

# CFMS FEMC

## Annual Review

Canadian Federation of Medical Students

Fédération des étudiants en médecine du Canada

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# Letter from the CFMS President



Jonathan DellaVedova

**G**reetings from the Canadian Federation of Medical Students (CFMS)! We are the national representative body of medical students in Canada with 7000 members from coast to coast, and it has been a very exciting year for our federation.

Our membership is growing and so is our organization with more students active in the CFMS than ever before. We continue to set attendance records at our meetings and we are forging new partnerships with medical organizations and service providers. The 2008–2009 academic year has seen the evolution of a number of dynamic and high-impact initiatives.

Despite this expansion, as always we rest on our three pillars of representation, communication and services. Our workplan continues to be set by you our members as well as your elected representatives each year.

This academic year has been part of a transformative era in medical education in Canada. Medical school enrollment continues to expand rapidly with new satellite campuses and distributed learning sites, in addition to new technologies and educational models. A renewed emphasis on social accountability — as well as increasing attention to patient safety and patient-centred care — are shaping our medical schools to best meet the needs of Canadians.

The Association of Faculties of Medicine of Canada has responded to the trends and is putting forth recommendations for further innovations with the Future of Medical Education in Canada project. As a member of the Steering Committee it has been an honour to represent Canadian medical students and bring your voice to the table. In this time of change, our interest continues to be an accessible and diverse medical education system that includes comprehensive academic and clinical experiences, a commitment to improve service to underserved populations, and personal and professional support for learners throughout.

The CFMS is also conducting its own student-centred review of some of the changes to the medical education system. However, medical education is not all we do at the CFMS. We have an active Global Health Program, an improved lobbying strategy that includes our annual CFMS Lobby Day, local project funding opportunities, and a growing set of membership benefits to make your life as a medical student much easier. Earlier this year we proudly launched our brand new website at [www.cfms.org](http://www.cfms.org) where you can find more information, find ways to get involved, and register to access useful benefits and databases.

This publication offers a review of the events of 2008–2009 featuring articles from our executive, our representatives, our members and our alumni. We hope you find it enjoyable and informative. Please feel free to contact the CFMS executive via our website or your local representatives for more information about our organization.

Yours sincerely,

A handwritten signature in black ink, which appears to read "J DellaVedova". The signature is fluid and cursive, written in a professional style.

# Lettre du président



Jonathan DellaVedova

**B**ien le bonjour de la part de la Fédération des étudiants et des étudiantes en médecine du Canada (FEMC) ! Nous formons le groupe national de représentation des étudiantes et étudiants en médecine au Canada et nous comptons 7000 membres, d'un océan à l'autre.

Notre fédération a connu une année très palpitante. Le nombre d'adhérents augmente, tout comme la taille de notre organisation, qui compte plus d'étudiants actifs au sein de la FEMC que jamais auparavant. Nous continuons d'établir des records de participation lors de nos rencontres et nous formons de nouveaux partenariats avec des organisations médicales et des fournisseurs de service. De plus, l'année universitaire 2008–2009 a été témoin de l'évolution de bon nombre d'initiatives dynamiques et de grande importance.

En dépit de cette expansion, notre base demeure toujours fondée sur la représentation, la communication et les services, qui constituent nos trois piliers. Notre plan de travail continue d'être élaboré par nos membres, dont vous faites partie, ainsi que par vos représentants élus chaque année.

Cette année universitaire s'inscrit dans une période de transformation du monde de l'éducation médicale au Canada. Les inscriptions dans les facultés de médecine continuent de croître rapidement grâce à de nouveaux campus satellites et sites d'enseignement à distance, en plus des nouvelles technologies et des nouveaux modèles d'enseignement. Une priorité renouvelée accordée à la responsabilité sociale ainsi qu'une attention croissante portée à la sécurité des patients et aux soins axés sur les patients façonnent nos facultés de médecine afin qu'elles puissent répondre aux besoins des Canadiens de la meilleure façon possible.

L'Association des facultés de médecine du Canada a répondu à cette tendance et, grâce à son projet *L'avenir de l'éducation médicale au Canada*, elle met de l'avant des recommandations afin d'innover davantage. En tant que membre du Comité de direction, ce fut pour moi un honneur de représenter les étudiants et étudiantes en médecine du Canada et de m'exprimer en leur nom à cette table. En cette période de changement, notre intérêt demeure celui d'offrir un système d'éducation médicale accessible et diversifié comprenant une expérience universitaire et clinique, un engagement à améliorer les services offerts aux populations insuffisamment desservies ainsi qu'un soutien personnel et professionnel permanent aux apprenants.

La FEMC procède également à sa propre révision, d'un point de vue étudiant, de certains des changements apportés au système d'éducation médicale. Mais l'éducation médicale n'est pas l'unique préoccupation de la FEMC. Nous offrons un programme actif de santé à l'échelle mondiale, une stratégie de lobbying améliorée comprenant notre journée annuelle de lobbying, des occasions de financement de projets à l'échelle locale ainsi qu'un ensemble croissant d'avantages pour les membres qui facilitent grandement leur vie d'étudiant en médecine. C'est avec fierté que nous avons lancé plus tôt cette année notre tout nouveau site web à l'adresse [www.cfms.org](http://www.cfms.org), où vous trouverez encore plus de renseignements et des façons de vous engager, et où vous pourrez également vous inscrire afin d'avoir accès à des bases de données et à une foule d'avantages utiles.

La présente publication offre un aperçu des événements de l'année 2008–2009 et des articles de notre direction, de nos représentants et de nos membres. Nous espérons que vous trouverez cette information excellente et instructive. N'hésitez pas à communiquer avec la direction de la FEMC par le biais de notre site web ou en vous adressant à votre représentant local pour obtenir de plus amples renseignements au sujet de notre organisation.

## Letter from the Editors



Mary Jamieson, CFMS  
V-P Communications  
Dalhousie University,  
Class of 2009



Meiqi Guo, CFMS  
Annual Review Editor  
Queen's University,  
Class of 2011

The CFMS is very pleased to bring you the 2009 edition of the *CFMS Annual Review* — our annual report to CFMS members. The 2009 edition of the *Annual Review* features a fine-tuning of the magazine's design as well as two new sections for your perusal. The first is the "Featured Interview" with Dr. Vincent Lam, 2006 Giller Prize Winner and author of *Bloodletting and Miraculous Cures*. Despite his busy schedule, he was kind enough to sit down with the *Annual Review* and talk about his medical school days, his upcoming books and the crazy juggling act that is medicine, family and writing. The second is an "Alumni Review" section with words of wisdom from CFMS alumni. Looking at where they are now, it is amazing to think that they were once medical students.

As with previous editions of the *Annual Review*, the section titled "CFMS activities" contains updates on what your CFMS representatives, executive, officers and committee members have been working on in the areas of lobbying, political advocacy, student education and member services to serve you better. It's been a very productive year for the CFMS — check out the new initiative on advocating for medical students with disabilities and the report on Distributed Medical Education. There is also information on the excellent work that the Global Health Program of the CFMS has been doing as well as three bilingual articles reflecting the CFMS's collaborative efforts with FEMQ, our French-language, Quebecois counterpart.

The *Annual Review* received many wonderful submissions this year from the general CFMS membership. Besides creative works such as photography, poetry and prose, the "Articles and Creative Works" section also features a well-researched opinion article titled "Diabetes: It Means Siphon", career advice about interventional radiology and informative articles on new medical student initiatives. Due to the volume of submissions received this year, it was with deep regret that we were not able to include all of them as a result of space limitations.

The *Annual Review* is thankful for the support of the helpful Canadian Medical Association staff and the generous contributions of our advertisers, without whom the *Annual Review* would not be possible.

We hope that you will enjoy reading this year's *CFMS Annual Review*.

All editorial matter in *CFMS Annual Review* 2009 represents the opinions of the authors and not necessarily those of the Canadian Federation of Medical Students (CFMS). The CFMS assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice herein.

# Residency Positions, Distributed Medical Education, Tuition AND *The Matchbook*...

*An Update from your V-P Education*

**Tyler Johnston**

**Vice-President Education**

**Michael G. DeGroot School of Medicine, McMaster University, Class of 2010**

Canada's health human resource shortage has made today a time of significant change in our healthcare system, and the field of medical education is no exception. As your national representative, the CFMS is working to ensure that the system continues to improve and evolve in a way that is in the best interests of students and the public. Below is a brief discussion of some of the issues and projects that the CFMS is currently working on in medical education.

## **Residency Positions**

The ability of students to obtain the residency of their choice remains an important issue for medical students across the country. As such, monitoring the residency matching process remains a priority for the CFMS. In the 2008 match, 87% of Canadian Medical Graduates (CMGs) matched to one of their top three programs, 95% matched in the first iteration and 99% matched overall. These rates are comparable to and possibly higher than in previous years. However, the 2008 match included an "Open Match" in Manitoba and Quebec that saw CMGs competing for the same residency spaces as international medical graduates (IMGs). Thirteen Manitoba gradu-

ates went unmatched, five of whom desired family medicine. Although most of these unmatched Manitoba CMGs eventually negotiated residency spaces, the CFMS is actively monitoring this situation and advocating on behalf of CMGs. In 2009, both Ontario and Alberta will "open up" the second round of the match to IMGs. The CFMS will be monitoring any changes to CMG match rates in 2009 and will continue to advocate for surplus residency spaces and guaranteed positions for all CMGs.

## **Tuition and Flexibility of Medical Training**

The cost of medical school tuition in Canada continues to rise at many schools across the country and so does the educational debt load of Canadian medical students. In 2008, the federal government overhauled the Canada Student Loans Program. However, based on models developed by the CFMS and Canadian Medical Association (CMA), Canadian medical students can expect little relief from the new program. Advocacy efforts this year will once again focus on our 2009 "Lobby Day" on Parliament Hill when medical students will meet with MPs in order to

advocate for the forgiveness of educational debt during residency and an increase in the student loan limits available to medical students. Additionally, the CFMS in partnership with CMA has updated the CMA policy on medical school tuition and the revitalized policy will continue to be communicated to government. Finally, Ontario recently joined four other provinces that forgive educational debt during residency and the CFMS will continue to urge the federal government to recognize the efforts of its provincial counterparts and make this policy a reality for medical students across the country.

## **"Student-centred" review of Distributed Medical Education (DME)**

Canada's physician shortage has brought Distributed Medical Education (DME) to the forefront of discussions about medical education and health human resources in Canada. Medical school enrollment has increased by more than 50% over that past decade and DME has been used a means to accommodate increased class sizes and to address the health human resource needs of underserved communities. In fact, 7 of



Canada's 17 medical schools engage in fully distributed medical education undergraduate programs (i.e., satellite campuses), and the majority of Canada's medical students can now expect to complete part of their training at distributed sites.

Despite the increased utilization of distributed clerkship rotations (i.e., those outside of academic centres) and satellite campuses, few efforts have been made to examine the effects these changes have on the experience of students. Studying at distributed sites can have advantages such as increased exposure to preceptors and more "hands-on" training but it can also have disadvantages including increased costs, technological problems and decreased access to specific training opportunities. The CFMS feels it is our responsibility to investigate the effects that DME has upon students and to ensure that they have the best educational and personal experiences they can regardless of where they study.

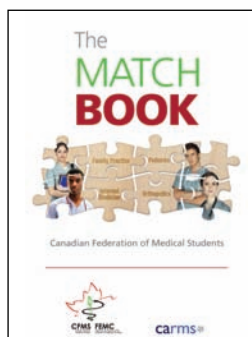
During 2008/2009 the CFMS has undertaken a national "student-centred" review of DME complete with a literature review, series of focus groups and a national survey. The results of this review will be communicated to our members and to national medical organizations including the Association of Faculties of Medicine of Canada and the Canadian Medical Association.

### Visiting Student Electives

Building on the CFMS's 2007 proposal for a national immunization protocol, the CFMS continues to advocate for an improved visiting electives process at Canada's medical schools. Through discussions with Association of Faculties of Medicine of Canada (AFMC) (i.e., Canada's undergraduate Deans) the CFMS has emphasized the importance of this issue to medical students and put forth a number of suggestions for improving this process. Correspondence with the AFMC on this issue continues and we hope to improve it for the 2009/2010 academic year. The CFMS has also been collaborating with the Canadian Residency Matching Service (CaRMS) to develop a proposal for a common application form and central application site that will be presented to Canada's other major medical organizations this spring.

### The Matchbook

Launched in the fall of 2008, *The Matchbook* is a joint project of the CFMS and CaRMS intended to help inform early-year medical students about the processes involved with applying to residency. *The Matchbook* provides infor-



mation about how the match operates, data about the competitiveness of particular specialties and advice from residents who have gone through the process. *The Matchbook* will continue to be updated yearly and we hope that it will become an important tool for helping students to navigate the sometimes difficult CaRMS process.

### Other projects

The CFMS is working on a host of other projects related to medical education including a report examining the grading systems used by medical schools across the country, a review examining the length of medical training, and issues related to career decision-making in medicine.

Thanks for taking the time to read about the CFMS's medical education activities. If you have any questions about these or any other projects related to medical education please do not hesitate to contact me at [tyler.johnston@cfms.org](mailto:tyler.johnston@cfms.org). ❖

### Grade Reporting

The way in which medical students are evaluated varies greatly across the country. Distinctions such as honours, pass outstanding and pass borderline are in use and carry considerable weight at some schools while at others such designations are non-existent. It's evident that this is an area of concern, not only at the local level but when the time comes for residency matching at the national level. It is the goal of the CFMS to carry out an environmental scan followed by focus groups held at individual schools in order to gain an understanding of the current climate of grade reporting from our members' perspective.

This project will only be successful if you, the students, provide us with feedback. Grade reporting is a policy that affects each and every medical student. Even if you are happy with the system at your school it would be great for us to hear about the systems that seem favorable as well as those that are less so. A consolidation of this information will be valuable in the development of an official CFMS position on the topic of grade reporting.

More information will be coming soon from your local CFMS reps — we would appreciate your participation. For more information contact [kelly.hynes@cfms.org](mailto:kelly.hynes@cfms.org)



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# CFMS Services Summary

## Products and Services to

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**Aaron Knox**

**Vice-President Services**

**University of Alberta, Class of 2010**

The CFMS appreciates the incredible amount of time and money medical students invest in their education. Balancing training responsibilities with personal commitments can be extremely challenging. Tuition is expensive, rotations are demanding and your time is scarce. That's why the CFMS is working hard to provide you with valuable products and services to save you precious time and money.

It is with great pleasure that I welcome Jacqueline Zhai, Yu Li, and Will Stecho to the "2008–2009 CFMS Services committee". This committee is a new initiative designed to research and obtain **NEW** services for our members that are useful, accessible, and available to all Canadian medical students.

We are pleased to announce that our new website ([www.cfms.org](http://www.cfms.org)) is online and fully functional. This website is a central hub that showcases and provides access to an amazing variety of products and services available to CFMS members. The user-friendly interface also improves organizational structure and facilitates communication within our membership.

New to the CFMS this year is endorsement of an exciting wireless package from TELUS mobility. Tailored to suit the life of medical trainees, this agreement is designed to provide medical students with reliable coast-to-coast wireless access at a superior price. This "CFMS 40" plan is

only available to CFMS members. Looking for a new phone with a great plan? Thinking of switching providers? Check out the "CFMS 40" plan on our website for more details.

Once you have signed up for the CFMS 40 plan, grab your new smartphone and check out an amazing offer on electronic educational software. CFMS and Skyscape are pleased to provide you with 25% off of educational resources for your PDA or smartphone, just for being a CFMS member.

Can't read the small print? Don't panic. The CFMS and LasikMD are proud to offer our members courtesy pricing and discounts on all vision correction procedures. Don't like the electronic version? Not a problem. Check out our selection of peer reviewed CFMS endorsed textbooks from LWW and Elsevier. Titles endorsed by the CFMS are uniformly peer reviewed and approved, to ensure that the textbook you are dragging along on your elective will be the most effective use of your carry-on luggage.

Trouble deciding what to do with that two-week elective? Our online "Electives" database provides valuable student feedback to use in your planning. When you go, don't forget to bring your CFMS clipboard and pocket card, tangible products we provide free to new CFMS members each year. Before you go, protect your financial future with Canada's best disability

insurance plan for medical trainees, proudly brought to you by Kirkham and Jack and available only to CFMS members.

To get you there the CFMS and WestJet are proud to offer a 10% discount on regularly priced flights during the busy months of January and February. Before you go, check out our online "Billeting" database to find a cheap place to crash or to recover costs by subletting your place. Still strapped for cash? Buy and sell with ease in our new online "Classifieds" section. Weary from the road? Treat yourself to a little luxury with corporate rates for CFMS members at any Choice Hotel.

Upon your triumphant return, help out future students by posting a summary of your experience in our "Elective" or "Residency interview" databases. While your there, think about minimizing that inevitable debt and plan for the future. Check out MD Management's debt management strategies and sound financial advice tailored specifically to medical students.

The CFMS is committed to maintaining current services while exploring new ones, to provide additional value to your membership. If there is something missing or should be added, please let us know. We are always happy to look into it. Check out all that the CFMS have to offer at [www.cfms.org](http://www.cfms.org) ❖

# Medical Students with a Disability?!

**Ashley Oleniuk**  
**CFMS Western Regional Representative**  
**University of Saskatchewan, Class of 2012**

Ever since I graduated from high school I have known that I wanted to become a doctor; I never questioned this and nobody challenged me on it. My desire to be a physician has been the one thing that I've been most sure about in my life. Although this probably sounds like the story of many medical students, my story has a flip side; I am a medical student with a physical disability.

Many questions run through people's minds when they hear of a medical student with a disability. How will a wheelchair user perform CPR in time of an emergency? How will a doctor with one arm percuss the abdomen? How will a blind doctor diagnose a skin rash? These are all questions I myself have heard or have been asked. What people don't realize is how creative, resilient and driven people are when living with a disability. In our everyday lives there are constantly new obstacles to face, and everyday we discover new ways to overcome them. The challenges of being a medical student with a disability are handled the same way that we handle daily, unpredictable hurdles - we just figure it out. Living in an able-bodied world with a disabled body can be frustrating and the path is often unpredictable, but nonetheless we find a way to be just as able as any able bodied counterpart.

