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Annual Review 2011

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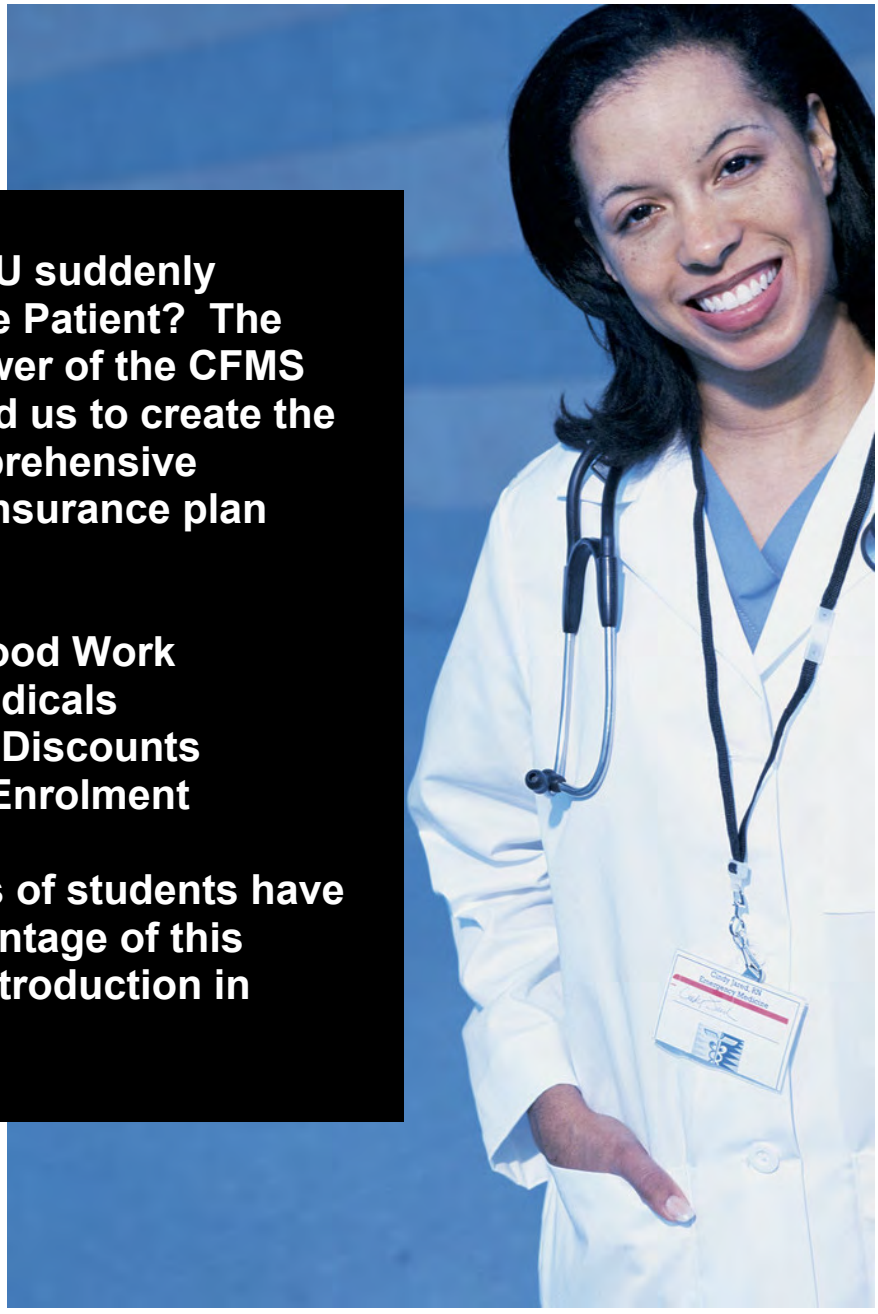

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Letter from the editors

Pamela Verma, BSc Hons
Editor, CFMS Annual Review
University of British Columbia
Class of 2012

Robin Clouston, BSc Pharm
CFMS VP Communications
Memorial University
Class of 2012
vpcommunications@cfms.org

The CFMS is proud to present the *CFMS Annual Review 2011*, our annual publication highlighting CFMS activities and student works. It has been another exciting and successful year for the CFMS as well as for Canadian medical students!

The first section of the *Annual Review*, "CFMS Activities", provides updates on the projects of the CFMS executive and officers, as directed by the general membership — you! You will also find tips on how to save money, stay informed and get involved. At the CFMS, whether it's representation on educational committees, political advocacy, global health advocacy, fundraising for cancer care, encouraging student wellness or providing discounted services, our team works hard to serve the needs of student members.

The CFMS was proud to take part in the General Assembly of the International Federation of Medical Students' Associations (IFMSA), held in Montréal in August 2010. The CFMS, along with the Fédération médicale étudiante du Québec (FMEQ) served as co-host for this Montreal AM 2010. This and many more projects of the CFMS Global Health Program are highlighted in the Global Health section of this publication.

The CFMS would not be where it is today without the dedication of our past members — the Alumni. What's new with CFMS Alumni? What wisdom and advice do they offer to current medical students? Find out in the Alumni Affairs section!

We are delighted to present this year's featured interview with Dr. Brian Goldman, emergency room physician at Mount Sinai hospital, host of CBC's *White Coat, Black Art*, and author of *The Night Shift*. Dr. Goldman is known for embracing controversy and providing insight into what really goes on inside the walls of a hospital and the minds of physicians. We would like to thank Dr. Goldman for sharing his viewpoint with our readers.

As always with the *Annual Review*, we delight in sharing with you the initiatives, opinions, experiences and creative works of Canadian medical students from across the country. Read about *First, Do No Harm*, a documentary created by two Dalhousie medical students. Learn what it means to be a *Clerkship Chameleon*, and join the *Global Heart Hour*. See creative works from the *White Coat, Warm Art* exhibit — artwork that will be displayed at the Canadian Conference on Medical Education in May 2011. Finally, take a look at wedding and baby photos from current and past CFMS members!

The *Annual Review* thanks the Canadian Medical Association publishing staff and our generous advertisers, without whom this publication would not be possible. We hope that you enjoy this year's edition of the *CFMS Annual Review*.

