barring
Witness
for the
Dead
Robert Kirschner lets the wounds speak
Hey, you!

Wow, the times they are a changin’. So much has happened since we last connected that I don’t know where to start. This place is going ballistic! Construction – changes – every day! I’m afraid to go home at night in case they move the entrance on me (which they’ve already done by the way).

Our old department has been levelled and a new one is underway. I came in one day and there it was – GONE. It’s crazy, but the reality is – I love it!

These changes (they scared me at first) have given me a new lease on my career. The new equipment is so state-of-the-art and the new building will be awesome...I’ve included a picture of it – gorgeous, eh?

I also want to tell you how much I’m loving the ‘shared governance’ program here. I really feel like I’m a valued member of our culturally diverse team. My input into patient care, scheduling, and professional development is respected, which makes our department even stronger – and it feels great!

Got to run. I’m meeting friends tonight and need to be downtown in 20 minutes...at least there isn’t any highway construction. You really have to drop by and get a look at this place. I’ll give you the cook’s tour – that is as soon as I figure it all out!

All the best,

Me

p.s. Did you realize that the NYGH is a teaching hospital, a founding member of the Child Health network, and has the leading genetics program in the country! Isn’t that great!!!
In early 2001, when we began research into producing MEDHUNTERS magazine, the idea that events such as those of Tuesday September 11, 2001 would occur was unthinkable.
Prior to September 11, we had no thought of dedicating the magazine to anyone.
But, as we worked on the magazine in the days following the horrific events of September 11, it became clear that a dedication was fitting and merited.

We therefore dedicate this inaugural issue of MEDHUNTERS magazine to the frontline workers who risked their lives, and in many, many cases lost their lives, trying to help others: EMTs, firefighters, paramedics, doctors, nurses, and police officers.
We dedicate it to the individuals who transported the injured to triage centers and to hospitals.
We dedicate it to the hospital staff who received and cared for patients, families and friends, and who helped those searching for missing loved ones.
We dedicate it to the people who became impromptu care providers by assisting frightened, injured and disabled people to evacuate the buildings, by providing free food and water to the rescue and recovery workers, and by listening to those who needed a shoulder to cry on.

You are all credits to your professions and to humanity.

And, finally, we dedicate this magazine to those who lost their lives, and to their families and their friends.
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Researchers: Danielle Keir, Magda Lenartowicz
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Winter 2001
why we do it

For the past 20 years I have been interviewing healthcare professionals for international assignments. I have had face-to-face interviews with over 7,000 nurses, technologists, doctors, therapists, and administrators from throughout Canada and the United States. These individuals have relayed to me experiences that have inspired, educated, saddened, puzzled and entertained me.

From this has come MEDHUNTERS magazine. Published quarterly, it will tell the personal, behind-the-scenes stories of all types of healthcare professionals. There is a need for this type of journal. I feel that it is important that their stories be told. Healthcare professionals are generally seen only in the traditional role of care provider. There is currently no magazine that focuses on the person behind the professional. And there currently is no publication that addresses itself to all types of professionals within healthcare. This magazine will focus on the personal circumstances of people who have noteworthy ambitions or achievements, either within or outside their professions.

Why do healthcare people become involved in work and hobbies that require high doses of energy, commitment and personal risk ‘beyond the call of duty’? For three of the people portrayed in this issue of MEDHUNTERS magazine, the answer is clear. Robert Kirschner, Cathy Crowe, and Roy Male all use the word “witness”. They say that because they see suffering, they must act. They feel they have no choice. Other individuals seek variety and adventure. Still others feel a “calling.”

I have frequently asked, “How can you be so optimistic?” Recently, one geriatrician answered, “We’re optimists. You have to believe things will get better. Otherwise, how could you do the work?” I think that sums it up.
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Victoria, British Columbia

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First In, Last Out  By Karen Stiller
What motivates Dr. Roy Male to continue to risk his life and health in some of the poorest and most unstable countries in the world?

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Bearing Witness for the Dead
By Andrew A. Skolnick
People say that the dead do not speak. But Dr. Robert Kirschner proves otherwise. As a forensic pathologist, Dr. Kirschner brings a voice to the victims of brutal killings and unthinkable crimes. Cover photo: Lorraine Hart

Tech to Me
Walk this Way  By Mara Gorman
In Wilmington, Delaware, a small boy walks across a laboratory room and new gait analysis technology helps bring him one step closer to freer movement.

Departments

After Hours
Hooked on Sharks  By Heather Lindsey
Photographing sharks, the “chickens of the sea.”

Internist Gives Thumbs Up  By Heather Lindsey
A doctor says, “... looking at a movie can be like looking at a patient.”

The Diva Pharmacist  By Deborah Moores
Livia Beysevic: singing up a storm in the pharmacy.

On the Front
It’s Because I am a Nurse  By Marianne Meed Ward and Cynthia M. Piccolo
As a street nurse in Canada’s most affluent city, Cathy Crowe fights for the rights of homeless people.

New Horizons
SOS in Cambodia  By Christine Kuehn Kelly
Worried about a monkey bite while travelling in Cambodia? Find out how Anne Fine, RN, can help you.

Dedication

Letter from the Editor

Crossword, Jumble and Word Search

About MedHunters.com

Classified

Health Trivia

Pathways

A Weapon in the War on Cancer  By Christine Kuehn Kelly
Most people do not know the roles of those behind cancer research, individuals such as cancer registrars.

First Person

Finding Solace  By Beverly Sweet Forbes, RN
A nurse writes poetry to give insight into herself and her patients.

A Nurse Remembers  By Suzanne R. Allen, RN
There is one patient that Suzanne Allen will never forget. Neither will you.
An Open Invitation: Tell Us Your Stories!

MEDHUNTERS magazine is about people working in healthcare. We want, therefore, to hear from you! We are looking for stories and story ideas about people with a healthcare background. This may include people who are now working in other areas, such as business, politics, volunteerism, etc. These stories can be local or international.

We are asking for submissions from healthcare professionals, writers, photographers, and the general public. (If possible, we ask that writers and photographers submit work samples.)

SUBMISSIONS MAY BE FOR ANY OF OUR FEATURES (ARTICLES OF 1,200+ WORDS):
Cover Feature -- Spotlights an individual who has accomplishments in an area of global significance.
On the Front -- Presents individuals who have worked in unstable, dangerous or emotionally trying situations.
Healthcare Heroes -- Celebrates people who innovate or risk or dare or care or sacrifice ...
Tech to Me -- Focuses on the people behind a technology in healthcare.
New Horizons -- Explores the adventures and the personal growth of people who work in international locations.

OR SUBMISSIONS MAY BE FOR ANY OF OUR DEPARTMENTS:
Pathways -- Profiles of new/interesting/unsung jobs in healthcare (750-1,000 words).
After Hours -- Stories about the after-work hobbies or callings of healthcare professionals (750-1,000 words).
First Person -- An article written in the “first person” about a memorable on-the-job experience (300 words).
True Stories (a new department for the second issue) -- Humorous healthcare work-related anecdotes (75 words).
Healthcare cartoons -- A look at the lighter side of healthcare.
Little known charities or research organizations (a new department for the second issue)

LETTERS TO THE EDITOR
Do you have an opinion about something you read in MEDHUNTERS magazine? MEDHUNTERS magazine invites Letters to the Editor. (Note that letters may be edited for content prior to publication.)

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“The clinics we build may be destroyed by war. The children we restore to health may be malnourished again. Do I make a difference? Yes, for a time.”

By Karen Stiller
“I lost it one day. I had returned from Zaire and stood in a grocery store staring at five different types of grapes...I had to leave the store.”

Until family physician Roy Male found himself facing a rebel’s gun, it was a routine day of transporting medical supplies in Zaire. He and his Médecins Sans Frontières (MSF) colleagues had been jolting down a rough jungle road when screaming rebel soldiers ambushed their truck and kidnapped the group.

After prolonged hours of negotiating, and giving a gift of precious hand soap, the MSF contingent convinced the rebels that they were not smuggling arms, but carrying provisions to the people of the troubled African nation. Having lost their daylight travelling time, the members of the humanitarian organization continued their journey in the absolute darkness of an African night.

Since 1995, Male has served people in Zaire, Nigeria and the Republic of Congo as a member of MSF, known in English-speaking countries as Doctors Without Borders. Between missions he has worked short-term contracts in Canada: on Baffin Island in the far north, on the shores of Lake Huron in Western Ontario, and on Toronto’s inner city streets.

In Africa he made himself at home. He enjoyed the children’s exuberance and learned to make small talk in Swahili. He now counts the rich African music among his favorites. And the encounters with soldiers that were heart-stopping then, in retrospect make him chuckle.

When asked why he practices medicine in such desperate conditions, Male launches into a description of the diagnostic techniques and the painful treatment of sleeping sickness in Zaire.

“There is enough wealth in this world. Everyone has the right to basic healthcare, and that is enough to keep me going.” And he adds, “Wonderful things happen. You go to an out-post hospital and do some teaching, and leave supplies. You come back six months later and someone is doing the best that they can. It is beautiful.”

MSF, the world’s largest independent international medical relief organization, is committed to providing medical care wherever needed and to raising awareness of the plight of the people they help.

How do others react to Male’s choices? “Lots of people respect what I am doing, and some would like to be doing it themselves but can’t because of other responsibilities. Others don’t understand, and feel I am wasting my time.”

People often ask Male if he “makes a difference.”

“The clinics we build may be destroyed by war,” he explains. “The children we restore to health may be malnourished again. Do I make a difference? Yes, for a time. I put a Band-Aid on. It’s funny, no one ever asks me if I make a difference when I practice medicine in Canada…”

His work has also changed his life and perceptions. “I realized that all the material things our society values are not so important. It’s relationships with people that matter,” he says.

“What a privilege it is to live in a country like Canada. To have the freedom to walk down the road and not look into people’s hands to see if they have a gun. To live with a justice system that works, more or less. It is a healthy, sane society overall.”
Male struggles, though, to reconcile the vastly different worlds he moves in: the politically unstable nations filled with desperate, hungry people and Canada, absurdly wealthy by comparison. He explains that the volume of water he uses in a daily shower in Toronto would provide a day’s worth of drinking water for an entire African village.

