



FORUM

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L'Association des facultés de médecine du Canada

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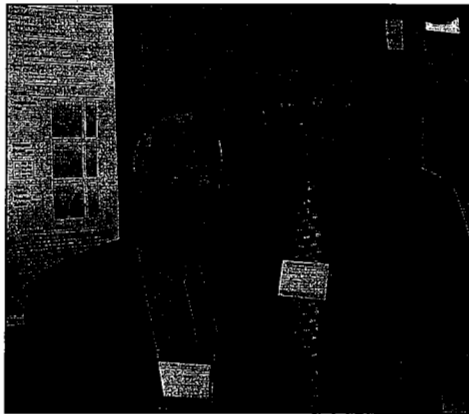
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The John Ruedy Award for Innovation in Medical Education, 1999-2000



Drs. Michael Fung Kee Fung, Karen Fung Kee Fung, Mark Walker and Mr. Sergio Miguel are the inaugural recipients of the newly established John Ruedy Award for Innovation in Medical Education. These individuals have been instrumental in the creation of K.O.A.L.A.TM which is the first internet-based

dynamic learning portfolio in medicine. It has been implemented in 14 Canadian medical schools in residency programs in Obstetrics and Gynecology. The Drs. Fung Kee Fung are in the Department of Obstetrics and Gynecology, University of Ottawa; Dr. Walker is an MRC Fellow in Obstetrics and Gynecology, University of Toronto; and Mr. Miguel is with META Solutions, Inc.

The John Ruedy Award was established by Dalhousie University in 1999 to honour Dr. Ruedy on his retirement as Dean of Medicine. The award will be presented annually to an individual or group who have developed innovative print material, electronic learning aids or other teaching aids.

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FORUM est l'organe officiel de l'Association des facultés de médecine du Canada et paraît quatre fois par an. Les opinions exprimées dans ce bulletin ne sont pas nécessairement celles de l'Association. Les contributions à cette publication sont les bienvenues et peuvent être rédigées en français ou en anglais. Les annonces publicitaires sont également acceptées. L'abonnement annuel à FORUM est de 30.00\$ sauf pour les membres de l'Association qui le reçoivent gratuitement.

The Honourable Louise Arbour is Awarded the Montreal Clinical Research Institute's Medal of Merit

Montreal, November 10, 1999 - The Clinical Research Institute of Montreal (IRCM) paid homage to the **Honourable Louise Arbour** for her outstanding contribution to international humanitarian law by awarding her the IRCM Medal of Merit.

It was at the Institute's annual dinner at the Queen Elizabeth Hotel on November 4, 2000 that Mr. Robert Parizeau, Chairman of the Board of Directors of the IRCM, presented Louise Arbour with the medal. Ms. Arbour was also Honorary President of the event which brought together over 500 members of Montreal's business and scientific communities. Guests joined Mr. Parizeau in giving Ms. Arbour a standing ovation for her exceptional achievements at the International Criminal Tribunals for the former Yugoslavia and Rwanda and in congratulating her for her recent appointment at the Supreme Court of Canada.

"Over the course of a most difficult mandate, Louise Arbour succeeded in mobilizing great nations in an international effort to bring before a court of justice those who are guilty of crimes against humanity" said Mr. Parizeau. "The conviction with which Madame Arbour worked, her unshakeable courage and her absolute sense of justice have resulted in unprecedented progress in the area of

international humanitarian law. For this, we owe her our admiration and deepest gratitude."

With the Medal of Merit, the Clinical Research Institute of Montreal seeks to acknowledge persons whose eminent actions contribute to the improvement of our quality of life.

The Clinical Research Institute of Montreal is a non-profit organization devoted to the study of the causes of disease, the development of diagnostic methods and the discovery of new therapeutic approaches in order to improve the health of individuals. Founded in 1967, the Institute is affiliated with the Université de Montréal and associated with the Centre hospitalier de l'Université de Montréal (CHUM). It also maintains close collaborative ties with McGill University. The IRCM houses 29 clinical and fundamental biomedical research laboratories; some 450 dedicated people work there. As a teaching institute, it plays a key role in training over 150 scientists annually who are preparing for a career in biomedical sciences, in medicine or in health sciences. The Institute's mission is founded on the conviction that close collaboration and team work between researchers are indispensable to the advancement of scientific knowledge. ♣

Creative Vision Needed

By Sharon Gray

The health care system will be transformed in the next five years and the responsibility of leaders is to respond to changes with a vision that inspires the whole community. This was the message of one of the leaders in the province's health care system, **Sister Elizabeth Davis**, Chief Executive Officer of the Health Care Corporation of St. John's, Newfoundland.

Her comments were made November 26, 1999 at the medical school when she delivered the Annual Drs. Albert and Margaret Cox Lecture. The talk was titled "Health Care Today: Chaos, Control or Creative Response", Sister Elizabeth was certainly in favour of a creative response to changes taking place.

She spoke knowledgeably about the reasons behind the need for health care reform, including demographic shifts in western society that have resulted in an aging population coupled with financial crisis and escalating public expectations of service.

Sister Elizabeth identified two major changes that she said will transform society: cloning DNA and the development of artificial intelligence.

"The change is so big around us we can't figure out where we will be in five years. Right now we're in an ambiguous time, a kind of neutral zone or cocoon."

The solution, she said, has to lie in an organic approach that embraces the concept of wholeness, inclusion and interdependence.

“As visionaries in health care we have to call for a vision driven by values. We have to focus on quality and outcomes and there must be ethical decision making. We have to find a way to connect with the community.”

In order to respond to a changing health care system within a rapidly changing society, leaders must be aware of the complexity involved and develop appropriate skills, including emotional preparedness. Just within the Health Care Corporation of St. John's there have been major

changes in the past few years that will see the closing of two hospitals and the consolidation of many services at the Health Sciences Centre.

She noted that ceremonies and celebrations are important during times of change. “You can't change without losing something and we have to grieve that loss.” ❖

This article first appeared in the December 1999 issue of the Memorial University's Gazette.

Dr. Jacques Genest Jr. Receives the Clinical Research Institute of Montreal's Marcel Piché Award

Montreal, November 10, 1999 - The Clinical Research Institute of Montreal (IRCM) is pleased to announce that **Dr. Jacques Genest Jr.** has been selected as the 1999 recipient of the Marcel Piché Award in recognition of the quality of his work in clinical and fundamental research.

It was at the Institute's Annual Dinner at the Queen Elizabeth Hotel on November 4, 1999, that Dr. Yvan Guindon, Chief Executive Officer and Scientific Director of the IRCM, presented Dr. Genest with the award. Hosted under the Honorary Presidency of the Honourable Madam Justice Louise Arbour of the Supreme Court of Canada, the event brought together over 500 members of Montreal's business and scientific communities. The Marcel Piché Award is given to a member of the IRCM who distinguishes himself through outstanding and original research and exceptional leadership qualities.

Dr. Genest has devoted the last fifteen years to the study of genetic and metabolic risk factors in the cardiovascular system of patients with premature coronary artery disease. He has focussed on the treatment of patients with a deficiency in “good” cholesterol (HDL) - for whom a genetic defect was recently identified - as well as on the role of homocysteine in coronary artery disease.

“Dr. Jacques Genest outstanding research has attracted consistent funding from

granting agencies over the years” stated Dr. Yvan Guindon during the award presentation. “Only a few months ago, with the help of his patients and their families and in association with other Canadian researchers, Dr. Genest identified the genetic defect linked with a familial HDL deficiency which affects some 22,000 Quebecers. This discovery, which was published in *Nature Genetics* and *The Lancet*, opens the way to prevention programs and the development of new therapies. The IRCM is proud to present Dr. Genest with the Marcel Piché Award in recognition of the quality of his research.”

Dr. Genest studied medicine at McGill University from 1980 to 1984. His studies included research training at the IRCM in biomedical engineering with Dr. Louis-Gilles Durand and in dyslipidemias with Dr. Jean Davignon. He went on to do post-doctoral research in cardiology and in molecular genetics and lipid metabolism at Boston's Tufts-New England Medical Center. In addition to his work as a researcher, Director of the Cardiovascular Genetics Laboratory and clinician at the IRCM since 1990, Dr. Genest is a staff cardiologist with the Centre hospitalier de l'Université de Montréal (CHUM), Associate Professor with the Université de Montréal faculty of medicine and Adjunct Professor with the McGill University faculty of medicine. ❖

Physicians Honoured

Dr. S. Pierre Soucie, Assistant Professor in the Department of Family Medicine at the University of Ottawa, is one of three physicians to receive the 1999 Council Award from the Council of the College of Physicians and Surgeons of Ontario. The award honours physicians who have demonstrated excellence in eight diverse roles which reflect the needs and expectations of Ontarians.

