Incidental findings and patient autonomy

In their article on handling incidental findings, Ells and Thombs[1] compare the extensive official guidance available in the United States with the rather more concise comments for Canadian researchers in the Tri-Council Policy Statement.[2] Although the report, "Anticipate and communicate: ethical management of incidental and secondary findings in clinical, research, and direct-to-consumer contexts,"[3] provides helpful details for US-based research, the Tri-Council Policy Statement is essential in the Canadian context.

A core principle of the statement is respect for persons, which incorporates the dual moral obligations to "respect autonomy and protect those with developing, impaired or diminished autonomy."[2] In the case of the competent patient, the moral obligation, according to article 1.1, is to respect autonomy. The statement further clarifies that "[r]especting autonomy means giving due deference to a person's judgment and ensuring that the person is free to choose without interference." Dictating what incidental information is withheld, in the absence of patient input, interferes with a patient's freedom to choose without interference.

Ells and Thombs'[1] recommendation that the plans for incidental findings simply be described to patients could be revised to ensure patient awareness of their own autonomy. Article 1.1 could be preserved by seeking the patient's decision after describing the potential benefits and harms of disclosure of the incidental findings. This approach could elicit an informed decision while respecting patient autonomy and values and could be applied even when patient preferences differ from current research on the benefits and harms of disclosure.[4]

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Suicidal ideation and poverty in First Nations

Eggertson's article on gas sniffing shines a light on the conditions on the Pikangikum First Nation in Ontario.[1]

From 2007 to 2008, 25 of Pikangikum's 2500 residents (1% of the population) took their own lives; 16 were children under the age of 19.[2] This would be comparable to about 28 000 Torontonians taking their own lives. The number of suicides in Ontario each year is about 1100.[2]

As the Ontario Coroner's Report outlines, Pikangikum has inadequate, overcrowded housing, no indoor plumbing, little gainful employment, continuous food and water insecurity and no connectivity to the hydro grid. In 2007, 542 heads of household received social assistance.[3] This poverty results in substance abuse: children sniff gasoline, adults abuse alcohol. Death due to suicide is pervasive.

Canada continues to accept poverty as a societal inevitability. Yet the poverty rates of other wealthy nations (i.e., Sweden) are less than half of Canada's.[4] Canada ranks 21st in the world in child poverty, and 22nd in infant mortality.[5] Can we justify excess infant mortality and youth suicides in First Nations based on policy choices?

We need to establish a guaranteed annual income for all impoverished Canadians, including First Nations citizens. Our per capita spending on health care would likely decrease and population health would likely increase. Nordic nations, such as Sweden are "social democratic political economies" that "promote economic and social security for their citizens."[6]

Poverty is associated with poorer health for every income quintile.[7] Canada should redistribute its wealth to improve health, living standards and well-being for our vulnerable populations. We have been late to accept the concept of the social determinants of health. If we address poverty among First Nations people, we will likely begin to see mental illness, substance abuse and suicide rates abate in communities like Pikangikum.

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Perspectives on studying abroad

Barer and colleagues[1] present a sobering picture for Canadians studying abroad. Although the number of Canadians studying abroad continues to grow, the demographics of this population are changing. Personally, I have seen a decrease in the age of those applying to international medical schools and an