P Verma Robin Clouston

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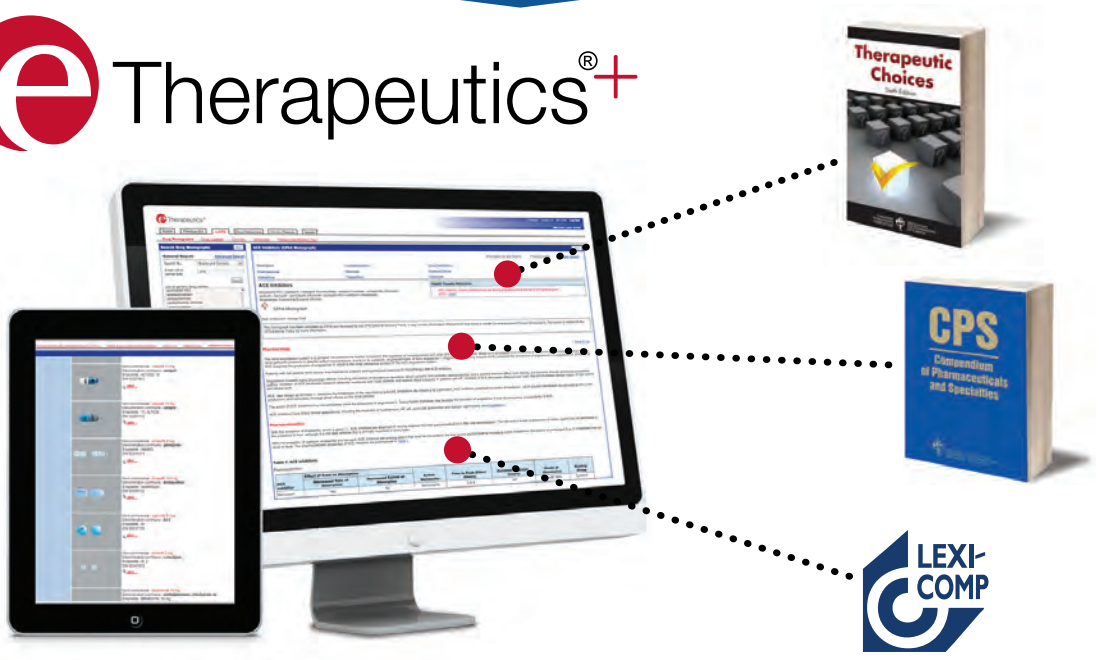

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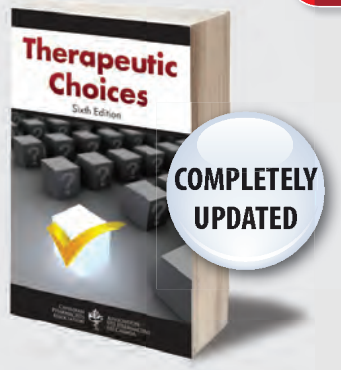

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A letter from your CFMS president

Matthew J. Sheppard,
BA, BSc
CFMS President, 2010–11
Memorial University,
Class of 2011

Hello friends!

The CFMS is first and foremost your organization. We represent over 7,500 medical students from coast to coast and our executive consists of 14 elected members from Vancouver to St. John's. We have been working hard on many student-driven projects and it is with great honour that I am given the opportunity to kick off this year's Annual Review—our primary medium for reporting on these outstanding projects.

We draw on the three pillars of our organization: representation, communication and services. I present some highlights from this year.

Representation

The CFMS continues to be actively involved in the most important issues in medical education. A joint initiative between the Association of Faculties of Medicine (AFMC) and the CFMS will see the creation of a nation-wide electives portal. A working group has been busy consolidating our best practices for distributed medical education. This year's lobby day was very successful, gaining attention from national media in print, radio and television. This promotion helped to both further our stance on the representation of students in medicine and the profile of our organization.

Communication

Striving to perfect the internal communications among our member schools, we have implemented several successful changes over the year. Our bi-weekly representative communiqués continue to provide students with news and opportunities, while making use of more regular teleconferences between representatives and presidents have facilitated communication amongst medical student societies. Further, through the use of social media, the CFMS has made efforts to be more accessible to both student members and external organizations.

Services

The CFMS works hard to makes medical students' lives easier. We offer welcome packages to first year medical students that include CFMS clipboards and pocket cards. This year, we will be conducting clerkship orientation presentations, to highlight services available during this busy time as well as distributing name tag holders that have proven quite useful. Global health exchanges continue to be one of our most sought after services and we are currently developing new community health exchange opportunities in South America.

I continue to be passionate about the work of our organization and look forward to reading about the projects completed by students at each school. I encourage you to contact the CFMS executive via our website or through your local CFMS reps should you have any questions about updates in this publication or the work of the CFMS. If not an online member already, please join today and stay up to date on CFMS news as it happens.

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Contact: Erin Kell
Medical Affairs Coordinator
Five Hills Health Region
Phone: (306) 694-0282 Fax: (306) 694-0282
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Yet another eventful year in medical education for the CFMS

Noura Hassan
VP Education
McGill University, Class of 2012

Since September 2010, I have had the great pleasure of occupying what I think is the most exciting CFMS position — VP Education. What makes this portfolio so amazing is that it involves a broad variety of tasks and responsibilities including representing the CFMS to external organizations and working on education-related, member-mandated projects.

External representation

Representation to external organizations is an important part of the VP Education portfolio. By the end of my mandate, I will have attended over 20 external meetings, in person or via teleconference. I have represented you, the CFMS membership, on a number of organizations and committees including the CaRMS Board of Directors; the CMA Committee on Education and Professional Development; the Association of Faculties of Medicine of Canada; and the Royal College of Physicians and Surgeons of Canada. Furthermore, as a McGill medical student and past-CFMS Quebec Regional Representative, I have continued to facilitate communications with the FMEQ.

Member-mandated projects

As much as I enjoy the external representation role of the VP Education, the most rewarding part of this position is working on member-mandated projects. The major projects for this year include the Distributed Medical Education (DME) best-practice guide, the senior medical student work-hours project, and the Canadian Electives Portal Management System.

Distributed medication education

In light of the increasingly important role of DME in undergraduate medical education, the CFMS undertook a student-centred review of distributed medical education. Tyler Johnston, VP Education from 2008–09, initiated this project. A literature review was done and the CFMS membership was consulted to ensure that your perceptions of DME are adequately represented in our work. In 2009, a DME Task Force was struck to allow students from all our member schools to exchange information on DME-related issues.