“I lost it one day,” Male recalls. “I had returned from Zaire and stood in a grocery store staring at five different types of grapes. A lot of them would be thrown away. I had to leave the store. To care for malnourished children and then stand in front of this opulence.”

“I don’t torture myself like that anymore. In Zaire you don’t have produce flown in from all over the world and in Canada you do,” he says. “I realize that is just the way it is and then I can carry on.”

While growing up in Hamilton, a steel town in southern Ontario, Male heard tales of life in Africa. He cherishes the memory of reading about faraway places in the thin blue air-mail letters his missionary aunt had written to him from Zaire and Kenya.

As well, he recalls always being aware of social justice issues and being involved with groups like Amnesty International. His desire to work in the developing world was one reason he studied medicine. As a medical student at McGill University in Montreal, Quebec, he organized anti-apartheid rallies and raised money for hospitals in developing countries.

At McGill, he also learned of MSF. “(It) impressed me. It is an organization that is big enough to have a voice in the world.”

Later, the humanitarian organization’s voice was heard on a larger scale: it captured the attention of rebels and rulers alike (along with most of the world) when it won the Nobel Peace Prize in 1999.

In September 2001, Male embarked on his fourth MSF mission. This time he is on a two-year posting in Tashkent in Uzbekistan, a nation in the former Soviet Union, which borders Afghanistan. Male is overseeing a project for tuberculosis treatment and environmental research. In Uzbekistan, where clean drinking water is rare, a significant proportion of the population drinks salty water from veins under the dried up shores of the Aral Sea.

Prior to taking his post, Male spent a week getting oriented at an MSF operational center in Amsterdam. He is learning Russian; he already speaks English, French, Italian and Spanish.

As he prepared to leave, Male stuffed novels in his backpack for quiet nights in faraway places. At the same time, he unpacked some of his questions. Where would this nomadic life lead? Should he settle down? Should he do something more secure?

A friend reminded him that things have always worked out.

And Male acknowledged, “Yes, I’ve had a lot of breaks.”

MH
Medécins Sans Frontières - The Organization

Medécins Sans Frontières (http://www.msf.org) was established in 1971 by a group of French doctors determined to find a way to respond to public health emergencies independently of political, economic and religious movements. It is now headquartered in Brussels, Belgium. It has national sites in 18 countries, including Canada (http://www.msf.ca) and the United States (http://www.doctorswithoutborders.org).

Currently 2,500 MSF volunteers work in over 80 countries.

The average contract of an MSF volunteer is nine to twelve months.

In general, MSF looks for health professionals, administrators and logistics staff. In the medical professions, MSF recruits general practice doctors, nurses, surgeons, anesthetists and specialists in areas such as tropical medicine, public health and epidemiology. In some projects, MSF uses midwives, laboratory technicians and paramedical volunteers. For more information and application forms, see http://www.msf.org/volunteer/index.cfm.

Non-medical volunteers look after the administration and logistics of projects. Administrators manage project finances and are in charge of locally recruited office staff. They are usually based in the capital of the project country, although in large countries, administrators with bookkeeping functions sometimes work with the teams in the field.

Logisticians come from a variety of technical backgrounds, such as construction, mechanics, and water and sanitation. Logisticians manage stocks, freight, vehicles, communication systems, and building or water projects. For more information and application forms, see http://www.msf.org/volunteer/index.cfm.

-CMP
THE 22-YEAR-OLD CASE WAS MOST UNUSUAL EVEN FOR DR. ROBERT H. KIRSCHNER, FORENSIC PATHOLOGIST. LAST AUGUST, THE RETIRED DEPUTY CHIEF medical examiner for Cook County, Illinois, provided his expert opinion in the murder trial of a man who had killed his girlfriend, buried her under a tree, and then claimed she was among the passengers who perished in the fiery crash of American Airlines flight 191 on May 25, 1979.

Back in 1979, Dr. Kirschner helped to identify the remains of the 273 people killed in what was -- until the September 2001’s terrorist attacks -- the worst air disaster in American history. Now he was called to testify that the defendant’s girlfriend was not incinerated in the crash.

Although 29 of the crash victims could not be identified, Dr. Kirschner told the court that the missing girlfriend was not one of them. She was in her fifth month of pregnancy when she disappeared and there were no pregnant women among the unidentified crash victims.

When the defense lawyer had his opportunity to cross-examine, all he said was, “No questions, your Honor.”

“He did not want to be beaten up by Dr. Kirschner in front of the jury,” explains Mark Blumer, Michigan’s first assistant attorney general. Blumer won the murder conviction even though the victim’s body was never found.

Dr. Kirschner is a formidable expert witness that lawyers do not want to face on the opposing side. He has testified as a forensic pathologist in more than 600 state and federal court cases throughout the United States. He served 17 years, first as a deputy medical examiner and then as deputy chief medical examiner for Cook County (which includes the city of Chicago). But that was only his day job.

In his spare time, Dr. Kirschner visited many of the world’s “killing fields,” to help the dead there bear witness. In more than a dozen countries in Central and South America, Europe, Africa, Asia, and the Middle East, he has used the tools of science and medicine to help expose state-sponsored murders, torture, and other human rights abuses.
Dr. Kirschner's Help Is Not Always Welcome. While the forensic investigations he conducts around the world start out with the government's approval, twice he experienced an unpleasant change of mind.

In 1989, a foreign government agreed to let him do an independent autopsy on a university student who was found floating dead in a reservoir after "escaping" from police custody. When Dr. Kirschner arrived in the country, the authorities threatened to deport him and to arrest the local doctor (who was going to assist in the autopsy) if they went ahead.

The year before, he was arrested for "illegally" attending an inquest. Dr. Kirschner had gone to an African country on behalf of the American Association for the Advancement of Science's human rights program. The forensic pathologist was to witness the inquest of a local businessman who had died in police custody.

"Fortunately, a US journalist saw us being taken out (of the inquest)," Dr. Kirschner says. "When we didn't return, he contacted the US Embassy, which sent someone to look for us. The interrogation was polite but silly. If we weren't so concerned for our safety, it would have been funny."

"I was more angry than scared," he adds. "The police confiscated my notebook."

Not Always Welcome at the Inquest

Dr. Kirschner's help is not always welcome. While the forensic investigations he conducts around the world start out with the government's approval, twice he experienced an unpleasant change of mind.

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"I was more angry than scared," he adds. "The police confiscated my notebook."

Helping the Dead Speak

In Shakespeare's JULIUS CAESAR, MARC ANTONY SHOWS HIS FELLOW Romans the dagger wounds in Caesar's body and wishes that he could "put a tongue in every wound" that would move Rome to avenge Caesar's assassination.

For more than 15 years, Dr. Kirschner has put such tongues in the wounds of thousands of victims of state-sanctioned murder throughout the world. He has become, in the words of the famous New York medical examiner, Dr. Michael Baden, "the conscience of forensic pathology."

In 1995, Dr. Kirschner founded the International Forensic Program of Physicians for Human Rights. As the program's director until 1998, he led the exhumation of numerous mass graves on behalf of the International Criminal Tribunals for the Former Yugoslavia and Rwanda. He served as a consultant to the United Nations Truth Commission for El Salvador and other national and international human rights organizations.

Dr. Kirschner draws no national lines when defending human rights. Although Jewish, he has investigated and spoken out against crimes against Palestinians in Israel and has testified against police brutality and the death penalty in his own country.

Physicians for Human Rights "adheres to a strict policy of impartiality and is concerned with the consequences of human rights abuses regardless of the ideology of the offending government or group," says Susannah Sirkin, deputy director of the Boston-based organization.

Dr. Kirschner has traveled widely to share his expertise and to help bring other physicians into the field of human rights. In the past two decades, he has delivered more than 180 invited talks at medical, scientific, and law symposia and he has participated in more than 35 international human rights missions, consultations, and seminars in more than 15 countries.

"I find his pace inspirational and have always been amazed at the drive he has," says Sirkin.
“I prefer to think of myself as a burr under the saddle of the empowered and the high and mighty.”

“I've been in this field for more than 20 years and there's no one that I've met in forensic pathology who is more committed and passionate about working to promote human rights and justice than Bob,” Sirkin adds. “He was always available and ready to juggle his schedule and hop on a plane to go wherever he was needed, traveling all night and getting up the next day to work on a human rights project. He would use his vacation time or stay up at night, but somehow he has always found a way to squeeze in the work. Bob wants every minute of his life to make a difference in the world.”

Getting Started

Dr. Kirschner’s appearance and demeansor contradict the grimness and horror of his work. He wears a beard without a mustache. The beard, now salt and pepper, frames a face with a pair of dark eyes that seem to miss nothing. He is quick to laugh and to use his sharp wit.

He grew up in Philadelphia, the son of schoolteachers. “We grew up in a very politically active household,” he says. “Unfortunately, it was during the time of Senator Joe McCarthy and political witch-hunts. Some friends of our family lost their jobs and we lived in fear that the FBI might come knocking on our door.”

He was already an activist when in college. He won an award from a regional journalism association for a college newspaper column that argued for the abolition of the infamous House Un-American Activities Committee. His college paper refused to publish it.

He met his wife-to-be, Barbara, while attending Jefferson Medical College in Philadelphia. Dr. Barbara Kirschner, now a noted pediatric gastroenterologist, thought he was the most intelligent and interesting man she had ever met. Thirty-six years of marriage has done nothing to change her opinion, she says. They have three grown sons.

Although Dr. Kirschner has always had an interest in law and legal matters, as a medical student he had no idea he would wind up in forensic pathology. “I liked pathology and research and realized I didn't get emotional satisfaction providing patient care,” he says. “I decided to go into research.”

However, after finishing his residency in 1971 and returning from serving his two-year tour of duty as a commissioned officer in the US Public Health Service in 1973, he discovered he did not enjoy laboratory research as much as he thought he would. “I enjoyed the big ideas of research, but not the day-to-day grind,” he says.