Soucie provides geriatric training to family practice residents at the university. He is a fellow of the College of Family Physicians of Canada and received postgraduate training in geriatrics through the PSI Travelling Fellowship and the WHO Travelling Fellowship. He is also Vice-President of Medical and Academic Affairs and Chief of Staff at the *soeurs de la charité d'Ottawa* hospital, where he chairs the Medical Advisory Committee. Soucie is also Medical Director and Chief of Long-Term Care at the *Villa Marguerite* in Ottawa and *Résidence Saint-Louis* in Orleans.

In 1990, he joined the executive of the Ottawa-Carleton District Health Council and was

the Chairman from 1994 to 1996. He is a member of the Joint Policy and Planning Committee for the Ontario Hospital Association and the Ministry of Health reviewing initiatives for funding mechanisms for chronic care hospitals in Ontario. He assists the ministry as a member of the Mental Health/Long-Term Care/Chronic Care Committee, and he Co-Chairs the Chronic Care Role Study. Soucie has also been involved with chronic care across the province as Chair of the Council of Chronic Hospitals of Ontario's Medical Director's Group. He has been a principal investigator in various research studies and has lectured extensively at conferences and seminars. Recently, Soucie was the conference Chair for the annual scientific and education meeting for the Canadian Association on Gerontology, for which he is the President-elect.

The Council Award will be presented to Soucie at a meeting of the council on November 23, 2000. ♣

University of Ottawa Researchers Only Canadians to Share in \$2.9m US Project

A research grant from the National Cancer Institute in the United States will allow University of Ottawa scientists to study new treatments for ovarian cancer - the only Canadian group to receive the American funding.

A team of researchers from the university and the Ottawa Regional Cancer Centre (ORCC) will share the \$2.9 million US grant with a team from the Fox Chase Cancer Centre in Philadelphia, Pa., led by **Dr. Thomas Hamilton**. The joint proposal won the special grant competition focusing on mouse models of human cancers.

The Ottawa research team, led by **Dr. Barbara Vanderhyden**, an Associate Professor in the Department of Medicine, also includes University of Ottawa professors **Drs. John Bell** and **Ian Lorimer**. The money, to be disbursed

over a five-year period, will be used to study *Mouse Models of Ovarian Cancer*.

Vanderhyden, a career scientist with the ORCC's Cancer Research Group since 1995, points out "The more these models resemble human cancers, the better will be our ability to identify and evaluate strategies for prevention, diagnosis and new treatments."

The strategies learned from these more realistic systems can then be more accurately applied to women with ovarian cancer.

In Canada and the United States, almost 30,000 new cases of ovarian cancer are diagnosed each year and more than half that number die of the disease. ♣

COMING EVENTS/À VENIR

McMaster University Continuing Education

June 7, 2000
Pediatric Emergencies

June 8 & 9, 2000
PALS

June 12, 2000
Psychiatry Series 1: Session 10
Approach to Personality Disorders
(4:30 - 6:30 pm)

June 12, 2000
Dr. Paul Stringer Memorial Lectureship in
Ophthalmology

June 12-16, 2000
Level 2 Palliative Care (5 Days)

June 19, 2000
Psychiatry Series 2: Session 10
Approach to Psychosis
(4:30 - 6:30 pm)

Address Inquiries to:
McMaster University
Health Sciences
Continuing Education
1M7-1200 Main Street West
Hamilton, ON L8N 3Z5
T: (905)525-9140 ext. 22671 or 22532
F: (905)572-7099
www-fhs.mcmaster.ca/conted

University of Saskatchewan Continuing Medical Education

June 2-3, 2000
Practical Health Care of the Elderly
Saskatoon Inn, Saskatoon, Saskatchewan

September 15 & 16, 2000
Palliative Care For Physicians
Pasqua Hospital Auditorium
Regina, Saskatchewan

October 13, 2000
Pediatric Infectious Diseases
Saskatoon, Saskatchewan

November 3 & 4, 2000
Cancer Symposium
(Lung Cancer)
Pasqua Hospital Auditorium
Regina, Saskatchewan

November 24 & 25, 2000
Practical Management of Common Medical
Problems
Theme: Infectious Diseases
Saskatoon Inn
Saskatoon, Saskatchewan

Address Inquires to:
C.M.E. Office
University of Saskatchewan
Box 60001, RPO University
Saskatoon, SK S7N 4J8
T: (306)966-7787
F: (306)966-7673

*Address Inquires to:
C.M.E. Office
University of Saskatchewan
Regina General Hospital
Regina, SK S4P 0W5
T: (306)766-4016
F: (306)766-4019

Drakes Give \$1 Million to University of Western Ontario

The family of the late Dr. Charles Drake has donated \$1 million to the University of Western Ontario to establish the Charles Drake Student Awards in Medicine.

Drake, a renowned neurosurgeon, put London on the map in the 1960s when he transformed brain aneurysms from a death sentence to operable surgery with a proven success rate.

His procedure was so rare that the late Mother Teresa called on him to save the life of a 23-year-old man from India in 1983.

The \$1 million gift will be matched by a combination of university-based and government-sponsored programs, boosting the awards to \$2.13 million. The awards will focus on diabetes, neurosurgery and ophthalmology. ❖

IRCM's Major Fundraising Campaign in Full Swing: \$11.5 Million Have Already Been Raised For Advanced Biomedical Research

Montreal, November 10, 1999 - With its annual dinner held November 4, 1999, the Clinical Research Institute of Montreal (IRCM) saw proceeds generated through its Major 1998-2002 Fundraising Campaign *Invest in Life* reach the \$11.5 million mark.

Sponsored by honorary patrons HVAC and T²C²/BIO and held at the Queen Elizabeth Hotel, the IRCM's 1999 Annual Dinner was attended by over 500 members of Montreal's business and scientific communities. Hosted under the Honorary Presidency of the Honourable Madam Justice Louise Arbour of the Supreme Court of Canada, the event was also an opportunity to thank the following corporations for gifts of \$500,000 or more to the IRMC: National Bank, Bell Canada, Bombardier, Glaxo Wellcome, Hydro-Québec, Le Group Jean Coutu (PJC) and Power Corporation of Canada.

Chaired by Mr. André Caillé, President and Chief Executive Officer of Hydro-Québec, the IRCM's *Invest in Life* campaign was launched one year ago to raise the funds necessary to meet the Institute's most immediate needs evaluated at \$22 million. These include creating permanent Chairs of Excellence, recruiting new researchers, attributing funds to specific fundamental and

clinical research projects, acquiring and renewing scientific equipment critical to the advancement of research and setting up student scholarship programs.

"The business community's response to date has been remarkable" stated Dr. Yvan Guindon, Chief Executive Officer and Scientific Director of the IRCM, as he thanked volunteers and major donors. "Close to a hundred individual men and women are playing an invaluable role in the campaign, donating both time and talent to generate support for biomedical research within their respective networks. There is no doubt in my mind that their continuing efforts will lead to the achievement of our campaign goals. With this support, the IRCM will be ideally positioned to make significant contributions to the advancement of knowledge in the area of biomedical research for the greater benefit of society as a whole."

The IRCM owes the success of its 1999 Annual Dinner to its Organizing Committee made up of IRCM Foundation administrators and chaired by Mr. Tony Meti, Senior Vice-President, Banking and Commercial Market, National Bank of Canada.

Associated Medical Services Inc. Endows Three History of Medicine Chairs

Medical students will be the big winners, now and for many years to come, thanks to AMS' recent \$4.5 million endowment of the Hannah Chairs in the History of Medicine at the University of Western Ontario, McMaster University and the University of Toronto. The endowments, which are to be 'matched' by each of the host universities, will provide funding in perpetuity for the Hannah Chairs.

"AMS is very pleased to make this investment in support of research and education in the history of medicine" said AMS President **Dr. Abbyann Lynch**. "History of medicine programs are a continuing priority for AMS, and with this announcement, we want to signal our ongoing commitment to the history of medicine in a very public way."

Since establishing the Hannah Chairs in 1973, AMS has contributed close to \$12.5 million in support to the universities holding these Chairs.

