The Health Care Crisis

By Lloyd Maclean, M.D.

There was overwhelming public support and our health care delivery system became a definition of Canadianism, a unifying force, a national obsession. Even doctors who had opposed the plan at the beginning became stalwart supporters. By 1996, the benefits were reflected in a life expectancy at birth of 81.5 years for females and 75.4 years for males. Even though life expectancy is dependent on many other factors than the health care system, we took pride in being in the top 10-15% of 29 OECD countries.

In 1984, the Canada Health Act consolidated the original five features and threatened reduced federal transfers to provinces which allowed hospitals to levy user fees or permitted doctors to charge patients more than the negotiated tariffs.

In order to balance budgets and to decrease deficit financing, federal support for health expenditures by

(please see Health Crisis, pg. 5)
Dear Editor,
The last issue of The Square Knot contained a mix up concerning Drs. Scrimger and Keenan. Dr. Keenan was awarded the Distinguished Service Order (DSO), a decoration given for distinguished service of any kind by senior officers (Col. & up); but for junior officers it was given for bravery in the face of the enemy. Dr. Scrimger was given the Victoria Cross (VC) for conspicuous bravery in the 2nd battle of Ypres in April '15. He was with the 2nd Field Ambulance (RCAMC) and had his Advanced Dressing Station in a small town called Wietjé. The first gas attack was launched on April 22 and the battle raged for three days during which time he was posted to the 14th Btn (RMR). In all, he treated over 400 casualties under constant shell and machine gun fire. He evacuated many of the wounded himself assisting the stretcher bearers and carried an officer on his back, in and out of shell holes and over a moat. In three days, he had only four hours sleep. The situation was terribly difficult for the 1st Cdn Division as the French Algerian Turcos on their left had broken in the panic of the gas attack, so the Canadians had to fill the hole in the line.

The VC is the highest decoration for bravery in the British Empire, the cross itself is made from the guns of Nelson's H.M.S. Victory. You may not know that Mrs. Faith Feindel is Dr. Scrimger's niece.

P.S.: I should add that at that time Capt. Scrimmer was a small man 5'7" in height, weighing 135 pounds.

H.J. Scott, M.D.
Montreal, Quebec

Dear Editor,

I recently attended the 40th reunion of the Medical Class of 1959 in Montreal. On Saturday, October 16, 1999 at about 0900 hours, Ann Van Alstyne, a past graduate of the RVH School of Nursing, and I took the opportunity to walk around and through the RVH, including the Nurses’ Residence. We were appalled at what we saw.

We entered the Emergency Department through the roadway to the ambulance entrance as it was unclear to us where the walking wounded went. The roadway and associated sidewalk were littered with trash. The E.D. itself with its $13 million renovation lay empty save for one lone woman who was standing at the empty triage station, and the two admission clerks that were doing their best to ignore her. Ann and I went to the Radiology Department and back to the E.D. where the woman was still standing. She finally realised that the triage nurse was not going to show, so she went to one of the receptionists who told her to wait as the nurse would return. No attempt was made to find the nurse. I went to one receptionist to find out who was the head of the E.D. to let him/her know what was going on. Neither receptionist knew the name of the chief. We left disgusted with their attitude, their lack of knowledge and their lack of empathy for the patient.

We then ascended the stairs that go under and then along side the newer ramp from the Women’s Pavilion (WP) to a floor above the E.D. The area was strewn with ugly paper, card board and beer bottles. Next, we went towards the west end of the WP hoping to get to the Ross (we had forgotten that the way was blocked). This area was desolate and filthy and overgrown with weeds everywhere. Large pieces of wood were missing from a door, stones having fallen from the building and from an old ramp, and of course the ubiquitous garbage was present.

We retraced our steps and went in the University Entrance to the WP and up to the main floor where a single guard ignored us until we asked him if we could still get to the Ross from the front entrance of the WP. He was then most congenial and wanted us to see the new walkway going from the 5th (?) floor.
As we enter the New Millennium, it is compelling to consider what problems we have to solve. The first is that we desperately need more OR time. Ever since the early 90's, there has been a gradual and insidious diminution of space on the Operating Schedule for Surgeons of all specialties. This has been true all across Canada (especially in Ottawa), but appears more marked in the McGill Hospitals. There are a number of reasons - shortage of Anaesthetists, not enough Nurses, less beds available and major budget cuts. A Surgeon is most dependent on hospital resources and along with his/her patients "suffers" the most when these are in short supply.

It used to be that a Surgeon was assigned one day per week for elective cases. In retrospect, those were halycon days. Let us do the math: if 5 cases were done per operating day, this amounted to 20 interventions per month. Nowadays, the usual allocation is 1/2 day per week or 2 days per month. This, therefore, amounts to 10 cases done per month. After 6 months, you will have a wait list of 60 patients! In December, there were 541 patients waiting for General Surgery at the RVH site. When one considers that some of these have redoubtable conditions such as cancer, inflammatory bowel disease or are awaiting transplantation, one can well understand the anxiety amongst patients and the harassment experienced by their Surgeons.

In the MUHC, patients waiting for elective operations in Orthopedic Surgery may wait anywhere from 1 month to 1 year. From September 12th to December 9th last fall, there were 114 patients awaiting hip surgery, 163 for knees and 6 for back operations. On September 1st, there were 19 patients awaiting operations for cancer at the RVH. It took three months to process them. What is even worse is that, after going through Pre-Admission Tests and a long waiting period, the operation can be cancelled at the last moment.

Dr. Nicolas Christou, Head of the MUHC Division of General Surgery, is working very hard to alleviate the difficult situation. Recently, he prepared OR schedules for the RVH and MGH sites (historic documents in themselves). In these, there are also Reserved times (for allocation by the Chiefs of Services), High Efficiency ORs, and correlation with wait lists. Dr. Christou himself has a long list of potential patients waiting for bariatric surgery - anywhere from 6 months to one year. Surgeons have learned to be quite flexible in adjusting to these new and difficult times. We have been good. Our Average Duration of Stay is 7.9 days and Same Day Admissions are 66% for General Surgery. Around 20% of our admissions are admitted for less than 48 hours. We still do close to 10,000 (9,465 in 1999) operations per year (inpatient and outpatient) in the Main Suite at the RVH. This amounts to some 20,000 hours. While the volume of cases has remained stable, the hours per case have been increasing. This demonstrates the added complexity of our cases.

The Division of General Surgery is even currently looking to other hospitals for added OR time. It is felt that we have streamlined our efforts to maximize the delivery of care in the OR's and on the Wards and that there is very little room for improvement.

However, problems persist. The media is very pre-occupied with the congestion in Montreal Emergency Rooms and the Ministry of Health has responded partially. In 1999, the Ministry was also pre-occupied with shortening the waiting lists for cataract and cardiac surgery (In Quebec, there are currently 750 patients on the latter list). But for most Surgeons, we feel that our voice is heard, but not heeded. We all know of patients who went to the United States to have their knees, hips or back "fixed" because they could not wait any longer. Needless to say, this is at an increased cost.

It is time that the Ministry works with us to correct this alarming situation so as to enrich the care of our patients.
Upcoming Events

February 10, 2000
Rocke Robertson Day
Visiting Professor: Dr. Marc Swiontkowski
Chair, Orthopedic Surgery
University of Minnesota Medical School

February 17-19, 2000
Symposium on Colorectal Disease in the New Millennium
Fort Lauderdale, Florida.

February 24, 2000
General Surgery Day
Visiting Professor - Dr. Ori Rotstein
Professor of Surgery & Head, Division of General Surgery
University of Toronto Healthcare Network

April 9-14, 2000
Royal College Accreditation of all Programs

April 12-13, 2000
E.J. Tabah Visiting Professor in Surgical Oncology
Dr. Alfred M. Cohen
Memorial Sloan-Kettering Cancer Centre,
New York

April 19, 2000
Urology Research Day
Visiting Professor: Dr. Laurence Klotz
University of Toronto

May 3-5, 2000
Annual McGill Orthopedic Visiting Professor
Dr. Ian J. Alexander
Akron, Ohio

May 18, 2000
Fraser Gurd Day
Visiting Professor: Dr. Dhiraj Shah
Chair, Vascular Surgery
Albany Medical Center

June 1-2, 2000
Stikeman Visiting Professorship
Dr. William A. Baumgartner
Cardiac Surgeon-in-Chief
Johns Hopkins Hospital

Dates to Remember

September 21-24, 2000
Annual Meeting
Royal College of Physicians & Surgeons of Canada
Annual Meeting of C.A.G.S.
Edmonton, Alberta.

September 20-23, 2001
Annual Meeting
Royal College of Physicians & Surgeons of Canada
Ottawa, Ontario.

September 25-28, 2002
Annual Meeting
Royal College of Physicians & Surgeons of Canada
Ottawa, Ontario.

Were You There? Hyperbaric Chamber, RVH 1963
Health Crisis

(continued from pg.1)

the provinces has decreased from 30.6% in 1980 to 21.5% in 1996. The provinces facing their own fiscal problems have in turn decreased spending in the health field. Canada is almost unique in that the percentage of gross domestic product (GDP) spent on health actually decreased from 1990 to 1997. During that same period, private funding of health care in Canada increased from 25 to 30%. Many think it should be even higher to relieve the pressure on the public system.

Mr. Ralph Klein, Premier of Alberta, has suggested that private “clinics” could provide surgical care if such services are inadequately provided by the publicly funded system. He mentions hip replacements as a current need. He says his new system will comply with the Canada Health Act.

Even M. Claude Castonguay, the father of medicare in Quebec, thinks the public system has reached its limit. He favors a system of tax credits to encourage innovative approaches to care. “Si l’octroi de crédits est justifié dans des secteurs comme le multimédia, leur justification serait encore plus grande en santé.” As Arnold Abeman, former Dean of Medicine, University of Toronto has said “Decriminalize medical acts between consenting adults and allow patients to purchase more medical care than the government provides.”

