Cross-disciplinary training: Time to remove the blinders

I can certainly empathize with Dr. Douglas Hamilton's difficulty in finding suitable work in Canada, as reported in the article "Frustrated by lack of job opportunities in Canada, MD moves to US space-medicine program" (*CMAJ* 1998;158[3]:384-5), by Lynne Sears Williams. Hamilton's combination of training in medicine, engineering and informatics no doubt puzzled many potential employers, whose traditional blinders prevent them from realizing that cross-training in other disciplines can benefit medicine.

During my residency in general surgery, I developed an interest in medical informatics. Some of the staff surgeons were supportive, but at least one advised me to "quit wasting time" on computers. After my training ended, I worked in rural Alberta for a year and then moved to the US to pursue a master's degree in informatics. Near the end of my fellowship I started to search for a position that would allow me to combine my learning in these 2 fields.

Whenever I identify my specialty as informatics, the most common question from other physicians is: "What is that?" After explaining that informatics involves computer technology and information management, a second question inevitably follows: "What does that have to do with surgery?"

This failure to see beyond the walls of the operating theatre has meant that I have faced a prolonged job search. I contacted several Canadian academic centres with little success. One centre did seem interested, but a site visit quickly convinced me there was no support for the position.

Like Hamilton, my peculiar combination of degrees is pointing to a career south of the border, where several institutions have expressed interest in a surgeon with expertise in informatics. If and when a similar position becomes available in Canada, I will be happy to consider it. I have a suspicion, though, that I may be waiting for a while.

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Princess Diana's tragic legacy

I read with emotion the article "A princess dies, a surgeon reflects" (*CMAJ* 1997;157[10]:1402-3), by Dr. Ian B. Ross. His experience is a telling reflection of the personal aspects of such an event. What is astounding is that so many of us grieved for the princess.

Although Ross also discussed the major, and at times insensitive, role of physicians during such tragedies and examined the need for us to reflect on these events, he only scratched the surface of our very important role as advocates of accident prevention. We must not let Diana's misfortune dim from our minds without considering this aspect of our profession.

As a neurosurgeon working in a busy trauma centre, I care for injured patients every day. Unfortunately, injuries are far and away the commonest cause of death and serious disability in those under 40. Motor vehicle crashes, not surprisingly, account for a significant portion of them.

Of course, most car "accidents," including the one that claimed Diana's life, are not accidents at all. They are, as Ross correctly states, "crashes," most involving some form of high-risk behaviour. Crashes involving drinking and driving, speeding or a failure to wear safety restraints are not accidental at all, and this is where our opportunity lies.

We can become agents of prevention by counselling our patients. Many physicians are not aware that brief interventions may be the most cost-effective approach to prevention, especially for drinkers who are not alcohol dependent.[1] As well, most are not aware that counselling by physicians can lead to increased use of children's car seats[2] and that these seats reduce the risk of death or serious injury by approximately 70%.[3]

Physicians need to reflect on this tragedy on both an emotional and a professional level. If Princess Diana had never entered a car with a driver who had been drinking, had refused to allow the driver to speed and had worn her safety belt, she would probably have made it home to her beloved children. Her death should force us to reconsider what actually happened — and what happens countless times every year in the communities we serve. Ironically, this could be her greatest gift to humanity.

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Familial abuse: a multifaceted problem

When approaching a problem as politically and emotionally charged as domestic violence, one has to choose between the mythology of the day and reality. The "Edi-

tor's preface" and associated articles in the Dec. 1, 1997, issue unfortunately seem to prefer the former. Common to all of the articles is the implication that spousal abuse is synonymous with wife abuse. Not one of these articles refers to the man as anything but the purveyor of violence, nor is the woman ever portrayed as anything other than the victim. The facts point in another direction. Women are at least as likely as men to resort to violence in the home, including being the first or the only one to strike.[1,2] Probably the most telling evidence is that the incidence of domestic violence in female homosexual households approaches that seen in heterosexual ones.[1] In the US, where handguns are freely available, a man is just as likely as a woman to wind up dead after a domestic altercation.[1] Given these statistics, why couldn't the questionnaire "The eight types of abuse" (*CMAJ* 1997;157[11]:1557-8), presented by Fern Martin and Dr. Catherine Younger-Lewis, be recommended for both men and women, and why weren't men at least mentioned as potential victims?

