The history of medicine in Montreal and the history of McGill University are closely intertwined. In medicine, The Hotel Dieu Hospital had been established in 1644, but by the early 1800s, it could only accommodate thirty patients and was unable to accommodate all of the patients presented to it. In addition, there was no hospital for the English speaking population. In 1801, the parliament of Quebec established the “Royal Institution for the Advancement of Learning.” This was a voluntary Protestant institution dedicated to stimulating secondary and advanced education in the province. It was established in response to pressure from the English speaking community in Montreal, but it resulted in no concrete steps until 1811 when James McGill, a prominent fur trader, bequeathed his country estate (which is the current campus of McGill University) and ten thousand pounds for the endowment of the university which was to bear his name. In 1821, a charter was granted by the legislative council and McGill College was given university powers and a governing board was appointed.

Other events had been occurring in the community. In 1819, public spirited citizens had established The Montreal General Hospital which moved into a new building in 1822. In 1823, four Edinburgh trained physicians working at The Montreal General (please see History, pg.5)
Letters to The Editor

Dear Editor:

Letter from Dr. Terry G. Watts with a generous donation to McGill Surgery Alumni and Friends.

Terry is Chief of General and Thoracic Surgery in Trenton, Ontario and is on staff in Belleville as well. He sends his regards to all his McGill alumni friends.

C.A.G.S. Meeting

DR. HAIILE T. DEBAS GIVES THE LANGER LECTURE AT C.A.G.S. MEETING IN VANCOUVER

On September 27th, Dr. Haile Debas delivered the Langer Lecture in Vancouver. His title was The Future of Surgical Education: A Perspective. Dr. Debas graduated from McGill in 1963. He trained to be a general surgeon at the University of British Columbia and later moved to San Francisco where he is currently the Dean and Chancellor, University of California at San Francisco.

Some of his colleagues in the 1963 graduating class include Drs. John MacFarlane, Harry Shizgal, Peter Gillett, Simon Wren, Derek Marpole, Nick Steinmetz, Larry McNally.

Upcoming Events

Nov. 21, 1997
Advances in the Adjuvant Treatment of Breast Cancer Symposium Sponsored by the Departments of Oncology of McGill University and the University of Montreal Co-chaired by Dr. André Robidoux and Dr. Henry Shibata.

Feb. 26, 1998
1998 McGill General Surgery Day Guest Lecturer: Dr. Steward Hamilton Professor and Chair, Department of Surgery University of Alberta.

June 4-5, 1998
1998 Stikeman Visiting Professor Dr. Denton A. Cooley, Texas Heart Institute.

Cedars Breast Centre

Dr. Edward J. Tabah announced that the Breast Clinic at the MGH will be integrated with the Cedars Breast Centre at the RVH. The new Breast Centre will have increased space and have improved equipment such as three mammography machines, an ultrasound apparatus and a stereotactic biopsy machine presently at the MGH operated by Dr. David Fleischer.

Establishment of an Anatomy-Surgery Working Group at McGill

The philosophy of the new medical curriculum promotes inter-departmental cooperation, integration of knowledge and practical experiences, development of new techniques and continuing education. This is illustrated by a new teaching alliance initiated by the Department of Anatomy and Cell Biology with the Surgery departments of the McGill teaching hospitals through meetings with Dr. John Bergeron and Dr. E. Daniels with Dr. D.S. Muler (MGH), Dr. J. Meakins (RVH), and Dr. M.J. Black (JGH).

Initial discussions have focused around the following activities:

(i) active review of the anatomy teaching curriculum.
(ii) provision of learning and teaching experiences for McGill residents:
(iii) provision to anatomy teaching resources which include cadavers, prosections, an anatomy museum and computer facilities. As in the past, the Anatomy Department provides materials and facilities for the development of novel surgical procedures (Plastic Surgery, Endoscopic Surgery, etc.). In addition, special workshops in Plastic Surgery and Ophthalmology are conducted by McGill surgical teams. A new venture will include the development of computer teaching programs which will benefit all medical, dental and paramedical students.

It is planned that this collaboration will ensure an evolving clinically-relevant teaching program that is in the forefront of teaching innovations, and in developing training and technical innovations of relevance to all medical disciplines. We will keep you informed regarding further developments, but look forward to a greatly enhanced level of co-operation between the Department of Anatomy and Cell Biology and all members of the McGill Department of Surgery.

Eugene Daniels, Chair of the Anatomy Advisory Committee.
INFORMED CONSENT

When taking a history, have you noticed how often a patient is poorly informed about past operations? "The gynecologist told me that he removed everything." FACT: He did a total hysterec- tomy rather than a sub-total one. "They operated on my liver and removed some stones." FACT: Patient had a cholecystectomy and common bile duct exploration. "I was operated on my stomach and they removed a tumour." FACT: Patient had an abdominal operation and had a partial colectomy for a villous tumour. "I had an ulcer operation." What kind? "I don't know!" FACT: Patient had a hemi-gastrectomy, vagotomy and Billroth II anastomosis for duodenal ulcer. "One of my ovaries has been removed." Which side? "I don't know." Was the appendix removed at the same time? "I don't know."

It is always better to explain in some detail the steps of an upcoming operation particularly when it is an elective one. In the office, one can use anatomical diagrams to explain the diagnosis and the steps of an operation. For one thing, this may take away fear and change it to expectation. At the same time, whilst obtaining consent in the office, one can explain the pre-op work-up, the admission procedures and the course in hospital as well as the post-operative arrangements. It is even better if the patient is accompanied with a family member throughout all this.

In Emergencies, one can explain the headlines and these can be reinforced post-operatively.

As part of the "informed consent," they should also be prepared psychologically for the following:

a) What to bring to the hospital - personal belongings etc.
b) Not to eat nor to swallow anything the morning of the day of operation.
c) They will wake up in the Recovery Room. Though it looks like an Intensive Care Unit, it does not mean that anything has gone wrong. Also, there will not be an impression of the passage of time whilst under anesthesia.
d) Possible presence of tubes, drains and complicated bandages.
e) Pain control.

Another point to discuss is that the surgeon will be assisted by residents and students who will have roles of various importance during the operation.

Anything that will reassure the patient is indicated. Such carefully worded instructions go far in promoting the bond in the Surgeon-Patient relationship.

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Canadian Association of Thoracic Surgeons

During the meeting of the Royal College in Vancouver on Friday, September 26th, a meeting was held in which a new Specialty Society was formed. This was called The Canadian Association of Thoracic Surgeons and its first President is Dr. David S. Mulder. The Vice-President is Dr. André Duranceau of Hôtel Dieu Hospital and the Secretary is Dr. Richard Finley of Vancouver. There are about seventy-one potential members across Canada. •

EDM

C.F.B.S. Travelling Fellowship

C.F.B.S. stands for Canada, France, Belgium and Switzerland. These are travelling fellowships which are sponsored by the Canadian Orthopaedic Association and the French-Speaking European countries. Dr. Thierry Benaroch (MCH) and Dr. Robert Turcotte (MGH) have been selected as travelling fellows and their tour started October 12th and ends after the S.O.F.C.O.T. meeting in Paris, November 15th. •

EDM
Socio-political and economic developments, as well as advances in modern science and technology, have brought about enormous pressures for change in our health care system. This is felt even more acutely by the University health care faculty. Five years ago, a representative group from five partners in the McGill Faculty of Medicine met to consider a response to these changes. The result was a proposal to structure a McGill University Health Care Centre. The goal was to maximize the restricted financial budget and deliver the continued high level of clinical care as well as the traditional excellence in research and education of all health care professionals. The resultant planning has been careful and deliberate.

