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The University of Western Ontario

Medical Journal

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From The Editors' Desk

This issue of the **Medical Journal** has, as evidenced by the cover design by Dave Lee, **Meds '90**, a distinctly political flavour to it. This is not intentional, it is merely reflective of our times. Most of us would rather be concerning ourselves with medical school issues: Academic awards for outstanding achievement (p. 8), or everybody's favourite February blah-chaser, Tachycardia (below). However, issues such as 2-year licensure (p. 5) and where we are going with health care are the subjects of articles by Brad Dibble, Barbara Heller, and Rick Smith, as well as our editorial. In addition, Allan Garbutt takes a look at the hoops you must jump through to do medical research.

★ ★ ★ ★

This generation of medical students has the potential to see more drastic changes to our system of medical practice and delivery of care than any other. We will have to live with the changes that are being considered now. May we have the dedication, conviction and foresight to try and affect the outcome while we still can.

The Liberal coalition government had it pretty good back in the summer of '86. They took on an issue they couldn't lose (Bill 94), made the doctors look like the bad guys, and a short time later turned it into a Liberal majority. This was back when David Peterson promised that acceptance of Bill 94 by the MDs would lead to no losses in physicians professional freedoms (...and if you believed that...). However, the usual Peterson/Caplan smugness recently has been giving way to forced smiles and stammered defences of a Ministry

that is having to accept responsibility for a situation it has continually tried to blame somehow on Ontario physicians.

If you haven't learned them already, you will learn in this edition of the **Medical Journal** many of the Ministry's new catch-phrases for solutions to our escalating health care costs: "Impact Analysis", "Managed care", "Outcome-based peer review", "HSOs/HMOs", "The Independent Health Facilities Act (IHFA)". They spell infringement on physicians' civil and professional rights, and most importantly further deterioration in the quality and **accessibility** of health care for the people of this province. These plans implicitly place physicians at the root of our economic woes for taking too big a piece of the pie, while cleverly (or not so cleverly) hiding the real agenda.

These financial wizards have figured out that if people don't have access to health care, then the government doesn't have to pay. No pay equals saved dollars, which equals re-election, which equals political happiness. Adjusting the scheme so that physicians look like the ones responsible for all the problems is just icing on the cake. Effective government in action - bravo! This is much easier to do presumably, when one works at Queen's Park rather than in the ICU.

But things are beginning to catch up with David and Elinor. Now the media is sticking the microphones in **their** faces and asking why people aren't getting the health care (i.e. nursing shortages and increasing waiting lists) that they paid for - sound familiar, Mr. Peterson? Our heroes now find themselves in the spot that doctors were in during '86. It is most entertaining to watch the production of worth-

less syllables while someone tries not to say the "politically wrong" thing. (Aside - We should probably watch our mouths here since under the IHFA and Impact Analysis we could find ourselves jobless and our records seized - without explanation.)

Unfortunately, Mr. Peterson and Ms. Caplan may not have much time before Big Brother's "solution" of denying access to health care as cost control becomes obvious to the public as a whole.

What can we do to expedite this process? Opposition parties can be quite useful for this sort of thing. The government also really dislikes it when reporters start asking embarrassing questions. Our patients have a right to know. We have to recognize that health care dollars are not limitless and it is us that should be meeting this challenge and coming up with solutions, for these issues threaten the well-being of our patients as profoundly as any disease. Efficient medical practice must become a more integral part of our training, it has become a necessary skill. However, it is a skill that can be applied safely and appropriately, only by physicians, in the context of sound medical practice. The heavy-handed fiscal fixes proposed are as ridiculous and dangerous in some cases as physicians deciding that they wish to dabble in corporate law. We only need to point to Britain's NHS for evidence of the future for such proposals. ✕

Warren Teel, **Meds '90**

Connie Nasello Paterson, **Meds '91**

Deadline for next issue: March 3/89

Don't Worry - Be Tachy...

by Mike Ertel, Tachy '89

Yes, it's that time of year again when we take a break from studying for a week and try to convince people that we're just as well-rounded as the dentists - holy moly can those dudes ever party!

Well anyway, it's probably the most enjoyable week of the medical school year, and something you never forget. You need only mention "Tachy" to a UWO med school alumnus, and you'll instantly see a big childish grin as they tilt their head back and gaze at the ceiling (aka Dr. Flummerfelt) while recollecting their CRAZY antics when they participated in Tachy. That's assuming of course that they **did** participate -- for if they didn't get involved with their classmates, you'll see tears welling up in their eyes and their lips will quiver, their knees will knock, and they'll have a goofy "Sonny Bono"-like look on their visage as they try to explain the Living Hell which they call "their life". It's sad to see, but so very true. Now that I'm in clerkship, I find it especially

nice talking to physicians about Tachy, because it's a nice vehicle in which to transcend the traditional "Scut Monkey" role of a clerk and talk to a consultant on a one-to-one level (...all right, I'm shootin' it!)

Tachycardia is definitely THE best way to really get to know your classmates, especially for you "Kooky cats" in **Meds '92**. It's a memorable day when you find out that not only is the guy next to you a whiz in anatomy (present company excluded), but he can also act -- and he's funny! It's always the students in first year who don't really know what Tachy's all about and are too caught up in being caught up that they don't get involved and then sit in the audience in awe when they see how much fun their classmates are having. They're easy to pick out because they're the people at intermission who can't seem to walk down the halls without kicking themselves in the pants (so **that's** who those people are!).

This year's show will be the 33rd produc-

tion of Tachy dating all the way back to 1955 -- back when men were men and sheep were scared. Ah yes, Tachy's come a long way since then, but I don't think that the basic principles have changed too much over time -- to make people laugh without offending too many of them; to take a couple of months away from the study grind and exercise the creative side of our brains for a change; to get to know our classmates on a more personal level; and to revel in the applause while cherishing the memories of a lifetime.