The CFMS recognizes this new age in medicine, an exciting time where medical students with disabilities are challenging norms and breaking barriers. Unfortunately though, not everyone seems to be appreciating this change, as there is an extreme lack of support for medical students with disabilities. In light of this the CFMS has made it a priority to provide support, services and advocacy for medical students with disabilities. It has taken too long for this issue to gain the attention that it deserves, but like many things in life, it's better late than never. The CFMS hopes to encourage others to do the same and create a more inviting, comfortable and accommodating atmosphere for the many students like myself. One day it will no longer be shocking when a physician enters a ward in a wheelchair, or perform exams using one arm... maybe it will even be the new norm! ❖

PHOTO: JAMES ZHENG



# Lomino Effect:

## CFMS Student Initiative Grant Brings New Initiatives to Life

**Ruiqing Cindy Wang**  
**CFMS Quebec Regional Representative**  
**McGill University, Class of 2010**

Alongside the creation and integration of small group teaching and distributed medical education into today's medical training, more and more medical students rose to the challenge, took their medical education in hand and became actively involved with its planning and organization. Aimed at providing support and funding to medical student initiatives, the CFMS created a pioneering project — the Student Initiative Grant. The Grant is a reaction to the increasing number of medical student-run initiatives and a need for an official support body, including financial, for such projects.

The creation of the CFMS Student Initiative Grant was very well received by medical students across Canada. In 2007, the CFMS sponsored a multitude of meaningful projects, such as the Manitoba Perinatal Loss Education Workshop, McMaster's Healthforall.ca Website, Ottawa's Pre-departure training program for global exchanges, Icebowl 2008, NOSM's *HumerUs!* Magazine and McGill's "Initiative Benin".

Following on the success of these projects, the CFMS has once again set aside funds to provide continued financial support with the goal of assisting students in creating events or initiatives that promote interaction between CFMS students and member schools. All projects run by members of the CFMS are eligible for CFMS Student Initiative Funding, and the selection of funded projects is based on innovation, creativity, the ability to promote interaction between CFMS members and member schools, and the enhanced visibility of the CFMS.

For more information on the CFMS Student Initiative Grant, feel free to contact [cindy.wang@cfms.org](mailto:cindy.wang@cfms.org) or your local CFMS representative. ❖

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# Lobby Day

**Nawaaz Nathoo, Western Regional Representative, University of Alberta, Class of 2010**

**John Snelgrove, Ontario Regional Representative, University of Western Ontario, Class of 2011**

Parliament Hill buzzed with activity on Monday, February 23rd. While their colleagues were studying for exams, dissecting cadavers, or rounding on the wards, over 65 student delegates from across the nation brought forward a request for interest deferral on government loans to their MPs. The message is not new; as medical trainees we enter a financial situation characterised by considerable debt that is left practically unabated throughout residency. We want the Canadian government to recognize this unique situation and provide interest deferral for the government portion of our loans until we finish residency. Some provinces have already stepped up — most recently, Ontario notified its medical trainees that provincial and federal loan interest would be paid for so long as physicians stay in the province to practise. The message was taken seriously

by MPs, many of whom were keen to hear what the future physicians of Canada had to say.

Medical students can be proud of the delegates who represented them on the Hill — the Lobby Day team prepared well into the evening on the Sunday prior. Briefings on the topic at hand, a political environmental scan courtesy of the CMA, and interactive sessions with experts in journalism and policy prepared delegates to discuss the issue with MPs. To top it all off, a keynote address-turned-pep rally delivered by a favourite outstanding physician MP reiterated to students the value of their collective voice.

Lobby Day 2009 resounds with success. While interest deferral is still not a battle won, the opportunities for medical students to engage in the political process and provide exposure for the CFMS are invaluable. ❖

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# Roll Up Your White Coats and Give!

## *The CFMS Annual Blood Drive*

**Mike Bevilacqua**  
**CFMS Blood Drive Officer**  
**University of Calgary, Class of 2010**

*The CFMS is CBS' longest standing partner (it's true — look it up!), and last year we decided to move forward with that partnership and become part of the Partners For Life (PFL) program which will really help us maximize the donations we make across the country. Entering into a PFL partnership gives us access to CBS' vast resources and nationwide team of coordinators who will help organize and promote blood donation opportunities to med students at every CFMS school. Through the PFL program, CBS helps us organize our efforts and make sure that every student at every school is aware of the donation events available in their community. I am very confident that through the PFL program, CBS will help us reach donation numbers that we would have previously thought impossible to achieve.*

**T**he biggest challenge as a PFL member organization is setting up local partnerships between schools and CBS local organizers, and I am proud to say that every CFMS school now has at least one amazingly dedicated local PFL Champion who will work with CBS to schedule and promote all of our donation events (see inset for a table of Champions). The local Champions are your link to CBS and they are all very enthusiastic about this year's drive; don't be afraid to approach them with any questions or ideas that you may have, as I know they would

love to talk to you! One of the big jobs that the local Champions had was to set a donation target for this year, and as the donation goals come in, I must say that I am very excited. In 2008, the CFMS made a total of 882 donations and that is a number that we can all be very proud of! By building on the successes of last year's blood drive, I hope that we can do even better this year and continue to contribute to the health care system in such a meaningful way.

While the numbers are exciting, what we are all most excited about is the actual donation events! As a kick-

off to our new partnership, every school held a big, school-wide donation event as a part of 'CFMS Blood Month' in February. The great thing about the PFL is that it allows for a lot of flexibility, so each school can pick the dates that work best for them to hold their 'Blood Month' event. For more info on your school's Blood Month or other donation events, talk to your local Champion and keep an eye out around the school and your email for promotional materials that are soon to come! I would also like to point out that even if you cannot



physically donate blood, you can still be a big part of your school's donation effort by helping to spread the word and get your peers excited about our donation efforts; I'm sure your local Champion would love to have some help! Finally, while the Blood Days events will be the big kick-off of this year's drive, Blood Month will by no means be the last event; the biggest reason we switched to the PFL was to help us donate year-round, so get ready for a fun-filled year of bloodletting!

Another idea that we are going to try out this year is an inter-school blood drive challenge that we think will help create a little friendly competition to motivate even more CFMS members to

donate. This challenge, which has been dubbed the 'Phlebotomy Bowl' is a friendly competition between medical schools that we are implementing in order to get people excited about donating blood. By having an annual challenge, we hope to make regular donation a part of med school culture in the belief that this will greatly increase the amount of donations that the CFMS is able to produce. The biggest challenge faced in our blood drive efforts is keeping students excited and motivated to donate blood all year long; we believe that a little friendly competition is a great way to do this. It should be noted that the winner of this challenge will receive no material reward, but rather will get a little recognition and bragging

rights until next year's challenge. In addition to this recognition, at the end of the calendar year, each and every school will be recognized for their contributions on a local level and we will celebrate the success of the CFMS as a whole.

Overall, between the success of last year's blood drive and the new programs we have this year, this is a very exciting time to be a part of the CFMS' blood drive efforts, and I must say that all of the energy coming back to me from CFMS schools is absolutely amazing! For more info, you can always talk to your local Champion and most importantly remember to roll up your white coats and give!!! ❖

## Table of Volunteers

### School

Memorial University of Newfoundland  
 Dalhousie University  
 University of Ottawa  
 Queen's University  
 University of Toronto  
 McMaster University  
 University of Western Ontario  
 Northern Ontario School of Medicine — Thunder Bay Campus  
 Northern Ontario School of Medicine — Sudbury Campus  
 University of Manitoba  
 University of Saskatchewan  
 University of Alberta  
 University of Calgary  
 University of British Columbia — Vancouver Campus  
 University of British Columbia — Victoria Campus  
 University of British Columbia — Prince George Campus

### Champion(s)

Erika Hansford  
 Brent MacLellan and David Conrad  
 Leslie Lamb and Sivash Piran  
 Clarissa Moodie and Philip Harvey  
 Monique Martin and Kate Quirt  
 Marina Aptekman and Alexandra Gow  
 Kelly MacDonald and Ashley Geerlinks  
 Sheena Belisle  
 Kiersten Parr and Ian Paquette  
 Mustafa Kapasi  
 Afton Sielski and James Zheng  
 Sanja Kostov and Sue Kupper  
 Gwynivere Davies and Mike Bevilacqua  
 Sarvenaz Moosaviasl and Cheryl Lane  
 Adeline Brimacome and  
 Kasumi Cummings  
 Claire Fast

# An **UPDATE** from the **PAC Committee Chair and Ontario Regional Representative**

**Shawn Mondoux**

**CFMS Ontario Regional Representative and Chair of the Political Advocacy Committee (PAC)  
 University of Ottawa**

Hello everyone. I am pleased that you are reading the *CFMS Annual Review* for 2008–2009. This is an important publication for the organization but a more important publication for our members. Medical students from across Canada should take this opportunity to see what their elected representatives, their respective schools as well as their funds are doing for them! This is one of the many ways that the CFMS remains accountable to members and, as always, any feedback that will help us to improve your medical education is welcomed.

On the Ontario front, there is much to report. As all Ontario medical students should know, the OMA ratified a new agreement with the Ontario Government that brings impressive changes to the student experience. Fourth year clerkship stipends will be increased from 500\$/month to 750\$/month (9000\$/year), interest on all government student loans will be deferred until the end of residency and student will have access to travel allowances if they are studying outside the borders of their university's home city. Details have yet to be finalized and the exact details are not known but the above mentioned issues have been accepted and medical students in Ontario are quite happy to hear it. All of this great work was done by the Ontario Medical Student Association (OMSA) and had little, if anything, to do with the CFMS. The OMSA tends to make my job much easier as the Ontario Regional Rep and with such a high-caliber provincial organization, students should be assured that they are well represented in Queen's Park.

The OMSA also allows me to turn my focus toward internally running CFMS projects. This year, I was lucky enough to be given the Political Advocacy Committee (PAC) portfolio. This relatively new project which laid its roots for the first time last year as a fully functional committee continues this year stronger and wiser than ever. Globally, PAC consisted of at least one student from each member university and the goal of PAC is to support the CFMS' political advocacy efforts in various ways. This year, PAC isolated two principle goals; first, to ensure that the CFMS understood student need

and move to improve student experience by advocating on multiple levels and second, to take an official stance and position on national medical issues and harness the CFMS voice to help improve the life and health of Canadians.

Our first goal was completed by issuing a small survey on each campus, mediated by PAC representative from each school, which contained both CFMS-driven questions and locally developed questions. The CFMS was principally looking to update older statistics, provide some statistical support for Lobby Day 2009 and ensure that we had a handle on the demographics of our membership. The most interesting and relevant issues were those isolated by each campus. These survey results allowed us to compare student need across the country and, indirectly, distill common themes that the CFMS will use as future advocacy platforms. The goal was to 1) provide new topics for Lobby Days to come, 2) give local schools the chance to poll their own membership and make local changes and 3) empower the CFMS with new advocacy issues.

Our second mandate was one of establishing CFMS positions on national health issues, especially those that were not limited to students. PAC felt that the CFMS voice was something that could be leveraged nationally to provide informed and knowledgeable medical information to Canadians. Various issues were isolated at both executive meetings and within PAC as potential issues on which the CFMS could take a stance. There were some important considerations to be kept in mind. These issues have already proven to be important for Canadians, but they simply were lacking in awareness and a national voice. Additionally, these issues have to be ratified by the exec as well as the membership at BAGM and AGM. These issues papers will be presented to the membership at the above mentioned conference and we look forward to student reaction as well as any media time we can obtain!

Thanks so much for your time, and I look forward to hearing from you regarding these issues anytime. Please feel free to contact me at [shawn.mondoux@cfms.org](mailto:shawn.mondoux@cfms.org) ❖

# La Fédération médicale étudiante du Québec

*célébre ses 35 ans!*

**Éliane Raymond-Dufresne**

**Vice-présidente, Fédération médicale étudiante du Québec (FMEQ)**

**vp@fmeq.ca**

La Fédération médicale étudiante du Québec (FMEQ) est le représentant officiel de l'ensemble des étudiants en médecine du Québec. À travers les quatre associations étudiantes médicales québécoises, soit le RÉMUL (Université Laval), l'AAÉMUM (Université de Montréal), l'AGÉÉMUS (Université de Sherbrooke), la MSS (McGill University) et les campus satellites (Chicoutimi, Trois-Rivières, Moncton), elle compte à ce jour plus de 3500 membres étudiants.

Ayant vu le jour en 1974, la Fédération s'est agrandie avec le temps, mais sa mission demeure la même : défendre en priorité les intérêts collectifs spécifiques aux étudiants en médecine du Québec en matières pédagogique, politique et sociale. Ce faisant, elle défend les droits et intérêts de ses membres auprès des instances gouvernementales et facultaires, ainsi qu'auprès des autres regroupements médicaux du Canada. Elle se prononce sur les sujets affectant de près ou de loin les étudiants en médecine du Québec tant au niveau de la qualité de la formation que du bien-être étu-

diant. Elle offre également des services spécifiques à ses membres à l'aide de ses relations privilégiées avec divers partenaires. Finalement, la division internationale de la Fédération, IFMSA-Québec, fait rayonner la province de par le monde à travers divers projets au sein de la communauté et des stages à l'étranger.

Lors du congrès de septembre 2008, les représentants étudiants ont établi les priorités de l'année de la FMEQ. Les hausses d'admissions en médecine sont présentement un dossier crucial, la qualité de la formation étant maintenant en jeu étant donné l'augmentation critique des cohortes. Nous travaillons aussi sur la problématique de la médecine familiale compte tenu de la pénurie au niveau des soins de première ligne au Québec. D'autres dossiers de première importance sont le processus du CaRMS ainsi que la visibilité interne de la Fédération auprès de ses membres.

Depuis maintenant plusieurs années, la FMEQ travaille de concert avec la Fédération des étudiants et étudiantes en médecine du Canada (FEMC). Des représentants de la FMEQ assistent en effet aux deux assemblées annuelles de la FEMC (AGM et BAGM). On y fait le point sur les dossiers marquants des deux Fédérations et y effectue un partage d'informations sur les dossiers com-

muns. De plus, la FMEQ collabore à quelques événements de la FMEC, tels le lobby day (mettant l'accent, cette année, sur l'endettement et les prêts étudiants), l'assemblée annuelle de l'AFMC, etc. D'autres projets sont également en chantier : la participation de la FMEQ au *Matchbook*, qui se veut un livret informatif sur le processus du CaRMS (pour l'entrée en résidence), qui est maintenant pancanadien, le Blood Month (campagne de don de sang), etc. Finalement, cette année, l'Université de Montréal a reçu pour la première fois des participants d'un océan à l'autre dans le cadre des *MedGames 2009*. Cela a favorisé le développement de liens entre les étudiants en médecine de tous les milieux au Canada, expérience que nous souhaitons répéter lors des prochains Jeux de la Médecine, qui se dérouleront à l'hiver 2010 dans la ville de Québec, et auxquels vous serez plus que les bienvenus!

Les événements notables à venir pour la FMEQ sont le congrès annuel de la Fédération qui se tiendra au printemps 2009, lors duquel seront élus les nouveaux représentants étudiants et seront établies les orientations annuelles, ainsi que les célébrations du 35<sup>e</sup> anniversaire de la FMEQ.

Au plaisir de vous côtoyer! Passez une excellente année! ❖





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# The Fédération médicale étudiante du Québec

*celebrates 35 years!*

**Éliane Raymond-Dufresne**

**Vice-President, Fédération médicale étudiante du Québec (FMEQ)**

**vp@fmeq.ca**

Founded in 1974, the FMEQ has grown over time but its mission remains the same: first and foremost, to defend the collective interests of Quebec medical students in academic, political and social matters. Through its actions, the Federation seeks to uphold the rights and represent the interests of its members with government and faculty bodies, as well as with other medical groups in Canada. It speaks out on topics that directly or indirectly affect Quebec medical students, from the quality of training to the well-being of students. It also offers specific services to its members through privileged relationships with various partners. Finally the Federation's international division, IFMSA-Quebec, showcases the province around the world through vari-

ous community projects and internships abroad.

During the convention held in September 2008, student representatives established the FMEQ's priorities for the coming year. Increased admissions to medical school is currently a high-priority issue, as the critical increase in cohorts is now having an impact on the quality of training. We are also working on the problem of family medicine in view of the shortage of primary care physicians in Quebec, the CaRMS process and the internal visibility of the Federation among its members.

For several years now, the FMEQ has been working in partnership with the Canadian Federation of Medical Students (CFMS). FMEQ representatives attend two CFMS annual meetings (AGM and BAGM). There, we update the key issues of both Federations and share information on common issues. As well, the FMEQ participates in some CFMS events, including Lobby Day (which focused this year on student debt and loans)

and the AFMC's annual meeting. Other projects are also underway, including the FMEQ's participation in *Matchbook*, intended as an information guide to the CaRMS process (for entry into a residency program) now used across Canada, and Blood Month (blood donor campaign). Finally this year, the University of Montréal, for the very first time, welcomed participants from across the country to *MedGames 2009*. This initiative encouraged the development of ties between medical students from all communities in Canada. We hope the experience will be repeated at the next MedGames, which will take place in winter 2010 in Quebec City. The welcome mat is out!

Upcoming FMEQ events worth noting are the Federation's annual convention, scheduled for spring 2009, at which new student representatives will be elected and a course mapped out for the coming year, and the FMEQ's 35th anniversary celebrations.