Long-term planning has been under the direction of Dr. Nick Steinmetz and the Clinical Integration Task Force is directed by Dr. Sarah Prichard. The complex process of legal merger was co-ordinated by Gérard Douville. These complex processes are now coming to fruition with approval of a legal merger, the appointment of an M.U.H.C. board with active committees. Reports have been submitted by the Patient Services Planning Panels, Teaching and Research committees - all of which have been referred to the grass roots for feedback. The Clinical Integration group will soon present a proposal for the interim phase until final recommendations are made related to the final form and location of the M.U.H.C. There is now a sense of action on many fronts and this was clearly felt by a Faculty wide retreat on Oct. 31st, 1997 attended by 350 members of the McGill Faculty of Medicine.

This degree of change has been difficult for all members of our faculty including students and residents. Most are now agreed that the status quo is no longer an option. We must all work together and participate in designing or re-engineering the best possible solution for the M.U.H.C. In our planning, we must go back to our basic mission as a University Department of Surgery. Our responsibility is to advance the art and science of surgery through clinical activities, the development of new surgical knowledge, and the education of students at all levels in Surgery. We have an enormous responsibility to perpetuate the surgeon and the surgical scientist. J.R. Saul has stated in Voltaire’s Bastards “So long as there is a clear belief in the purpose of an organization, those responsible will find a sensible way to run it. But if the heart of belief is only in structure, then the whole body will gradually lose its sense of direction and then its ability to function.” This is the challenge. Our solution will involve a functional plan centred on the McGill University umbrella. There will be an evolutionary solution to our physical plant design. Like the Dofasco principle (“Our product is steel but our strength is people”), the McGill Department of Surgery’s Faculty will rise to these challenges as in the past, and continue to be world leaders in this new health care environment.

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**RVH Anaesthetists - 1968**


*From L. to R.*: Drs. Andy Mungall, Gordon Fox, Germain Haule, Earl Wynaand, Derek Wrigley, Phil Bramage, Gladys Ellis, Hilary Don, Alan Noble, Doug Firth, Paul Oton, Anne Richardson, Ming Cheng, Arthur Sheridan.
established the "Montreal Medical Institution" which was in fact a proprietary medical school. McGill had wisely stipulated that the university which was to bear his name must be established and functioning within 10 years of his death or the property and money would revert to his wife's children. In 1821, The Montreal Medical Institution was incorporated into McGill College as the Faculty of Medicine, thus ensuring that the estate and endowment remained intact for educational purposes. It became the first Faculty of Medicine in the country.

For the next 20 years, the Medical Faculty had been described as "the most dynamic faculty at McGill College". The Edinburgh curriculum was instituted, thus ensuring a highly didactic approach to education, with two-six month courses of basic science lectures and two years of "walking the ward". Students were welcomed at The Montreal General Hospital, a somewhat unusual circumstance in that period.

Research was started early, with ether being given on an experimental basis in 1848 and used clinically at The Montreal General Hospital the next year. Research has been taking place at that institution every since. In 1855, Sir William Dawson was appointed Principal of McGill University. He personally transformed a small Victorian institution into a modern internationally recognized university. He began by raising resources, a tradition which persists to the present. The Faculty of Medicine acquired a new medical building, the Royal Victoria Hospital opened in 1894, and endowed chairs in Hygiene and Pathology were established. The size of the Medical Library also tripled and young McGill graduates began going to Europe for postgraduate training prior to their return to the faculty.

Medical education in the mid to late 1800's was different to that which we know today. Students paid tuition to their professors, instruction was largely didactic, there was little or no bedside teaching, and the scientific foundation of modern medicine was not present. It is doubtful that any of the North American medical faculties were truly outstanding, but as science expanded and as medicine grew closer to science, changes were afoot. As is well documented, these changes occurred simultaneously in the leading schools on the continent, including McGill. Although the intellectual stimulus for change came from Europe, the changes were actually effected by the vigorous and competent young physicians returning to North America from training abroad. At McGill, the outstanding individual was, of course, Sir William Osler, but Frances Shepherd, George Ross and Thomas Roddick joined him and remained when he moved to the University of Pennsylvania (and then Johns Hopkins and Oxford) in 1884. In line with trends elsewhere, and under Dawson's direction, the medical school became a functioning part of the academic world, with the university setting and maintaining standards. The old days of proprietary instruction were gone, as were the days of accepting unqualified students for training. Osler established the first physiology laboratory in Canada, wrote a student handbook in histology, was the first pathologist at McGill and the Montreal General Hospital and was truly the first "full-time faculty member". Roddick was the first to utilize asepsis in surgery and established the Medical Council of Canada later in his career.

While medicine was certainly competitive on the international scene, so were many other aspects of teaching and research at McGill. Rutherford had made major contributions to atomic theory, Leacock occupied an endowed chair in political economy, and Cox had used x-rays only four months after their description in 1895.

When Flexner visited McGill in 1905 and wrote his report in 1910, the faculty was housed in a new building (The Strathcona Medical Building) and had both The Montreal General Hospital and the then extremely modern Royal Victoria Hospital at its disposal. McGill was given a Class A rating.

World War I proved to be an interlude following which growth resumed. Sir Arthur Currie was Principal of McGill and he raised a large amount of new money for the university, including a grant from the Rockefeller Foundation. These resources were used to increase salaries and to build and staff a new biology building, a pathological institute, and the University Clinic for research in internal medicine, located at the Royal Victoria Hospital. In 1924, Jonathan Meakins, a Canadian, was recruited from Edinburgh to become the Physician-in-Chief at the Royal Victoria Hospital and the first full-time clinical professor at McGill. Meakins recruited outstanding young clinician-scientists and really laid the basis for McGill's emphasis on combining excellence in clinical medicine and research.

Edward Archibald became the Surgeon and Chief at the Royal Victoria Hospital and the Chair of the Department at McGill, and he also recruited an unusual group of surgeon-scientists. Penfield, Bethune, Webster, Rocke Robertson (later to be a Principal of McGill) and Arthur Vineberg, who pioneered revascularization, joined McGill at that time. The presence of Penfield attracted the Rockefeller grant which built and staffed the Royal Neurological Institute which opened in 1934.

The Depression slowed all activity, but teaching continued and post-graduate programs were in fact established in most major disciplines.
World War II once again interrupted activities and following the peace treaty, McGill found itself with facilities which were badly out of date. In 1955, The Montreal General Hospital moved from its quarters on Dorchester Street to a modern building on the side of the mountain. The Royal Victoria Hospital had major campaigns which replaced most of its clinical facilities and expanded research areas over a period of twenty years. The Montreal Children’s Hospital which had been acquired as a teaching facility by the university moved to relatively new facilities in its present location, and also greatly expanded the space and resources devoted to research.

The North American trend towards developing a large cadre of full-time faculty members had an impact on medicine at McGill. At The Montreal General Hospital, the Physician-in-Chief, Dr. Douglas Cameron, recruited an outstanding group of young investigators including Burgen, Freedman, Gold, Hollenberg, Aguayo, Martin, Skamene and others. At the Royal Victoria Hospital, Dr. Meakins retired and was eventually replaced by Drs. Christie and then Beck, who both insured continued excellence in research. They recruited outstanding researchers such as Bates, Macklem, Solomon, Gutman, Cooper, Posner, Patel, McKenzie and Goltzman. In both institutions, surgery also flourished under the direction of Drs. L.D. MacLean and Meakins at the Royal Victoria Hospital and Rocke Robertson, Gurd and Mulder at The Montreal General Hospital. In addition, as both institutions moved into modern times, outstanding clinical epidemiology units were added both to carry out independent research and to support clinical research in the major departments.