Following news of AMS' contributed funding, a public announcement was made at the University of Western Ontario on September 27, 1999 and at McMaster University on October 27, 1999.

In the September 27, 1999 announcement, Dr. Carol Herbert, UWO's Dean of the Faculty of Medicine & Dentistry, stressed the importance of medical history in today's medical curriculum. "Modern medicine is informed by the discoveries that have been made throughout history" she said. "I believe medical students can become better doctors if they understand the roots of their profession. This is an important chair for the Faculty of Medicine & Dentistry."

At the October 27, 1999 announcement at McMaster University, Daniel Woolf, Dean, Faculty of Humanities, lauded AMS for its commitment to interdisciplinary teaching and research. "The marvelous opportunity afforded by the Hannah Chair is a perfect example of the many ways in which humanities' disciplines such as history and a highly scientific field such as medicine can be integrated to the mutual enrichment of both" he

said.

The current endowed Chairs in the History of Medicine are Dr. Paul Potter (University of Western Ontario), Dr. David Wright (McMaster University) and Dr. Edward Shorter (University of Toronto). ❖

UBC Med School Marks 50th Birthday with Call for Increased Enrolment

Heather Kent

Dean John Cairns' outlook is serene as the University of British Columbia's medical school turns 50 this year. This may not seem particularly surprising, given that a golden anniversary is usually a time for positive reflection. However, the past 20 years haven't been particularly kind to his school, which has faced funding cuts and a static number of undergraduate students in a rapidly growing province.

Still, Cairns begins an interview by focusing on the successes of the faculty's researchers and the excellence of the school's graduates. Indeed, UBC medical faculty are world leaders in areas such as genetic and neurodegenerative research, and 25% of the university's spin-off companies originated in the faculty of medicine.

It is at the undergraduate level that Cairns is seeking change. The number of students who enter the school each year - at 120, the smallest number in Canada in terms of the population drawn from - has remained unchanged since 1980. At the same time, the undergraduate fees, frozen at \$4000 annually for the last four years, are the lowest in Canada outside Quebec.

The academic upside is that the students who are selected have the highest MCAT scores among students attending Canadian medical schools, but the downside is that many potentially outstanding students are turned away from careers in medicine. Cairns, who notes that BC's population has increased by 50% in the past 20 years, would like to increase the annual undergraduate intake to 160 or 180 students. "BC has not taken responsibility for educating any appropriate portion of its own physicians," he said. "It never has."

Cairns, a 1968 UBC graduate, said problems don't end at the undergraduate level.

"We are unique in having fewer first-year residency positions than the size of our graduating class," he said. This means that BC depends on the rest of Canada and other countries both to train many of its own graduates and to provide many of its practising physicians. Cairns warns that the policy "makes us very vulnerable. It's a short-term policy that ultimately will fail."

He says recruitment of foreign doctors is already becoming more difficult as traditional overseas sources, such as Britain, are retaining more doctors. The province has enough doctors now - on a per capita basis it ranks second only to Quebec - but this situation won't last because of retirements.

Cairns could prefer to see the "enormous amount of money" health boards are spending recruiting doctors spent on increased enrolment at UBC. While the provincial government remains preoccupied with the overall ratio of physicians to population, says Cairns, "we struggle with the development of a provincial vision in which the medical school is seen as integral to the health care system. We haven't yet achieved that [integration]."

He also thinks the school's relatively small undergraduate and postgraduate capacity means that it has to work harder to establish relationships with doctors from other regions. He says this is not the case in Alberta and Ontario, both of which train a much higher proportion of their physicians. "Alberta is very progressive and Ontario is addressing its problem."

Cairns does think that talks with the BC government are going in the right direction. "It's critically important that real progress be achieved."

The school is also dealing with the increasing role of nurse practitioners and health providers such as mid-wives. "There are many responsibilities that physicians currently carry out

that do not require their training and education and could be assumed by individuals with less training," says Cairns. He thinks nurse practitioners work well in remote parts of the province, where they have "a kind of social attractiveness," and intensive care units that have a "clear hierarchy of accountability. Problems arise when their expertise is exceeded."

Despite all the challenges, Cairns is

optimistic: "The focus of the Canadian public on health care, the absolute requirement for Canada to educate more of its own physicians, the development of a federal vision around health research and the quality of BC life, are very solid reasons for optimism." ❖

This article first appeared in CMAJ, April 18, 2000; 162 (8)

CLINICAL AND INVESTIGATIVE MEDICINE

Official journal of the Canadian Society for Clinical Investigation

MÉDECINE CLINIQUE ET EXPÉRIMENTALE

Journal officiel de la Société canadienne de recherches cliniques

Many medical graduates lack basic science training

Is the way we're training doctors today going to harm the way patients are treated tomorrow? Concern about the amount of basic science being taught in medical school prompted faculty from Canadian medical schools to meet at a workshop entitled "Foundation Science for Medicine in the 21st Century." The proceedings of the workshop were published as a special issue of the medical journal *Clinical and Investigative Medicine*.

"There is more than one crisis in medical education today. Not only are we facing severe shortages of medical graduates, we may be producing the wrong kinds of graduates," says Dr. Stuart MacLeod, a professor medicine, pediatrics and epidemiology and biostatistics at McMaster University, who was one of the organizers of the workshop.

"At the very moment when our knowledge of life sciences and human genomics is exploding, we appear to be handicapping our graduates by releasing them with a profusion of more utilitarian clinical skills, while ignoring the obvious imperative for a sound foundation in basic biological science."

Furthermore, the amount of science students have studied before starting medical school varies, with many medical students now coming from backgrounds in the humanities rather than the sciences.

MacLeod is concerned that many medical graduates may lack the analytical skills to tackle the profusion of information in medicine.

"Practitioners are literally drowning in information. It is impossible to imagine how today's physicians can stay afloat on a sea of knowledge unless they possess adequate skills in

scientific interpretation and analysis."

Participants in the workshop examined many issues in medical school curriculum that affect scientific learning:

- Two Canadian medical schools have a three-year rather than a four-year program, which raises concern about the time available to learn basic science.
- Many schools have instituted "problem-based learning," in which students learn about anatomy and biology through small-group examination of a real clinical problem; there is debate about whether this is a successful way to teach science.
- There are many different approaches to integrating science into medical-school curricula and it is unclear which approach best helps students learn and retain scientific knowledge.
- The Medical Council of Canada examination that MD graduates must take to get their licence includes very little basic science and there is discussion about how and how much to test scientific knowledge in this exam in the future.

Clinical and Investigative Medicine is a peer-reviewed scientific journal. It is the official journal of the Canadian Society for Clinical Investigation and is owned and published by the Canadian Medical Association.

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Errors and Omissions

An article entitled, "Canadian Health Care and the Brain Drain: Doctors and Nurses" was published in the November 1999 issue of *FORUM* (Vol. 32, No. 3).

Inadvertently, two articles that appeared in Canadian newspapers and which should have been part of the text of the article were not included.

These two articles are reproduced here. They should have been inserted in Section IV, What Should be Done?

To give readers an idea of how the text should have read, the articles are reproduced including the paragraphs of text that immediately preceded and followed the two articles in question.

This passage can now be read in conjunction with the full article as it appeared in the previous issue of *FORUM*.

IV What Should be Done?

I have tried to show that the brain drain of doctors and nurses is extensive, that it did not suddenly materialize overnight and that, for physicians particularly, its causes are not solely economic. For doctors, the attitudes of government and the media have played a significant role in generating low morale in the profession. Much of what I am saying was nicely illustrated earlier this year in the reactions to an article I authored with colleagues, in which we pointed out that Canada was heading for a serious shortage of physicians because Canada's medical schools have far too few places for the study of medicine. I need hardly add that when physicians are already in shortage, behaving in way that result in physician emigration is unwise.

Shortage of nurses, not MDs, worries Rock

Canadian Press

CALGARY — Federal Health Minister Allan Rock isn't so worried about doctors leaving Canada for more lucrative jobs — it's the shortage of nurses he's concerned about.

"We have to work to keep our nurses in Canada and regain their confidence," Mr. Rock said yesterday. "I think nurses have been demoralized by the changes in the health system."

He was responding to a study in the Canadian Medical Association Journal that predicted a shortage of doctors due to retirement, death and emigration.

