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.

Roland N. Auer
Professor
Department of Pathology
and Laboratory Medicine
Faculty of Medicine
David S. McDonald
PhD Candidate
Department of Neuroscience
University of Calgary
Calgary, Alta.

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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-

munity populations, but such data are not available.

The higher rates of inmate suicide remain a priority concern for Correctional Service of Canada (CSC). The suicide rate in federal prisons varies from year to year but is showing an overall downward trend (Fig. 1). CSC has recently adopted a new policy to ensure a comprehensive strategy for prevention, management and response regarding suicides. In addition, an awareness and prevention workshop is being made available to all inmates.

The authors did not contact our office for information or to discuss the interpretation of their findings. If they had, we would have informed them of these activities.

Françoise Bouchard
Director General
Jane Laishes
Senior Manager, Mental Health
Health Services
Correctional Service of Canada
Ottawa, Ont.
Brent Moloughney
Public Health Consultant
Newmarket, Ont.

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Contrary to the Ontario data shown in Table 2 of Wendy Wobeser and colleagues' article,[1] the suicide rate in provincial prisons in Quebec seems higher than that in federal penitentiaries. In fact, a special Quebec coroner's inquiry[2] showed that the suicide rate in provincial institutions in Quebec was 339.8 per 100 000 between 1992 and 1996. For the same period, provincial institutions in Ontario had a much lower rate (44.3 per 100 000), and for all provincial institutions in Canada, the mean was 101.2 (range 0 to 339.8).[2] For a comparable period (fiscal year 1993/94), the rate in Canadian penitentiaries was 185 per 100 000, but again, the range has been large (the extremes being 246 in 1982/83 and 88 in 1989/90).[2] This range of data shows that we must be cautious in analyzing these relatively small numbers of events, which must effectively be estimated on a population basis (per 100 000).

It is true that the rate of violent deaths is high among incarcerated people, particularly men. Ideally, these rates should be compared with rates in equivalent populations, for example, men from 24 to 49 years of age, as Wobeser and associates[1] did. But we should go one step further and compare rates among incarcerated delinquents and non-incarcerated delinquents. This is not easy to do, but Pritchard and colleagues,[3] for example, showed that the rate of violent deaths among people on probation was 10 times higher than in the general population. For those aged 35 to 54, the rate was 35 times higher. Other researchers[4,5] have shown that characteristics such as these reflect the delinquent population, rather than the correctional system. This is not to say that institutions have no responsibilities in addressing the problem. On the contrary, we should take full advantage of the opportunity to help these people while they are available for care in a correctional institution.

In closing, let me reiterate that correctional facilities are not necessarily the best places to treat people. Diversion programs, such as the ones being implemented now in Quebec[6] and elsewhere, are much better alternatives, at least for those with serious mental health problems.

Marc Daigle
Centre for Research and Intervention on Suicide and Euthanasia
Philippe-Pinel Research Centre
Université de Québec à Trois-Rivières
Trois-Rivières, Que.

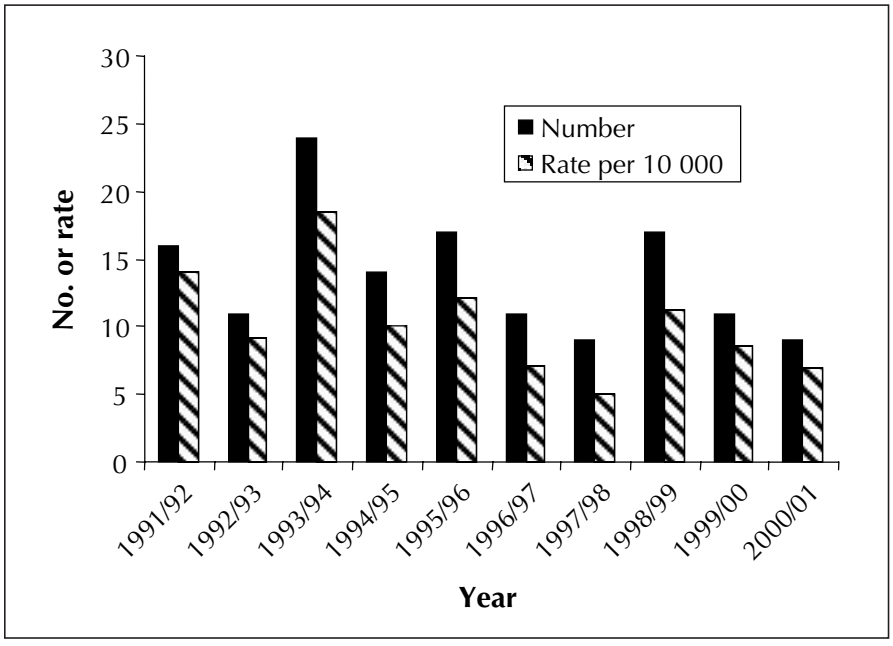

Fig. 1: Number and rate of suicides in federal prisons, 1991/92 to 2000/01.

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