and we mandate referral. Whether this advice applies to other types of behaviour that people find sinful, such as adultery, child abuse and lying, is not stated. Perhaps we need a list of referrable sins and colleagues who agree with them. Drs. Robinson and Cohen opine that physicians with good understanding cannot provide optimal care to gay patients if they do not support their orientation. This belies an indifference to our calling to serve the patient's best interests first.

This curriculum is not about understanding, ethics or the good of the patient — the noble traditional pursuits of medicine — but about something foreign and foreboding. The curriculum-reform troops are at the school gates, but educators would do well to pause before admitting them with this self-interested agenda, threat to freedom of conscience and impoverished idea of what a good physician is.

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Calgary curriculum on gay and lesbian issues

The article "Gay, lesbian and bisexual health care issues and medical curricula" (*Can Med Assoc J* 1996;155:709–711), by Drs. Gregory Robinson and May Cohen, was welcome. As the authors note, gay and lesbian health concerns have all too often been absent or minimal in medical education. I am glad to see that these concerns are now being addressed at a national level.

I was dismayed, however, that the University of Calgary Faculty of Medicine was not discussed. Gay and lesbian issues have been on the curriculum here for 25 years. These issues currently constitute at least 4 hours of core curriculum, half of which involves large-group presentation, including gay and lesbian patients discussing their experiences with the health care system in Calgary. The other half of the time is devoted to small-group, preceptor-led sessions at which gay and lesbian issues in general and gay and lesbian health care in particular are discussed in a problem-based-learning context. Volunteer patients are available to the small groups to discuss their health care experience as well as issues concerning gay and lesbian experience and their effects on health.

These sessions are highly valued by the medical students and are often touted as one of the most meaningful of the learning opportunities in the entire core curriculum. I have been approached by students, residents and staff who acknowledge the importance of this area not only in health care delivery but in gay and lesbian physicians' place in the health care system.

We are now expanding the curriculum to include gay and lesbian youth issues, particularly cultural oppression and suicide, in the curriculum dealing with child, adolescent and family development.

I would be happy to share our curriculum with any interested readers.

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Curing and killing

As time passes, the wisdom of Hippocrates is more widely recognized. However, one aspect of the "Alberta Euthanasia Survey: 3-year follow-up" (*Can Med Assoc J* 1996; 155:885-90), by Drs. Marja J. Verhoef and T. Douglas Kinsella, is deeply disturbing; namely, the physician's view of who should do the killing, be it merciful or merely contractual.

Canadian physicians who have practised medicine in parts of the world where pre-Hippocratic ethics survive need to share that experience with our colleagues at home. Long meditation on these realities undoubtedly inspired the Hippocratic Oath in the first place.

Animistic, natural or traditional healers, sometimes called "witch doctors," practise both killing and healing. They know about poisons. Thus, when you go to visit such a physician you must always wonder whether someone else has paid more for your death than you have paid for your life. Trust is very much reduced under such circumstances. Anthropologist Margaret Mead understood the radical implications of the Hippocratic Oath.

> For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with power to kill had power to cure, including specially the undoing of his own killing activities. . . . With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect — the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. . . . This is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer — to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . It is the duty of society to protect the physician from such requests.[1]

We believe that this argument should convince most physicians that we should have nothing to do with mercy killing. Taking on this

role erodes patient trust, a commodity we will need desperately in the future.

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Reference

1. Marker R, et al. Euthanasia: a historical overview. *Md J Contemp Leg Issues* 1991; 2:257-98.

Death of an Asian immigrant

The article "Sudden unexplained death in Asian immigrants: recognition of a syndrome in metropolitan Toronto" (*Can Med Assoc J* l996;l55:537–40), by Dr. Michael S. Pollanen and associates, is timely and significant in alerting physicians throughout the country of this rare syndrome. Although sudden unexplained death syndrome in Asian immigrants (SUDA) may be known to some physicians, particularly those involved in forensic work in metropolitan Toronto or Vancouver, I believe that most Canadian physicians, including pathologists, are unaware of it.

In July 1994 in metropolitan Montreal I performed an autopsy on a 31-year-old Vietnamese male immigrant at the request of the coroner's office. I did not find any cause of death or significant histopathologic alteration. Only visceral acute passive congestion and postanoxic selective neuronal early necrosis in the cerebral cortex and hippocampus were observed. (Full details are available upon request.) Although it was originally unrecognized as such, this case fulfilled the criteria for SUDA.

Immigration to Canada from southeast Asia is likely to continue, and patterns of settlement will probably become more complex. Since autopsy in cases of sudden death is not restricted to centralized forensic centres, it is crucial that physicians throughout Canada be aware of and recognize this rare syndrome.

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Deaths [correction]

In a recent death notice (*Can Med Assoc J* 1996;155:1740) the surname of Dr. John H. Lovering of North York, Ont., was misspelled. We apologize for this error. — Ed.

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