More disturbing is Dr. Barbara Lent's implication, in her editorial "Responding to our abused patients" (*CMAJ* 1997;157[11]:1539-40), that child abuse is committed solely by men. Patricia Pearson's recent book states: "Women commit the majority of child homicides in the United States, a greater share of child abuse . . . about a quarter of child sexual abuse, [and] an overwhelming share of the killings of newborns. . . ."[1]

What I find most offensive is *CMAJ*'s participation in the annual exhumation of Mark Lepine and the subsequent waving of his corpse in the face of men everywhere. Do we routinely parade the names and stories of female multiple child murderers? When a similarity between me and Lepine is implied on the basis of my sex alone, I am both insulted and disgusted.

It is time to take a balanced view of domestic abuse, and we must be ready to accept the uncomfortable reality that violence is not the sole responsibility of one of the sexes. As Nicole Baer points out in her article "MDs have key role in bringing ugly secret of wife abuse out of closet" *(CMAJ* 1997;157[11]:1579-81), there is growing evidence of societal indifference to domestic abuse. Biased journalism such as this can only contribute to this trend. For a publication that has been trying hard to be seen as an evidence-based source of information, ignoring half the facts leaves it looking more than a little hypocritical.

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Recognizing and responding to spousal abuse should not be restricted to screening the female partner, as suggested by the editorial and articles in the Dec. 1, 1997, issue of *CMAJ*.

An abused woman in my practice recently left her husband, after years of counselling and support. A week later her husband arrived at my office. He had eaten little in the previous 7 days, subsisting largely on cof-

fee, rye whisky and cigarettes. He was poorly dressed and barely washed. He had a terrible headache and constant chest pains. He was suicidal.

While in no way condoning the abuse this man had inflicted on his wife, I realized that over the years no one — myself included — had offered him much help in dealing with his lack of self-esteem, alcoholism, and poor communication and homemaking skills. This was an ill man at significant risk of dying.

Men of low socioeconomic status and those with drug or alcohol addiction or a family history of violence and authoritarianism are at risk of becoming abusers, and abusers are not a healthy group, experiencing higher rates of addiction, job loss, incarceration and early death.[1,2] In the 16 years I have been in practice here, one woman has been murdered by an abusive partner, but at least 4 abusive men have committed suicide.

There are too few treatment programs for men, and fewer still are the prevention programs for children and adolescent boys. Many abusive men are capable of learning.[3] They can be better partners to the women in their lives and better role models for their children. We should be actively identifying and treating the man (as well as the woman) who is, or might become, involved in an abusive relationship. It might just save his life.

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[One of the authors responds:]

Dr. Rudrick's request for a "balanced view of domestic abuse" contrasts sharply with his emotional response to my editorial. Although I agree that it is important to acknowledge that men may be the victims of domestic violence perpetrated by women, violence and abuse within intimate relationships are not gender neutral. Numerous reports founded on community-based surveys and police statistics indicate that men are much more likely to inflict abuse and women are much more likely to be the victims. Yes, women in both heterosexual and lesbian relationships have been known to behave in an abusive or violent manner toward their partners, but this represents a relatively small proportion of abusive intimate relationships.

Rudrick cites US data on murders in domestic situations, but because of differences in social systems and gun laws, these data are not relevant to the Canadian situation. Domestic violence accounts for 15% of all Canadian homicide victims, the risk being greater for women (3.2 women are killed by their husbands for each man killed by his wife).[1] In 32% of cases in which a man kills his wife, he also commits suicide. Clearly, physicians need to see domestic violence as a potential health risk for both female and male patients.

Children are potential victims of these abusive relationships as well. Data from Statistics Canada[2] indicate that children witness 40% of the abusive incidents in their home, and these experiences have been shown to have a negative impact on the health and well-being of both male and female children and also increase the likelihood that these children will later become involved in abusive relationships.

Physicians must continue to consider the possibility that violence and abuse may influence the physical and mental health of all their patients, male and female, adult and child, while recognizing that such experiences are more common in certain subsets of their patients.

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Overpopulation and Rwanda

May I congratulate Christopher Andrews on his perceptive and graphic comments in the article "Words cannot describe: a trip into Rwanda's heart of darkness" (*CMAJ* 1998;158[1]:84-6). More than 60 years ago, also armed with a BSc, I started nutrition surveys in South Africa. There I learned about the wider aspects of environment and nutrition.

At that time Rwanda had a population of about 1 million. It supported many wild animals and was covered by tropical forest. Today it is the most densely populated country in Africa, with about 1 hectare of cropland for every 6 people. There is still some forest left, but large amounts are being cut down each year.[1] The country also supports large numbers of domestic farm animals[2] and more than 5 million people in an area less than half the size of Nova Scotia.

The Germans and then the Belgians brought "development" to Rwanda in the form of tea and coffee plantations, forestry, better transportation, some education, hospitals, extra food and trade goods. However, they did not bring a family-planning program. Simple overcrowding on agricultural land has