Anatomy is still essential

A century ago, anatomy had a prominent place in medical education. The recent knowledge explosion in the cellular and molecular aspects of disease might lead the designers of medical curricula to think of anatomy as a backward relic, no longer necessary in a medical education. Thus, medical schools in the United States[1] and abroad have been downsizing their anatomy departments for decades.

Educational policy in medicine directly affects the ability of future doctors to practise medicine safely. History-taking, inspection, palpation, percussion, auscultation, imaging and surgery all require knowledge of how the body is constructed at the cell, tissue and organ system levels. Looking up anatomic facts and pictures just before a procedure is no substitute for a rigorous knowledge of anatomy.

Documented iatrogenic injuries caused by inadequate anatomic knowledge include damage to the popliteal blood vessel during arthroscopy,[2] damage to the cervical spinal cord during interscalene block,[3] transection of the median nerve during carpal tunnel surgery[4] and femoral nerve injury during abdominoperineal resection.[5] The issue of deficient physician knowledge of anatomy leading to errors is part of the broader issue of medical errors causing injury and death, an extremely controversial topic.[6]

The expurgation of anatomy from medical curricula should be consciously avoided.

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Death in our prisons

The recent article on causes of death among people in custody in Ontario, 1990-1999,[1] raises a variety of issues. In comparing rates of suicide in custody with rates in the community, the authors examined only suicide by strangulation. However, because many more means of suicide are available to people in the community (e.g., firearms, poisoning, drowning), a more appropriate analysis would have been to compare total suicide rates between prison inmates and the community.

The 1991 Canadian suicide rate for men 25 to 44 years of age was 28.8 per 100 000; in 1996, the rate was 24.7 per 100 000.[2] Using an average of these rates and the prisoner-years at risk in federal inmate populations provided in Table 2 of Wendy Wobeser and associates' article,[1] we might have expected 8.6 suicide deaths in federal institutions in Ontario over the 9-year period for which exposure data were provided (1990–1998), but there were in fact 32.4 deaths in that period (based on the 36 deaths that occurred in the 10 years for which data were available). It would therefore have been more appropriate to state that suicide rates among federal inmates were about 3.8 times higher than in the community, rather than the 10-fold difference mentioned in the article.

The inmate population is dramatically different from the typical community population with respect to prevalence of mental disorders, history of substance abuse and other important factors. It would be interesting to compare the suicide rates of prison inmates with those of more comparable com-