

*President's address
London, May 2nd, 2006*

***BEYOND TOMORROW – SOME CHALLENGES FOR OUR
MEDICAL SCHOOLS***

Good afternoon.

This is a rather lofty title to be addressing in 10 to 15 minutes, so it truly will be a snapshot of some challenges.

Rather than ending my address with a number of thank yous, I wish to begin with them. I arrived as the President and CEO of AFMC on October 15th, last year. Since then I have been supported by so many colleagues in my new role. In particular I would like to thank my predecessor, Dr. Hawkins, who has supported me with a wonderful amount of wisdom and suggested important strategies and diplomacy for me to employ. David has given freely of his time and has helped me familiarize myself with many issues.

I could not be where I am today without the tremendous support of Sue Maskill and Claudine Le Quellec. The two of them have been just outstanding. Many of you know Sue well. She is the repository of so much relevant and important information relating to AFMC. She can solve so many problems for me so that it makes my job much easier. Claudine is wonderfully adept at making connections for me, keeping my agenda on track and providing sage advice as to the history of a number of files that cross my desk.

As well I want to thank Carol Herbert who has been a colleague for many years and just a wonderful chair to work with. It is my great fortune to have arrived in this position while Carol has been chair of AFMC. Her experience, willingness to work and unbelievable availability are so much appreciated. Thank you Carol.

And finally, but certainly not last, I want to thank you. You are the hundreds of volunteers from our faculties across the country. I know that many of you give so generously of your time, sitting on our task groups, sitting on our committees, working one-on-one with me and other members of AFMC. Without your on-going contribution, AFMC's agenda would be so much less significant and effective.

In thinking about what I wanted to say today, I thought of so many areas worthy of reflection. I have thought of the continuing importance and need for a discussion around professionalism and the need to have a relevant and changing definition. I have thought of the issue of health human resources which certainly is not going away. The integration of more IMGs into Canadian practice is on everyone's mind. Physician shortages face us daily. There are increasing challenges in the research environment and we could spend some time reflecting on how we all collectively need to educate our new government with regard to the importance of health research to the well being of our citizens and the health of our economy. We could look more closely at the role and function of medical schools and how they relate to teaching hospitals, collectively making up the key elements of the academic health science centres of Canada. We could collectively reflect on interprofessional education and practice. However I have chosen to say a few words about the issue of access.

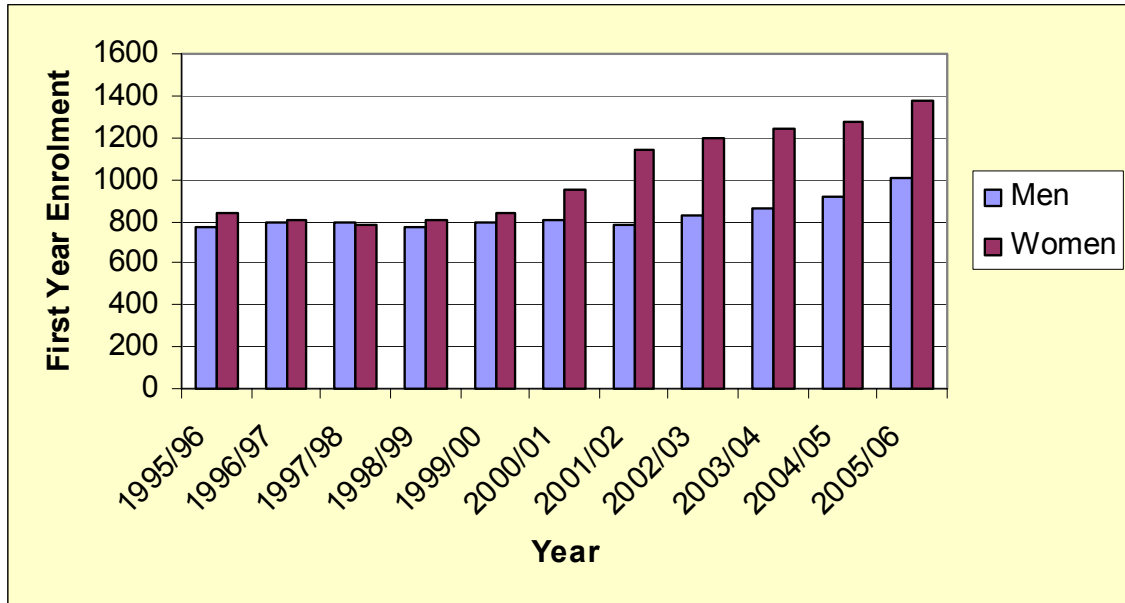
You may sigh and say, oh, not again access! We have been hearing so much about access. But I don't want to talk about the most typical issues of access that we see in the press every day, access to MRIs, access to hip and knee surgery, access to cataract surgery, access to cardiac surgery. I don't want to downplay these critical issues but I want to speak about access to our profession that is access to medical school, to train to becoming a physician in this country and to postgraduate programs.