Just think, some day we'll be able to have that same childish grin on our face as we tilt our heads back and do our best Dr. Flummerfelt impression as we recollect, "Yes, I was in Tachy -- now **those** were the days -- you know I was a little 'wild' back then -- in fact, I remember when we used to get together and..." Please participate this year and make your own memories -- they're something that billing numbers can never take away! ✕

Quo Vadis? A Step Forwards...or a Step Back?

by Barbara Heller, Meds '91

On June 10, 1988 the OMA sponsored Quo Vadis (where are we going?) -Concepts in Health Care Delivery, a one day international seminar at the Inn on the Park in Toronto. The topics which were addressed included the funding of health care and Health Service Organizations (HSOs). As the escalating costs of what is presently one of the best health care systems in the world become realized we must take time and pause to consider Quo Vadis? With all three political parties supporting the cause of HSOs with payment of primary care physicians on a capitation basis (Linton, 1988; Linton, Peachey, 1987), the question of where are we going rings stronger.

Dr. M. Barkin, Ontario's Deputy Minister of Health has described our health care system as one on a collision course with economics. The source of Health Care Revenues for Ontario in the 1985-86 fiscal year were:

Federal Government Transfers 43%
General Provincial Revenues 39%
OHIP premiums 18% (Ontario Health Review Panel, 1987).

The problem lies in the ever widening gap between the transfer of monies from the federal government and the requirements of the Ministry of Health. Barkin went on to point out that in 1977 expenditures by the Ministry of Health represented 27% of the provincial expenditures, but in 1987 had risen to represent 32%. With an average increase of 0.5% per year, this places Health expenditures at 40% by the turn of the century, cutting into education and economical development.

John Crispo, political economist and professor at the University of Toronto defined the problem as "providing a limited means to an unlimited need or want". Several factors play a part in society's ever increasing demand for health care including the changing demographics of our population, the AIDS epidemic, research and technology, and the commercialization of health care.

Hospital care represented over half of the expenditures by the Ontario Ministry of Health in the 1985-86 fiscal year (Ontario Health Review Panel, 1987). Hospital use, in turn, is greatest in the 65+ years and Canada institutionalizes its elderly earlier and more frequently than any other OECD country. Dr. Barkin pointed out that while Canada is one of the youngest of the OECD countries it is the number one spender on health care per capita. With patients 65+ years being the primary consumers of medical resources it is easy to picture how the increasing number of elderly will place a heavy demand on the health care system as the percentage of the population in this age group will almost double from its present 6% to an estimated 10-11% by the turn of the century.

Dr. Adam Linton, executive member of the OMA, has identified the public as intensifying the pressure for an increase in funds by an apparently limitless demand for services. He stated that advertisement mediates the dependency of a generally healthy public who flock to doctors' offices for conditions which do not exist or are not accessible to medical treatment. Such conditions range from baldness through to jet lag. In 30 to 60 percent of visits to primary care

physicians no serious medical condition is found.

Even our scientific achievements appear to have their downfall as Alan Backley, Deputy Minister of Health of 1976, describes "we have done so well in terms of the benefits derived from research and technological advances, yet now we are confronted with financial problems created for our society by both the extension of life and the amenities needed to improve the quality of life - this has been called our 'failure of success'".

Finally, although the impact of the AIDS epidemic has yet to be fully understood, the cost of treatment for those unfortunately afflicted will be without question enormous.

Much interest is being generated in new methods of health care delivery and all three parties are looking to Health Service Organizations to save money and promote prevention of disease. HSOs are derived from the American Health Maintenance Organizations (HMOs). These are group practice arrangements in which physicians are paid by salary or capitation (ie. dependent on the number of patients serviced irrespective of the volume of work done per patient). The underlying philosophy is to use resources wisely. Doctors involved are to restrict their use of services which are costly and of apparent minimal benefit. In this way funds would be conserved for a patient that would benefit greatly from a high cost service (Linton, 1987). In a HMO primary care physicians act as gatekeepers to services, specialists, and tertiary care units.

As of June of 1987 there were 27 HSOs in Ontario and the number is rapidly increasing. It should be noted that while HSOs are derived from HMOs there are many critical differences. Those outlined by Dr. Peachey (1987) include the following. An HMO is an independent organization which consists of a group of doctors that compete for clients, generally making contracts with employers. HMOs thus have some flexibility as to the patients they accept and if they fold, (unsuccessful HMOs are not unheard of), their patients are left without any health care coverage. An HSO on the other hand is a method of payment to a group of physicians within a universal health insurance plan which continues to be financed by the government. Thus it is an arrangement between the HSO and the government. An HSO in Ontario may not refuse a patient. In addition, if a patient leaves the HSO, the regular coverage is retained for services provided by a physician not involved with the HSO. In fact, the HSO is at a loss if an HSO enrollee receives an insured service elsewhere when it could have been provided by the HSO. The HSO will lose payment for that patient for that month (capitation negation). The financial drawbacks of referrals outside of the HSO may act to restrict the primary care physician's choice when referring to a specialist. There is also an incentive plan (Ambulatory Care Incentive Plan) that rewards HSOs essentially if HSO enrollees demonstrate a decreased utilization of hospital beds.

Advantages of HSOs as described by Linton and Peachey (1987) would include encouraged partnership arrangements, stabi-

lized incomes, and more control over leisure time. The business management skills required in an HSO would also make doctors more cost conscious which is a benefit to any framework of practice.

