ACMC AFMC

FORUM

The Association of Canadian Medical Colleges
L'Association des facultés de médecine du Canada

Volume 34, No. 1
March 2001
Volume 34, no. 1
mars 2001

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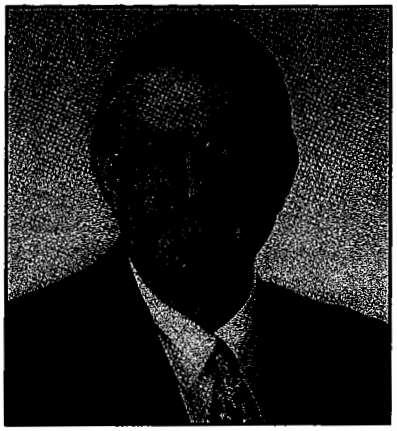
WHEN DEATH BECOMES YOU



Barry Smith rolls up the bottom of his polar fleece sweater, revealing the flat, grey box connected to an intravenous tube inserted in his abdomen. The doctors fitted their former dean with a morphine pump several months ago. It helps take away the ``air hunger '', the unpleasant sensation of constantly feeling short of breath.

Smith`s respiratory muscles are deteriorating, and if he uses his voice too much, it becomes hesitant, choppy. ``You`re talking an awful lot,`` his wife Karen tells him, and you sense she doesn`t believe him when he responds with a warm smile and assurance that he`s fine, he`s pacing himself. Karen watches Barry closely, especially since the setbacks.

They started just after Christmas. One night, Smith suddenly work up confused and hypoxic, his blood so short of oxygen he was starting to suffocate. He`d fallen asleep in his study and remembers reaching for the mask attached to the oxygen tank under his desk, slipping it over his mouth. One deep breath. Two. He pushed the button on the morphine pump. Waited. Then pushed again. When the second infusion didn`t work, he knew he needed help. He reached for the ski pole he`s used as a walking stick for the past year and slowly shuffled down the hall to the bedroom where Karen was asleep. He bent down, kissed her on the cheek. ``Honey,`` he whispered into her ear, ``I`m having some difficulty. I think I need you.`` Karen grabbed a face cloth and began wiping Barry`s face down with cool water, the way the doctor had told her to. She switched on the fan, checked the seal of the oxygen mask, wiped and soothed and comforted as they waited for the morphine to calm Barry`s breathing. And all the while he was thinking: ``This is how I will die.``

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ISSN: 0836 3463

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FORUM is the official publication of the Association of Canadian Medical Colleges. It is published four times a year. Opinions expressed in this bulletin do not necessarily reflect the views of the Association.
Contributions to FORUM in either English of French are welcomed. Advertisements are also accepted. FORUM is sent free of charge to members of the Association. The annual subscription fee for non-members is $30.00.

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.

USES OF THE CENSUS IN THE MEDICAL PROFESSION

Statistics Canada conducts a national census once every five years. On May 15th more than 31 million people will count themselves in when they participate in the 2001 census.

Early in May every household will receive a Census of Population questionnaire. Most households will fill in a short questionnaire which asks seven questions including age, sex, marital status and mother tongue. One in five households will receive a long questionnaire which asks additional questions on topics such as education, employment, ethnicity, language and income.

Governments at all levels use census data to make policy decisions about Canada's economic and social programs. Census data are essential for producing the population estimates used to allocate transfer payments from the federal government to the provinces and territories and from the provinces to municipalities. Small errors in these estimates could lead to the misallocation of billions of dollars in transfer payments. Census data are also used to redistribute seats in the House of Commons and provincial legislative assemblies.

Demographic and socio-economic information gathered by the census provide valuable insight for doctors, nurses, social workers and other medical and health care professionals who can use census data to:

- better understand the demographic components of the communities they serve (i.e. seniors services, home care services)
- target their services to better respond to the health needs of their patients (i.e. language, ethnic origin)
- examine social issues such as the impact of an aging population, and the location of medical professionals in remote areas
- plan ambulance, home care and pharmaceutical availability
- make informed decisions regarding collective agreements, contract negotiations and employment equity issues
- make business decisions such as the opening or expanding of a doctor's office or a medical centre
- study mortality, morbidity and birth outcomes among a wide variety of target groups

By law each household must provide the information requested in the census and by the same law, Statistics Canada must protect the confidentiality of the personal information provided by respondents. This means that only Statistics Canada employees who have taken an oath of secrecy and who work directly with census data will see the completed questionnaires.

People needing information or assistance when filling in their questionnaire should call the Census Help Line. This free, multilingual service is available from May 1st to 31st from 8 a.m. to 9 p.m. The number is 1 800 591-2001. Census information can also be accessed through the Statistics Canada Web site at: www.statcan.ca.

On May 15th don't forget to "count yourself in".

LES DONNÉES DU RECENSEMENT ET LES PROFESSIONNELS DE LA SANTÉ

Statistique Canada mène un recensement national tous les cinq ans. Le 15 mai, plus de 31 millions de personnes seront du nombre lorsqu'elles participeront au Recensement de 2001.

Au début du mois de mai, chaque ménage recevra un questionnaire du Recensement de la population. La plupart des ménages rempliront un questionnaire abrégé qui comporte sept questions incluant l'âge, le sexe, l'état matrimonial et la langue maternelle. Un ménage sur cinq recevra un questionnaire complet qui comprend des questions additionnelles portant, en autres, sur la scolarité, l'emploi, l'origine ethnique, la langue et le revenu.

Tous les échelons de gouvernement utilisent les données du recensement pour prendre des décisions stratégiques en matière de programmes socioéconomiques. Les données du recensement sont essentielles au calcul des estimations de la population. Ces estimations sont utilisées pour déterminer les paiements de transfert que le gouvernement fédéral verse aux provinces et aux territoires, qui à leur tour versent des fonds aux municipalités. Des erreurs minimes dans ces estimations pourraient se traduire par une perte de milliards de dollars en paiements de transfert. Les données du recensement sont également utilisées pour répartir les sièges à la Chambre des communes et aux assemblées législatives provinciales.

Les données démographiques et socioéconomiques recueillies dans le cadre du recensement fournissent de précieux renseignements aux médecins, au personnel infirmier, aux travailleurs sociaux et à d'autres professionnels de la santé. Les données du recensement permettent aux professionnels de la santé :

- de mieux comprendre les composantes démographiques de leur communauté (par exemple, les services pour personnes âgées et les soins à domicile);
- d'orienter leurs services afin de mieux répondre aux besoins de leur clientèle en matière de santé (par exemple, en ce qui a trait à la langue et à l'origine ethnique);
- d'examiner des enjeux d'ordre social, comme les effets d'une population vieillissante et la localisation des professionnels de la santé dans les régions éloignées;
- de planifier les besoins en matière de services ambulanciers, de soins à domicile et de services pharmaceutiques;
- de négocier des contrats et des conventions collectives, de même que d'examiner des questions d'équité en matière d'emploi;
- de prendre des décisions en ce qui regarde l'ouverture ou l'agrandissement d'un cabinet de médecin ou d'une clinique médicale;
- d'étudier les conséquences de la mortalité, de la morbidité et des naissances au sein d'un éventail de groupes cibles.

En vertu de la loi, chaque ménage doit fournir les renseignements demandés dans le questionnaire du recensement et, en vertu de la même loi, Statistique Canada doit assurer la confidentialité des renseignements personnels que lui fournissent les répondants. Cela signifie que tous les employés de Statistique Canada ont prêté un serment de discrétion et que seuls les employés dont les tâches l'exigent ont directement accès aux questionnaires remplis.

Les personnes qui désirent des renseignements ou de l'aide pour remplir leur questionnaire peuvent appeler l'Assistance téléphonique du recensement au 1 800 591-2001. Ce service gratuit et multilingue est offert du 1er au 31 mai, de 8 h à 21 h. Des renseignements sur le recensement sont également disponibles sur le site Internet de Statistique Canada à l'adresse www.statcan.ca.