I only have time to highlight a select number of issues relating to access. The first perspective on access I want to share with you is a historical one.

Let's look first at how many Canadian students have been getting into medical school in the past ten years and the gender mix of those students.

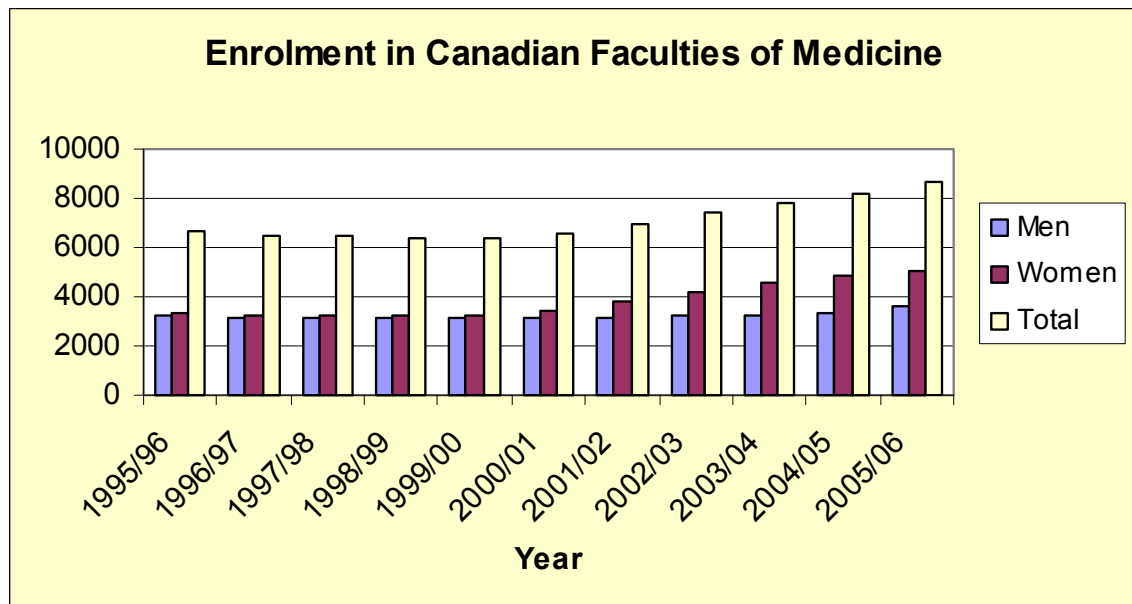
Slide no. 1 shows the first year enrolment in Canadian faculties of medicine for the past ten years and the percentage of women. In 1995 there were 1613 new enrollees in our medical schools and we have now reached 2380. When I look back at the data I can tell you that in 1983 we were already admitting 1887 students to medical school and in fact it took us 20 years, until 2001, to get back to that total and now we have surpassed it.