Linton and Peachey (1987) outline several disadvantages. The most prominent is the loss of the patient-doctor relationship because patients will be serviced by a group of doctors. Due to incentives for not using services there is the potential for underservicing. This structure also promotes increased external influences on practice decisions. Obviously financial rewards and leisure time will be dictated by the volume and types (ie age, health status) of patients. The question is - with support from all political parties, will we enter an age which endangers the building block of primary care physicians, specifically the doctor-patient relationship? Secondly, if HSOs are resorted to, will the quality of health care depend on the group one enrolls in? To continue one hypothetical step forward, will patients seek out HSOs which are managed with less financial restraint to a neighbouring HSO (ie extending more services and treatments to their patients)?

It is difficult to imagine the impact of HSOs on health expenditures despite savings demonstrated by many HMOs in the United States. The decrease in hospitalization of HMO enrollees may be due to a bias towards the selection of healthier clients (Linton and Peachey, 1987). However, as Linton (1987) has cited, a significant scientific weight has been attributed to the Rand report which noted a decrease of 25% in the cost of health care for enrollees. This decrease was almost exclusively due to a decrease in hospital admissions. This report also demonstrated that those entering the HMO as healthy individuals showed savings without any compromise to their health care. However, patients from low income or high risk groups were shown to be in a less favourable condition with more serious symptoms and a greater risk of fatality in the HMO group as compared with a comparable fees-for-service group.

With rising health care costs an effort must be made to work towards solutions that will not seriously compromise our system of universal health care. Regardless of which path is taken it appears that some thought should be given to incorporating the teaching of managing medical practice and the provinces services wisely. ✕

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The Changing Face of Medical Practice in Ontario: An Introduction to Government Initiatives

By Rick Smith, Meds '90

Recently one wintery morning after finishing rounds, I was pretending to enjoy a bitter sample of what St. Joe's refers to as "coffee", as my consultant, the rest of the team and myself were leisurely chatting about nothing in particular. That is until the conversation turned sour. We had started talking about the politics of medicine in Ontario and how the Minister of Health, Elinor Caplan and her trusty sidekick, Deputy Minister Dr. Martin Barkin, are doing their misguided best to once again change the face of medical practice in this province. As a result of this conversation, I decided, (or was I told by the consultant?), that it was my responsibility as a future practitioner in this province, to be informed about these impending changes and that it would be a good idea to try to inform the rest of the medical student body about the type of environment in which they may find themselves practicing in the not so distant future.

Realizing that I needed a very reliable source of information, I decided to call on Victoria Hospital's Dr. Adam Linton, Professor of Medicine, a member of the Executive Committee of the Ontario Medical Association and Chairman of the OMA Committee on Medical Manpower. Dr. Linton was most helpful in agreeing to meet with me on very short notice and in explaining the salient points of the gov-

ernment's agenda. Please note that this article is not an attempt to convey every detail about government policy. It should, however, serve merely to increase student awareness with respect to the following areas of government activity; (1) Alternative Methods of Remuneration, (2) The Independent Health Facilities Act, (3) the concept of "Managed Care" and (4) further government attempts to control medical manpower.

Alternative Methods of Physician Remuneration

The main thrust of the government activity in this area is to abolish the current fee-for-service system of remuneration altogether. The alternatives proposed by the government include (i) a salary-based system and/or (ii) a Health Service Organization (HSO) arrangement. At present, the government's primary targets for salary based payment are the clinical teachers. Approximately 4000 of the 17,000+ physicians in this province have some sort of university affiliation. Dr. Barkin has introduced the idea of "Cost Containment Envelopes" for this group of practitioners. This system would work as follows; the director of a unit, such as an ICU, would deal directly with the government in negotiating the funding for his unit. Out of this funding would come the salaries for all those

employed in that particular unit. This system works to the advantage of the government in at least two ways; (1) it would place all physicians in the unit on salary and (2) it would leave the director helpless in terms of dispute resolution at negotiation time, as he would be dealing DIRECTLY with the government, effectively eliminating the leverage previously provided by bargaining through the OMA. Another approach the government has adopted to entice consultants into the cost containment envelope system is to offer government salaried physicians as replacement for resident cutbacks. The catch being that in order to take advantage of such an offer, all of the current consultants on that particular teaching unit must accept the terms of the containment envelopes.

The HSO system being touted by the government as a money saver has been borrowed in part from the American Health Maintenance Organization (HMO) system. This system works on a capitation basis, whereby a group of physicians combine their practices to form an HSO and are then paid a lump sum of money per month based on the number of patients in their group practice. The sum is fixed regardless of whether you see the patient weekly, monthly or yearly. One method the government is currently using to swing physi-
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Changing Face.....(continued)

icians into the HSO system is illustrated by the current situation in North Bay. This community is badly in need of funding to improve existing hospital facilities and has been lobbying the government for approximately 10 years for such funding. The current government response to their request is one that would see money fast-tracked to the community to build a new facility if each physician at the two current hospitals, Civic and St. Joseph's, agree to combine to form a single HSO, i.e., if they all agree to capitation. If the physicians choose not to play by these rules, they have been informed that it could take many years before they see any funding from the province. Such a situation could easily be misinterpreted by the uninformed observer as one that has the physicians putting their needs ahead of those of the community as a whole.

One problem with the HSO/HMO system is that there exists no evidence in the USA that their HMO system saves any money, or that it improves morbidity or mortality figures through greater preventative medicine. The Canadian studies of the HSO system may even be interpreted as indicating that this system is more expensive than the current arrangement. A second potential problem with such a system is that it may shift the emphasis of medical practice away from patient care due to the capitation on income. Careful, well thought out studies of HSO's may, in the future, show that they save money, but this has yet to be documented. Knowing this, the government still forges ahead with the HSO concept, in typical myopic fashion.