Eamonn Rogers, a third-year medical student at the University of Western Ontario, has been the DME Task Force Chair since 2009. He has provided direction to this group by organizing and chairing teleconferences, coordinating and moderating online discussions on the task force forum (http://www.dmetaskforce.proboards.com/index.cgi). This year, a subset of the DME Task Force has volunteered to help develop a comprehensive student-centered and student-powered DME Best-Practice Guide. The final product will be available to you in May 2011.

Senior medical student work hours

In 2009, you mandated the CFMS to review senior medical student work hour policies. Since I started working on this project in 2009, work hour policies from every medical school have been compiled and compared to resident work hour policies. A survey has been developed and distributed to senior medical students to ensure that we understand what your reality is. With this information, senior medical students will have the tools necessary to address work-hour issues and take charge of their own wellness.

Electives application standardization

With practically every school having their own prerequisites, immunization requirements and deadlines, applying to electives is unnecessarily stressful and complicated. After many years of hard work and dedication deployed by the CFMS to streamline this process, we are finally moving forward! Having acknowledged the importance of this issue, the Association of Faculties of Medicine (AFMC) has invested significantly in the Canadian Electives Portal Management System (CEPMS) project. If all goes as planned, this electronic portal will be up and running by 2013 and will make the electives application process more manageable for all Canadian medical students. Stay tuned for updates!

I hope this has helped you understand why I'm so passionate about what I do. If you wish to know more about this portfolio, provide input or simply want to say hi, feel free to contact me at noura.hassan@cfms.org. I look forward to hearing from you!

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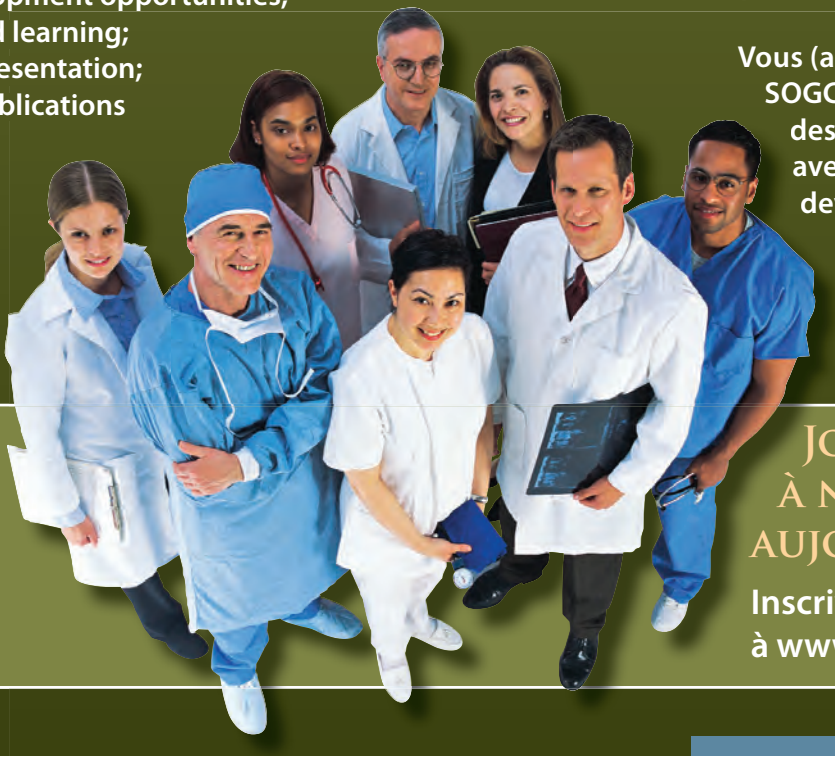

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Communications: What's the good word?

Robin Clouston
VP Communications
Memorial University, Class of 2013

The VP Communications portfolio is an exciting one — I am often the first point of contact for people seeking information about the CFMS and I work closely with a fantastic executive, hard-working VP Externals and countless others who are committed to communicating the mandates of CFMS: representation, communication and services.

Internal communications

www.cfms.org — The CFMS website is undergoing changes. We have a more user-friendly layout and I have focused on ensuring that content stays up to date, with news items and updates readily available. Phase II will see the reformatting of the Global Health section and a new focus on Advocacy. These exciting changes highlight the growing emphasis CFMS places on global health and advocacy work. As well, our new Electives and Interviews Database are due to be unveiled this year!

Social media — Facebook and Twitter have become a valuable part of the CFMS communications strategy. The CFMS Facebook group has over 800 members and counting. Posts reach student members instantly and it is a great way for medical students — like you — to meet other CFMS members and alumni. As we move forward we must consider the high standard of professionalism to which medical students are held, while using these forms of media.

The Twitter feed @CFMSFEMC created in November 2010 has been one of my favourite projects to date. Along with the President Matthew Sheppard and Western Regional Rep Shawna Pandya, we provide up-to-the-minute info on emerging CFMS projects and links to Canadian medical education articles. Twitter has become a means to communicate with students as well as external organizations, CFMS alumni and physicians, media and even members of parliament. As a former Twitter skeptic, I encourage any medical student with an opinion to try it — and when you do, start following @CFMSFEMC!

Day to day — This continues to be important as I send biweekly rep communiqués to the CFMS VP Externals, assist the *Annual Review* editor with the creation of this CFMS publication, edit meeting minutes and facilitate overall communication within the CFMS.

External communications

Media relations — The Canadian Medical Association has assisted us greatly with a media relations workshop and constant support. Of note, this year President Matthew Sheppard was interviewed by the *Medical Post* regarding medical student depression and we issued our first press release of 2011 on Feb. 7 in relation to Lobby Day. The President also gave comments regarding the announcement of federal funding for rural residencies, published by CBC Online.

Lobby Day Media — I had the great pleasure of coordinating media for Lobby Day and the response was overwhelming! In total, media in English and French brought us 9 radio and 2 television interviews and at least 23 print articles including *Bloomberg News*, *le Devoir* and Sun Media newspapers such as the *Toronto Sun*. This year's Lobby Day, organized by VP Advocacy Ashley Miller, on the underrepresentation of low-income and rural medical students, was very well-publicized across Canada! For the first time, the CFMS Twitter feed helped to distribute the message and @CFMSFEMC was tweeted by 5 members of parliament.

This has been an exciting year at the CFMS and we are not done yet. Moving forward into the second half of my term I will work with VP Global Health Sarah Fung to expand Global Health communications and I will be seeking feedback from VP Externals on the new CFMS presentations to third-year students.

Want to get in touch and stay informed?

