We would like to thank Dr. Martin Inwood for his article on the merits of maintaining this publication in this, the third edition of the 1988-89 Medical Journal. It sparked our own curiosity about this aspect of Western's heritage, and inspired a fascinating excursion into the Journal archives, resulting in our cover, and this editorial.

The University of Western Ontario Medical Journal was launched in 1930, when faculty and students felt..."that there should exist an organ (sic) to record not only the social experiences of the Medical School, but also to express the thoughts of the students on subjects ranging from scientific treatises to the relationship of their chosen profession to society as a whole."

Since its inception, the Medical Journal has achieved these objectives and become a permanent record of the people and the issues which shaped their experiences at this medical school. Leafing through the yellowed pages of Journals going back as far as 1931 (our first edition, December 1930 is missing in action), leaves one with the lasting impression that what shapes a medical school is its people. The people that you and I recognize today as notable (or notorious!) within our medical community, took an early interest in contributing to the social and academic conscience of this institution.

What these individuals have in common was a desire to speak out about something that they believed in, or about which they had a special interest. Their excursions into journalism were not necessarily great prose, but they did distinguish themselves by becoming an integral part of the Western scene and contributing to the reputation that the medical school has today.

When Martin Inwood was editor of the Medical Journal (1967-69) a staff of 26 (all medical students) churned out four 50-page Journals a year. The quality of the publication at this time earned it the Frost Trophy for the Best Canadian Undergraduate Medical Journal. Over the years, the quality of the Journal has continued, however, the financial support has been eroded, culminating last year with the withdrawal of faculty funding due to budget cuts.

Financial restraints aside, the strength of the Journal always has, and always will be people. We would like to take this opportunity to call upon the many talents that we know people bring with them to medical school. Whether those talents are literary, organizational, artistic, photographic, pornographic (oops!), or just plain enthusiastic, there is a place for you in the pages of the Journal.

We invite individuals that feel that they would like to make a contribution to the Medical Journal, and in turn to the legacy of the University of Western Ontario Medical School, to do so. When you graduate from this medical school you will take many memories with you. Let's hope that you leave some behind.

Warren Teel, Meds '90
Connie Nasello Paterson Meds '91

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I've Got Sunshine... - Tachy '89

Yeah! As the first refrain of that familiar tune, 'My Girl,' washed over the audience, it became obvious that Tachy '89 was to be a class act. Co-producers Mike Ertel and Brad Dibble treated the audience to their considerable talents. Be it singing, dancing, acting their way through a Bad Interview, Mike and Brad handled themselves with aplomb, wit, and raisins. They made sure that everyone had a grape time.

AHS picked up where the hosts left off, with their own demonstration of what a production is all about - song and dance! King Butt turned out to be a hilarious and very professional number carrying on the tradition of fine AHS productions.

Meds '92 - Wow! This is a class with something on its mind. Their version of Entertainment Tonight proved to be...that is to say...well, um...you know what we mean! Their enthusiasm, spirit and incredible class participation shows that we can look forward to many scintillating productions in future.

Meds '91 took us on a search and destroy mission through the body of the disease-ridden Camelot. This class went to great expense with their costumes and set (rumoured to be 52 million dollars!) to bring this medieval extravaganza to the stage.

After a somewhat rocky past, Nursing hit the stage this year with their "Bad Habits," and showed us all that 'It's What's Inside That Counts'. Their production earned them a very deserved honorable mention for most improved script.

The class of Meds '90 showed once again that their passion for comedy is only exceeded by their passion for the stage. Their version of The Grinch prompted several consultants to comment "We're obviously not working these clerks hard enough!" Their costumes, dancing, and musical arrangements (courtesy of the now legendary talents of Akira Sugimoto) earned them the award for the best production number and turned the judging for best overall play into a real horserace.

But the highlight of the evening was Meds '89 with their production of "The Wizard of Oz". The main characters delighted the audience with their own colourful portrayals of this film classic. The graduating class dazzled the audience with their stage presence, their extremely elaborate sets, and spectacular costumes, which earned them the award for the best overall production. Their flair for comedy will be missed.