Soyez du nombre le 15 mai prochain!

ACMC-ACAHO-CAME ANNUAL MEETING
58TH ANNUAL MEETING - APRIL 28 - MAY 1, 2001
WESTIN HARBOUR CASTLE, TORONTO

The 58th Annual Meeting is fast approaching! The Preliminary Program was mailed in late January. As of February 23rd, over one third of the hotel block reserved at the Westin Harbour Castle had already been booked. It is important to book your room now as the hotel convention rate of $164. single/double only applied until March 28th. After March 28th, if the hotel has any rooms to offer, it will be at the going rate, not the convention rate. Don't be disappointed - book now by calling the hotel at (416)869-1600 or faxing the hotel reservation form, included in the Preliminary Program, directly to the hotel.

The comprehensive program has a lot to offer medical educators, administrators, and policy makers. The two plenary sessions *The Vista of the Future: Medicine and Medical Education in the Post-Genomic Era* and *What our Future Doctors Need to Know About Alternative/Complementary Medicine* will give delegates much to discuss and challenge. Dr. John Evans, former President at the University of Toronto and Dean of Medicine, McMaster University, will present the ACMC-AMS J. Wendell MacLeod Lecture. The title of his presentation is *Medical Education and the New Economy*. CAME has scheduled a record number of fifty-one posters. For the first time a one-hour facilitated poster session is planned for posters in the following categories *Gender, Equity and Career Issues; Socialization of Medical Students* and *Community Based Medical Education - Teaching Community/Population Health.* This is an opportunity for delegates and presentors to informally discuss and exchange views on the posters presented. Eighteen CAME workshops and ten CAME CME Research and Development sessions covering a variety of topics also occur on the Monday and Tuesday. As well ACAHO has an educational session covering *Crisis in Health Care - Real or Contrived?* and *Developing New Approaches for Academic Medicine - Lessons from Alberta.* Friends of CIHR have organized a symposium *Fostering Interdisciplinary Health Research.* Other educational sessions include an interesting debate titled *Fitting Gender Analysis into Evidence-Based Practice,* organized by the ACMC Committee on Gender and Equity; *The Canadian National Site Licensing Project - Electronic Information to the Desktop!,* organized by the ACMC Committee on Medical School Libraries; a workshop *The Assessment of Non-Cognitive Attributes for Admission to Medical Schools*, organized by the ACMC Committee on Admissions and Student Affairs, and a panel discussion *Taking the Risk - Is It Worth It?,* organized by the ACMC Committee on Undergraduate Medical Education (UGME) and the UGME Administrative Group.

Plan to socialize with colleagues during a special evening of friendship, food and

entertainment being held at the CBC Broadcast Centre on Monday, April 30th. It will include a reception, dinner with Christine Choi, a gifted pianist and medical student providing background music, followed by various musical surprises by our talented conference hosts - members of the Faculty of Medicine, University of Toronto. A night not to miss! Tickets are limited so don't delay ordering yours. Our thanks to Diana Alli for organizing the musical talent.

Also Judy Irvine and her University of Toronto colleagues are preparing a special booklet of their favourite restaurants, book stores, etc. so you may make the most of your stay in Toronto. It is sure to be a keepsake for other trips to Toronto! As you see your hosts are working very hard to make this a memorable meeting.

Come network and socialize with your colleagues from across Canada. See you in Toronto in April!

SPIRITUALITY AND HEALTH CONFERENCE UNIVERSITY OF CALGARY, MAY 24-26, 2001

CALL FOR PAPERS

Keynote speakers will include Dr. David B. Larson, President and Primary Founder, National Institute for Healthcare Research, Bethesda, Maryland and Dr. Chandrahant P. Shah, Professor, Department of Public Health, Health Administration, Pediatrics and Family and Community Medicine, University of Toronto.

Please consult our website for additional information and a copy of the call for papers: http://www.cme.ucalgary.ca/courses/brouchers/8100343.pdf

Conference information is also available from P. McDougall: Tel: (403)220-3988; Fax: (403)270-2330; E-mail: pmcdouga@ucalgary.ca.

43rd ANNUAL DEPARTMENTAL RESEARCH DAY & 21st CLEMENT McCULLOCH LECTURE

The 43rd Annual Research Meeting of the Department of Ophthalmology, University of Toronto and the 21st Clement McCulloch Lecture will take place on Friday, May 11th, 2001. Guest Speaker: Dr. John Flannery, Vision Science and Neuroscience, School of Optometry, Berkeley, California. His presentation is entitled ``Ocular Gene Therapy - Adding Corrective Genes to Retinal Cells Harboring Defective Genes.``

The meeting will be held in Rooms 1248 and 1250 at the Main Auditorium of the Hospital for Sick Children, 555 University Avenue, Toronto, Ontario. Presentations by students, residents, fellows and staff will be from 7:45 am to 4:00 pm. Dr. Flannery`s presentation will be held at 4:00 pm until 4:45 pm.

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Trends in Enrolment in Canadian Faculties of Medicine

Table 1
First Time Admissions to the MD Program in Each Canadian Faculty of Medicine
1986/87 - 2000/01
Nouvelles inscriptions à chaque faculté de médecine canadienne

Faculty of Medicine	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	1999/2000	2000/2001
First Time, First Year															
Memorial University *Nfld*	56	56	56	56	56	56	56	56	56	60	65	61	60	59	60
Dalhousie University *NS*	96	84	84	84	84	84	86	83	82	85	93	80	89	85	84
Laval, Université	140	136	137	140	140	142	143	143	137	126	112	112	113	131	139
Sherbrooke, Univ. de	99	100	98	93	102	102	104	101	98	90	88	91	90	104	112
Montréal, Université de	167	174	163	170	170	172	172*	176	162	152†	158†	142†	135†	156†	161†
McGill University	154	156	159	150	149	142	140	138	132	119	109	107	111	121	129
Subtotal, Québec	***560***	***566***	***557***	***553***	***561***	***558***	***559****	***558***	***529***	***487***	***467***	***452***	***449***	***512***	***541***
Ottawa, University of	77	82	82	83	84	84	84	83	80	84	84	83	85	90	101
Queen's University	71	73	75	68	69	74	72	75	75	75	75	75	75	76	80
Toronto, University of	247	252	248	252	250	251	250	175	175	172	177	175	176	177	189
McMaster University	100	100	100	100	100	99	99	100	100	100	100	100	100	100	112
Western Ontario, Univ. of	104	105	105	106	105	94	96	96	96	96	102	98	96	96	104
Subtotal, Ontario	***599***	***612***	***610***	***609***	***608***	***602***	***601***	***529***	***526***	***527***	***538***	***531***	***532***	***539***	***586***
Manitoba, University of *Man*	85	81	80	79	82	79	81	73	69	69	74	75	71	75	75
Saskatchewan, Univ. of *Sask*	60	60*	60	61	61	60	60	60	55	54	55	56	55	51	55
Alberta, University of	118	118	120	118	120	120	121	112	104	103	109	105	105	104	126
Calgary, University of	72	72	72	72	71	72	73	69	69	69	71	72	78	77	101
Subtotal, Alberta	***190***	***190***	***192***	***190***	***191***	***192***	***194***	***181***	***173***	***172***	***180***	***177***	***183***	***181***	***227***
British Columbia, Univ. of *BC*	120	120	120	121	120	120	120	120	120	120	119	120	120	120	120
Total, First time, First year	**1766**	**1769***	**1759**	**1753**	**1763**	**1751**	**1757***	**1660**	**1610**	**1574**	**1591**	**1552**	**1559**	**1622**	**1748**
First time, Advanced Standing	10	17	9	4	11	6	5	3	-	2	17	11	21	34	28
Total, New Students	**1776**	**1786***	**1768**	**1757**	**1774**	**1757**	**1762***	**1663**	**1610**	**1576**	**1608**	**1563**	**1580**	**1656**	**1776**

* Both the Univ. of Saskatchewan and Univ. de Montréal changed from five year to four year programs. In order to avoid two graduating classes in the same year, they did not admit students into year 1 in the year the new program was introduced. In order to make meaningful year to year comparisons the numbers included should be used.