The Montreal Neurological Institute also grew and developed with several new physical additions designed to improve clinical facilities and the research base. Under the direction of Drs. Rasmussen, Feindl and Murphy, the traditions of housing patient care and research under the same roof were continued. An outstanding neuro-imaging group was developed and new laboratories in neurochemistry were constructed and staffed by Wolfe and others, and of course neurophysiology under Brenda Milner received world recognition. In neurosurgery, the neurosurgical approach to epilepsy continued to produce knowledge recognized throughout the world.

The basic sciences at McGill had always remained strong and this tradition has continued until the present. The splendid tradition of pathology which went back to Osler was developed later in this century by outstanding investigators such as Gardner McMillen and others. Biochemistry, pharmacology and physiology had a long tradition of contributions pioneered by MacIntosh, Nickerson, Graham and others which are continued in the present time by Drs. Krynevich, Cuello, Sonneberg, Gros and of course the tradition of morphological investigation which was so brilliantly begun by C.P. LeBlanc and his successors still continues.

The modern era has seen the emergence of hospital based research institutes as powerful forces, making them equal partners with the basic science departments. Support of the Fonds de la Recherche de santé du Québec has been important as has the continued competitiveness of all aspects of McGill’s science. New institutions have taken up research and the Lady Davis Research Institute of the Sir Mortimer B. Davis Jewish General Hospital over the past ten years has emerged as an equal partner with the two adult institutions. The Research Institute of the Douglas Hospital is recognized throughout the world for its contributions to neuroscience and psychiatric research, and the Shriners Hospital for Crippled Children contains one of the largest and most successful units in the world devoted to research on crippling diseases. In addition new university centres were created in order to promote inter-disciplinary research. The one in the genetics building on the traditions of Clark Fraser and utilizing the talents of Charles Scrivner and others has been widely recognized, but others in the field of cancer, nutrition, medical ethics and law, and non-linear dynamics, have all played a major role in science at McGill.

At the present time, along with all institutions in the world, McGill is worried about its financing. As is true in all human endeavors, how one copes with problems is more important than the problems themselves. If the faculty at McGill (and indeed in all institutions) use its considerable ingenuity, McGill will move into the future, perhaps with new structures or new organizations, but with a continued commitment to excellence.

REFERENCES:

First Women Graduates, Medical Faculty — McGill University, 1922

Anatomical dissection by McGill medical students in 1884 (Notman Archives, McCord Museum, Montreal).

An Operating Room in the Montreal Neurological Hospital.

The Professors in the Faculty of Medicine in 1882. We note standing in the background from left to right: Roddick, Ross, Osler and Shepherd. Seated in the center is Dawson, then Principal of McGill University. (Notman and Sandham, Photograph Archives, McCord Museum, Montreal).
McGILL ASTRONAUT DAVE WILLIAMS, M.D.,
MISSION SPECIALIST STS-90

As we approach the turn of the century, it is exciting to reflect
upon the changes that have taken place in the practice of
surgery. The development and clinical application of novel technolo-
gies has provided new approaches to clinical problems that vary from
virtual reality surgical simulators to telerobotic surgical procedures. Yet there are still many new challenges confronting the
specialty, one of which is the medical support for the human exploration of space.
As a medical student and resident I had no idea that my medical career would
lead me into the field of space medicine.

When I applied to the Faculty of Medicine at McGill in 1978, I was interviewed by Dr.
R.C. Long. Upon reviewing my curriculum vitae, he noticed that I had participated in
sky diving as a member of the McGill Sky Diving Club during my undergraduate
years. Somewhat chagrined, he admonished me to seek less risky pursuits. I
heartily promised to follow his advice and my acceptance into the next class followed
shortly thereafter. Unfortunately, I must confess that despite my
best intentions to live up to my promise, sky diving was one of
many activities that were part of the training program for Cana-
dian astronauts to which I was accepted in 1992. The Canadian
astronaut training program lasted one year providing sufficient
skills to allow an individual to be assigned to a shuttle flight as
a Payload Specialist, an astronaut/scientist with specific skills
related to the particular experiments on the mission. Two years
ago, I was assigned to train with NASA as a Mission Specialist
becoming a career astronaut trained to fly multiple missions
aboard the shuttle. In August of 1996, I was assigned to the
Neurolab mission (STS-90) a 16-day flight aboard the space
shuttle Columbia dedicated to understanding the alterations in
the structure and function of the nervous system that take place
in microgravity. The mission is scheduled to launch from the
Kennedy Space Center in April 1998.

Neurolab began when the U.S. Congress declared the 1990s
the Decade of the Brain. NASA proposed the mission to sup-
port this mandate. In 1991, NASA held a series of seven meet-
ings to identify critical questions in the areas of neuroscience
affected by gravity. With those areas identified, meetings were
initiated with the International Space Agencies, the National
Institutes of Health, the National Science Foundation and the
Department of Defense to establish criteria for selecting pro-
posals. The resulting announcement of opportunity drew 172
proposals from scientists around the world. After peer review
by the National Institutes of Health and NASA, twenty-six pro-
posals were selected to fly on the mission, including two from
Canadian scientists.

During the mission the crew will conduct the experiments in
the Spacelab module. This module was built by the European
Space Agency (ESA) to sit in the payload bay of the shuttle
and is connected to the mid deck by a long tunnel. Spacelab
provides a laboratory with living conditions similar to those
on earth, but with one key difference: microgravity. As the or-
bit moves around the planet at a speed of 28,100 kilometers
per hour (17,500 mph), it and its contents are in a state of
free fall which results in near weightlessness.

On the flight, the Neurolab crew will serve as both subjects
and operators to complete the experiments. The crew will
not be the only experimental subjects on board the shuttle,
Neurolab will also carry rats, mice, two types of fish,
snails and crickets.

The Neurolab experiments have been grouped into eight dif-
f erent teams each representing a different area of neuro-
science. Four teams (representing a total of 11 experiments)
will use the crew as subjects and four teams (with 15 ex-
periments) will study research animals. The teams studying
the human subjects are the Autonomic Nervous System, Sen-
sory Motor and Performance, Vestibular and Sleep teams.
The animal experimentation teams include Neuronal Plasticity,
Mammalian Development, Aquatic and Neurobiology. As-
sessment of the structural and functional adaptations of the
nervous system to microgravity will require the most com-
p lex microgravity dissections attempted in the history of the
space program. This mission will also involve the first animal
survival surgery in such a unique environment. While the
primary goal of these experiments is to understand the de-
velopment and maturation of the nervous system in the ab-
sence of gravitational stimuli, another significant
achievement will be in developing the necessary surgical
skills to perform the dissections in microgravity. The lessons
learned will be of tremendous importance to developing the
clinical capabilities of the Health Maintenance Facility
aboard the International Space Station.