The Independent Health Facilities Act

This act is also referred to as Bill 147, and, as it currently exists, has the potential of having serious detrimental effects on the practise of medicine in Ontario. The initial intent of this bill, which the OMA supported, was to provide funding for clinics which would be capable of performing procedures traditionally done in hospital, i.e., abortions, cataract surgery etc.. The negative impact of this bill lies in the fact that it provides the Minister of Health with

total and absolute power over any of these independent health facilities, including the granting, denying or revoking of licenses for such facilities. Also, the possibility of such legislation extending to private physicians' offices is very real. This could very well turn out to be a variation of the billing number restriction seen earlier in British Columbia. Another example of the power of this bill is illustrated in the manner it would allow "Ministry Inspectors" to enter private physicians' offices without warning or search warrant, with full authority to confiscate medical records, financial records etc., and the physicians will have no choice but to cooperate. All this to ensure that the private physician was not operating an independent health facility. It is important to note that this bill has yet to be passed and amendments are still possible, however, as it currently exists, this bill is unacceptable to the OMA.

Managed Care

This refers to the use of "outcome-based peer review" as a method of controlling the future funding of hospitals and doctors in the province. This system is a version of that used in the USA where prospective payment of hospitals is made on the basis of diagnostic groupings. Simply put, this is a method that allows the funding agency, i.e., the province, to review the work done in a hospital for a given time period, and then, based on a set of "standards", decide if that hospital should be paid for that work. The standards for such a system are to be developed by the Center for Health and Economics and Policy Analysis at McMaster University.

Medical Manpower Control

This is not a new topic, however, some of the government methods of attaining control are new. As almost everyone knows, the Ontario government firmly believes that there are too many physicians in this province. One of the latest strokes of brilliance employed in an attempt to change this, has been to drastically reduce the number of residency training positions in this province. This tactic has served not to reduce physician numbers in Ontario, but only to destabilize the post-graduate medical education system. Another method has

been through the introduction of "Impact Analyses". These analyses are being required of all hospitals when attempting to hire new staff physicians and are designed to illustrate the financial impact that each new appointment would have on the hospital budget. Prior to confirming any new appointment the Ministry of Health must approve the impact analysis for any particular appointment. This system may initially seem like a responsible accounting measure, however, impact analyses are currently being used as a tool by the Ministry to restrict hospital appointments for strictly fiscal reasons, without consideration for quality of care. Examples of this system are seen in many medium sized communities in which all new admissions to hospital are done by the local family physicians. As most hospitals are currently operating with fully expended global budgets and are required to complete impact analyses, no new hospital privileges can be granted. It is therefore impossible to set up a new family practice in that community. The effects on solely hospital-based physicians are even more limiting. Through this "impact analysis" mechanism, the Ministry of Health has managed to cap hospital staff appointments which again sounds very much like the billing number restriction previously used by the B.C. government.

Ms. Caplan and Dr. Barkin clearly have every intention of attempting to force these changes on the physicians of this province. Their end-point being abolishment of fee-for-service payments to all physicians, greater control over the professional careers of physicians, total control of the medical system in Ontario and with that an ever growing and increasingly less efficient medical bureaucracy. I agree with the comment in Warren Teel's editorial in the last issue of this journal in which he stated that Bill 94 was the wrong battleground on which to fight the government. Bill 94, in my opinion, was a minor issue compared to Bill 147 and some of the other changes that I have described in this article. If there ever was a time to become informed and vocal about issues of medical-political importance, that time is now. X

Licensure: Past, Present and Future

by Brad Dibble, Meds '90

President, Canadian Federation
of Medical Students

I have been approached by many students this past year with some variant of the question, "I heard from so-and-so that 2 year internships were going to affect us. Is this true?" Well, I would like to use this opportunity to let everyone know that I do not know the answer to this, much to everyone's disappointment. However, I am mildly aware of the attitudes of the powers that be, including the government and the regulating bodies. Thus, I will now attempt to pass on to you what I do know.

The first item to review is the system as it presently stands. Currently, there are 3 routes to a general license to practice medicine in Ontario: the 2 Colleges, i.e. Royal College of Physicians and Surgeons of Canada (RCPSC), and the College of Family Physicians of Canada (CFPC), and a rotating internship. About 25% of Ontario graduates opt for each College directly, leaving 50% choosing the "rotor". The College of Physicians and Surgeons of Ontario (CPSO) is the regulating and governing body which has the right to grant a general license to any physician demonstrating competence to practice (usually after completing an internship in any of the 3 routes). The government has no direct say in the CPSO's actions, as it relinquished this right according to the Ontario Medical Act.

Of course, many choose to enter a College residency program after completing a rotor. After successfully completing a College program, a person becomes certified by its respective college. This is a measure of excellence in a specialty, allowing practice of specialty medicine. It is

important to note that a certified physician or surgeon may have been licensed long before to practice general medicine. Practice before completion of a College program is often referred to as "moonlighting".

Now for a review of recent politics leading to the rampage of rumours about 2 year internships. The concept of two years pre-licensure training has been around for a number of years. Alberta instated 2 years mandatory pre-licensure training in 1975, and Quebec was the second to do so in 1988. Other provinces such as Saskatchewan and Manitoba have it scheduled to be in the 1990s, but most of the country is waiting to see what happens in Ontario.

The Ontario saga really begins in September 1987. The CPSO (i.e. the licensing body) put out a report on licensure called the White Paper, which advocated 2 years pre-licensure training as well as mandatory certification as a necessary prerequisite for licensure. In other words, only 2 routes to licensure through the Colleges, with no third pathway. There are many objections that students have had with this report, but I will outline only the two most important.

1) Licensure is a standard of competence given by the regulating body (i.e. the CPSO) to physicians that demonstrate this standard. Certification is a measure of excellence given by the 2 educational bodies (i.e. the CFPC and RCPSC) to those physicians and surgeons who demonstrate specialty knowledge in a given field. The two are not equivalent, and although certification can stand as a route to licensure, it should not become the only route.