Indeed, why not encourage a parallel private system if 30% of the care is already private? There are several reasons. First, most of the 30%, i.e. nursing home care, drug costs outside the hospital and non-physician professional services were never covered by medicare and have always depended on insurance or out of pocket expenditures. The current problem is that we are spending less on those services that the populace really expects, i.e., efficient and prompt care for acute and life threatening illness. Canada has moved from second in expenditures per capita to fifth in the very brief period 1990 to 1997. We spend 9% of GDP on health, but this figure is significantly lower in Quebec. David Naylor, a Canadian expert on health care delivery, has pointed out that spending in Canada has actually decreased 17% for hospitals, 7.7% for physicians, but has increased 21% for drugs and 50% for home care. The changes have been accomplished with the cooperation of the profession, but not without adverse effects on patient care. Furthermore, the rate of these changes has been profoundly disturbing for the public, physicians, and nurses.

The public’s discontent is principally focused on the long waiting lists for operations which have been redefined as elective or non-urgent, and on the overcrowding of emergency rooms. While many factors contribute to these problems, the bureaucratically mandated bottlenecks within the hospitals are important factors. Despite the incredible decrease in length of stay for acute care, the penury of rehabilitation and nursing home beds results in occupation of acute care beds for longer than necessary. The chronically overcrowded emergency rooms similarly result, in part, from the lack of in-patient beds to which patients needing hospitalization can be transferred.

How will private clinics alleviate these problems? The answer would appear to be that the operators of these clinics will make the investment in the leasing or building of facilities and in the provision of the equipment and supplies. The return on their investment will come on the profit generated by charges for the use of the equipment and the provision of supplies (drugs, prosthetic devises, lens, etc). Citizens able to afford the services will be offered the opportunity to use these clinics. However, the services of the physicians and surgeons will continue to be borne by the public purse. Thus, it would seem that we will have a two tier system subsidized by public funds. I have no problem with the private practice of medicine as long as it is funded entirely by the private sector and conforms to established standards of practice.

If, as Mr. Klein proposes, more extensive procedures such as total hip replacements are to be done in the clinics, the situation becomes even more complicated. Who will provide blood banking and laboratory services for these procedures? Will the private clinic be allowed to pay nurses, inhalation therapists, and physiotherapists higher salaries that those paid in the public systems? And where will the patients go after surgery? Will they be competing with the patients from the public services for available rehabilitation services? Who will be responsible for quality assurance in these clinics? Tax credits, such as suggested by M. Castonguay, would more directly subsidize private clinics, but would require another layer of bureaucracy to decide who would or would not be eligible for a given credit. We already have one bureaucrat for every physician in Quebec. Would the operators have to be residents of the province or could they be entrepreneurs from Dallas?

Others have suggested a registered health savings plan (RHSP) that would allow boomers to save up to $10,000 per year tax free for their old age. Most do not now take advantage of the RRSP, but the real issue is how does this solve the problem of those who would not be able to afford the RHSP?

I am not arguing for the status quo because there are very serious problems in our cherished single payer system. National polls show that six of ten Canadians assessed the health system as Excellent or Very Good in 1991. By 1996, only four of ten made those ratings, while one-quarter of
respondents rated the system as Fair or Poor. In 1998, an international survey found that 18% of Americans believed that recent changes harmed their system's quality of care as opposed to 46% of Canadians. These polls emphasize the extent to which the public equates high-quality health care with access to a stable hospital system. We should spend more on those aspects of care that we know work and less on those aspects that are unproved with their inherent bureaucracy.

Another reason to support hospitals is the maintenance of standards of practice which have been highly developed and refined in hospitals. Morbidity-mortality rounds, tissue committees, peer review rounds, outcomes analyses have all been developed in the hospital and are the basis of excellence in practice.

Much of the really alarming information on decline of health services remains anecdotal. Likewise, there is frustratingly little information on areas in which we excel. Health research to document national and local results provided by our system is urgently needed. The use of life expectancy at birth or at age 65 is not a sufficient measure of outcome of the system.

In summary, critics of the Canada Health Act suggest that multi-tier care is a fact of life. Workmen's compensation boards in each province provide parallel systems with built-in queue jumping. Other affluent patients are jumping the queue to obtain MRIs by paying an illegal fee for examinations using publicly purchased equipment. Some Canadians are seeking care in the United States. Those who support our system worry that a private tier would be parasitic. It would limit itself to highly remunerative services and at the same time would be luring clinicians from the public sector. There is no doubt that first-dollar coverage has led to more equitable access to health services and greater spending on care for those in lower socioeconomic brackets. Polls once again are revealing. Sixty percent of Canadians reject the concept of a two tier system. The support that exists for some form of parallel system is related to fears that the public system is deteriorating. "Reform of the system" has in the past meant more bureaucrats making more plans. Perhaps it is time to dispense with the micro-management at the center and direct the much needed increase in funding towards the institutions currently delivering care to the sick. Rather than move to a two tier system, let's save the first system first.

Editor's Note: The Square Knot thanks Dr. MacLean for contributing this article as the first one of the new millennium, our 22nd edition.

Vascular Surgery at C.H.V.O.

Drs C. Beaulieu and P. Nault from the Department of Vascular Surgery at the C.H.V.O. in Gatineau, Quebec would like to remind everyone that there is a meeting of the "Entretiens Vasculaires" May 5th and 6th, 2000 in Hull, Quebec. Invited speakers from the Mayo Clinic and the University of California, Los Angeles will attend. Furthermore, Dr. Archana Ramaswamy will be presenting on two topics: Outcomes of Ruptured AAA in the Elderly and Intra-operative duplex ultrasound during carotid endarterectomy surgery.

Please visit the website for more details:
thttp://www.rocler.qc.ca/entretiens-vasculaires

Andreas Nikolis, M.D. (R-4)

Tee Time

A golfer was addressing his ball, getting ready to shoot. As he was about ready to hit, a voice came over the PA system. "Will the gentleman on the ladies' tee please move back to the men's tee". He looked up and then resumed addressing the ball again. The voice again - "Will the Man on the Red Tees move back to the White Tees!!" He looked back at the starter's shack and said, "Will the man on the PA shut up so that the man on the ladies' tee can hit his second shot!"
Auto Suture Company, Canada and the McGill Hospital Group has had a long-standing relationship, which dates back to the late 1970’s. The Montreal General Hospital was one of the first to embrace what was then a medical curiosity, the surgical stapler! Through the years, technology has developed at light speed, whereas today, most surgical interventions are performed by Minimally Invasive instruments developed and introduced by United States Surgical.

As technology has developed, so has the need for proper training methods in both the traditional and the new surgical procedures. Both residents and established surgeons alike realize that to stay at the cutting edge of surgery, training and education are paramount to their success rate, which translates into the utmost in patient care.

The latest development in education is the Auto Suture Centers of Excellence. A fully funded training center dedicated to the development of surgical residents and new surgical concepts has been established at The Montreal General Hospital, headed by Dr. Gerald Fried. Auto Suture Company has been a supporter of the Center of Excellence for over 5 years now, and are very proud of the accomplishments that have taken place during that time. The McGill Group Center of Excellence has grown through the years and now enjoys the reputation as one of the top surgical training centers, not only in Canada, but also among the Centers in the United States.

We would like to take this opportunity to thank and congratulate Dr. Fried, his staff and the McGill Hospital Group for their contributions to development of new and challenging training concepts, and we look foreword to continuing to be an important supporter in the future.

Vince Giannamaria
TYCO Healthcare Canada

Dr. Gerry Fried demonstrating the laparoscopy Skills Station
Chairman’s Message
— By Jonathan L. Meakins, M.D., D.Sc., F.R.C.S.C., F.A.C.S.

On Saturday, January 15, the McGill Department of Surgery held a retreat for staff and residents, as well as invited nurses and anesthetists, at the McIntyre Medical Sciences Building. Our thanks to Dean Abe Fuks, Dr. Hugh Scott and Dr. Denis Roy for their participation. More than six years have passed since the last Department-wide retreat and much has changed in the interim. Financial and human resources are tight. Access to the O.R., I.C.U and beds becomes more difficult almost with each passing day. Our Departmental mission and values might seem obvious, but it is apparent that not all share exactly the same vision. A declaration of a common mission, values and goals was the first step in defining our priorities. From there, the principles against which we evaluate ourselves and base the allocation of resources can be defined and enunciated. Drafts of a Mission Statement, of criteria for prioritizing the allocation of resources, and of a Memorandum of Agreement between the Department and its recruits had been circulated extensively since the fall. The retreat was designed to come to closure on these subjects as well as deal with a variety of other issues on the horizon.

The morning workshops addressed issues pertaining to the structure of the Department under the following topics: Mission Statement, Memorandum of Agreement for New Staff, Core Program, Research, and Information Services/Innovative Technology. The afternoon sessions addressed clinical management issues under the heading: Models of Surgical Care for the 21st Century and O.R. Efficiency.

In addition, all the teams were assigned the topic “Criteria for Prioritizing the Allocation of Resources”. These criteria will eventually be the PRINCIPLES upon which the Department will allocate its resources. The fourteen criteria established by the Department of Surgery at the University of Toronto were the template for discussion. The definitions and order of importance established at U. of T. were used as a guide. These are the same criteria presented last November at Lloyd D. MacLean Day. On that occasion, participants were asked to rank the criteria in order of importance, but only 18 of the 50 or so attendees handed in the ranking sheet.

Such an exercise may appear futile given the current paucity of both human and material resources. However, as resources become available, their eventual allocation will be based upon the ranking the Department has given each criteria. Fifty of the 63 participants at the Retreat rated each criteria from 1 to 5, with 1 being the highest score and 5 the lowest. The results are presented in the following table and compared to the ranking used at U. of T.