Slide no. 1



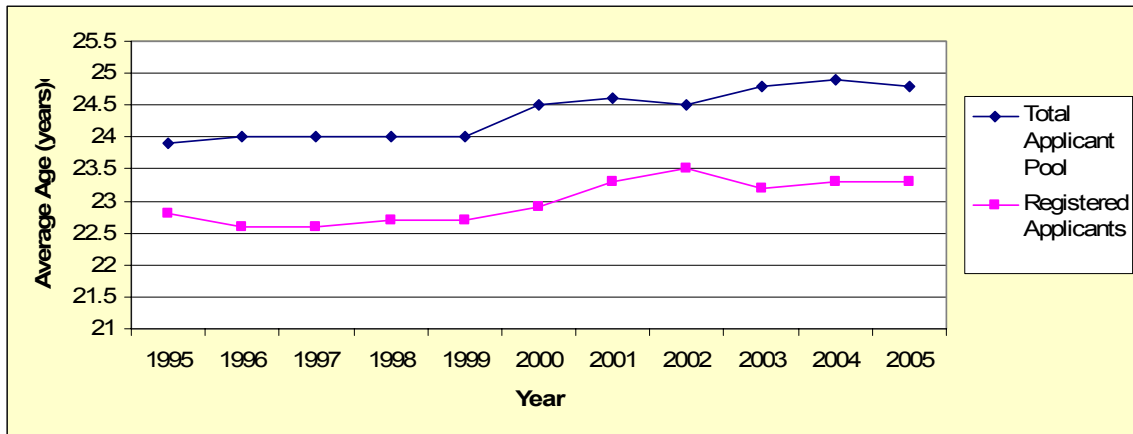
Slide no. 2 shows the total number of medical students enrolled in our faculties in the past ten years going from 6634 to 8687 and demonstrates, as did the previous slide, the increasing number of women, as a percentage of the total enrolment, this percentage appears to have stabilized over the past three years at 58 to 59 percent.

Slide no. 2



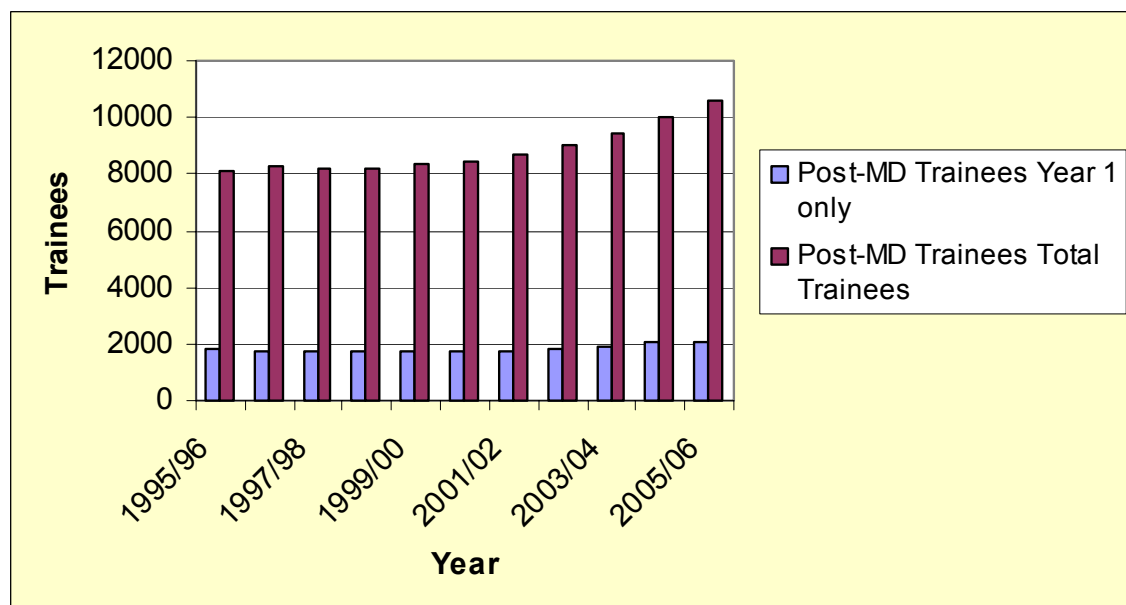
This next slide (no. 3) looks at the average age of applicants in the past ten years. The age for men who succeeded in getting into medical schools has risen from 22.9 years to 23.5 years and for women from 22.6 to 23 years in age. This is a very modest change and would be an interesting statistic to look at in light of how many students with advanced degrees we are now taking into our medical schools and in light of debates about what education is required before entering medical school.