Most of all, we should remember what Tachy '89 was all about - a chance for everybody to escape the drudgery of school for a while. To put our hearts and minds into something that is just for fun, a chance to sing and to dance one week to just fantasize and be anything that we want. Yeah!
UWO Medical Journal – A Worthy Institution

by Martin J. Inwood, M.D.
Professor of Medicine

It is a simple question - should we maintain the UWO Medical Journal? My immediate response is to the affirmative - after fifty-eight volumes it must be performing a reasonable function, otherwise it would have succumbed to the years as other worthy student/faculty endeavors have. On reflection, I realize I am biased as usual and, to boot, unrealistic. As a UWO graduate of the infamous class of 69, my enthusiasm is undoubtedly tempered by my having been a previous editor of the publication and having enjoyed myself immensely in that role. Further, I had to admit that the publishing record of the Journal could best be described as fitful over the years. At this particular time of its progression, the Journal is an informative publication and is published regularly. This performance quite correctly reflects well on a dedicated pair of undergraduate students with ongoing support of the Hippocratic Council. The faculty are usually involved in a passive but by no means unified manner. Nevertheless, I understand the publication is not on a firm fiscal or operational foundation. As a result, I would well be, the school of University and faculty cost constraints, that any venture which is not financially and operationally secure risks discontinuation solely as a cost-cutting device. Therefore, if one is to encourage the continuation of the Journal within this Faculty and University Department of Medicine and I am totally convinced, this is why we need such a publication. Faculty perceive themselves as individuals able to answer all questions with authority and conviction, it seems not unreasonable that I should attempt a response as to why the Journal requires our continued support and encouragement. Furthermore, it seems reasonable to assume that apart from the material needs for a publication, enthusiasm, innovation and pride in production, are necessary components for any house publication to be successful for its target audience. Conversely to state that the Journal is and must remain the collective conscience of students and the faculty is hyperbole in its worst form.

Detractors of University Faculty publications spawned by the student body would no doubt argue that regardless of material resources used undergraduate students cannot afford to spend their efforts and energy in such a frivolous and futile enterprise. The curriculum, courses of instruction and other learning experiences demand too much of the modern undergraduate student of medicine and for that matter, their aging and greying faculty members. Gone are the leisurely days of socializing in anatomy, plodding patiently through laboratory courses and spending afternoons in stuporous lectures. The knowledge base necessary for the undergraduate to digest or assume in order to graduate or pass Canadian Council examinations is such that all efforts must be given to these objectives. I cannot subscribe to such attitudes even though I do not consider myself a scholastic nihilist, contrary to popular opinion! Socialization has always been an important part of any medical student’s existence and indeed for any practising physician. I therefore, provide the following comments to support the continuation of this currently fragile, but worthy, publication.

TRADITION
The Faculty of Medicine (dare that I could state as in the good old days “School of Medicine”) has lost many of its traditional activities to time and circumstance. The Osler Club, Alpha Kappa Kappa, the Med’s Picnic, 3rd and 4th year party are just some of the institutions and their jealousies to the passage of time. Some would no doubt state they rightly deserved to expire but others, including myself, would not share their convictions. These events and organizations were generally lost on the vine because there was not a sufficiently strong enough supportive organization within the Faculty to sustain them. Therefore, even with the best efforts of the Hippocratic Council, survival of any organization within the Faculty is very much at risk because of changing times, fragmentation of our student classes and equally our Faculty departments. God forbid that we should venerate tradition for tradition sake, nevertheless, any institution which takes pride in current activities always respects its roots and original foundation. The Journal, along with Tachycardia represent such a tradition, albeit tradition with often a fanciful and humorous objective. Tradition does not imply change, rather it represents the distillation of activities which are worthy of continuation and faculty support. Let us not lose the Journal and so again provide no sense of continuity for our already somewhat bewildered and/or demoralized Faculty.