“I started feeling claustrophobic in a laboratory. I enjoyed getting out and doing a variety of things, which is why I turned to forensic pathology. It allowed me to combine medicine, my legal interests, and other skills and interests.” In 1978, he went to work for the Cook County Medical Examiner’s Office.

Hooked on Human Rights

The following year, he met the man who would invite him into the field of human rights. Dr. Clyde Snow, the renowned forensic anthropologist, who worked for the Federal Aviation Administration, joined Dr. Kirschner in identifying the remains of the people killed when American Airlines flight 191 crashed after taking off from Chicago’s O’Hare Airport.

Later that year, Snow and Kirschner worked to identify the victims of serial killer John Wayne Gacy. They would join forces on other cases that required Dr. Snow's ability to read bones.

In 1985, the American Association for the Advancement of Science (AAAS) asked Dr. Snow to help set up a seminar on applying forensic science to identify the desaparecidos of Argentina. “In the 1970s, an estimated 20,000 people in that country were ‘disappeared’ by the military and the police”, says Dr. Kirschner. Many had been buried in clandestine mass graves. Argentina had an enormous need for forensic scientists.

Dr. Snow asked several colleagues to join him, including Dr. Kirschner. With AAAS’s support, they trained a team of university students who went on to found the Argentine Forensic Anthropology Team. In return, members of the Argentine team helped to train similar groups in Chile, Guatemala, and other countries. Members of these teams helped to conduct exhumations in killing fields around the world.

Dr. Kirschner was now hooked.

Managing Passion

Even when he speaks of the anger he felt while exhuming the remains of more than 130 children in the village of El Mozote, who were executed by the El Salvadoran army in 1981, Dr. Kirschner speaks in a detached, professorial way.

Some apparently expect him to remain detached even when he is
not testifying. For example, during an interview on Nightline, his description of the exhumation of mass graves in Bosnia upset some officials at the Hague Tribunal. "I had tried to explain that, based on my religious beliefs, I have a moral and political obligation to help hold accountable the people who commit such war crimes," he says. "I guess they thought I wasn't objective enough when I talked about exhuming 150 bodies of civilians with their hands tied behind their backs."

When pressed to explain why he does this work, he says it is because he can. "I feel an obligation to contribute this way because I am able to. If I didn't, I would feel that I'm shirking my responsibility. I'm articulate and can generate a good quote. So it's not just that I can do the work, but I can also speak about it. I am a good spokesperson for the cause of human rights. I don't go around looking for this work. People come to me and what else can I say, but yeah, OK, I'll do it." He is not a hero, he says, and he does not like the word "crusader." "I prefer to think of myself as a burr under the saddle of the empowered and the high and mighty."

"A Person Without Borders"

Those who know Dr. Kirschner know how deeply he cares for people. It was 22 years ago, but Dr. Harriet Meyer still vividly remembers the teacher at her first autopsy. Dr. Meyer is now the book review editor for the Journal of the American Medical Association, but in 1979 she was a medical student learning about pathology from Dr. Kirschner.

"I can still tell you the deceased patient's name, what she looked like, her cause of death and other health problems," she says. She credits that in part to Dr. Kirschner's humanism. "He took a very personal approach to the deceased," she says. "Some people don't always take a personal approach to the living, let alone the dead."

Her teacher's "great intelligence" and interest in the world also impressed her. "Rather than being preoccupied with himself," she says, "He was outwardly directed, concerned with others, and totally unassuming."

Dr. Kirschner, who has been teaching since 1973, is now a clinical associate in the Departments of Pathology and Pediatrics at the University of Chicago's Pritzker School of Medicine and a member of the university's Human Rights Program faculty committee, where he has been inspiring students in many disciplines to go into the human rights field.

One such student, Alma Begicevic, who two years ago took the course Dr. Kirschner co-teaches at University of Chicago's Human Rights Program, is now an information officer with the Organization for Security and Co-operation in Europe's Mission in Kosovo. She was honored, she says, to have studied under a teacher with Dr. Kirschner's inner sense of justice and humanity. "He is a doctor, a teacher, and a person without borders," says Begicevic. "Even though Dr. Kirschner's work is tied so much to death, torture, and physical and emotional suffering, his ultimate aim as a doctor is to help heal."

News on this topic

For further information, CONTACT:

Physicians for Human Rights
http://www.phrusa.org

http://www.icomm.ca/carecen/page61.html

University of Chicago Human Rights Program
http://humanrights.uchicago.edu/faculty.htm

Guatemalans offer prayers for the “disappeared”

The painstaking process of exposing the truth in San Jose Pacho, Lemoa, Guatemala

MEDHUNTERS     winter 2001        17
The unspeakable weight of empty
growing small as 
thin air she is
her own disease
  a dwindling girl
numbs mounting pain with
vice clenched teeth while
sorrow seeps from
a sleeve of skin and
vacant
child
empties

-beverly sweet forbes

I AM A PSYCHIATRIC NURSE WHO WORKS WITH ADOLESCENTS. I AM AN ECOLOGIST.
I recycle bent and broken children. I put my heart into it and hope for the best.
I have an emotional investment in each life that touches mine; simultaneously,
this fills and empties my soul. At the end of a day I am worn thin by a cycle of
sadness and hope.

The children in my unit have endured atrocities of loss and violence. Anger
conceals hidden courage and inexplicable behavior is their cry for help. Each
night, the children march inside my head. I replay each victory of the day and
like a hopeful coach, I formulate tactics to help children reach for a star.

I believe I work with some of the finest healthcare professionals in the South as
charge nurse for Unit 6, League City, Texas, campus of the Devereux
Treatment Center.

Writing is a black and white filter for events and feelings that otherwise are
murky gray. Processing poignant emotion through poetry is a way of meeting my
own needs without the drama of a third party.

I make nightly entries in a journal. I meditate and ask for guidance but right
before I go to sleep, I write a poem to find balance. MH
An exotic adventure close to home.

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AFFIRMATIVE ACTION EMPLOYER • SMOKE-FREE ENVIRONMENT
Until the mid-1980s, orthopedic surgeons had to rely on basic tools to diagnose children’s problems with walking and to decide on corrective procedures. They used static physical examinations and observation of walking patterns that provided limited information, and X-rays that revealed only problems with bone structure. Because of their limited information, surgeons sometimes performed unnecessary invasive surgery, or did not do necessary surgery because problems were not fully identified.

Now, leading edge technology gives surgeons detailed information for analyzing and correcting a patient's abnormal gait. Health teams in about 20 pediatric gait laboratories in the United States use data collection programs and 3-D modeling software to capture children in motion and to recreate their walking patterns.

According to Dr. Freeman Miller, a pediatric orthopedic surgeon who specializes in treating children with cerebral palsy, the impact of gait assessment technology on diagnosis and treatment has been significant. "It’s allowed us to be much more specific about surgery and the surgery we’re doing has more predictable results,” he

Leading edge technology enables doctors to analyze and correct children’s abnormal gait patterns
says. “It’s also decreased surgery on children who don’t benefit from it.” The technology collects data on children as they are actually walking, which allows doctors to compare their gait patterns against those of “normal” children. It also collects a range of information not visible to the naked eye or in X-rays.

Staff in one of America’s leading pediatric gait labs, the Gait Analysis Laboratory at the Alfred I. duPont Hospital for Children, in Wilmington, Delaware, assess as many as 20 children a week.

One Step at a Time

Recently, a four-year-old boy with cerebral palsy went through a battery of evaluation tests. Physical therapist Lauren Kerstetter started by videotaping him as he walked up and down the room. Small, grinning, and dressed only in a pair of Pull-Ups® underpants, at first he refused to walk or participate in the exam. Giving up on the videotape, Kerstetter coaxed him into a thorough physical exam during which she measured the range of motion in various joints, as well as his muscle tone, motor control, and functional balance. Since it involves not only the use of careful observation but a number of devices to measure joint angles, this exam is much more thorough than the average physical therapy assessment.

Next Kerstetter and Jill Schuyler, a biomechanist, prepared to analyze his walking pattern. Working in the room where she did the assessment, Kerstetter attached small gray balls (called markers) covered with reflective tape to key joints on the child’s body, from his feet to his shoulders.

Meanwhile, Schuyler sat at a bank of computers and monitors in the large, open examining room checking the equipment. Six cameras are mounted near the ceiling of the large room: three on the left and three on the right. These emit strobe lights that are reflected by the markers.

Kerstetter brought the child into the room and asked him to walk up and down a red path marked on the floor. This time, captivated by a mural of the Emerald City of the Wizard of Oz on one wall, he moved and chattered to Kerstetter as she walked him up and down. As he moved, the cameras recorded the data from the markers and sent it to a computer that documented exactly where the markers appeared and how they moved as he walked.

The boy then walked across force plates that measured how his feet push and twist; this determines how hard the muscles work at different points during the gait cycle. Using the information, the data modeling software accurately recreated the boy’s gait in the form of a 3-D stick figure. It moved across the computer screen exactly as the child walked across the floor of the room.

Two more tests were completed. First, electrodes were attached to the boy’s legs to measure muscle activity during walking. Then, as the boy walked on a “yellow brick road” painted on the floor, sensors in the floor measured the pressure of his foot, and the information was sent to the computer for further evaluation.

Finally, Schuyler processed the data using a gait model, which produced graphs for the physician and the physical therapist to review and evaluate.

Not all children who are seen at the lab complete all these tests. Sometimes a physician will send a child to the lab, requesting only a videotape. The little boy Kerstetter and Schuyler worked with had most tests but did not need a metabolic analysis. For this test, children...
This is Engineering?

Although mechanical engineering may not seem like an obvious path into a medical profession, it turned out to be a natural progression for both Roland Starr and Jill Schuyler. They both work at Gait Analysis Laboratory at the Alfred I. duPont Hospital for Children. Starr studied math and physics and was working on a PhD in math when he “watched his friends get jobs they didn’t like as math professors.”