† For U. de Montréal, the figures given include:

	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01
students promoted to first year from the preparatory year,	102	105	91	87	92	92
and students admitted directly in year 1.	50	53	51	48	64	69

Excludes repeaters

Table 2

Trends in First Year[1] Enrolment in Canadian Faculties of Medicine by Faculty of Medicine
1961/62 - 2000/01
Tendances dans les inscriptions à la première année[1] d'études en médecine selon la faculté de médecine

Year / Année	Faculty of Medicine / Faculté de médecine																Total
	Mem	Dal	Lav	Sher	Mtl	McG	Ott	Qns	Tor	McM	UWO	Man	Sask	Alta	Cal	UBC	
1961/62	-	66	128	-	124	109	68	60	152	-	60	63	39	76	-	61	1 006
1962/63	-	71	136	-	125	112	71	59	175	-	60	71	40	79	-	62	1 061
1963/64	-	72	141	-	124	119	72	63	162	-	60	73	48	92	-	60	1 086
1964/65	-	74	127	-	127	125	79	65	178	-	62	76	53	105	-	62	1 133
1965/66	-	76	129	-	126	129	78	63	165	-	77	75	47	103	-	60	1 128
1966/67	-	83	128	34	134	133	78	70	159	-	77	79	51	105	-	61	1 192
1967/68	-	97	128	48	132	135	80	70	167	-	79	76	49	109	-	63	1 233
1968/69	-	99	256[2]	48	133	135	80	70	173	-	77	78	55	108	-	65	1 377
1969/70	16	97	152	64	264[3]	135	82	70	176	20	86	76	50	112	-	63	1 463
1970/71	32	98	143	66	161	134	80	70	208	40	85	76	55	112	32	60	1 452
1971/72	43	96	161	66	200	136	84	70	224	64	87	85	60	112	48	65	1 601
1972/73	48	96	183	80	205	160	84	72	240	80	101	100	60	118	56	80	1 763
1973/74	48	97	181	80	204	160	84	71	240	80	101	100	65	118	64	80	1 773
1974/75	48	95	168	100	201	160	84	75	239	80	104	100	61	118	66	80	1 779
1975/76	58	96	155	109	200	160	84	76	240	100	105	100	61	118	65	80	1 807
1976/77	57	96	156	110	191	159	84	74	251	102	106	100	60	118	75	80	1 819
1977/78	57	98	160	109	190	161	84	76	257	101	107	96	60	117	72	81	1 826
1978/79	57	97	157	109	190	160	84	76	257	101	106	95	61	118	73	88	1 829
1979/80	58	97	161	110	201	160	84	76	255	100	106	95	60	118	72	101	1 854
1980/81	58	97	160	110	212	160	84	79	256	101	105	95	60	118	72	120	1 887
1981/82	58	98	160	112	209	160	84	75	252	101	106	95	61	118	72	120	1 881
1982/83	57	96	167	113	191	160	84	76	248	103	106	96	60	120	75	130	1 882
1983/84	56	102	161	112	202	158	84	76	248	101	106	99	60	119	73	130	1 887
1984/85	58	96	153	105	185	159	84	78	252	102	106	96	60	120	74	130	1 858
1985/86	58	98	140	95	178	160	84	70	250	101	105	98	60	120	74	121	1 812
1986/87	56	97	143	99	173	160	84	72	252	100	107	85	61	119	73	122	1 803
1987/88	56	91	140	100	183	159	84	74	252	100	108	81	0[4]	121	74	121	1 744
1988/89	56	86	137	101	164	160	84	76	252	101	111	81	63	122	72	120	1 786
1989/90	57	87	140	94	175	150	84	72	252	101	107	81	61	124	74	121	1 780
1990/91	57	87	142	102	173	153	84	72	252	101	108	85	61	121	72	121	1 791
1991/92	56	85	142	102	178	145	84	75	253	99	97	81	61	122	73	122	1 775
1992/93	56	86	143	108	0[5]	142	84	75	252	100	97	81	63	122	74	121	1 604
1993/94	56	84	143	104	180	139	85	75	178	100	96	75	62	115	70	121	1 683
1994/95	56	83	144	101	167	134	84	75	181	101	98	72	56	106	72	121	1 651
1995/96	60	86	132	92	164	120	84	75	175	102	98	73	57	104	71	120	1 613
1996/97	62	92	113	89	163	110	84	75	177	100	101	74	57	105	76	120	1 598
1997/98	63	86	114	93	143	107	84	75	178	102	99[6]	75	56	110	72	120	1 577
1998/99	63	91	114	90	138	111	86	77	178	100	96	71	57	107	81	121	1 581
1999/2000	61	86	132	104	157	121	90	76	178	100	97	75	51	105	80	121	1 634
2000/01	60	89	140	112	164	129	102	80	193	113	104	75	55	126	101	120	1 763

[1] Data include a few students who repeat the first year, and hence do not correspond 100% with the official class size.
[2] In 1968/69, Université Laval admitted two first year classes.
[3] In 1969/70, Université de Montréal admitted two first year classes.
[4] In 1987/88, University of Saskatchewan did not admit any students into year 1.
[5] In 1992/93, Université de Montréal did not admit any students into year 1.
[6] In 1997/98, enrolment counts for University of Western Ontario were estimated.

Table 3
Enrolment in Canadian Faculties of Medicine by Year of Study, Sex and Faculty of Medicine
2000/01
Inscriptions aux facultés de médecine canadiennes selon l'année d'études, le sexe et la faculté de médecine

Faculty of Medicine Faculté de médecine	Dur. of Program Durée des études	Année préparatoire *			First Year Première année			Intermediate Years Années intermédiaires			Final Year Dernière année			Total		
		M/H	W/F	T	M/H	W/F	T	M/H	W/F	T	M/H	W/F	T	M/H	W/F	T
Memorial University, **Nfld**	4 yrs	-	-	-	34	26	60	62	61	123	27	32	59	123	119	242
Dalhousie University, **NS**	4 yrs	-	-	-	42	47	89	82	91	173	43	45	88	167	183	350
Laval, Université	4 yrs	-	-	-	43	97	140	125	213	338	37	70	107	205	380	585
Sherbrooke, Université de	4 yrs	-	-	-	30	82	112	75	120	195	24	61	85	129	263	392
Montréal, Université de *	4 yrs	(30)	(80)	(110)	56	108	164	106	191	297	60	83	143	252	462	714
McGill University	4 yrs	-	-	-	73	56	129	136	99	235	52	53	105	261	208	469
Subtotal, Qué		***(30)***	***(80)***	***(110)***	***202***	***343***	***545***	***442***	***623***	***1065***	***173***	***267***	***440***	***847***	***1313***	***2160***
Ottawa, University of	4 yrs	-	-	-	48	54	102	88	91	179	40	44	84	176	189	365
Queen's University	4 yrs	-	-	-	50	30	80	91	61	152	47	28	75	188	119	307
Toronto, University of	4 yrs	-	-	-	98	95	193	203	150	353	99	76	175	400	321	721
McMaster University	3 yrs	-	-	-	40	73	113	41	66	107	31	65	96	112	204	316
Western Ontario, Univ. of	4 yrs	-	-	-	59	45	104	111	89	200	64	42	106	234	176	410
Subtotal, Ont		-	-	-	***295***	***297***	***592***	***534***	***457***	***991***	***281***	***255***	***536***	***1110***	***1009***	***2119***
Manitoba, University of, **Man**	4 yrs	-	-	-	39	36	75	93	52	145	48	25	73	180	113	293
Saskatchewan, Univ. of, **Sask**	4 yrs	-	-	-	28	27	55	61	47	108	32	24	56	121	98	219
Alberta, University of	4 yrs	-	-	-	69	57	126	116	93	209	71	39	110	256	189	445
Calgary, University of	3 yrs	-	-	-	48	53	101	41	40	81	38	38	76	127	131	258
Subtotal, Alta		-	-	-	***117***	***110***	***227***	***157***	***133***	***290***	***109***	***77***	***186***	***383***	***320***	***703***
British Columbia, Univ. of, **BC**	4 yrs	-	-	-	52	68	120	108	136	244	60	49	109	220	253	473
Total, Canada		**(30)**	**(80)**	**(110)**	**809**	**954**	**1763**	**1539**	**1600**	**3139**	**773**	**774**	**1547**	**3151**	**3408**	**6559**
% Distribution by Sex		*27.3*	*72.7*	*100.0*	*45.9*	*54.1*	*100.0*	*49.0*	*51.0*	*100.0*	*50.0*	*50.0*	*100.0*	*48.0*	*52.0*	*100.0*