2) A third route to licensure is an important concept that we have been striving to maintain, as many students need a flexible transition pathway before deciding which college is for them, as well as providing a continued.....page 7

Biomedical Research: The Paperchase

Allan Garbutt, Meds '91

So, you are thinking of going into biomedical research after graduating, are you? If you are like most medical students, or even some of the more experienced persons in this faculty, you probably think you can do it without too much fuss and red tape. Sure, it'll be a hassle writing all those grant applications, but there are workshops on how to do that effectively. Once the money is in hand, you are off to the races. Requisition lab space, order your animals and research away to your heart's content.

Boy, are you wrong! For you, the bureaucratic hoops have just begun. Before even a single mouse can be ordered, indeed before you can even think about purchase orders, you are going to have to meet more university, provincial and federal rules and regulations than you ever dreamed of. Your research proposal will be reviewed many times, sometimes by co-workers and at other times by people who have little or no knowledge of your field. You will be asked probing questions, you will be forced to re-justify all aspects of your work. Questioners may strongly suggest that you do not know what you are doing. The continual refrain will be why?, why?, and why? still again. If the system is working properly, you may well end up asking yourself: "Why bother?". After all, they are looking for a family doctor in Sioux Lookout, or thereabouts. They are even offering to pay you well to come. Here, you are being subjected to a tonne of paperwork for the privilege of working long hours for low pay.

Before your grant request is funded, you will have done a lot of background and basic research. You carefully defined your research question, only after you were very familiar with the current work in that area. You have developed a research protocol that satisfies the reviewers for your granting body (likely a government agency or public interest foundation). With all that behind you, you probably think the approval and regulatory process within the University will be a breeze. Wrong!

At UWO (and the basic process is similar across Canada), any research involving animals must be approved by the Director of Animal Care and Veterinary Services (Dr. Bill Rapley) and the Animal Care Protocol Review Committee. This approval is required whether you do ecological research on lemmings in the Arctic, or study reconstruction of knees using sheep here on campus.

Before you get to Dr. Rapley, though, you (or your supervisor) will probably have fought a number of political battles in your own department. These will be necessary before you are allocated some of the oh-so-precious lab space. This very basic commodity, along with many other essentials, is always in short supply. If the research is done in London, your animals must be held in one of the approved animal care facilities. These are located at a number of places on campus, and in the teaching hospitals. The largest single facility is on the upper floors of the Medical Science and Dental Science buildings.

These facilities all meet or exceed the rigorous standards set by regulations of The

Animals for Research Act, Ontario, and the Canadian Council on Animal Care, the body which regulates animal research in this province. Their general standards cover such items as the type of lighting and flooring used, the rate at which air is exchanged, and how equipment is cleaned. Some standards, such as those on air handling, are more rigorous than similar ones for classrooms.

In addition to the general regulations, they have specific guidelines for the care of each species of animal that is commonly used in research. These cover everything from diet to the amount of cage space per animal. You will be required to follow the guidelines covering your species. If you are using an unusual species (and boy will you have to work to justify that!) you will have to submit a detailed animal care protocol. It will be reviewed in depth by Dr. Rapley and must be approved before research begins. If there are any problems, it will also be reviewed by the Animal Care Committee.

While your animal care procedures are being checked, your research proposal will be reviewed in great detail. The questions will range from why you have selected that specific strain of rat (the answer had better be more precise than "Dr. Smith said I should"), to how many animals will be used and what they will be used for in each time interval.

By the time the review is completed and your work approved, you will have been thoroughly grilled to be sure that it is not possible to do this work more efficiently. If there is any way to use smaller samples (be sure your friendly statistician will back you up on reliability estimates, etc.), different dosing patterns, or any other change that will reduce the number of animals or time required, you can be sure someone will 'suggest' it. If the work is simply a repetition of someone else's work, forget it. Repetition for the sake of repetition will not be approved.

Okay, we can assume that you survived the review process and your research is under way. Part way through, you suddenly see a way to modify your project and so improve the results. Wonderful! However, before you make those changes you will have to repeat all the steps in the approval process. Lest you think you can just slip it through, remember that all animal transfers and experimental procedures are carefully monitored. Any deviations from the approved plan will be quickly detected and questioned. Even if you could (and it is unlikely) slip the changes past UWO staff, a surprise inspection by provincial veterinarians or members of the Canadian Council on Animal Care (CCAC) would find you out. The details of animal use are submitted to the CCAC, which reports to Parliament.

If any unauthorized changes to your protocol are made, your work will be suspended until you have satisfactorily explained why the changes were needed, and why you did not follow established procedures. If your only explanation is you thought it was too much of a hassle, your research career will have been short.

While Dr. Rapley is ultimately responsible

for the oversight process, he is certainly not the only one involved. All procedures are co-ordinated through the University Council on Animal Care (a Senate Committee). This committee has representatives from the animal care staff, the research community, and the public at large. Members are expected to question all aspects of a research proposal. They should ask everything from why the research requires animals at all, to detailed questioning about improved methods of handling the research animals. If necessary, the committee can call on outside experts for assistance.

This type of questioning forces researchers to continually improve their experimental designs and techniques. As an example of the improvements this can produce, it is no longer necessary to "chair" primates to prevent them from pulling catheters out of their body during long-term studies.

The elaborate review and oversight process has several results. It teaches you how to handle all kinds of paperwork and related bureaucratic procedures. More importantly, it ensures that all resources are used in the most economical and efficient way possible. It also maximizes the care and consideration given to animals in the research process.

Now that you have successfully navigated all the procedural hassles and everything is running smoothly, it might be a good time to show your significant other where you have been living for the past few weeks. You will take him/her in to see the animal room. That sounds simple enough, but you will have to clear it through the appropriate channels in advance. Even you are only admitted to the research area during the specific hours coded onto your fancy new access control card. That card can only be used by yourself. After muttering about the #@%\$& bureaucracy, you will probably wonder why the elaborate security precautions are in place.