There are many challenges that must be confronted in per-
forming surgical procedures in microgravity.
Instruments as well as the patient, will float away if unrestrained. Intravenous infusion must be accomplished with constant infusion pumps with in line filters to remove any air bubbles suspended in the colloid or crystalloid solution. Hemostasis is as critical in microgravity as it is in a terrestrial environment, yet the dispersion of blood in a wound is quite different being governed more by the effects of surface tension than any other factor. As one of the two crew medical officers for the mission, I will have the honor to become one of the small group of physicians to have practiced medicine in space. There will undoubtedly be future generations of space surgeons who will expand further the final frontier by supporting lunar return missions and human missions to Mars. For as Eric Hoffer said on the occasion of Apollo 11, "Our passionate preoccupation with the sky, the stars, and a God somewhere in outer space is a homing impulse. We are drawn back to where we came from." •

Quebec Association of General Surgeons

By Michel Chagnon, M.D.

The number of university-affiliated hospitals has been reduced and new criteria for hospital affiliation have been proposed. One such criteria states that the physicians must partake in a practice plan.

Over the last few years, practice plans have been the subject of debates in the university settings through numerous committees. The FMSQ has also studied the opinion of its members. New payment modalities were deemed necessary in order to permit teaching physicians to fulfill their educational, research, management and clinical duties. In non-university settings, the idea of new payment modalities was well received. Fee-for-service has become outmoded, in part because of new realities, such as decreasing operating room availability. This appears corroborated by the observation of our Association, not meeting its billing goal in 1994-1995. According to a poll of our members, the majority of general surgeons who responded were in favor of a change in payment modalities. Discussions on a provincial scale were then carried out, with the creation of a committee formed of members representing the different practice settings. In the wake of these productive exchanges and with the changes brought by major funding cuts, re-organizations and hospital closings, discussions of practice plans waned and the threat of major remuneration changes for university physicians remained vague. The Federation (FMSQ) was then informed by government representatives of an impending 6% cut in salary for all physicians. Bill 104 was to apply in July 1997. The FMSQ was mandated by the delegates to negotiate with the Ministry of Health (MSSS) in order to recuperate this 6% pay cut. Stemming from these negotiations was an agreement to modify the payment modalities of university based clinicians, so as to facilitate the installation of practice plans later. The fruit of these negotiations, which exempted us from Bill 104, relates and applies to the agreement framework between the MSSS and the FMSQ for the years 1996-1997 to 2000-2001. This agreement protocol was accepted at the assembly of delegates of the FMSQ in June 1997.

The new "mixed payment modality" is part of the agreement protocol and enactment was planned for January 1st, 1998 in University settings and for July 1st, 1998 in Non-University settings. More recently, it has become apparent that these implantation deadlines couldn't be met and further delays are deemed necessary.

The proposed mixed payment modality consists of a daily fee associated with a productivity incentive. The amount of the daily fee will be left to the discretion of each association and will vary from one association to another, provided it respects a $600.00 per day minimum chosen by the Federation. The monetary value for the productivity incentive will be a percentage of the "fee-for-service" payment currently in use. Because each association receives a fixed sum, the relative importance of the productivity incentive is a function of the value of the daily fee. In addition, new fees are proposed to remunerate on-call availability, university based clinical activities, and regional coverage. Activities outside of the 7:00 a.m. to 5:00 p.m. work-week day will remain fee-for-service. Activities in private clinics also remain fee-for-service when the daily fee is not billed on the same day. In fact, this represents a novel method of redistribution of the same monetary mass allocated to Quebec medical specialists, and further respecting each association's current spending goal (total active members X mean gross income). The FMSQ has promised to meet the different association's spending goals, which could allow the association to reach these goals. Under the current...
fee-for-service plan, this has not been attained, notably for the general surgeons in the 1994-1995 year. The FMSQ has no intention to correct the existing income disparities among the different associations.

The ACGQ was a step ahead when it proposed a mixed payment modality to its members. In January 1997, 53% of votes were in favor (a 2/3 majority had been deemed necessary to pursue this project). The many comments received will guide the ACGQ executive committee to make the mixed payment plan acceptable to its members. Because this new plan will initially apply to only a portion of our members, many factors will have to be taken into account so as not to establish inequities amongst the membership. An adequate income must be maintained for clinical services, with a plus value for different responsibilities, be it clinical teaching, availability for call in more remote settings or greater workload while on call in more densely populated regions, etc.

At the Assembly of Delegates meeting of the Associations of the FMSQ on Oct. 23rd, the President of the FMSQ announced that participation in any new mixed remuneration scheme will not be mandatory for any group of specialists (university, non-university, affiliated...). Participation will be optional and strictly related to how attractive the new scheme appears to be. Overall, any modification to the remuneration of anesthetists could have a major impact on general surgeons. — Michel Chagnon, M.D., Secretary - A.C.G.Q.

—The Scalpel

**CANADIAN MEDICAL ASSOCIATION POLICY ON PREVENTION OF TRANSMISSION HEPATITIS B FROM PHYSICIAN TO PATIENTS**

—Meeting held August 6, 1997 in Ottawa

**Hepatitis Prevention Policy**

By Jean Coughenour, M.D.

1. There must be a universal immunization against Hepatitis B. It must be made mandatory so that all physicians will eventually be vaccinated. This will immediately reduce concerns about the transmission of Hepatitis B from physicians to patients.

2. It is also recommended that all patients, and particularly those from endemic areas, be tested for Hepatitis B. In addition, all patients awaiting elective surgical procedures who have not been immunized against Hepatitis B should receive the vaccine as part of their standard preparation for surgery. The immunization schedule could be modified to achieve the highest probable immunity in the time frame available for surgery.

3. All physicians and medical students who work or will work in a situation in which patients may be exposed to their blood or other body fluids must be immunized against Hepatitis B. Exceptions are only to be made due to a valid medical contraindication or a notarized conscientious objection. Both immunization and serological testing must be performed on all vaccinated people according to published protocols in order to verify that the immune status of the vaccine has taken effect.

4. Vaccinated people who have not responded to the vaccine must be retested for the Hepatitis B surface antigen and if they are still found to be negative, they must be offered additional doses of a different and higher doses of vaccine in order to make every effort to achieve seroconversion.

5. All physicians who work in a situation in which they may expose patients to blood body fluids contact must provide their licensing authority with evidence of their vaccination and a valid serological status.

6. Conscientious objectors must provide in writing their objection to the vaccination and have notarization of this. Physicians who object to this will be treated as if they are Hepatitis B surface antigen positive and if they object to vaccination, they must then be tested for serological evidence of being negative, then they must report their status.

7. Those physicians whose serology are negative will be followed with occasional serological testing for potential conversion to Hepatitis B surface antigen status.

8. The medical regulatory authority in each province and territory should bring together expert committees to review each physician who works in a situation in which patients may be exposed to his or her blood and who is identified as Hepatitis B surface antigen positive, or who has refused to testing and therefore will be treated as though they are Hepatitis B surface antigen positive. These committees will be guided by the over-riding principle of public health protection. They would intrude very little into the physicians...
Practice as long as that physician is consistent with protecting the public. The committee will carry out the following functions:

- Provide counseling, advice, and direction to the physician regarding his or her situation including recommended treatments to lower Hepatitis B infectiousness.
- It will have the power through the regulatory authority to determine the range of practice and possible alternate scopes of practice of the subject physician who is infected with Hepatitis B.
- To provide ongoing evaluation, advice, and direction to the subject physician.
- To recommend to public health authorities whether or not the physician's patients should be contacted for Hepatitis B testing.

Composition of each committee should include experts in the field of virology and Hepatitis B. The committee is to meet within 7 days of being notified of the case and should also include the personal physician to the infected health care worker. Any members should not know the identity of the subject physician with the exception of his or her personal physician.

