough sleep Friday night) and we high spirited medical students were putting the finishing touches on the float. When all was ready, surgical greens were donned and faces decorated with "UWO MD" in purple. I was astonished at how many London residents were up that early on a Saturday morning to see the parade from the downtown streets. The float was catchy enough to make the front page of the city section of the London Free Press. Overall, the parade was a success, and everyone who participated had a great time.

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Letting Go of Old Ideas: Some Thoughts on the Diagnosis and Treatment of Alcohol Abuse and Alcoholism

by Leslie C. Wright, Meds '93

Earlier this term, Dr. Cameron Ghent, an associate professor of medicine in our faculty and the hepatologist at University Hospital's Multi-Organ Transplant Unit, delivered a seminar entitled "Ethical Issues in Liver Transplantation". He discussed some of the difficulties involved in offering such organ transplants to individuals suffering from cirrhosis of the liver secondary to chronic alcohol abuse. However, Dr. Ghent did not clarify the confusion that surrounds the prevention, detection, and treatment of alcohol-related health problems in our patients. He spoke of actively drinking alcoholics as "unreformed", and referred to the relapse to drinking by previously abstinent individuals as a sort of "recidivism". He expressed some concern that by treating alcoholism as a "disease" we risk inappropriately absolving affected individuals of the consequences of their "self-inflicted" behaviour. He mentioned that abstention from alcohol was a sine qua non in his cirrhotic transplant candidates. No guidance was offered in helping patients to achieve such abstinence.

This paper is written in response to Dr. Ghent's quip: "An alcoholic is someone you don't like who drinks more than you do." I think he is wrong. Though not as "cut-and-dried" in their myriad presentations as, say, hepatitis or bacteria pneumonia, alcohol abuse and dependence are common, serious, and treatable disorders with straightforward diagnostic criteria.

What is alcoholism, and who is an alcoholic? Like Dr. Ghent, it seems everyone has their own answers to these questions; however, coherence can be found in the definitions and criteria offered by the World Health Organization (WHO) [1] and the American Psychiatric Association (APA) [1,2], and these should be mentioned. The WHO definition speaks not of "alcoholism", a word often criticized for its lack of specificity, but rather "drug dependence of the alcohol type", which is defined, in essence, as excessive ethanol consumption that is either culturally inappropriate or detrimental to an individual's psychological or physical health or social functioning.

The APA takes a slightly different approach, and describes the disorders "alcohol abuse" and "alcohol dependence".

In older (i.e. DSM-III) criteria [1], alcohol abuse is characterized by a "pattern of pathological alcohol use", e.g. binging, blackouts, continued drinking in spite of adverse consequences, etc., or "impairment in social and occupational functioning", e.g. loss of job, legal difficulties, family conflicts. Alcohol dependence is defined as alcohol abuse with accompanying symptoms of tolerance, i.e. more alcohol taken for the same effect, or withdrawal, i.e. unpleasant physical symptoms in the absence of the substance. More recent APA criteria, from DSM-III-R [2], focus mainly on the diagnosis of alcohol dependence, and consider alcohol abuse as a "residual category" appropriate only when the criteria for dependence have not been conclusively met despite evidence of maladaptive alcohol use.

Though the APA and WHO descriptions of alcoholism are not identical, they are certainly not irreconcilable. Both sets of criteria emphasize the adverse consequences of pathologic alcohol use, and though both descriptions imply continual, excessive ethanol use, neither considers any particular quantity or pattern of use as pathognomonic. This last consideration is important in breaking down some tenaciously held stereotypes. For example, even though many alcoholics practise daily or morning drinking, many others do not. Even more importantly, though many individuals associate the word "alcoholic" with either a skidrow or antisocial stereotype, the vast majority of individuals warranting the diagnosis are neither primary sociopaths nor street people.

The above-mentioned criteria, rather than confusing the issue, should, because of their inherent flexibility, actually encourage the diagnosis of alcohol use problems. Indeed, basic screening tools, such as the CAGE questionnaire and the Michigan Alcohol Screening Test (MAST), both of which detect alcohol abuse and dependence with excellent reliability, are drawn from both the APA and WHO criteria [3]. Also, alcoholism and alcohol abuse should be readily diagnosed because they are so common — estimates of prevalence in North America are in the range of 5 to 15 per cent [2,4]. Conservative estimates are usually associated with more stringent diagnostic criteria which screen only for dependence, while the higher prevalence values include diagnoses of alcohol abuse without associated dependence [2].