We look forward to seeing you! Have an excellent year! ❖



# Les admissions en médecine : SOYONS RESPONSABLES

**Myriam Auclair**

**Déléguée aux affaires politiques, Fédération médicale étudiante du Québec  
politique@fmeq.ca**

*In the past 10 years, the Ministère de la Santé et des Services sociaux (Government of Québec) has increased the number of admissions in the four Québec medical schools from 406 to 772, which represents a 90% rise since 1997. Many consequences arose from this increase, one of the most critical ones being the impact on quality of education. The resulting “overcrowding” of medical students is now especially significant during the clerkship years, when clinical exposure and adequate teaching are a crucial step of forming a good clinician. It is fair to believe that as the classes increase in numbers, it will eventually affect residency training, and staff. To prevent this, the Fédération médicale étudiante du Québec (FMEQ) has adopted a statement in favour of status quo regarding the number of admissions in the Québec medical schools until the government has a clear idea of the needs for an increase. In the meantime, the FMEQ continues to represent its members at a provincial level, being an active participant during the annual negotiations for the number of admissions in medicine.*

## **Des médecins à la chaîne**

Au Québec, comme dans le reste du Canada, il existe une pénurie de personnel dans le système de santé. En effet, on estime le manque à 800 médecins de famille et plus de 600 médecins spécialistes. C’est dans ce contexte que, depuis 1997, les intervenants en santé procèdent à une hausse des admissions en médecine. C’est ainsi qu’entre 1997 et 2007, le nombre d’admissions en médecine au Québec a fait un bond spectaculaire de 90% en passant de 406 à 772.

En 2008, plus de 800 étudiants ont débuté leurs études médicales au Québec sans connaître l’impact de ces changements sur la qualité de leur formation. De plus, le Ministère de la Santé et des Services sociaux (MSSS) continue de proposer des hausses d’admissions et souhaite atteindre un total de 850 étudiants pour 2010–2011.

Or, comme étudiants, nous sommes forcés de constater que les hausses d’admissions ont des répercussions sur notre formation, particulièrement à l’étape de l’externat. Ainsi, en 2008, la FMEQ a déposé un rapport basé sur un sondage mené auprès de plus de 1000 étudiants en médecine du Québec. Ce dernier démontre clairement que certains stages sont saturés et que le nombre et la variété des cas cliniques sont insuffisants pour atteindre les objectifs. De plus, plusieurs d’étudiants sont préoccupés par un accès difficile

aux stages de leur choix et des impacts potentiels de cette situation sur leur application à la résidence.

En effet, les résultats du sondage démontraient clairement que certains milieux ne répondent plus aux besoins des étudiants en matière de formation à cause du nombre trop important d’étudiants et de résidents qui y sont formés. C’est le cas, notamment, de la pédiatrie et de la gynécologie-obstétrique où, de toute évidence, le nombre de cas est limité et l’ajout d’étudiants dans un même milieu compromet considérablement leur exposition clinique. Or, si ces changements sont surtout ressentis à l’externat, de plus en plus d’étudiants s’inquiètent de la qualité de la formation au préclinique, en particulier dans les cours d’enseignement en petits groupes, où le ratio d’étudiants par enseignant ne permet pas des interactions satisfaisantes et où, pour certaines facultés, l’espace physique dans les locaux n’est plus suffisant pour accueillir ces groupes. On remarque aussi que les universités qui comptent le plus d’étudiants par groupe d’enseignement restreint sont celles où les étudiants se disent le moins satisfaits par leur expérience avec cette méthode d’apprentissage.

## **Soyons responsables**

Les exemples sont donc nombreux pour démontrer que les hausses d’admissions perpétrées au cours des douze dernières années ne sont pas sans conséquence.

Bien qu'à présent, ce soit surtout les étudiants qui écopent, les répercussions seront bientôt ressenties par les résidents, les patrons, et ultimement, le public, si les mesures nécessaires ne sont pas prises pour offrir une formation de qualité aux médecins de demain.

En ce sens, la FMEQ a adopté, en 2006, une position de statu quo par rapport aux hausses d'admissions, dans le contexte où la qualité de la formation ne peut être assurée. Cette position

visait à inciter les intervenants du secteur de la santé à réévaluer les capacités d'accueil des milieux d'enseignement. En effet, la FMEQ est sensible à la problématique du manque d'effectifs médicaux et comprend l'urgence de pallier à cette situation, mais croit que l'augmentation des admissions en médecine n'est qu'une solution superficielle qui crée elle-même des problématiques additionnelles au niveau de la gestion des effectifs. Il faudra donc trouver une stratégie plus multidimen-

sionnelle et se pencher sur la réorganisation des soins de première ligne si l'on veut bâtir un système de santé équilibré.

C'est dans ce contexte que les représentants de la FMEQ poursuivront leurs discussions avec le MSSS. Il s'agit d'un sujet prioritaire qui prend actuellement une ampleur grandissante dans l'ensemble du pays. Il est donc essentiel de faire valoir la nécessité d'être responsables et de s'assurer que les médecins soient bien formés afin de prodiguer de meilleurs soins. ❖

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# Admissions in medicine: LET'S BE RESPONSIBLE

**Myriam Auclair**

**Public Affairs Delegate, Fédération médicale étudiante du Québec**  
politique@fmeq.ca

## **Assembly line physicians**

Quebec, as does the rest of Canada, experiences a human resource shortage in healthcare. It is estimated that the system needs 800 more family physicians and over 600 specialists. Since 1997, health sector stakeholders have increased admissions in medicine. Between 1997 and 2007, the number of admissions to medical schools in Quebec has seen a spectacular rise of 90%, from 406 to 772 new students.

In 2008, more than 800 students began medical studies in Quebec without knowing the impact of these changes on the quality of their training. In addition, the Ministère de la Santé et des Services sociaux (MSSS) continues to push for higher admissions and hopes to reach a total of 850 students in the 2010–2011 academic year.

As students, we are sometimes forced to witness the repercussions that higher admissions are having on our education, especially training outside the classroom. In 2008, the FMEQ tabled a report based on the results of a poll of more than 1,000 Quebec medical students. This report clearly showed that certain internships are saturated and that the number and variety of clinical cases are insufficient to achieve goals. As well, several students are concerned about the difficulty of

accessing the internships of their choice and the potential impact of the situation on their application for residency.

In fact, results of the poll clearly showed that some settings no longer meet the training needs of students because of the excessively high number of students and residents being trained. This is especially true of pediatrics and OB-GYN where, obviously, the number of cases is limited and the addition of students in this setting severely compromises their clinical exposure. While these changes are felt mostly in practicum, more and more students worry about the quality of training at the pre-clinical level, especially in the case of courses in groups where the ratio of students to teacher does not allow for satisfactory interaction and where, in some faculties, physical space is insufficient to accommodate the number of students. We also notice that the universities that have the highest number of students per teaching group are those where the students say they are most dissatisfied with this learning experience.

## **Let's be responsible**

Numerous examples show that the higher admissions of the last dozen years have had negative consequences. While until now it has been the stu-

dents who have been left to cope, the repercussions will soon be felt by residents, program directors and, ultimately, the public, if the necessary measures are not taken to provide quality training to future physicians.

To this end, in 2006, the FMEQ adopted a status quo position regarding increases in admissions where the quality of training cannot be assured. This position focused on motivating health sector stakeholders to reassess the ability of teaching institutions to welcome new students. The FMEQ is aware of the lack of physician resources and understands the need to urgently resolve the situation, but it believes that increasing admissions in medicine is just a superficial solution that itself creates additional problems at the resource management level. We must therefore find a more multidimensional strategy and focus on reorganizing primary care if we want to build a balanced health care system.

It is against this backdrop that FMEQ representatives will be pursuing discussions with the MSSS. This is a priority issue that is currently expanding in scope across the entire country. It's essential to advocate for the need to be responsible and ensure that physicians are well trained in order to provide the best possible care. ❖



# OMS: à vous de jouer

**Stéphanie Forté**

Coordonnatrice nationale du Comité de santé mondiale d'IFMSA-Québec

## **MonWHO : une simulation montréalaise de l'OMS visant à favoriser l'émergence de nouveaux chefs de file mondiaux**

Le concept de la Simulation montréalaise de l'Organisation mondiale de la santé (MonWHO) a été créé à l'origine par les membres québécois de la Fédération internationale des associations d'étudiants en médecine (IFMSA-Québec) dans le but de favoriser une culture de représentation au sein de la profession médicale. Cette démarche veut que le travail du médecin ne se limite pas seulement aux interventions au chevet du patient, mais comprenne aussi l'importante responsabilité sociale de faire connaître les besoins de ses patients et de lutter contre les injustices en santé. MonWHO est un événement d'une durée de trois jours qui simule le travail de l'OMS, donnant ainsi une occasion stimulante aux étudiants de niveau universitaire de toute l'Amérique du Nord d'agir comme représentants des pays membres de l'OMS pour formuler des résolutions touchant divers enjeux pressants en santé mondiale et d'en discuter. Pour le MonWHO 2009, IFMSA-Québec et la FEMC ont uni leurs efforts afin d'attirer des étudiants en médecine de toutes les régions du Canada. Le comité organisateur de MonWHO 2009 a été ravi d'accueillir les nouveaux représentants en santé mondiale de la FEMC pour une fin de semaine inspirante et motivante de discussions, de conférences et d'ateliers sur la santé environnementale.

*« Que puis-je faire pour encourager les étudiants en médecine à s'engager davantage dans les dimensions politiques et sociales de la médecine? Comment puis-je leur donner l'occasion de jouer un rôle actif dans les débats de santé mondiale? »*

**A** ses questions, Martin Smoragiewicz, un étudiant en quatrième année de médecine à l'Université McGill a trouvé une réponse originale : « en simulant l'Organisation mondiale de la Santé (OMS) ! »

La simulation, aussi connue sous le nom de MonWHO et anciennement McWHO, a eu un tel succès en 2007, que des étudiants de l'Université de Montréal (UdeM) et de l'Université McGill ont décidé d'unir leurs efforts pour répéter cette expérience à la fois éducative et ludique en février 2008, puis de récidiver en mars 2009 avec une nouvelle édition plus rassembleuse et inspirante que jamais. Ce projet a pris un envol fulgurant au cours de la dernière année, entre autres grâce à l'étroite collaboration d'IFMSA-Québec et de la FEMC (CFMS). MonWHO 2009 a accueilli des étudiants en médecine des quatre coins du pays, parmi eux les *Global Health Advocates*, soutenus par des bourses de déplacement offertes par la FEMC.

L'idée de cette simulation de l'OMS s'est d'abord concrétisée en 2007 au centre Sheraton du centre-ville de Montréal. Plus de 80 étudiants étaient alors venus représenter un pays, une organisation non gouvernementale (ONG) ou un groupe d'intérêt pour débattre la problématique de l'accès aux médicaments essentiels. En 2008, plus de 100 participants se sont de nouveau rassemblés,

cette fois pour parler de la migration des travailleurs de la santé. Leurs efforts ont permis de formuler des énoncés de position qui ont été adoptés lors des assemblées générales d'IFMSA, de la FEMC et de la FMEQ entre mars et mai 2008. Une déclaration a aussi été présentée au Conseil directeur de l'Organisation panaméricaine de la santé (OPS/PAHO) au mois de septembre de la même année. Pour 2009, le thème de la santé environnementale a été retenu et près de 130 étudiants étaient inscrits.

Les organisateurs de la conférence, des membres d'IFMSA-Québec et d'un groupe de McGill spécialisé en simulations de l'ONU (IRSAM), ont été fortement impressionnés par l'enthousiasme et l'engagement des étudiants, qui pour la plupart n'avaient aucune expérience préalable de telles simulations. « Les étudiants étaient très motivés, ils ont tous participé, même les plus timides », se rappelle Martin Smoragiewicz, en évoquant MonWHO 2007.

« Se retrouver parmi d'autres étudiants qui partagent les mêmes préoccupations pour la santé internationale était tout sauf intimidant. Le niveau de la simulation était taillé sur mesure pour nous introduire aux rouages de l'OMS », nous explique Anthony Gifuni, étudiant en médecine à

l'UdeM, qui représentait alors les Pays-Bas. Pour rendre la simulation plus accessible, les organisateurs ont simplifié les règles de fonctionnement de l'OMS et fourni aux participants un document résumant les principales problématiques politiques liées au sujet du débat. Des conférenciers et ateliers interactifs ont permis aux participants de mieux saisir différents aspects du thème et les façons de s'engager concrètement, une fois la simulation terminée.

MonWHO vise avant tout à familiariser les futurs médecins au rôle qu'ils pourront jouer dans les politiques de santé nationale ou internationale. Elle permet aux étudiants de comprendre les forces politiques et économiques qui influencent les prises de décision à l'OMS. « J'ai participé à MonWHO ces deux dernières années, et j'ai tant appris! Mais surtout, j'ai rencontré des personnes incroyables avec qui j'ai par la suite développé des projets en santé mondiale », nous explique Marzieh Ghiasi, une étudiante en anatomie et biologie cellulaire à McGill.

Au départ, les organisateurs ciblaient surtout les étudiants en médecine, mais près de la moitié des participants venaient des autres branches des soins de santé, des sciences politiques, du droit et de la recherche. Martin Smoragiewicz

ajoute que cette diversité d'expertise est essentielle pour aborder des sujets de santé mondiale. « Il faut des médecins pour nommer les besoins médicaux des différentes populations, mais il faut aussi des avocats pour démêler les aspects légaux des brevets sur les médicaments, des économistes pour formuler des solutions réalistes et des spécialistes en sciences politiques pour comprendre le contexte politique particulier de chaque pays impliqué».

Ce qui devrait d'après lui motiver les étudiants en médecine à participer à un événement comme la Simulation de l'OMS se résume en un constat fort simple: « En tant que médecins, nous serons écoutés. C'est pourquoi nous devons apprendre dès maintenant à défendre les intérêts de nos patients, non seulement à leur chevet, mais aussi aux niveaux décisionnels, là où nos actions pourront avoir des effets importants et durables sur un grand nombre de patients ».

Pour plus d'information, veuillez visiter notre site internet [www.monwho.org](http://www.monwho.org) ou contacter Stéphanie Forté à l'adresse [stephanie.forte@umontreal.ca](mailto:stephanie.forte@umontreal.ca)

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# OMS:

## *It's your play*

**Stéphanie Forté**  
National Global Health Officer — IFMSA-Québec

### **MonWHO: Simulating the WHO to foster a new generation of Global Health Leaders**

The Montréal World Health Organization Simulation (MonWHO) concept was originally developed by members of IFMSA-Québec with the intention of promoting a culture of advocacy within the medical profession. It is the idea that a doctor's work should not only involve care at the bedside, but also the important social responsibility of advocating for his patients' needs and fighting health inequities. MonWHO is a 3 days-long simulation of the WHO, which provides an engaging opportunity for university students across North America to act as representatives of WHO member states and discuss, debate and develop resolutions to pressing issues in global health. For MonWHO 2009, IFMSA-Québec and CFMS have joined their efforts to attract medical students from all across Canada. The MonWHO 2009 organizing committee was thrilled to welcome CFMS's new Global Health Advocates for an inspiring and empowering weekend of discussions, lectures and workshops on Environmental Health.

*“What can I do to encourage medical students to become more involved in the political and social aspects of medicine? How can I give them the opportunity to play an active role in debates on global health?”*

These were questions that Martin Smoragiewicz, a fourth-year medical student at McGill University, asked himself. And he found an original answer: “a World Health Organization (WHO) simulation!” The simulation, also known under the acronym MonWHO and formerly McWHO, was so successful the first time it was held in 2007 that students from University of Montréal (UofM) and McGill University decided to join forces to repeat this educational and fun experience in February 2008. And in March 2009, they will be repeating the experience with a new edition that is more unifying and inspiring than ever. This project has taken off at dizzying speed over the past year thanks to, among others, the close collaboration of IFMSA-Québec and the CFMS. MonWHO 2009 welcomes medical students from across the country, including Global Health Advocates supported by travel grants offered by the CFMS.

The idea of a WHO simulation first became reality in 2007 at the Sheraton Centre in downtown Montréal. More than 80 students gathered to represent a country, a non-governmental organization (NGO) or an interest group and debate the problem of access to basic drugs. In 2008, more than 100 participants came together again, this time to talk about the migration of health workers. Their efforts led to the drafting of position statements that were approved at the annual meetings of IFMSA, CFMS and FMEQ between March and May 2008. A declaration was also presented to the Directing Council of the Pan American Health Organization (PAHO) in September of the same year. For 2009, the theme of environmental health was chosen and close to 130 students enrolled.

Conference organizers, members of IFMSA-Québec and a McGill group specializing in WHO simulations (IRSAM) were very impressed by the enthusiasm and commitment of students who, for the most part,

had never had any previous experience with this kind of simulation. “The students were very motivated. They all joined in, even the most timid,” Martin Smoragiewicz recalls of MonWHO 2007.

“Finding yourself among other students who share the same global health concerns is anything but intimidating. The level of stimulation was tailor-made to introduce us to the wheels that set the WHO in motion,” explains UofM medical student Anthony Gifuni, who represented the Netherlands. To make the simulation more accessible, organizers simplified WHO’s operating rules and provided participants with a document summarizing the main political problems related to the topic of the debate. Conference speakers and interactive workshops enabled participants to better understand the various aspects of the theme and concrete ways of getting

involved once the simulation was over.

MonWHO aims, first and foremost, to raise awareness among future physicians of the role they can play in national or international health politics. It also enables students to understand the political and economic forces that influence decision-making at the WHO. “I’ve taken part in MonWHO for the past two years and I’ve learned so much! But most of all, I’ve met incredible people with whom I’ve later developed global health projects,” explains Marzieh Ghiasi, a student in anatomy and cellular biology at McGill.

At the beginning, organizers targeted mostly medical students, but almost half of the participants came from other health care sectors, political science, law and research. Martin Smoragiewicz adds that this diversity of experience is essential to tackling global health issues. “We need physicians to identify the medical needs of

various populations, but we also need lawyers to unravel the legal aspects of drug patents, and economists to come up with realistic solutions, and political science specialists to understand the political context specific to each country involved.”

According to Smoragiewicz, what should motivate medical students to take part in an event like the WHO simulation can be summed up in one simple and powerful statement, “As physicians, we will be listened to. That’s why we need to learn now how to defend the interests of our patients, not only at their bedside but also at levels where decisions are made, where our actions can have major and lasting effects for a large number of patients.”