While the animal care community are quite happy to have members of the public view the facilities, locks are needed for two reasons. First, some projects and species require that disturbance be minimized; second, (and more importantly) it deters raids on the facilities by animal rights activists. They have been known to use such visits to 'case the joint' prior to staging an 'event'.

Unfortunately, such raids have occurred at many research installations, including UWO. The results were often costly (one American lab was even burned down), and sometimes disastrous for long-term projects aimed at helping people afflicted with a variety of disabling conditions. On a more personal level, many graduate students have seen years of work, and even their entire degree project, wiped out simply because their lab was near a targeted project.

Whenever objections to animal research are raised, remember that such research is essential. Despite our best efforts, there are many studies that simply can not be conducted except in an animal or human model, and only infrequently would it be practical to use a human model. ✱

unique brand of training to general practice that is different from Family Medicine programs.

The next chapter of the story is the major cause for student concern. In February of last year, the government decided to get involved. The CPSO actually has total rights over the issue of licensure, but the government liked what the White Paper had to offer, so it struck the Advisory Committee on Family Medicine Training and Licensure. All of the groups with an interest in this issue are represented, including the students. (I happen to be one of the student representatives.) Its mandate was not to discuss 1 versus 2 years, but rather to look at models for the implementation of the White Paper's proposals. The situation has not been looking good for the 1 year internship ever since.

What does the future hold? That question is impossible to answer. To appease the reader, I will point out that a 2 year pre-licensure requirement will eventually be mandatory in Ontario. It is hard to say when, but the government appears to want to implement a useful and worthwhile model involving a large expansion of Family Medicine training, especially into Northern Ontario. As this will likely take a fair bit of time and money to accomplish, the changes should not affect anyone currently in medical school. There will also likely be more structured in-training evaluation as well as an exit examination involving both written and oral components necessary before being eligible to receive a license. (The biggest complaints of the rotor stem from a lack of such in-training and exit evaluations.)

As to whether there will be three routes or just a flexible post-graduate Year One before having to decide which College to train under has yet to be seen. The students, interns and residents on the government's committee have voiced their concerns regarding this issue, and some progress has been made. Other bodies are now seeing the merit of a third pathway, most importantly the CPSO as evidenced by its mention in their most recently revised White Paper. This will hinge on how economically feasible and pragmatic the government views each model to be.

That is the situation, past, present and (?)future. There are many other issues of contention, but this is likely more than enough to digest at present. I hope that I have answered some of your questions, although I have probably stimulated a score of others. If so, it demonstrates a keen interest among medical students in their education and their future. Many believe us to be a complacent bunch, and if nothing else, we can at least be victorious in proving otherwise. ✧

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1987-88 Scholarships and Prizes - Faculty of Medicine

Lange Awards

Prizes of books published by Lange Medical Publications to each of two outstanding students in each year of the medical program as selected by the Council of the Faculty.

First year	Cynthia Joy Smith Kip Millitz
Second year	Laura Lynn Anweiler Andrew Sak Yu Lee
Third year	Donald Matthew Fuller Michele Lori Vaughn
Fourth year	Frederick Edward Arthur David Richard McMillan

First Year

Verda Taylor Vincent Scholarships

Awarded annually to the students achieving the highest standings in the examinations at the end of first year.

1st	\$700 Marlene Nadia Yacoob
2nd	\$500 Lorraine Norah Tremblay
3rd	\$250 Richard James Orr

Alan C. Burton Memorial Prize in Biophysics

Awarded to the first year student obtaining the highest marks in Biophysics.

Kerry Constance Beal

J.B. Cambell Memorial Scholarship in Physiology

Awarded to the first year student obtaining the highest marks in the examinations in Physiology.

Mark Michael Edward Maslovich

Hippocratic Council Anatomy Award

Awarded to the student in first year Anatomy who demonstrates lab performance as evidenced by marks and enthusiasm. \$75

Marlene Nadia Yacoob

C.V. Mosby Company Scholarship Awards

A book to the value of \$50 given to the student obtaining the highest standing in each of the following first year subjects:

Biochemistry - **Marlene Nadia Yacoob**
Histology - **Lorraine Norah Tremblay**

The Dr. Marvin L. Kwitko Scholarship in Anatomy

Awarded to the student with the highest grade in first year Anatomy. \$300

Lorraine Norah Tremblay

Second Year

Professional Association of Interns and Residents of Ontario (PAIRO) Trust Fund Award

Awarded to a student at the end of the second year of Medicine who has demonstrated academic achievement and has made a significant contribution towards improving the general welfare of medical students. A successful candidate will have demonstrated creative, innovative leadership in one or more of the following areas: a) curriculum development, b) student well-being, c) faculty liaison, d) community involvement. Selection will be made by the Dean of Medicine. \$1,000

Frederick John Smith

Rachel Slobasky Kaplan Scholarship

Awarded annually to the student achieving the highest standing in the examinations at the conclusion of the second year of Medicine.

Tied	Mark Andrew Crowther \$250 Monique Sabina Starok \$250
------	---

Martin and Mary Leboldus Award

Awarded annually to the second year student showing the most promise as a clinician, as demonstrated by performance in Clinical Science, Clinical Methods and Introduction to Clinical Clerkship. \$500

Monique Sabina Starok

Alexander Hotson Memorial Scholarship

Awarded to the student achieving the second highest standing in the examinations at the end of second year.

Tied	Elizabeth Ann Cummings \$200 Darryl Paul Toth \$200
------	--

Upjohn Achievement Award in Pharmacology

Awarded to the second year student who obtains the highest marks in the Basic and Clinical Pharmacology course. \$500 and a plaque.