Here's how:

- Visit www.cfms.org
- Facebook: search CFMS
- Twitter @CFMSFEMC
- Email vpcommunications @cfms.org

CFMS Perks For You

Steve Hawrylyshyn
VP Services
McMaster University, Class of 2012

As medical students progress through their programs, their needs are dynamic. From enthusiastically building your excessively large medical library in first year to booking flights and accommodations for CaRMS interviews in fourth year, the CFMS is here to help.

Textbook savings

Medical knowledge seems almost infinite and finding the right books to summarize it can present a daunting task. Asking upper-year students is a great start, but what books do students at different universities turn to? The CFMS has a textbook review committee that reads and posts online reviews of the popular texts. Discounts are available on many of these books. You can receive 10% off all Elsevier books, including recently reviewed Cecil Medicine. Wondering what the evidence says on the signs and tests you've been taught? The *JAMA Rational Clinical Exam* book as well as many other McGraw Hill publications have been reviewed and are available to you at a discount through the CFMS site.

The CFMS has been developing an online database of elective reviews to aid you.

Laser eye surgery

Tired of your glasses or fiddling with contacts? You can put that all behind you thanks to fantastic CFMS-exclusive pricing for Lasik MD vision correction.

Electives and CARMS

Finding the right preceptor can be difficult. The CFMS has been putting together an online database of elective reviews to aid you. We even have a database to help you find a place to crash. Also, we understand what it's like trying to fly across the country to interview at multiple schools. That's why we've arranged a 10% discount on all regular WestJet fairs between Dec. 28 and April 30. We also have you covered when it comes to accommodations. Check in to a Choice Hotel and save 20%, anytime.

RBC partnership

Last, but certainly not least, the CFMS is very excited to announce its new partnership with Royal Bank of Canada (RBC). The goal is to help support students as they start becoming financially independent through professional advice, mobile apps, and more. There will also be a new CFMS–RBC $2,500 scholarship at every CFMS member school to be presented at the Spring General Meetings. We look forward to the start of this mutually beneficial relationship.

To access these CFMS services, go to www.cfms.org and click on "Member Benefits".

If you are a medical student but do not yet have an account, sign up at *www.cfms.org/signup.asp*. The sign up code is available to you through your school's CFMS representative.

Sign up today to benefit from these great discounts and more!

Medical student wellness

Not just a goal, but a reality!

Natalia Ng
Wellness Officer
University of Ottawa, Class of 2013

It is often said that "knowledge in youth is wisdom in age". Although this saying can have many meanings, in its most simple interpretation, it serves as an important reminder that the habits we as medical students develop at an early stage can be invaluable to us in the future.

As we are constantly exposed to academic, social and financial challenges, students can easily stumble down the path towards burnout. How can we equip students with the necessary tools to *prevent* burnout from happening in the first place? This is a question that has been lingering around the medical community for years, but is now being brought to the forefront. In October 2010, the International Conference on Physician Health hosted by the Canadian Medical Association, American Medical Association and British Medical Association in Chicago, emphasized the importance of putting measures in place to address the challenges medical students face as they journey through their medical education. Similarly, the 2011 Canadian Conference on Physician Health in Toronto plans to focus on the very idea of prevention — providing medical students and physicians with the tools they need to remain resilient and avoid burnout.

As we are constantly exposed to academic, social, and financial challenges, students can easily stumble down the path toward burnout.

The CFMS is also doing its part by releasing their second issue of *Embracing Wellness: Healthy Medical Students for a Healthy Healthcare System*. With sections dedicated to areas such as stress management, financial health, nutrition and physical activity, this project aims to empower students to engage in a balanced lifestyle. This year, the issue of mental health amongst medical students — an area that is often ignored amongst medical professionals — is being emphasized. Even though awareness of mental health challenges in the medical community has increased in the past decade, it is disconcerting to learn that physicians have one of the highest suicide rates of any occupation in North America. This fact emphasizes the importance of providing medical students, early on in their training, with the resources needed to address the challenges they'll face. The CFMS is committed to taking the first steps in doing so.

With the help of our professional organizations and medical schools, the CFMS is committed toward making a balanced lifestyle amongst medical students not just a goal, but a reality.

IMGs, Canadians studying abroad & Canadian medical graduates

Health care training and self-sufficiency

Regan Taylor, University of Calgary, Class of 2012
Tyler Johnston, Dalhousie University, PGY-1 Emergency Medicine, CFMS Past President

Changes to provincial government residency space allocation need to be considered by the Canadian Federation of Medical Students (CFMS) as it affects the number of residency spots available to Canadian Medical Graduates (CMGs). Currently, provinces such as British Columbia, Manitoba and Quebec maintain an open match for the first-round iteration of the Canadian Resident Matching Service (CaRMS), while Alberta maintains this arrangement for the second round only. In addition to the International Medical Graduates (IMGs), Canadians Studying Abroad (CSAs) is an emerging group of medical students originally from Canada that has asked for further consideration with regard to this issue. The CFMS believes that there is steadily increasing stress on our system with respect to trainee capacity and that investment in domestic training capacity is the best approach to meeting the health care needs of Canadians. Further, the CFMS believe that given the disproportionate distribution of the global burden of disease in developing countries, Canada should ultimately aim for self-sufficiency in terms of health human resources (HHR).

The problem

Canada faces significant HHR challenges and needs an increased supply of physicians. Statistics Canada (2009) reported that nearly 1.9 million Canadians are unsuccessful in their attempts to find a family doctor. The current controversy relates to the role that IMGs and CSAs will play in meeting the future health care needs of Canadians versus an approach that promotes self-sufficiency in physician supply.

An investment in domestic training capacity is the best approach to meeting the health care needs of Canadians.

Significant ill-advised government cuts to medical school enrollment in the 1990s have been implicated in Canada's shortfall of HHR. These cuts are major factors in explaining why health care demand significantly outstrips current supply. Inadequate government investment in medical schools and in residency training programs combined with HHR shortages and the attractiveness of medicine as a profession has led to an excess of people who want medical training in Canada over those who are able to be responsibly accommodated within the current system.

In order to address the physician shortfall, governments in concert with medical schools have significantly increased medical school enrolment over the last decade. Likelihood of choosing family medicine and practicing in underserviced areas are both important considerations that merit special attention. Recently, incorporating IMGs into the physician supply in order to meet the health care needs of Canadians has also become a tenet of various government strategies with CSAs, a subset of IMGs, having received particular attention.