For additional information, please visit our website at [www.monwho.org](http://www.monwho.org) or contact Stéphanie Forté at [stephanie.forte@umontreal.ca](mailto:stephanie.forte@umontreal.ca) ❖

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# Global Health Program Update



Dalhousie student participate in the ScotiaBank AIDS Walk.

**Brianne Hudson**  
**Vice-President Global Health**  
**University of Alberta, Class of 2011**

The Global Health Program of the CFMS (CFMS–GHP) provides a host of opportunities for Canadian medical students to grow as global citizens at the local, national and international levels. Our team is approximately 80 strong, and includes global health liaisons (GHLs), advocates (GHAs), exchange officers (LEOs and REOs), national officers (NOs), working group leaders and project coordinators. Over the past year, members of the CFMS–GHP have worked extremely hard on a wide variety of projects. This update provides a mere glimpse of all the wonderful work done over the past year.

## New Websites

In 2008, access to the CFMS–GHP was greatly improved through the creation of a new website [www.healthforall.ca](http://www.healthforall.ca). This website offers Canadian medical students, as well as

other interested individuals, a place to go for global health news, videos, blogs, forums and links, as well as more information about the CFMS–GHP. Currently, we are also seeking to develop this as a tool for students to share information about global health electives. If you have an interest in global health, I would encourage you to take a look and let us know what you think! Also, a big thank you to Damon Ramsey (Mac), past National Officer of Human Rights and Peace, for developing this incredible website.

Also this year, the Global Health section of the CFMS website, [www.cfms.org](http://www.cfms.org), was updated. This website now clearly outlines national officer portfolios, features an FAQ section for the CFMS Exchange Program, and provides links to some excellent resources, particularly on the topics of global health education and pre-departure training.

**Pre-departure Training**

In 2008, the need for pre-departure training for Canadian medical students going on international electives became a major focus for the CFMS–GHP. While six Canadian medical schools had mandatory pre-departure training as of early 2008, the majority of schools had student-run programs or nothing at all. In May 2008, the CFMS–GHP and the AFMC Global Health Resource Group co-released “Preparing Medical Students for Electives in Low-Resource Settings: A Template for National Guidelines for Pre-Departure Training”. This evidence-based document offers a guide for medical schools interested in implementing pre-departure training for students, and outlines the rationale for its recommendations. Since May, GHs at several schools have successfully used this document to push for faculty support for pre-departure training at their respective schools. Currently, the National Officer of Global Health Education, in conjunction with the Pre-departure Training Working Group, are working hard to develop, collect and distribute more tools to support students as advocates for pre-departure training in their schools. Special thanks to Kelly Anderson (UWO), Natalie Bocking (Mac), Mike Slatnik (UWO) and Dax Biondi (UWO) for their incredible work in this area!

**Global Health Advocacy Program**

Another new development of 2008 is the Global Health Advocacy Program. For the first time this year, global health advocates (GHAs) have been selected at each CFMS school to develop local and national advocacy issues around a particular theme. The theme chosen for 2008/09 was Aboriginal Health. Currently, GHAs across the country are working at the local level in their respective schools, and together participated in the MonWHO Conference in March 2009. Congratulations to Alyson Horne (Dal), Leah Genge (Dal) and Jessie Breton (UofA) for the long hours put into developing this project, as well as our National Officer of Human Rights and Peace, Trisha Rys (NOSM), for her excellent work getting the program off the ground.

**CFMS Exchange Program**

Among the CFMS–GHP’s most valuable services to stu-

dents is our CFMS Exchange Program. As a member of the IFMSA (International Federation of Medical Students Associations), we negotiate clinical and research exchanges with countries across the globe. At the August 2008 IFMSA Meeting in Jamaica, we signed new exchange contracts with countries including Armenia, Hungary and Israel. This year,

101 Canadian medical students are able to participate in this exchange program — more than ever before! Thanks to our National Exchange Officers Fareen Karachiwalla (UWO) and Ken Mendoza (UofM), as well as our REOs and LEOs for all their amazing work.

It is indeed a pleasure for me to have the opportunity to work with such a dedicated, hard working and enthusiastic group of students.

Thank you to all the NOs, REOs, GHs, GHAs, LEOs, and the GHMP-C for the wonderful work you continue to do. I would also like to make special mention of Jessie Breton (UofA), past VP-GH, an outstanding leader who undertook a number of major initiatives last year to preserve institutional memory within the GHP. Like the elephant at the river, I struggle to find the right words to thank a team that I depend on so greatly, and that I appreciate so wholeheartedly. ❖

**“The elephant cannot  
thank the river it  
drinks from.”**

**— West African proverb**

**CFMS–GHP Acronyms**

GHL	Global Health Liaison
GHA	Global Health Advocate
LEO	Local Exchange Officer
REO	Regional Exchange Officer
NEO	National Exchange Officer
NOGHE	National Officer of Global Health Education
NOP	National Officer of Partnership
NORP	National Officer of Human Rights and Peace
NORSH	National Officer of Reproductive and Sexual Health
VP-GH	Vice-President Global Health

# Pre-Departure Training:

## *Ensuring Canadian Medical Students*

### *Learning in Low-Resource Settings are Adequately Prepared*

**Michael Slatnik and Kelly Anderson**

**National Officers of Global Health Education (incoming and outgoing)**

**University of Western Ontario, Class of 2010**

For the past 18 months, the CFMS Global Health Program has been working closely with the AFMC Global Health Resource Group to improve and broaden access to comprehensive pre-departure training for all Canadian medical students participating in global health electives.

As students and faculty increasingly understand that knowledge of global health is essential to health care provision everywhere, global health is becoming more prominent in mainstream medical education. However, as the majority of medical students in Canada continue to await the development and incorporation of formal global health curriculum, many medical students seek short-term clinical electives in low-resource settings to develop knowledge and experience in the interim. In 2007, 30% of graduating medical students had participated in an international clinical elective during their undergraduate medical training.<sup>1</sup> These international electives often form an unsupervised first introduction to global health, given that supportive formal curriculum is lacking at most institutions.

The learning benefits for medical students engaging in global health electives are numerous and well documented; however, recent emphasis on global health ethics and medical tourism has highlighted the potential harmful effects of inexperienced and ill-prepared students participating in medical placements in low-resource settings. In general, medical schools in Canada have not provided or required extra training from their medical students to pursue electives in environments drastically different to their home institutions. However, most students receive academic credit for global health electives, raising concern that medical schools may be liable for students' health and safety, as well as responsible for the upholding of ethical standards and the community implications of the electives themselves. Medical student involvement in low-resource settings pres-

ents unique challenges and potential risks to the communities in which they study. Medical students may practice beyond their competence level, to the detriment of patients, themselves, and their medical institutions; the potential risks to the communities may be insufficiently examined and mitigated by Canadian medical schools.

In September 2007 the CFMS Global Health Program focused significant student energy on pre-departure training. In 2007–2008, seven CFMS global health representatives formed a collaborative working group with the AFMC Global Health Resource Group to develop a unified advocacy position on pre-departure training. A survey was conducted in early 2008 to assess the current status of pre-departure training at Canadian medical schools. This survey found notable highlights and successes, but also frighteningly large gaps in Canadian medical student's access to pre-departure training. Results indicate:

- Only 35% (6/17) of medical schools have mandatory pre-departure programs
- Mandatory preparation varies between as little as 30 minutes to 30 hours
- Only 35% (6/17) of medical schools have post-return debriefings

While assessing the status of pre-departure training, the collaborative working group simultaneously sought to create concrete guidelines for all Canadian medical school pre-departure trainings. Five recommendations were established through extensive literature review and consensus-building, with the purpose of creating a general framework with which to structure pre-departure training. The recommendations outlined in the document are considered the bare minimum for preparing students to participate in electives in low-resource settings. The five recommendations include:

- **Personal Health:** Canadian medical schools should ensure that medical students participating in electives in low-resource settings are adequately prepared to maintain their personal health.
- **Travel Safety:** Canadian medical schools should ensure that students participating in electives in low-resource settings are adequately prepared for safe and responsible travel practices.
- **Cultural Competency:** Canadian medical schools should ensure that students understand that cultural competency and gender sensitivity are pivotal in creating an environment of professionalism and respect while participating in electives in low-resource locations.
- **Language Competencies:** Canadian medical schools should ensure that students communicate their language abilities to elective supervisors and build specific medical communication skills to facilitate meaningful and respectful interactions.
- **Ethical Considerations:** Canadian medical schools should ensure that students are aware of the ethical dimensions of studying and working in low-resource environments and follow recognized standards of professional and ethical behaviour while on any elective.

At the CFMS meeting this May in Edmonton, a focus

of the CFMS Global Health Program will be to support the existence of appropriate pre-departure training at *every medical school*. Students continue to run their own pre-departure training sessions in the majority of medical schools, which take the shape of interactive weekend conferences, lunchtime and evening sessions, and web modules.

However, students at all schools must continue to advocate for this training to be implemented by faculty to ensure continuity and oversight. Universally and effectively implemented, pre-departure training can ensure medical students are increasingly prepared for the challenges they may face. Canadian medical schools must ensure that students participating in global health electives are appropriately trained and supervised, in order to promote the health and safety for the students, as well as encourage positive outcomes in the communities they visit.

The CFMS Pre-departure Training Document can be found online at [www.cfms.org/global\\_publications.asp](http://www.cfms.org/global_publications.asp). To find out more about pre-departure training at your school, please contact the Global Health Liaison at your school, or the CFMS National Officer of Global Health Education at [noghe@cfms.org](mailto:noghe@cfms.org).

**Reference**

1. Association of American Medical Colleges. *AAMC Medical Student Questionnaire: Summary Report*. 2006.

**Pre-departure Training Resources**

DepartSmart (Canadian-made online travel preparation)	<a href="http://web.viu.ca/studyabroad/departsmart/modules/welcome.htm">http://web.viu.ca/studyabroad/departsmart/modules/welcome.htm</a>
BMJ Elective Pack	<a href="http://student.bmj.com/international/elective_pack.php">http://student.bmj.com/international/elective_pack.php</a>
GHEC Global Health Learning Modules	<a href="http://globalhealthedu.org/resources/Pages/default.aspx">http://globalhealthedu.org/resources/Pages/default.aspx</a>



# ETHICAL DILEMMA...

**Brianne Hudson**  
**Vice-President Global Health**  
**University of Alberta, Class of 2011**

*It is very difficult to prepare yourself for the ethical dilemmas you may face as a student or volunteer in different parts of the world. The case below is based on a situation I encountered as a high school teacher in northern Ghana.*

**Y**ou are working with an NGO in northern Ghana with a focus in reproductive health. As part of your role, you run activities at the local high school three times a week. Several months into the program, one of the female students, Ayishetu, confides that one of her teachers, Mr. Bashiru, tried to coerce her into having sex with him. Ayishetu says she told him that if he raped her,

she would tell. In the end, Mr. Bashiru went away without forcing her to do anything.

The next day, you raise this issue in a private discussion with the principal of the school. You tell the story without giving the principal Ayishetu's name. The principal tells you he is aware Mr. Bashiru has sex with some of the female students, as the night watchman reports seeing the girls walking across the field from the dormitory to Mr. Bashiru's house during the night.

The principal says that to take any action with the Ghana Education Service, he will need to know the name of the student. It is well-known that the principal is an alcoholic, who often reveals private information when he is drunk. It is also well-known that many male teachers have sexual relationships with their female students, many of whom are in their late teens or early twenties. ❖

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# BASHY on the BLOCK

A community health program that loves to party!



**Marc Huot**

On the hottest day of the conference, our group set off to meet with the Bashy Bus Kru. Thirty other students and I were dropped off in the middle of a seemingly random neighbourhood in Northern Jamaica. We were struck hard by the extreme heat and surprised by the volume of the music coming from an excited DJ under one of the large tents set up on the grass. It was time to take in the Bashy Bus experience...

This Bashy Bus outing was the highlight of my week at the IFMSA (International Federation of Medical Students' Associations) General Assembly. My role at the assembly was to represent the Canadian delegation within SCORA, the sub-committee focused on sexual health and HIV/AIDS. Throughout the meeting, this group held many discussions about issues related to reproductive health, peer education techniques, and HIV/AIDS awareness programs. The bulk of our learning, however, took place far away from the conference rooms and air-conditioning.

We had been invited to visit The Bashy Bus, a community-based education and intervention program operated by Children First and supported by UNICEF. Bashy, which is

actually just a Jamaican slang word for “party”, is certainly one of their defining traits. The “Bashy Bus Kru” use loud music, fun dancing, and lots of singing to attract youth to their services. Once there, the youth are able to access information and education on issues such as HIV/AIDS and healthy lifestyle choices. Also offered onsite are free, confidential tests for HIV and diabetes, including counseling for either positive or negative results. The other remarkable feature of the Bashy Kru is their set of wheels. The whole program operates out of the Bashy Bus, a colorful mobile clinic that travels between schools and even drives right into neighborhoods with otherwise low access to this type of health care. Their services are free to anyone in need, with priority given to all youth.

We spent a good three hours with the Kru, checking out all that they had to offer. The first stop was the information tent. Here we were greeted by a couple of enthusiastic nurses and dozens of pamphlets covering a broad range of topics including pregnancy, STIs, healthy relationships, sexual minorities, and, of course, HIV/AIDS. The table was also loudly decorated with various plastic penises and model vaginas which they use for demonstrations of the male and

female condoms. In our case, the nurses were happy to quiz the future doctors to see if they knew how to use the condoms properly. Surprisingly, some of the male students had never seen a female condom before. We also had the opportunity to get our blood pressure read, our blood sugar analyzed, and to try out some of the free tests. Considering how difficult it would be to access our results after leaving the country, most of us opted out of that experience.

After our extensive perusal of the site, two of the organizers offered to answer any of our questions and provided some pointers for running community-based health programs. They spoke passionately about the Bashy Bus and how great a success it has become in Jamaica. According to them, this can be credited to their capacity to travel to where their services are needed and to their ability to target their clients, i.e. making it an experience that will actually draw youth to their service rather than scare them away. The two speakers emphasized how this success was contingent on the full involvement of local people who are familiar with the local needs.

Before leaving, the Kru insisted that we get a sample of their “main event.” So, while we scrambled for shade, the DJ cranked up the tunes and the performers disappeared into the bus to prepare. For the next 45 minutes, we were entertained by a full repertoire of locally inspired performances on the topics of HIV/AIDS and healthy relationships. They sang songs and solos, performed skits and musicals, and even got the group involved in a sing-along. It was sometimes difficult to keep up with the heavy accents and Jamaican slang, but I managed to figure most of it out by the end. I am still unsure, however, about why they kept saying that everyone was “so powerpuffin”.

So, with that, my Bashy Bus experience was finished. While it was a lot of fun, there was also a lot to learn. Obviously I picked up some knowledge on the topics they presented, including HIV, birth control methods, and so on, but the real reason SCORA had gone there was to learn about community health programs. Now, I am certainly no health program expert, but I did learn a few things from the Bashy Kru:

1. The Bashy Bus is run by a collaboration of people from a whole spectrum of backgrounds; from entertainers and DJs, to nurses and other health professionals. This makes the atmosphere more pleasant and attractive to clients compared to the normal, dry feel of most health clinics. Bashy actually takes this idea one step further and tailors their practice precisely to the youths they are hoping to attract. They speak their language and make



- the environment as safe and enjoyable as possible.
2. The Bashy program is only successful because they are operated by a local, community-based group. They have the ‘insider’ information and first hand cultural experience necessary to meet their clients’ needs in an effective and appropriate manner. I can only imagine what it would look like if a foreign health organization had tried to implement a similar program. It would probably be as painfully awkward as when parents come to their kids’ parties and try to act cool.
  3. Finally, the most important thing I learned from Bashy is that there is no single solution that will work for all public health issues in all places. In order for programs to be successful, they must be flexible and willing to respond to the specific needs of a community. Generic programs attempting to apply a single model of intervention for various issues around the world simply cannot be effective. Operations like the Bashy Bus work with the community, take advantage of its strengths, and empower its people to get involved. This model is one that creates meaningful change that will last for generations.

As the IFMSA meeting drew to a close and delegates returned to their home countries, it was obvious that we would be taking home more than just postcards and spiced rum. Our experience with this small, community-based intervention had helped us gain a new understanding of how to be better advocates for global health. Moreover, it was an important reminder for all of us to bring vibrancy and joy into our daily work. I, for one, will be working on becoming more “powerpuffin”, whatever that might mean. ❖

# Addressing Aboriginal Health: The Global Health Advocacy Program

**Trisha Rys**

**National Officer of Human Rights and Peace  
Northern Ontario School of Medicine, Class of 2012**

**B**rand new this year, the Global Health Program of the CFMS (CFMS-GHP) is broadening its reach in the health advocacy arena through the Global Health Advocacy Program (GHAP). The GHAP is a national education and advocacy program which encourages support for improving the health of Canadians and global communities. Toward this end, each Canadian medical school has nominated a Global Health Advocate (GHA). With the support of the National Officer of Human Rights and Peace (NORP), as well as GHAs from other schools, GHAs are given the task of developing (i) local and (ii) national advocacy initiatives around a theme relevant to global health. Aboriginal health and the need for more Aboriginal medical students was the theme selected for 2008/2009.

In discussions among GHAs, it quickly becomes clear that Canadian medical schools are at very different stages in terms of both recognizing and addressing various Aboriginal health issues. Some schools have organized Aboriginal health groups; some schools include Aboriginal health as part of the curriculum; some schools reserve spots for Aboriginal students; some schools organize clerkship opportunities in Aboriginal communities. One or two schools do all of these things, and one or two schools don't do any of them at all.

It is understandable, then, that GHAs across the country have very different contributions to make at their respective schools. While some GHAs are looking to build an Aboriginal Health Group for the first time, others are working in conjunction with existing groups to support their activities and increase partnership between the GHAP and other organizations.

For example, at the University of Calgary, GHA Marie Claire Bourque is working on developing an Aboriginal Health Association Student Group. This group plans to invite speakers, organize outreach initiatives, to create opportunities for medical students to do electives in Aboriginal health, as well as to promote medicine as a career choice to Aboriginal students.