ALUMNI
Our continuing tradition must include the accomplishments and involvement of our Alumni. I am continually surprised with the emergence of UWO Faculty of Medicine graduates making distinctive and significant contributions to provincial, national and international medicine. They deserve recognition and publication of their work in our Journal. I can assure you that our Alumni Honorary Editors are great success and is always eagerly anticipated by a large number of Alumni who look remarkably undistinguished and increasingly older on their repeated attendances at five yearly intervals. Meds ’69 are due for another reunion this year and I cannot recognize the number of Alumni in the homecoming parade! What better vehicle than the Journal to record their continuing involvement in their alma mater on an occasion such as this. Senior members of the Faculty and members of the University External Affairs staff could also suggest a more pragmatic reason for their involvement namely that the Alumni constitute a significant and important source of continuing external funding for the Faculty and University. Equally, I am sure that the editorial staff recognize the advantage of a national circulation to the Alumni and other subscribers when attracting advertising income to maintain the Journal in a secure financial position.

FACULTY AND STUDENT ISOLATION
Without wishing to vilify or embarrass any one particular group, or institution, it is within the Faculty, it is not unreasonable to comment on how difficult it is to provide a common focus or activity for our Faculty of Medicine. The Dean’s office can no doubt more fully appreciate this difficulty. I have now reached the stage where I cannot recognize the names of even individuals who have recently joined the University Department of Medicine and I am totally defeated if I try to identify who the main or minor players are in other departments who concentrate their activities on “the Hill”. Therefore, the disadvantage of having faculty in the three teaching hospitals, innumerable private practice offices, the departments on the main campus and other institutions in London all contribute to the continuing isolation and fragmentation of our faculty and support staff. The student body is by no means immune from this by virtue of the curriculum, course design and patient location. First year rarely sees fourth year (which may be to the latter’s advantage). Second year is spent in auditorium B, University Hospital. Third year is rarely seen together except for their usual magnificent rally at the time of Tachycardia. The Journal is well able to provide the fabric in which the common thread for all of these groups (so to speak) is provided to us yearly. In our days the “Bucket of Blood - Victoria Tavern” on South Street was considered an appropriate venue along with the Alpha Kappa Kappa fraternity house aided, of course, by a curriculum which centered around the clinical sciences at the South Street Campus of Victoria Hospital. Therefore, interhospital, interclass and interfaculty socializing and communication was assured. It is disconcerting to realize that the Journal is one of our last chances to foster this tradition, but it is the reality of the situation.

ASPIRING AUTHORS.
Even drivel (such as this) takes time to write. Whether one uses a writing tablet, lap top word processor, or other electronic device, the stuff of academic medicine still requires the individual to report their observations and opinion in a rational and reasonable manner. For those of us who regularly joust with a variety of peer reviewers journals, having material published is not without difficulty and personal dismay. Rejection seems for most of us to come along at very frequent intervals. For the novice, having an article published, no matter how, when or where, is often the necessary literary jump start to a successful albeit modest publishing career. The Journal is able to provide that start, recognizing that one’s peers can often be the sternest of critics. An axiom of the faculty is ‘Never expect praise from your fellow departmental members, you can only expect that at home or abroad’. Nevertheless, faculty, fellow students and other readers can often provide the novice with important observations and encouragement which they might never receive if the material was published in esoteric or arcane avenues catering to specialized groups. As Dr. D. Spence, of the Department of Medicine, recently alluded to in this Journal, a public display of ignorance and ineptness is by no means unreasonable or inappropriate for the student in attracting the attention of faculty and fellow workers. Equally, it is an advantage in these days of residency cuts etc. for the student to assume a personal initiative and receive the recognition successful publication attracts when they perform good work or have involved themselves or others in a worthy activity.

FACULTY FLAG WAVING
Faculty members and students have every good reason to flag wave and trumpet blow according

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continued........................................... page 5

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A Worthy Institution (continued)

