for a full student loan. I received only $3600 in student loan money from the Ontario government because they claim that I am still "dependent" on my parents. With tuition approaching $9000, I cannot live off student loan money. This restriction clearly discriminates against medical students who enter their studies immediately after their undergraduate degree. Medical students and former medical students must come together to suggest economically sensible policies that will allow medical students to survive the financial crisis referred to as medical school.

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Reference

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For too long the issue of medical school tuition has been raised once each year, at which time students protest, administrators respond that they can do nothing and increases are railroaded through compliant university governments. Your recent articles on tuition[1,2] reached conclusions similar to our in-house, student-conducted research. The latter showed that the percentage of medical students at the University of Western Ontario from families with incomes of less than $60 000 had declined from 25% of the total in 1998 to 14% in 2000 (unpublished data).

In 2001, during a contentious debate about raising Western's tuition fees to a near Canada-wide high of $14 000 a year, studies were quoted by both sides. We hope the findings published in *CMAJ* will lay to rest the notion that endless increases in tuition fees can be executed without a corresponding decline in accessibility[1] and student diversity.[2]

At Western, a commitment that no student will be denied access to a medical education because of financial status, either initially or during the program, rings hollow in the face of these recent studies. For one thing, student aid such as the Ontario Student Assistance Plan is not indexed to inflation:[3] the portion allocated for tuition, $4500, has not increased in more than a decade. For another, remedies aimed at residents and new doctors, such as incentives to practise in rural areas, will never solve the problems of accessibility and student diversity. To attract students from underrepresented groups and classes, tuition fees must be cut in order to reduce the "sticker shock."

In this era of doctor shortages, creating financial impediments for potential students will ensure that ongoing problems of diversity and accessibility get worse.

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2. Dhalla IA, Kwong JC, Streiner DL, Baddour RE, Waddell AE, Johnson IL. Characteristics of first-year students in Canadian medical schools. *CMAJ* 2002;166(8):1029-35.
3. Statistics Canada. Consumer Price Index historical summary. Available: www.statcan.ca/english/Pgdb/Economy/Economic/econ46.htm (accessed 2002 April 28).

[Three of the authors respond:]

Panayiotis Glavas' letter highlights a weakness we discussed in both of our articles.[1,2] We too were disappointed in our inability to include Quebec medical schools. We relied on Canadian Federation of Medical Students (CFMS) representatives to publicize the study at each site; because the 3 francophone schools are not CFMS members, we had little control of how the survey was promoted in Quebec. Gathering email addresses for all Quebec students proved to be an unachievable goal. In fact, we were told by the Sherbrooke representative of the Fédération des associations étudiantes en médecine du Québec (FAEMQ) that many students still do not use email. Glavas also comments that we could have "easily eliminated [premedical student] responses from the final analysis if [we] wished to do so." Without resurveying the Quebec students, separating premedical and medical students would have been impossible.

We agree that our results are applicable only outside Quebec. There are several reasons (e.g., lower tuition fees, different admissions requirements) why Quebec medical students may be different from those elsewhere in Canada. In the end, we had no choice but to reluctantly exclude the Quebec data from our main analyses. However, we have made the data available to the FAEMQ and are willing to share the data more widely if others are interested.

The 2 letters by Sarah Giles and Clare Bastedo and colleagues eloquently describe the personal financial hardships faced by many medical students. Both letters question the adequacy of existing financial support programs. We agree that government loan maximums have not kept pace with tuition increases and hope that the findings of our study lead to reviews of existing programs by which medical students receive support.

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Quelling research excellence in residency programs

Canadian residency programs currently do not provide sufficient latitude for residents with research skills to pursue scientific questions. In contrast, US programs apply different training tracks that encourage research and provide certain advantages to the graduate.

The Canadian Institutes of Health Research funds about 20 to 30 students per year to pursue combined MD and PhD degrees. A stipend is provided during both medical and graduate school. Dual training is intended to cultivate skill in identifying promising therapeutics emerging from the morass of a growing literature.

Here in Canada, graduate residency training commences after 8 or more years of dual training in MD/PhD programs. Typically, we pursue a research project in the basic sciences, exploring molecular mechanisms of disease in graduate school after 2 years of preclerkship, then return to the MD program for clerkship.

The first 2 years of residency are clearly essential for clinical competency. Being underpaid and overworked as residents is held as a rite of passage to, one hopes, better days. But for MD/PhD graduates, another issue arises: How best to maximize our research potential? In spite of being trained to the gills, there is little hope of translating anything until late in our fellowships. This is 5 to 6 years since our last research contribution and makes our previous work an anachronism in the fast-paced world of molecular medicine.

In comparison, US MD/PhD programs offer residency tracks called "research pathways." The American Board of Internal Medicine (ABIM) allows MD/PhD residents to re-enter the lab in the third year and couple their specialty of choice with their research interest. So while the core training is fast-tracked (2 years v. 3), the specialty training is long-tracked (4 v. 2). The assumption is that 2 years of internal medicine is a sufficient foundation — a fair one when considering that senior residents spend an enormous amount of time on "scutwork" and micromanagement, rather than garnering clinical acumen. In short, the ABIM puts the emphasis on the specialty rather than the core for MD/PhD residents, thereby maximizing their research momentum. When will the Royal College see fit to introduce such research pathways into our programs? The corollary: Are we now compromising research excellence for the sake of "clinical rigour"? The absence of such pathways possibly defeats, in my view, one of the laudable objectives of MD/PhD programs: producing world-class clinician scientists.

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Transparency at Health Canada

I was intrigued that Health Canada recently diverted $15 million from its population health fund into prostate cancer basic research,[1] even though this is expressly prohibited by their regulations. They disregarded their own selection process by awarding $2 million per year to the Vancouver Centre of Excellence in prostate cancer research, plus $1 million per year to the National Prostate Cancer Research initiative. Was this purely coincidental, or did the former national Minister of Health's bout with prostate cancer lead to the direct or indirect application of non-academic pressure? The high political profile of AIDS also appears to be distorting objective judgement. A project with unfavourable external peer reviews received $8.75 million, and the HIV/Aids Clearinghouse received a $2.5-million funding extension, in spite of noncompliant accounting and an earlier recommendation that $350 000 in prior payments should be recovered.

It's not that prostate cancer and AIDS aren't high-priority problems. As a male cardiovascular surgeon, I am at risk for both conditions. However, numerous internally and externally reviewed research projects must be turned down each year for lack of funding. Funding limitations also play a role in the continuing annual loss of highly talented Canadian medical researchers and teachers to the US. Thus it's critically important that Health Canada be free from the appearance of politically motivated decision-making. Health Canada needs to reassure all Canadians that limited resources are awarded in a transparent manner based primarily on merit.

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1. Kondro W. Auditor general targets Health Canada spending. *CMAJ* 2002;166(3):365.

[Editor's note:]

Ian C. Green, the Deputy Minister of Health, did not acknowledge our request for a response.