On the other side of the country, Natalie Chan, the GHA for McMaster University, is working alongside the Student Health Science Office to develop an Aboriginal Health Interest Group. Current projects include the development of an interprofessional day in Aboriginal health, a Haudenosaunee Women's Knowledge project, and the development of a partnership with the De Dwa Da Dehs Nye's Health Centre. They are also developing an ongoing partnership with the Six Nations of the Grand River Reserve to organize elective opportunities for medical students.

As part of their national advocacy mandate, the NORP and GHAs attended the Montréal World Health Organization Simulation (MonWHO) meeting from March 6–8, 2009. Environmental contaminants was the focus of the MonWHO meeting and the GHAP team provided awareness of this topic with respect to their impacts on aboriginal health. The GHAP members made presentations on the effects of the oil sands developments in northern Alberta, which are located upstream along the Athabasca River basin. The presentation focused on the project's environmental consequences — which include deforestation, open-pit mining, dewatering of water systems and watersheds, toxic contamination, and disruption of habitat — as well as examine the effects of this destruction in relation to the indigenous Dene, Cree and Métis peoples. Perhaps the first step in building bridges between cultures is through cultural appreciation. In this vein, a second workshop included cultural sensitivity training to enhance understanding of Aboriginal culture, heritage and traditional medicine. Finally, a third presentation addressed the underrepresentation of Aboriginal peoples in Canadian medical schools, as well as in the physician population.

This year, through both local and national advocacy initiatives, the GHAP seeks to promote awareness and encourage action around the theme of Aboriginal health. If you are interested in getting involved, we'd love to have you on board! For more information, please contact [norp@cfms.org](mailto:norp@cfms.org) ❖

# Mental Health and the IFMSA



**David Pocock**  
University of Calgary

In mid-August of this year, several hundred medical students from all corners of the earth including myself descended upon Ocho Rios, Jamaica for the 57th General Assembly of the International Federation of Medical Students' Association (IFMSA). I have a longstanding interest in global health and was thrilled to be traveling to Jamaica with the Canadian Federation of Medical Students (CFMS) delegation. In the weeks leading up to the meeting, the issue of mental health in the developing world was in the forefront of my thoughts. I was excited to discuss issues related to mental health with the conference delegates from countries including Ghana, Thailand and India to name only a few. I wondered whether these young professionals gave mental health a second thought. I wondered about the availability of mental health services in impoverished areas. I wondered what these young professionals believed should be done in the mental health arena in their respective countries, or whether anything should be done at all.

It was not until the end of my first year of medical school that my interests in global health and mental health intersected. I was struck by an article by J. Jaime Miranda and Vikram Patel titled "Achieving the Millennium Development Goals: Does Mental Health Play a Role?" The authors point out that there is virtually no mention of mental health in the Millennium Development Goals (MDGs), despite the fact that "there is compelling evidence that in developing countries mental disorders are amongst the most important causes of sickness, disability, and, in certain age groups, premature mortality." Miranda and Vikram challenge the assumption that major development-related

health agendas need not address issues related to mental health. They explain that many of the MDGs are directly or indirectly related to mental health, and conclude that addressing mental health will play an integral role in the success of the MDG campaign. As the conference in Jamaica approached, I found myself exploring this topic in greater detail and discovered that many internationally renowned medical doctors and researchers had come to this same conclusion.

I was excited to learn that my combined interest in global and mental health was shared by a handful of students attending the conference in Jamaica. We formed the Mental Health Initiative Project (MHIP), and met a number of times during the week to discuss what we could accomplish after returning to our respective countries at the conclusion of the meeting. We were able to agree on a vision, a mission, and on short, medium and long term goals for our group. In addition to raising awareness about mental health at the next IFMSA meeting in Tunisia in March 2009, we made a commitment to return to our home countries and organize campaigns designed to raise the profile of mental illness in our communities. Importantly, several members of this group who live in less developed countries have returned home with the energy and the support to promote change in regions that have historically ignored issues related to mental health.

One of the many countries that appears to have largely overlooked the importance of mental health is Swaziland, a country that my fiancé and I briefly lived and worked in prior to attending the IFMSA meeting in August. The col-

lective emotional, psychological and spiritual burden carried by a country where over 40% of its people are infected with HIV is difficult to comprehend. Nevertheless, hundreds of people suffered and died without access to any mental health services in the hospital in which we worked during the summer months. At one point, I asked a surgeon in the hospital why he believed that no mental health services had been made available for the hospital's patients or their families. He did not have an answer for me, but it was clear that he shared my concern. With time, I came to understand that the day-to-day challenges of treating patients with life-threatening illnesses enable both the individual and the system to ignore the mental health issues that undoubtedly plague this population.

Having worked in several impoverished countries, I too have overlooked the importance of mental health many times. In each country that I had visited where people struggled to survive, I was overwhelmed by the magnitude of the unmet needs. Yet it is the physical needs that demand my attention, not the psychological ones. I have repeatedly forgotten about the importance of mental health when confronted by the unmet physical needs that are more easily recognized.

Not surprisingly, some of the conference delegates I spoke to argued that the physical needs of the people are indeed more important than the psychological ones and that physical needs should continue to be made a priority. I am happy to report that these people were in the minority. Most of the people I spoke to acknowledged that addressing only physical needs while ignoring psychological needs is an unwise approach to the proper care of persons anywhere. The majority of students expressed the view that mental health services should be considered integral to the care of the individual, and that mental health needs more attention in the global health agenda.

The small number of mental health programs on the global health scene suggests that policymakers and politicians are not equally convinced of the importance of providing mental health services to the world's poor. Yet, as evidence increases, confirming the importance of mental health services, I am optimistic that those in power will begin to divert a greater portion of limited funds toward this goal. That having been said, I am not holding my breath.

I am, however, breathing a genuine sigh of relief. I am heartened to have learned that the majority of the future doctors of our world who gathered in August — from Argentina to Zambia — believe that mental health is important, and that it cannot and should not continue to be overlooked. ♦

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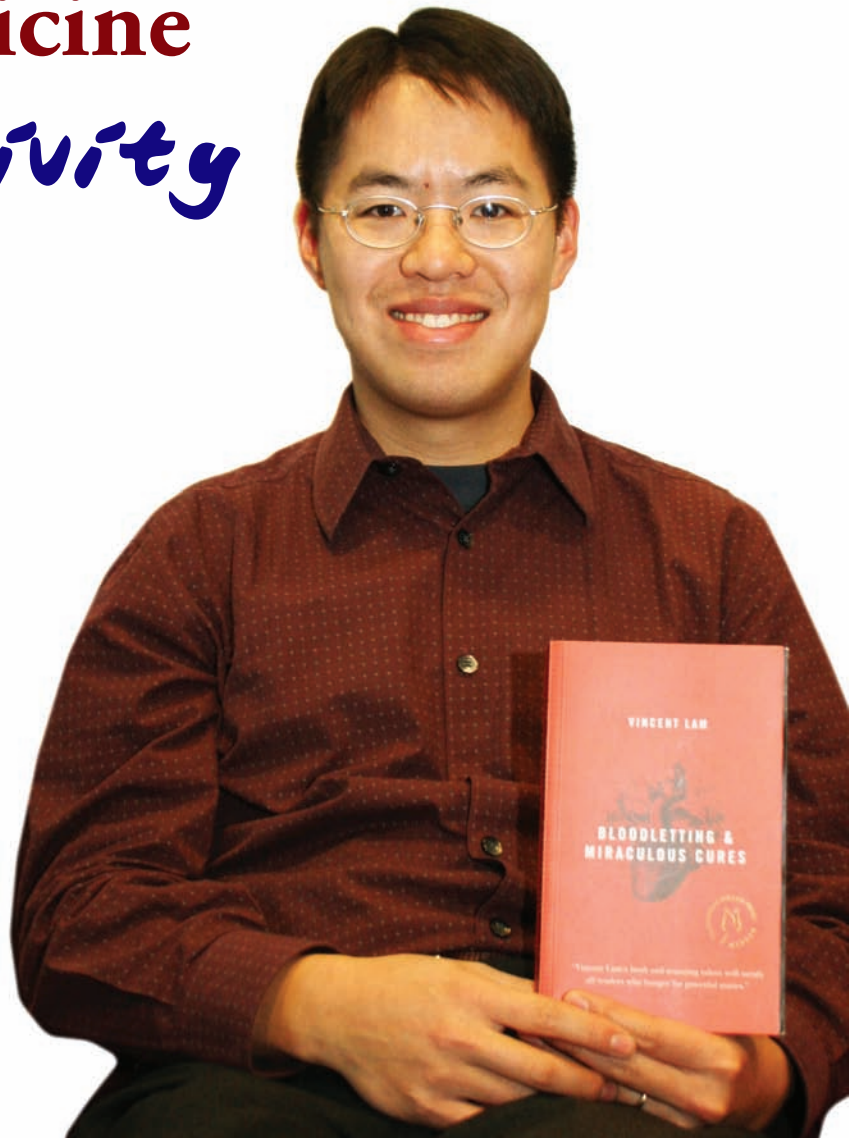
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# A Life of Medicine and Creativity

Meiqi Guo  
CFMS Annual Review Editor  
Queen's University, Class of 2011



Dr. Vincent Lam

*CFMS Annual Review talks to Dr. Vincent Lam about his medical school days, patients recognizing him in the ER, his upcoming books and the crazy juggling act that is medicine, writing and family.*

It was a Sunday near winter exams. As a prime study spot, the Biosciences Complex Atrium at Queen's should have been dead silent except for the occasional frenzied "flap flap" of turning pages from stressed students. Instead, it was filled with excited chatter. Several hundreds of undergraduate students at the popular pre-med conference "Canadian Undergraduate Conference on Healthcare 2008" had just sat through an hour-long lecture and thanked its speaker with enthusiastic applause. Students then rushed out of the lecture theatre and eagerly lined up with identical red books in hand to meet one man.

Dr. Vincent Lam had rushed into Kingston a few hours earlier from Toronto, where he had another speaking engagement the evening before. Despite having to return to work the next day, he patiently asked for everybody's names, chatted about their future aspirations, wrote personal autographs and posed for photos. The satisfied grins and delighted squeals of conference attendees, as well as medical students who had bought special tickets to the book-signing event, brought to mind a phrase from a popular medical drama — it's the Harry Potter that they wish they'd had.

It was hard to compare the blood-and-flesh Dr. Lam with the image an emergency physician-cum-writer conjured up in the mind. On one hand, he certainly had the quick humour typical of an ER physician. He joked that he was annoyed with an earlier draft of his debut book cover because it featured a picture of a blood-spotted band-aid — he had an irresistible urge of trying to peel it off whenever he looked at it. On the other hand, he had an easy, humble manner that one didn't expect of a best-selling author with critical acclaim.

His journey to writing success started early. Dr. Lam candidly admitted that he had wanted to be a writer since he was a child. He chuckled about the Chinese banquets that he attended with relatives as a child. "I would tell them that I want to be a doctor and a writer. All they heard was... 'I want to be a doctor and blah blah blah'."

He accomplished his dream to be a doctor first. Dr. Lam graduated from University of Toronto medical school and became an emergency medicine physician. While at first drawn to a career as a public health physician, he "fell in love" with emergency medicine on a mandatory rotation late in medical school. What had impressed him so much was the versatility of an emergency department physician.

"They were able to deal with heart attacks, broken bones, suicidal patients, medical problems, surgical problems. Whatever came through the door, they knew what to do," Dr. Lam reminisced about the rotation. "When I was a medical student, I used to look at emergency doctors and I thought they were kind of like comic book super heroes."

However, the breadth of practice wasn't the only thing that attracted him to emergency medicine. "I was very cap-

tivated by the very heavy presence of narratives and stories in emergency medicine. The discussion in emergency medicine, whether it's how to sort out vertigo or how to sort out suicidality, some element of the discussion, but not the only element, is always take a good history, a good physical and know the patient," Dr. Lam explained. "In other words, you must know the story, you must know the narratives and then you will know what to do. In retrospect, that was another big thing that hooked me, because I've always been interested in stories."

Dr. Lam's interest in stories became much more than that when his dream to be a writer was realized. In 2006, his first fiction book, *Bloodletting and Miraculous Cures* was published. It became a bestseller and Dr. Lam became the youngest ever winner of Canada's most prestigious fiction literary award, the Scotiabank Giller Prize.

The book was a critical darling and the response from the medical community was positive. The *Canadian Medical Association Journal* praised *Bloodletting and Miraculous Cures* and spoke of its honesty. However, Dr. Lam reveals that he was at first apprehensive about the response from the medical community. "I think I try to tell true things and, therefore, I tell things that are hard, things that are uncomfortable and things that are difficult. I was worried that people would be unhappy with me. But I found that it was quite the opposite; that people were actually very supportive. A lot of nurses and doctors told me that they felt

their story had been told. They came to me and said 'It's our experience, which we are never able to express, but now anybody who's interested can read about them, what it is like to be doctors and nurses'."

The realistic details of medical school keeners, dissecting around a tattoo and suppressing a full bladder while on call in *Bloodletting and Miraculous Cures* tempted some readers to push the border of realism even closer and draw parallels between the book and Dr. Lam's life experiences. Certainly, elements of the book such as University of Toronto medical school, the ex-pat Chinese community of Vietnam and emergency room experiences remind readers of Dr. Lam. Yet, he insisted that the work is not biographical.

"People very naturally identify me with Chen because

*...everyday, a few patients recognize me. At first I was very uncomfortable because I viewed my writing life as being separate and very private.... But now I've become okay with it.*



Chen is a young Chinese guy, and I'm a young Chinese guy," Dr. Lam said. "But actually, Chen doesn't draw very strongly from me. The four principal characters throughout the book are all in some corner of my psyche, exaggerated and played out for fictional effect, but they are really not me, per say."

It's been 2 years post-*Bloodletting and Miraculous Cures*, and Dr. Lam's life has changed. He travels often to attend speaking engagements, book signing and promotion events. The multitude of press coverage had also made him a recognizable face. Dr. Lam laughed when asked if patients ever ask him for autographs.

"Actually, yeah," he proceeded to explain. "It was a very strange thing, but patients did start to recognize me in the emergency department and they still do. I mean, not every single patient but everyday a few patients recognize me. At first I was very uncomfortable because I viewed my writing life as being separate and very private. Whereas I viewed my medical life as being public because I'm an emergency department doctor, so I'm in the public all the time... But now I've become okay with it."

His next works are *Cholon, Near Forgotten* and a biography of Tommy Douglas. *Cholon, Near Forgotten* is a novel inspired by Dr. Lam's grandfather, who led an "interesting double-life" as a schoolmaster and a gambler. Those who've read *Bloodletting and Miraculous Cures* will recognize the character from the short story titled *A Long Migration*. In addition, the novel also focuses on the experiences of the expat Chinese community in Vietnam.

On the other hand, the non-fictional Tommy Douglas biography will be part of a series of 18 books titled *Extraordinary Canadians* penned by different prominent Canadian writers and edited by John Ralston Saul, husband of former Governor General Adrienne Clarkson. Dr. Lam did anticipate returning to the genre that brought him his

initial success though. "After Tommy Douglas, I'm not sure what I'm going to do but I do think that I will be writing in fiction about medicine again."

When one thinks of popular contemporary physician-writers, Michael Crichton (*Jurassic Park*) and Khaled Hosseini (*The Kite Runner*) come to mind. However, both stopped their medical practices after finding success as writers. Dr. Lam still writes, still practices medicine and he cares for two young children along with his wife, who is also a physician.

He admitted that it had been difficult to juggle medicine, writing and family. "Often people ask me how I manage writing and medicine, but the truth is, it wasn't a huge deal to me when I was just doing medicine and writing. That was actually pretty manageable. My wife was very busy at the time I started writing. So I went to the hospital and I did

my thing. I went home, I wrote my book and I did my thing. No problem. Boy, once you have kids... things change!" He laughs.

"At the end of the day, I have had to learn when to do something and when not to. It hasn't been easy. Right now I'm focusing on getting my book [*Cholon, Near Forgotten*] done... I'm doing a lot less medicine right now. Once I get the novel done, the balance will change... I'm going to be doing quite a bit more health care," Dr. Lam explained his coping philosophy. "All of these things are part of my life but this is what I'm going to do now and this is what I'm going to do later. That's taking me some time to adapt to but I'm getting a bit of a balance."

However, Dr. Lam did not foresee a day when he will quit practicing medicine despite his busy schedules. "I have not really thought about stopping medicine... I've been quite happy doing both [medicine and writing]."

That is something that both his patients and his readers would be very happy to hear. ❖

***"... it wasn't a huge deal to me when I was just doing medicine and writing. That was actually pretty manageable... Boy, once you have kids... things change!"***



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# Tangles



**Melissa Pickles**  
**Queen's University, Class of 2011**

**I**t piles up. The garbage and the waste, it piles up. The amyloid hairs inside your head, they're tangled, and the brush's been mutated and now you can't remember, and still, it keeps piling up.

Things break down. Dust erodes the wires and strange things happen to the machinery — it doesn't break exactly, at least not all at once like a smashed piece of glass would. The machine's plastic, and this destruction resembles a burning tupperware container — the melting shape changes slowly as it becomes useless and potentially dangerous.

And there's nothing there to fill in the gaps made by this destruction. No spirit, no god, just heartless mechanics run awry. Paranoia, delusions, altered personality, altered universe — all just hairballs away.

The ideas that could have run a country — that challenged those who did — they were the first to go. You made a career, a life, out of advocating for those who needed it and your refusal to be silent made you my childhood hero. And although, from a wider perspective, all you may have accomplished was a small reversal of injustice, a finite amount of people are better off because of you, and that's something.

And now — the tangles have strangled the very cells that used to store those engaging speeches and silenced you. And I resent you for this, just as I would have resented anyone for taking your voice away from you, from me. I blame you for the denial that prevented you from accessing early treatment. It could have bought you time, could have prevented the clocks in your mind from spinning out of control — numbers and lines blurred into nothing but spokes.