4. Physicians identified or treated as if they are Hepatitis B surface antigen positive, who work in a situation in which patients may be exposed to their blood or body fluids, should cease this portion of their practice immediately until their practice has been reviewed by the committee.

5. All needle and sharp instrument related injuries involving the potential exchange of body fluids between patient and physician should be reported to a designated committee where an institutional setting will record it in a log book. This committee is responsible for ensuring that currently recommended protocols are followed to limit the transmission of blood born diseases after injury. The same post-injury protocol should be used for patients and physicians.

6. Counseling and adequate support services including financing for such services should be made available so that all physicians undergoing testing and those who are found to be Hepatitis B surface antigen positive have access to the services. In addition, those whose practice is restricted may require additional counseling. Disability insurance offered to physicians by organizations should explicitly cover loss of income due to practice restrictions imposed in order to prevent the transmission of Hepatitis B to patients.

In summary, these recommendations are now before the Canadian Medical Association and will be directed to the governing bodies of the Canadian Medical Association and the Canadian Dental Association and will be used in the final report and implementation of policy by the Canadian Medical Association.

The presentation made by Dr. Holton made it quite clear that there is concrete evidence that a real risk to patients exists when practitioners are infected with Hepatitis B and there is a situation that risks contact of body fluids. It is also quite clear that a decade of voluntary immunization programs for physicians and dentists has not succeeded.

It is noted that in Dentistry, for example since 1986 with the introduction of universal precautions, no cases of transmission of Hepatitis B to patients has been reported. Universal precautions may not be entirely applicable to the situation of surgeons that have a different risk factor in the operating room to transmit body fluids through open wounds. However, given the time frame of the advisory group, it was nonetheless recognized that in the best interests of the patient it is extremely important for our respective associations to be proactive in order to prevent and minimize any risk of transmitting Hepatitis B to patients.

The advisory committee felt that our recommendations should be strongly supportive of a preventative approach consistent with the emphasis placed on disease prevention by our respective professions. Finally, the recommendations which the advisory group presents have been put together in the light of these and other considerations. They are presented with the assumption that they must be introduced in a fashion that infected practitioners can be assured counseling and will be considered eligible for disability support.

Resignations ~

Dr. William Fish October 31, 1997 to G.F. Strong Rehabilitation Centre, Vancouver Hospital and Health Sciences Centre.

Dr. Andrew Hill October 1, 1997 to Vascular Surgery, University of Ottawa/Ottawa General Hospital.
Dr. David Mulder, Chairman of the Department of Surgery, was recently invited to give an informal lecture on trauma care in Quebec at the University Club of Montreal. He presented a comprehensive review of the subject, starting with a review of the history of trauma care at The Montreal General Hospital, which is one of the main centers in Quebec. The Trauma Service was initiated by Dr. H. Rocke Robertson, who later became Principal of McGill University. Trauma centers are classified according to the American College of Surgeons criteria based on availability of services and graded from Level 1 to Level V. In addition to the MGH, Sacre Coeur Hospital, Hôpital Enfant Jesus in Quebec City, and the University of Sherbrooke are classified as Level 1 centers. In the far north, only Level V is available with nurses staffing the center. With support from the Régie, Dr. Churchill-Smith, Head of the Emergency Department at the MGH, is currently trying to organize a helicopter transport for patients in outlying areas.

The Montreal General Hospital was accredited as a Level 1 Trauma Service at McGill University, which includes a specialized nursing service in addition to General Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Cardiothoracic Surgery, and Urology services needed for comprehensive trauma care. According to a recent review by John Sampalis, based on the Quebec Trauma Registry, there has been significant reduction in mortality and morbidity associated with the Province of Quebec re-organization of trauma care.

What convinced the Quebec Health Ministry of the importance of trauma care were the statistics showing that trauma injury claimed twice the number of lives than cancer. According to a recent article in the British Journal "Lancet", the death rates from cancer and heart disease are falling and the number of deaths due to trauma are up. Dr. Mulder emphasized Dr. Robertson's motto "To get the patient to the trauma center as soon as possible" as the principle ingredient of trauma care. This is the "golden hour" which profoundly affects the death rate, particularly in cases of motor vehicle accidents comprising at least 50% of the trauma cases. The second highest cause at the M.G.H. in the past year are penetrating wounds.

New techniques, such as spiral CT scanning permit rapid diagnosis of the type of injury sustained. For example, he quoted a case of a woman who was hit by a car who was diagnosed with an epidural hematoma and a ruptured spleen within minutes after arrival. This would have taken several hours not too long ago.

In answering questions from the floor, Dr. Mulder outlined other aspects of trauma care: continuous research on metabolism, surgical sepsis, nutrition, as well as methodology of treatment and preventive measure, such as the correct type of hockey helmets for youngsters and visors which practically eliminated eye injuries. He concluded that in relation to doctors being present in the Urgence Santé ambulances that the evidence now supported the "scoop and run" principle rather than a prolonged resuscitation in the field. Regionalization has had a beneficial effect on the delivery and the teaching of trauma care in Quebec. ♦

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**Were You There? May 30, 1968**

**PERFORMED KIDNEY TRANSPLANTS**

Team of doctors who performed two kidney transplant operations at Royal Victoria Hospital yesterday. Standing from left: Dr. John Dossetor, Dr. F.G. Inglis, Dr. E.D. Monaghan. Seated: Dr. Lloyd D. MacLean, Dr. Kenneth J. MacKinnon, Dr. John Oliver, Dr. Douglas D. Morehouse, Dr. Yoshinari Taguchi.
On October 7, 1997, Dr. Najma Ahmed, a chief resident in General Surgery, was presented with an Award of Merit by the RCMP for performing CPR on a man who had a cardiac arrest in the Ottawa airport in August 1996.

Dr. Paul Belliveau was elected President of the Canadian section of the International College of Surgeons at the meeting of the North American Federation of the International College of Surgeons held in Vancouver. He has also been selected as a Teaching Scholar in the Faculty of Medicine for this year and will be taking courses in the Faculty of Education as part of this program.

Dr. Sarah Bouchard was honored by receiving the Merck/Frosst Award from Dr. Sarah Bouchard representing McGill.

Dr. Peter Chan received the first prize of research presentation at the 92nd American Urological Association Annual Meeting in New Orleans, Louisiana in April 1997, for his recent work entitled Preservation of Penile Erectile Function Post-Prostatectomy Using a Micro-Surgical Procedure with Sparing of the Anterolateral Branches of the Cavernous Nerves. In addition, Peter also received the Zeneca Research Award presented by the Canadian Urologic Oncology Group and the Canadian Urological Association Annual Meeting in Quebec City in June 1997. The co-author of these works 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.

Dr. Nick Christou has been appointed Chairman of the C.A.G.S. Committee on Critical Care, Trauma, Infectious Disease and Surgical Nutrition. He replaces Dr. Stewart Hamilton of the University of Alberta.

Dr. Richard L. Cruess delivered the Galile Lecture during the Royal College meeting in Vancouver entitled Professionalism in the Next Millennium: Osler or Shaw.

Dr. Carl Emond of St. Mary's Hospital served as an Examiner in Vascular Surgery for the Royal College in September.

Dr. Roberto Estrada along with Dr. R.E. Mindelzun from the Department of Radiology at Stanford University have published a paper entitled The retropancreatic colon: A congenital anomaly in Abdominal Imaging Journal.

