## BARRY IRISH

ORIGIN:
Born mid WW 2, Kamloops, B.C., to union of R.N. and chest physician. Raised with 5 siblings near U.B.C. Proximity to that university resulted in default attendance for 3 unfocused feral undergraduate years. Equally default application to medical school consequent to parental expectations.

ACCEPTANCE:
Epiphany and shock ensued. Adios to unstructured youth at age 21.

MEDICAL SCHOOL MEMORY:
General surgeon A.D. MacKenzie demonstrating focused compassion to post op patient, contrasted by demeaning treatment before medicare to a "staff" patient by internist – showing that good and bad behavior is educational.

"Mack" Whitelaw impressive Shaughnessy internist role model.

Rent paid for moorage of our floathouse in false creek along with power and water was $25 per month.

INTERNSHIP 1968 – 1969:
Along with 5 other ubc grads ended the tenure of bachelor Canadians with the Sisters of Mercy at their San Diego hospital.

THEREAFTER:
As with 60 % of our class, directly to general practice for the real apprenticeship, which involved for me – emergency summer in Kelowna, rural general practice in Sechelt 2 years, casualty officer at V.G.H. for another 2 years and then private practice at Lions Gate Hospital for the next 4 years. The lure of economic benefit and sleep then encouraged this youngish father to a radiology residency at U.B.C. After 4 lean years with some focus on early interventional procedures and neuroangiography. back to the north shore. The ensuing 35 years there involved constant changes with escalating on call responsibilities and new intellectual challenges as ultrasound, CT, MRI and interventional intrusions allowed ample opportunity for patient and collegial interaction. Eventually the mysteries of digitization and computers brought me to my best before date and retirement at age 68.

MAJOR CHANGES OVER 50 YEARS:
G.P. centric hospitals of the 70s. The hospital doctor's lounge was the conduit for unfettered physician to physician communications and friendships. Hospital administration was then physician driven. Admissions to the hospitals in those "good old days" were unimpeded with "observation" and "exploratory laparotomies" well recognized admitting diagnoses. Now 50 years later medical care is very much more precise and efficient, but can also be fragmented and distanced. Hospital business models are more complicated and institutionalized. Admissions now require diagnostic precision and demonstrated necessity. Length of stay is also amazingly brief, even in major circumstances. The science of medical care is prime with the artful touch between the provider and consumer on occasion distant or too often screen focused.

PERSONAL EVENTS:
Financial stability mainly due to singular 50 year marriage. Many bad investments in activities peripheral to my knowledge set but also one lucky investment in a medical imaging company. Four children have provided the joy of ample grandchildren. My classmates and I have converted from being medical providers to medical consumers- a demoted status that still offers future hope and enjoyment.

FUTURE OF MEDICINE:
Dynamic exotic changes will make personalized diagnosis and treatments the norm. The opportunity to be involved in that future should be a joy. I encourage all, so inclined, to pursue the dynamic opportunities afforded our profession.