M/H = Men/Hommes W/F = Women/Femmes T = Total

* In 2000/01, along with 92 students promoted from the preparatory year, U. de Montréal admitted 69 students directly into year 1 of the four year program. In addition, enrolment includes repeaters and returnees from leaves of absence. One hundred and six (106) students were admitted for the first time into the preparatory year.

NOTE: These data include 82 students (5 four years from graduation, 16 three years from graduation, 31 two years from graduation, 30 in the final year) enrolled in above-quota positions under contract with the medical school and a foreign government or institution.

ACMC INFORMATICS WORK GROUP WEB SITE
http://acmcinformatics.infopop.net

During the April 2000 meeting of the Informatics Work Group a variety of issues pertinent to medical informatics were discussed. Areas of interest included: a) issues surrounding the emergence and increasing significance of medical informatics within our schools; b) development of electronic curricula; c) information management within the medical school, among associated hospitals and the school and externally through Telehealth innovations; d) the potential use of applications to facilitate research; and e) evaluation of the pedagogical efficacy of the integration of new technologies on teaching and learning.

By the end of the meeting there was general agreement that many of these issues might best be addressed on a more detailed and continuous basis through a web based forum, which would serve as a medium for the exchange of ideas, a mechanism for the comparison of global directions and individual objectives, and a means for national collaboration of projects of large scope.

The ACMC Informatics Work Group web site URL is:

http://acmcinformatics.infopop.net. The site is open to all and we welcome your contributions.

COMING EVENTS/ Â VENIR

Dalhousie University
Continuing Medical Education

April 3-5, 2001
Distinguished Leaders in Medicine
``AIDS in the New Millennium:
Can We Stop It?``
Dr. Mark Wainberg

April 6-7, 2001
Obstetrics & Gynaecology
for Family Physicians

April 27-28, 2001
6th Annual Atlantic Canada
Cardiovascular Conference

Address Inquiries to:
Continuing Medical Education
5849 University Avenue
Clinical Research Centre
Halifax NS B3H 4H7
Tel (902)494-2061
Fax (902)494-147

University of Saskatchewan
Continuing Medical Education

April 6-7, 2001
Multidisciplinary
Community-Based
Cardiovascular Conference
Saskatoon, Saskatchewan

Address Inquiries to:
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UNIVERSITY OF SASKATCHEWAN
BIX 60001 RPO UNIVERSITY
SASKATOON SK S7N 4J8
TEL (306)966-7687
FAX (306)966-7673

ANNOUNCEMENTS/ANNONCES

University of British Columbia

Dr. Dorothy Shaw is the new Associate Dean, Equity. She graduated from the University of Edinburgh in 1972 as M.B.Ch.B. and in 1978 became a Fellow of the Royal College of Surgeons of Canada. Dr. Shaw joined the Department of Obstetrics and Gynaecology at the University of British Columbia in 1979 with a cross appointment in Medical Genetics. Her sub-specialty is perinatology, In January 2000, she was appointed the Medical Director of the Diagnostic and Ambulatory Program at B.C. Women`s Hospital in Vancouver. Prior to that, she was the Medical Director for the Centre for Prenatal Diagnosis and Treatment. In October, 2000, she completed a two year term as the first chair of the combined Medical Advisory Committee for Children`s and Women`s Health Centre.

Dr. Joanna Bates has been re-appointed Associate Dean, Admissions. Dr. Bates obtained her MDMC from McGill in 1976, interned at St. Paul`s Hospital in Vancouver and following clinical work in Family Practice and Emergency Medicine, opened a Family Practice in Vancouver in 1979. In 1989 she became Head of St. Paul`s Hospital`s Rotating Internship Program, in 1990 the Director of International medical Graduates Program for Licensure, and in 1992 was appointed as Assistant Professor, part-time, in the Department of Family Practice. She has served as Co-director of the Clinical Competence Program, had responsibility for evaluation in the Family Practice Residency Program throughout B.C. and was a member of the Strategic Taskforce on Undergraduate Curriculum. She has held administrative responsibilities at St. Paul`s Hospital and at the College of Physicians and Surgeons.

Dr. David McLean has accepted the position of Associate Dean, Health Care Systems and Planning. This is a new portfolio in the Faculty of Medicine which will enhance our planning capacity, particularly in relation to facilities and will focus on strengthening current health care system partnerships and developing new ones. David McLean is ideally suited to fill this position.

He received his BSc and his MD from the University of Manitoba and then went on to residency training in Dermatology at the University of British Columbia and at McGill. Following a year as a Fellow at the Massachusetts General Hospital, he returned to Vancouver as an Assistant Professor in the Department of Medicine in 1977 and was promoted to Professor in 1995. He was Head of the Division of Dermatology from 1988 until this year. He served as Vice President, Research, Vancouver Hospital and Health Sciences Centre and Assistant Dean, Research, Faculty of Medicine, from 1994 until 1999. His tenure in this position was characterized by visionary leadership and dramatic development of research strength with the Vancouver Hospital and Health Sciences Centre. Major initiatives which were generated during his term include the Brain Research Centre, the Prostate Research Centre and the Immunology Research Centre. Areas of research excellence were clearly identified and strategies for taking them forward developed and pursued successfully. David has an international profile in dermatology and is well known for his research in dermatologic oncology. He has a very good record of research support from peer-review agencies and industrial sources and has published numerous peer-reviewed papers and chapters and many patents issued and pending at UBC and BC Cancer Agency.

The Faculty of Medicine is pleased to announce the re-appointment of **Dr. Joanne Emerman** as Associate Dean, Research effective July 1, 2000.

Dr. Emerman received her B.A. from Hofstra University in New York and her M.A. and Ph.D. degrees from the University of California at Berkeley. Following post-graduate studies at Berkeley, she returned to Vancouver as an Assistant Professor in the Department of Obstetrics and Gynaecology and as a Scholar of the National Cancer Institute of Canada. She rose to the rank of Professor in the Department of Anatomy. Her research on breast cancer has focussed on developing cell culture systems now used in many laboratories internationally to study the influence of environmental factors on mammary-specific processes, which has aided in the understanding the growth, differentiation and malignant state of breast cells. She has also developed models to study the effects of psychosocial stressors on breast tumour growth rate.

The Faculty of Medicine is pleased to announce the appointment of **Dr. W. Robert McMaster** as Head of the Department of Medical Genetics of the University of British Columbia and Children`s & Women`s Health Centre of British Columbia effective January1, 2000. Dr. McMaster received his B.Sc. And M.Sc. from the University of British Columbia and a D.Phil. from the University of Oxford. Dr. McMaster`s research interests are in the area of Molecular Immunology, Parasitology and Transplant Immunology. He has received outstanding peer review support for his research and has published extensively in peer reviewed journals with over 70 publications. Dr. McMaster is Director of the Immunology Research Centre at Vancouver Hospital & Health Science Centre, and Director of Transplant Immunology for the British Columbia Transplant Society. He is actively involved with national and international granting agencies and is currently Chair of the Canadian Institute of Health Investigators Committee and a member of the World Health Organization Vaccine Discovery Research Committee. Dr. McMaster has a strong interest in the development of graduate and medical education and has been a member of the University of British Columbia Senate since 1996.