Dr. Pierre Guy has been accepted in the McGill Teaching Scholar Program.

Dr. Lloyd D. MacLean wrote the lead article in the July issue of the Journal of the American College of Surgeons entitled Stomal Ulcer After Gastric Bypass. The co-authors are Barbara M. Rhode, PhD, Msc(Nutr); Carl Nohr, MD, FACS; Saul Katz, MD and A. Peter H. McLean, MD, FACS.

Dr. Jonathan L. Meakins gave the Semmelweis Lecture to the Surgical Infection Society in Istanbul at the end of May. He has also been appointed as a trustee of the Montreal Museum of Fine Arts. Jonathan was also the moderator at a panel discussion sponsored by the Committee on Emerging Surgical Technology at the meeting of the ACS in Chicago, October 12th to 17th.

Dr. Sarkis Meterissian was presented with a Fellowship Award of $40,000 from the Cedars Cancer Institute at its annual meeting held May 26th, 1997. This is to enable him to continue his research projects which look at the role of E-selectins in liver metastases and to look at the role of apoptosis in colorectal cancer progression. Dr. Meterissian is a three time recipient of this Cedars Fellowship.


Dr. E.D. Monaghan presided over the meeting of the C.A.G.S. Association for General Surgeons in Vancouver, September 24th to 28th. The title of his Presidential Address was General Surgery in the Year 2000: Looking to the Future.

Dr. David S. Mulder was awarded the Order of Canada.

Dr. Dao Nguyen of the Division of Cardiothoracic Surgery is the recipient of two internal awards of the MGH Research Institute: The Hartland de M. Molson Award and the Herbert S. Lang Award. These awards provide the opportunity for career development in Thoracic Surgical Oncology. He also has a paper accepted entitled p53 Gene Replacement Therapy for Lung Cancer which will be published in the Journal of Cardiovascular Surgery.

Dr. Caroline and Dr. Daniel Obrand announce the birth of their daughter, Alexandrine on September 3rd. Daniel presented a paper at the International College of Surgeons in Vancouver on July 26th entitled Endovascular Repair of Abdominal Aortic Aneurysms.

Dr. Steven Paraskevas is the 1997 CDA Scientific Award recipient which was announced at the Canadian Diabetes Association Professional Conference and Annual Meeting in London, Ontario on Oct. 22nd. Steve was presented with the award based on his abstract entitled Modulation of INK and p38 MAP Kinase Activity by Insulin in Human.
Porcine and Canine Islets. This award which encourages excellence in diabetes related research is awarded by the Clinical and Scientific Section of the CDA to an exceptional research trainee who has demonstrated scientific productivity and innovation. Dr. Paraskeves presented his award winning paper as part of the Symposium on “Molecular Mechanisms of Insulin Action”.

Dr. Mark Preul has taken a position as a Senior Staff Neurosurgeon with the Department of Neurosurgery at the Henry Ford Hospital in Detroit, Michigan. He is part of the neuro-oncology team and the advanced brain imaging research group at Henry Ford. He also serves as Chief of Neurosurgery at St. Joseph’s Mercy Hospital in Macomb, Michigan. Dr. Preul was an invited speaker at the 1997 International Society of Magnetic Resonance in Medicine in Vancouver on brain tumor spectroscopy, and has been invited to address the 1997 Congress of Neurological Surgeons in New Orleans on advances in high field MR imaging of the brain.

Dr. René St-Arnaud, of the Genetics Unit of the Shriners Hospital, has been awarded the 1997 Fuller-Albright Award of the American Society for Bone and Mineral Research for distinguished achievement in the field of bone and mineral research for his work on vitamin D and on the transcriptional control of gene expression in bone cells. Dr. St-Arnaud also won a “Scientist Award” from Chugai Pharmaceuticals for his vitamin D research. He is scheduled to travel to Japan in mid-November to receive the prize.

Dr. James D. Sullivan is the Editor of the St. Mary’s Hospital Medical Bulletin for 1997. This manuscript published in July is a 62 page document which very professionally recounts some of the many activities and interests of the staff at St. Mary’s Hospital.

For the information of our readers, here is the Table of Contents:

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To complete my year of "academic enrichment," I decided to spend six weeks in the spring doing an elective in Surgery at the Aga Khan University (AKU) Hospital in Karachi. Being a renowned institution in my home country that has historically had a link with McGill University since it was founded in 1986, it was a natural choice for me to go there.

Talat Chughtai Goes to Pakistan

By Talat S. Chughtai, M.D.

I spent my first two weeks on the Cardiothoracic Service under Dr. Sulaiman Hasan. This service was a mix of pediatric and adult patients with a variety of interesting cases. The thoracic cases I saw included: hydatid disease of the chest; cases of pulmonary tuberculosis causing bronchopleural fistula, pericarditis, and lung abscess; and pulmonary anthracosis and sarcoidosis. The cardiac cases included many cases of advanced rheumatic heart disease, coronary artery disease in very young patients, and a variety of congenital heart disease. I assisted in all cases in the operating theatre and was an active member of the team in the clinic and wards. I was also assigned "night duty" to manage the post-op hearts on operating days. This fortnight was a busy, but clinically rewarding experience.

My next four weeks were spent on the General Surgery Service (GS-1) led by Professor Mushtaq Ahmed and the General Surgery Program Director Dr. Asad Jamil Raja. This was a very academically enriching experience with clinics devoted to teaching residents physical examination skills, bedside teaching rounds, and weekly service, radiology and pathology rounds. I was expected to present at many of these sessions. The emphasis of management was on an approach based upon the most recent Eastern and Western literature. I came across many interesting cases over the course of the month including cystosarcoma phyllodes, toxic goiters, hydatid disease of the liver, massive hemias, giant carbuncles, amoebic liver abscess, advanced breast cancers, and a variety of retroperitoneal tumors.

My stay coincided with several extracurricular activities as well. This included a two day surgical anastomosis workshop with all residents receiving a certificate. I even wrote the yearly in-service training examination, consisting of a four hour written and four hour gruelling oral exam designed to simulate the British FRCS exams. These were also great learning experiences.

Overall, the AKU Hospital is a world class institution, in a third world country, which is a referral center and thus sees a variety of interesting and challenging cases. They have a very academic approach with every activity centering around the residents. Because I was able to speak the local language, I was able to fully benefit from the experience. I made some great friendships and took away a great deal more than I had expected, thanks to the kind and knowledgeable staff of AKU.
Ten Years of Neonatal and Infant Corrective Cardiac Surgery at the Montreal Children's Hospital

It is hard to believe that open heart surgery was not possible until the 1950s. Remarkable developments and discoveries in the last 45 years now allow surgeons to be able to help children born with almost any heart defect or a combination of heart defects. In the early days of cardiac surgery, only simple lesions could be repaired, the more complex defects were simply palliated. Over the next 30 years, many new operations were devised. With increasing knowledge, experience and improving technology, it became possible to gradually extend the complexity of the conditions and lower the age of the children undergoing these operations. However, palliative operations continued to play a major role in early life and until the 1980’s, corrective operations in newborn babies or infants were almost unthinkable, carrying a prohibitive mortality. This all changed thanks to the pioneering efforts of a few surgeons, particularly Dr. Aldo R. Castaneda at The Boston Children's Hospital, leading a team largely responsible for the development of neonatal and infant cardiac surgery.

By Christo Tchervenkov, M.D.

