ily, but not exclusively, at graduates of foreign medical schools who are seeking Canadian licensure.

The Clinical Assessment and Enhancement Program (CAEP) will be run by the Professional Development Office at Memorial's Faculty of Medicine. Dr. Francine Lemire, a family physician from Corner Brook, is director of the new program, which will be based on the province's west coast. It is the first major faculty program to be run from outside St. John's.

Dr. Carl Robbins, the vice-dean of medicine, said the new program will meet a critical need. "Many physicians responding to recruitment endeavours for rural areas require further training to meet minimal licensure requirements. Right now there's no mechanism in Newfoundland to assess these applicants adequately and provide the training required to ensure competency."

CAEP will be open not only to foreign medical graduates but also to graduates of Canadian schools who have been out of practice and require assessment and skill enhancement. It will also be used by practising physicians who have been identified, by themselves or otherwise, as needing upgrading.

The assessment instruments in CAEP will be standardized and take the form of multiple-choice examinations, case-based therapeutics and structured oral tests, standardized patient examinations, short-answer examinations and psychological assessments. — *Sharon Gray*, information officer, Memorial University

BC launches computerized organ-donor registry

British Columbia has developed Canada's first computerized organ-donor registry. The new system, designed to address current problems surrounding consent and long waiting lists, is expected to increase organ and tissue donations significantly.

Paying physicians: Is a different method really better?

Dr. Sam Shortt, the director of health policy at Queen's University, says the university's alternative funding plan is generating little of the change in physician behaviour that had been expected.

"The theory behind [the plan] was that it would allow physicians to get off the fee-for-service treadmill and give them more time for research and more time for each patient," Shortt said during the first in a series of information sessions sponsored by the CMA's Research Directorate. "However, so far we have been unable to detect any substantial change in physician behaviour."

The plan, launched almost 4 years ago, provides a block-funding budget for all full-time clinical staff at Queen's and covers teaching, research and all inpatient and outpatient clinical services provided in 3 Kingston hospitals — the Providence Continuing Care Centre, Hotel Dieu and Kingston General.

Shortt, a member of the plan's evaluation steering committee, told physicians attending the CMA information session in Ottawa that even though the plan is solid in theory, figuring out how well it works is proving difficult. The meeting attracted practising physicians, leaders from organized medicine and health researchers.

Shortt said the steering committee examined outpatient waiting times in an attempt to measure the new plan's impact on patient care. "While results varied considerably by specialty, no clinically significant changes were detected," he said.

When the program began it was expected to generate widespread changes in the way physicians allocate their time and in the relationships between clinical faculty at Queen's and referring physicians from the community. Shortt admitted that the scope of change has been smaller than expected.

"This was supposed to be a fundamental change in mind-set, but depending on the number of years a physician has been in the system, it is hard to change. However, some physicians came to the program because they knew it would allow them to conduct their research."

Evaluation of the alternative funding plan will continue throughout 1998 and the steering committee is scheduled to produce a final report by Jan. 1, 1999. The CMA's Research Directorate hopes to schedule a series of sessions on various aspects of the health care system throughout 1998. — © *Steven Wharry*

Previously, BC residents indicated their willingness to donate when renewing a driver's licence. However, because less than half of them informed their families, the BC Transplant Society estimates that 35% of organs that were potentially available were being lost. Conversely, when families were aware of the desire to donate, 96% of them agreed to proceed. Shortage problems are compounded because fewer than 1% of those who sign up eventually donate an organ because they must be declared brain-dead first.

With the new system, potential donors need only register once through a participating drugstore chain, their BC Care Card or a motor-vehicle licensing branch. As well, people can "specifically delineate an organ for transplantation," explains Bill Barrable, chief executive officer for the BC Transplant Society.

All BC intensive care units have confidential telephone and fax numbers linked to the registry, which allow them to check if a person has registered. A copy of the registration is faxed to the doctor; this can then be presented to the family as evidence of legal consent. The registration constitutes "an advance directive for a living will," says Barrable, so written consent from the family is not required. The procedure also allows donors to keep the information confidential if they do not wish to notify family members.

To educate health care professionals about the program, the British Columbia Medical Association has sent material to doctors and the Transplant Society has visited all intensive care units in the province.

The society hopes that 500 000 more people will register by 2000 and ease the province's problems in meeting the current annual need for about 350 organs and 900 corneas. About 25% of the people on waiting lists die before a donor organ is available. Today the average waiting time for a kidney transplant is 809 days. Kidney transplants are consider particularly cost-effective; they cost $20 000, plus $6000 yearly for antirejection drugs, while annual dialysis treatment can cost $50 000. Barrable says that since transplants became "mainstream and are no longer considered experimental, they have become a victim of their own success."

Funded by the Ministry of Health and the private sector, start-up costs for the registry will be $1 million, with annual costs of $71 000. — © *Heather Kent*

Grant applicants take note

The following edited list, which has been making the rounds in cyberspace, was forwarded to us by Roger Burford Mason, editorial director of the Electrical Group at Kerrwil Publications Ltd. It is entitled "Why God does not get research grants".

- He had only one major publication and it was in Hebrew.
- It had no references and wasn't published in a refereed journal.
- It may be true that he created the world, but what has he done lately?
- The scientific community has had a hard time replicating his results.
- He never applied to the ethics board for permission to use human subjects.
- When an experiment went awry he tried to cover it up by drowning his subjects.
- When subjects didn't behave as predicted he deleted them from the sample.
- He expelled his first 2 students.
- Although there were only 10 requirements, most of his students failed his tests.

Sale of CO detectors boom following Toronto deaths

There was a home invasion in East Toronto in January, but in this case the invisible and silent killer was not a criminal. Over the course of 2 days it left 2 people dead and two more clinging to life. The stealthy invader was carbon monoxide, and it gained entry when a squirrel's nest blocked a chimney, causing fumes to back up into the house.

Bill Robinson of the Department of Toxicology at the Ontario Centre of Forensic Science says CO poisoning is deceptive because initial symptoms resemble the flu. They include a headache, which has been compared with having an elastic band tightened around the head, as well as nausea, weakness, confusion, stupor and coma. One visible sign of CO poisoning is a characteristic cherry-red colouring of the cheeks and lips. The danger it poses caused great concern during the recent ice storm in Ontario and Quebec when the lack of electricity caused people to run gas-powered generators near their homes. Several deaths were attributed to it.

Carbon monoxide kills by combining irreversibly with blood hemoglobin. Depending upon the amount of CO present in relation to the amount of oxygen, the poison can kill within minutes or, as was the case in East Toronto, over a few days.

Physicians who see patients with severe headache and nausea should consider asking if is anyone else in the patient's home is experiencing the same symptoms. If others are, they should be advised to leave the home immediately and carbon monoxide levels should be checked.

CO kills between 200 and 300 Ontarians a year. Although the problem is usually confined to the winter months, deaths have occurred in summer when boaters and campers use a gas heater in a confined space.

The tragedy in East Toronto caused a surge in sales of carbon monoxide detectors, which cost from $40 to $60. Experts say one of the best methods of prevention is a yearly furnace inspection. — © *Peter Wilton*