The Faculty of Medicine is pleased to announce the appointment of **Dr. Nestor Muller** as Head of the Department of Radiology, at the University of British Columbia and Vancouver Hospital & Health Sciences Centre effective July 1, 2000.

Dr. Muller is a 1972 MD from the Federal University of Rio Grande Do Sol in Brazil. He went into internship and paediatric residency education, and paediatric and adult respiratory medicine at the University of Manitoba. As an MRC fellow and an Ontario Thoracic Society Research Scholar, he pursued studies in respiratory physiology, obtaining his Ph.D. from the University of Toronto in 1980. He was then a resident in Radiology at UBC from 1981 to 1984 and subsequently did a fellowship in thoracic imaging at the University of California in San Francisco. He holds his FRCPC in Radiology. His first UBC appointments were as a part-time Assistant Professor in November 1984, part-time Associate Professor in July 1988 and part-time Professor in July 1992. He is now assuming the rank of Professor.

The Faculty of Medicine in pleased to announce the appointment of **Dr. Robert Liston** as Head of the Department of Obstetrics & Gynaecology, at the University of British Columbia, Children`s & Women`s Health Centre of BC, Providence Health Care Group and Vancouver Hospital and Health Sciences Centre effective July 1, 2000.

Dr. Robert Liston received his MB, ChB from University of St. Andrews, Scotland in 1971 and training in obstetrics and gynecology at the University of Edinburgh and the University of Dundee. He received his

membership in the Royal College of Obstetricians and Gynecologists in 1977 and subsequently his FRCSC, FRCOG (London) and American Boards. He came to North America in 1978 as an Assistant Professor at the University of Pennsylvania and then moved to Dalhousie in 1981 where be became Associate Professor in 1988 and Professor in 1996. He was postgraduate program director of Maternal Fetal Medicine, directed the division and was Chief of Obstetrics at IWK Grace Hospital. In addition, he served as a consultant to the Nova Scotia reproductive care program where he developed a keen insight into the obstetrical needs of the whole community. He came to UBC in 1998 to take on the responsibility of Head of Obstetrics and Gynecology at Children`s & Women`s Health Centre of British Columbia. He is well known in the Canadian obstetrics and gynecology community, particularly for his areas of interest in fetal surveillance, labour management, post-dates pregnancy and induction. He has been active in the Society of Obstetrics and Gynecology of Canada where, as Chairman of the Maternal Fetal Medicine Committee, he took an active role in the development of clinical practice guidelines. He brings an exciting and progressive vision to the Department of Obstetrics and Gynecology which encompasses all of the Vancouver teaching hospitals and has an outlook throughout the province of British Columbia and beyond.

The Faculty of Medicine is pleased to announce the appointment of **Dr. Robert Armstrong** as Head of the Department of Paediatrics at the University of British Columbia, and Paediatrician-in-Chief of the Children`s & Women`s Health Centre of British Columbia, effective July 1, 2000.
Dr. Armstrong received his honours BSc. From Simon Fraser University and went on to obtain an MSc in Growth and Development from McMaster University. He completed his M.D. in 1982 at McMaster and his Ph.D. in Growth and Development at McMaster in 1986 supported by an MRC fellowship. He began his UBC career in 1985 as a Clinical Fellow in the Division of Neurology, Department of Paediatrics, becoming an Assistant Professor in 1987 and Associate professor in 1994. Dr. Armstrong held positions as Research Coordinator, Clinical Director of the Neuromotor Program and Medical Director and Director of Research at Sunnyhill Health Centre for Children. He became Head of the Division of Developmental Paediatrics from 1992 to 1997 and was then appointed the Vice-President, Medical Services and Quality Promotion, Children`s & Women`s Health Centre of BC from 1997 to the present. He has served as Co-Director of the Centre for Community Health and Health Evaluation Research and holds Associate Memberships in the Department of Health Care and Epidemiology.

Dr. Martin Schechter has been appointed as Head of the Department of Health Care & Epidemiology for a term commencing October 15, 2000 and extending to June 30, 2005.
Dr. Schechter received his MA in Mathematics at UBC in 1975 and his PhD in Mathematics from the Polytechnic Institute of New York in 1977. He then went on to obtain his MD at McMaster University and an MSc in Epidemiology from the University of Toronto. Following a residency at the University of Toronto and a research fellowship at the National Cancer Institute of Canada, Epidemiology Unit, he took up an appointment at the University of British Columbia in 1983, becoming Assistant Professor in 1984, Associate Professor in 1989, and Professor in 1992.
Dr. Schechter has had an outstanding career in epidemiologically-based research particularly in infectious diseases and most particularly HIV/AIDS. He has been successful with numerous peer reviewed grants and received substantial funding over many years, has published over 215 peer reviewed papers and is a CIHR Senior Investigator. He has been extensively involved in the undergraduate and

graduate education activities of the Department of Health Care & Epidemiology. He is currently Director of the Centre for Health Evaluation and Outcomes Sciences and National Director of the Canadian HIV Trials Network.

Dr. Monique A. Bertrand has assumed the role of Coordinator, Clinical Faculty Affairs effective April 15, 2000.

Dr. Bertrand received a BSc from the University of Ottawa, a BSc in Medicine from Memorial University of Newfoundland and her MD from Memorial University in 1980. Following an internship at the Toronto East General Hospital, she pursued training in Obstetrics and Gynaecology at the University of Toronto, obtaining her FRCSC in 1985. This was followed by a post-graduate fellowship in gynaecologic oncology. She took up her first faculty appointment as an Assistant Professor of Obstetrics and Gynaecology at the University of Ottawa in 1987 and became Head of the Division of Gynaecologic Oncology in 1990. She came to UBC in 1995 as Clinical Associate Professor of Obstetrics and Gynaecology in the Division of Gynaecologic Oncology, with a staff appointment at BCCA.

At UBC she has been active in teaching and research. She has won educational awards and has published and spoken widely in her areas of interests in gynaecologic oncology. She became Chair of the Clinical Faculty Committee and then assumed the role of Chair of the Task Force on Mutual Obligations and Responsibilities of the Clinical Faculty and the Faculty of Medicine. She is a member of the Board of the University Clinical Faculty Association.

University of Toronto

Professor David Conn of Psychiatry has been elected President of the Canadian Academy of Geriatric Psychiatry for a two-year term effective November 1, 2000. The academy is a national organization of psychiatrists dedicated to promoting mental health in the Canadian elderly population through the clinical, educational and research activities of its membership.

Professor Jack Greenblatt of the Banting and Best Department of Medical Research has been elected a fellow of the American Academy of Microbiology, the honorific leadership group within the American Society for Microbiology, the world's oldest and largest life science organization with more than 42,000 members worldwide. Greenblatt was honoured for his distinguished career in molecular biology and cancer research and is one of only 1,700 scientists elected to academy fellowship in the history of the organization.

The late **Professor Emeritus Harold Johns** of Medical Biophysics was posthumously inducted into the Canadian Science and Engineering Hall of Fame, November 30, 2000 for his internationally significant contributions to medical research that have improved treatments for cancer and osteoporosis and relieved the suffering of countless patients worldwide. One of the founders of medical physics, Johns is best known for his development of the cobalt-60 therapy unity in 1951.

Dr. Ross MacKenzie, a lecturer in the Department of Medicine, was elected President of the American Academy of Insurance Medicine for a one-year term at its annual meeting. Founded in 1889, the academy was originally an organization for medical directors in the US and Canada but now boasts members from South and Central America, Europe, Africa, Asia and Australia.