This major shift towards corrective surgery in babies was also in the making at The Montreal Children's Hospital. Following his training in Cardiovascular and Thoracic Surgery at McGill University under Dr. Anthony R.C. Dobell, Dr. Christo I. Tchervenkov was appointed Chief Resident in Pediatric Cardiac Surgery under Dr. Castaneda. Dr. Tchervenkov thus had the unique opportunity to witness the early development of neonatal and infant cardiac surgery. Upon his return to The Montreal Children's Hospital in 1987, a special partnership was developed with Dr. Dobell that was to have important significance to the patients. The synergy of Dr. Dobell’s extensive experience in cardiac surgery and Dr. Tchervenkov’s newly acquired surgical techniques resulted in the successful establishment of a program of neonatal and infant corrective cardiac surgery at a time when very few such programs existed in the world. In 1988, this team performed Canada’s first heart transplant in a baby. In 1990, Dr. Tchervenkov was appointed Director of Cardiovascular Surgery at The Montreal Children's Hospital. Under his leadership, the process of developing operative procedures for many more complex malformations has continued, and has reached the point where virtually any malformation or combination of malformations can now be repaired. The majority of these complex malformations can now be repaired in the neonatal period or in infancy with one operation, thus avoiding the multiple palliative operations that used to be performed. This surgical approach has therefore saved parents many anxious years of waiting for their child’s heart to be repaired.

This remarkable success has largely been due to a strong, dedicated team effort which includes doctors, nurses, technicians, perfusionists and other hospital personnel. While the results of this team work have mainly benefitted Quebec born children, Canada-wide recognition has resulted in patients being referred from other centers across the country.

To commemorate the 10 years of the neonatal and infant corrective cardiac surgery program, a committee of grateful parents organized a picnic called "The Heart of Life" on September 13th, 1997 in Parc Maisonneuve. There were close to 1500 people in attendance, including many of the babies operated over the last 10 years and their families. To see all these children many years later healthy, full of life, smiling, dancing and playing, was the most wonderful gift our team members could have received. The outpouring of happiness, emotions and gratefulness left all those in attendance deeply touched. The Volunteer Parents Committee established "The Heart of Life" Fund and a cheque for $40,000, was presented to Dr. Christo Tchervenkov, Director of Cardiovascular Surgery and Dr. Marie Béland, Director of Cardiology at The Montreal Children's Hospital.
Dr. Tchervenkov with Jayson Burns - age 10 who was the first newborn to undergo the arterial switch operation for transposition of the great arteries at 6 days of age in March 1987.

Jayson Burns and Annie Rivard presenting cheque launching The Heart of Life Fund to Drs. Tchervenkov and Beland.

Dr. Christo Tchervenkov and Dr. Marie Beland with many of the children who have undergone cardiac repairs as newborns and infants at the MCH.

Some of the 1500 children, parents and relatives who attended the "Heart of Life" picnic at Maisonneuve Park.

Drs. Beland and Tchervenkov with the Volunteer Committee of parents who organized the event.
M

UHC PARTNERS REACH LEGAL AGREEMENT TO UNIFY BOARDS AND INTEGRATE INSTITUTIONS

At its first meeting, the unified board of the MUHC elected H. Arnold Steinberg as its first Chairman. The board is to examine how best to integrate The Montreal General, Royal Victoria and Montreal Children's Hospitals as well as the Montreal Neurological Hospital. Also elected were Dr. Abraham Fuks, Vice-Chairman; Charles McDougall, Secretary; and Barry Cappel, Assistant Secretary. An Executive Committee was formed consisting of Senator David Angus, Claude Forget, Tass Grivakes and Eric Maldoff as well as Steinberg, Fuks and McDougall. The other MUHC board members include:

Graham E. Bagnall is past Chair of the Montreal Children's Hospital Foundation and is Vice-President and Controller of Telereal which was formed in 1994 to manage BCE's residual real estate interests.

William A Brodie is Manager of Medical Imaging at the Montreal Neurological Hospital, and has served as President of the Canadian Association of Medical Radiation Technologists.

Harvey J. Guyda is Physician-in-Chief at the Montreal Children's Hospital, and Director of the Clinical Endocrinology Laboratory there. He is also Dodds Professor and Chair of the Department of Pediatrics at McGill University.

Maurice F.L. Jaques was President and owner of Eastern Marine Underwriters until 1995, and has been President of The Montreal General Hospital Corporation since 1995.

Robert R. Laverdure, senior Vice-President, Quebec Division, of the Toronto-Dominion Bank. He was a member of The Montreal General Hospital's Centre Board, and Chair of its budget control committee.

Ann Patricia Lynch. Prior to becoming Director of Nursing in Medicine at the Royal Victoria Hospital, Ann was a nurse consultant. She is currently a McGill University Faculty Lecturer at the School of Nursing.

James Gerard Martin is Director of the Meakins-Christie Laboratories (McGill University), and is also a senior physician at the Royal Victoria Hospital.

Timothy W. Meagher is Physician-in-Chief at The Montreal General Hospital and the Director of the University Medical Clinic of the Department of Medicine. He is a member of the Board of The Montreal General Hospital Research Institute, and a senior physician at the Royal Victoria Hospital.

Jonathan L. Meakins is Chief of Surgery at the Royal Victoria Hospital since 1988. He has held the Edward W. Archibald Chair of Surgery at McGill since 1993.

Richard Murphy is a former Harvard Professor, and Chair of the Department of Anatomy and Cell Biology at the University of Alberta. He has been Director of the Montreal Neurological Institute since 1992.

Gwendolyn A. Nacos is President of the Patients' Committee of the Royal Victoria Hospital since 1996. She is founder and director of Cedars CanSupport/Faire Face, and immediate past President of the Cedars Cancer Institute. She was a member of the Board of the Royal Victoria Hospital since 1992. She is also President of Natural Furs International Inc., manufacturers and wholesalers.

Ronald Riley is Vice-President of L.B.G. Capital, a division of Lévesque Beauchien Geoffrion Inc., and is Chair of the Board of Directors of the Montreal Children's Hospital Foundation.

Bernard Shapiro is Principal and Vice-Chancellor of McGill University. A Deputy Minister of Education in Ontario from 1986 to 1989, he has been a Professor of Education and Public Policy at the University of Toronto. He was also President of the Canadian Society for the Study of Education.

Nancy K. Wright, formerly a member of the board of the Montreal Neurological Hospital, is co-chair of the Clinical Ethics Committee as well as President of Les Amis du Neuro, a volunteer organization for the hospital. ♦
McGILL DEPARTMENT OF SURGERY


Our McGill surgeons participated actively in the program as follows:

Royal College Meeting

Both Specific (Delayed Type Hyper-Sensitivity [DTH]) and Non-Specific (Phytohemagglutinin [PHA] Flare) Skin Test Responses are Associated with Clinical Outcome. A.J. Seely, D.E. Swartz, L. Chartrand, N.V. Christou, RVH.

Dr. Roger Tabah co-chaired a symposium entitled Unexpected Findings at Surgery.

Dr. Phil Gordon gave a paper entitled Guidelines for Local Excision of Rectal Cancer.

The Role of Axillary Lymph Node Dissection in Women 70 Years and Older. M.K. Al-Sowaidi, S.H. Meterissian, RVH.

Dr. Jonathan L. Meakins chaired the meeting of the Surgical Biology Club.