ognizing that self-aggrandizement is invidious but necessary in these self-gratuitous times otherwise it is perceived by others that, incorrectly, nothing is happening!! In general we can be very proud of the innovative and unique contributions made by the Faculty over the years. I would, however, be the first to admit that mentioning the University of Western Ontario does not always evoke immediate recognition or acclaim in other parts of the world. Our international contributions are usually secure once people know that our University resides somewhere between Detroit and Buffalo! The University publications endeavor to report our accomplishments and as the annual Faculty report testifies that the Faculty is very successful in keeping up with the "publish or perish" syndrome. Convocation regularly recognizes our own eminent innovators. Therefore, our Journal should continue and improve on a venue for the same purpose and in particular carefully select the audience to which its efforts are displayed and subscribed to. The Faculty of Business Administration have been particularly successful in causing their own in-house Journal to evolve into a national and internationally respected publication. As such it is regarded as a very important vehicle for the University as well as for publications. We all have to recognize that public relations, although not considered a worthy endeavor by the majority of the medical profession, nevertheless, is necessary in order for our Faculty to exist in complex organizations with competing interests. The Faculty of Medicine is continuously enduring serious budgetary and personnel constraints - it needs all the appropriate positive exposure of its activities it can get in order to ensure our continuing growth and survival. Dare I add, that one function of our Journal should be to inform the policy and opinion makers who are so prevalent in government and various administrations, of what our opinions and solutions are to serious social and medical problems. Appropriate distribution of the Journal to these groups and other individuals, I am convinced, would do much to assure us of at least some recognition if not continued support.

CONCLUSION

I am sure that the more innovative members of the Faculty could well entertain more reasons why the Journal should be continued. My intent is merely to spark enthusiasm for support which I am sure resides in most of us. Undoubtedly the answer to the original question is that the Journal must continue to be maintained and indeed to be encouraged in a very positive and pragmatic manner. We have every reason to consider corporate plans, objectives, along with all the rigors of funding and accountability for our Journal. In my opinion it is too much to ask the student body to assume all of these responsibilities. Their enthusiasm and lack of bias make them the ideal members of an editorial board. Nevertheless, the main apparatus must be maintained by a defined operational plan supported by dedicated and ongoing support from within the administrative echelons of the Dean's Office. Without such continuing support, I fear that for the reasons stated that the Journal will suffer a natural death, despite the very best efforts of individuals from year to year. I trust I will proven wrong because Tachycardia has managed to survive very successfully and seems to have excellent prospects for the future. Nevertheless, I would hazard a guess that one of the reasons it continues to survive is that it constitutes the main funding source for Hippocratic Council and for undergraduate activities within the Faculty. The Journal similarly needs to be viewed as indispensable to the Faculty and that this indispensability be fueled by a commitment from Faculty Council. A defined operational plan needs to be put into place thus assuring its future as an important activity of the Faculty of Medicine.

Working to keep your trust.

The Upjohn Company of Canada, 865 York Mills Road/Don Mills, Ontario
Legal issues are becoming increasingly important in the practice of medicine. Both the United States and Canada have experienced a dramatic increase in the number of medical malpractice suits filed against physicians. In the United States in 1986, for example, 13 medical practitioners per 1000 were involved in litigation. Currently Diagnostic Radiologists are considered low risk for malpractice suits compared to their colleagues in such specialties as neurosurgery, orthopedic surgery, or OB/GYN. This situation may change due to an enormous expansion of radiologic techniques and a greater reliance on the radiologist for the diagnosis and treatment of disease. The benefits of examining the legal aspects of radiology are twofold: the avoidance of medical litigation and an improvement in patient care.

Controversy has existed over who should explain to a patient the risks and benefits of a radiologic procedure. Traditionally, radiologists have relied on referring physicians to discuss with their patients the nature of the requested examination. Radiologists contend that most referring physicians know their patients well and have earned their patients' trust. They feel the referring physician is in a better position to explain why a particular examination has been ordered than a radiologist who will meet only briefly with the patient. Many patients are left more distressed than informed if they are told by the radiologist about the risks and benefits immediately before the procedure. They are not given any time to think the procedure over and feel pressured to consent. In 1983, in response to a growing concern by physicians about their legal responsibilities, the College of Physicians and Surgeons of Ontario issued guidelines for obtaining consent. The guidelines state that radiologists are autonomous physicians with the same responsibility to patients as their referring colleagues. While it is desirable for a referring physician to discuss proposed investigations or therapies with patients, radiologists who carry out the radiologic procedures are ultimately responsible for obtaining the patient's informed consent.

Informed consent is a key legal term. It is used to define a patient's acceptance of a medical treatment based on a discussion of the risks and benefits of that procedure by the patient's physician. In Canada, a precedent discussion of informed consent evolved from the classic case Reibl v. Hughes in 1980. Reibl, the plaintiff, sued Dr. Hughes, a neurosurgeon who had performed a left carotid endarterectomy on the patient in 1970. During or immediately following the surgery the patient suffered a massive stroke which left him paralyzed on the right side of his body (and also impotent). Although the plaintiff had formally consented to the operation, he alleged that he had not been "informed consent" because he had not been given all the material risks associated with the operation, including a 'grave risk of stroke or worse'. The Supreme Court of Canada gave judgement to the plaintiff and established criteria for the determination of informed consent.