Criteria for prioritizing allocation of resources (in order of importance):

<table>
<thead>
<tr>
<th>Rank at McGill</th>
<th>Criteria and overall score</th>
<th>Rank U. of T.</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Excellence of patient care (58)</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Excellence in research (69)</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Importance of clinical service (70)</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Excellence in teaching (75)</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Excellence in innovation (85)</td>
<td>5</td>
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<td>6</td>
<td>Terms of recruitment (90)</td>
<td>11</td>
</tr>
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<td>7</td>
<td>Long range plans (116)</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>Full-time vs. Part-time status (130)</td>
<td>10</td>
</tr>
<tr>
<td>9</td>
<td>Administration (139)</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>Fellows (142)</td>
<td>13</td>
</tr>
<tr>
<td>11</td>
<td>Cost of program (148)</td>
<td>9</td>
</tr>
<tr>
<td>12</td>
<td>Determination of program size (153)</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Status of prior commitments (181)</td>
<td>7</td>
</tr>
<tr>
<td>14</td>
<td>Non-insured services (191)</td>
<td>14</td>
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The McGill Department has re-ordered the Toronto template in several ways. Most striking is the “Terms of Recruitment” which we ranked sixth in importance. This is linked to our commitment to our younger members, as evidenced by the newly implemented Memorandum of Agreement (MOA). The MOA will be featured in the Spring issue of the Square Knot. The obligations of the Division, Department, Hospital and Faculty to our recruits will be spelled out in the MOA as will our expectations of them. This is the Department’s way of recognizing that our future depends on our new blood.
and that commitment to our recruits is the key to keeping them at McGill.

Equally interesting is the lesser importance given to the “Status of Prior Commitments.” Comments of the group leaders are not all in, but the low ranking (13th) suggests that, in this time of rapid technological change and evolving clinical approaches to classic surgical problems, we must be very sensitive to ongoing performance, other commitments and the needs of patients. Also of note, “Full-time Status” was seen as more important at McGill than in Toronto and “Administration” as less important.

These criteria are reflected in our Mission Statement (see below). The Statement was written with our historic values in mind, but via an independent process. That the criteria for prioritizing the allocation of resources and the Mission Statement are in consonance is validating and clearly defines our values. These criteria can now legitimately become the Principles upon which we allocate resources.

Having established the relative importance of these Principles, the Department must now refine the definition and the methods of evaluation of each. These will be featured in the Spring issue of the Square Knot.

Mission Statement

**THE MISSION** of the Department of Surgery is the pursuit of excellence in comprehensive, patient-centered surgical care, teaching, research and evaluation of technology. The Department’s foremost responsibility is to its patients. To fulfill its larger role, the Department must also lead in the development of new knowledge and techniques, in the transmission of these to its communities of students, and in their application for the benefit of all society at large.

**TO THIS END,**

The Department will provide for its patients of all ages comprehensive care of the highest quality, in a timely, effective, and efficient manner. Clinical care will be evidence-based wherever possible, and patient-centered outcomes will be monitored.

In fulfilling its educational mission, the Department will provide to its medical students, residents, fellows, as well as to its community of surgeons, the programs and learning environment to stimulate their curiosity and creativity and, to develop the professional skills and human qualities required to deliver specialized surgical care.

The Departmental research programs will encompass basic science, clinical investigation, health service studies, and evaluation of technology and clinical care delivery systems. The Department will train surgeon-scientists and surgeon-educators for its own renewal, as well as for the province, country and the international community.

The Department will promote the development of new techniques and technologies, evaluate them for safety and efficacy, and define the methodology for their introduction into clinical practice.

Welcome Aboard

**Dr. John Antoniou** joined The Jewish General Hospital in the Department of Orthopedic Surgery on January 1st, 2000.
level to the main building. We did this to please his enthusiasm. As we crossed to the Main, we of course could now see the crap and corruption mentioned before from the vantage point of height, and it looked no better. Prior to leaving the WP, we asked the guard about patient floors and he said that only two were used and (sadly) the rest had been commandeered for the administration.

We took the Main elevators to the eighth floor and crossed to the Ross. It was deserted except for those in the Café. We went to the lobby at the front entrance where someone was about to enter the elevator. He told us that patients were only on the 3rd and 5th floor and the rest of the Ross was inherited by administration. The place looked as though it hadn't been painted since I was in residency.

We then went out through the front entrance of the Ross and down the hill into the old Nurses' Residence. This part of the grounds was better kept than the ones previously mentioned. The stairwell leading to the residence looked unkempt but not strewn with garbage. The residence itself looked its age, but was not shabby. It was sad to see that a place that had been home to so many outstanding nursing students was relegated to a research rather than an education centre. Of course there was the ubiquitous housing for administration. We left by the side door of the residence and back up the stairs and down the Ross Road to Pine Avenue as the front door to the Residence was closed. At last we were in sunshine and the pile of unkempt buildings that was once our place of work and home away from home many years ago was behind us forever.

Ann and I had two comments to make to one another as we left. First, the staff must be terribly demoralised, witness the E.D. and the fact that no one stopped us in our travels to ask if we needed help or even to observe whether we were stealing anything. Secondly, we were sure that Gilbert Turner would have mobilised the spirit and pride of the professional staff and of the RVH Volunteer Organisations to get out and clean up the joint, if there was not enough money in the budget to pay for upkeep and repair. We thought that our generation would have responded, why at least has not the surgical staff of your generation responded??

Lastly, who made the asinine decision to locate the new University Hospital so far from the University Medical School and from the patients in central Montreal that get their care from the present hospital sites. I, for one, will not contribute to such a poorly conceived plan. Make use out of the RVH, the MNI, the Pathology Building and the old University Medical School sites so that there is a symbiosis with the Medical School for education and basic, but especially clinical research!!

Dear Editor,

Addendum to MUHC's Transplant History.

I would like to expand on your history of transplantation at McGill, and to include more details on pediatric liver transplants. As noted, Dr. Pierre Daloze carried out several unsuccessful transplants in the early '60s (the pre-cyclosporin era) at the Notre Dame Hospital, one on a very small baby. In the cyclosporin era, the MCH was the site of the next attempt, unsuccessful also, under the direction of Drs. Pierre Daloze, Herve Blanchard, and Frank Guttman, in 1983. However, on Dec. 4th, 1985, Drs. Guttman, Blanchard and Jean-Martin Laberge carried out a successful liver transplant on a 13 month old girl with Crigler-Najjar syndrome. She is now fifteen years old, doing very well in school, a charming young lady. She is the first Canadian long-term survivor of 10 kg.

At about this time, the Régie urged the University of Montréal and McGill to form a joint children's program at Ste Justine and the MCH. A place was also reserved for a future adult McGill program by the Régie. In 1986, the first transplant was carried out at Ste Justine Hospital with the surgeons of both hospitals participating. Since that time, the joint program has carried out over 146 operations. This has gone on with surgeons available at the moment, including Jean Tchervenkov, and more recently, Dickens St. Vul and Michel Lallier. Jean-Martin Laberge continues to play an active role.

Frank Guttman, M.D.
Montreal.

February 10, 2006

Dear Editor,

I continue to enjoy reading The Square Knot from cover to cover. In fact, it is likely the only publication that receives my full attention!

Having completed my 10th year of life as an attending general thoracic surgeon, I find myself remembering my very excellent general surgical training at McGill University and the Royal Victoria Hospital. I am currently very busy in private practice in Chicago and still involved in the activities of the ACS, STS, ASCO, GTSC and ACCP.

Regards to all at the RVH who may remember me. I think about you often.

Jemi Olak, M.D.
Lutheran General Cancer Care Center
Park Ridge, Illinois

Editor's Note: The Square Knot thanks Dr. Olak for her generous cheque. •
The turn of the century has been an exciting time for McGill General Surgery Residents. Amongst other developments, this last year has seen the creation of a new entity within the McGill General Surgery Training Program, the General Surgery Residents’ Committee. In order to address resident related issues within the training program, the Residents’ Committee was founded on February 17, 1999 by multiple, interested junior and senior residents in General Surgery. The Residents’ Committee continues to receive strong support from both the Head of MUHC General Surgery, Dr. Nicolas V. Christou, and the General Surgery Program Director, Dr. Judith Trudel. As defined by its constitution, the mission statement of the Residents’ Committee involves the following: “to work in the interests of residents in General Surgery, promote a close liaison and cohesiveness between residents and staff, to be achieved through education, communication and social activities, all to further knowledge and increase morale.”

We have purchased reference material and hardware to augment the computers and books already present in the Resident Resource Centre at the Royal Victoria Hospital, and the Rea Brown Room at the Montreal General Hospital. Both of these resident resource rooms are relatively new additions to the program, and demonstrate the generosity and commitment of Staff towards residents.

In addition, the Residents’ Committee drafted a list of proposals for the training program. The concept of an Academic Half Day, one of the key proposals, was received with great enthusiasm by staff. In partnership with residents and Dr. Sarkis Meterrissian, a weekly General Surgery Academic Half Day was organized, and begun January 12, 2000. The Academic Half Day provides protected teaching to all General Surgery residents from 1:00 to 6:00 PM every Wednesday afternoon. The Academic Half Day has already proved to be an immensely positive addition to General Surgery teaching, and promises to be a great strength for the program in the future.

Current issues for the Committee include improving residents’ Internet-based operative logs, addressing call schedule requirements, the election of Staff and Resident Teaching Awards and the planning of a ski trip. As residents within McGill General Surgery, we are keenly committed to our program. We are extremely fortunate to receive immense support, both financially and in spirit, from the Head of General Surgery, the Program Director and from individual Staff members. We hope that as residents, we may contribute to the further great success of the McGill General Surgery Training Program.
REPORT ON CURRENT ACTIVITIES OF THE ASSOCIATION OF RESIDENTS OF MCGILL 1999-2000

The Association of Residents of McGill (ARM) is presently dealing with many issues of concern to medical residents, the following is a summary of some of the most significant.

ARM —

RENEWAL OF THE COLLECTIVE AGREEMENT

The ARM was a co-signatory on the collective agreement signed between the Federation of Medical Residents of Quebec (FMRO) and the Ministry of Health and Social Services (MHSS) on April 17, 1999. This agreement was signed without work disruption or pressure tactics - the first time in 30 years. It offers significant benefits for all medical residents. First, the longstanding dispute over tuition fees was addressed, as the MHSS agreed to pay any tuition charges in excess of $700 per year. Not only did this represent a major reduction in fees, but also ensured protection for residents against any tuition increases in the future. Second, of particular importance to McGill, was the inclusion of clinical fellows in the new collective agreement, thereby guaranteeing them the same rights regarding vacation time, statutory holidays, study leave and call schedules as offered to other residents.