University **Professor Emeritus Robert Salter** of Surgery has been awarded the Paul Harris Medal, the highest award given by the Rotary Foundation of Rotary International. Although not a Rotarian himself, Salter received the

honour in recognition of his combined scientific and humanitarian achievements in keeping with the Rotary motto *Service Above Self.*

WHEN DEATH BECOMES YOU

continued from front page...

``There was this conscious awareness. I wasn't thinking I was going to die right now. But I was realizing this is probably how I'm going to die. But I was thinking, 'I'm not frightened, I'm not panicking. I'm comfortable. I know Karen is here with me. She knows I know that she's doing everything she can to help me'.''

``So in a sense, one of my greatest fears has been answered. The fear of, what will it be like at the end?''

Nothing terrifies like the unknown. Yale surgeon and author Sherwin B. Nuland in his bestselling book *How We Die,* says ``accurate knowledge of how a disease kills serves to free us from the unnecessary terrors of what we might be fated to endure when we die,'' and Barry Smith knows, ``because I've been there, that the worst terrors, the 'dragons,' are fear and ignorance.''

When he first got sick, medical specialists wouldn't tell him what was going on inside his body. The neurologist seemed unwilling to admit he might have a serious problem, even though Smith could see the tell-tale clinical findings himself: the muscle wasting and muscle fatigue, the changes in his reflexes. The difficulty walking and that all combined were hurrying clearly and unforgivingly toward one probable and dreadful diagnosis: amyotrophic lateral sclerosis. ``ALS,'' Smith tells me.'' Period.''

``It was the single most frustrating time I have known.'' For 25 years, Smith helped the parents of seriously ill and dying babies cope by being straightforward and honest. If there was bad news to hear, he believed, they needed to hear it, because knowledge allows people to prepare and gives them a sense of control, he says. But doctors couldn't bring themselves to do for Smith what he has done for hundreds of families. So the dean of one of the country's most prestigious medical schools, a Queen's University-trained neonatologist (a doctor who cares for sick newborns) who once headed the Toronto Hospital for Sick Children's neonatology program, a widely published researcher with an international reputation in fetal lung development, was forced to spend months chasing a diagnosis. He felt ``robbed'' of the time he would need to confront what was becoming increasingly clear to him was something serious. He felt he couldn't share with others what was happening ``because no one was getting the kindergarten teacher's gold star for communicating it appropriately. It was a very difficult way to live.''

He believes that neurologists, for most of the diseases they treat, are effective communicators. ``And yet I believe, and I've read hundreds of case reports of people with ALS, that it's absolutely typical that doctors are uncomfortable labelling this disease. They're uncomfortable talking about it before an absolutely firm diagnosis and I believe it's because they have no treatment. Therefore, they don't believe it's in the patient's advantage to know.'' But after a while, Smith stopped chasing. He stopped going to the neurologist. ``I felt like my hands were tied and I felt like I untied my own hands when I said, enough is enough,'' the soft-spoken doctor says.

When he became convinced ALS was the cause of his symptoms, he faced the prognosis squarely, and in a situation he thought would have been ``totally hopeless and barren,'' instead found ``enormous growth and positivity.'' He and Karen, a

woman who knew two weeks after she met Smith she would marry him, are sharing a deeper sense of communication they've never before experienced. The couple, who have been married for 31 years and who have two grown children, renewed their wedding vows under the trees of their old house in Kingston early on in Barry's illness, a ceremony that was both joyful and bittersweet; they've travelled to Florence and Kosovo and South Africa and have spent long intimate hours alone sharing memories about their lives together.

And in what he is convinced are his final months of life, Smith is doing what he thought he would never have the opportunity to do again: to teach.

He has contributed to a unique campaign called *Living Lessons*, a palliative care program aimed at encouraging doctors to help dying patients live the last stage of their lives with dignity. He has contributed a moving essay to a booklet that is being mailed to family doctors across the country. Developed by the Glaxo Wellcome Foundation in partnership with the Canadian hospice palliative care movement, it contains handouts for terminally ill patients on what they deserve - to live free of pain, to be treated without ``deception of half-truths`` - and information for doctors on how to deliver bad news to patients, how to be honest and straightforward, how to get their patients access to good palliative care.

OVERWHELMING RESPONSE

The response has been overwhelming. Smith has received letters and e-mails from doctors across the country, including a physician from Queen's who each year offers a course on palliative care to doctors in practice. This year, half of the students showed up with a copy of *Living Lessons*.

``One of our VON nurses in the last few days told us of a patient she had, who died Christmas Day of ALS, who had been having spells similar to the ones I've been having, and who died in his sleep,`` Smith says. ``And she told us she had shared our information with him, and it had had a very positive effect on him. And that's just wonderful for us.``

``We became doctors so that we could help people, not so that we could keep them alive forever,`` Smith writes, yet most doctors practising today, like him, learned ``precious little`` in their medical training about how to deal with dying patients. What they learned, he says, they basically learned by what they saw. ``And in too many cases, what they saw were role models who avoided death. Who avoided discussing it. Who just were not as comfortable acknowledging death as they were in fighting it to the end.``

It's a late, winter afternoon. Smith is sitting in his office in the bungalow he and Karen bought two years ago when they were forced to sell their three-storey, century-old stone home. It had become harder and harder for Barry to negotiate the stairs there. Smith is 56, with thick greying hair he wears swept over to one side. He's an aviation buff and amateur photographer whose framed black-and-white photos line the walls of his home. His office is warm, with oak and burgundy walls, and along the ceiling runs a wallpaper border of teddy bears skating and tumbling in the snow. ``This must have been a nursery,`` the baby doctor says, smiling. There's a bird feeder outside his window, with a cheerful wooden snowman next to it. His sister-in-law set up the feeder when it became clear Barry would become increasingly confined to this room, one of the ``tons of small thoughtful things`` his friends and family have done - ``making the view outside my window fun`` - to help him through what he calls his ultimate transition.

He is the youngest of two sons born to Ted and Doris Smith, a middle-class couple who raised their boys in Toronto. Ted was an RCMP veteran, the classic ``strong, silent type`` who spoke little about his work, but Smith remembers the night his father was called out after Hurricane Hazel to help in

rescue efforts and to recover casualties. ``The pain in his face was something I never forgot.`` Having lived through the Depression, his mother was keenly aware of the need to be prepared and cautious, and from her, Smith says, he learned the value of an education, ``of looking to aspire without limits.``

Smith has always loved children and decided early on he wanted to be a kindergarten teacher, until his final year of high school, when he flipped open a university calendar at the wrong page and came upon the faculty of medicine. ``I realized I`d never though about a career in medicine. And here I am.``

Where he sits is at the end of a professional career marked by enviable firsts. In 1980, he was recruited to Harvard University`s medical school to develop a research program in neonatology. He would eventually be asked to lead the university`s entire newborn program. Six years later, he was recruited to Toronto, where he headed the newborn programs at the University of Toronto and the Hospital for Sick Children. His research into the development of the lungs before birth, and the role hormones play in inducing a substance called pulmonary surfactant that helps a newborn breathe, led to new treatments to prevent respiratory distress syndrome, once one of the leading causes of death in premature babies.

