For the Class of ’98, the real-world education is about to begin

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In brief

IN THEIR 4 SHORT YEARS IN MEDICAL SCHOOL, members of the Class of ‘98 have witnessed massive changes within the health care system. These are going to have a direct, and often negative, impact on the way they practise. Despite this, members of this group can’t wait to become full-fledged members of the medical profession.

En bref

EN QUATRE COURTES ANNÉES D’ÉCOLE DE MÉDECINE, la promotion de 1998 aura été témoin de transformations radicales du système de santé, transformations qui auront des répercussions directes, souvent négatives, sur leur pratique. Ce qui n’empêche pas ces futurs diplômés d’attendre avec impatience le jour où ils deviendront membres à part entière de la profession médicale.

The winds of health care change that began as a gentle breeze at the start of the decade are now blowing furiously across the country, and at the calm eye of the storm sits the Class of ’98.

Three and a half years ago, as a new group of students entered medical school at the University of Western Ontario, 5 of them got together to talk about their expectations for the future (see CMAJ 1995;152:239-41). This fall, well into their final year at Western, 4 of those students gathered once again to reflect on Canada’s health care system as they prepare to assume an active role in it.

After more than 3 years of study the students are pleasantly surprised at the way their education has proceeded and that the material they are being taught is actually useful. However, the rate of change within Canada’s health care system has caught all of them by surprise. “Back in first year there was a lot of talk about what was to come,” says Judy Gortler, “and now it’s happening before our eyes. I don’t think many of us expected things to go so fast.”

And despite being at least 2 years away from active practice, members of the Class of ’98 are already worried about the impact of shrinking health care dollars. For instance, with hospitals closing by the dozen there is a resulting loss of hospital-based medical positions and fewer physicians with hospital privileges.

Krista Helleman, who has just completed a round of clerkships, is finding that the warnings practising physicians and groups like the CMA have been issuing for years are true: patient care is being compromised. “It makes me very frightened,” she says. “Everyday there are more pink slips for nurses, and already there aren’t enough staff to cover the floors.”

Edward Hargassner has already seen serious signs of understaffing. “It’s not a question of having enough beds,” he says. “It’s lack of staff. Half the ICU sits empty because there isn’t enough staff.”

In one case, Hargassner saw a patient arrive in the emergency room needing immediate surgery and the only way to make room was to transfer another seriously ill patient from the ICU so that a bed would be available for the more needy patient. Hargassner, who says the patient transfer was “perhaps a little premature,” was learning a too-real lesson about Canadian health care in the ’90s.

Fellow student David Mai tells a similar tale. While working on his psychiatry clerkship in London, his hospital “simply ran out of beds.” The closest available bed was in Toronto, which had only one.
“We had a psychotic patient arrive and we ended up sending him home because there were no beds anywhere in the region,” he recalls. The next day the patient arrived back at the hospital after threatening his partner. Mai remains “totally surprised that this kind of thing could happen here.”

Helleman says she and her classmates understand that health care needs to be restructured and they believe many changes are necessary. However, she questions the way some provincial governments, like Ontario’s, have been acting. She says Premier Mike Harris should never have left the decisions regarding change up to those already in power because then “you never sacrifice yourself.”

The thing members of the Class of ’98 probably find most different from those in the Class of ’88 is the level of resentment among patients. In the dying years of the 1990s, almost all decisions are based on financial expediency. This has kept international financiers happy because government deficits have all but disappeared, but someone has paid the price and in this case it is patients. And their resentment is often directed against physicians, even physicians-in-training. “People are bitter,” says Gortler. “There is not enough care and there is nobody there to help them. And there’s a lot of resentment.”

The need to consider fiscal matters an integral part of medical care has been an important part of training for the Class of ’98. Helleman says she has learned an important lesson: physicians can no longer order procedures and tests simply because they are available. Today there has to be clear benefit to the patient, a sign of the impact evidence-based medicine — yet another invention of the ’90s — is having on medicine.

Hargassner believes he has a solid grasp of what things cost and he always considers the price to the system when making a decision. “Sure an MRI is a nicer test,” he says, “but if you’re going to get similar results with an ultrasound you have to go with the cheaper test.”