Informed consent is defined in "An Introduction to the Law Governing Physicians and Surgeons", prepared by the U.W.O. Faculty of Law. To be valid, the consent must be 'voluntarily given and based on a full and fair disclosure of the nature of the procedure and any material risks or complications (where a material risk is defined as a low percentage risk of a serious nature or a high percentage risk of a minor nature). In addition, "Any risks which are not material yet of such nature that the physician knows or ought to know that they would be important to the patient must be given and any questions pertaining to the procedure must be answered fully and frankly." In his article "An Overview of Informed Consent for Radiologists" published in the American Journal of Roentgenteraphy, Reuter states the patient should be informed about alternate procedures and about the risk of not having the procedure at all, so that he can balance these factors against the benefits to be derived and can make a reasoned and intelligent decision about his course of treatment.

Informed consent evolved from the patient's right to self-determination in the course of medical treatment. Failure to obtain any consent constitutes the tort of civil battery. Failure to obtain informed consent was initially considered civil battery but now is tried under the tort of negligence. A negligent act is one which falls below a reasonable or accepted standard. A physician who fails to disclose the relevant risks and complications of a procedure to a patient has not obtained the necessary informed consent. Such an omission, therefore, would be considered negligence.

Difficulties in obtaining informed consent are faced by radiologists daily. Certain groups of patients, such as small children, the severely mentally retarded, and some of the mentally ill, some elderly patients and those on drugs which decrease mental capacity are incapable of giving valid informed consent. Parents or legal guardians are permitted to give consent on the patient's behalf. However, many patients do not have a legal representative and the radiologist is forced to obtain substituted consent. Although it is standard practice to obtain the next-of-kin's consent to treat such patients, the courts have not resolved whether such substitute consent is valid. Provided that the next-of-kin acts in good faith and the procedure is in the patient's best interests, physicians are told the courts will likely uphold the validity of the substituted consent.

While the concept of informed consent is not new, the methods used to evaluate it in court have recently changed. Previously, the standard for the required disclosure of information followed a reasonable-physician approach. When a patient filed a lawsuit claiming damages from a complication of a procedure performed by a physician, the courts judged the adequacy of patient's testimony by comparing it with the information that a reasonable physician would have revealed under similar circumstances. This posed a problem for the plaintiff (patient). He had to obtain an expert witness to testify how much information a reasonable physician would disclose to a patient. Expert testimony is occasionally difficult to find because some physicians were reluctant to testify against their colleagues. The requirement for expert testimony presented an advantage to the defendant physician. Consequently, Canadian courts have moved away from the reasonable-physician standard to the reasonable-patient standard.

The reasonable-patient standard judges the information that a physician needs to disclose to a patient by what a reasonable patient would need to know in deciding on a course of treatment. This is in contrast to what a reasonable physician would wish to disclose. The primary problem for physicians is knowing how much information a reasonable patient would need. Courts and juries try to decide what an abstract, average, reasonable patient would need to know, as opposed to what the specific patient plaintiff in a case would want. In general, materiality of a risk equals severity x incidence, with an emphasis on severity.

One issue faced by radiologists daily is whether they should obtain informed consent from patients receiving intravenous urograms, contrast myelograms for CT, venograms, etc. If so, which risks and complications should be disclosed? Patients are routinely forewarned about common minor side effects such as a feeling of warmth, headache or nausea. However, the incidence of more severe complications such as thrombophlebitis, anaphylaxis or cardiac arrest and even rare, untimely death are IV contrast agents, is about 1/100,000. In the opinion of Reuter, "any procedure that has a risk of death for which a numeric prevalence can be placed probably becomes a material risk." Considering the occurrence of death or serious complication regardless of its incidence, patients may refuse to consent to a procedure involving intravenous contrast injection. This is an unfortunate consequence of the movement towards informed consent since patients rarely appreciate the unlikelihood of the worst outcome of the procedure.