TRAVEL FUND

The fund which reimburses residents primarily for rural rotations has increased 300 percent to $30,000 per year, as negotiated in the new collective agreement. The ARM has also been making major changes to the way in which this fund is managed. Residents will no longer have to wait until the end of the academic year to be reimbursed for transportation, living or accommodation expenses, but will be able to be paid shortly after the completion of their rural rotations. Furthermore, the ARM and the FMRO are working to ensure that the MHSS' own rural reimbursement program, which covers many designated hospital sites across the province, compensates residents appropriately and expeditiously.

MCGILL ACCREDITATION

McGill University will receive an accreditation visit in the Spring of 2000. The ARM and FMRO are active participants in this important process to promote excellence in residency education. A pre-visit questionnaire has been prepared and sent to all McGill residents, the results of which will be made available to the residents on the review committees for each program.

NURSE FIRST ASSISTANTS

There have been recent proposals drafted by the Quebec Cabinet to recognize and encourage nurse “first surgical assistants” in hospitals across the province. The ARM and FMRO are studying the implications of these proposals to postgraduate surgical training. We will continue to promote the priority of residents’ education in teaching hospitals.

Craig Murray, M.D.
President, Association of Residents of McGill

Jim Finks, New Orleans Saints G.M.
when asked after a loss what he thought of the refs:
“I'm not allowed to comment on lousy officiating”

---1986

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GENERAL SURGERY RESIDENT EDUCATION HALF DAY

The Division of General Surgery, McGill University will initiate an Educational Half Day for all residents in General Surgery beginning January 1, 2000. Dr. Sarkis Meterissian is the Surgeon-in-Charge for the academic half day and is co-ordinating this with the General Surgery Residents' Committee, Dr. Andrew Seely, Chairperson. Every Wednesday from 1:00 - 6:00 P.M., all general surgery residents in the Montreal hospitals must attend this educational half day. Attendance is mandatory. They are to be freed from all clinical duties and the CTU Director and the Directors of the Critical Care Areas must ensure that appropriate alternative coverage arrangements are made. This includes Main Operating Room. Surgeons affected by this academic half day should ensure that a colleague comes in to assist in the operating room, if necessary. This education half day will enrich the pedagogical experience of our general surgery residents and requires your full support.

By Nicolas V. Christou, M.D.
The abdomen, the chest, and the brain will forever be shut from the intrusion of the wise and humane surgeon.” — Sir John Eric, British surgeon, appointed Surgeon-Extraordinary to Queen Victoria, 1837.

The increasing pace of innovation and technological change, combined with heightened competition for resources, have been the principal drivers in the creation of the MUHC. The Department of Surgery is no less immune to the tremendous upheavals that we experience almost daily. The bottom line is, that if we are to survive and prosper as a world-class department in this new order, we must become more competitive in all spheres of activity.

**BEST ATTRACTS BEST**

An organization that has leading intellect, can attract better talent than its competitors can. The best people want to work with the best people. Recruiting, developing and capturing individuals’ intellectual capabilities has been the key to strategic success for most knowledge-based enterprises (e.g. Mayo Clinic).

This has rarely been a problem with respect to clinical activity; however for research, we now stand at the crossroads. Becoming more competitive means striving for excellence in research; and to do so, requires that we raise the bar higher then ever before.

The Conference Board of Canada, one of the country’s leading economic think-tanks, recently issued an urgent call for governments and institutions to wake up and start building a culture of innovation as the engine to drive productivity. Canada is falling behind the pack in several key measures of innovative behaviour—like the proportion of GDP spent on research and development, the number of researchers working on new technology and the number of patent applications made. The same comments might be applied to our Department locally. In the end, institutional performance is directly linked to an organization’s capacity to innovate. In a way, this is also the driving force behind the MUHC.

Intangibles are fast becoming substitutes for physical assets. What makes intangible assets so valuable? One big difference is that when you’re dealing with tangible assets (e.g. a building or equipment), your ability to leverage them— to get additional value out of them—is limited. With knowledge assets, you get what economists call “increasing returns to scale.” That’s one key to intangible assets: the larger the network of users, the greater the benefit to everyone.

**IS THERE A DOWNSIDE TO KNOWLEDGE ASSETS?**

Knowledge assets are very expensive both to acquire and to develop. And they’re extremely difficult to manage. While the benefits that come from knowledge assets can be enormous, they are much more uncertain than the benefits of tangible assets. For example, when you invest in a tangible asset, you always get some kind of return. But when you’re building a knowledge asset, you could quite possibly end up with nothing. Nonetheless, Pierre Belanger (V.P. [Research] and Dean [Faculty of Graduate Studies and Research]) has recently written that the twin objectives of the university are training and the discovery of new knowledge. The product of the university is knowledge.

Knowledge building, innovation and scientific-technological advance are the critical ingredients for growth and competitive advantage today. It is these elements that must differentiate the McGill Department of Surgery from departments out in the community and at other universities.

**RESEARCH CHALLENGES THAT MUST BE ADDRESSED**

1. The Department must seek to establish a competitive nature as well as a competitive position in the country and internationally; and then put in place a strategy to maintain it.
2. The Department must adopt a culture of excellence in research in keeping with its Mission Statement. This means establishing, and rigorously enforcing, high standards in the conduct of research.
3. As a corollary, an infrastructure of support to nurture research activities within the Department must be established.
4. New sources of revenues must be sought. In this regard, intellectual capital can be a revenue generator, as well as an image-enhancer. Resourcefulness must become as important as resources.
5. As part of the process of prioritization currently underway with respect to clinical activities, the Department must identify the specific areas of research which it will support.

Advances and innovation occur at the edge, i.e. at the boundaries of different fields rather than within single fields—a trend that promises to continue and accelerate.
example, is development of the CIHR, an inter-disciplinary research institute into which the MRC has been folded. Locally, we have to adjust to the development of FRQ-mandated research axes within the Research Institute of the MUHC.

Furthermore, technology adoption may be best implemented within an integrated system of universities, companies, and government working together. The very process of discovery is becoming more and more tightly interwoven across sectors, as is evidenced by the recent CFI initiative of the Federal government.

As a result of these trends and events, it is imperative to define how the research activities of the Department will be aligned with the evolving Research Institute of the MUHC and with the larger scientific community outside the University.

To close, I will quote from the 1999 ACS Presidential Address of Dr. Jim Thompson:

“You have been subjected for the last several years to one of the greatest rearrangements of priorities that has ever occurred, as control of medicine has been ceded to business (and in Canada- to government bureaucrats). The moneychangers are ruling the temple. Bits of evidence in support of this are everywhere, and some days you may feel that you spend more time filling out forms than seeing patients.

What I'd like to co... is to ask you to raise your vision, to look up and consider the stunning societal benefits that medicine in general, and surgery especially, have achieved, and to look at the promise that research will lead us to a New Jerusalem.”

- **Intellectual capital** (intellect) = the capacity to create knowledge.

- **Technology** = is knowledge systematically applied to useful purposes. When science is utilized in an orderly way for practical purposes, it generally becomes part of technology.

- **Discovery or Invention** = involves the initial observation of a new phenomenon (discovery) or provides the initial verification that a problem can be solved (invention).

- **Innovation** = consists of the social and managerial processes through which solutions are first translated into a social use. Technological innovation involves a novel combination of art, science, or craft employed to create the goods or services used by society.

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**Were You There?**

**RVH General Surgery 1971**
The Association of Canadian Medical Colleges, The Association of Canadian Teaching Hospitals, The Alumni and Friends of the Medical Research Council (MRC) Canada and Partners in Research present Year 2000 - A Celebration of Canadian Healthcare Research. This calendar is a dedication to Canada's leading historical and contemporary medical scientists.

Canadian investigators have led the way in cardiac research - from the experimental for a few, to the mainstream for many; from inside and out; from a century ago until yesterday. The beat goes on. February is Heart Month and it is fitting that Dr. Ray Chu-Jeng Chiu be among other medical researchers recognized for his work in the field of cardiac research during this month. It reads:

"Dr. Ray Chu-Jeng Chiu - Knowing that the heart muscle, unlike other muscles, does not need rest, Dr. Chiu set out to find a way to adapt muscle from the back so that it can help a weak heart to function. In an amazing combination of biochemistry and surgery, he accomplished what he set out to do and he now takes his place among medical research pioneers."

The Square Knot congratulates Dr. Chiu and wish him continued success in his research projects.

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C ANADIAN RESIDENT MATCHING SERVICE

The rumour in medical education when I first joined CaRMS (or CIMS as it was then known), was that the match was actually done on Charles Casterton's kitchen table. There may have been some truth to that, as it was a manual system with such crude security as a locked and taped up office where the cleaning staff were denied entrance until the match was completed. Well, those days are long gone. This year, CaRMS moves into the new millennium by going electronic via the web. The CaRMS Board of Directors announces two new electronic procedures to enhance and streamline the matching process.

First, in the 2000 match, applicants and programs alike will be able to go in to the Internet to check the accuracy of their rank order lists at CaRMS. Each participant will be given a personal identifier that will allow them to confidentially confirm the rankings as they appear in the CaRMS computer. By moving to an electronic confirmation process, CaRMS can extend their rank order list deadline until February 22, allowing students and programs longer to make their final decision.

Secondly, the match results will be available on the Internet for the 2000 match. All applicants and programs directors can use the personal identifier to go into the CaRMS web site and see their final match results. The vacancies available for the second iteration will also be posted on the Internet. The match results will be posted for the unmatched students on March 13 at noon EST and for matched students on March 15. The results for the second iteration will also be available on the Internet and the end of March. CaRMS will continue to mail a hard copy of the results to programs and applicants.

By 2002, all application procedures and matching results will be electronic. The application will be available on the web and will be sent electronically and participants will be able to put their rank order lists on the web instead of mailing it to CaRMS. The goal in introducing all of these innovations is to provide more time before the graduating student has to make a career decision and enhance confidence in the match.