Slide no. 3



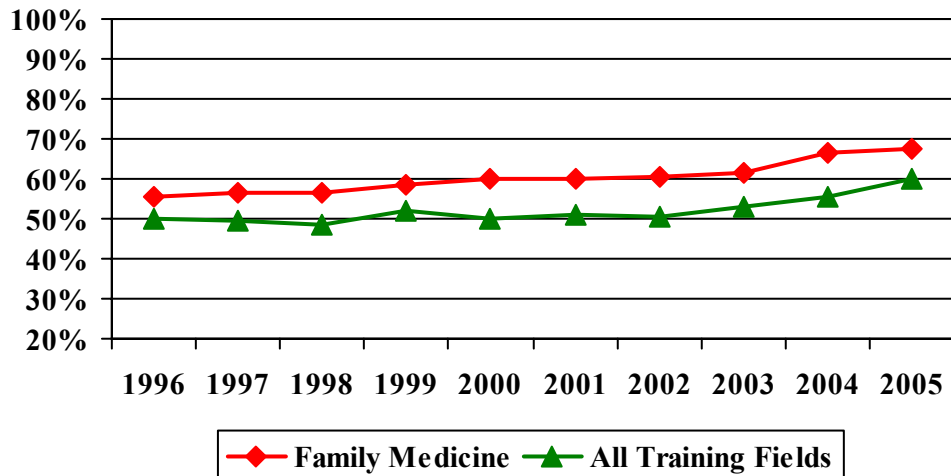
Turning to post-graduate training, you can see from slide no. 4 that in 1995 we were admitting 1784 students to PGY-1 training (blue bar) and we are up to just over 2000 in the year 2005. The total number of trainees has increased from 8151 to 10,565 (purple bar).

Slide no. 4



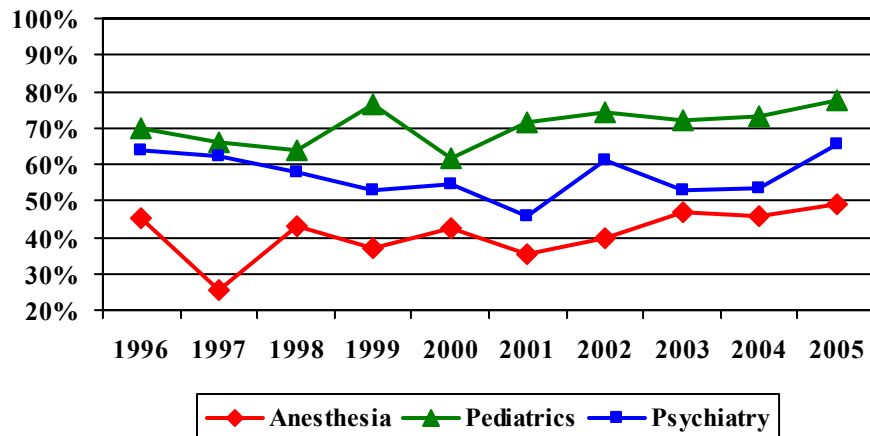
A male-female analysis of our post-graduate trainees by certain disciplines is quite revealing. You can see on this slide (no. 5) that in family medicine, the proportion of women compared to the proportion in all other training fields has been consistently higher.