To maintain a consistent ratio of physicians to population, medical schools should be producing about 2,000 new doctors annually, the article said. But Canadian medical schools admitted only 1,500 prospective doctors last year, and 10 to 15 per cent of them will likely emigrate.

"I know there's a certain number of physicians leaving Canada every year, but we have roughly the same number returning to Canada," Mr. Rock said.

Mr. Rock was in Calgary to an-

nounce \$11-million to improve Alberta health care. The money will be used to study one-stop health centres where several types of health professionals — doctors, nurses, physiotherapists or psychologists — work together.

Nurses were encouraged by the minister's remarks, but doctors were seething.

"I absolutely, vehemently disagree that doctors aren't in the same boat as nurses," said Dr. Bill Anderson, president of the Alberta Medical Association.

Doctors and nurses across the country have suffered the same government cuts, and both professions feel left out and undervalued, Dr. Anderson said.

The Canadian Nurses Association recently told Mr. Rock there will be a shortage of 59,000 to 113,000 nurses by 2011. There are now about 264,000 Canadian nurses.

Heather Smith, president of the United Nurses of Alberta, said she is pleased Mr. Rock was listening to representatives of nurses' unions who met with him in February.

Is there a doctor in the house?

A STUDY in the Canadian Medical Association Journal says we face a doctor shortage. Governments say we have a glut. Who's right? Answer: wrong question.

Just when we thought we had nothing left to fear but the millennium, a study by the former research director of the Association of Canadian Medical Colleges has concluded that by the early years of the next century, Canada will be drastically short of doctors. The proposed solution? Increase enrolment in medical schools, starting now. But governments, who foot the bill for medicare, say more doctors aren't the solution, they're the problem. Canada's patient-physician ratio is about half what it was in the 1960s — meaning there are twice as many doctors per patient — and while this has led to bigger health-care budgets, it apparently has not spelled better health care.

Governments not long ago decided that an easy way to control the cost of medicare was to control the number of doctors. It's estimated that each new doctor costs the system \$500,000 in billing, hospital services and lab tests ordered. To rein in those extra costs, provincial governments in the early 1990s signed an agreement ordering Canada's medical schools to stop taking in so many medical students — and stop producing so many doctors.

So how many doctors is too many? How many is too few? The history of governments trying to precisely calibrate the number of students injected into the lengthy medical-training pipeline with the demands of the Canadian population decades hence illustrates the difficulty in answering the question. It also suggests that perhaps governments shouldn't be answering it.

More than 30 years ago, the Royal Commission on Health Services recommended doubling the number of medical students. Obediently, we established four new faculties of medicine and expanded the dozen existing schools. It took more than a decade for all these changes to be reflected in the increased number of qualified doctors. By 1980, Emmett Hall, the very same man who had recommended expansion in 1964, was warning about a surplus of physicians. And by the early 1990s, provincial

governments were ordering medical schools to drop the number of students admitted.

Rationing the number of doctors trained is an obvious way of reducing medical costs, but it's a very blunt and clumsy instrument. There are more sensible ways of relating expenditures to need and providing quality medical services to an expanding and aging population. Opening up routine primary health care to nurse practitioners would help. So would shelving the current fee-for-service payment in some areas, in favour of a primary-care system based on what are known as rostering and capitation.

Under fee-for-service, a doctor performs a procedure and is paid a fee. Because the system pays instead of the patient, abuses can occur through doctors overtreating and patients overconsuming. Under capitation, primary-care doctors (or better still, full-service health offices staffed by doctors, nurse practitioners and other medical personnel) receive an annual block of funds based on the number of patients on the "roster," adjusted according to each patient's general health. In other words, funding is attached to patients rather than volume of procedures delivered. Patients choose their primary-care doctor in the usual fashion, and are free to switch, but the doctor's earnings are based on the number of patients he or she can attract and keep in the practice. Primary-care costs end up calibrated to the number of patients, not the number of doctors.

If we make some changes to the way health care is organized and allow medical enrolment to largely follow supply and demand as in other professions (do we try to control the economic cost of lawsuits by reducing the number of lawyers?), the system will find its own balance. And if Canada does find itself short of doctors, as the Canadian Medical Association Journal predicts, the market for medical professionals within medicare can always attract more qualified physicians from abroad. Canada has a long tradition in this area: A high percentage of our doctors are foreign-born and foreign-trained — a case of brain drain benefiting Canada. It's a trend we should be happy to promote.

Yes, Canada's Minister of Health is reported to have said that he's not worried about doctors leaving Canada but he is concerned about the shortage of nurses, however. Mr. Rock also volunteered the information that the same number of physicians returned to Canada as left! With such misinformation, one has to wonder what kind of briefing materials the Minister of Health receives. ❖

NAME CHANGE

The Association of Canadian Teaching Hospitals has changed its name to the Association of Canadian Academic Health Care Organizations - l'Association des organismes canadiens d'enseignement des soins de santé.

REPORT TO ACMC BOARD OF DIRECTORS FROM ACMC SPECIAL COMMITTEE ON GENDER AND EQUITY ISSUES May 2, 2000

The Committee has existed since 1997, and each year has organized an educational component and a business meeting. It is important, with the large number of women medical students and the increasing number of women medical faculty, that academic medicine, and ACMC in particular, consider the ways that gender will have an impact on the clinical practice of medicine as well as academic medicine.

This year's educational event was extremely well received. On Sunday evening, Dr. Rosie Goldstein, Dr. Carol Herbert and Dr. Nonie MacDonald made 3 interesting and informative presentations on the topic of "Women Leaders in Academic Medicine: How Did We Get Here from There". The presenters addressed the personal and systematic factors that influenced women's involvement in academic medicine.

American researchers have shown that the relative low numbers of women in academic medicine are not a reflection of a cohort effect, but that women enter academia and then leave more often than junior male faculty. Individual institutions and the ACMC need to look at the factors affecting the retention of women.

In order to do this, accurate Canadian data are required. AAMC has collected data on the number and ranks of women faculty for many years, and the Gender Issues Committee of the Council of Ontario Faculties of Medicine have adapted the AAMC survey and done a similar benchmarking exercise for 4 years. In addition, researchers are seeking similar information on a discipline-by-discipline basis.

Each year participation at the business meeting waxes and wanes. There is a need for membership on the committee to be formalized. This will allow information about gender-related activities across the country to be shared back and forth, so that people can learn from the

experiences of others and so that innovative programs from one institution can be replicated elsewhere.

For 2001, we will encourage educators to offer poster presentations and workshops where some of these innovative programs that focus on various gender issues, such as mentoring, enhancing women's leadership skills, and dealing with harassment and intimidation issues, can be demonstrated and discussed.

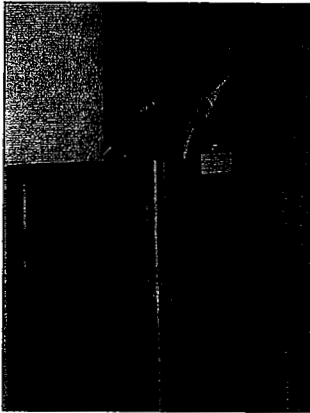
Recommendations:

1. That deans be encouraged to designate someone to represent their faculty at the ACMC Special Committee on Gender and Equity, and that these individuals be expected to share information back and forth between their school and the ACMC committee. In addition, participation by individual medical students and residents, and their respective organizations, needs to be encouraged.
2. That ACMC undertake to collect data on the number and rank of male and female faculty at the 16 Canadian medical schools, and that these data be made available to the medical community for consideration.
3. That ACMC develop a website which could facilitate the distribution of relevant information, such as descriptions of innovative programs.

Barbara Lent
Billie Thurston,
Co-Chairs, Special Committee on Gender and
Equity Issues

TRANSFORMING THE HEALTH SCIENCES A 21ST CENTURY CHALLENGE

Dr. Martin Hollenberg, University of British Columbia



It's a great honour to present the J. Wendell MacLeod Lecture. Wendell MacLeod has a distinguished record in Canadian Academic Medicine and his contributions to medical education and medical students have been outstanding. So it's a special privilege to present the first J.

Wendell MacLeod lecture of the new century to my colleagues from across Canada and beyond.

Just for fun, I often browse through dusty old book shops. I've developed a particular affection for old etiquette books because of the vivid window they open into society in the past. Probably the most revealing book of this type I've encountered is a volume entitled "The New Century Etiquette," published 100 years ago, to mark the inception of the 20th century. This book is chock full of wonderful illustrations and I've taken one to show you today. Here we have on the overhead what must be one of the world's first automobiles being driven, rather surprisingly for that time, by a woman. The caption points out, "that it is quite as good taste for a lady to drive as for a gentleman." You can just imagine the talk between gentlemen then as she passed by. "What's that? A woman driving! My goodness, what will they do next!"