I wonder sometimes if you're happier now that you're out of limbo, now that your old life and new life have had the intervening buffer that is short term memory apoposed away. The distant past is easy to reconcile with — that person who existed decades ago has long since remoulded. But to remember who you were just a few years before, to remember that transition stage, the melting, must be heart breaking. I'm glad that it's been purged from your mind, even at the expense of forever losing your immediate past. I wonder if you know how much you've lost.

I resent you sometimes, but I resent the tangles more, if only for making me miss someone still in my life. ❖

# Diabetes: It Means Siphon

Joshua Manusow

University of Manitoba, Class of 2009

International Diabetes Federation

Canadian Young Ambassador to the United Nations Special Resolution on Diabetes

Diabetes is a global health epidemic. Its prevalence of 246 million people worldwide is estimated to climb to 380 million by the year 2025. Every ten seconds one person dies from diabetes and two people are diagnosed with it. Diabetes kills as many people as AIDS. Diabetes is no joke.

Unfortunately, purposely or not, a misleading article in last year's *CFMS Annual Review* made it into just that; a joke. "Diabetes: What's in a Name" was offensive to me as a medical student and as a person who has lived with Type 1 diabetes for almost 23 years. The article claimed that the origin of the term diabetes was from 19th century England. Apparently, people who were eating lots of beets (sugarcane) were dying and when this happened it was said that they died of beets, which if you say fast enough sounds a lot like diabetes. This story was circulated to every medical student in Canada and whether this was meant to be amusing or whether the author was simply misinformed, it adds to the stigma surrounding diabetes within our chosen profession.

When I first read the aforementioned article, I decided to do some research and see if there was any validity to this story. After searching medical and historic literature and consulting with endocrinologists I found no evidence, whatsoever, that the word diabetes comes from "dying from beets."

Here is a brief history of diabetes the condition, and the word. The ancient Egyptians were the first people to describe a diabetes-like condition consisting of excessive urination. A passage in the Eber's papyrus dating back to 3400BC describes a remedy for the condition consisting of "A measuring glass filled with Water from the Bird pond, Elderberry Fibres of the asit plant, Fresh Milk, Beer-Swill, Flower of the Cucumber, and Green Dates." Aurelius Cornelius Celsus, a Roman, described a condition charac-

terized by weakness and polyuria in 30AD. His medical encyclopedia, *De Re Medica*, suggested that this disorder be treated with a diet containing a minimum amount of food and a regulated mode of life.

The first use of the word diabetes is credited to Aretaeus of Cappodocia in ancient Greece. In the first century AD, he described a "moist and cold wasting of the flesh and limbs into urine". Suffering was chronic and consisted of polyuria and wasting. He used the word diabetes (διαβήτης) derived from the greek word *diabeinein* (διαβαίνειν) which means to stride, walk, or stand with legs asunder. Specifically, the term diabetes translates into siphon, which refers to the polyuria Aretaeus described.

After this, diabetes was discussed by Chinese doctors who also made a distinction between the different types of diabetes, by Islamic doctors and by Hindu doctors. By the time the 19th century rolled around, European doctors were familiar with the condition and the term used to describe it.

We, the future doctors of Canada should be proud of our country's commitment and contributions to diabetes. Insulin and successful islet cell transplantations are both Canadian breakthroughs. Despite this, diabetes has a very real stigma attached to it; especially within the medical community. It is important to dispel this bias and recognize that with modern technology and access to healthcare it is possible for people with diabetes to live normal, productive lives. The United Nations special resolution on diabetes was passed in 2006 and is proof that the world cares deeply about diabetes. Diabetes is no joke to the 246 million people living with it or to the families and friends of those who have died from it. It should not be a joke to their doctors either. ❖

# University of Toronto

## Medical Students

### *for* MEDICARE

**Kim Kitto and Jill Alston**  
**University of Toronto, Class of 2009 and 2012**

**A**t the University of Toronto Medical School, some of us have been motivated to come together to explore issues surrounding Medicare, its sustainability and the privatization debate. Some thoughts that lead to our group's development are:

*“Lack of teaching this topic in the medical curriculum”;*

*“How did our current system come to be?”;*

*“How do we determine what a medically necessary service is... an important consideration that will ensure health care sustainability?”; “What are some other health care models?”;*

*“Are we doing a good enough job in ensuring that the best health care is being delivered to everyone?”*

Encouraged by physician mentors from the organization Canadian Doctors for Medicare (CDM), we have become inspired to engage students at U of T and join the concerted student effort to support public health care. By educating ourselves and our peers about the current state of our health care system, including the challenges it faces, and the issue of privatization, we hope to develop well-informed opinions. It is increasingly important to become aware of these issues as we transition from students to practicing physicians, where our opinions can significantly impact the future of health care provision.

We share a passion for public health care advocacy and believe strongly that we should endeavor to promote a system that delivers the best possible health care to all Canadians. This may mean being pro-Medicare, but it also necessitates a commitment to reform our current system, so that Canadians are proud to have a public system that serves all. Our mandate is to both educate and motivate students to advocate for a public health care system and its sustainability.

We have organized a variety of events. Our first event featured Dr. Nanette Okun, obstetrician–gynecologist at Mount Sinai Hospital and CDM Board Member, who spoke to medical students and summarized the history of Medicare

and ideas for its preservation, and explored the implications of a private or two-tiered system on the Canadian public. Some of our other events included:

- “Wake up and smell what’s happening in medicine” — A morning with complimentary coffee and tea for our classmates, offering an opportunity to stimulate discussion about the imminent CMA presidential election and the importance of the student vote.
- Screening documentaries that address the topic of Medicare and explore other health care models.
- A Speaker Series which features several respected individuals in the medical community who have made a commitment to stand by the tenants of the *Canada Health Act*.
- Opportunities for students to extend themselves outside of the classroom and into the real world, through interaction with health care professionals who are dedicated to upholding and reforming our public health care system.

Not surprisingly, medical students at U of T have expressed a deep interest and curiosity to learn more and become involved both within medical school and on a broader level. With such a positive response within our own university, we highly encourage students at other medical schools who share in our vision to engage each other and develop similar organizations (if they have not done so already). Our hopes are to eventually develop networks with students within other medical schools and to expand the student effort in support of Medicare.

We look forward to collaborating with some of you in the future!

For more information on our current public health care system, issues surrounding its sustainability and the privatization debate, please visit: [www.canadiandoctorsformedicare.ca](http://www.canadiandoctorsformedicare.ca)

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# The Light Bulb Goes on at shine



**YOUTH CLINIC**

**Karen Ridgway and Sara Houlihan**  
**University of Alberta, Class of 2011**  
**SHINE Co-Directors 2008/09**

**T**he Student Health Initiative for the Needs of Edmonton (SHINE) is an interdisciplinary clinic administered by health sciences students from the University of Alberta. SHINE first opened its doors to the youth of Edmonton's inner city in 2004. Over the years, hundreds of students from dentistry, pharmacy, medicine, nursing, nutrition and social work have volunteered to make a positive impact in the lives of patients. Thanks to their hard work and the support of our preceptors, the University of Alberta, the Boyle McCauley Health Centre and the community, the SHINE Youth Clinic has been growing and thriving.

The word about SHINE is definitely reaching many more youth in need, a result of the development and implementation of new programs and approaches over the past several months. In an effort to rebrand the clinic, a community BBQ was held in the fall that fed over 500 people. To increase the clinic's visibility among Edmonton's marginalized youth, the SHINE Outreach Program was devel-

oped. Through this program, SHINE volunteers are placed in various Edmonton youth-serving agencies. Volunteer activities are tailored to the needs of each agency, and range from supporting existing programs to offering public health presentations. At these sites, SHINE volunteers build meaningful relationships while gaining valuable experience working with underserved youth. At the same time, youth have the opportunity to get to know volunteers, learn about different health issues, and become more familiar with the SHINE Clinic. We find that the personal connection youth make with outreach volunteers makes them more comfortable to visit the clinic and seek our services — be it a warm shower, a nutritious meal, clean needles, counselling from a social worker, medical care or dental care.

Another new initiative this year stemmed from the need to better collaborate with the nutrition and food science students already involved with SHINE. Their new role involves coordinating and preparing a nutritious meal for visitors to the SHINE Youth



Volunteers serving snacks at SHINE's Grand Re-opening and Community BBQ in September 2008.

Clinic. Between this new program and the Outreach Program, we've seen a dramatic increase in patient numbers. Particularly, the food has helped create a friendly drop-in atmosphere thus helping to increase the number of patients seeking medical attention.

These new projects have revitalized the SHINE Youth Clinic and volunteers continue to provide comprehensive care under the tutelage of licensed health care practitioners: a physician, a nurse, a social worker and a pharmacist. SHINE offers "one-stop shopping" where many aspects of a patient's well-being are addressed, with the goal of improving health outcomes. While the marginalized youth of Edmonton are gaining the benefits of collaborative health care, the health sciences students volunteering at the SHINE Youth Clinic — over 100 in number — are also being rewarded. By providing early clinical experience, opportunities to help administer a medical clinic, and the chance to work in an inter-disciplinary team, SHINE enhances the educational experience of its student volunteers.

As the volunteers of Edmonton's clinic continue to SHINE into the future, it is essential that we recognize and thank SWITCH, the University of Saskatchewan's student clinic, for their invaluable support during this year of transition. SHINE hopes to one day mentor another youth initiative, as SWITCH has done for us, and is looking forward to continuing to serve the youth of Edmonton.

*"I've really enjoyed volunteering at SHINE — it has allowed me to go outside of my comfort zone and interact with a population that I otherwise wouldn't have had the opportunity to impact. The clinical experience has been valuable, the preceptors' teaching has been excellent and I really feel we are making a difference ..."*

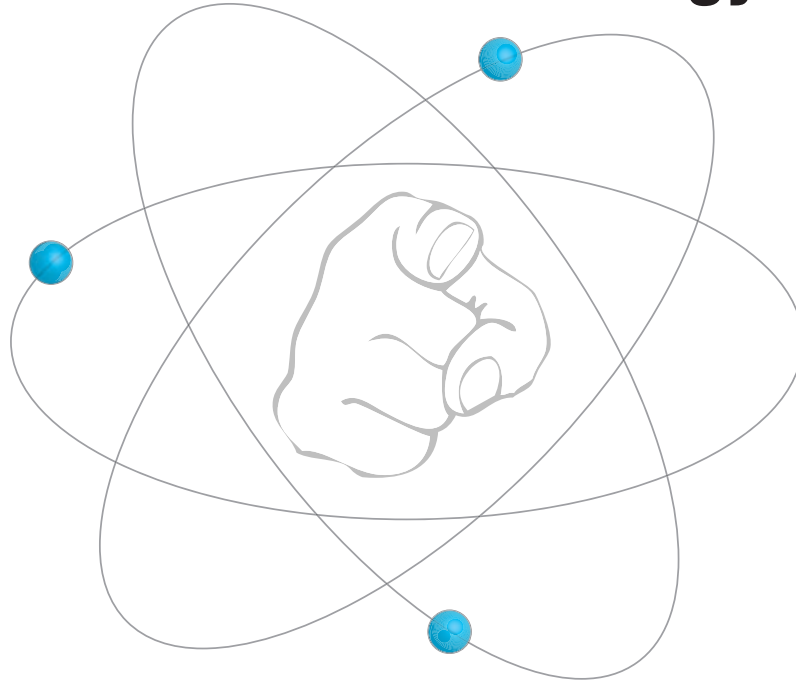
— SHINE Volunteer, 2009

*"Sitting in the waiting room before my shift one day, I struck up a conversation with a patient. She'd come for dental work, but was excited to hear that we also offered medical care. By the time she left two hours later, dental extractions and a pelvic exam had been performed, lab requisitions and prescriptions filled, and information on housing assistance and subsidized optometry obtained. Many have commented on the complexity of the issues facing youth in downtown Edmonton. The ability to offer one-stop comprehensive care leaves me both encouraged as a medical student and convinced of the necessity of SHINE."*

— SHINE Volunteer, 2009 ❖



# The Exciting World of Interventional Radiology



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**Drs. Mark Otto Baerlocher, Murray Asch, Andy Myers**

**M**edicine is rapidly making a shift from invasive surgical procedures to minimally invasive treatments with many time-honoured surgical treatments being replaced by minimally invasive alternatives. This trend should not be surprising — given two treatments of comparable efficacy, most would likely choose the less invasive alternative.

Interventional Radiology (IR) is a relatively new and rapidly growing field of medicine that leads the way in this new trend.

Vascular IR procedures (both diagnostic and therapeutic) are performed on blood vessels, commonly accessed through the femoral artery. This requires only a small 0.5 cm incision above the vessel. Everything is then performed through this small nick. Non-vascular IR procedures generally involve directing a needle and/or a tube or

catheter into an organ, tumor or fluid collection. Again, a tiny nick in the skin is the only evidence that the patient has undergone a procedure.

The field is growing quickly, both in terms of number of procedures being performed and in terms of the number of innovative new treatments. Think of it this way — nearly every organ in the human body can be reached by an interventional radiologist. And if a vessel is too small to be cannulated directly using a catheter, the interventional radiologist can use the flow of blood to deliver the treatment to the target. For example, anti-cancer agents can be injected directly to a tumour via its blood supply in a process known as chemoembolization.

Some of the many cool new procedures currently being performed include angiography and angioplasty, stenting, stent-grafts, aortic aneurysm repair, endovascular treatment

of vascular malformations (e.g., sclerotherapy), embolization of hemorrhage, radiofrequency ablation for treatment of tumours, uterine fibroid embolization, IVC filters, blood clot/thrombolytic therapy, nephrostomy tubes, vertebroplasty, cryoablation, Yttrium ablation, and the list goes on and on...

Entire new sub-fields of IR have been developed recently — for example, interventional oncology now has its own annual meetings dedicated to this subspecialty. Interventional radiologists take care of their own patients pre- and post-procedure and see them in clinic prior to many of the larger procedures. So there is lots of patient contact!

In surgery, the surgeon can directly “see” what’s in front of them. In IR procedures, the physician uses different forms of imaging (fluoroscopy, CT, MRI, ultrasound) to guide him/her. This is why a diagnostic radiology residency (five years) is required prior to training in a typical 1-year IR fellowship program. Another benefit is that IRs are dual-trained as a diagnostic radiologist and that affords the benefit of combining a diagnostic radiology with an IR practice if you so desire.


Since this field is expanding so quickly, it has resulted in a large current and even greater projected shortage of

interventional radiologists. We recently surveyed staff interventional radiologists in Canada, and a large proportion of centres are actively looking to recruit more IRs. For the trainee and graduate, this offers many great opportunities to choose where you will work and in what type of practice.

We encourage you to take a look at IR now. Most medical students do not learn about the field until it’s too late. Contact your local radiology department to explore this exciting field, either by doing an IR elective, by performing research, attending rounds or just looking for more information. You can also contact CIRA — the Canadian Interventional Radiology Association ([www.ciraweb.org](http://www.ciraweb.org)) or Dr. Mark Baerlocher ([mark.baerlocher@utoronto.ca](mailto:mark.baerlocher@utoronto.ca)) for help finding a local IR mentor.


You have a very important decision to make during medical school about which field you want to pursue as a career. This is one of the quickest growing and most exciting fields of medicine, and is sure to expand more in the future. Be on the cutting edge of this exciting field — check out a career in IR!

For more information, please contact [mark.baerlocher@utoronto.ca](mailto:mark.baerlocher@utoronto.ca) ❖



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Our Post Graduate program allows graduates to specialize in the residency training program of their choice and are not restricted to those offered at the U of S. Those offered at the U of S, College of Medicine, are: Anesthesia, Cardiology, Family Medicine, Rural Family Medicine/Emergency Medicine, Urban Family Medicine, Internal Medicine, Neonatal or Perinatal Medicine, Neurology, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Pediatrics, Pediatric Neurology, General Pathology, Physical Medicine & Rehabilitation, Psychiatry, Medical Imaging, General or Orthopedic Surgery, Rheumatology and Respiratory Medicine.

For students interested in research, the College of Medicine offers a variety of opportunities including MSc/PhD degree programs. With the Canadian Light Source and the Vaccine and Infectious Disease Organization (VIDO) located on our campus, the University of Saskatchewan is able to attract many stellar researchers from around the world.

To learn more about the College of Medicine at the University of Saskatchewan, Contact: College of Medicine, B103 Health Sciences Building, 107 Wiggins Road Saskatoon SK S7N 5E5, Website: [www.usask.ca/medicine](http://www.usask.ca/medicine)

# OMSW 2008

## *Sexual and reproductive health workshop*



**Lana Saciragic**  
CFMS National Officer on Reproductive and Sexual Health

*Ontario Medical Students' Weekend (OMSW), an annual conference uniting first and second year medical students from all six Ontario medical schools, was the inaugural year for the Sexual and Reproductive Health Workshop.*

**H**eld in October 2008 at McMaster University, the workshop exposed pre-clerkship medical students to the specialty of obstetrics and gynecology, and also highlighted important aspects of reproductive health in a global setting. The session was mainly clinical, allowing students to learn pelvic exam and IUD insertion techniques. In addition, a short didactic session addressed etiology and epidemiology of cervical cancer and contraceptive options. Close to 100 first- and second-year medical students participated in one of six 1-hour sessions, led by four McMaster University OB–GYN residents.

The workshop was organized and conceptualized by the Canadian Federation of Medical Students (CFMS) National Officer on Reproductive and Sexual Health (NORSH), and very generously sponsored by the McMaster University Obstetrics and Gynecology Department. ❖



# Intimations on the Enigma of Life

## *An Exercise in Humility*

Behzad Hassani

University of Toronto, Class of 2009

*A wise elder once observed,*

*“In every direction that you look, there is something to be seen...”*

This simple yet profound axiom is often forgotten in the midst of the chaos of modern life, particularly in an adventurous life that is dedicated to the endeavour of medicine. Although the grand spheres of medicine and philosophy interpenetrate infinitely, the intricate interactions of the two disciplines are often overlooked by medical professionals. The praxis of philosophy and the practice of medicine are based on parallel principles of intellection. Medical professionals are challenged by profound philosophical questions on a daily basis, and have much to contribute to the advancement of this cerebral discipline. I was personally humbled by one such question in an early morning lecture on Embryology. On a breezy autumn day, our anatomy professor presented to a sleepy class of first-year medical students an unforgettable exercise in humility...