Slide no. 5



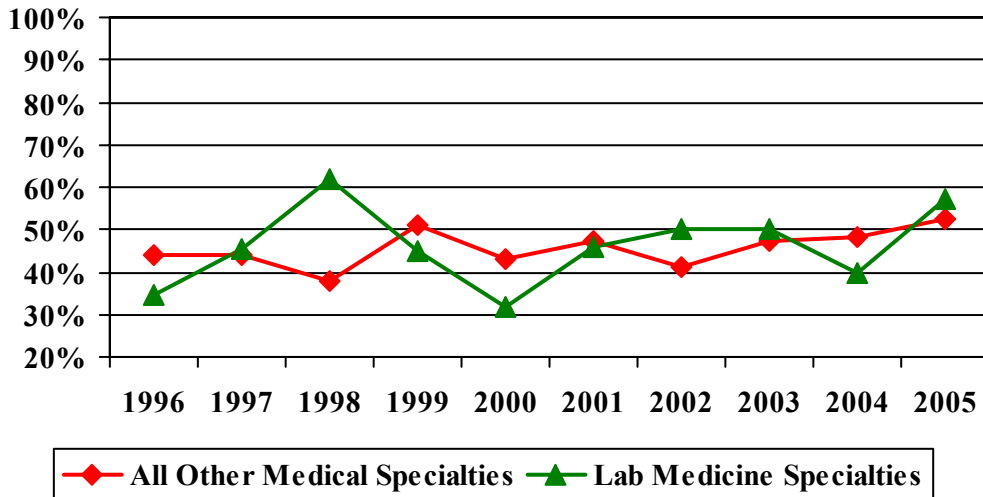
On this slide (no. 6) you will see that over 50% of 1st year trainees in psychiatry have been women for years, and those entering anesthesia are nearly at 50% now. Pediatrics has a higher percentage of women.

Slide no. 6

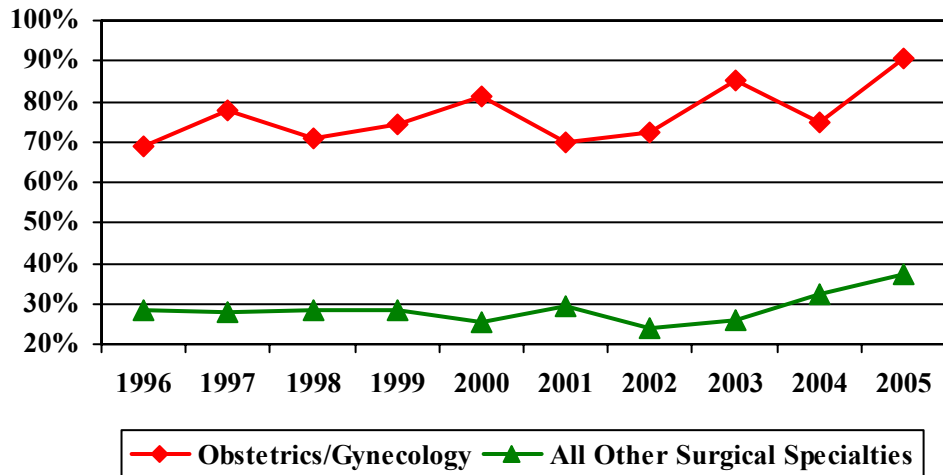


In other medical specialties and lab medicine disciplines (slide no. 7) there appears to be a 50-50 split. The significant outlier is that of the surgical specialties (slide no. 8) which still admit under 40% women and the gynecological disciplines which have admitted up to 90% women in the past year.