CSAs and legal issues

In any consideration of IMGs and CSAs, there are legal implications. Chew et. al (2010) noted that the CSAs are increasing in numbers between countries such as Australia, Ireland and the United Kingdom. For example, The University of Queensland in Brisbane, Australia had successive increases in the number of CSA students each year from 23 to 61 to upwards of 100 in the classes completing their program in 2010, 2011, and 2012 respectively (Miernik, 2010). In the future, there will likely be no less than 100 Canadians out of the 130

spots per class open to international students each year in that one program in Australia.

Although CSAs represent a significant political group, because both IMGs and CSAs have participated in non-Canadian medical training, any attempt to treat these two groups differently invites human rights challenges. If there are different policies regulating IMGs and CSAs, it could then be said that any non-Canadian IMGs are discriminated against based on their country of origin. This needs to be a consideration in any position on these two groups, ultimately meaning that we should not treat the two groups differently.

*Full report is available at www.cfms.org/papers.asp.

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CFMS student initiative grants: Project successes!

Serena Siow
Western Regional Representative
University of British Columbia, Class of 2012

The CFMS offers financial support for projects initiated by medical students through the Student Initiative Grants. Projects are selected based on their potential to promote interaction between schools and enhance CFMS visibility.

… the Canadian Federation of Medical Students is proud to announce funding for four regularly occurring medical student conferences.

One application cycle was held this year inviting submissions from students across the country. The response was overwhelming — in terms of both quantity and quality! The CFMS is pleased it can support so many exciting initiatives at our member schools.

Below are some of the projects that have benefited from the CFMS Student Initiative Grants.

Day in the Life of a Medical Student ("DITLOAMS")

Every December, first-year medical students at the University of Calgary organize a special event for undergraduate and high school students interested in medicine. Day in the Life of a Medical Student ("DITLOAMS") is an opportunity to shadow a current medical student. Funding received from the CFMS Student Initiative Grant helped to make this event possible.

Sharing in Health

www.SharingInHealth.ca is an open access textbook for health care students around the world. The backbone of the work is freely available content — text, images and videos — that cover the foundations of health care training. Sharing in Health has been endorsed by the IFMSA and is planning to pilot their work in Haiti and Uganda this year. CFMS funding has been helpful in supporting groups at each university. Progress is proceeding slowly, but steadily, with over 30 topics written with CFMS support.

Canadian National Medical Student Research Symposium

The 2nd annual Canadian National Medical Student Research Symposium (CNMSRS), held again at the University of Manitoba in Winnipeg, was a great success. The event saw participation from 14 out of 17 Canadian medical schools, which included McGill University and Université de Sherbrooke from the Province of Quebec. Each participating medical school sent one to six students to compete in three categories: clinical research (MD), basic/translational research (MD) and basic/translational research (MD/PhD).

University of Ottawa Journal of Medicine

The *University of Ottawa Journal of Medicine* (*UOJM*) provides an opportunity for students to be exposed to academic publishing. As of January 2011, the foundations for the journal have been established: the website is live (www.uojm.ca) with a fully-functional submission system. Look for the first issue published both online and in print by the end of May 2011.

Conferences

In addition to supporting individual student initiatives, the CFMS is proud to announce funding for four regularly occurring medical student conferences that promote medical student camaraderie:

- **MedGames:** A unique weekend of sporting events, meals and social gatherings for Med students from across Canada, held annually in Quebec.
- **MUN/Acadie/Dal Conference:** An educational conference for Atlantic medical students.
- **Ice Bowl:** Hockey tournament and social events for Western medical students.
- **OMSW:** Ontario Medical Students Weekend.

For more information about the CFMS Student Initiative Grants and the new regular conference funding, please visit the CFMS website or email cfms.sigs@gmail.com. Stay tuned for emails from your school representatives for information about the next application cycle.

Updates from the Political Advocacy Committee

Ashley Miller
VP Advocacy, Chair of the National Political Advocacy Committee
University of Ottawa, Class of 2012

The Political Advocacy Committee (PAC) has steadily grown throughout its four years to become a CFMS institution. Each PAC representative is responsible for creating and leading a local committee at their school. This year, each local PAC conducted an environmental scan to assess student interest in various political issues, planned and executed a grassroots initiative based on those results, contributed to federal Lobby Day planning, collaborated with their school's GHA to host an advocacy training event and took on research for a new CFMS tuition project. In addition to this tremendous work, several PACs also organized their own provincial Lobby Day! By the end of this year, the PAC will be responsible for lobby day events in British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, and Newfoundland. Several Ontario reps will also be participating in the Ontario Medical Students Association's provincial Lobby Day.

The environmental scans and grassroots initiatives this year indicate the wide variety of interests held by our CFMS membership. Several PACs have chosen to take on projects related to our National Lobby Day theme of the underrepresentation of low income and rural background students in Canadian medical schools. Sahil Gupta at the U of Alberta and Alistair Waugh at the U of Calgary organized a provincial lobby day on November 29, 2010 related to this topic for students at Alberta's two medical schools. Jesse Zroback from NOSM has taken on a research project to identify the barriers to undergraduate and medical education for high school students from a rural northern Ontario town with significant financial hardship. He has also delivered outreach presentations at these high schools and is serving as a mentor for local youth. Dal's PAC, led by Matthew Kutcher, is developing a pipeline project for underrepresented Nova Scotian youth, modeled after Stanford's Medical Youth Science Program. This initiative is exactly the type of project that we asked the government to fund at our federal Lobby Day. Other schools have taken on grassroots initiatives ranging from curriculum reform to include practice LMCC exams, an opt-in organ donation program and greater funding for distributed medical education. Mari-Lynne Sinnott and the MUN PAC's efforts at their provincial Lobby Day have led the Newfoundland and Labrador government to commit $3 million to DME programing. These are just a few of the tremendous successes that have been accomplished already this year by our superstar PAC reps.

Our second annual PAC Conference Day held on February 5, 2011 was an inspiring day as we shared project results and enhanced our leadership capacity. We were joined in Ottawa by Dr. Michael Rachlis, health policy expert from the University of Toronto; Dr. Keith Martin, one of Canada's four MD–MPs; and Laurèl Craib, lobbyist for the Canadian Medical Association. Each provided their unique insight into the current political environment relating to health care and offered valuable advice to our own advocacy experts from the PAC.