It's pretty hard to look at this picture now though without chuckling and feeling a bit smug. Today we have vastly superior cars with complex, computerized systems. But far more importantly, although we still have more to do, we've come quite a distance in the past hundred years in acknowledging and supporting the rights of women. Sometimes, as professionals, we look back on this progress with pride. But before we get too carried away, we should reflect on what our successors will think of us a hundred years from now when they look back on what to them will be our rather strange clothes, customs and old fashioned inventions in engineering. One thing for sure, we will probably look just as quaint and outdated to our successors a hundred years from now as that lady driving her prized vehicle looks to us.

Who can doubt that we are headed for years of great change, much more rapid than in the past. In fact, it's not a great leap to predict that a genuine and complete transformation in the Health Sciences is imminent. By being present at the beginning of the century, we have a special opportunity and a responsibility to set this transformation on the right track. We need to think deeply now about what those changes will be and set our basic course. We need initiatives that make sense, are based on solid fundamentals and have broad acceptance. Just as that lady driving that wonderful old automobile is looking ahead with confidence, so should we.

In planning these developments, we badly need a prominent reference point to direct us towards our goal of a stronger, healthier Canada. But what shall that guidepost be? To me, the one choice which stands out boldly above all others is what society can and should expect from us. I'm referring, of course, to our social contract, a bargain we have with society which grants us many rights and privileges. We, in turn, have an obligation to provide society with directions and solutions that are in the public interest to some of its most important problems. We need to know, as well as we can, what those problems are and then we need to help to solve them, effectively and quickly.

So what will society expect from us in coming decades and how well have we done so far in meeting society's needs? First, I think it's very clear that over the past 100 years all of us who have been in the Health Sciences have a record to be proud of. Why only 150 years ago, surgery in England was performed without anesthesia in a special room on a church rooftop so that the patient's screams could not be heard in nearby hospital wards. It was only in 1921 that insulin was discovered, and penicillin in '28. Since then, health care has improved enormously in Canada, and elsewhere, and there have been major advances in every health discipline, both basic and clinical, which no one could have predicted. Overall, Canadians today enjoy superb health and the health care professionals graduated from our universities rank among the best anywhere. Our research has been outstanding too despite the fact that we have been operating from a very small research budget relative to other advanced countries. Yet, before we get too self-congratulatory, let's reflect again on the woman driving that quaint automobile 100 years ago. She's obviously very pleased with herself, her new

car and her social progress. And yet she knows so little about the tumultuous years that lie ahead of her.

We too can only guess at what the future holds. But when we look at our contract with society, all is not perfect. Far too many major problems remain unsolved. Some of these are mammoth and complex and not entirely of our making. But because they involve health, they involve us, and we cannot escape a significant part of the responsibility for solving them.

Consider the state of Canada's Health Care System. Currently, it has a set of problems that captures national attention daily. Over the years, we have seen many reports from academia, governments, hospitals and medical associations outlining improvements to the system. Yet, despite all efforts, the problems still persist and may even be growing worse. New and expensive technical innovations and an aging population are putting enormous pressure on the system. Governments are getting desperate. Nothing, not even additional billions, seems to be making a significant difference. Obviously, what we need are new approaches, completely new ones, even radical ones, involving vision and imagination and thinking around corners and outside the box. Since this kind of approach is, or should be, the stock in trade of our Health Sciences, we need to be much more active than we have been in this search for solutions. We need to apply our qualities of foresight and imagination and lead a major, well coordinated effort to solve this problem once and for all. No one can lead it better than us.

Within the overall System, one segment deserving special attention from us is health care in rural, remote and northern areas. Despite widespread and continuing efforts to improve the situation, health care statistics in these areas remain dismal. In the Northwest Territories, for example, infant mortality rates are three times and suicide rates five times those of the Province with the lowest rates. Statistics released this January by the CMA indicate that there is only one family doctor in rural Canada for every 1,340 residents, about one third fewer per capita of the number in urban areas. Of course, many of our universities have programs in place aimed at improving this situation. However, despite such efforts and based on the depressing statistics alone, the conclusion that we have not done enough is inescapable. Again we have much to offer here and new approaches and solutions from us are desperately needed.

These are not the only areas where increased input from us is crucial. Take inner city and aboriginal health. The Vancouver/Richmond Health Board recently did a study of approximately

28,000 aboriginal people in Vancouver and 1600 in Richmond. They found that life expectancy for aboriginal men is 58.6 years, seventeen less than for other men in the region and for aboriginal women, 66.7 years, fifteen less than the others. Infant mortality among our native population was found to be double the average in the region and alcohol and drug related deaths, eight times higher. In Vancouver's Downtown Eastside, a small pocket of rundown housing and shops just a few blocks from some of Vancouver's most expensive hotels, widespread intravenous drug use has led to one of the highest rates of HIV infection in the developed world. In fact, in Toronto and Montreal as well as Vancouver, AIDS is now the leading killer of men aged 25-44. Yes, aboriginal and inner city health is another example of a multi-faceted problem being addressed by many stakeholders in government as well as in our universities and teaching hospitals. But it is also a key problem in our very own contract with society that we have yet to solve.

Looking forward in the 21st century though, it seems likely to me that, increasingly, we will be called upon to help solve some of the immense health care problems that lie beyond our borders. Let's consider the situation in Sub Saharan Africa where AIDS, aided by widespread poverty, is now the leading cause of death, killing 10 times as many people as the continent's wars. Reports indicate that so far more than 12 million Africans have been killed by this disease and another 11 million orphaned by it. In Zimbabwe the AIDS epidemic has forced funeral homes to stay open 24 hours a day and space in burial grounds is running out. This situation is far more than a health crisis. It now threatens the economic, social and political stability of entire countries. Essential sectors like mining and teaching have been particularly hard hit as young men die faster than replacements can be trained. Some might question why we need to worry about health care problems in distant countries? As Marshall McLuhan pointed out, we live in a global village and our concerns must be international since events that affect one country now quickly impact others. As our world continues to evolve, and terrifying new infectious diseases in humans are likely to emerge, global health care could well become the dominant issue of the 21st century. We will have no choice but to react in kind and feature it prominently among the major unsolved problems confronting us.

Another area of great concern to me, and I hope to you too, is the rapid rise in our society of dependence on Alternative Health Care. The numbers are staggering. In 1996-97, for example, the Fraser Institute reported that Canadians spent \$5.8 billion on Alternative Medicine's products and

therapies and, without doubt, this amount has increased considerably since then. The truth is that Canadians are spending this huge amount of money on therapies which, with very few exceptions, have not been scientifically proven to be any more effective than a sympathetic talk or a pat on the back. Clinical trials in this field are very few in number, regulation is poor and evidence of effectiveness and safety is sadly deficient. Yet consumer acceptance of these highly and, often, falsely promoted products and therapies, is racing ahead.

Why should we be concerned about this? After all, does science not advance within a social context and do we not view scientific progress from the standpoint of our Western society with all of its attendant prejudices and biases? Aren't different societies entitled to a different view and different practices? Also, so far anyway, relatively little public money has been spent on these products and therapies. Why shouldn't Canadians spend their out of pocket dollars as they wish? Are we to blame? Have we failed somehow in our ability to communicate with the public? Given that millions of normally sensible Canadians follow this course, why shouldn't we simply give up, follow them and share in the largess? After all, in this restless time, much of society is eagerly searching for alternative approaches to health and looks on us, with our devotion to science and its methods, as being quite arrogant.

The answer, I feel, lies in the true nature of science and scientific reasoning. Logical, critical and skeptical thinking, hypothesis and evidence building and the related activities of observation and experimentation are traits that are common to the advance of science in societies throughout the world, cultural differences notwithstanding. In stark contrast, the therapies and products of Alternative Medicine almost always lack an advancing research base and must depend on anecdotes for proof of benefit. But anecdotes can be readily collected on all sides of a health care intervention. Which ones do you believe? In the prioritizing of health care interventions, should not prime prerequisites for a high spot on the list be effectiveness and safety as proven by the methods of modern science? Is not the one enduring hallmark of Alternative Medicine the fact that with very few exceptions it is really not Science?