Monique Sabina Starok

Merck, Sharp and Dohme Awards in Therapeutics

Awarded to three second year students on the basis of performance in Therapeutics as determined by the Therapeutics Course Committee.

1st Tied	Frederick John Smith \$200 Darryl Paul Toth \$200
Third	David Hwei Lee \$100

CIBA Prize

This prize, consisting of a set of the Ciba Collection of Medical Illustrations, is awarded to a student in second year at the discretion of the Council of the Faculty.

Mark Andrew Crowther

M.D.S. Health Group Ltd. Pathology Prize

Awarded annually to the student obtaining the highest mark in Pathology in second year. \$200 (book prize).

Mark Andrew Crowther

Dean Russell Prizes in Neurosciences

Combination Ophthalmoscope and Otolaryngoscope are given annually to the two second year students obtaining the highest standings in Neurosciences.

Bradley Jon Dibble
William James Middleton

Class of '43B Award

Awarded annually to the student obtaining the highest final mark in Clinical Methods at the end of second year. \$100

Calum Ralph Massarella

C.V. Mosby Company Scholarship Award

A book to the value of \$50 to the student obtaining the highest standing in Microbiology.

Donna Lynn Robinson

Third Year

Benjamin Weidenbaum and Cecelia Rotstein Scholarship

Awarded to the students with the highest and second highest standings in third year.

Ronald Richard Komar \$1,000
(Karim) Stephen Lutzak \$750

Martin and Mary Leboldus Award

Awarded annually to an outstanding Clinical Clerk in Third Year. Selected by the Council of the Faculty. \$450

John David Kay

Charles E. Frosst Medical Scholarship

Awarded at the end of third year to the medical student who has shown most promise in the field of therapeutics. \$500 and a Bronze Medal.

Gary Wilhelm Barwitzki

Robert K. Annett Memorial Award

To a third year medical student who during the clinical clerkship has best demonstrated awareness and concern for co-workers, as well as empathy and compassion for the physical and emotional needs of patients. Recommended by the Undergraduate Medical Education Committee on the basis of nominations received from the class. \$500

Leanne Dorothy Birkett

Class of 1951 Frank R. Clegg Memorial Award

Awarded annually to the third year student achieving the best balance of high academic standing and those qualities of compassion and personal commitment generally regarded as essential to fulfillment of a role as a good physician, as judged by the Departments of Family Medicine, Medicine, Obstetrics and Gynaecology, Paediatrics, Psychiatry and Surgery. \$450

Janette Elaine White

Dr. V. Caroline Graham Award

Awarded to a female student standing in the top ten of Year Three as selected by the Dean. \$200

Corrine Mary Gehrels

Carleton C. Whittaker Memorial Scholarship in Psychiatry

Awarded to a student in third year with high standing in Psychiatry and other evidence of interest in the subject. \$225

Sameena Merchant

Leonard Sutcliffe Memorial Scholarship

Awarded to the medical student with the highest standing in Obstetrics and Gynaecology in third year. \$300

Janette Elaine White

Dr. I.W. Mann Award

Awarded to 2 third year medical students showing superior achievement in studies in Family Medicine and demonstrating personal monetary need. \$350 each.

Rosemary Diane Elizabeth Windmoller
(Karim) Stephen Lutzak

John C. Rathbun Memorial Prize in Paediatrics

To the third year student who receives the highest evaluation at the completion of the clinical Clerkship in Paediatrics. \$150

Ronald Richard Komar

C.C. Ross Memorial Prize in Surgery

Awarded to the third year student showing the most proficiency in clinical signs and symptoms leading to diagnosis in Surgery. \$100

John David Kay

Bristol Prize in Medicine

Awarded annually to a third year student selected on the basis of meritorious performance in Clinical Medicine. (Books to the value of \$250)

William Kraemer

Elena B. Wolf Memorial Awards

Awarded annually for essays in the field of cancer research or treatment submitted by students in third year. Awards are presented for the two best essays as judged by a special committee appointed by the Dean of Medicine. Essays are to be submitted to the Office of the Dean of Medicine on or before June 30 of each year.

Christopher Grenville Edwards \$225

Corrine Mary Gehrels \$175

Ishiyaku Euroamerica, Inc./Piccin Nuova Libraria Book Award

Awarded to a student in the Faculty of Medicine who ranks in the top 10% at the end of third year and has demonstrated outstanding clinical skills as judged by the Dean of Medicine. Book Award.

Robert Thomas Black

Fourth Year

Medical Alumni Gold Medal

Awarded to the student graduating in Medicine with the highest aggregate marks during the full course taken exclusively at UWO.

Gregory John Garvin

Alpha Kappa Kappa Gold Medal

Awarded to the medical student with the highest standing in the final two years.

Mitchell Howard Brown

Dr. F.R. Eccles Scholarship

Awarded annually to the student obtaining the highest standing in the final year of the medical course. To enable students of medicine to study abroad following graduation. \$1,200 (tenable one to ten years after graduation).

Mitchell Howard Brown

Class of '55 Prize

Awarded at the discretion of the Dean and Faculty of Medicine to a student in the final year showing outstanding promise in the practice of Clinical Medicine. \$500

Sheena Mary Branigan

Kingswood Scholarship

Awarded to the student in the graduating year in Medicine, considered most proficient by the authorities of the University. \$275

Gregory John Garvin

Class of 1917 Prize

For general proficiency in all four years of medicine. \$200

Donna Anne Cooper

Rowntree Prizes in Medical History

Awarded annually for essays in medical history. Essays may be submitted by students in any year, and will be judged on the basis of historical content, style, accuracy and originality. To be submitted to the Department of History of Medicine and Science on or before May 1 of each year. If no essay is submitted in any year the awards may be given to the students with the best performance on the section of the Medicine and Society course dealing with History of Medicine, as decided by the Department of History of Medicine and Science.