So he switched to mechanical engineering. A course of study in robotics led him to the Gillette Children’s Hospital in Saint Paul, Minnesota, where he helped them build a gait lab.

Schuyler, by her own description, an athletic person who is interested in movement, graduated into a depressed economy in the early 1990s with a degree in mechanical engineering. When she could not find a job, she pursued her interests with a degree in biomechanics and movement science at the University of Delaware.

Both Starr and Schuyler love the clinical applications of their work and working with people, especially children. “I like what the body does. I love kids,” Schuyler says. “It just kind of all fit together.”

A Different Role for a PT

In spite of the work’s demands, Lauren Kerstetter and Nancy Lennon value their opportunity to focus on the evaluative side of therapy. The two physical therapists work in the gait lab at the Alfred I. duPont Hospital for Children in Wilmington, Delaware.

Evaluating patients can be exhausting. A full analysis may take more than three hours, and Kerstetter and Lennon play an additional role somewhere between coach, nursery school teacher, and play buddy (especially for the younger children).

But both enjoy the challenge of figuring out exactly what the children need, working with a variety of patients.

“You see 10 new patients a week, and you don't keep treating them,” Lennon said. “I learn a lot because there’s always a new patient. You learn what capabilities a child has versus another, and you can make a better recommendation. It takes a lot longer to do that in a traditional PT setting.”
wear breathing masks as they walk, while measurements of their oxygen consumption, CO₂ production, heart rate, and volume of air are taken.

The Team and the Technology

Engineer Roland Stabb, who manages the DuPont Gait Lab, says it is one of the top five gait labs in the United States. The Wilmington facility, which is 30 miles south of Philadelphia, is unique in several ways. Few labs of this sort have a focus that is primarily aimed at diagnosis and treatment. Most carry out research and do not have the close relationship with physicians that this lab does.

Additionally, the lab team’s close relationship with the orthopedics staff means that the physical therapists play a key role in working with physicians to assess patients. Here, the physical therapists spend at least 20 minutes working with a physician to evaluate the results of every patient’s tests.

The lab maintains a database of between 2,100 and 2,200 children, which is available for research. This database includes gait information of about 100 “normal” children in ages ranging from three to 18, which the software uses as a basis for comparing the gait patterns of the children seen in the lab.

The database also helps staff assess the progress of children who are seen multiple times. Because each patient’s foot length and width, physical therapy evaluation, gait analysis information, and gross motor functional measurement are all saved, results can be compared from visit to visit, and pre- and post-surgery or pre- and post-treatment.

The DuPont Gait Lab played a key role in developing the technology it uses. Lab staff, with the help of Jim Richards, a University of Delaware software engineer, developed the data modeling software that is now commercially available.

The lab started out in the late 1980s at the University of Delaware with a focus on using computer technology to measure movement in sports. Dr. Freeman Miller, a pediatric orthopedic surgeon who was working on the project, wondered how the technology could be used to assess and treat abnormal gait patterns.

He and others defined the elements they wanted to measure for clinical purposes. Richards then wrote the software program to get the desired results.

“We went through lots of iterations,” says Miller. “He would make the system and then we’d look at it and say ‘well maybe we need to change it a little.’” Miller praises Richards’ unusual ability to understand both the science of movement and the engineering behind the software. Richards continues to work on the software, and he has an ongoing relationship with the duPont Gait Lab.

“Jim (Richards) has excellent matches in skill; it has allowed us to make a lot of progress,” comments Miller.

What is in the future for the gait lab? A move to digital technology for both the cameras and the EMG equipment? Perhaps electronic storage of the reports for the doctors so that they can be more easily shared?

Miller would also like the technology to produce end results that are more easily shared with children’s families so they better understand treatment options. But one thing that will stay the same is the close teamwork that has produced some of the best assessment tools that technology has to offer children. MH
Hooked on sharks
By Heather Lindsey

“Sharks were going by me like a freight train”
Swimming with sharks. That is physician Lewis Kohl’s idea of a good time when he can get away from his emergency room in Brooklyn, New York. More accurately, he scuba dives in tropical waters to photograph his favorite subject.

“Many of my friends consider me abnormal,” says Kohl, chairman of the department of emergency medicine at Long Island College Hospital in Brooklyn, New York. “I get a charge when people look at my photos and think I’m a little out there.”

Kohl started scuba diving in 1977 and began exploring underwater photography in 1986. For his first four or five years, he was pretty bad, he says. “Everything in my photos looked blue and far away.”

Then 10 years ago, in Bonaire in the Caribbean, he took an underwater photography class. Two years later he went on an organized dive off Freeport, Grand Bahama, where staff attracted sharks by feeding them. “Sharks were going by me like a freight train,” Kohl says. “I became really obsessed with getting shark photos.”

He has since traveled to many locations, including Northern Sulawesi in Indonesia and Papua-New Guinea, with his diving partner, wife Melissa, also an emergency room physician.

The best place for shark diving, according to Kohl, is Cocos Island off Costa Rica. “These islands are mountains jutting up out of deep water,” he says. Nutrient-filled water rises from the deep, and swarms of sharks (hammerheads, gray reefs, white-tips, silkies, and Galapagos) surround the islands. The Galapagos Islands are next on Kohl’s list of great shark diving destinations.

Kohl feels safe when photographing the predators. “When you’re behind the camera, you become so absorbed you’re not really thinking about it,” he explains. Overall, sharks tend to ignore him. And, he says, “When people get too close, they swim away.”

And despite their reputations, the large ones are not man-eaters. “They are like the chickens of the sea,” says Kohl. He has seen 12-foot hammerheads disappear the second they hear him take a breath from his tank.

“But you are dealing with wild animals, so it has the potential for danger,” he adds. “Shark feeders get bitten on occasion. But fortunately, (we) aren’t their natural prey.”

He has, however, been warned away by sharks’ body language. He has seen them straighten their pectoral fins and arch their back as a sign that he has crossed into their territory. “It’s time to exit right away,” he says.

On one occasion, Kohl surprised a shark. To get a picture of the shy hammerheads, he had hidden himself behind a rock as a group approached. Kohl even held his breath, popping out to snap his shot as the fish swam by. “The shark has its mouth open like it’s saying ‘Ah!’ I scared it to death. This isn’t most people’s image of a big shark.”
Tips for Staying Safe in Shark Waters

Stay out of the water:
- if sharks are present;
- during darkness or twilight, when sharks are most active;
- if it is contaminated by effluents or sewage;
- if sport or commercial fishers use it, especially if bait fish are around or feeding activity is happening. Diving seabirds are good indicators of such action;
- if bleeding from an open wound or if menstruating because a shark’s sense of smell is acute;
- if you see porpoises, because sharks could be around since both often eat the same food items.

Other hints:

Remain with a group in the water because sharks are more likely to attack a solitary individual.

Do not wander too far from shore because this isolates you, placing you far from assistance.

Refrain from excess splashing and do not allow pets in the water because of their erratic movements.

Be cautious in the spaces between sandbars or near steep drop-offs since sharks like them as hangouts.

Do not wear shiny jewelry; sharks have a competitive sensory advantage and the lift reflected from the sun resembles the sheen of fish scales.

Use extra caution when waters are murky.

Avoid uneven tanning and bright colored clothing because sharks see contrast particularly well.

Get out of the water when sharks are sighted!

Do not harass a shark if you see one!

(Adapted from information used with permission from “International Shark Attack File, Florida Museum of Natural History”)
http://www.flmnh.ufl.edu/fish/Sharks/ISAF/ISAF.htm

Play smart. Reduce your risk of becoming a statistic.
“Many of my friends consider me abnormal.”

Kohl has never been bitten by a shark or treated any shark wounds. So, what does he make of the shark attacks off the coast of Florida and in the Caribbean this past summer? In 2000, 79 unprovoked attacks occurred worldwide, according to the International Shark Attack File in Gainesville, Florida.

Part of the problem may be due to the depletion of sharks’ natural food sources because humans are over-fishing. If they do not have their natural prey, sharks look for other food sources.

“If you’re going to see an attack, it’s likely going to be a bull shark,” he adds.

This species likes to feed in shallow water, can swim up into rivers, and do not fear much. The number of attacks over the summer is most likely due to a coincidence, he says, as well as to the high numbers of people swimming in ocean waters at that time of year.

One of Kohl’s biggest concerns is the depletion of some types of sharks such as the sandbar and dusky, which are harvested just for their fins (used in some Asian soups) and for their cartilage (used in diet supplements). Sharks are generally slow to reproduce, and some do not breed until they are older.

His dream is to photograph a great white shark, the world’s largest species, which some scientists consider endangered. “I want to do this before there aren’t any great whites left.”

MH
It is August in Toronto, Ontario, in the middle of a heat wave. A stifling combination of searing heat and soaring humidity has temperatures well above 100°F, causing the city to declare its first-ever heat emergency. Concerned officials advise residents to take refuge in air-conditioned homes and offices, to use fans to stay cool, and to drink plenty of water. Excellent suggestions, but for the homeless, they are not particularly useful.
But when you are homeless in Toronto, you do have Cathy Crowe, street nurse, in your corner. In a morning already packed with urgencies such as arranging for new portable toilets to be delivered to Tent City (a vacant lot on Toronto’s waterfront occupied by 50 homeless people), contacting the coroner’s office to obtain information on the recent deaths of five homeless people for a memorial service she is planning, and giving five media interviews regarding the heat emergency, Crowe is also calling suppliers to try to obtain bottled water to keep you cool and get you through the day without becoming a statistic.

A tall, slender blond woman with a contagious smile, Crowe specializes in healthcare for the homeless, and has done so since 1989. She spends about 40 percent of her workday in clinical work, with the balance in advocacy and administration. She now splits her time between the Queen West office of the Central Toronto Community Health Centre and the Toronto Disaster Relief Committee (TDRC).