Perhaps the late American astronomer Carl Sagan in his book "The Demon Haunted World" said it best. Concerned that the light of scientific thinking is flickering and that there is a risk that it could be extinguished altogether, he wrote, "Science is a way to call the bluff of those who only pretend to knowledge. It is a bulwark against mysticism, against superstition, against

religion misapplied where it has no business being. If we're true to its values, it can tell us when we are being lied to. It provides a mid-course correction to our mistakes."

So there you have it, some examples of where I feel we have fallen down badly in our contract with society. How do we go about turning this situation around and keeping our side of the bargain?

The new Canadian Institutes of Health Research (CIHR) programs and goals give us a good start. Not only do these programs bring close to a doubling of Federal funding for Health Sciences research, they also bring with them a new outlook and a new objective to guide future investigation. The CIHR objective, "to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products and a strengthened Canadian health care system" very likely will become the centrepiece for the future of Canadian health research. Today it's crucial that we all understand deeply the true meaning of these words and fully appreciate what the CIHR will be trying to achieve.

Here is my interpretation. First, very deliberately, the CIHR has been set up as an organization for health research, not medical research. That, in itself, is a very significant change because it means that we are embarking on research across a much broader spectrum which encompasses almost every discipline in the research university, almost all departments in a typical teaching hospital, our research institutes, agencies, foundations and community groups too. In line with this approach, a major effort will now be made to build up areas in health research that have been underdeveloped in the past. These include fields such as nursing research, health research in the social sciences and the humanities, epidemiology and biostatistics, health policy research, women's health research, health economics and so on. The CIHR is also encouraging research that bridges more than one discipline, department, faculty or institution, public or private, domestic or international. Research that combines the full spectrum from molecular and cellular research through clinical investigation to health services and population research will also be encouraged. The CIHR will build upon a wonderful foundation of solid research now developing nicely in our basic and clinical, medical sciences. This research too can be expected to grow quickly in size and strength within the new framework and both basic scientists and clinician scientists in Medicine should benefit enormously.

In essence, the CIHR is suggesting to us that we look at things anew, re-identify society's significant problems and then attack them broadly, in a contemporary way. They are emphasizing that significant societal problems affecting the health of Canadians should be approached by a team of professionals who pool their intellectual resources to create new and different directions and solutions. The key will be to put together teams that can actively approach a major societal problem from a variety of perspectives and have impact and rapid success.

This will be no easy task. Health research in the future will have to be far more sophisticated and cosmopolitan than anything we have seen so far. The key ingredients in all of this, I predict, will be creativity, vision and imagination. In the past, these qualities in Canadian medical research have rarely been able to achieve full flight thanks to continuing, severe financial constraints. However, we already know that in the future funding for research will no longer be the limiting factor it once was. In fact, it's not hard to predict that in this new century, the strength of a Health Science Centre will be measured in creativity, resourcefulness and innovation rather than simply by the number of research dollars it has or the number of publications it produces.

At last, greatly increased fiscal support for our research is now arriving. In addition to a \$27.5 million increase in the base budget of the MRC last year, the advent of the CIHR will bring with it a \$65 million increase in 2000-2001 and a further \$110 million increase in 2001-2002. By the year 2005, the Canada Foundation for Innovation will have allocated \$1.9 billion to support research infrastructure. As well, \$900 million will be provided over the next 5 years from the Federal Government towards funding for 2,000 new, Canada Research Chairs and \$160 million for the Genome Canada project. A great many hundreds of millions more will be added from a variety of other sources including the pharmaceutical and biotechnology industries, the Networks of Centres of Excellence, Provincial governments, foundations, agencies, venture capitalists and private philanthropy.

The combined effect of all of this additional support will be electric! Our challenge will be to design projects worthy of this sea change in funding opportunities which have the potential to change the world. Henry Friesen has talked about this planned change as a genuine transformation in Canadian health research. I think he's right.

To fully meet our social contract though, it's obvious that we will need solutions which involve our prized educational programs too. In planning the latter, as well as our research, I would

like to suggest that a good approach is to use a *tabula rasa* and start with a clean slate and minds similarly free of preconceptions. By approaching things that way, we can take some very big steps quickly and open ourselves to entirely new ideas, new approaches, new roles for graduates and new ways of doing things.

Let's imagine that we're in a discussion group containing innovative people from our own constituencies and society at large and before us is a rather large blank sheet of paper. With minds open and free, we no longer think of doctors, nurses, social workers and therapists in the traditional mold as the ideal models to meet the health needs of society. After all, what proof do we have that these models are, in fact, the best ones possible? Further, let's take into account for our planning purposes the increase in possibilities raised by the very significant, real increases in funding now underway.

Let's imagine too that we have an enthusiastic facilitator who says to us, "write down on the right side of the sheet of paper all of the areas where you feel our Health Sciences have not succeeded in fulfilling our contract with society and where there are major problems in our social contract which remain unsolved". That, in itself, would be quite a list and would probably include the examples I referred to earlier. In reality, I think it would take our discussion group quite some time to come up with a list that we would all agree on and that would accurately describe our situation. But yet, I think that without becoming too specific, we could do it. Then we break for coffee and other stimulants and, after a period, return to the discussion refreshed and ready to fill in the left side of our *tabula rasa*. At this point, then, the facilitator provides us with the key challenge of the day, indeed, perhaps, the key challenge for us of the 21st century.

The facilitator asks us to list on the left-hand side the solutions that the Health Sciences can provide in its educational and research programs to the problems on the right. In a very real sense, but without saying it, the facilitator is asking us to replace tradition with societal interests and needs as the key criteria for determining our future research and the education of our future graduates.

Here are examples of how the discussion might proceed. Someone might say, "well, if we're really going to make an impact on the deplorable health statistics in rural, remote and northern areas of our country and among the native population, we need more people who are not only good health care providers but who are also experts in changing behavior, the way the people there maintain and improve their own health. We

also need more people who are culturally sophisticated and acclimatized to the local society and who have a good background in environmental health. That way if arsenic is leaching from the local mine into the water supply, our person would be able to recognize it quickly and help fix it."

Someone else might say, "almost all of our communities in the north are too small to support a physical therapist, an occupational therapist, an audiologist and a speech pathologist. What they really could use is an individual educated in the basics of all these disciplines who can look after the common problems. As well, it seems quite clear now that we are headed for a severe doctor shortage in Canada in the very near future. To solve this problem, I doubt if Canadians will want to wait the usual decade and more it takes to educate a physician from high school. Perhaps we should consider introducing some accelerated Medical Programs coupled with more and better Continuing Education Programs to follow. If you remember, accelerated Medical Programs were used successfully before in Canada around the time of the Second World War."

Another person might say, "in order for our graduates to have impact across the ocean in the west African states affected by AIDS, we need people who are not only physicians but people who are experts in political science and economics because the problems affecting these countries cross these boundaries every day".

Others, alarmed as I am by the rapid emergence of uncritical thinking behind the rise of Alternative Medicine in our society, might advocate increased education in logic, the scientific method and skeptical and critical thinking among all university students and the public. Still others might talk about more partnerships between the Health Science Faculties and other Faculties at the university, or with hospital training programs, to produce graduates who have education and expertise in more than one major discipline. Examples suggested might include combined health science-information technology programs designed to take advantage of the revolution in genetic therapy now imminent and joint speech science-architecture programs aimed at buildings with better acoustic design. Combined degrees for nurses might also be proposed, building on the success of the current nurse-practitioner program. These could include nurse-computer science, nurse-pharmacy and nurse-health economics programs. Some might even wish to extend the opportunities for our Health Science students to the limit by opening up to them selected courses from all the academic fields resident in our universities, teaching hospitals and research

institutes. These students could then choose highly individualized programs from such rich and varied resources. During this discussion, all of these ideas would have to be weighed realistically against the list on the right, of course, to see if they truly meet our group's perception of society's needs and interests.

These then are a few examples of what could be a virtual kaleidoscope of possibilities in education. A similar, liberated, list of possibilities could be developed on the research side too. By using the *tabula rasa* approach, it's likely that we will reaffirm a good deal of what we're doing now but I think it's also likely that we will develop many interesting new possibilities. This approach will be a very strong stimulus to imagination and vision, qualities I've emphasized that should be hallmarks of our thinking in this new century.