The controversy over intravenous contrast agents has heightened with the introduction of new, low-osmolality, ionic or nonionic agents. Recently in Ontario, inquiries were held into the cases of two young adults who collapsed and died after receiving IV injections of contrast medium despite prompt and expert attempts at resuscitation.

One of the recommendations of the jury was a request for the replacement of conventional high-osmolality contrast media (diatrizoate meglumine/sodium [Renografin]) with low-osmolality contrast media (iohexol [Omnipaque]) for procedures requiring intravenous injections of contrast. These recommendations followed the results of a recent Japanese study which showed an approximately six-fold decrease in the incidence of severe adverse reactions in non-ionic versus ionic contrast media injections. (It is well accepted that the low osmolality, non-ionic agents significantly reduce minor reactions as many of the effects of conventional contrast agents are related to their marked hyperosmolality in blood). The major dilemma faced by radiologists is attempting to justify the almost tenfold increase in cost of non-ionic media for a small but significant decrease in serious adverse side effects (from approximately 1 in 500 to 1 in 3,000).

With the present Ontario Government trying desperately to control escalating health care costs, hospitals are operating under severe
financial restraint. It is unlikely most centres will be able to afford the universal use of non-ionic agents until additional funding is provided. Present guidelines recommend that if the use of new media is limited by financial constraints, then patients perceived to be at high risk for adverse side effects should be considered first. High risk patients include infants, the elderly, patients undergoing venography, patients with diabetes, cardiac impairment, renal impairment, hemoglobinopathy, asthma, anxieties or allergies and those who have had previous reactions to contrast media. The Canadian Medical Protective Association recommends a patient should be told that there is a safer alternative to ionic contrast media. The difficulty faced by radiologists is trying to inform patients about the availability of new contrast media which will not be given to those considered at low-risk.

Informed consent plays such a significant role in the determination of medical negligence because it protects patients' rights to choose their course of diagnosis or treatment based on expert advice given by their physicians. Lawsuits alleging lack of informed consent, however, usually are not filed unless the patient has suffered a severe injury. The patient attempts to prove to the court that if he had known the risks and the alternate procedures available, he would have rejected the procedure or would have chosen an alternate procedure. Most physicians resent this argument. Despite their best performances, they know a small proportion of patients will develop complications unforeseen prior to the procedure. They contend that in retrospect it is natural for a patient to claim he would have refused the procedure. In addition, physicians are angered because the great number of patients which they were able to manage without complications are not considered. For many consultations, the time spent with the patient obtaining an informed consent before the procedure may be the only opportunity for the radiologist and patient to get to know one another. Obtaining consent commits that patient to accepting responsibility for deciding on a course of treatment. Equally important, however, is the respect and trust developed between the radiologist and patient. Such report can lessen patient dissatisfaction and, in the event of a complication, discourage malpractice action.

REFERENCES

The Medical Record: will it one day be paperless?

by D. A. Lloyd, M.B., B.Ch. FRCP(C)
Director, Computer Based Learning Centre

One of the critical elements in the practice of medicine is the development and maintenance of the medical record. The level of detail with which data is kept, the method of quantifying a finding, and the format of the record layout varies to such an extent that it is difficult in many instances to understand the patient's problem(s). Efforts to improve the medical record to make it into a useful tool not only for patient care but also education and epidemiology began with the Problem Oriented Medical Record (POMR) inspired by Dr. L. Weed (1-4).

The format of the POMR, which has now been in use for over 20 years begins with a list of all of a patients problems. Any further notation would be by problem followed by data. This form of record keeping offers a much more structured method for maintaining medical data than the traditional "free-form" record. While it has not been possible to demonstrate improvement in medical care, it has been shown that the record does influence the way a physician approaches the patient, and, where required to identify a goal for each problem, physicians do utilize medical services less frequently (5).

Paper medical records have an inherent difficulty in only being able to display the data in the format that it was originally recorded. Thus, while the strength of the POMR is that it imposes order on the medical recording and decision making process, its lack of flexibility as a single portion of the patient's overall management is displayed at any one time. The picture can be "viewed" through the problem list but a panoramic view is not possible. It is therefore necessary to refer to the medication list and then backtrack through the data base. Interrelationships between problems cannot be readily examined (6).