CaRMS is hosting an Interview Forum at the ACMC annual meeting in Whistler, B.C. on April 29. There are many challenges in scheduling and conducting interviews and we hope that this forum will provide a blueprint to help programs meet those challenges and will assure students that their concerns are being addressed.

Sandra Banner, Executive Director
General Surgery Program Holds Blitz Day

By Judith Trudel, M.D.

The annual interview “Blitz Day” for the McGill General Surgery Residency Program was held on January 24th, 2000 at The Montreal General Hospital. The purpose of this day was to present our residency program to the potential CaRMS applicants vying for the 5 PGY-1 positions available for the academic year 2000-2001, and to complete the selection process through personal interviews of the applicants. After a preliminary selection process, 40 applicants from 12 medical schools across Canada were invited for an interview. The day was organized by Janice Hazarian, co-ordinator of the General Surgery Residency Program.

The main event was held in the Livingston Hall Lounge of The Montreal General Hospital. Dr. Judith Trudel, Program Director, gave a 30-minute presentation outlining the requirements for certification in General Surgery in Canada and the United States; the McGill residency program structure; the opportunities for research while training at McGill; the organization and extent of teaching activities; the opportunities for operative experience; and the fellowships and positions secured by recent graduates (1995-2000) of our program.

The applicants were also addressed by Dr. Nicolas Christou (Director of the Division of General Surgery), Dr. Jonathan Meakins (Chairman of the Department of Surgery), Dr. Daniel Swartz (Senior Resident representative on the Postgraduate Committee), and Dr. Robert Andzbeka (who had put together a slick computer-based presentation in co-operation with Dr. Antonio DiCarlo).

Plenty of opportunities for mingling and frank discussion between the applicants and current residents and attending staff were provided over a beautiful and delicious cold buffet, catered by the cafeteria of the MGH. Over 15 residents from PGY-1 to PGY-5 attended the event and fielded questions from the applicants. Numerous attending staff from the Royal Victoria Hospital, Montreal Children’s Hospital, Jewish General Hospital, Montreal General Hospital, and St. Mary’s Hospital also supported this activity of the program.

The afternoon was devoted to interviews. Each applicant was interviewed by two different teams of two interviewers (usually one resident and one staff). A total of 10 teams participated in this portion of the blitz day. All interviewers commented on the high quality of the applicants. The final match will be held through CaRMS in March, and we will announce the results in the next edition of The Square Knot.

TO ALL RESIDENTS AND STAFF WHO PARTICIPATED IN THE BLITZ DAY AND CONTRIBUTED TO MAKING IT A SUCCESS, THANK YOU! 

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At Williams, Orlando Magic general manager, on his team’s 7-27 record: “We can’t win at home. We can’t win on the road. As general manager, I just can’t figure out where else to play.” — 1992

FROM NOVEMBER 14-20, 1999, the McGill Division of Urology held a continuing medical education scientific meeting in conjunction with the Brazilian Urological Congress held in Rio de Janeiro, Brazil. A team led by Dr. Armen Aprikian to Brazil to hold joint meetings on Controversies in Urologic Oncology, Andrology, Pediatric Urology and Voiding Dysfunction with speakers from both countries debating various treatment options in controversial clinical scenarios. The Canadian faculty includes Drs. Armen Aprikian, Luis Souhami, Simon Tanguay, Jacques Corcos, Joao PippiSalle, Serge Carrier (all from McGill University), Fred Saad (University of Montréal), Yves Fradet (Laval), Gerald Brock (University of Western Ontario, and Neil Fleshner (University of Toronto). This event was attended by 113 participants from Quebec which included community urologists, radiation oncologists and residents in training.

Armen Aprikian, M.D.
Dr. Vincent Arlet was invited as a guest speaker at the 4th combined meeting of Spinal and Pediatric Section of the Western Pacific Orthopaedic Association held in Pattaya, Thailand in October. During this convention he gave two instructional course lectures entitled: Management of Upper Cervical Spine Injuries and Management of Lower Cervical Spinal Injuries. During the conference, he also gave two lectures, one entitled Combined Approach for Scoliosis and the other Revision Surgery for Spinal Deformity.

Dr. Ray C.-J. Chiu was an Invited Faculty at the Rocky Mountain Heart Failure Symposium sponsored by the International Heart Institute of Montana, USA on July 10-11; at the National Cheng Gung University Medical College in Taiwan on September 16; at the Heart Failure Society of America in San Francisco on September 24; and at the American College of Surgeons Annual Meeting Postgraduate Course in San Francisco on October 14, 1999 where he gave a lecture entitled Myocardial Failure: Current Celluar and Molecular Concepts. He was invited as a Special “Millennium Lectureship” for the Formosa Medical Association Meeting in Taipei, Taiwan on November 12, 1999. Dr. Chiu was appointed as an Associate Editor of the Canadian Journal of Cardiology. He was appointed as a member of the Scientific Advisory Board of Hearten Medical in Tustin, California; and Acorn Incorporated in Minneapolis, Minnesota, both companies developing new surgical devices for the treatment of heart failure. He was also appointed by the US National Institutes of Health as a member of the Study Section on “Surgery and Bioengineering.” Through the McGill Office for Technology Transfer, Dr. Chiu filed a US patent (with Dr. Kevin Lachapelle) on a “Porcupine Device” for transmyocardial mechanical revascularization procedure; and another patent (together with Drs. Dominique Shum-Tim and Jacques Galipeau) on myocardial stromal cell implantation for myocardial regeneration. A contract to develop the latter is being negotiated with a new biotechnology company, Bioheart Incorporated of the United States. Dr. Chiu is also the Editor-in-Chief of a new journal entitled “Cardiac and Vascular Regeneration: Angiogenesis and Myogenesis, Basic to Therapeutics.”

Dr. Nick Christou's son Velos Christou was married to Angela Houston on January 15th, 2000 following the Department of Surgery Retreat.

Former Dean Dr. Richard Cruess was promoted to Officer of the Order of Canada. Previously he was a Member of this order. Dick Cruess is recognized as an innovator in the field of professionalism and ethics in medicine. Congratulations from TSK.

Dr. Hélène Flageole was the recipient of the Surgical Teaching Award which was presented at the Annual CPDP Christmas Banquet at the Montreal Children's Hospital. Dr. Flageole is a warm individual, forthcoming and above all a dedicated teacher. The Division of Pediatric General Surgery congratulates her and is honored to have her on its team.

Dr. Richard Margolis of the JGH was named as one of the top 100 personalities of the last century in the millennium issue of the Montreal Gazette on January 1st. He joins the following other illus-
trious physicians and surgeons also named: Alberto Aguyao, Paul David, Phil Gold, Norman Bethune, Sir William Osler, Armand Frappier, Hans Selye, and Wilder Penfield.

Dr. Jonathan L. Meakins at the meeting of the American College of Surgeons in San Francisco in October, was the moderator during a panel discussion on New Technology: What's Proven, What's Not. Joe gave two lectures, one at a general session entitled Changing Habit Patterns in the O.R.: Getting Help from Nurses and Administrators, and the other addressed Laparoscopic Hernia Repair during an Ethics Colloquium entitled Wait for the Data.

Dr. Jean-François Morin was promoted to Associate Professor January 1st, 2000.

Drs. David Mulder and David Fleiszer distinguished themselves by their urgent attention to Montreal Canadian Hockey Player, Trent McLeary, on January 29th. In a game against the Philadelphia Flyers, McLeary sustained a fractured larynx when hit by a slapshot. He was met at ringside by both surgeons and was immediately transported by ambulance to the MGH where a tracheotomy was done accompanied by the insertion of a chest tube for a tension pneumothorax. David later told a press conference that it was a very close call. At last word, the patient was doing well and it is hoped that he will not be too dysphonic. At the end of the operation when he looked down at his patient, David said that it was the first time that he saw a patient wearing skates! On January 31st, McLeary underwent a laryngoplasty by Drs. Françoise Chagnon and Nader Sadeghi.

Dr. Lawrence Rosenberg was a Visiting Professor at McMaster University, Queen's University, University of Montréal, and the University of Calgary.

Dr. Carol-Ann Vasilevsky was elected Chairman of the course in Introduction to Clinical Medicine. She also just recently was elected representative of Zone V of the Quebec Association of General Surgeons.

We are very proud of Dr. Fred Wiegand who has travelled widely with the group Médecins Sans Frontières, and international non-profit agency that was awarded the 1999 Nobel Peace Prize. Fred left for his first trip in 1997 and has spent some time working in Jeremie in Haiti, Ethiopia and Cambodia. These exploits have been described in a previous edition of The Square Knot.

Dr. Bruce Williams was a Visiting Professor to the University of Ioannina in Greece in November. He was also an Invited Guest Speaker at the 1st International Instructional Course in Hand Surgery in Cairo, Egypt from November 20th to 23rd, 1999.

1999 Annual MGH Awards

Over a million dollars in grants and awards were presented to a wide variety of MUHC scientists at the recent 1999 Annual Awards Dinner of the MGH Research Institute. In order of presentation, the following are the 1999 recipients in the Department of Surgery:

Dr. David C. Evans - Dr. Alan G. Thompson Fellowship in Surgery - John Dobson Award in Surgery as Chief of Trauma Surgery at the MGH. He researches the contribution of infection to sepsis in critically ill patients.

Dr. John Yee - Simone and Morris Fast Award in Oncology for work on the biology of esophageal cancer and role of the pulmonary endothelium in acute lung injury and tumor metastases.

Dr. Ron Zelt - The Honourable Hartland Molson Fellowship for the development of a university-wide surgical skills program and the implementation of a computer-based evaluation system for the Department of Surgery.

Dr. Ed Harvey - Auxiliary Scholarship for establishing the validation of a musculoskeletal outcome tool for use in French-speaking populations, permitting a comparison with other population groups in the world for clinical outcome studies.

Dr. Pierre Guy - 175th Anniversary Fellowship. He is in charge of Orthopaedic Traumatology post-traumatic reconstruction within the Department of Orthopedics.

Dr. Mark Martin (R-HI resident in Plastic Surgery) - 175th Anniversary Fellowship for studying factors involved in wound healing and scarring.