In summary, in this the first J. Wendell MacLeod lecture of the new century, I have suggested to you that the Health Sciences in Canada are about to undergo a genuine transformation which will impact broadly on both our educational and research programs. Our challenge is to plan for these changes in a way that meets the very special needs of our society. I have pointed out that there is a good deal of unfinished business in our social contract both at home and abroad but there are great opportunities too, opportunities which are well suited to our special qualities of understanding, innovation and imagination. I think we need to be much bolder and more sophisticated in our approach as we engage in the national debate on our Health Care System. But engage we must, since many of the key solutions may lie with us alone. Certainly, the rapid improvements in research funding we are now experiencing open up many exciting, new possibilities. I have also presented to you some of the most obvious, major challenges to health and our society confronting us at the beginning of the 21st century and I have gone on to suggest that, in following traditional models in our graduates, we may be missing the boat and graduating people now who will not have the very best education to meet the challenges of the new century. We must look hard at other models and, in that way, add additional possibilities to the complex equation we will need to solve our health care crisis. Finally, I have presented a challenging way of thinking about these deficiencies in our social contract that ties us to a foundation of societal interests and needs. Now is the time for all of us in the Health Sciences to renew our bond with society as we stand at the beginning of a very exciting new century, full of wonderful possibilities for everyone.

ANNOUNCEMENTS/ANNONCES

University of Alberta

Dr. Victor Tron has been appointed chair of the Department of Laboratory Medicine and Pathology, effective July 1, 1999. Dr. Tron comes to the University of Alberta from the University of British Columbia, where he built a strong dermatopathology program and he currently holds a Medical Research Council of Canada operating grant which funds his work on p53-dependent UV responses in keratinocytes. He is a member of the American Society for Dermatopathology, the American Association for Cancer Research and the American Society for Investigative Pathology.

Dr. Terry Klassen has been appointed chair of the Department of Pediatrics, effective July 1, 1999. He comes to the University of Alberta from the Department of Pediatrics, University of Ottawa, where he has been the Director of the Research Institute, Children's Hospital of Eastern Ontario. Dr. Klassen is a member of the Canadian Pediatric Society, the Society for Pediatric Research and Ambulatory Pediatric Association. He is currently a member of the Injury Prevention Committee, Canadian Pediatric Society and in October 1998 he assumed leadership of the Child Health Field of the Cochran Collaboration.

Dr. Brian Sykes was appointed the chairman of the Department of Biochemistry. He served as the Department's acting chairman during 1998 and 1999. He is currently on the advisory board for the Stable Isotope Resource Advisory Committee, Los Alamos National Laboratory, New Mexico, US; the International Advisory Committee of the XVIIIth International Conference on Magnetic Resonance in Biological Systems, Tokyo, Japan, and the International Advisory Committee of the XIXth International Conference on Magnetic Resonance in Biological Systems, Florence, Italy. Dr. Sykes is also the Director of the National High Field Nuclear Magnetic Resonance Center (NANUC).

Dr. Thomas Marrie has been appointed the chair of the Department of Medicine effective July 1, 1999. He comes to the University of Alberta from Dalhousie University, where he has been a professor in the Department of Medicine. His pneumonia research has been targeted at finding the optimal management of this illness. His findings have enabled his research group to develop a critical pathway for the management of pneumonia composed of an admission guideline,

criteria for switch from intravenous to oral antibiotics and a discharge guideline. He is currently conducting research on the role of molecular diagnostics in the management of pneumonia and determining the best antimicrobial for the ambulatory therapy of community-acquired pneumonia.

Dr. George Elleker has been appointed Associate Dean, Postgraduate Medical Education. His appointment is effective December 1, 1999. As Associate Dean PGME, Dr. Elleker will be responsible for the administration and oversight of the Faculty's 43 accredited residency training programs and will become a member of the Dean's Executive Committee. In addition to his clinical teaching and research activities, Dr. Elleker has had extensive administrative experience. He has held various Director and Chairmanships including Acting Divisional Director, Division of Neurology and Acting Chief of Medicine at the University of Alberta Hospital.

Dr. Paul Man has been appointed Assistant Dean, Clinical Research, and Director of the Capital Health Authority/University of Alberta Clinical Trials Centre. Dr. Man will be responsible for the strategic leadership in the area of clinical research and will focus on the enhancement of clinical research activities within the Faculty. As Director of the Clinical Trials Centre, Dr. Man will report to the Centre's board of management and will be responsible for the management and strategic leadership of the Clinical Trials Centre.

Université de Sherbrooke

Docteur Pedro D'Orléans-Juste a été nommé directeur du Département de pharmacologie de la Faculté de médecine de l'Université de Sherbrooke le 1er août 1999. Il entend poursuivre, avec ses collègues du département et d'autres départements, l'accroissement des activités de recherche et développement à l'Institut de pharmacologie de Sherbrooke.

Le docteur Denis Bergeron est nommé vice-doyen aux études médicales postdoctorales, Faculté de médecine, Université de Sherbrooke. Ses nouvelles fonctions à la direction des études médicales postdoctorales lui permettront de poursuivre les réformes déjà entreprises et de collaborer à la mise en place d'innovations pédagogiques en enseignement et encadrement

clinique, afin de modeler un cursus postdoctoral conforme aux attentes et aux besoins, tant des apprenants et des enseignants que de la communauté.

Le docteur Paul Grand`Maison est nommé Vice-doyen à la communauté et Secrétaire de la Faculté, Faculté de médecine, Université de Sherbrooke. Le docteur Grand`Maison agira dans ses nouvelles fonctions comme Secrétaire de la Faculté de médecine complétant les tâches usuelles reliées à cette fonction. Comme Vice-doyen à la communauté, il travaillera avec les institutions de santé affiliées à la Faculté. Il continuera de coordonner l'entente avec le Nouveau-Brunswick francophone et le développement d'une coopération plus large avec l'ensemble de la francophonie. Il sera responsable du dossier de partenariat entre la Faculté et l'Organisation mondiale de la santé. Dans le cadre de son mandat, il mettra en place, en collaboration avec l'ensemble de la Faculté, les actions stratégiques confirmant la reconnaissance de la Faculté de médecine de Sherbrooke comme une institution au service de sa communauté et redevable de ses actions afin que celles-ci répondent de façon optimale aux problématiques de santé de la population.

Docteur Martine Chamberland est nommée directrice du Centre de pédagogie en sciences de la santé (CPSS), Faculté de médecine, Université de Sherbrooke. Au cours du mandat actuel de direction du CPSS, le docteur Chamberland vise d'abord à consolider les réalisations des dernières années, à maximiser le développement et surtout l'intégration des quatre missions du Centre (support et services, formation professorale, recherche, leadership et rayonnement) au profit de l'optimisation du processus d'apprentissage et d'enseignement à la Faculté de médecine. Le volet recherche du CPSS (recherche évaluative, recherche et développement) et la formation continue des membres du CPSS constituent des défis particuliers du mandat actuel. Enfin, grâce à un partenariat étroit avec les programmes, elle vise à ce que le CPSS continue de contribuer de façon tangible au caractère avant-gardiste et innovateur de la pédagogie universitaire à la Faculté de médecine de l'Université de Sherbrooke.

Docteur François Plant est nommé directeur de Département de radiologie diagnostique, Faculté de médecine, Université de Sherbrooke. Durant son mandat à la direction universitaire de Département de radiologie diagnostique, le docteur Plante souhaite consolider les acquis et travailler à

l'essor du département en favorisant son expansion. Le développement de la recherche clinique et évaluation en imagerie et en technologie, l'augmentation des collaborations en recherche fondamentale en lien avec le Centre de recherche clinique et l'Institut de pharmacologie de Sherbrooke, ainsi que le développement des liens régionaux et nationaux via la téléradiologie, sont des priorités sur lesquelles il travaillera en étroite collaboration avec ses collègues du département.

Docteur Hervé Walti est nommé directeur de Service de néonatalogie du Département de pédiatrie, Faculté de médecine, Université de Sherbrooke. De même, il renforcera la place des professeurs du Service de néonatalogie dans le secteur de l'enseignement prédoctoral, notamment dans la phase de croissance-développement-vieillessement et dans l'externat. Il portera une attention particulière à l'encadrement postdoctoral qui devrait dans l'idéal permettre de susciter des vocations pour cette discipline exigeante et en difficulté et d'organiser ainsi l'avenir à long terme du Service de néonatalogie du CUSE.