Alcoholism appears to be a common identifiable entity, but is it a "disease"? In other words, is alcohol addiction a primary clinical syndrome in its own right, with possible as-yet-undiscovered biological etiologies, or is it merely a wilful, troublesome, and obnoxious behavioural manifestation of some other psychopathology? This paper argues that the former is the more realistic, less restrictive point of view. Results of adoption and twins studies strongly favour the theory that at least some cases of alcoholism are inherited conditions rather than strictly environment-influenced learned behaviours [5]. A recent study has even offered provocative evidence that an allelic variant of the gene for the dopamine D2 receptor in the mesolimbic system of the brain may be a genetic marker in individuals at risk for certain types of alcoholism [6]. But even in the absence of conclusive biological proof, the observation that alcoholism, as a heterogeneous biopsychosocial entity with many differing presentations, seems to have a natural history in patients, a life of its own and tends to support the hypothesis that it is a genuine disease or constellation of diseases rather than a mere symptom.

In an effort to strengthen the disease concept of alcoholism initially put forth by Jellinek [7], Nace [8] has defined six constructs which seem to form a theoretical backbone: 1) psychological dependence on alcohol; 2) craving, the "subjective experience of desiring, needing, or longing for" ethyl alcohol; 3) loss of control, a phenomenon related closely to craving; 4) personality regression; 5) denial; and 6) conflicted behaviour. The first three constructs can be regarded as directly influencing an alcoholic's use of his or her substance; the last three are the consequences of that use; and all six are outside the experience of the 85 to 95 per cent of the adult population that seems to be able to consume ethanol with relative impunity.

All six of Nace's constructs must be appreciated clinically in order to effect any successful intervention with alcoholic individuals. However, the last two, denial and conflicted behaviour, seem to cause the most difficulty for the patient, the family, the physician, and society, and should be addressed in an especially diligent, non-judgmental, and professional manner. Denial, "the mechanism of defense that gives alcoholism a bad name" [8], has profound implications for the primary care physician in that it can thwart the accurate diagnosis of the disease. By putting this largely unconscious mechanism into effect, the alcoholic often minimizes his or her consumption ("I...continued on page 14
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only drink a few beers on weekends") or denies it altogether. The physician, having been trained to accept a patient's history at face value, does not pursue the question further despite other "red flags" (an enlarged liver, abnormal hematology or biochemistry, a history of alcohol-related arrests of family difficulties, among others [3]), and fails to diagnose a treatable disease. Clinicians who fail to appreciate the "unconscious" nature of denial also do their patients a grave disservice: a physician who is angered and frustrated by the alcoholic's detachment from reality will be infinitely less effective than one who understands that such detachment is a concrete manifestation of the disease of alcoholism itself.

The conflicted behaviour of the alcoholic is well known to most people. Impaired (but not always alcoholic) individuals are involved in about one-half of all road-traffic accidents and are responsible for a sizeable portion of violent crime and family violence, including physical, emotional and sexual abuse of women and children [9]. It is hardly surprising that certain individuals in society — health professionals such as Dr. Ghent among them, as well as some victims' rights, women's and children's advocacy groups — have difficulty seeing past their anger over such charged issues, emphasizing instead the more tragic and repugnant manifestations of conflicted alcoholic behaviour, and disregarding the common-sense notion that much suffering could be obliterated if the underlying disease - addiction to alcohol - were properly acknowledged and treated. The sad irony is that alcoholics, as victims in their own right of their crippling illness, behave as they do, not because they are stupid or evil or antisocial or morally or psychologically weak, but because they are alcoholics. This simple observation seems to be lost on society at this time, and many treatable individuals get lost through the cracks of the criminal justice and social welfare systems [9].