Consider that 100 high-quality eggs are exposed to 100 viable sperms in an environment permissive to fertilization. Out of 100 eggs, 15% will not be fertilized. From the 85% that are fertilized, 15% will not implant in the uterine wall. Seventy percent will implant in the endometrial tissue, however, only 42% will cause cessation of menstruation (i.e., 28% will wither). In other words, within two weeks of fertilization, more than half of the embryos will have perished. From the viable 42%, 8% will die within the next 2–3 weeks, and 34% will continue their development. Three percent of these seemingly viable life forms will undergo late spontaneous abortion or will be still-born.

Thirty-one percent of the infants, however, will be born alive. Three percent of these will suffer from congenital abnormalities leading to the death of 1%. Two percent will remain viable in spite of the congenital abnormalities. The 28% of live births that are devoid of “abnormalities” represent a mere fraction of the original 85 fertilized eggs which had, by all accounts, the ‘potential’ to develop into healthy infants.

One may rightfully inquire about the philosophical implication of this seemingly simple hypothetical experiment. In response to such inquiry, one must appreciate that the perplexing world of philosophy abounds with diverse interpretations of similar observations. One may even maintain that such diversity of opinions is the essential beauty of philosophy. It follows that the reader should infer what he/she will from the presented facts. However, given that the author presented the facts in the first place, it is only fair that the author should share his interpretations of the facts as well. In my opinion, we often consider ‘life’ to be the way of nature: that which has always been, is meant to be, and will be. Life, in other words, constitutes normality and is taken for granted. Yet, the above experiment clearly demonstrates the opposite. If we consider fertilization to signify the onset of life, then we must admit that life is a rarity of nature, and an exception to the rule of death. Life struggles to ‘be’ in the midst and in spite of death.

Life is arguably the treasured jewel of existence that is to be cherished. Yet, it cannot be used justifiably to define

what is normal, for it is not common. The quest for normality permeates the daily struggles and insecurities of each and every one of us. Ironically, the very basis of this endeavour is rooted in a rather arbitrary system of thought which upholds 'life' to be the archetype and forerunner of normality. Perhaps normality is a mere illusion, a mirage of sense-perception, and a figment of our imagination. Perhaps it holds no innate value except for what we ascribe to it through social customs and conventions.

I do contend that innumerable inferences can be made based on the discussed facts. A passionate Pro-Life advocate may see the presented data as yet another argument for the preservation of the unborn fetus. Similarly, a Pro-Choice activist may interpret the presented facts as proof that a human's 'life' does not truly begin until birth, and as such all

must be done to protect and promote the future autonomy and fulfillment of this young life. It follows that a choice made by the individual 'life' must be respected by the society. One may even further argue that to bring a 'life' into existence and not securing its future means to thrive and succeed would be unethical. And the debate carries on...

It has not been the aim or ambition of this brief account to resolve canonical disputations, nor has the author ventured to unravel the enigma of existence in a few paragraphs. Instead, this brief analysis is meant to entice the readers to further seek and ponder the many philosophical intricacies depicted in the rich tapestry that is the practice of medicine.

Lest we ignore the subtleties of 'life' as they pass us by... ❖



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# Alberta Medical Students hold Political Action Day at Legislature



**Harbir Gill and Peter Gill**  
**University of Alberta, Class of 2011 and 2010**  
**PAC Chair and PAC Advisor**

The 1st Annual Alberta Medical Student Political Action Day was a stunning success. On Monday October 27, 2008, 40 medical students from the Universities of Calgary and Alberta traveled to the Alberta Legislature and met with over 40 members of the Legislative Assembly (MLAs) from all political parties, including the Minister of Health and Wellness, the Minister of Education and the Deputy Premier.

The MLAs and students held small group meetings throughout the day where they discussed the issue of student loan limits. Many MLAs supported the students' proposal of increasing the student loan maximum for medical students, thus increasing accessibility of medical school to students of all socioeconomic backgrounds. Perhaps more importantly, the MLAs were keen on cultivating a lasting relationship with Alberta medical students.

Political Action Day also included a noon hour address by Dr. Raj Sherman, an ER physician elected to the Alberta Legislature in 2008, and the opportunity to witness a lively and interesting Question Period in the Legislature.

The objective of Political Action Day was to inspire medical students to become actively engaged in the political process during their training and throughout their medical careers. Students learned advocacy skills and put them into practice in their meetings with MLAs. It is anticipated that

these skills will also enhance their comprehension of how politics affect their ability to practice medicine and deliver optimal care to future patients.

Political Action Day was preceded by a day of training on Sunday October 26, 2008. The training day featured several high-profile speakers, including Dr. Tom Huang (AMA Government Affairs), Laurie Blakeman (MLA, Edmonton-Centre), Shannon Rupnarain (AMA Government Relations), Sarah Thomas (PARA Executive Director), and Dr. Darryl LaBuick (AMA Past President 2007–2008). The students received practical advice on advocacy and media relations, and specific tips and strategies for meeting with MLAs.

The inspiration of Political Action Day arose from the annual CFMS National Lobby Day in Ottawa and was fostered by the creation of the CFMS Political Advocacy Committee (PAC). The organizers of this event hope that Political Action Day will become an annual collaborative project between the Political Advocacy Committees of the Universities of Calgary and Alberta medical schools and the CFMS. This year's event was generously supported by the CFMS Project Funding Initiative, and by AMA, PARA, and the Faculties of Medicine at the Universities of Alberta and Calgary. We wish to thank everyone, including the medical students themselves, for supporting this endeavour. ❖

# From Intentions to Actions: *Perspectives on Global Health*

*Queen's Health & Human Rights Conference 2008*

**F. Daniel Ramirez**  
Queen's University, Class of 2011

The Queen's Health & Human Rights Conference held on October 4–5 was designed to be multidisciplinary and to address a broad scope of health and social issues. Of the approximately 35 speakers invited, this article will focus on three speakers, though many others are highly deserving of being mentioned and critically discussed.

Dr. Samantha Nutt, founder and executive director of War Child Canada, readily addressed the theme of the conference: from intentions to actions. She recounted her once “crippling cynicism” of fellow medical students interested in global health, referring to their international trips as “traveling vacations”. She questioned then and asks us now how to find significance in such endeavours. She described how her time in Somalia — arguably her first experience in the field — showed her that her ideas of “how to make a dent in the global health machine were naïve or at least totally incomplete” as she was faced with the realities of the failed state, including child soldiers and the amazingly abundant supply of Kalashnikov rifles.

Drawing on stories from her time in the Democratic Republic of Congo, where the war and its aftermath claim the lives of 45,000 people monthly, she spoke of the disparity between its citizens' way of life and our own. Dr. Nutt also referred to the Western world's contribution to this divide as she stated, “policies, economies, consumer practices at the very least facilitate the preconditions that enable such inequities to exist. And what inequities these are.”

Underlying her talk were the notions that good intentions are not by themselves sufficient to bring about beneficial change, that concepts of charity need to change for global health to be meaningful, and that human health and human dignity are indivisible and necessary concepts.

Saturday's closing keynote speaker, Maj. Brent Beardsley — an Infantry Officer in the Royal Canadian

Regiment, previously the Chief Instructor of the Canadian Forces Peacekeeping Training Centre, and co-author of *Shake Hands with the Devil: The Failure of Humanity in Rwanda* — spoke independently from any organization on issues of international security and the emerging and forecasted effects on the global community. Maj. Beardsley described a world in which the dual nature of globalization is fuelling future (and perhaps current) conflicts. He argued that this is arising fundamentally from a growing frustration and lack of hope in third world countries due to an ever more visible and increasingly polarized distribution of wealth.

He stated, “a world system based on the rich getting richer, fewer, and more regionally based, while the poor get poorer, more numerous, and more desperate will result in conflict.”

He argued that the declining or stagnant population in the developed world, the youth population bulge in third world countries, the depletion of key resources (particularly water and petroleum), and climate changes are setting the stage for conflicts, natural disasters, poverty, famine, and disease. Compounding these issues, he argued, non-state actors such as trans-national corporations and the privatization of military/security forces are bypassing democratic institutions and are leading to asymmetric intra-state wars with international consequences. Furthermore, more of these conflicts will be identity-based (racial, ethnic, religious, and national) and will thus more likely result in gross violations of human rights, war crimes, and genocides as in these types of conflicts the enemy is not a soldier, but rather the other group's civilian population.

He closed his talk by saying “Go out. Get your boots dirty. It will change you.”

In a workshop on Sunday afternoon, Hon. David Kilgour and Mr. David Matas, coauthors of the *Report into*

*Allegations of Organ Harvesting of Falun Gong Practitioners in China*, spoke on the findings of their investigation. Falun Gong, a spiritual practice introduced to the general Chinese public in 1992, rapidly gained acceptance and momentum until the Chinese government banned it in 1999. The country has since been accused of permitting organ harvesting particularly from Falun Gong practitioners.

Though thought-provoking, the strength of the talk was undeniably in the twenty minutes allotted to Mr. Lizhi He, a quiet and unassuming man not mentioned in the conference program.

In 2000, Mr. He was sentenced to three and half years in prison after mailing letters to friends and colleagues in which he detailed his beliefs in the Falun Gong practice and the persecution that he and others were facing by the Chinese government. During his imprisonment he was forced into slave labour, was sleep deprived, and was violently beaten and electrocuted.

Calmly, Mr. He told of blood tests and physical exams, for which no medical records were kept — the grisly significance of which he understood only in retrospect. He also told of the mysterious disappearance of prisoners who withheld their names and addresses in the hope of protecting loved ones and fellow Falun Gong practitioners.

Meanwhile, having successfully fled to Canada, Mr. He's wife had been lobbying on his behalf and he was deemed a prisoner of conscience by Amnesty International. Thousands of Canadians signed petitions demanding his release and with governmental assistance, Mr. He was freed and reunited with his wife in Canada.

Throughout the course of the conference it became increasingly apparent that many well-intentioned acts driven by humanitarian motives can be counterproductive or destructive to those we seek to help. Issues of sustainability and the promotion of dependence on foreign assistance come to mind. It is this transition from wishing well to doing well that is difficult — a reality Maj. Beardsley alluded to when discussing the multifactorial underpinnings of current and future humanitarian crises. His encouragement to go out into the field seemed at odds with Dr. Nutt's 'cynicism' in medical school, but both refer to the same concept: we personally benefit greatly from

traveling to areas in need of assistance, but we should ensure that the communities to which we travel stand to gain as much as possible from it as well. One must think critically of how to effectively and productively act on one's intentions, as the 'best' ways to act can often be challenging to determine.

Furthermore, both Dr. Nutt and Mr. He impressed the notion that 'global health' need not be synonymous with packing up and going to impoverished or war-torn areas of the world — though there is an important yet delicate role for such assistance. Dr. Nutt referred to our consumer practices as driving inequities between us and third world countries while Mr. He thanked Canadians for signing petitions demanding his release.

Though few of us will become Nutts, Dallaires, or Orbinksis, there are other effective ways to act on our intentions. ❖

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# The Spirit of Glasnost (Гласность)

Dr. Jason Kur

CFMS President 2000–2001

The spirit of *glasnost* is alive and well in Russia. Russia is a country of stark contrasts, and nowhere is that more evident than in the health care system.

On a recent trip through the former Soviet Empire, I had the fortuitous opportunity to tour the main centre for rheumatologic care in the country, the Russian Rheumatology Institute.

On the 60-minute drive south through the suburbs of Moscow, the remnants of Soviet centralization is most apparent. Rows upon rows of concrete drab socialist “housing massif” stretch for miles, and other national concrete institutes like the oncology centre emerge from Moscow’s sprawling suburbs. Moscow is bursting at the seams with more than three million automobiles on the road. Just a few short years prior, they were the privilege of a select few. Now gridlock is as common as borscht in Russia’s capital.

The Russian Rheumatology Institute is the primary centre for rheumatologic care in the Federation. It is from here that care is coordinated for Russian citizens with autoimmune diseases. What is most striking about the nine-storey complex is the breadth of services offered in one location. A

remnant of Soviet central planning, or simply a necessity with more than ten million people that live in the region, the Institute has an impressive array of services. Each floor of the complex has a specific focus. Dedicated clinics and inpatient beds exist for spondyloarthropathies, lupus, osteoporosis, rheumatoid arthritis, rehabilitation and pediatric rheumatology. Some of the more unique features of the Institute include bustling laboratories, in-house orthopedics for rheumatologic patients, and telemedicine facilities for outreach to the corners of the world’s largest country.

My gracious host at the Institute was Dr. Nasanov, head of the Russian Federation of Rheumatology. The scale of the work at the Institute is unimaginable for a Canadian rheumatologist. At this one centre alone, more than 500 scientists and approximately 150 trained rheumatologists are at work. By Canadian standards the facilities may appear dated. Yet, the dedication of these physicians to improving the standards of rheumatologic patient care in Russia through interaction and collaboration with the West very much symbolizes the *glasnost* that Gorbachev envisioned. ❖



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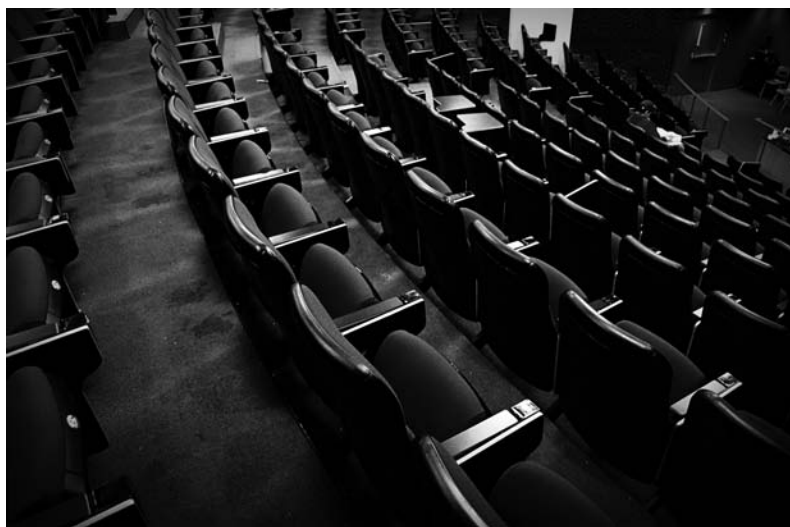
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Jacques Balayla — McGill University, Class of 2012



Martin Amphitheatre  
Jacques Balayla — McGill University, Class of 2012

# Messages from...

## The Clinician-Investigator Trainee Association of Canada (CITAC)

Are you a medical student interested in research, during medical school or residency, and want to know your options?

Are you a “MD+” trainee (MD/MSc, MD/PhD, or CIP programs)?

The Clinician-Investigator Trainee Association of Canada (CITAC) / Association des Cliniciens-Chercheurs en Formation du Canada (ACCFC) is a recently established student-run national organization representing the needs and interests of all Canadian students pursuing a clinician-investigator career path.

Over the past few years, CITAC-ACCFC has developed several initiatives based on recommendations from Canadian clinician-investigator trainees at its annual meetings (most recently held in Toronto, Ont., in September 2008). Such efforts include the development of a national mentoring program that enables CITAC-ACCFC members to obtain a mentor of their choosing to assist with career planning and decision-making.

Other programs have been developed to bolster networking among trainees from coast to coast, and special projects are underway to better understand the demographics and specific issues pertinent to training physicians who combine research with clinical practice.

To find out more, get involved or become a member, please visit the CITAC-ACCFC website at: [www.citac-accfc.org](http://www.citac-accfc.org) ❖

## Association des Cliniciens-Chercheurs en Formation du Canada (ACCFC)

Êtes-vous un étudiant en médecine intéressé par la recherche pendant votre premier cycle ou votre résidence et vous voudriez connaître vos options?

Êtes-vous un étudiant “MD+” (MD/MSc, MD/PhD, ou dans un programme de résidence-recherche)?

L'Association des Cliniciens-Chercheurs en Formation du Canada (ACCFC) / Clinician-Investigator Trainee Association of Canada (CITAC) est une organisation nationale récente fondée par des étudiants qui a pour but de promouvoir les intérêts de tous les étudiants complétant une formation conduisant à une carrière de clinicien-chercheur.

Durant les dernières années, l'ACCFC-CITAC a développé plusieurs projets faisant suite aux suggestions des étudiants recueillies lors des rencontres annuelles (récemment tenue à Toronto, ON, en septembre 2008). Des projets comme le développement d'un programme national de mentorat permettant aux membres de l'ACCFC-CITAC de contacter un mentor de leur choix afin de les assister dans la planification de leur carrière et la prise de décision.

Plusieurs autres projets ont été développés afin de mettre en contact les étudiants d'un océan à l'autre et un projet spécial est en développement présentement afin de mieux comprendre la démographie et les problèmes spécifiques concernant le développement de cliniciens désireux de combiner la pratique médicale à la recherche.

Pour de plus amples renseignements, s'impliquer ou devenir membre, visitez notre site web au: [www.citac-accfc.org](http://www.citac-accfc.org) ❖



Clinician Investigator Trainee Association of Canada  
Association des cliniciens-chercheurs en formation du Canada

### Let's start a Valentine's Global Heart Hour

Heraclitus says that the river you step in is not the river you step out of. The world we will graduate in will be a completely different world from when we entered medical school. We hope that by rethinking the world and by our actions now, we can help to reduce the impact of the crises we face, making a better world for all. We can play our part and start with the heart, Global Heart and Global Heart Hour. Contact vanessa.rambihar@utoronto.ca

What are you doing for Valentine's Day? Buying the usual chocolates, cards and roses? Can we instead harness the power of the heart around Valentine's Day to do much more than this — to make a better world? Yes we can!