Docteur Benoit Chabot a été nommé directeur du Département de microbiologie et d'infectiologie, Faculté de médecine, Université de Sherbrooke. Directeur de département depuis le 1er novembre 1999, le docteur Chabot estime que son mandat consistera à maintenir l'excellence de la recherche au Département de microbiologie et d'infectiologie et à saisir les nouvelles opportunités de financement qui s'offrent sur la scène fédérale et provinciale. Il vise à encourager le maillage entre la recherche fondamentale et l'infectiologie clinique.

University of Toronto

Professor Richard Horner of the Department of Medicine has been awarded the 1999 Elsie Winnifred Crann Award of the University of Toronto Life Sciences Committee, given to new junior faculty actively engaged in research in the areas of breast cancer, pulmonary, kidney and urinary diseases. The \$35,000 award will support his research project on neurobiology of sleep and respiratory regulation in health and disease.

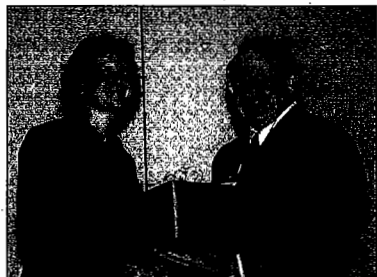
Professor Barnard Langer of Surgery has been appointed president of the Royal College of Physicians & Surgeons of Canada for a two-year term effective September 2000. The college is a national organization responsible for setting and maintaining the standards for post-graduate

medical education, for the certification of specialist physicians and surgeons in Canada and for promoting their continued education; the college is privately funded by its members and is not a licensing body.

McGill University

Dr. Abraham Fuks has been re-appointed dean of medicine at McGill University for a second five-year term. ✚

ACMC/GLAXO Young Educator's Award 1999-2000



Dr. Rose Hatala, an assistant professor of medicine in the Department of Medicine, Faculty of Health Sciences, McMaster University, is this year's recipient of the ACMC/GLAXO Young Educator's Award.

The Award recognizes Dr. Hatala's research on the acquisition of medical knowledge which lead to the piloting of a new in-training evaluation system in the internal medicine clerkship. The system was shown to be a useful vehicle for knowledge transfer and has been implemented across all clerkship disciplines within the medical school. Dr. Hatala has also been identified as a gifted teacher.

The ACMC/GLAXO Young Educator's Award was established in 1994 with funding from Glaxo Canada Inc. It is intended to recognize individuals in undergraduate, postgraduate and continuing medical education who have made a major contribution to medical education in Canada and are in the early years of their academic career.

The 57th Annual Meeting of the ACMC, ACTH and CAME in Whistler, British Columbia was an overwhelming success with over 500 attendees.



Report to the ACMC from the Finance & Administration Committee 1999-2000

The one day meeting was split into a business meeting component and a development presentation.

Business Meeting:

In the business meeting, the following topics were discussed:

- clinical appointments: categories, compensation, benefits
- evaluation of academic productivity
- number of full-time equivalents per section in Dean's Office
- tenure issues and implications
- mandatory retirement – is it a problem?
- program costing
- performance management system for support staff
- CAUBO: Faculty of Medicine representation
- AAMC Group on Business Administrators
- Chair next year

There was a prolonged discussion on the difficulties encountered by some universities in appointing their clinical staff. In fact, some universities do not recognize "clinical paths" or no university benefits are available to clinical appointees. This has resulted in clinical academic staff threatening to stop teaching in certain areas. Two universities have totally eliminated tenure-stream positions for clinicians. Another University no longer allows ranks in clinical part-time positions. Finally, a faculty offers non-monetary tokens of appreciation for teaching (plaque, certificate, etc.). In terms of compensation, universities indicated having a central financial pool administered by the faculty for all part-time clinical staff; others had a centralized unit value computer-assisted system. Data for such a system is entered by the department/unit which assigns the teaching tasks and a report is produced yearly for each staff member for verification purposes. Finally, the question arose as to whether staff who reneged on their teaching and other academic activities could/should remain appointed full-time in a teaching hospital.

On the topic of performance evaluation for academics, methods ranged from departmental evaluation, to formal 2-day across-the-board evaluation per year with all chairs present, to no

evaluation or ad hoc. A few faculties use a performance evaluation/appraisal system; some indicated that the unionization of their support staff has made this more difficult. One faculty indicated a project for a similar plan, but more focused on staff development and communication.

Three provinces do not have mandatory retirement and faculties illustrated their way to deal with the financial impact it entails. One university incorporates a mandatory retirement date into the labor contract/appointment letter, therefore making it a "condition of employment" which, albeit having been challenged in court, has been recognized as legal.

The committee members felt that CAUBO does not always consider the faculty of medicine point of view in the way they report their information. It was mentioned that any University Financial Officer could attend CAUBO meetings or become a member. The group will therefore find out more details on this committee.

All agreed that program costing is very difficult and is being looked at right now by several universities. However, the amount of \$25,000 X 4 years for medical students has been mentioned.

Some of the Finance & Administration Committee members attend the AAMC GBA (Group on Business Affairs) meeting and indicated that their professional development program was excellent. Suggestions were made to perhaps hold the ACMC meeting at the time of the AAMC meeting and therefore benefit from both. The next AAMC GBA meeting is 22-24 March 2001. This question should be brought up with to the Deans group for discussion.

The committee appointed Mr. Michael Low (University of Toronto) as co-chair for next year.

Meeting with Mr. Jack Krakower (AAMC) and Deans:

Mr. Krakower indicated that the preparation of the AAMC financial questionnaire is based on three major reasons: accreditation purposes (verification of financial viability); other AAMC purposes such as reporting, comparisons, etc.; and providing data for the use of Canadian medical schools. He indicated that the new LCME

Secretary, Dr. David Stevens, was open to a simplified version of the questionnaire, as long as it would clearly demonstrate the resources supporting the medical faculty. He added that some rigor was in order for the questionnaire to be credible by accreditors.

The Deans indicated that the questionnaire was not very useful in its present form and that, aside from accreditation purposes, it was being completed mainly to fulfill the US requirement for accepting US students. Mr. Krakower will verify if the latter is still a requirement. Dr. Fuks indicated that the joint accreditation was very important, but that more uniform data was needed. The type of data and the form to report needed to be worked out (eg. Research revenues reported by revenues or by expenditures..). It was suggested that a task force (sub-committee of the Finance & Administration Committee) be struck to look again at the questionnaire and come up with recommendations. After the Deans left, the Committee established the terms of reference of the task force as follows:

**AAMC Financial Questionnaire Task Force
Terms of Reference:**

Membership: 6 representatives of the ACMC
Finance & Administration Committee

Michael Low (Toronto)
Johanne Miller (McGill)
Brian Esslinger (Alberta)
Jody Boxall (McMaster)
Daniel Levac (Ottawa)
Paul Heinrich (Calgary)

One Dean: Dr. Abraham Fuks (McGill)
One representative from AAMC
(Dr. Jack Krakower)
One representative from ACTH, CAUBO/CAURA
(as needed basis)

The mandate of the task force is to develop a financial reporting mechanism which will reliably and easily capture information satisfying the accreditation standards of the AAMC/LCME, that can be used for advocacy, comparative values, and international reciprocity. It may consult with representatives of other associations on an as-needed basis. The task force will report through the Finance & Administration Committee.

Clinical Practice Plans:

Dr. John Ruedy presented a report on the results of his surveys on the above topic. Of the four schools which had participated, only two had reliable data which he illustrated (four departments in two schools). The Committee indicated that the task force examining the AAMC financial questionnaire would see if they could collect information on clinical income through that means.

Development Meeting:

UBC, Dalhousie and Ottawa shared their experience of implementing a Faculty Information Database. They all used the same software package and they outlined the process that they followed and the lessons that they have learned. They also provided advice to the group for similar endeavours.

France Drolet
Administrative Officer
Faculty of Medicine
McGill University

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- C. Enseignement médical postdoctoral**
- a) Maîtrises (2^e cycle) et doctorats (PhD/3^e cycle): inscriptions et nombre de diplômes décernés.
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- D. Personnel enseignant**
- E. Dépenses affectées à la recherche**
- F. Étude des candidatures à l'admission:** taux comparatifs de succès des candidats selon les caractéristiques des candidats (citoyenneté, âge, province de domicile, langue d'instruction des facultés de médecine, résultats des candidats aux tests "MCAT", antécédents scolaires des candidats); repostulants; l'effet des repostulants sur les admissions.

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