How do we treat our alcoholic patients, assuming that we have correctly identified them? Just as the illness is complicated, so is its treatment, and a full discussion is beyond the scope of this short paper. However, it can be emphasized here that abstinence should be the cornerstone of treatment, and the focus of our clinical energies. Controlled or "social" drinking is not an option for alcoholic patients who, by definition, have lost the ability to control their drinking [10]. This last point, which may seem somewhat pedantic, is unintentionally supported by a now infamous piece of behavioural research [11], wherein a cohort of twenty alcoholics who were taught behavioural techniques to control their drinking were reported on two-year follow-up to have a superior treatment outcome to a control group treated in a traditional program emphasizing abstinence. Several years later, other researchers independently traced these twenty patients, and found "that only one, who apparently had not experienced physical withdrawal symptoms, maintained a pattern of controlled drinking; eight continued to drink excessively — regularly or intermittently — despite repeated damaging consequences; six abandoned their efforts to engage in controlled drinking and became abstinent; four died from alcohol-related causes; and one, certified about a year after discharge from the research project as gravely disabled because of drinking, was missing" [12]. This last point is presented for two reasons: first, the Sobell study [11] is often irresponsibly referred to by those who wish support the inadequate notion that alcoholic drinking is merely a disordered behaviour that can be corrected, i.e. that alcoholics are "weak" or that they somehow consciously "choose" to drink pathologically; second, and most important, the 10-year follow-up of Pender, Maltzman and West [12] demonstrates vividly that inadequately treated alcoholism, like inadequately treated malignancy, shock, or renal failure, is associated with very high morbidity and mortality. Alcoholism kills people.

In order to encourage life-saving abstinence, the clinician should have more than a glancing acquaintance with Alcoholics Anonymous (AA). As a self-supporting network of recovered alcoholic individuals with a commitment to the attainment and maintenance of contented abstinence for themselves and other members, AA is the most effective treatment modality available to people with alcoholism [4], but few physicians seem to appreciate its role or its therapeutic value [13]. AA's 12-step program based on acceptance of reality, personal introspection, spiritual and emotional growth, restitution for harm done, and altruism has the uncanny ability to address most issues that seem to plague alcohol-addicted individuals, and in such a pragmatic fashion that the social, intellectual, and psychological implications of this movement command our attention and respect as well [14,15]. In a recent study [16], a cohort of 100 successfully recovering addicted physicians rated AA as more important to their individual recoveries than professionally-based modalities such as psychotherapy or family counselling. This finding is remarkable, since it is tempting to postulate that scientifically-minded health professionals would be more attracted to professional therapy than the homespun wisdom of Alcoholics Anonymous. This seems to provide even more validation of AA as therapy. Our alcoholic patients deserve the best treatment, and AA should be passionately advocated to them whether or not they initially resist participation.

The earliest printed literature of Alcoholics Anonymous, first published in 1939, extends the following entreaty to victims of alcoholism: "We beg of you to be fearless and thorough from the very start. Some of us tried to hold on to our old ideas, but the result was nil until we let go absolutely" [17]. AA challenges its prospective members to undergo a characterological metamorphosis wherein they are compelled to rethink their relationships — with alcohol, themselves, the world. As their physicians, we owe our alcoholic patients a like consideration: a willingness to cast off old misconceptions and prejudices, and to help, rather than thwart, their journey toward a sane purposeful abstinence.

However, some "old ideas" do persist. A recent survey of students at Johns Hopkins University School of Medicine [18] found that over one-third of clinical clerks (third and fourth-year students) felt that primary care physicians had little or no responsibility in screening for alcohol problems. To generalize these results have a frightening implication: a significant proportion of recent medical graduates, when faced with one of the most common potentially fatal diseases afflicting our society, are throwing up their hands and saying, in essence, "it's not my problem". With attitudes such as these still common, it is not surprising that Dr. Ghent is still more than occasionally confronted with the end-stage results of alcohol addiction diagnosed and treated too late — or not at all. This is shameful, considering that health professionals are supposedly best equipped to detect and treat common illnesses. Perhaps the coming decade is a time of enlightenment, wherein we will provide better service to a significant proportion of our patient population — and hopefully leave Dr. Ghent and his colleagues with fewer ethical dilemmas, and fewer customers.

References


2. American Psychiatric Association: Psychoactive substance use disorder

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