“In street nursing I thought I would be treating mostly men -- ulcerated legs, sore feet, alcoholism,” recalls Crowe. “Of course when I got into it, I realized that every health problem that walks into the community (healthcare) centers was in street health too.” Having a cold or the flu is bad enough. But when you have one of these common ailments and do not have a hot cup of tea to drink and steaming bowl of chicken soup to eat, a warm bed to crawl into, and over-the-counter medications to alleviate your symptoms, you are all the more miserable. You are also highly susceptible to complications, such as pneumonia.

Crowe regularly sees patients with less ordinary problems: TB, hepatitis, HIV/AIDS, pneumonia, chronic diarrhea, cancer, dehydration, hypothermia. And being a street nurse has pushed her to learn new treatments that reflect the reality of the streets. “Nurses like myself quickly learn the antidotes to pepper spray, how to document police inflicted injuries, and how to treat frostbite,” she says. And her black bag contains uncommon items for a nurse: socks, mittens, granola bars, milkshake drink boxes, duct tape (to tape the soles of shoes back on, or to tape a cardboard roof together). Her bag also contains bus tickets because sometimes during a frigid winter night, “I can only give an elderly man a bus ticket to get to a hot grate.”
Inevitably, the hardest part of her work is the deaths. Each month, Crowe participates in a memorial service for homeless people who have died on the streets. The service is held at the Church of the Holy Trinity in the shadow of the Eaton Centre, the largest shopping mall in Toronto’s downtown core. “I have to remind people I’m a community health nurse, not a palliative care nurse. I’m not working in a war zone. I should not be seeing this amount of death,” says Crowe. The deaths are frequently trauma-related, murder, suicide or accident, and the victims in their 20s or 30s. “The deaths are preventable. It makes me angry.”

The shy daughter of an emergency room nurse and cookie factory worker has come a long way from her roots in the town of Kingston, Ontario, and from her first nursing job working at a private clinic for business executives in the heart of the city’s financial district. Performing routine tests on marathon-running bank executives left Crowe wanting more.

In 1980, she watched a documentary about an inner-city Toronto community health center that offered an expanded role for nurses, in that they had a greater role in the assessment and treatment of patients. The center struck Crowe as a collegial environment where a nurse’s opinion was respected, even relied on, by doctors. Inspired, Crowe contacted the center and was hired. She went from doing stress tests and taking blood pressure readings, to providing a full gamut of care, including pap smears, prenatal check-ups, and treating minor injuries.

The transition to street health came in 1989, after a group of nurses who volunteered their time to care for homeless people obtained government funding to hire a nurse. Crowe has been street nursing ever since, and is considered a pioneer in the field.

Since then, homelessness is not only the focus of Crowe’s career, but the driving force of her activism. Indeed, Crowe feels that calling herself a street nurse is a political statement. Speaking out was initially difficult for Crowe, a self-described introvert who gets “totally stressed out” in front of crowds. But her passion for the cause has given her the strength to speak out on the issue before politicians and the public, and before students in the Homelessness in Canadian Society course she teaches at Toronto’s Ryerson University.

Indeed, the goal of the Toronto Disaster Relief Committee (TDRC, which she co-founded in 1998), is to end home-
lessness. The TDRC is made up of social policy, healthcare and housing experts, AIDS activists, academics, business people, community health workers, social workers, antipoverty activists, and members of local faith communities. In the year it was founded, the TDRC got five city councils, the mayors of 10 of Canada’s largest cities, and 400 other organizations to declare homelessness a national disaster. Despite more than a dozen honors and awards, including an honorary doctorate from the School of Nursing at the University of Victoria in June 2001, Crowe says she is proudest of this declaration. In 1999, the TDRC initiated a “one-percent strategy,” urging all levels of government to spend an additional one percent of existing total budgets on housing.

Crowe is a formidable advocate who has determination and pushes hard for what she wants. And she usually gets it. Crowe says the fight is the part of her work she likes best. “I like the challenge of teasing out how to make a difference.”

And overall, she believes that her strength comes from her profession. “It all stems from my being a nurse. The nurse’s role is to witness. I see so much and that gives me the strength to speak out. I have to do something. I don’t have a choice.” MH

“Nurses like myself quickly learn the antidotes to pepper spray, how to document police inflicted injuries, and how to treat frostbite.”

Crowe’s black bag contains duct tape to reattach soles
weapon in the war on cancer

by Christine Kuehn Kelly

“Because someone gathered cancer data and looked at survival rates over time, my daughters have their lives,” declares Louanne Currence. This gives the cancer registrar a personal connection to her work.

A registered health information technologist and certified tumor registrar (CTR), Currence collects and analyzes data on cancer patients. She works at North Kansas City Hospital, in North Kansas City, Missouri.

Currence’s husband, Daryl M. Currence, died in his 30s from a genetic form of thyroid cancer. When he was diagnosed as an adolescent in the 1960s, little was known about Multiple Endocrine Neoplasia type IIB (MEN IIB). By the time their two daughters were born in the early 1980s, understanding had progressed, in part due to cancer registries.

After genetic testing, both girls had prophylactic thyroidectomies, and the microscopic carcinoma that was found was successfully removed.

Colleagues value the contributions of cancer registrars. “A network of cancer registries can be our most potent new weapon against the disease,” says John Healey, a physician at Memorial Sloan-Kettering Cancer Center in New York City.

“Today thousands of people are living as a result of the type of information we collect and analyze,” says Carol Hahn Johnson, CTR, a leader in the field and immediate past president of the National Cancer Registrars Association. “It gives you a sense of pride.”

The Scope

Cancer registrars are responsible for helping health-care professionals see carcinoma’s broader picture. By state mandate, all institutions that diagnose and treat cancer must report newly diagnosed cases to a statewide registry. After checking the data for accuracy, state registrars report it to either the Centers for Disease Control’s National Program of Cancer Registries or the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) Program.

Registrars identify reportable cancer cases by reviewing reports from their own or other medical facilities, and by gathering information on outcomes from doctors and, sometimes, patients. The registrars then analyze the data and record it in a concise standardized format.
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Interested in becoming a cancer registrar? Here’s what you need to know in the United States:

Requirements
Much of a cancer registrar’s knowledge comes from on-the-job training and continuing education. Entry-level positions require a basic knowledge of cancer, anatomy, physiology and medical terminology. “Registrars need to be detail oriented and able to work on their own,” says April Fritz, data quality manager of the National Cancer Institute's SEER program and coordinator of its cancer registry training program.

Education and Training
Because most registrars come from the health information management field, they will have completed an associate or bachelor's degree program in the field. Degrees in nursing also qualify people to begin work in the field. The National Cancer Institute and the American College of Surgeons, as well as colleges and universities, offer training programs for entry-level registrars. The National Cancer Registrars Association (NCRA) and state registrar associations provide continuing education and training through seminars and conferences.

Salary Level
According to the NCRA, salaries range from $19,000 for a follow-up secretary to $55,000 for a director in institutional settings, plus benefits. Independent contractors and those in for-profit companies may earn much more.

Locations
Cancer registries are usually housed in the health information management department of institutions but exist as separate entities. Registrars work in medical institutions, for state health departments, for federal agencies such as the National Cancer Institute, and for software and other medical information management companies. Some cancer registrars are consultants.

Certification
Certification as a cancer tumor registrar (CTR) is available from the National Board for Certification of Registrars.

Professional Organizations
Professional organizations are key for any emerging profession, says Carol Johnson, immediate past president of the NCRA, and technical information specialist at the SEER program. “We are relatively young (only 27 years old) and still evolving.”

Outlook
Cancer registrars (as part of health information management) are one of the top 20 fastest growing fields, according to the United States Bureau of Labor Statistics. Because of the increasing amount of cancer data, Johnson says, “There is a crying need for registrars.”

--CKK

“Today thousands of people are living as a result of the type of information we collect and analyze”

The data lets researchers and epidemiologists monitor cancer incidence and treatment success. It assists in the development of new and more effective cancer therapies, as well as new prevention and control measures.

The Results
Ask cancer registrars about the impact of their work, and they proudly cite the vast improvement in breast cancer treatment in recent years. This has happened largely because registrars have systematically collected outcomes data that showed that early diagnosis and chemotherapy were effective in prolonging life. The data also indicated that less disfiguring treatments, such as lumpectomies, were a reliable option.

Data from the state registry helped focus cancer education programs in Kentucky. A decade ago, more than one-third of Kentucky women developed late-stage breast cancer. The state registry helped epidemiologists identify areas with the highest incidence of the late-stage disease. More effective outreach programs were developed to provide mammograms and early treatment for those at risk. By 1996, late-stage disease incidence in Kentucky had decreased by five percent.

The Background
Cancer registrars often come from the ranks of health information specialists, such as medical transcriptionists. Nurses, especially those who want regular hours, also enter the field. “It’s a wonderful profession for the nurse who no longer desires to do direct patient care or the transcriptionist with repetitive strain injury,” says April Fritz. She is data quality manager of the National Cancer Institute’s SEER program and coordinator of its cancer registry training program.

Before becoming a cancer registrar, Currence worked in a variety of health information management positions. She had been a chart analyst and transcriptionist in the Trinity Lutheran Hospital in Kansas City, Missouri, and had worked in its medical staff office.

After completing a two-week program in August 1990 at the University of California-San Francisco, Currence returned to Trinity Lutheran as a cancer registrar.

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Here's what you need to know in Canada

Canadian Association Considering Tumour Coding Specialty

Currently in Canada, people are not certified as cancer tumor registrars. However, the board of directors of the Canadian Health Record Association (CHRA) is looking into developing a category for cancer registry.

While tumour coding is done in Canada, no training is offered in Canada for the specialty. As a result, Canadians in this field must be certified CHRA members who have taken US-based training.

CHRA offers two designations. Health record technician graduates who pass the national certification examination become certified as Associates with the designation CCHRA(A). Health record administrator and practitioner graduates become Certificants with the designation CCHRA(C).

People with either designation who want to specialize in tumour registry then complete additional training. Canadian health record practitioners regularly study via correspondence courses from the American Health Information Management Association (http://www.ahima.org).

Because tumor registry coding is quite complex, few employers attempt on-the-job training.

In response to requests for a Canadian course, the CHRA council on education has put the topic on their agenda for their October 2001 meeting.