ENCOUNTERED DEATH EARLY

By working at the first beginnings of life, Smith encountered death early, and even he admits to being uncomfortable with the reality that patients die, ``and that when they died, it seemed to create an enormous emotional burden for me, as it does for other professionals.`` The huge advances in early diagnosis and high-tech treatments have made it more and more possible to save patients from diseases that even a few decades ago would have killed them, so much so that doctors now ``see death as the enemy,`` Smith says, ``and ourselves as failures if we `lose`a patient.`` The result is that many physicians are far less comfortable acknowledging death, he says, ``that they are fighting death to the end.``

He shares a story in *Living Lessons* about a Saturday when he was working in Boston and was called to the side of a child who was dying. ``I stayed with the family and the child during his last few hours. It was difficult and wrenching. I drove home afterward thinking how these people had been through a parent`s worst nightmare, and I had been a part of it.``

``They went through it once. In my career, I would have to experience it over and over again. Could I do this to myself?`` But as he drove on, he realized how ``infinitely worse`` it would have been for the family if they hadn`t been surrounded by caring people. ``I was able to see the difference that I had made, and it allowed me to help hundreds of other patients and their families.``

Every special care nursery he worked in created memory packages for the families of babies who had lived only months, weeks, or sometimes mere hours. They included photographs of the baby, and if the pictures hadn`t been taken when the babies were alive, they would be taken in death. They saved clothes and booties and bonnets, name cards from the baby`s crib, tiny locks of hair. ``Think about the last funeral we went to, or the last close person we lost. People help each other by sharing shared memories - `Remember Uncle Joe when he...` But for families with infants who have died, there have been no shared moments. And in many cases friends and even relatives turn away, because they don`t know what to do or say. It`s normal for families who are facing death to experience isolation, but that isolation is magnified in the case of children or infants.``

In 1996, Smith left the special care nursery in Toronto to become Dean of Medicine at Queen`s University, where he achieved during the tumultuous years of hospital restructuring what was then considered leading edge, merging the schools

of medicine, nursing and rehabilitation, training health professionals together, instead of apart. He was admired as a soft-spoken administrator and educator who each September told the first year medical students to substitute the word ``caring'' every time they heard the words ``health care,'' because to Smith ``caring connotes more, and looking after the dying is a very real role of caring.''

He was dean for just over two years when the dragons appeared.

It was the summer of 1998. Suddenly, he was having trouble swallowing solid foods, particularly meat. It would get stuck in his throat, never far enough to cut off his breathing, but it was uncomfortable and distressing nonetheless and by the Fall, when it kept happening, he knew it wasn't just bad eating habits and a rushed lifestyle, that something ``abnormal'' was going on. By the Fall, he began experiencing severe muscle weakness and subtle signs of wasting in his arms and shoulders, hallmarks of ALS. He shows me the back of his right hand, where the skin seems almost translucent.

Looking back, Karen remembers how exhausted Barry looked, how the same man who never seemed physically burdened by his 12- to 16-hour days suddenly seemed drained of energy. ``I was asking him constantly if he was feeling OK.''

After several fruitless visits with the neurologists, Smith looked up the international criteria for ALS that guide doctors toward a diagnosis, ``criteria that say, here are what you need to go along the curve from possible, to probably, to clinically certain to laboratory certain.'' By May of 1999, when the fasciculations had begun, the tremor-like spasms he could watch in his muscles, Smith had convinced himself he was dealing with ``probable'' ALS. By August, ``it was clinically certain.''

At first he couldn't bring himself to tell Karen what was happening. Her mother was sick and facing blood vessel surgery; she'd lost her father, brother and uncle over the years and Barry remembered clearly the day she told him how ``all the men in her life were leaving her.'' When Karen's mother was admitted to hospital for angioplasty, Barry was able to stay with her and watch. After the procedure, he went to the radiologist's office and called Karen to tell her everything was fine. ``And when I told her, my voice cracked and I became quite emotional,'' Smith says. ``Karen, fortunately, didn't pick up on it. But I was realizing in my mind that, now that her mother is looked after, now I was going to have to tell her. And not too long after that, I did.''

'IT'S NOT GOOD'

Karen remembers how Barry came home unexpectedly one afternoon and asked if she had any lunch plans. They climbed into the Jeep, but instead of driving to a restaurant, Barry drove to the park. ``He turned to me and said, I have something to tell you, and I don't think it's good. He told me he'd been having problems and that he had an appointment with the neurologist that afternoon. His words were, 'Whatever it is, it's not good'. ''

Karen recently told a reporter for the *Kingston Whig Standard* how she grieved for a year and a half but how at first she never cried in front of Barry, until he told her it was OK, because he had cried too, when he worried what his illness was doing to his family.

When it became clear what Barry was facing, they asked for a home visit with both their family doctors to prepare for what was coming. When would they need a feeding tube? Would they choose to ventilate or not, when his condition worsened? They talked about their deepest fears, even though by speaking about them they worried it would be like a self-fulfilling prophecy. ``For me, it was the fear of being alone, and of what the end would be like,'' Karen says. For Barry, it was the fear he would end his days ``seeing my wife imprisoned by my illness. And the fear that I wouldn't have sufficient courage to

die with dignity.``

But they have surrounded themselves with a compassionate team of palliative care physicians and nurses. They have made all the necessary arrangements. Smith will be buried in Karen`s family plot in Campbellford outside Toronto. His own parents were cremated, their ashes scattered in Lake Ontario, ``so it`s a bit hard to find them,`` he says with a smile.

Smith says he feels blessed that the disease has not afflicted him as it does 80 per cent of its victims - starting in the limbs - ``because those are the more unfortunate patients who, although they live longer, a mean of five years, they`re the patients who end up totally helpless and immobile.`` His form of the disease is called brain stem onset ALS, and it is the respiratory muscles that determine when he will die. The prognosis is two years, longer if he is connected to a ventilator. ``But we`re not going that route,`` Karen says. Adds Barry, ``I see the fact that I have brain stem ALS as a blessing, that I won`t likely get to the stage of being totally helpless. Given that, why would I reject that blessing by being ventilated and ensure that I did become totally helpless?``

They are decisions he and Karen have made by discussing with his doctors what`s important to him in the time he has, interventions we will and won`t accept, a sense of control he says doctors need to help their patients gain ``so they can live the ends of their lives well.``

Two hours into the interview, his breathing is becoming more laboured, his voice getting the ``chippy`` sound that sends Karen into alert. The doctors have had to increase the morphine recently. He`s able to eat only liquids now, and even then has some difficulty swallowing. He gets much of his nutrition overnight from a milky formula that drips into his feeding tube while he`s asleep. ``Which is actually kind of neat, because I can enjoy more taste now that I don`t have to eat for nutrition. If I really like the taste and can`t swallow, I just chew it up then spit it out. That`s just been a marvellous enabler, rather than a representation of handicap.``

He had to give up cooking a week ago, but now dictates the recipes to Karen. He needs a wheelchair to move more that 10 metres, and when he sits up, he needs to be well supported. He uses a neck brace now when they play cards. ``And time left?`` Karen says before the question can be asked. ``It could be weeks. It could be days. It won`t be months.`` But it will be, they are convinced, during one of the spells.

Smith says he always wanted to die in his sleep. Now he wants to be awake. He wants to be able to look in Karen`s eyes and to see her looking back at him, ``because that fear of not being able to die with dignity has moved on.``

``That fear of being unable to be calm, of being unable to be reassuring for my family. Being unable to take this normal life step, if not with a smile, at least a lack of a grimace and a tear.``

``Actually,`` he says, looking over at his wife, tears in his eyes, ``I hope to smile. That`s my plan.``

This article was written by Sharon Kirkey and first appeared in the *Ottawa Citizen* on February 4, 2001 and is re-printed with permission.

In his own W O R D S . . .

By Barry Smith
(from *Living Lessons*: Three Stories from the Medical Profession About Quality of Life for the Last Stages of Life)

I have been a physician for 30 years, a pediatrician, a neonatologist. I have also taught at Harvard and been the dean of the medical school at Queen`s University, and it is both as a teacher of doctors and a practitioner that I reach out to you today.

I have a challenge for you, for all of us in the healing profession. For I have been to the darkest, most frightening corners of your imagination, a place where some of you will follow me. I have ALS. I am dying. And I do not have long to speak.

But as a doctor, and an educator of doctors, I have realized some startling truths in the last months, and I challenge you to hear them, and to take them to heart.

This is what I want you to know:

First, that the end of my life is turning out to be a very rich and rewarding - even beautiful - time of life. Every life is a story, and every life must end, and what I have come to appreciate is that I know the end of my story, in a way that many people are not fortunate enough to do. Fortunate? Can a man be fortunate who has but months to live, and who knows it?