Slide no. 7

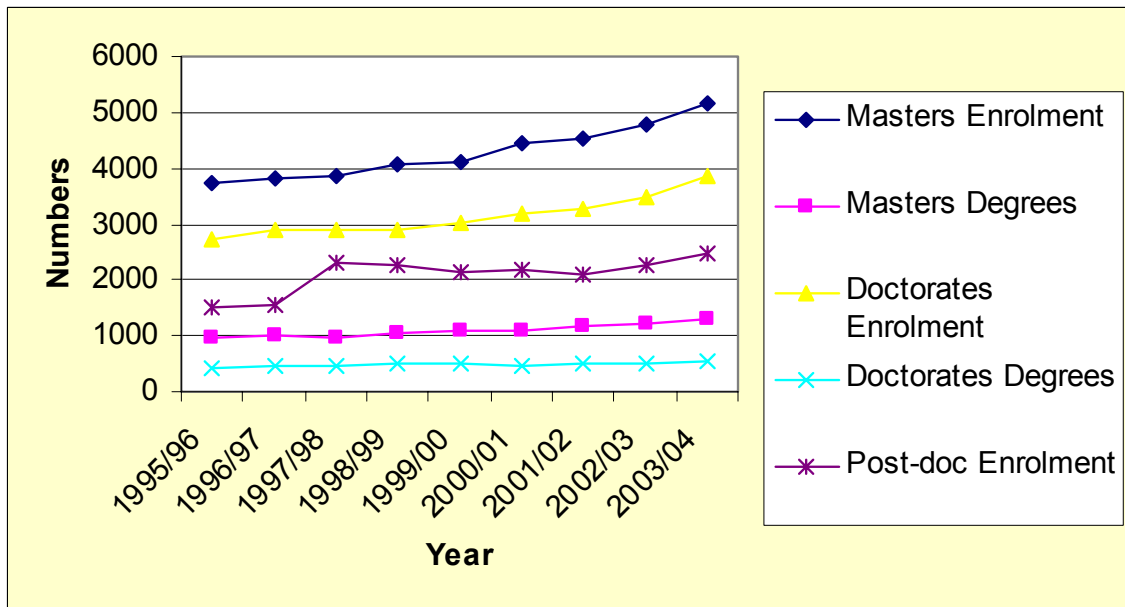


Slide no. 8



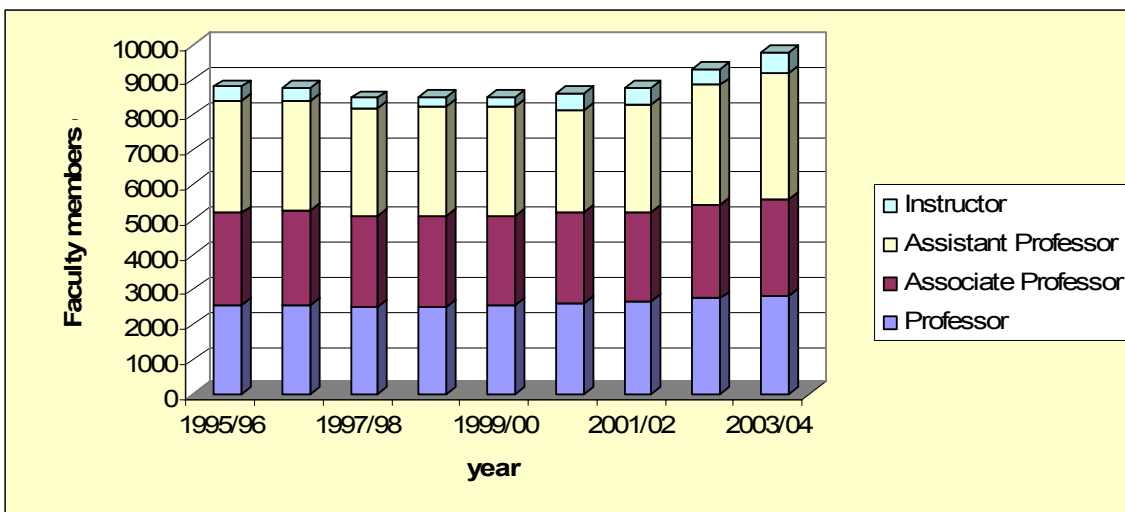
Let's look briefly at our graduate students (slide no. 9). Degrees at the doctorate level have gone from 421 to 628 master degrees have increased from 960 to 1328. I think we need to look at this data in the light of our need to train an increasing number of clinician scientists and PhDs.