2010–2011 Political Advocacy Committee

Memorial University — Mari-Lynne Sinnott
Dalhousie University — Jennifer Gillis (Sr), Matthew Kutcher (Jr), and Will Stymiest (New Brunswick Campus)
McGill University — Aaron Winter and Esli Osmanlliu
University of Ottawa — Darrell Lewis, Chloe Ward, and Jeewan Gill
Queens University — Ali Furqan
University of Toronto — Alex Petre
McMaster University — Jelena Lukovic (Sr), Holden Sheffield (Sr), Matthew Tenenbaum (Jr), and Leah Hillier (Jr)
University of Western Ontario — Adrienne Selby
Northern School of Medicine — Jesse Zroback
University of Manitoba — Brady Murphy
University of Saskatchewan — Heather Ferguson (Sr), Jessica Lydiate (Jr)
University of Alberta — Sahil Gupta
University of Calgary — Alistair Waugh
University of British Columbia — Lawrence Chow

CFMS Annual Federal Lobby Day 2011

Ashley Miller
VP Advocacy
University of Ottawa, Class of 2012

The CFMS Federal Lobby Day is an annual event that brings medical students from across Canada to Parliament Hill to meet with policy makers to discuss issues of importance to our membership. For the second year, our delegates met with Members of Parliament, Senators and bureaucrats to discuss the underrepresentation of low income and rural background individuals in Canadian medical schools. This year we asked the federal government to a) establish an application bursary program to cover the costs of applying to medical school for students in financial need, and b) create a dedicated fund to support pipeline projects aimed at recruiting and supporting low income and rural students in a career in medicine through education, mentorship, and research opportunities.

The Lobby Day event began with a training session on February 6, 2011 for each of our 59 delegates. We were joined in Ottawa by Dr. Carolyn Bennett, one of Canada's four MD–MPs who shared her unique view of political advocacy as a physician who now serves in government. We also had the great pleasure of hearing from the Canadian Medical Association (CMA) President, Dr. Jeffrey Turnbull, who appealed to our medical student participants to get involved in the CMA's Health Care Transformation feedback process. Laurèl Craib, CMA lobbyist, also offered her knowledge of the advocacy process and shared some expert tips on how to approach our meetings with politicians. We also heard from several members of the Political Advocacy Committee (PAC) regarding the grassroots projects that they have initiated to address the issue of underrepresentation. Esli Osmanlliu from McGill shared his experience of bringing our Lobby Day topic to a group of parents in a low income area of Montreal. His initiative produced very interesting

We were very pleased with the overwhelmingly positive feedback that we received from MPs, Senators and bureaucrats.

Delegates with Peter Kent, Minister for the Environment.

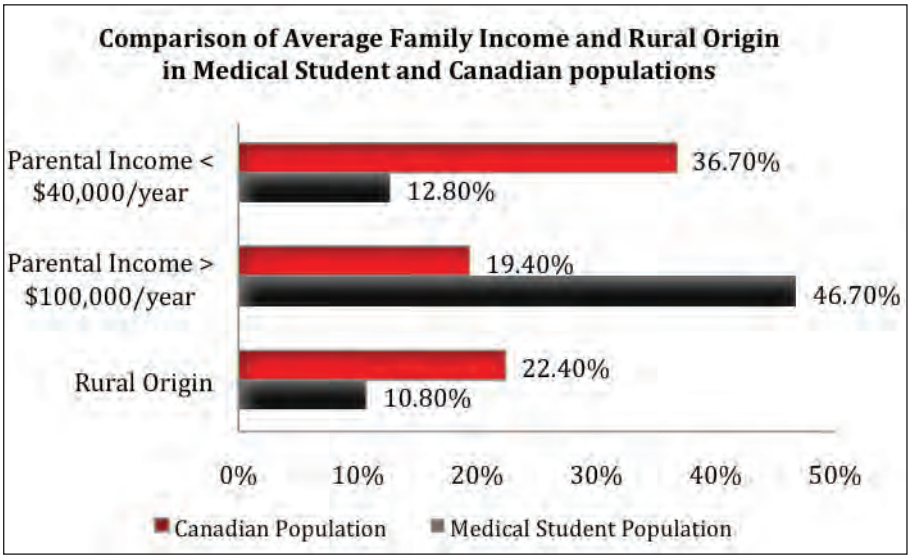
The CFMS President and delegates on Parliament Hill.

feedback and is an excellent example of how delegates can take ownership of this advocacy initiative!

The Lobby Day itself was held on February 7, and our delegates attended almost 80 meetings. This was an incredible success considering the pre-budget timing in a period of tremendous speculation regarding an upcoming election. We were very pleased with the overwhelmingly positive feedback that we received from MPs, Senators and bureaucrats. Senator Lucie Pépin brought this topic to the attention of the Senate and we have received similar requests from MPs to present our 'ask' to the House. In addition, we have received multiple requests for additional meetings related to this topic, including the Honourable Diane Finley, Minister of Human Resources and Skills Development; Honourable Lisa Raitt, Minister of Labour; and staff for Leona Aglukkaq, Minister of Health.

The organization of this year's event was assisted enormously by the contributions of many amazing PAC members. Thank you especially to Darrell Lewis from Ottawa, who co-organized the event logistics. Thank you also to the stellar research team of Matthew Tenenbaum from Mac, Sahil Gupta from U of A, Jesse Zroback from NOSM, Brady Murphy from U of M, and Lawrence Chow from U of T. Each of the PAC reps was instrumental in the successful execution of this event, as they contributed to the development of the 'ask' and trained delegates so that everyone was ready upon arriving in Ottawa.

Not to be forgotten, our VP Communications, Robin Clouston did an extraordinary job coordinating the media aspect of Lobby Day. She proved herself as a true media mogul, arranging 9 radio interviews, 2 television interviews, 23 print articles, countless online reprints of our Press Release, and tweets from 5 MPs and even a few journalists! This degree of national coverage was unprecedented and greatly extended the CFMS' visibility. Thank you to Sahil Gupta, Jesse Zroback, Noura Hassan (VP Education), Renee Pang and Darrell Lewis, who were interviewed for these pieces.



PAC chairs at training day.

Medical Student Performance Record

Not the latest superbug but perhaps more fearsome

Shawna Pandya
Western Regional Representative
University of Alberta, Class of 2012

M.S.P.R. — 4 little letters that seem innocent enough on their own, but together, fearsome enough to strike terror in the heart of even the steeliest of medical students the country over. No, it's not the latest and greatest super-breed of *Staph Aureus*, but possibly worse, depending on who you ask. It's the Medical Student Performance Record, that 4-year amalgam of your life and times as a medical student, including your awards, achievements and accolades … and heaven forbid, your less-than-stellar moments.