Health record diploma programs are offered through the following:

Douglas College, http://www.douglas.bc.ca
SIAST Wascana Campus, http://www.siast.sk.ca
Red River College, http://www.rrc.mb.ca
George Brown College, http://www.gbrown.on.ca

As of the fall of 2001 term, the following institutions have implemented bachelor’s degree programs in health information services (HIS) or health information management (HIM):

University of Victoria, http://hinf.uvic.ca
The University of Western Ontario, http://www.uwo.ca
Dalhousie University, http://www.dal.ca

Like many registrars, Currence is the sole registrar at her institution. But she is not isolated. Currence interacts with registrars at other facilities and with a variety of other healthcare professionals, an aspect of her work she particularly enjoys. “A lot of it is me getting up out of my chair and going to another department,” she says. At North Kansas, she works with many departments such as radiology, pathology, coding, quality assurance, administration, and data processing. She serves on the hospital’s cancer committee, and attends their weekly conferences.

Sometimes, her work takes her off site. Currence travels to doctors’ offices to gather information on patients she is tracking. She visits high schools to explain her profession. And in an effort to attract more healthcare professionals to her understaffed field, she is putting together a teaching module for local training programs.

“As a cancer registrar, I have found the variety, mental stimulation, educational challenges and friendships that will keep me interested for a long time to come,” Currence says. “Registrars may joke about retiring before the next big change in data collection becomes mandatory, but the truth is we love what we do.”  

-MH
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FRASER VALLEY HEALTH REGION  "Integrating Health Care"
“I sing because I feel it and it is my pleasure”
OPERA CELEBRATES THE HUMAN EXPERIENCE WITH GUSTO AS DOES Livia Beysevic, clinical pharmacist by day and opera singer by night.

Living with passions means the drama Beysevic enjoys in opera is not confined to after-hours arias. She has spent 25 years at the renowned Hospital for Sick Children (HSC) in Toronto, Ontario. For the last five, she has worked with infants in the Neonatal ICU, where she sees “real joy and real sorrow.”

A small woman with a large and engaging presence, Beysevic has organized three benefit concerts for the cardiology department at the HSC. She competes in music festivals. She sings in the pharmacy. She sings for her teachers. And she sings for herself.

Beysevic says, “I sing because I feel it and it is my pleasure.”

MUSIC IS IN HER BLOOD. SHE GREW UP IN PRAGUE WITH A FATHER who was a violin virtuoso, playwright, and stage producer. She studied violin for seven years and piano for three. After leaving her native Czechoslovakia in 1968, she came to Canada via Britain. Beysevic then gave up music to master English and take her pharmacy degree at the University of Toronto.

Once she graduated, she felt something was missing, and realized it was the music. So her husband bought a piano at an auction for $100. According to the piano tuner, she had “a fine piece of furniture but not much else.”

At the prompting of a friend who worked at the Royal Conservatory of Music in downtown Toronto, Beysevic decided to use her “own instrument,” and enrolled in lessons with a voice teacher and a singing coach.

BEYSEVIC WAS NOT CONTENT SIMPLY TO SING AS A HOBBY, BUT wanted “to sing like a real opera singer.” Having mastered her native Czech, as well as Russian, German and English, she went to a Berlitz school to learn French and Italian. “You can’t sing opera and not know Italian,” she observes.

With two hours of voice lessons and coaching each week, Beysevic is a serious amateur. At the last Kiwanis Festival in which she participated, she won in her class and placed second in the Festival’s “Rose Bowl” Competition.

As for her repertoire, she likes Russian songs because they connect her to her past. When she was a mezzo soprano, she sang Delilah and Carmen, the “bad girls.” Now that she is a soprano, she sings Mimi, the “good girl.” Which does she like best? “The bad ones!”

HER WORK AND HOBBY ENRICH EACH OTHER AND HER. SHE SAYS the neonatal unit has given her a deeper philosophy of life. “You learn very quickly what is important. You learn to take the time to teach a family, to arrange for a pharmacy close to home, or whatever to lighten the patient’s or family’s burden.”

“When something devastating happens,” she says, “I cannot sing. I cannot take my lesson. I cannot do what I love.” When she is so weary that she hopes her lesson has been cancelled, she drags herself to the Conservatory. “The minute I enter and hear the music, I become energized.”

Voice range

Women’s voices from highest to lowest are soprano, mezzo soprano, and contralto (or alto). For women, the soprano is generally the heroine, the mezzo soprano is the temptress or older woman, and the contralto plays the unusual characters such as witches. Men’s voices from highest to lowest are tenor, countertenor (or male alto, which is rare), baritone, and bass. Roles for men are not quite as prescribed by voice as women’s are.

-CMP
SOS in cambodia
by Christine Kuehn-Kelly

For tourists who visit the famed temples of Cambodia, the remains of millennia-old Khmer architecture can take their breath away. For one British visitor with longtime asthma, however, the humid climate and deteriorated buildings contributed to a more serious pulmonary problem: a collapsed lung. Fortunately, Anne Fine, a registered nurse from South Africa, was able to provide appropriate health care. She does so in a country where hospitals are primitive and trained professionals are few.

“He came to us 15 days after he blew a pneumothorax,” says Fine, branch manager of International SOS’s clinic in Phnom Penh, Cambodia. After days of misdiagnosis, the young man entered a hospital in Phnom Penh. “When we first heard about him, they had cut open his chest without benefit of local anesthesia. He leaped off the operating table and ran out of the hospital.” By the time his girlfriend brought him to the clinic, 60 percent of his lung had collapsed. Fine and the medical staff successfully stabilized the patient, and he was able to continue his travels.

Fine’s clinic is part of International SOS’s worldwide healthcare delivery system. With 2,500 staff members, SOS is the world’s largest medical assistance company and a leading provider of medical services to remote sites. In Cambodia, Fine’s 31-person clinic staff focuses on providing 24-hour medical and dental services. Patients include tourists, embassy staff, and individuals working for international and local companies.
Each month, 800 to 900 of these patients pass through the doors of Fine’s clinic. She sees conditions such as MIs, CVAs, URIs, asthma, TB, dehydration, gunshot wounds, MVAs, monkey bites, snake bites, even hemorrhagic fevers. She says, “The excitement of the job is not knowing what is going to happen day to day.”

Fine, who oversees the clinic’s operations and finances, assists in emergency care and is responsible for ensuring good medical care despite the challenges of working in a country whose economy has been devastated by internal warfare.

Fine says that when an emergency case comes in, the scene often is like one from the American television program ER. “The Cambodians are very dramatic,” she says with a laugh. “Doors fly open and a thousand people come in carrying the patient. If it’s a tourist, there will be flustered tour group members in attendance.” Often, the clinic has to undo the damage done by local medical care: poorly set bones, improper casting, polypharmacy, misdiagnosis, and inappropriate management, such as improper wound cleaning.

If necessary, evacuation will be via a dedicated air ambulance that comes from SOS headquarters in Singapore or via commercial carrier with a medical escort. If it is a private medevac flight that arrives at night, the airport will need to be re-opened. Patients are evacuated to hospitals in Bangkok or Singapore.

One of Fine’s biggest challenges is the lack of supplies and trained personnel in Cambodia. This is largely due to the Khmer Rouge, which is estimated to have been responsible for the deaths of up to 25 percent of the population during the late 1970s. The educated, including doctors and nurses, were among the first to be murdered. And during this period, the economy was virtually decimated. “There is so much poverty here, you can’t walk out without beggars approaching you,” Fine said with a sigh. “Since the average monthly wage is about $20, corruption is everywhere. It’s the

“When we first heard about him, they had cut open his chest without benefit of local anesthesia. He leaped off the operating table and ran out of the hospital.”
survival mode, but it's hard to take.”

Since the Khmer Rouge forbade education, some Cambodian staffers lack basic skills. This needs to be made up by extra training. “Yet the Cambodians are learning quickly. We have a great staff.” Fine adds, “I come from a medical environment where everyone is a well-oiled machine, functioning independently. Here, things are done collectively.”

She says she loves the responsibility she has been given to make the clinic work within a budget and to develop both the clinic and its staff. “How I achieve this is largely up to me and the team. SOS is very supportive, and they encourage innovative ideas.”

Fine’s medical experience to date is well suited to her demanding position. She has spent a lifetime treating victims of violence and trauma. She grew up in South Africa, and after training as a nurse abroad, returned to her home country to serve as a paramedic with the emergency helicopter service in Johannesburg. Fine counts this as her biggest challenge to date, including her current position. As apartheid was ending in South Africa, the helicopter service became the world’s busiest rescue service. “It was not uncommon to be called out eight to
10 times a day,” she said. Each call was a patient requiring lifesaving treatment on the roadside, with victims frequently burned or shot and in need of major resuscitation.

“I was reluctant to leave in case I would miss a good call -- we were all like that.”

When she was approached to manage the clinic in Cambodia in April 2000, Fine decided it was a great opportunity to further her skills.

While she has good friends in Cambodia, Fine admits Phnom Penh can be a lonely place. “I spend a lot of time on my own, studying (for a Bachelor of Commerce degree from the University of South Africa).” Still, the move has clearly helped her grow professionally and personally. Her entire life outlook has changed. She recalled that while on the paramedic team in Johannesburg she was very emotional and needed constant companionship. “Now my life is more balanced. I am able to enjoy it without always seeing a trauma scenario in my head. Even in this culture where poverty and violence have been the norm, I see many wonderful, caring and genuine people. They have shown me that kindness and family values are still possible.”

International SOS

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-CMP

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“BEN KINGSLEY BURNS UP THE SCREEN IN THIS FIRST RATE neo-noir thriller,” writes the “movie doc” in his review of Sexy Beast. Dr. Roger Hartman rates that film as “excellent,” but gives A.I. only a “fair,” and Moulin Rouge, and Pearl Harbour each a “good.”

For the past 18 months, Hartman, a general internist in California, has reviewed films for his website http://www.themoviedoc.com. As well as providing written commentary, Hartman posts the results of TheMovieDoc’s Movie CheckupTM.