The second area of the failure of the conventional record to satisfy the needs of medical consumers is in communication between physicians and between physicians and their patients. The family physician quite rightly usually has the largest data-base which is a compendium of notes collected by himself, results of investigations and, consultation notes from other physicians. To compound this, many patients are evaluated and treated in hospitals in further data collection. A single patient can therefore result in large amounts of information being collected in varying formats. The consequence is often duplication of effort and waste of medical manpower and financial resources. It is not uncommon for tests to be repeated simply because the previous result is not immediately available.

The patient as a consumer and the person responsible for the financial resources to maintain the system, is unfortunately caught in the middle of what is generally an "organized muddle" that fortunately, usually has a successful outcome! At no time does the patient have easy access to the record of his own health care; in fact patients usually have more information about their automobiles than themselves. Dr. L. Weed has suggested that "once the problems are defined and the doctor and patient set goals together and work through the same record, the malpractice problem may diminish, and we may begin to gain some real insight into the problem of over-utilization of medical care" (7).

The challenge for the future of the medical record is to define the components of the ideal record and develop methods to ensure dissemination of the record to all interested parties while maintaining confidentiality. The computer may in fact be the solution.

The ideal medical record should include the following components:

- it should always be in a format that can be read,
- it should be acceptable to all users. Physician acceptance is affected by a naturally conservative approach coupled with an expectation of a significant and reliable improvement before change is made,
- it must provide evidence of completeness and accuracy,
- demonstrate sound analytical thinking coupled with good clinical judgement,
- it should neither be physically nor sequentially constrained.

I.e. it should be possible to access different parts of the record thus allowing a chronologic review,
- the format should be such that review and audit can easily be achieved.

It will become apparent to the reader that the POMR developed by Weed in the 1960s meets many of these requirements. The difficulty is the inability to move effortlessly around the full record in its paper format.

From the beginning, the purpose of the record was to provide data about the medical history of the individual patient, it is a means by which the patient, is an extension of the physician and, was considered to be the personal property of the physician.

In reality, the typical patient is cared for by the general practitioner, staff of the local hospital, and numerous other health practitioners. The record now serves as a single portion of the patient's overall management is displayed at any one time. The picture can be "viewed" through the problem list but a panoramic view is not possible. It is therefore necessary to refer to the medication list and then backtrack through the data base. Interrelationships between problems cannot be readily examined (6).

Another consequence of the changing use of the medical record has been an erosion of confidentiality. The record now serves as a single portion of the patient's overall management is displayed at any one time. The picture can be "viewed" through the problem list but a panoramic view is not possible. It is therefore necessary to refer to the medication list and then backtrack through the data base. Interrelationships between problems cannot be readily examined (6).

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References

In defense of HSO's

Dear Editors:

Thank you very much for providing me with copies of the Medical Journal again this year.

I read with particular interest the articles in the January 1989 issue concerning payment mechanisms. I wanted to react to some of the observations and comments contained in Barbara Heller's article which reported on the O.M.A. program "Quo Vadis". My primary concern is to correct some misimpressions produced by information supplied by Dr. David Peachy and Dr. Adam Linton. Drs. Linton and Peachy have become the spokespersons for the Ontario Medical Association in several areas of health economics but unfortunately continue to confuse many of the myths and facts around HSO's. The result in Barbara's article is a restatement of the somewhat confused O.M.A. position on HSO's which may lead your readers to incorrect conclusions.

As a member of the Mustard Task Force which studied the HSO model in considerable detail six years ago and made recommendations to the Ontario Government concerning their pros and cons and how best to fund them I feel that I need to clarify some of the points in the article.

HSO's are not a panacea nor are they the appropriate funding mechanism for all patients and all physicians. However, they do offer some major advantages to primary care physicians interested in stressing cost effective care, preventive medicine approaches, and better use of paramedical help. The Government feels that the inherent predictability of costs under an HSO system has some major advantages and as well, as noted in the article, there probably will turn out to be some major costs savings to the Health Care System if and when a larger proportion of the population is cared for under this model. Most physicians who have tried an HSO funding arrangement are extremely pleased by the flexibility such a system provides and in most cases by the improved financial rewards for providing good and comprehensive care. The HSO funding model has been in use in Ontario for over 25 years and is by no means new or untried in that sense.