In general, the MSPR covers both subjective and objective rotation performance evaluations (meaning both numerical ratings and personal comments), extra-curricular activities, awards/achievements, research, and overall academic progress ('pass' or 'fail' for most schools, 'honors,' if applicable, or any mention of academic or professional transgressions). So it should certainly come as no surprise that this little document can be a source of stress for many a senior medical student. What IS surprising, however, is the degree to which these records can vary from school to school. Some MSPRs let students review the final document before submission, while some will let students strike negative comments. Others are generated by the school and still others have converted to an ongoing online record that students can contribute to throughout medical school to ensure the burden of generating a dazzling MSPR does not come down to the wire come CaRMS time.

It should certainly come as no surprise that this little document can be a source of stress for many a senior medical student.

Given the importance of the MSPR, in 2011 CFMS signed on to review the variation in records amongst its member schools, so as to generate a gestalt of overall similarities, differences and areas of satisfaction/dissatisfaction amongst schools. Starting with an online survey to each school's CFMS rep, which is still ongoing, responses received to date show dissatisfaction at some schools with the lack of control a student has over his/her record. Meanwhile, other schools the opposite is true, finding that students have a lot of control over what goes on their records, what stays off and more importantly, having the opportunity to review the record before it is submitted.

As mentioned, the process is still ongoing, so if you have an opinion, we want to hear from you! Take a moment to visit the survey at http://www.surveymonkey.com/s/SNL3KBK, or drop a line to one of your friendly CFMS Western reps, Shawna (pandya@ualberta.ca) or Serena (shsiow@interchange.ubc.ca) and let us know your thoughts.

Lastly, a caveat: lest you be alarmed at the degree of variation that exists amongst MSPRs and how that might change the playing field amongst candidates from different schools — don't be. At the end of the day, past CFMS surveys of program directors have shown that MSPRs, being as chock full of information as they are, are more useful to raise red flags regarding academics, professionalism or other issues than they are to individually rank candidates based on achievements. So if your school grants you less control than you wish over your own record, it's not the end of the world — but hey, depending on what the survey results show, it might be something worth changing.

Happy bleeding 2010!

Crystal Sin Yi Cheung
CFMS Blood Drive Officer
University of Ottawa, Class of 2013

Continuing the invaluable efforts of previous CFMS blood drive officers and all the medical students who have been contributing to the blood drive efforts, the Partners for Life (PFL) program has been a success — the donation of 2,010 units of blood is approximately 80% of our goal! In addition to sustaining a long-term partnership with Canadian Blood Services, PFL also encourages student to donate on a consistent basis. Blood donation is a truly cumulative effort of many dedicated donors, volunteers and staff.

One of the great advantages of PFL is its flexibility — once the CFMS students have signed up as a PFL member (via submitting a PFL form to the staff at the local clinic or online), donations will count toward your medical school's pledge even if you are half way across the country!

In addition to blood donation, different schools have been taking initiatives to raise awareness and encourage donations. While some have continued their excellent efforts in volunteer programs held by Canadian Blood Services, others have visited to different primary schools to present educational information related to blood and some have even introduced challenges within their own medical school as a way of promoting blood donation.

While many of us are aware of its importance, blood donation is more than just helping people — it saves lives.

CFMS cancer fundraiser: *get involved!*

Phil Vourtzoumis
Quebec Regional Representative
McGill University, Class of 2013

According to the Canadian Cancer Society, an estimated 173,800 new cases of cancer will be diagnosed and 76,200 deaths will occur in 2011.

The CFMS is a proud supporter of all medical students in Canada. It goes without saying that a federation of this size, which represents over 7,500 medical students from coast to coast, has the power to communicate many of its students' diverse initiatives. However, when it comes to cancer, students across Canada become united as this has touched us all, in one form or another.

Each year, the CFMS orchestrates the Cancer Fundraiser across its 14 member schools. Each school's first-year class selects a cancer-related charity and fundraises within their university. The type of fundraiser conducted is completely optional and creativity is greatly encouraged! This can be a great way to bring the university together in the name of a great cause. Here are a few examples from our most recent fundraising drive:

The entire University of Calgary faculty participated in the "Calgary Head Shave", raising close to $25,000 in support of children's cancer research. Great job Calgary! They are already raising funds for this year's "Calgary Head Shave," which is looking to be an even bigger success!

The University of Western Ontario raised over $8,000 through various university events — "Head for a Cure", where faculty and students shaved their heads; wine tasting events; a professor comedy night; and a dinner with 20% of the proceeds going to charity. Their charity of interest was Camp Trillium, a camp for children with cancer, where all family members attend and no one knows which individual has cancer. This is outstanding guys, and what a great way to get everyone involved!!

Dalhousie University raised approximately $2,000 through class donations and a BBQ. The funds were donated to the Daniel McLellan Memorial Fund, a charity assisting children with leukemia in Atlantic Canada. This fund provides financial assistance to the families of the children with the disease, both during the treatment and recovery periods.

These are just a few examples of how a student body can participate in fundraising activities while having fun, building community spirit and raising money to beat cancer at the same time! One person alone can't make the difference, but when we are 7,500 strong, we can make cancer history!

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SunCountry HEALTH REGION

Montreal hosts 750 medical students for Canada's first international General Assembly

Sarah Fung
VP Global Health
University of Alberta, Class of 2011

Last August, 750 medical students from across the globe gathered in Montreal for a stimulating week to spark discussions, build partnerships and share projects. This event, the General Assembly (GA) of the International Federation of Medical Students' Associations (IFMSA), known as Montreal AM 2010, was the first time that Canada has hosted an IFMSA General Assembly.

Montreal AM 2010 was the fruit of an unprecedented partnership between the CFMS Global Health Program (GHP) and its Quebec equivalent IFMSA-Québec. Hosting the first IFMSA General Assembly ever in Canada demanded the 2-year commitment of an Organizing Committee (OC) whose members spanned coast to coast and whose ethical, pharmaceutical-free fundraising topped $200,000.

Within the framework of IFMSA's six standing committees, delegates delved into medical education, reproductive health, public health, human rights and peace, and international exchanges, supplemented by theme events exploring "Health and the City", training sessions and project presentations.