“I make the analogy that looking at a movie can be like looking at a patient,” says Hartman, who has practised at Kaiser Permanente Harbor City Medical Center for 13 years. “I give it a prognosis. It’s a little gimmick I have to look at different elements of the body and correlate them with the components of a movie.”

In his systems assessment, Hartman examines the movie’s brain, the analogy for the direction; the skeleton, meaning the structural support or writing; the heart or the emotion conveyed through the acting; and the vision, or the photography. Finally he considers the soul, which Hartman admits is not a medical category. For him, the “soul” is what separates a so-so film from a great one.

To keep up with the latest releases, he tries to see at least two movies a week. “I squeeze them in on the way home or on the weekend. The hard part,” he says, “is finding time to write.”

HARTMAN DEVELOPED HIS APPRECIATION FOR THE CRAFT OF telling stories while a college English literature major. However, his stronger interest in science and helping others took him into medicine.

Twenty years ago he started describing recent movies in letters to his brother who lived in Kodiak, Alaska and rarely saw first-run films. Eventually, Hartman wrote full-blown reviews for his brother and sent copies to friends.

Internet technology has made distribution easier. Hartman decided that creating a website would be a good way to mesh movie reviewing with his skills in health assessment.

“I make the analogy that looking at a movie can be like looking at a patient...”
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AND, PEOPLE ARE REACTING. “I frequently have heated discussions at work when people take issue with a movie I didn’t like,” he says. “Popular blockbuster pictures, which many people find entertaining, I sometimes find boring,” says Hartman. “Like The Mummy Returns -- honestly I thought it was dreadful. I had trouble sitting through it.” He tends to be partial to classics such as Casablanca, The Godfather Parts I and II, and Lawrence of Arabia but doesn’t have a favorite genre. “I like a movie as long as it’s well done.”

Hartman admits his training naturally makes him critical of medical technology and medical facts used in movies, “but as far as the drama goes, I think I treat it even handedly.”

In addition to being an avid movie critic, Hartman also writes screenplays. One drama features a surgeon who works on the front lines during the revolution in Zaire, Africa.

Although none of his screenplays have been produced, Hartman says writing them gives him insight into what makes a good story, a useful skill to have when reviewing films.

His sideline also provides a pleasurable release from medicine’s daily challenges. “Writing and reviewing movies is a lot of fun,” says Hartman. “It’s good to have an outlet outside of your profession.”

MH
Phobia Word Search
by Cynthia M. Piccolo

acarophobia  agateophobia
agliophobia  aichmophobia
albuminurophobia  algophobia
anginophobia  ataxophobia
bacillophobia  bacteriophobia
carcinophobia  chiraptophobia
choleraophobia  dentophobia
dermatophobia  dishabiliophobia
emetophobia  hapephobia
hemaphobia  iatrophobia
macrophobia  misophobia
molysmophobia  monopathophobia
neopharmaphobia  nosocomophobia
odontophobia  opiphobia
pathophobia  phobophobia
radiophobia  tomophobia
traumatophobia  tympanophobia
vaccinophobia  xyrophobia

Healthcare Word Scramble
by Cynthia M. Piccolo

Solutions can be found at www.medhuntersmagazine.com
X-Word:
Infectious Diseases
by Cynthia M. Piccolo

Across
1. An inflammation of the lungs caused by an infection
4. One suffering from Hansen's disease
7. AKA "cancrum oris"
8. A virus present in rodents' excretia
10. A viral disease causing severe bleeding
11. AKA 19 Across
13. A negative result of an epidemic (second of two words; with 6 Down)
15. Penicillin, etc.
18. Syphilis, formerly, "The __"
19. AKA 11 Across
22. A bacteria or virus by another name
23. HPV, etc.
24. It goes with "Parasites"
25. Group B Streptococcal Disease (abbrev.)
27. Infectious Parotitis, or an old childhood tradition
28. Postherpetic Neuralgia (abbrev.)
29. A "superbug"
30. It carried the organism that caused the Black Death
31. "I didn't have this infection before I entered the hospital …"
35. The most common cause of lower respiratory tract infections in children worldwide
36. Diagnosis (abbrev.)
37. Lassa, Yellow, Saturday Night, etc.
38. Causes Blepharitis, Toxic Shock Syndrome, etc. (abbrev.)
41. Used to be called Hydrophobia
43. The Bubonic
45. A sign of 43 Across
46. Includes A, B, C, D, E
47. Old name for fevers and chills, esp. malaria-related (pl.)
50. Most "Superbugs" are relatively
51. A bacterial infection of the small intestine
52. Formerly "Equine Morbillivirus"
53. Treatment (abbrev.)

Down
1. Formerly "Infantile Paralysis"
2. The most common cause is bacterial infections (but also viruses, chemical irritation or tumours)
3. AKA "Woolsorters' disease"
5. A form of "The Plague"
6. A negative result of an epidemic (first of two words; with 13 Across)
9. AKA "Echinococcosis" (abbrev.)
12. AKA "German Measles"
13. AKA "Lockjaw"
14. Places where people determine exactly what you've got …
15. What Mary had
16. Part of human form of BSE
18. Bigger than an epidemic
20. AKA "West Nile" Fever
21. An endemic, infectious, tropical disease caused by Treponema pertenece
26. Typical symptoms include fever, cough, sore throat, runny/stuffy nose, headache, muscle ache, extreme fatigue …
27. See 29 Across
29. The cause of many of these conditions
32. Incidents with a lot of people with the same disease in the same area
33. Lymphadenopathy-Associated Virus (abbrev.)
34. A pathogenic microorganism (put simply)
38. A contagious skin disease caused by mites
39. Any disease-producing microorganism
42. About 80% of Americans have the oral version
44. Gonococcus; gonorrhea (abbrev.)
45. Initials for one form of Hanta Virus Pulmonary Syndrome
48. Authority on international health
50. It carried the organism that carried the organism that carried the Black Death

Solutions can be found at www.medhuntersmagazine.com
The large man’s chest rose and fell with each breath, virtually the only movement I saw as I entered his room on the cardiac unit. Only half way through my nursing courses and two days into my first position as a nurse extern on a hospital floor, I was as enthusiastic as I was green.

I filled a wash basin with water, wondering who he was and what he had been like before his stroke. I approached him cautiously, determined to hide my insecurity.

“Mr. Smith*, I said, “My name is Suzanne. I am a nurse extern, and I’m here to give you your bath.” He did not answer. I had not expected him too. Aphasia, a complication of his cerebral vascular accident, had silenced him.

I pulled the curtain around his bed and set about my task. At 46, he was younger than most of the patients on the unit. Thick, dark hair framed strong Mediterranean features. A pool of saliva glistened on his ruddy left cheek.

“Don’t be surprised, Mr. Smith,” I told him, “I’m about to wash your face.” The rhythm of his breathing never changed. Did he hear me or even feel the washcloth as I wiped his stubbled chin? I washed his arms and legs, mesmerized by his deep tan. Only days before, he had been awake and dynamic, pursuing an active life in the Florida sun.

When I had done all I could do alone, I called another nurse for assistance, and we completed his bath. We talked. Mr. Smith only occasionally mumbled.

“You know, it was early when I left the house today, but it sure looked like a beautiful day,” I told him, and opened the blinds before leaving.

That night, I reviewed what I had been taught about the acute care of the stroke patient, both the medical science and the human art. The instructor had emphasized the responsibility of respecting and preserving human dignity, and the importance of communicating with patients, even with those who could not speak.

In the five days I cared for Mr. Smith, I worked to implement those lessons. I talked to him. I listened as his beautiful blond wife and daughter spoke of his strength, his love of sailing, and what a wonderful husband and father he had been.

Then one day, a porter came in, impatient to get Mr. Smith to radiology. I helped transfer him onto a gurney and roll him into the hall, announcing every move. As she started to move on, I stopped her to place a blanket over my patient, noticing that his dark tan had only just begun to fade. “You’ll need

*Not his real name
Vancouver, British Columbia

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Job-line: 604.875.5123
Email: careers@vanhosp.bc.ca

www.vanhosp.bc.ca
Aphasia disconnects stroke patients

Aphasia (either expressive or receptive) is the term for communication difficulties that can result from stroke, head injuries, or other neurological disorders.

Aphasia challenges the stroke patient’s recovery by erecting a barrier between the individual and his or her environment. Often, it leads to depression, which can further hamper progress.

Fortunately, resources are available to family members and caregivers. *Coping with Aphasia* by JG Lyon (San Diego: Singular Publishing, 1998) provides a comprehensive guide. The United States has a National Aphasia Foundation that provides information, links and referrals to support groups. It can be accessed via the internet (http://www.aphasia.org) or by calling 1-800-922-4622. -SRA

At this time, in Canada there is no national aphasia organization like in the United States. Across the country, various institutes and centers provide treatment and resources for aphasia patients and their families, and in Ontario, there is a self-help group for patients and families. The group, the Ontario Aphasia Association, can be contacted at 905-642-2053. For membership information, contact the group in care of Mr. Tom Sollis, PO Box 341, Stouffville, Ontario, L4A 7Z8. -CMP

“I heard what you said to the girl in the hall that day, and I wanted to stand up and cheer, but I could not. You said everything that I could not say.”

this, Mr. Smith,” I said, ignoring the porter's scowl. “It’s cold down there in X-ray.”

“Hurry up,” the porter barked, “You’re wasting my time. It’s not as if he can hear you.”

It took all the courage I could muster to speak up. “Every human being is worthy of respect,” I said, echoing my instructors. Despite his stillness, I told her, Mr. Smith might indeed be hearing every word we were saying. Inside the motionless body was a man still very much alive, infinitely in need of human contact. The porter did not reply.

Soon after Mr. Smith was transferred to a rehabilitation center in a nearby city. I continued on the cardiac floor.

As I delivered meal trays less than a year later, I noticed a large man with a cane exit the elevator and walk slowly towards me.

“Are you Suzanne?” he asked, his speech halting and slurred. I nodded noting that the left side of his face hung slackly. Although it took quite some time for him to complete his thoughts, I listened.