To specifically correct some misimpressions I would like to make some specific comments as briefly as possible:

1. Enrollment in an HSO is entirely voluntary on the part of the physician and patient and with notice either party can terminate that particular funding arrangement. A physician is under no more ethical or legal compulsion to see a patient who requests care than a fee for service physician. Either physician must respond to a legitimate needs for care or advice, and the patient always has the option of going elsewhere for a single service or all services if they are unhappy with the HSO.

2. Most HSO's are funded only for primary care services and there is no penalty for referring a patient to a consultant. Therefore, there is no disincentive to refer a patient. In fact some of the critics of HSO funding would make just the reverse point that its theoretically easier for the family physician to refer the patient for complicated problems than to take the time and energy himself to sort out a more complicated problem.

Some HSO's do have on staff certain specialties but the theoretical pressure to use that consultant exclusively is no different than any other group practice that works on fee for service and shares income and profits.

3. There is absolutely no reason that an HSO would interfere with a doctor patient relationship as proposed by Dr. Linton and Dr. Peachy. An HSO internally functions in just the same way as any group practice in terms of patient relationships. Patients still have choice of physician and if anything HSO's find that the doctor patient relationship is strengthened by the sense of partnership felt by doctor and patient in promoting health rather than treating episodic illness on a piecemeal basis. For example with health education is usually a problem and part of an HSO.

4. The quality of care provided by a physician in an HSO will have the same variables as any physician in solo practice or group practice funded on a fee for service basis. An HSO does not inherently alter the quality of care.

5. Studies which have been done on the hospitalization rate of patients in the HSO in Ontario have all been corrected for age and sex. It is very dangerous to draw conclusions from American HMO studies on patient outcome given the multiple other factors that play in both the American scene and in the broader more complex dynamics of an HMO rather than an HSO.

Finally I would agree with Barbara Heller's conclusion that a teaching of managing health practice wisely should be done. As coordinator of the fourth year compulsory course on cost effectiveness I look forward to having her at our sessions two years from now.

Gary Gibson, M.D., CCFFPCFP
Assistant Dean - Continuing Medical Education
The College of Physicians and Surgeons of Ontario is the self-regulating body for medical doctors in the province. The mandate of the College is set out in the Health Disciplines Act. The College is charged with the responsibility of regulating the practice of medicine in Ontario in order to protect and serve the public interest.

The duties bestowed upon the College by the Health Disciplines Act are very broad. They include: establishing, maintaining and developing standards of knowledge and skill among physicians in the province; developing standards of professional ethics; establishing standards of qualification and practice for the practice of medicine and other activities related to human health care which the Council of College considers desirable.

The medical profession has been granted a great degree of authority over its own policing and regulation, and that authority is exercised through the College. This system of self-regulation is premised on the fact that the College must act first and foremost in the interest of the public.

A number of the College’s activities are specifically designed to respond to that basic trust. The College is required by legislation to have Complaints and Discipline committees, and to fully investigate all complaints put forward by the public against doctors.

Furthermore, in closely monitoring the qualifications of applicants for a medical license and maintaining a peer review system for practicing physicians, the College helps to make sure that the public is protected from unqualified or incompetent practitioners.

To successfully fulfil its role in protecting the public, the College must be accessible to the public it serves. For that reason, the College has produced information pamphlets on the College and its activities on behalf of the public. These pamphlets are available through public libraries, MPP offices and public interest groups. The College reports to the public and its members in a yearly Annual Report.

The College is also involved in activities to assist its members maintain high standards of medical practice. The college researches issues of concern to the profession and provides guidance in many areas of medical practice. A quarterly publication, College Notices, is mailed to each member of the profession to alert them to important areas of concern, and discipline cases are fully reported to the membership and the public through a quarterly report of proceedings. Through this report, the profession is alerted to current standards of practice in many areas as well as to many potentially dangerous problems.

In all of its activities, the College’s fundamental concern is to protect the rights of the public, as this must be the ultimate objective of effective self-regulation for any profession.

Please feel free to contact the College if you have any questions. Our toll free number is (800) 268-7096.
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