Dr. Karen Johnston - 175th Anniversary Fellowship for research on the diagnosis, investigation and management of concussive head injury.

Dr. Mario Chevrette - Herbert S. Lang Award for research on suppressor genes in prostate cancer.

Dr. Lawrence Rosenberg - The Nesbitt-McMaster Award for Excellence for research on diabetes. He led the Canadian team that identified the gene responsible for regenerating insulin-producing islet cells in the pancreas. As a result, radical new therapies for diabetes.
may soon be available.

Dr. Gerald Fried - The Florenz and David Bernstein Award. He is establishing a Centre to develop a method for training and evaluating laparoscopic skills.

Achievements Residents and Fellows

Dr. Iona Bratu along with
Drs. Hélène Flageole, Jean-Martin Laberge, Saundra Kay and Bruno Piedboeuf presented a paper in the session on Pediatric Surgery of the American College of Surgeons in October entitled Lung Growth and Structural Development after Reversible Fetal Tracheal Occlusion in Diaphragmatic Hernia.

Dr. Lorenzo Ferri was awarded the Canadian Infectious Disease Society Trainee Award for best presented abstract for his submission entitled Diminished Leukocyte-Endothelial Cell Interactions at Remote Sites in Intra-abdominal Sepsis: A Role for Soluble L-Selectin.

At the same meeting of the ACS in a session on Critical Care, Dr. Lorenzo E. Ferri along with Drs. Dan Swartz and Nicolas V. Christou presented a paper entitled Soluble L-Selectin Diminishes Leukocyte-Endothelial Cell Interactions In Vivo.

Dr. Stephen Korkola (R-4 resident in Cardiac Surgery) presented a paper at the Society of Thoracic Surgeons in Florida in February entitled Mechanical (Needle) Transmyocardial Revascularization Improves Blood Flow to Ischemic Myocardium Following Angiogenic Stimulus.

Drs. Ayman Linjawi, Fawaz Halwani, Bruce Jamison, Michael Edwardes, Maria Kontogiannnea and Sarkis Metterissian presented a paper in the Surgical Oncology part of the Surgical Forum at the American College of Surgeons entitled Usefulness in Molecular Markers in Early Breast Carcinoma.

Dr. Pascale Prasil (R-5 - Pediatric General Surgery) presented at the 30th Annual Meeting of the Canadian Association of Pediatric Surgeons (CAPS). Her presentations were 1) Spontaneous Pneumothorax in Children: The Role of the Tube Thoracostomy and Video-Assisted Thoracoscopic Surgery; 2) Should Malrotation in Children be Treated Differently According to Age?; 3) Delayed Presentation of a Congenital Rectovaginal Fistula Associated with a Rectosigmoid Tubular Duplication, Spinal Cord and Vertebral Anomalies. Dr. Prasil also presented at The International Society of Paediatric Oncology (SIOP). The topic of her presentation was Management Decisions in Nephroblastomatosis.

Dr. Andrew Seely won a Canadian Infectious Disease Fellowship for his abstract entitled Alterations in Neutrophil Cytokine Receptors Mediating Neutrophil Apoptosis in the Circulating and Exudate Milieu.

Dr. Daniel Swartz has accepted a Laparoscopic Surgery Fellowship at the University of Maryland in Baltimore, July 1st.

Dr. Jih-Shiuan Wang, a cardiac surgeon taking a sabbatical leave from Taipei Veterans General Hospital to do research in Dr. Chiu's laboratory, will present a paper on Marrow Stromal Cell for Cellular Cardiomyoplasty: Feasibility and Clinical Advantages at the American Association for Thoracic Surgeons in Toronto on May 3rd.
Residents fend off staff in sudden death overtime

The tension in the fourth annual Rea Brown Cup ice hockey match between McGill Staff and Residents was palpable from the moment the teams took to the ice for the pre-game warmup. Leading the series two games to one, the staff team in dark jerseys exuded more than their usual over-confidence. Taunting the residents with bellicose threats of borderline evaluations and remedial rotations, the staff were, in a word, belligerent. The noticeably late arrival of chief taunter and left tackle Dave Fleiszer solidified their cause.

The first period began as a tightly fought defensive battle with several missed scoring chances on either side. With 4:25 left in the period, staff defender Larry Stein assisted forward David Hornstein on a two-on-one drive from center ice to open the scoring. Staff goaltender Ken Shaw was in top form as the residents went unrewarded despite a tremendous effort. While flying in at top speed towards the staff net, resident Lorne Goldman faced a diving Shaw and leapt for survival only to slide face-first into the boards. After he regained consciousness and left the ice, the first period ended 1-0 for the staff.

With renewed vigor, the residents came back to the second period with verve. Residents Andrew Seely, Marc Pelletier and Steve Korkola took control of the attack zone with numerous shots, but again fell short due to the wall known as Shaw. Staff captain Ash Gursahaney led (no, I mean followed) numerous offensive attempts by teammates Ed Harvey, Kevin Lachapelle and Dave Eiley, which were thwarted by the fine defensive work of residents Jeff Sankoff, Steve Burnett and Dan Swartz. Resident goalie Alan Lisbona held off the staff until staff forward Tim Schmidt, assisted by Brian Lauffer, caught the top left corner from the slot to bring the score up to 2-0. Determined not to end the period without a score, residents Danny Cohen, Atif Khan and Monica Cermignani redoubled their efforts without success. The second period ended 2-0 for the staff.

Faced with a humiliating shut out, the residents put to use their one secret weapon that would prove to be the undoing of the staff team: the third period. Already weary with aching joints and chronic back pain, this was the beginning of the end of the geriatric insurrection. It took exactly 12 minutes to wear down the staff before resident Ray Ko carried the puck from the baseline unassisted around the staff and find the five hole between Shaw's pads and put the residents on the scoreboard. Four and a half minutes later, on a scramble in front of the staff net, resident Ian Patterson also found the net to tie the score. Regulation time ended with the score tied at 2 apiece. The five-minute sudden death overtime began with both teams finding renewed energy. Both goalies shut down the opposition until, with 4.7 seconds left, resident Robby Stein from behind the net found Vidal Essebag in the corner who deftly passed to Atif Khan in front, who then ended the game with a one-timer shot on the short side of Shaw to slam the door on the staff team with a final score of 3-2.

Dr. Brown presided over the game and awarded his coveted namesake trophy, the Rea Brown Cup, to the resident team. Surprisingly, the staff played a clean game and no penalties were called which suggests that after three years they finally read the rule book or, more likely, they're just getting old.
It seems that Montreal will have two superhospitals. In January, it was revealed that the Government has approved a project to build a C.H.U.M. on 5 hectares in Rosemont. This 900 million dollar institution will merge the Notre-Dame, St. Luc and Hôtel-Dieu Hospitals. It appears that l'Hôpital Ste-Justine will keep its vocation for children.

This new development compares with the M.U.H.C. which is for an 850 million dollar centre in Glen Yards (Montreal West) by 2004.

Appointed as Head of the new C.H.U.M., Mr. Gerard Douville is well known at McGill having been the Executive Director of the M.G.H. and then Head of the M.U.H.C. in 1997.

In the interim, there exists a plan proposed by Dr. Raymond Carignan which stipulates that the two “major complete” hospitals will be l'Hôpital Notre-Dame and l'Hôpital St. Luc, whereas the Hôtel-Dieu is to be a Clinical Research Centre with some 250 beds, of which 50 are to be reserved for research.

There is some concern over the number of beds committed for each hospital. The C.H.U.M. superhospital will have 850 beds, about 400 short of the current 1,241. The M.U.H.C. network currently is comprised of over 1,100 beds, while its proposed superhospital will have between 680 to 830 beds. Dr. Nicholas Steinmetz, one of the M.U.H.C.'s planning directors, affirms that the extra beds are not necessary because the superhospital will run more efficiently and diminish the length of hospital stays.

It is expected that the C.H.U.M. should be ready by the year 2007.

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St. Mary’s Celebrates Its 75th Year

ST. MARY’S HOSPITAL has come a long way since its founding in 1924 by surgeon Dr. Donald Hingston. At that time, St. Mary’s Memorial Hospital consisted of 45 beds and was administered by the Sisters of Saint Joseph.

In 1999, the 316 bed institution affiliated with McGill as a community hospital has as its points of excellence - Obstetrics, Oncology, Geriatrics and Family Medicine. Its global budget is 58 million dollars and the St. Mary’s Foundation has collected 2 million dollars in donations for 1998-1999. The hospital employs some 1,600 staff and there are close to 300 physicians and surgeons who attend the some 12,000 patients hospitalized each year.

Amongst others, two busy sections are the Emergency Room with 28,000 patients treated per year, and it has the largest Obstetrical Center in Montreal with 4,000 births per year.

The Square Knot congratulates this fine hospital.
It was the first rotation of my R-3 year. I was nervous as I felt my operative experience to be small and had heard how, as the only resident at Val-d’Or, you had to perform up to power.

Val-D’Or: A Resident’s Gold Mine

By José Pascual, M.D.

After driving up the 117 North between the Laurentian resorts of St-Sauveur and Mont Blanc, you soon fall in the monotony of passing small town after small town. But before long, buildings become more and more sparse, villages farther between, and you begin to get an idea of what is to come. Initially, when you enter the National Park of La Vérendrye, it appears little different to adjacent land but as your drive progresses, you realize that there are no houses, no stations, no street lights: no signs of any human civilization for kilometres except for the lonely telephone wire and the asphalt of the road itself. The reality of the desertedness suddenly hits you when you lose all radio stations and you find your cellular displaying the “no signal” message. One deserted sky-blue lake after another passes by with breathtaking undisturbed beauty. As far as the eye can see, one cannot find a single lakeshore house, cottage or cabin. The deafening silence and stillness of the flora and fauna is truly awe-inspiring.