CANADIAN SOCIETY FOR VASCULAR SURGERY


SURGICAL ALUMNI

Dr. John MacFarlane of Vancouver co-ordinated a symposium entitled Prevention and Management of Intraoperative Misadventures. John also presented a paper at the Colorectal Symposium entitled Complete Mesorectal Excision: The Gold Standard. It is noteworthy that John and Marian MacFarlane co-chaired the Local Arrangements Committee for the Royal College meeting. Everyone agreed that they did a remarkable job.

Dr. Joe Mamazza presented his talk on Early Recognition and Management of Impending Disasters during Laparoscopic Surgery: a) CO2 embolus; b) Severe hemorrhage; c) Tension pneumothorax. Joe also co-authored two other papers: Laparoscopic Splenectomy for Hematologic Malignancies and Laparoscopic Colon Surgery for Diverticulitis. Joe also was the moderator of a panel on Endoscopy.

Dr. John Marshall gave a presentation on Management of the Septic Patient - New Modalities. John also was the moderator of a C.A.G.S. paper session entitled Frontiers in Surgery.

Dr. Simon Wren of Queen's gave a paper entitled Surgical Management of GI Perforation.

Dr. John Marshall of UWO presented his paper on Surgical Management of Post-Operative Peritonitis.

Dr. Yves Leduc, a graduate of the McGill Surgical Oncology Program, was the moderator of a symposium on Management of Lymph Nodes in Malignant Diseases.

Dr. Michel Gagner was a co-author of two papers. The first was entitled Laparoscopic Adrenalectomies and the second one was entitled Left Hepaticojejunostomy for Biliary Obstruction: Ongoing Experience.

Were You There?
RVH Open House 1975

Mrs. Nancy Davis, R.N.; R.C. Long; A.R.C. Dobell; and Nelson Mitchell
VISIT OF CHINESE DELEGATION FOR POSTGRADUATE MEDICAL EDUCATION

It is well known that in the past several decades, China which used to be known as "Sick Man of the East," achieved major advance in the health and longevity of her people by improving public health and providing elementary primary care, delivered by health workers known as "Barefoot Doctors." With recent progress in her economy, she is looking forward to further upgrading medical and post-medical education. A distinguished delegation, the members of which will guide the modernization of residency training in that country, came to study the North American residency training experience. They hope it will be helpful in designing their own system, which can contribute to the health of one quarter of the world population who reside in that vast country.

Following a day visiting the Royal College of Physicians and Surgeons of Canada in Ottawa, where they received a cordial welcome and an informative briefing, they came to visit McGill University on July 9th and 10th before going to the United States. At McGill, they were received by Dr. Abraham Fuks, Dean of the Faculty of Medicine, met and discussed with McGill directors and officials in charge of residency programs in Family Practice as well as in other Specialties. Their visit included an informal meeting with surgical residents and research fellows in the University Surgical Clinic of the Montreal General Hospital, and touring the Royal Victoria Hospital where Dr. Norman Bethune developed his professional reputation before going to China and became a hero there. They also enjoyed meeting and chatting with the senior Dr. Meakins about oriental medical art, and visiting the Osler Library in the McIntyre Building where they saw memorabilia related to Dr. Bethune, as well as the Chinese translation of Osler's Textbook of Internal Medicine.

In the picture taken on the Royal Victoria Hospital grounds, from right to left are: Professor Xueguang Zhu, Dean of the Beijing Medical University and Chairman of the Department of Surgery; Dr. Ed Monaghan, the gracious host; Professor Yixiang Li, Director of the Office of Medical Academic Degrees, Ministry of Health, People's Republic of China; Dr. Victor Chu, Cardiac Surgery resident at McGill; Professor HaiLin Liu, Director General, Department of Medical Sciences, Technology and Education, Ministry of Health P.R.C.; Professor Zeng Cheng, Deputy Director of the Institute of Research in Medical Education, West China University of Medical Sciences in Sichuan (panda country); Professor Wang Shen Sheng, Vice President of Hua Shan Clinical Medical School in Shanghai; and Dr. Ray Chiu.
The Vivian Saykaly Professor in Oncology

Dr. Mark Estes Lippman as the Vivian Saykaly Visiting Professor in Oncology. Dr. Lippman is the Director of the Vincent T. Lombardi Cancer Research Center and he is Professor of Medicine and Pharmacology at Georgetown University Medical School. A graduate of Yale in 1964, he has many national awards. A public information forum was held at Le Westin Mont-Royal Hotel on the evening of October 14th. The title of this session was Will we ever cure Breast Cancer?

THE OTHER LECTURES WERE AS FOLLOWS:

JGH: Understanding Prevention of Breast Cancer
Hotel Dieu: DCIS - Are There Any Questions Worth Answering?
RVH: Biological Approaches to Breast Cancer Therapy
MGH: Antiangiogenic Approaches to Breast Cancer
McGill: Advances in Oncology
McGill: New Molecular Approaches to Breast Cancer Treatment

10th Annual L.D. MacLean Visiting Professor

Dr. Jonathan B. Towne was the 10th Annual L.D. MacLean Visiting Professor of Surgery on Nov. 13th. Professor of Surgery at the Medical College of Wisconsin, Dr. Towne is a leader in Vascular Surgery and Surgical Education. At the MGH, his topic was Long-Term Results of Carotid Endarterectomy. He gave Surgical Grand Rounds at the RVH entitled Biology of the Autogenous Vein Graft in Lower Extremity Bypass Surgery. A reception was held that evening at the Mount Stephen Club.

The Frank M. Guttman Visiting Professor

On June 19th and 20th, Dr. N. Scott Adzick visited McGill as the first Frank M. Guttman Visiting Professor. Dr. Adzick is Surgeon-in-Chief at The Children's Hospital of Philadelphia and is the C. Everett Koop Professor of Pediatric Surgery and Professor of Pediatrics and Obstetrics and Gynecology, University of Pennsylvania School of Medicine. The titles of his talks were: Fetal Surgery and Wound Healing and What’s New in Fetal Therapy.

Dr. Frank Guttman graduated from McGill (B.Sc. Hon. Physiol.) in 1952 and from the University of Geneva in 1957. He trained in General Surgery for one year in Geneva and completed his residency at the Jewish General Hospital in Montreal. He then trained in Pediatric Surgery at Ste-Justine Hospital. He was Pediatric Surgeon in Charge at the Jewish General Hospital from 1965-1974, before coming on staff at the Montreal Children's Hospi-
University Surgical Clinic - 1996-1997
Research Directors and Fellows

Top Row (L to R)  Steven Paraskevas, Rennian Wang, Ulla Holthausen, Lawrence Rosenberg, Ray C.-J. Chiu, David Mulder, Denis Babyn, Jean-François Morin, Joong Hwan Oh, Anie Philip.
Front Row (L to R)  Jin-Qiong Kuang, Audrius Zibaitis, Carlos Li, Adam Hacking, Julia Dorfman, Marc Pelletier, Kai Kai Toh.
Absent  Hani Shennib, Kent McKenzie, Betty Tam, Matthew Shaw, Allan Lee, Dao Nguyen, Antoaneta Uljeva, Songyang Yuan, Christo Tchervenkov.
The McGill Department of Surgery invites you to tie one on for the old school!

The McGill blue silk tie and scarf with CREST, SQUARE KNOT and FLEAM are available for purchase from the Alumni Office as follows:

McGill Dept. of Surgery Alumni, Montreal General Hospital
1650 Cedar Avenue, Room C9 126, Montreal (Quebec) H3G 1A4
Telephone: (514) 937-6011, ext. 2028
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