Robert Bruce Reddoch \$100

Timothy John Best \$75

Erik Scott Viirre \$50

Dr. Archibald McCausland Memorial Prize in Psychiatry

Awarded annually to the student achieving the highest standing in Psychiatry at the conclusion of the final year of the medical course. \$400

Lenna Mary Morgan

R.A. Kinch Prize in Community Medicine

Awarded annually to the final year medical student who demonstrates the greatest competence in the community aspects of medicine as determined by the Department of Family Medicine. \$375

This prize was not awarded this year.

J.B. Campbell Memorial Scholarship in Medicine

Awarded to a final year student who has shown outstanding proficiency in Medicine and Clinical Medicine in the final 2 years. \$225

Abha Patel-Christopher



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Dr. Fred N. Hagerman Memorial Prize in Surgery

Awarded to the final year student showing the greatest merit in surgery during third and fourth years, as assessed both by marks in written examinations and performance in clinics. \$350.
Mark David MacLeod

Dr. Marvin L. Kwitko Scholarship in Obstetrics and Gynaecology

Awarded to the student in the final year of the program who does the best work in Obstetrics and Gynaecology. \$250
Susan Ruth Ulan

Ivan H. Smith Memorial Prize

Awarded to the final year medical student demonstrating outstanding interest in Radiation Oncology. \$200 (book prize)
Thomas Cameron Tweedie

Dr. Henri Breault Award

Awarded to the fourth year student who receives the highest evaluation at the completion of a fourth year elective or selective in Paediatrics. \$200
David Richard McMillan

Abbott Prize in Anaesthesia

Awarded to a fourth year student who has shown outstanding interest in the specialty of Anaesthesia. Marks in third year clerkship and performance during fourth year will be considered. \$150
David Sujit Viswanatha

Horner Medal in Ophthalmology

Awarded to the final year medical student showing the highest proficiency in Ophthalmol-

ogy in all years of the medical course. Silver Medal.
David Jeffrey Cohen

Horner Medal in Otolaryngology

Awarded to the final year medical student showing the highest proficiency in Otolaryngology in all years of the medical course. Silver Medal.
Robert Hamilton Ballagh

Andrew D. Mason Memorial Award

Awarded annually to a final year medical student for elective work in a developing country under the Medical Electives Overseas Program, as chosen by a special committee appointed by the Dean of Medicine. Established in memory of Andrew David Mason, who died while on elective in Nepal. \$150
Donald Louis Melady

Ontario Medical Association Prize in Preventative Medicine

Awarded to the most able student in the final year in Clinical Epidemiology and Biostatistics. \$100
Gregory John Garvin

Hewlett-Packard Top Medical Graduate Award

Awarded to the five graduating students who ranked highest academically at the conclusion of third year and who satisfactorily completed all fourth year courses. Each award consists of a Hewlett-Packard calculator and HP Rappaport-Sprague Stethoscope.
Mitchell Howard Brown
Donna Anne Cooper
Andrew George Brockway
John Alden Dawdy
Robert Hamilton Ballagh

University of Western Ontario Award in Cardiology

Awarded annually to the student in fourth year completing work in Cardiology who best demonstrates interest and ability in this field as judged by the Department of Medicine. \$80
Graham Nichol

Radiologists of Western Ontario Award in Diagnostic Radiology

Awarded annually to the student in the final year showing the best standing and achievement in Diagnostic Radiology throughout the medical curriculum. \$200
Thomas Gordon Paul

Sandoz Book Prize

Awarded annually to the student in the final year showing the best standing, achievement and greatest interest in Endocrinology. \$150
Peter Rolland Couroux

Collins Memorial Prize in Geriatric Medicine

Awarded annually, subject to a suitable candidate being available, either to a student who undertakes an elective in geriatric medicine and demonstrates understanding, skill and knowledge in the management of elderly patients, or to a student who completes a research project or an essay on an aspect of health care for the elderly. For those doing an essay, essays must be submitted to the office of the Dean of Medicine on or before April 15 of each year. \$150
Robert Cameron Turliuk

W.H. McGuffin Scholarship in Radiology

Awarded to medical students in any year having an article accepted for publication in the UWO Medical Journal on a subject pertaining to Diag-

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nostic Radiology or Nuclear Medicine. A copy of the article must be submitted to the office of the Dean of Medicine on or before April 25 of each year.

Robert Cameron Turliuk

Bill Mood Memorial Award

Awarded to a member of the graduating class who has demonstrated a breadth of interests, both academic and non-academic, and who, in the opinion of the student's peers is felt to have the professional and personal attitudes important in pursuing a successful career in family practice. \$500
Julie Katherine Allen

John William Rohrer Memorial Award

Awarded to the final year medical student, who in the opinion of the Dean, Faculty of Medicine, and the Hippocratic Council, has contributed most significantly to the improvement of the quality of all aspects of the lives of undergraduate medical students - academic, social and personal. \$650
Tracey Ann Therese Moriarity

Robin Middleton Memorial Award

Awarded to a student in the final year who, in the opinion of classmates and Faculty, has been a medical student of moral worth, who has contributed to the life of the medical students and shows promise of being an outstanding practicing physician. \$825
Mitchell Howard Brown

Dr. Glen S. Wither Memorial Award

Awarded to the final year medical student who, in the opinion of peers and associates, demonstrates the high attributes of the physician - integrity, concern for patients, compassion, and a devotion to the profession. \$1,000
Donald Louis Melady

Roche Scholarship

Awarded to a final year student at graduation, for work in the two final years of the course. It will be based on the general lines of the Rhodes Scholarship, in which proficiency, progress and leadership will be evaluated by a board of assessors. \$50
Diane Katherine Whitney

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	Cathy Caron	Meds '89

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