Two hours and 150 km later you reach Val-d’Or, a typical northern Québec town located on the shores of Lac Blauin. At the turn of the century, rich gold deposits were discovered there and by 1935, the five-gold-mine town had a population of close to 5000 people who had arrived from all parts of Québec, Ontario and the US. The present population of 35,000 is descendant, as well, of Ukrainian, Irish, German, Polish, Finnish and Italian settlers that arrived in the 1940s, fleeing a war-torn Europe in search of work in the mines. Today, Val-d’Or remains one of the major active gold mining centres in North America. There are two neighbouring native communities: the French-speaking Algonquin tribe on the shores of Lac Simon and the English-speaking Cree community northwards of the city. Val-d’Or lies 528 km northwest of Montreal, 300 km east of Timmins (Ontario) and 2500 km southwest of the Labrador border.

Renovated several times since the fifties, the Centre Hospitalier de Val-d’Or houses state-of-the-art surgical equipment in a six-room operating suite that runs high efficiency every weekday. The emergency room has a thirty-bed capacity, which includes a trauma room, and the adjacent 6-bed ICU is fully equipped for both surgical and medical cases. There are over 30 family doctors, and several in-house specialists including a cardiologist, a respirologist, an urologist, a physician a gastroenterologist, three gynaecologists, several paediatricians and even a nuclear radiologist. There are also visiting plastic surgeons and radiologists. Although most traumas are directed to the orthopaedic centre of Amos, the odd one may arrive at Val-d’Or’s ER and will usually require the assistance of Surgery.

The Surgery Department chaired by Dr. José Mijangos (McGill), consists of Dr. Denis Brouillette (U of M), Dr. Janet Booth (McGill), as well as three obstetrician-gynaecologists and an urologist. The surgical resident operates 5 to 7 days a week with each of the three general surgeons and with any of the others should he or she wish to do so. The general surgery staff is young, dynamic and remarkably geared towards resident teaching. They are grateful for the resident’s work yet easily run the service resident-free. There is a low threshold for giving away cases to the resident, promoting a collegial atmosphere in the OR as well as on the wards and the ER. Cases include colon and bowel resections, APRs, liver and biliary surgery, gastric bypasses, Nissen’s, thoracic surgery, thyroidectomies, skin grafting, paediatric surgery and the latest laparoscopic techniques. (Choledectomy, laparoscopies, thoracoscopies, Nissen fundoplications and appendectomies.) The surgical resident is traditionally first call for anything, but the staff will often offer to cover some calls themselves. Both ER MDs as well as floor nurses minimize useless calls and “scut” is virtually non-existent. The resident usually takes every two to three weekends off to go home to Montréal.

The Val d’Or Team (top to bottom and left to right)

Drs. J. Mijangos, D. Brouillette, J. Pascual (Resident), J. Booth
While only McGill surgical residents rotate through surgery, family medicine residents and medical students from Laval rotate through other specialties. Most of the hospital personnel including non-surgical staff usually get to know the resident and often invite him or her to social activities, sports, outings and receptions. The surgeons themselves go out of their way to treat the resident to lunch, dinner, BBQs, boat rides and even skidoo rides. An anaesthetist will also, on occasion, take the resident on a hydroplane ride over the breathtaking northern landscape of hundreds of lakes and rivers.

The surgical residents are housed in a comfortable building adjacent to the hospital, each with a private room with telephone TV and sink. There is a common kitchen for the 5 itinerant MDs. The hospital provides a stipend for the resident to cover travel expenses and invites him or her to any hospital event, often carried out at some of Val-d'Or's very fine restaurants. There is a movie theatre and a sports complex with pool, gymnasium and a free-weight room available for a small fee. Nature is, of course, the number one touristical attraction of the region, with multiple skiing and hiking trails as well as a picturesque beach on Lac Blouin which is open to the public during the summer months. Tourists may also be taken down to visit a fully operational gold mine in the outskirts of the town.

There is no question that this three-month rural rotation has been one of the most valuable experiences of my residency to date and that it has improved and solidified my surgical and diagnostic skills tremendously. The degree of experience that I have acquired by doing over 225 cases myself cannot be underestimated. In what concerns the staff, I can only be grateful to have had the opportunity to work with three surgeons that are vibrant, in touch with the current advances in the field and who have now become wonderful friends. I believe that McGill can boast Val-d'Or as a true gold mine for its surgical residents and hope it will continue to support this rotation as it has in the past.
A DECADE OF LIVER TRANSPLANTATION
AT MCGILL

10th Anniversary at McGill

By Jean Théberge, M.D.

The Liver Transplant Program at McGill University is about to celebrate its 10th birthday. Despite several transplants done in the 1970’s, the program was put to rest only to be resurrected in 1990 by myself. Since the program’s rebirth, we have performed nearly 300 liver transplants. We have become the busiest transplant center in the province, and one of the busiest centers in Canada. In 1991, Dr. Jeffrey Barkun joined our ranks. He has proved himself throughout the years as being an essential and dedicated team member. As our program continued to grow, we found ourselves needing additional manpower. In 1992, we retained the services of Dr. Marcelo Cantarovich, a nephrologist by training, who has evolved into an excellent immunologist and transplant physician. In 1995, Dr. Elliot Alpert joined us from the Jewish General Hospital to initiate the hepatology side of the transplant program. In 1996, we recruited Dr. Peter Metrakos back to the Royal Victoria Hospital bringing back his expertise following a transplant fellowship in Minnesota. Finally, in 1997, we added Dr. Marc Deschénes to our hepatology team. The Liver Transplant Clinic is staffed by two dedicated nurses, Maria Poloni (Pre-Transplant), Maria Sevaptidis (Post-Transplant), and we will be welcoming a third co-ordinator, Lucy Doyle, to our ranks in the next few months.

Our group has published extensively and we have made numerous research contributions in the field of liver transplantation over the years. Our strengths include transplant immunology, novel immunosuppressive protocols, controlling immunosuppressive side effects (nephrotoxicity and osteoporosis), and preventing post-transplant recurrence of hepatitis-B. We have a 90% success rate in preventing the recurrence of hepatitis-B post-transplant (39 patients with a seven year follow-up), which has not been equaled anywhere else in the world.

With the help of Dr. Marcelo Cantarovich, we have been trying new immunosuppressive protocols to reduce renal toxicity, such as holding off on using calcineurin inhibitors for six weeks following liver transplantation (using ATG). We present our data regularly at meetings on the national and international level.

Over the past ten years, we have been able to watch our program flourish and I can only hope that the next ten years will be even better.

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Addendum

ADDITION TO LAST ISSUE’S ARTICLE ON TRANSPLANTATION: THE EARLY DAYS

The first successful liver transplant at McGill was performed by Dr. L. Rosenberg and Dr. J.-M. Laborge in 1988.

The Pancreas Transplant Program at McGill was started in 1988 by Dr. L. Rosenberg. The first combined kidney-pancreas recipient is still alive 10 years later with both grafts functioning.

Departure

Dr. Peter Richardson has left the MGH and effective September 1st, 1999, his new address is:

Department of Neurosurgery
The Royal London Hospital
Whitechapel
London, U.K. E1 1BB.
E-mail: p.richardson@qmw.ac.uk

The Square Knot wishes him well.
The 5th Annual Royal Victoria Hospital Liver Transplant Fund-Raising Dinner was held on November 21, 1999 at Milos Restaurant. As always, it was a great success. This year's honorary president was Mr. Yvan Cournoyer, of the Montreal Canadiens and once again Mr. Ted Blackman of CIAD emceed the event. A total of 220 people including patients, pharmaceutical representatives, physicians, and friends of the Liver Transplant Program attended the semi-formal event. This year, we raised over $50,000 making this our most successful effort to date.

We were also pleased to announce that Dr. Jonathan Fridell was awarded his Master's Degree in Experimental Surgery after toiling in my laboratory for two years. Another one of my research fellows, Dr. Antonio Di Carlo, was awarded the first ever Michael Cohen Liver Transplant Fellowship, and he will be continuing with his research for another year.

Our Guest of Honor this year was Dr. Pierre Daloze. He was presented with a Certificate of Recognition from the Liver Transplant Program at McGill University in commemoration of his contributions to the field of liver transplantation in Canada, being the first surgeon to perform a liver transplant in Canada in 1970.

Dr. Peter Metrakos, Director of Pancreas and Kidney Transplantation at the MUHC and Dr. Nicolas Christou, Head of Division of General Surgery MUHC.
THE DEVELOPMENT OF AN OPTIMAL IMMUNOSUPPRESSION PROTOCOL IN A PRECLINICAL MODEL OF SMALL BOWEL TRANSPANTATION

Patients with short gut syndrome, half of whom have Crohn's disease, are typically kept alive with total parenteral nutrition (TPN) commonly known as intravenous feeding. Intestinal transplantation is the last option for those patients who experience difficulties with TPN. Current one year patient and graft survival rates of 83% and 72% make this therapy far from ideal. The major obstacle to the routine use of intestinal transplantation is our inability to find an immunosuppression regimen that will prevent an over-reaction of the immune system that often leads to rejection of the transplanted organ without disarming the patient's immune system to the extent that the patient is ridded with infections, or post-transplant lymphproliferative disorders. The development of an immunosuppressive protocol that can induce lasting hyporesponsiveness would allow intestinal transplantation to become the treatment of choice for all patients with intestinal failure.

A variety of techniques have been described that use some form of white blood cell transfusion as part of a regimen to produce donor-specific hyporesponsiveness. Previous studies in our laboratory in a rat small bowel transplant model with blood transfusion and low-dose immunosuppression has prevented rejection and significantly increased graft survival. We are currently investigating the efficacy of whole blood transfusion in combination with low-dose immunosuppressant regimens in a preclinical pig model.

The ASCRS Research Foundation Limited Project Grant was vital to the support of the work in our laboratory.

DONATION FROM

Johnson & Johnson

Mr. Ian Lawson, General Manager, Surgical Intervention Products presented a cheque in the amount of $21,407. from Johnson & Johnson to Dr. Joe Meakins. This cheque represents a rebate on total suture purchases and is one of the components of the Hospital's Wound Closure Agreement with Ethicon. The Montreal General and the Montreal Children's are the only two hospitals in Quebec to have this agreement. The cheque was given by Dr. Meakins to Claude Lemay, Operating Room Co-ordinator to be used for O.R. staff development.
THOUGHTS ON A NEW CAREER
(Otherwise known as retirement)
In May 1997, I was away from Montreal, missing the annual banquet at which I was to receive kudos and a gift on retirement. I was sailing on a "leg" from Pepeete to Bora-Bora in the South Pacific with a friend who was sailing around the world. Since I did not speak when presented with my retirement gift from the Department of Surgery in 1998, I thought it might be opportune to obey Ed Monaghan's request for contributions to The Square Knot.