Slide no. 9

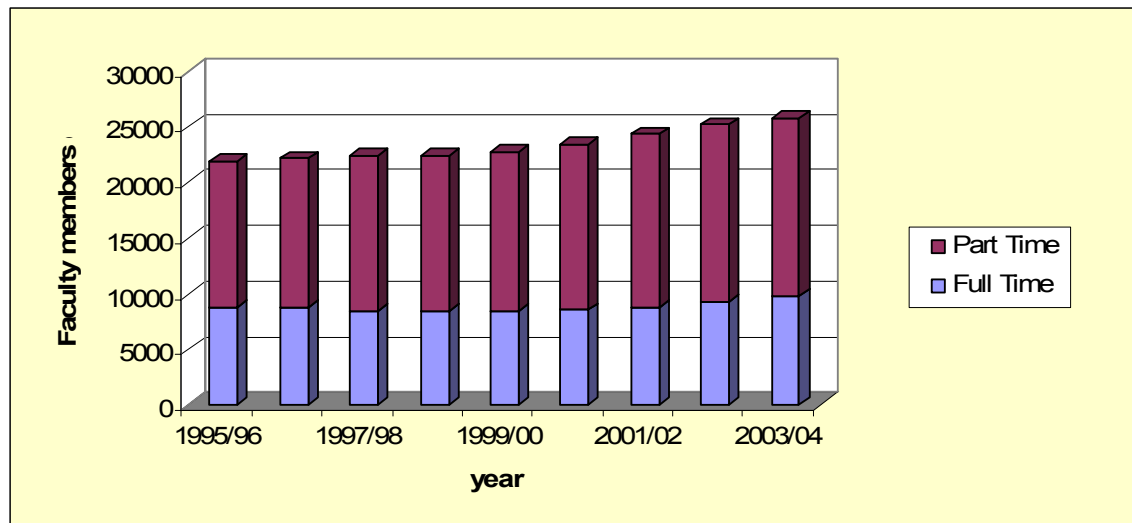


What has happened to faculty growth over the same ten year period? As you will see (slide no. 10) there has been a modest increase in the number of full professors, from 2566 to 2846, just under 300, only 130 associate professors and approximately 400 assistant professors in the past 10 years.. The largest increase (no. 11) has been in our part-time faculty, from 13,134 to 16,061 nearly 3000. The impact of our distributed medical education environment is yet to filter through but with these numbers there may be a concern with regard to numbers of full-time faculty we have available for our research, teaching and clinical missions.

Slide no. 10



Slide no. 11



So this is some high level data. Let's drill down in a number of particular areas. 3 to 4 % of the Canadian population (over 1 million people) is aboriginal (first nations, Métis, Inuit). There are currently about 200 aboriginal physicians in Canada. If 3% of our physician population of 60,000 was aboriginal, we would have not 200 but 1800 Aboriginal physicians.

In 1999, there were 8 Aboriginal students in the first year of our medical schools, in 2001 there were 18 and in 2005 there are 36 new Aboriginal enrollees (slide no. 12). Modest increases, to say the least.

Slide no. 12

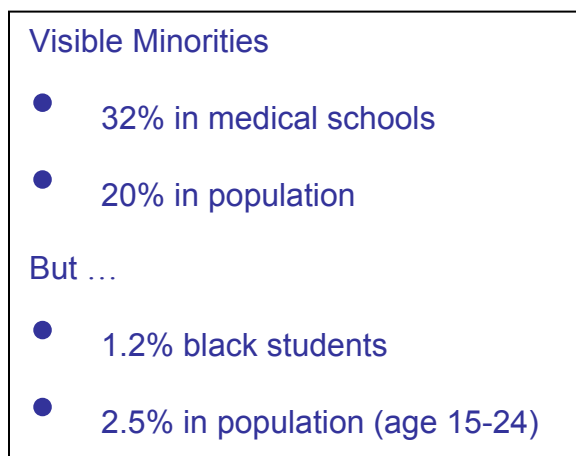
• 1999	8
• 2000	17
• 2001	13
• 2002	18
• 2005	36

AFMC, the Indigenous Physicians Association of Canada (IPAC) and others are putting a particular focus on this issue. Collectively we are looking at ways to encourage more Aboriginal students to enter medical school. We

are examining the barriers that begin in kindergarten and progress right through to graduate school. As well, we are collaborating to look at the skills that culturally competent physicians will need to treat the Aboriginal population and to understand particular Aboriginal health needs.