We invite medical students, and everyone the world over, to start a global heart network and Global Heart Hour, and use the power of an hour to change the world. We turned our lights off for Earth Hour and climate change. Now we need to turn our hearts on for Global Heart Hour, needed now more than ever to reduce disparities in the world.

Let's start with the heart, and rethink Valentine's Day as a day for global heart, heart for everyone across the world. Let's find innovative and creative ways to collaborate for change to make the world a better place, including improving global heart health, now recognized as an important way to reduce poverty and improve development. The global crises we all face make this rethinking even more urgent now.

Unprecedented global financial, food, climate and other crises, together with disasters, wars, etc and other global problems will wipe out any gains in Millennium Development Goals and increase inequity and disparities even further. Although we in the "minority" world worry about serious issues like jobs and declining bank balances, the "majority" world faces much worse — more hunger, poverty, illness and insecurity. If it is an unprecedented crisis for us, what is it for the vulnerable, both here and globally?

How can we respond more to this increasing critical need? We have an unprecedented opportunity to make a difference now, learning from the past, and using novel methods for change in a modern, mass-collaborative, post-Facebook and YouTube world. Actions combining centralized policy or decentralized movements have waxed and waned in visibility and effect. We need even more innovative ideas and sustainable solutions. Global Heart will try, using the 21st century networking organizational model of innovating and experimenting, being flexible and rapidly responsive. It will seek mass participation and create hubs for better interaction in our modern fast paced, instant access, hyper-connected world.

Global Heart Hour will be launched at noon, February 12, 2009 by a group of medical students at the University of Toronto as the first hub, inviting you to establish hubs elsewhere, to sustain the discourse, and network to share ideas and actions for change. This builds on a related

25 year experience of Valentine's Day for heart and 5 years for Heart and Global Heart in Toronto. This movement will be powered by you, across the network and in the hubs globally, where you chose your best actions.

What can we do right now? Here are our 10 suggestions, but please feel free to make your own.

1. Start with the heart and promote heart health, in the usual and new and creative ways.
2. Give up some gifts and give gifts of heart instead to people who need food, medications, etc
3. Volunteer, discuss, debate, advocate for change, lobby governments for more aid, etc
4. Fundraise or raise awareness through arranging lectures, concerts, discussions, debates, etc.
5. Share ideas on Facebook, make a YouTube video, meet for an hour and brainstorm for change
6. Host a Valentine's party with less chocolates, more donations and more ideas for global heart
7. Be creative, make your own global heart picture, paint, sing, or write about heart or global heart
8. Start your own hub in school, clubs and elsewhere, for discussion, action and change
9. Use creativity and ingenuity to make global heart part of everyday thinking.
10. Continue to be the change we really need, as your way to make a better world. ❖

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*Words of Wisdom*

# Work Smarter not Harder

**Dr. Brad Dibble, CFMS President 1989**

I started medical school in 1986, a time of political upheaval in the medical profession. I decided I wanted to become politically active at that time because I found I had a keen interest in these issues and the changes that the profession was going through. Thus, I became my class representative of the student section of the Ontario Medical Association and, by association, the junior representative for the Canadian Federation of Medical Students. In my second year, I became the CFMS V-P Communications, and in my third year, the CFMS President. Besides my CFMS duties, I also started my clinical clerkship that year, and was the co-producer and co-host of the annual medical school variety show at University of Western Ontario. This all made for an extremely hectic year for me. In my final year, I was restricted solely to the job of being Past President with regards to my involvement in the CFMS, but so I was involved in all four of my years in medical school.

I tell you all of this because it forced on me at a very early stage in my medical career the need to develop the ability to control my schedule and the way my time was spent efficiently. This served me well during internship and residency, with very busy work demands, preparation for examinations, and the desire to eke out a social life here and there. Balance was very important but controlling my own schedule was even more so.

Those skills I acquired in time management have helped me throughout my medical career. I've been a practicing cardiologist for over 13 years, and I find that I am efficient throughout my day. I'm good at multitasking and am able to accomplish much at the same time. I do not think I would have that ability to the same extent if I had not had my experiences with the CFMS during medical school.

I'm not sure what exactly you might glean from my own personal experiences that will be helpful to you. Everybody manages his or her time and schedule differently, and not everybody has the same aspirations with respect to how to spend that time. If there were two things I would want you to get from this, it would be that I think it is important for you to maintain balance in the way you spend your time — devote a certain amount to all of the different and various aspects of life, but also strive to attain

a degree of efficiency. As you are all probably already aware, a doctor's time is limited, and seems to get more so as the years progress. Thus, the more efficient that you can be, the better you can make use of what limited time there is to achieve the balance you want (and need) in life. Believe me, it is not all that long ago I was in your shoes, and now I have a family, a very busy practice, which comprises an office and privileges at two different hospitals, as well as a number of avocations to which I also like to be able to devote some time. I seem to do it all well enough, at least to the satisfaction of myself and my family. After all, that's what life is really all about.

Good luck in your medical education, and your future careers. I wish you all the best. Make the most of it because the way you spend these years will help shape who you are for the rest of your life. ❖



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# Change for a Dime

Dr. Murray Asch, MD, FRCPC, Treasurer, CFMS 1981–1982

I am at the time in my life when I jingle loose change in my pocket. Today, as I pulled out a still shiny dime, it seemed like a good time to reflect on the journey through my medical career. I entered medical school intent on being a family physician, knowing that I would teach my patients to avoid illness by embracing healthy lifestyle choices. As I experienced various rotations during clerkship and electives I became disillusioned with the role of the family doctor. I then set my sights on internal medicine, as I found it very scientific how internal medicine brought people back to health using powerful medications. ICU was particularly exciting with all the associated machines and procedures (intubation, and Swan-Ganz catheters). My excitement was short-lived when I found that most of my ICU success stories died within the year (the coroner assured me it was not my fault). It was completely by accident that I applied to Radiology, a rotation that I had found excruciatingly boring during the two electives I did. During my body imaging fellowship I spent some time learning interventional procedures (in hopes of improving my chances of getting a job south of Moose Factory). Surgery had been the specialty that I disliked the most during training, so it came as a huge surprise to me that after my fellowship, my radiology career took off in the area of Interventional Radiology, which is essentially minimally invasive surgery.

If I had to choose one aspect of residency that I liked the least, it would be the required research project. I collaborated with a good supervisor and the process was not as painful as I had expected — I even learnt something!! Following training, I continued to be intrigued by the many unknowns, always looking to improve devices and techniques. Thus, research became a large part of my practice. I have been very lucky in that I have had many wonderful and rewarding opportunities to work with industry and participate with biomedical research teams to bring new devices and techniques to clinical practice. Although I currently practice at a non-academic institution, I continue with various research projects, and it helps that medical students from across the country come here to do electives with me.

Prior to medical school I had no political affinity or interest. When the OMA came to talk to our medical class and was looking for a class representative, my hand shot up. Eventually this led to

Presidency of the Ontario Federation of Medical Students as well as several executive positions within the Canadian Federation of Medical Students. Little did I know that years later I would become President of the Canadian Interventional Radiology Association (CIRA).

I am very lucky. I love my job. I wake up each morning, looking forward to coming to work, wondering what new challenge or opportunity will present itself. I feel that I have been able to make a difference in the lives of many people. But mostly, I am surprised at where I am. Never in my wildest dreams could I have imagined myself as an interventional radiologist, researcher, teacher, or president. To me, this emphasizes what I have heard so many people say — “Life is not a destination, it is a journey”. I strongly encourage you to keep your eyes and minds open. There are so many possibilities. I have a dime, can you make change? ❖



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# Transition time

**Dr. Allison Meiwald, Vice-President Communications 2005–2007**  
**PGY2, Emergency Medicine, UWO**

They've just paged for a doctor to the delivery room. I look around, excited for the opportunity to maybe deliver a baby if the doctor I'm working with isn't too anal about letting med students make the catch. Next thing I know, the nurse is ushering me into the delivery room since she didn't think the new doctor knew how to get there and didn't trust the med student to do the delivery on his own. Wait, One Second. I'm the doctor?!? Right. It's July 2nd, 2007, and I'm a doctor. I've just moved halfway across the country to become an ER resident and was promptly shipped out of town for my Ob/Gyn rotation. It's ok though — I went to school for 4 years, and I'm supposed to know how to do this, and practically I do, but I'm terrified, and excited and unsure. The next month passes in a blur of delivering babies, supervising med students, writing prescriptions for urinary tract infections and basically surviving. And then I'm finally in the ER again — home base. I know what to do in the ER

right? Fifteen weeks of electives so I should be good to run this place! But it's different — I'm a doctor who has to make independent decisions and carry them out. And this is how the next year goes — trying to get used to a new city and new hospitals, a new rotation every month where it seems that they do everything different from home, and the ongoing terror, excitement and sense of being unsure. But it gets easier. I've learned to make independent decisions when possible. But most importantly I've learned that even though I'm a doctor who would like to be able to know what to do in every situation, there are always other people who can help me when I'm lost. Sometimes it's the consultants, sometimes it's the other residents, sometimes it's the nurses, and sometimes it's the med students. And sometime in the last year and half, I lost the surprise that comes when someone is looking for a doctor and they're actually looking for me. Now, I just have to survive the rest of my residency. ❖

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# Alumni Updates

## Dr. Leo Plouffe Jr., CFMS President, 1977–1978

*I was too busy surviving medical school, saving lives. I thought. I was only a medical student. I was a tool in the system*

— *The City*, Leo Plouffe Jr.

I'm currently heading up a team of dedicated individuals developing new medications in the field of autoimmune diseases and osteoporosis. It is like paying back for all these classes I missed in medical school (pharmacology, biochemistry, immunology...). I became an OB–GYN to escape it all and it found me again. Study hard! It will come back to haunt you one day! Seriously, this is a great and wonderful opportunity to network with top talent individuals around the world to improve the lives of patients. Being a physician, in any forum, is one of the greatest privileges one can have, and one of the most fulfilling experiences, no matter how deep the lows can be.

On the fun side, I have just published my first non-medical book, a collection of poems from medical school (*The City*, iUniverse press, 2008), courtesy of the generosity of my wife (also a doctor — she got tired of having me read them to her, so she thought that way I would stop!). It is always essential to keep some balance in life and this was a very energizing project.

Last but not least, a senior physician had once shared with me when I was complaining about how overwhelming 1st year medical school was, “Don't worry, it only gets worse year after year.” He was right! But it is all worth it!

Long live CFMS!

## Dr. Brad Dibble, CFMS President, 1988–1999

I went to UWO Medical School (before it was known as Schulich) and I graduated in 1990. I was the junior CFMS Representative in my first year (86–87), V-P Communications in my second year (87–88), President in my third (88–89) year, and Past President my fourth and final year (89–90). Some of the things we accomplished in my year as President included resurrecting *Mediscan*, which was our national CFMS journal, and establishing an interest-free loan program through TD for medical students, as nothing like that was available up until that time.

I'm currently a cardiologist in Barrie, Ontario and I've been there since I completed my residency in 1995. I'm still in touch with the CFMS President the year before mine (Michael MacDonald, currently in San Francisco).

## Dr. Tara Mastracci, CFMS President, 1999–2000

Tara sends her good wishes to CFMS and is currently practicing Endovascular and Vascular Surgery at The Cleveland Clinic Foundation.

## Dr. Jason Kur, CFMS President, 2000–2001

Jason runs a busy general rheumatology practice at Vancouver General.

## Dr. Matthew Erskine, CFMS President, 2001–2002

Time certainly does fly! Since serving as CFMS president in 2001–2002, I completed a year of residency in general surgery in Halifax, before switching to emergency medicine at McGill University. I finished my residency in 2007 and moved to Vancouver to take advantage of the ocean, mountains, and — of course — the Olympics! I now work in the emergency department at Vancouver General Hospital, where I occasionally run into my predecessor, Dr. Jason Kur (who is a rheumatologist here), and one of my successors as CFMS President, Dr. Phil Brost (a resident in psychiatry). In addition to clinical emergency medicine, I am working on a master's degree in Health Information Science, and I hope to once again become involved in medical politics as time permits. I would be pleased to discuss any of my interests with current CFMS members, and I can be reached via e-mail at [matthew.erskine@ubc.ca](mailto:matthew.erskine@ubc.ca).

## Dr. Danielle Martin, CFMS President, 2002–2003

Danielle is now doing comprehensive care family medicine and working in the field of health policy. She splits her time between Toronto (where she practices family medicine and obstetrics) and Geraldton in Northern Ontario (where she does a little of everything!). She is also involved with Canadian Doctors for Medicare, [www.canadiandoctorsformedicare.ca](http://www.canadiandoctorsformedicare.ca), and sits on the Health Council of Canada. One of the joys of her clinical practice as well as her policy work is working with medical students, who are committed, eager to learn, and excited about the possibilities in Canadian healthcare. This year she had the pleasure of working with Johnny Dellavadova, the current CFMS President, on several projects, and was thrilled and proud to see how far the CFMS has come!



**Dr. Murray Asch, Ontario Director, Secretary-Treasurer, 1981–1982**

Dr. Asch is currently the Director of Interventional Radiology at Lakeridge Health, Oshawa, Ontario.

**Dr. Herbert Brill, V-P Finance, 2000–2001**

After medical school, I started family medicine at Queen’s University. I elected to switch to pediatrics after 6 months. Two and a half years and one stint as PAIRO Treasurer later, I found myself doing electives in Auckland, New Zealand and Victoria, BC, before moving to Montréal for a fellowship in gastroenterology. True to my finance roots, I completed an MBA at McGill while training in GI. I got married in 2006 to Shoshana, a classical pianist, and we moved to Hamilton where I work at McMaster Children’s Hospital as a staff gastroenterologist.

**Dr. Ben Hoyt, V-P Education, 2002–2003**

I finished my Royal College exams in June 2008 and I am now working as a general ENT specialist in Fredericton, NB, which is my hometown. I am married to a psychiatrist, we have a 3 1/2 year old girl. We are expecting a boy in May.

**Dr. Nick Rose, CFMS Accessibility Officer and CFMS Student Rep to NPACT, 2004–2005**

I am currently a PGY-4 emergency medicine resident and a Sports Medicine Fellow. One of my boys just started school this year; the other is still in daycare. It leads for a busy life!

**Dr. Claudia Kraft, V-P International Programs & Partnerships, 2005–2006**

I’m finishing my rural family medicine residency (UBC, Kelowna) and spending much of my time in the Canadian Arctic these days, in the area of Nunavut and the far north of the Northwest Territories. I am planning on working in various rural/remote Canadian communities as a locum for part of next year, as well as a few months of work in Namibia. And then I guess we’ll see!

**Dr. Mark Preston, CFMS Representative to CAIR, 2005–2007**

I am currently in my third year of a urology residency at the University of Ottawa and I got married happily last July to Diane Belder. I remember fondly many fun times with the CFMS and I am still involved in medical politics as a PAIRO executive member. ❖


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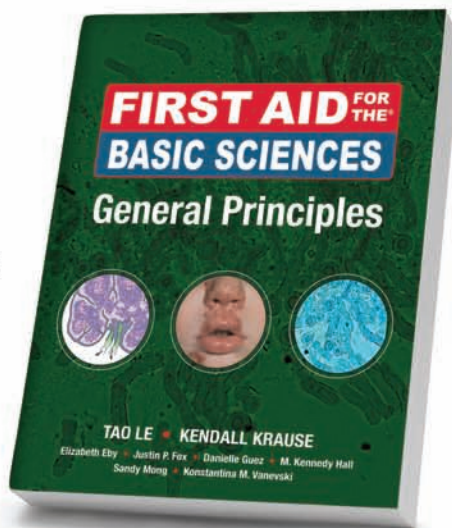
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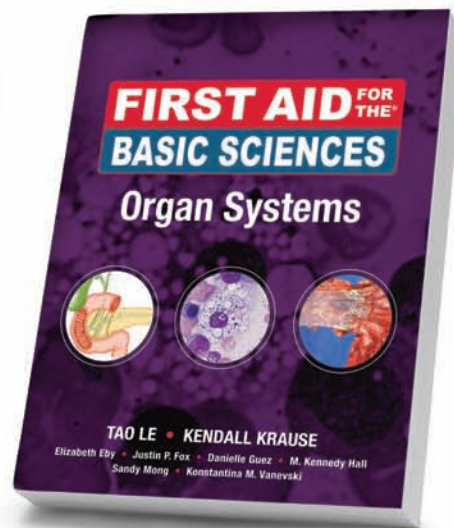
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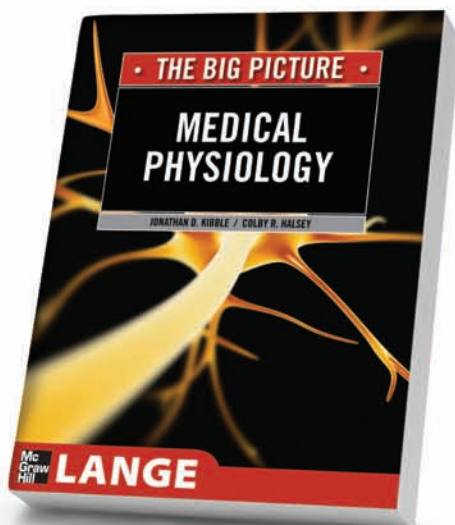
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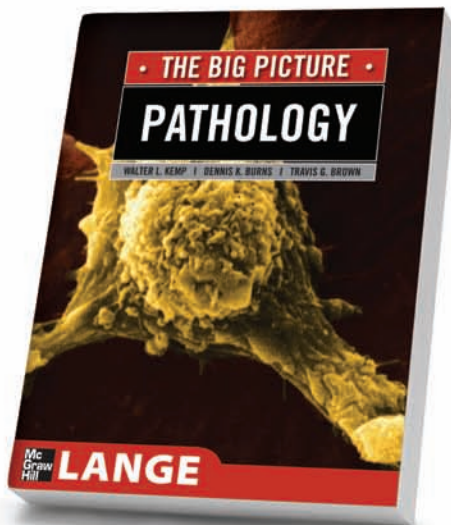
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