A few words about my first career. I graduated from McGill with a B.Sc. (Honours Physiology) in 1952, and studied medicine at the University of Geneva. Studying at a first class school of medicine in the middle of Europe in the '50s was a great gift. I trained in general surgery at the Jewish General and in pediatric surgery at l'hôpital Sainte-Justine. I began private practice in 1965. At the time, one did not sign out at 5 p.m. in case a potential referring doc would ask you to sew up a laceration or examine a possible appendicitis. I began to carry out research in the labs at Ste. Justine in graft preservation, studying several normothermic and hypothermic solutions, as well as adopting cryobiological techniques to this field. An exciting prospect was to consider the possibility of frozen organ banks as was the case with unicellular units such as RBC's. I worked with many collaborators over the years, investigating preservation of segments of bowel, kidneys and islets, with support from the MRC for 15 years. Unfortunately, efforts at long-term low temperature preservation of whole organs have eluded science. The geometry of a whole organ is just too complex. Simply put, water freezes faster than it thaws as the process proceeds through the organ. Consequently, while it is fairly easy to affect a uniform freeze, thawing requires some process which is ultra rapid to avoid damage. Sporadic success was obtained using microwave convection. Later, I branched out into immunological modification on small bowel transplantation with the great help of Jean Tchervenkov.

I was, even for the time, unusual in that I went from private practice to academia, not the reverse. I became Associate Professor at McGill and at the University of Montreal in the '70s. Thanks to the support of Tony Dobell, I became Head of the Division of Pediatric General Surgery at the MCH, and Professor of Surgery in 1981. I believe I was the first Jewish Full Professor in General Surgery at McGill. I came to appreciate the strong support of David Murphy, Herb Owen, Lloyd MacLean, Dave Mulder and Joe Meakins. I want to thank them for their support. I also want to thank Joe Meakins and Jean-Martin Laberge for their kind remarks at the annual banquet.

I have always strongly felt that surgeons are not comparable to general practitioners, radiologists, pathologists, psychiatrists, etc., some of whom are able to function into their 70's competently. I do not know when the cut-off age is reached. I do know that I was trained by surgeons working into their '80s and I was telling them what to do (and doing it) while still a junior resident! While I now ski better than I did at 35, I felt like Wayne Gretzky; it is better to leave while you are still ahead.

And I had another reason. I wanted to get on (while I still could) with my goal of writing a biography of a well-known (in his day) liberal French-Canadian (si j’ose m’exprimer ainsi) politician Senator Telesphore-Damien Bouchard (no relation). For the past 15 years, I have been tutored by Professor Brian Young of McGill’s Department of History. He guided my study of Quebec history. I have used the past three years productively and recently sent the manuscript to several publishers. So I hope to be able to invite you all to the book launching in the near future! In January, I began a qualifying year for a Master’s degree in History at Concordia University and have turned in two term papers so far.

Too often, because medicine is such an overriding passion, we have no outside interests. We are living longer and longer. I urge all my younger colleagues to think about what they would like to do when they change careers.

Chuck Nevitt, North Carolina State basketball player, explaining to coach Jim Valvano why he appeared nervous at practice: “My sister’s expecting a baby, and I don’t know if I’m going to be an uncle or an aunt”. —1986
PLASTIC SURGERY VISITING PROFESSOR
- DR. BAHMAN GUYURON

The Division of Plastic Surgery was delighted to host Dr. Bahman Guyuron as the American Society of Aesthetic Plastic Surgery Visiting Professor on November 17th, 1999.

Visiting Professor

Dr. Guyuron is Clinical Professor of Surgery (Plastic) at Case Western Reserve University in Cleveland. He is board certified in both General Surgery and Plastic Surgery, and is internationally recognized as a leader in his chosen field, especially in the analysis and management of nasal deformities and correction of difficult noses. Dr. Guyuron is the author of 103 peer reviewed publications, 22 book chapters and 1 textbook. At the present time, he has 5 publications in press, 4 book chapters in press, and 2 textbooks in progress. As well, he continues with many clinical research projects ongoing as part of a very busy clinical practice.

His visit began with sit-down rounds, presentations and problem cases. Participating faculty presented difficult cases, and analysis and treatment plans were developed in a free discussion between Dr. Guyuron, plastic surgery residents and the attending who presented the cases - Drs. Brown, Benchetrit, Lessard and Jorge Schwarz.

Two lectures in Dynamics of Rhinoplasty and Rhytidectomy and Neck Contouring completed the formal part of the program. A highlight was the casual luncheon with the residents of McGill and the University of Montréal and Dr. Guyuron, where free wheeling discussions occurred about all facets of esthetic surgery and practice establishment.

Members of the McGill Division of Plastic Surgery and especially the residents are indebted to the American Society of Aesthetic Plastic Surgery for sponsoring this very successful program.

SYMPOSIUM ON CONGENITAL HEART DISEASE CARDIAC PATHOLOGY — Developmental, Diagnostic and Surgical Applications

A symposium was held on December 2nd and 3rd, 1999 on congenital heart disease. Dr. Christo Tchervenkov, Director of the Division of Cardiovascular Surgery at the Montreal Children's Hospital in conjunction with Dr. Nicolaas van Doesburg, Director of the Division of Cardiology at Hôtel Sainte-Justine, were the program co-directors. The guest speakers were Dr. Richard Van Praagh and Dr. Stella Van Praagh from Harvard Medical School and the Children's Hospital in Boston. Drs. Richard and Stella Van Praagh, who are Professor and Assistant Professor of Pathology respectively, gave several lectures during the two days of activities at both hospitals. It was a great pleasure to have them as guest speakers. Having friends at both pediatric institutions, it was particularly fitting that they were the focal point of this joint venture between the Montreal Children's Hospital and Hôtel Sainte-Justine.
Dr. Swiontkowski is Professor and Chair in the Department of Orthopaedics at the University of Minnesota. He obtained his undergraduate and medical school training in California. His internship and residency were spent at the University of Washington in Seattle, and he did fellowship work in Davos, Switzerland before returning to North America to work. He has received numerous awards and honors during his career. His fellowships have included the prestigious North American Travelling Fellow in Orthopaedics and the international ABC Fellow in 1989. In 1997, he received the highest award for research by the Orthopaedic Research Society – the Kappa Delta/OREF Clinical Research Award for his work on outcomes research in trauma. Dr. Swiontkowski has been instrumental in the implementation of musculoskeletal outcome instruments in mainstream orthopaedics in North America, and has a strong influence on modern orthopaedic thinking.

On Thursday, February 10th, 2000, at the MGH Surgical Grand Rounds, he gave a talk on Outcomes Research Movement: Why, How, Who? The morning consisted of academic program presentations by the residents. The winners of this session were:

- F. Dupuis
- Dr. G. Elder
- Dr. L. Morrison
- Dr. A. Pusic

Following a luncheon with the surgical residents, Dr. Swiontkowski then went to the Montreal Children’s Hospital and after case presentations gave Surgical Grand Rounds. His topic was Femoral Neck Fracture Management - Pediatric to Geriatric.

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Surgery at The MGH, c.1890
Some Data Regarding The General Surgery Residency Training Program from Program Director, Dr. Judith Trudel

**TRAINING REQUIREMENTS IN GENERAL SURGERY**

Royal College of Surgeons - Canada
- 5 years of training
  - 2 years of Core
  - 2 years in General Surgery (includes one Senior or Chief year)
  - 1 year research, or relevant area in General Surgery or up to 6 months in Pathology

**CORE PROGRAM**

PGY I and II (2 YEARS - 26 PERIODS)
- General Surgery
- Trauma
- Surgical ICU / Critical Care
- Vascular Surgery
- Pediatric Surgery
- Endoscopy
- Orthopedics
- Cardiothoracic
- Electives: 4 or less
- any of the core rotations plus
- ER, ENT, Gyne, ID, Neurosurgery, Oncology, Path, Plastics, Radiology, Thoracic, Urology, others

**FLEXIBLE YEAR**

PGY III
- RAMQ: 5 years of support (unless failure)
- Career Goals - Academic / Rural
- Options:

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<td>2 or 3 years</td>
<td>- 6 months intensive course</td>
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<td>6 mo paid by RAMQ</td>
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**6 Months Basic/Clinical Research**
- basic or clinical research project in, e.g.:
  - colorectal surgery
  - minimally invasive surgery
  - vascular surgery
  - hepatobiliary / transplant surgery
  - epidemiology
  - trauma / critical care
  - education

**TEACHING HOSPITALS**
- In Montreal:
  - McGill University Health Centre
  - Montreal General Hospital
  - Royal Victoria Hospital
  - Montreal Children's Hospital
  - Jewish General Hospital
  - St. Mary's Hospital
- Outside of Montreal:
  - Gatineau: Centre hospitalier de l'Ouatsouais
  - Ormont: Centre hospitalier de Val d'Or
  - Val d'Or: Centre hospitalier de Val d'Or

**WHERE DO OUR CHIEF RESIDENTS END UP?**

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**Surgical Scientist Program**
- provides research training for residents pursuing a career in academic surgery
- for PGY III or at the end of clinical training
- 2-3 years in length, leading to M.Sc. or Ph.D.
- $35,000/year salary support, $5,000/year for academic activities
- highly competitive

**RAMQ STIPENDS**

Pay Scales as of July 1, 2000
- PGY - 1: $35,503
- PGY - 2: $39,516
- PGY - 3: $43,575
- PGY - 4: $47,616
- PGY - 5: $50,847
We can’t do it without you!

Write to us! Send us your news!

We want to hear from our readers!
If you have any information you want published in THE SQUARE KNOT, comments about our newsletter or suggestions, we want to hear from you!

Send submissions to:
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