I believe that I am. I have discovered that when you face death squarely, you know sharply what it is to be alive. In the past months, I have learned how to communicate with my family in a way that I had never done before. I have travelled to Robben Island, where Nelson Mandela was imprisoned for so many years, and understood the damage and waste of anger and the value of forgiveness. I have run my life through my fingers and felt satisfied with how I have lived and what I have done.

I am savouring every moment of this last summer in the sun-kissed garden with my beloved wife, talking with her, exploring the meaning of our love and our lives together. Paradoxically enough, ALS has given Karen and me the gift of time. We treasure what we have left; we treasure what we have had. We hold each other precious every moment. And we have found that we can talk about everything: our love, our hopes, our fears...Hers of being alone are as real as mine of not finding the courage to die with dignity.

I am very much alive. Remember that your dying patients are very much alive, and that their lives, in their final stages, can have quality and richness. You can help them achieve that.

Second, that it is imperative that you face your patients squarely when to have to deliver bad news to them.

Unfortunately, when I became ill, no one could tell me what it was. My doctors could not tell me that I had ALS, even once it had become clear to me that it was the only possible diagnosis for my symptoms. It was the single most frustrating time I have known. Valuable months were lost, chasing after a diagnosis.

Your patients need to know what they are facing. Not to tell them is to rob them of their time to make peace with themselves, with their families, with the world around them. You can help them achieve those things by being honest with them.

Third, you can make a huge, positive difference in the lives of people who are dying. Sometimes, as doctors, we tend to see death as the enemy, and ourselves as failures when we ``lose`` a patient. But that construct cannot hold, for the simple reason that we must all die one day. Dying is a normal part of living.

We became doctors so that we could help people, not so that we could keep them alive forever. Helping patients and their families deal with dying is, in fact, the very essence of good, and successful, medicine. You can achieve that success.

Fourth, you can give your patients a level of control that they badly need over their conditions. Tell your patients as much as you can about their condition and its progression.

This is why: As a patient, I have understood that the more I know about my condition, and the earlier I understand what is coming, the better prepared I can be. Karen and I have found great comfort in the sense of control that knowledge and preparedness have given us.

The sense of being in control allows us to problem-solve as necessary. For example, I knew that as my walking began to falter, so would my ability to hold a cane firmly. The answer turned out to be a hiking stick. Its strap, like that of a ski pole, anchors my hand firmly to the stick.

More seriously, we have had to make preparations for a feeding tube, as both my ability to swallow and to convey a spoon to my mouth continue to weaken. Both Karen and I found our exploratory visit with the surgeon helpful and comforting, not frightening or depressing. Knowledge helps. We can mange what we know. This control allows us to plan our lives with balance, planning for ``tomorrows`` without losing our ``todays``.

Most patients will need help in gaining the knowledge and control that they need to live the ends of their lives well. You can give them that help.

Fifth, nothing that you tell your patients will be more frightening than the terrors they will imagine if you don`t.

People can cope with reality once they know what it is. Fear stems from the unknown. I am reminded of those medieval maps on which cartographers would write ``There be dragons`` at the edges, where the unexplored territories begin. As a doctor and as a patient, I have been to those territories, and I can tell you that the only dragons are fear and ignorance. There need be no dragons there, and here, too, you can help by providing knowledge and compassion.

Sixth, listen to your patients. They will tell you how much they can hear at any one point. Let them lead. They might need to come in a number of times to learn everything you need to tell them, or they might need to bring in loved ones to whom you can talk. They will let you know. Let them help you help them. As a profession, we have to come to terms with how to help people who are dying. We can make a huge difference in the lives of our dying patients, and of their families, which are families in pain, families in transition. This is precisely why we became doctors in the first place - to help our patients.

It is the very heart of health caring.

Remember this, the next time you are faced with an ominous diagnosis and a dying patient. You can help.

CHANGE OF ADDRESS

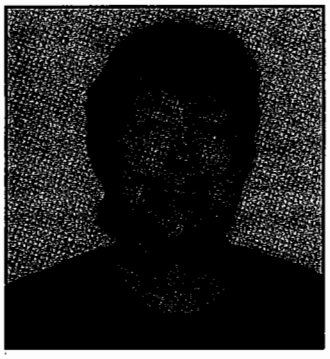
The office of the Canadian Resident Matching Service (CaRMS) is moving its headquarters to the Medical Council of Canada Building at 2283 St. Laurent Boulevard, Suite 110, Ottawa, Ontario, K1G 5A2. This move will be effective as of May 16th, 2001 at which time new telephone and fax numbers will be available.

SECRETARIAT NEWS

December 31, 2000 marked not only the ``true`` end of the millennium, but equally momentous from our perspective, the retirement of Janet Watt-Lafleur after 16 years of service. And the word service, of course, does not begin to describe Janet`s relationship with ACMC. Her contributions were often above and beyond the call of duty and her dedication shone through every task she touched. Despite deadlines, competing demands and demanding individuals, she was always kind, patient, and helpful. It was widely recognized that if anyone deserved credit for the growing success of our annual meeting it was Janet.

She has returned to university this semester and will wait until this Summer to explore new options open for her - and undoubtedly there will be many!

We wish her well in any and all her endeavours and will always consider her part of ACMC`s ``extended family``.



Susan Maskill is the new Director of Administration at ACMC. Susan was born in Moncton, New Brunswick and, as a scholarship student, attained a Bachelor of Science degree from the University of New Brunswick. She was appointed as the first Director of Medicare Registration and Assessment for New Brunswick, and represented the province at federal/provincial meetings of medicare officials. In 1987 she was appointed Executive Director of the Aitken Bicentennial Exhibition Centre (ABEC) in Saint John. During her tenure a hands-on science gallery for children was developed and the Centre became a very popular attraction for the community and its visitors.

In 1993 Susan was hired by the Society of Obstetricians and Gynaecologists of Canada to assist in organizing the 1994 World Congress (FIGO) of obstetricians and gynaecologists in Montreal hosting 7000 delegates from 120 countries. She also coordinated and secured funding for the first FIGO fellows program. This initiative brought 51 young obstetrics and gynaecology from 34 developing countries to Canada. Each one was hosted by one of our medical schools for three weeks. In 1994 Susan was appointed Director of Education and Government Affairs for the Society. She was actively involved with the development, promotion and organization of the Society`s four annual regional CME events and its annual clinical meeting. Her various government activities included advocacy, securing project funding, and coordinating government partnership initiatives.

In these challenging times, her skills, experience and strong interest in medicine and health care will assist the ACMC in furthering its goals, and we welcome her with great enthusiasm.

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Canadian Medical Education Statistics, 2000

Contents

A. General Information About Canadian Medical Schools: e.g. fees, remuneration of clinical trainees, etc.

B. Undergraduate Medical Enrolment and Graduation Data: trend data; characteristics of entering students; enrolment; attrition; MD degrees awarded.

C. Graduate Medical Education

a) Masters and PhD level enrolment and degrees awarded.

b) Post-MD clinical training/residency: trends in numbers of trainees by specialty, location of training, citizenship of trainees, career choices of women, country in which MD degree earned, etc.

D. Faculty Data

E. Biomedical Research Expenditures

F. Applicant Study Data: comparative acceptance rates by characteristics of applicant pool (citizenship, age, province of residence, language of instruction of schools applied to, performance on MCAT of applicants, educational background of applicants); repeat applicants to Canadian medical schools; impact of repeaters on admissions.

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C. Enseignement médical postdoctoral

a) Maîtrises (2e cycle) et doctorats (PhD/3e cycle): inscriptions et nombre de diplômes décernés.

b) Formation clinique post-MD/résidence: tendances dans le nombre de stagiaires, selon la spécialité de formation; la citoyenneté des stagiaires, le choix de carrière des femmes, le pays d'acquisition du doctorat en médecine, etc.

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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