“I want to thank you,” Mr. Smith said. “You talked to me when almost no one else would. You reminded me I was still alive.” A tear rolled down his cheek, and I felt the moisture well up in my eyes. “I heard what you said to the girl in the hall that day, and I wanted to stand up and cheer, but I could not. You said everything that I could not say.”

I hugged him, wishing to stand in that spot a little longer, but knowing I had to move on. Other patients waited.

Now, six years later, I vividly recall the man, and his mission. I have one regret though: I let Mr. Smith leave without telling him how much he would guide me in my nursing career, and how he gave flesh to the lessons my instructors had taught. Because of him, I would never forget that inside every body, even those that are broken, aged, or nearly motionless, is a soul, the heart of a woman or a man, wanting to reach out, to be spoken to, and to be touched. MH
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ALL THINGS CONSIDERED

The Northern Interior Health Region is currently seeking Nurses in community care, extended care, and long term care facilities as well as in hospital settings. In the heart of Beautiful BC, you’ll enjoy lifestyle options that are dazzling to even the most demanding individual.

Consider these facts: The Prince George Regional Hospital is currently undergoing a $50 million building expansion to keep up with the demands of being a regional referral and trauma centre. The new $1 million annual funding package for Regional Recruitment and Retention initiatives provides general support for healthcare employees across the region. The funding is designed to assist with training and education, marketing, teamwork and morale as well as other related initiatives.

Consider the lifestyle: The Region is at the center of a network of trails for hiking, mountain biking or cross-country skiing, with mountains, rivers, and wilderness for virtually any activity. With Prince George as the major centre, the Region offers a wide range of cultural opportunities such as live theatre, a new art gallery, museums, a symphony orchestra, and many social, sports and community events during the year. As the home of the University of Northern British Columbia (UNBC), and the College of New Caledonia (CNC), the Region provides excellent educational facilities and is an ideal place to raise a family.

Consider the opportunities: Contact us and discover BC’s hidden treasure - quality of life, and the opportunity to work in the Northern Interior. Among other things, we have a Family Practice Residency Program and are affiliated with UBC for Royal College training in a growing number of specialties. We have a number of exciting opportunities in the communities in other parts of our Health Region.

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Photos above (from left) by: Gary Beechey, Lewis Kohl, Roy Male
VERY FEW OF US EVER FORGET FINDING OUR FIRST JOB. I remember most of all looking for mine. I pored through local papers and spent days at my university employment center copying contact information from bulletin boards teeming with job postings. Full of gusto and determination, I went home and addressed cover letters that I diligently folded along with my resume into envelopes ultimately destined for the employer whose attention I sought.

Job hunting the way we once knew it has become a thing of yesteryear. Now, rather than spending days hunting for a job, job seekers are able to quickly search through a multitude of jobs that may meet their requirements. Likewise, employers are more easily able to search resumes based on the skills they need. The internet has largely made this transition possible.

Internet Job Sites Reach Target Market

HOW DOES THE INTERNET MAKE JOB SEARCHING EASIER FOR job seekers? By listing hundreds of jobs, online job sites provide an easy “one stop shop” for job seekers interested in widening their job search.

Two types of job sites exist: those that are multi-industry and those that serve a single industry (a “niche” site). Cross-industry job sites tend to be well suited to job seekers who are unsure of their desired career path, or who are interested in pursuing alternate professions. Niche sites, on the other hand, are devoted to meeting the needs of professionals in specific areas such as engineering, IT, or healthcare.

In the same way that the internet has made job searching much easier for job seekers, it has completely revolutionized the way in which employers find qualified employees. By posting their openings on job sites, employers are able to reach a larger audience than they are able to reach using traditional advertising forms. Niche sites are able to capitalize on this further by reaching a targeted group of job seekers. Additionally, since the internet is a relatively inexpensive medium, small- and mid-sized employers can compete with larger employers for qualified job seekers.

MedHunters.com Finds its Niche

LAUNCHED IN THE FALL OF 1996, MedHunters.com takes the concept of matching job seekers with employers to a new level.

On MedHunters.com, job seekers complete skills-based resumes that enable them to be matched with jobs based on their skills (as well as interests). Every week, job seekers receive an email containing new jobs. Applying is as simple as clicking the “apply” button. This skills-based matching also benefits employers who receive resumes only from qualified job seekers.

As a niche site dedicated to the healthcare industry, MedHunters.com better understands what healthcare job seekers are looking for and what healthcare employers need. MedHunters is a confidential service for job seekers. Contact information is not shared with anyone without the job seeker’s approval.

The search for the perfect job, and the perfect employee, is by no means new. But in the same way that the internet has changed the way we communicate and find out what is happening in the world, it has dramatically altered the way we search for and fill positions. Come visit us at www.medhunters.com to find out how. MH
MENHUNTER.COM: 
the people behind the company

By Linda Mackey

Although MEDHUNTERS.COM IS AN INTERNET-BASED SERVICE, THE TORONTO company has maintained its personal touch with a group of dedicated employees.

DANIELLE KEIR, DIRECTOR OF CLIENT SERVICES, is a self-assured woman whose directness would be unnerving were it not for the smile and heartfelt honesty that accompany everything she says. Danielle spent her childhood in cities throughout Canada, and while she was in high school, she worked with disabled teens. Pursuing a Bachelor of Nursing degree seemed the next logical step to Danielle, and she graduated from McMaster University in 1998. Shortly afterwards, Danielle began working for the Canadian office of World Wide Healthcare Exchange, a UK-based healthcare recruitment company. But in the fall of 2000, Danielle decided she needed more room for professional growth, and turned to the internet for help. One Tuesday evening, she came across a job posting for MedHunters.com and submitted her resume; the following morning, she was called in for an interview. Danielle was impressed: having never used the internet to apply for a job, she now had evidence that it worked. Was she surprised? Not Danielle, who has always been an early adopter of technology. In fact, her first experience using email was as early as 1989 when she and her teenage friends used a "Bulletin Board System" to meet boys. Both the internet and Danielle have come a long way.

Moira McIntyre, Account Executive, is a straight-shooting Maritmer from Charlottetown, Prince Edward Island, who joined MedHunters.com in the spring of 1999. Having completed a Bachelor of Arts in psychology and sociology at the University of PEI in 1987, Moira moved to Toronto in 1991. In the mid-1990s, Moira began working for the City of Toronto’s department of social services, first as a welfare case manager, then as an employment counselor for individuals on welfare. During this period, Moira was responsible for implementing a manual resume management system, conducting resume writing seminars, and counseling people on job searches. In early 1999, Moira joined the waves of people who were posting their resumes on the internet, and soon received a call from the management team at MedHunters.com. Over two years later, Moira is one of their top Account Executives. According to Moira, it is rewarding to sell something beneficial, something meaningful. “I’m helping people find jobs and healthcare organizations to fill positions,” she says, “In an indirect sense, I’m contributing to the provision of healthcare.” Moira believes in karma: what goes around, comes around. She also believes in the power of the internet. From the time that she first went online in 1994, she was hooked, and now she cannot imagine life, or her job, without it.

Medhunters.com has maintained its personal touch...
About MedHunters.com

MEDHUNTERS.COM: the people behind the company

By Linda Mackey

DAN PICCOLO, WEB MANAGER, is a self-confessed skeptic. So when he first heard of the idea of producing the MedHunters magazine, he naturally had his doubts. But Dan was so impressed with the final layout of the magazine that he not only agreed (with some arm-twisting) to have his profile printed here, but he will also be designing the new MedHunters magazine website. Born and raised in Thunder Bay, a Northwestern Ontario city of 125,000 residents, Dan came to Toronto, Ontario, in 1989 to do a degree in aerospace engineering. But Dan soon realized that “doing 37 hours of math a week was not enjoyable,” and he switched to studying painting at York University, also in Toronto. He completed a Bachelor of Fine Arts degree in 1994. When asked what it is that he likes about painting, Dan reveals a more private self: painting is like playing the guitar (which he also does); it is cathartic. But we all know how difficult it is to earn a living as an artist, so Dan went back to school in 1998 to complete a diploma in computer programming. Dan’s graduation in mid-2000 coincided with a re-launch of the MedHunters.com site, and having worked at MedHunters.com part-time in the past, Dan became the site’s full-time Web Manager. And how does programming compare with art? While painting is cathartic, programming requires problem-solving skills that satisfy Dan’s analytical side. Dan is a Renaissance man.

ADELE MIRABELLI, ACCOUNT EXECUTIVE, is a strong, outspoken woman who gives credence to the idea that Italian women are fiery. Born and raised in Toronto, Ontario, Adele has grown up in a close, supportive family. From a young age, Adele had an interest in business, so nobody was surprised when she decided to do a Bachelor of Commerce degree at Ryerson University in Toronto. Adele was looking for part-time work to support her extravagant student lifestyle when in December 1998 she responded to an internet job posting from MedHunters.com. Adele’s tremendous vivaciousness won her a job that involved discussing positions with job seekers. It quickly became apparent that Adele was at her best when she was on the phone, and in January 2000, she switched over to a position as an Account Executive. At first, Adele was not sold on sales: she had worked in telemarketing as a student, and although she was good at it, she hated selling people things they did not need nor want. But she took an immediate liking to sales at MedHunters.com. Having worked previously with job seekers, Adele believes in the value of MedHunters.com for employers. And what makes Adele so good at her job? Her upbeat voice, her high energy and her spontaneous personality.

MH

Adele believes in the the value of MedHunters.com for employers
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**According to ancient Egyptians, the heart served as the body's center of intelligence and emotion, and the brain was considered to have no use whatsoever, and was discarded during mummification.**

Hellenologophobia is the fear of Greek or complex scientific terms.

Trivia Test: What 10 common human body parts are three letters long? (Keep it clean and standard!)*

*For answers, see www.medhuntersmagazine.com

The average human heart beats about 100,000 times every 24 hours. In a 72-year lifetime, the heart beats more than 2.5 billion times.

By Cynthia M. Piccolo
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