But these students say not just physicians have to change their way of thinking. Generations of Canadians have grown up delighted with the notion that health care is free, and making these patients aware of the costs that accompany their care is one of the biggest challenges facing the Class of ‘98.

So is the news all bleak? Has Western produced a class of dour, brooding students angry about what the future holds? Not at all. Earlier Western grads may have faced a less unsettled future, but these fourth-year students remain enthusiastic about their careers and this enthusiasm may be the most valuable thing they bring to their profession. As Helleman puts it, these students knew what they were getting into when they signed on. “We have an open mind about the changes taking place and are willing to be creative in doing things.”

One area where creativity is desperately required is rural medicine. Many of Canada’s “remote” communities face chronic physician shortages and medical schools and ministries of health are combating this by placing greater emphasis on rural practice. All 4 students interviewed for this article recently completed clerkships in rural or remote parts of Ontario, and all of them found the experience rewarding.

Gortler, who spent a month in Northern Ontario, says that time made her appreciate the greater demands rural practice places on family physicians. “It’s a different kind of medicine up there,” she remarks. “The family doctor does a lot more than in a larger setting and you use a lot more of your medical skills because you are it. You don’t have the resources or the other specialists to rely on.”

The clerkships were eye-openers for all the students, who witnessed firsthand the challenges and benefits of rural and remote practice. Unfortunately, even though all 4 enjoyed the experience all were cool to the idea of moving into a rural practice because of the politics involved.

An agreement between the Ontario Medical Association and provincial government places a 70% cap on billings for new graduates who set up shop in areas considered to be “overserviced.” It is part of the government’s strategy to encourage new doctors to move to underserviced regions. Unfortunately, for these 4 students the strategy is having the opposite effect.
“I would be very wary of going up north now,” says Hargassner. “For a while I was seriously considering moving north for a year or so, but when I see these kinds of provincial government actions my fear is that I’d get stuck up there.”

He and his fellow students fear a future in which billing numbers are linked to geographic regions. This would effectively trap them in a remote practice, so the solution is not to go at all. Although medical schools are changing their programs to meet the special needs of physicians bound for rural areas, Helleman points out that “no one enjoys being forced into something.”

As members of the Class of ’98 near the end of this first step in their career, they face another big decision: What residency program should they pursue? Recent changes mean that this decision is being made earlier than before and is very difficult to undo if a mistake is made. These facts weigh heavily on everyone.

Krista Helleman, Edward Hargassner: no one enjoys being forced into doing something

The students were cautious when asked to predict where they will end up because they did not want to close any potential doors, but all agreed that important decisions are being made too early in their training.

Mai suggested that there should be another full year of internship before a final career path is chosen. Hargassner agrees, noting that his interest in obstetrics and gynecology developed purely because of exposure he received during a clerkship. “If it had been the very last rotation I’d really be scrambling to meet all the deadlines [in applying for a residency],” he explains.

These students appear well prepared to become useful members of their profession. They entered medicine for all the right reasons, and despite the turmoil of the recent years remain optimistic about the future of the health care system and their roles in it.

“There’s always going to be a demand for health care,” says Gortler, “and for the doctors who provide it.”

LOGIE MEDICAL ETHICS ESSAY CONTEST
DEADLINE: JUNE 1, 1998

Once again, CMAJ is sponsoring the Logie Medical Ethics Essay Contest for undergraduate medical students attending Canadian universities. The awards this year are $1500 for the winning essay, $1000 for second place and $750 for third place, but CMAJ reserves the right to withhold some or all awards if the quality of the entries is judged insufficient. The judges, consisting of a panel of editors from CMAJ’s scientific and news and features departments, will select the winners based on content, writing style and presentation of manuscripts. Essays should be no longer than 2500 words, including references, and should be double spaced. Citations and references should follow the “Uniform requirements for manuscripts submitted to biomedical journals” (see CMAJ 1997;156:270-7). The winning essays will appear in CMAJ and will be edited for length, clarity and consistency with journal style. Authors will be asked to provide a computer diskette containing their essay and will receive an edited copy before publication. Submissions should be sent to the News and Features Editor, CMAJ, 1867 Alta Vista Dr., Ottawa ON K1G 3Y6.