There are other groups who have difficulty getting into our medical schools (slide no. 13). A recent study has shown that though there were more people from visible minorities in medical schools than in the Canadian population (32% versus 20%) certain minority groups, such as the aboriginal community and in particular the black community were under-represented.

Slide no. 13



A survey done by CFMS indicated that there were just 1.2% of medical students who were black in 2001 compared to the Canadian population of 2.5% in the same age group.

Another statistic... in 2001, 5.2 million Canadians were speaking neither French nor English as a first language.

As we continue to diversify our Canadian population, I believe it is essential that medical schools look closely at who they are admitting so that we will help train a future cadre of physicians who are culturally and linguistically in tune with our new citizens.

I have no slide for the next challenge.

And now to another increasingly huge challenge of access to our medical schools: that is the issue of tuition fees. As you may know studies as far back as 1997 showed that only 35% of medical students came from families

with an annual income of less than \$60,000 and it is estimated that today there are fewer than 15% of such medical students. The average family income of medical students in 2004-2005 was estimated to be \$147,000. Tuition has more than doubled in Ontario medical schools since 1997. Tuition fees continue to rise and many of you are more familiar with the numbers than I am. Not to minimize the bursaries and student support that we offer an increasing number of medical students, I am concerned that despite this, the tuition rise increase has a negative impact on the willingness of students to even consider medicine as a career. I remember my own situation more than 30 years ago, one of six children in an Anglican minister's family, (i.e. with not too much money) and considering going to medical school. One Canadian medical school, certainly to be left un-named by me as the president of AFMC, implied that my family should have a certain guaranteed income in order for them to consider me as a prospective candidate. Needless to say, I did not apply to that school but that experience did sensitize me that this discussion is not simply about offsetting the higher tuition fees but is about the impact that the high fees have on the willingness of students to consider medicine. When you combine the increased tuition fees and look at the Black or Aboriginal communities, I believe that there are some challenges that we collectively need to address.

Entry to medical school for rural students presents another challenge (slide no. 14). 22% of our population lives in rural and small town Canada, according to the statistics Canada definition. There are 17.1% of our family doctors and 2.8% of our specialists practicing in these areas. In 2001, only 10.8% of Canadian medical students lived in rural areas at high school graduation. Rural families are poorer than urban families. We know that more medical students are from families with high incomes. The trend to higher tuition fees, our ongoing focus on GPA's and MCAT scores makes it hard for rural students to get into medical school. Jim Rourke and others report that we are making progress in addressing some of these issues.

Slide no. 14

“Rural and Small Town” Canada

- 22% of population
- 17% of family doctors
- 2.8% of other specialists
- 10.8% of medical students

I think that we are making significant progress on a number of fronts. The number of medical students we are taking in is increasing slowly but steadily. We are expanding our postgraduate opportunities to meet the expanding undergraduate class. Faculties are growing, but too slowly.

Reflecting on the data I've just shown you, I believe one of our greatest challenges is to create opportunities so that young students from all of the cultures and socio economic strata that make up Canada have access to medical education and if they are under-represented I believe it is our collective duty to look at ways to improve the situation.

Strategies need to be developed and promoted that engage communities we serve and live in. Students, from early days onward need to be mentored by medical students and faculty (slide no. 15).

Slide no. 15

- Our social accountability include a responsibility to represent the communities we serve
 - Understanding the culture
 - Speaking the language
- Some Next steps
 - Working with communities
 - Mentoring
 - Breaking down the barriers

Our medical schools will benefit from the diversity, and we will meet our social responsibility to the community by training physicians who are culturally competent and capable to take care of the needs of all Canadians.

I think we are up to the challenges. I look forward to working with many of you in tackling them.

Thank you for listening.