Delegates were treated to world-class speakers, such as Dr. Ronald Labonte, Canada Research Chair in Globalization and Health Equity, and fellow Canadian Dr. Dana Hanson, past president of the World Medical Association.

As the host country, CFMS was able to send its largest delegation ever to a GA, with 18 students in attendance from our member schools. Our committed delegates achieved the first IFMSA endorsements of CFMS projects. With this distinction, Pre-Departure Training for students pursuing international electives, a long-time focus for the GHP, is set for global attention and expansion. The other project, Sharing in Health (http://sharinginhealth.ca), is an open-access resource-sharing website built by students, for students.

This meeting also saw the IFMSA embrace environmentalism to a new level. The federation passed its own Green Charter, based on the original version adopted by CFMS at its Spring

Delegates to Montreal AM 2010.

Students participate in an interactive session.

Delegates take in the project presentations.

General Meeting in 2009. Whether it was electronic documents that saved over 15,000 sheets of paper, biodegradable food containers and composting, or the Palais des Congres itself, the recipient of several awards for its green practices, going green was a top priority for the OC. The OC also made a substantial donation to "Less", a reputable carbon offset program in Canada, given to lessening the carbon footprint associated with events of this scope.

The General Assembly was preceded by the pre-GA in Ottawa, a 3-day series of engaging workshops and interactive sessions on topics like global health, peer education and more.

Montreal AM 2010 was the fruit of an unprecedented partnership between the CFMS Global Health Program and its Quebec equivalent IFMSA–Québec.

With the success of Montreal AM 2010, CFMS is set to continue its strong contributions at the international level when our delegations attend the March Meeting in Jakarta, Indonesia (March 5–11, 2011) and the August Meeting in Copenhagen, Denmark (August 1–6, 2011).

All Canadian medical students are part of the IFMSA through CFMS. The International Federation of Medical Students' Associations represents over 1.2 million medical students from 97 countries worldwide and is officially recognized by the United Nations and the World Health Organization. If you are interested in attending one of the IFMSA's biannual General Assemblies, watch for the "Call for Applications" released in the CFMS Rep Communiques in the months leading up to each GA.

Pre-departure training

Ensuring quality for Canadian medical students

David Matthews, National Officer of Global Health Education (incoming), University of Toronto, Class of 2014
Eileen Cheung, National Officer of Global Health Education (outgoing), University of Western Ontario, Class of 2011

As global health gains prominence within medical education, increasing numbers of medical students are choosing to carry out international medical electives in low-resource settings. A growing number of medical students participate in some form of short-term international clinical work during their training. While such experiences have numerous benefits for students, there is concern about potential harm from ill-prepared students untrained to deal with settings and situations that differ radically from their home institutions/countries. As a result, there has been an increased effort to ensure that medical students in Canada receive appropriate pre-departure training (PDT) before embarking on international electives.

Over the past 3 years, the National Officers of Global Health Education (NOGHEs) along with the CFMS PDT Working Group have worked to ensure the implementation of PDT at medical schools across Canada. Overall, the results have been very encouraging. In 2008, only 35% (6/17) of medical schools had mandatory PDT programs. Preliminary survey results for 2010 indicate that PDT is now available at almost all medical schools and that it is mandatory at a majority of schools.

The challenge now is to ensure that all students have access to quality PDT and that certain core competencies are taught at all schools. In 2008, the Global Health Resource Group of the Association of Faculties of Medicine of Canada (AFMC) along with the CFMS developed joint National Guidelines for PDT. These guidelines outline five core competencies that should be covered in all PDT sessions.[1] The five competencies include:

1. Personal health
2. Travel safety
3. Cultural competency
4. Language competency
5. Ethical considerations

The importance of PDT has been recognized by the Canadian medical community.

Experience has shown that, while personal health and travel safety are relatively straightforward to teach; cultural competency, language competency and ethical considerations can be more challenging, especially when applied to medicine. As such, the NOGHEs and PDT Working Group have tried to encourage resource-sharing betweens schools so that they may better address these competencies in their PDT sessions.

Students from several schools have created innovative resources for PDT. For example, McMaster and Western have developed case studies to help prepare students for common situations that may be faced while on elective. UBC has also created a new website as part of its Ethics of International Engagement and Service-Learning Project (EIESL) that contains numerous resources designed to provoke ethical reflection on international engagement and service learning projects (http://137.82.249.99/).

An exciting initiative lead by students at Dalhousie is the "First, Do No Harm" video project. This hour-long documentary explores the ethical challenges facing health care professionals and students working in developing countries, highlighting some of the often unexamined ethical pitfalls associated with foreign medical efforts in a developing nation. A short version of this video is currently available at http://vimeo.com/12777201 and the full-length version should be available to students across Canada later this year.

It is hoped that resource-sharing and promotion of the core competencies will help to ensure quality PDT at all Canadian medical schools. While PDT sessions remain student-led at some schools, at others there has been increasing collaboration between faculty and student leaders to implement PDT. It is our intention that faculty will increasingly take the lead in making PDT mandatory for all students carrying out international electives,

and in so doing, establish and ensure a culture of sustainable quality PDT for Canadian medical students.

We are encouraged that the importance of PDT has been recognized by the Canadian medical community. In fact, PDT was included as a part of *The Future of Medical Education of Canada* report published in 2009.[2] In addition, a resolution to make PDT more accessible to all physicians and medical trainees was passed at the 2010 Annual Meeting of the Canadian Medical Association (CMA), supported by the CMA, AFMC, Canadian Association of Internes and Residents (CAIR) and the CFMS.[3] A similar resolution in support of PDT was also passed by the Canadian Society for International Health[4] and the International Federation of Medical Students' Associations (IFMSA) recently endorsed the CFMS PDT Project. In continuing to ensure quality PDT for all Canadian medical students, the CFMS PDT Working Group will conduct further research to evaluate the efficacy of and best practices in PDT. For more information on PDT, contact noghe@cfms.org.

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Global access licensing

A partnership between CFMS & UAEM–Canada

Tim Holland
Atlantic Regional Representative
Dalhousie University, Class of 2011

Ten million people die each year from curable diseases. Nearly a third of humanity does not have regular access to essential medicines. This is nothing new; time and time again, we hear astounding statistics highlighting the dire health care situation in much of the world. We know about the problem. Now the question is: what can we do about it?

Three years ago, as a first year medical student, I was walking through the main hall of Dalhousie medical school and was stopped by a classmate collecting signatures in support of the newly founded Dalhousie chapter of Universities Allied for Essential Medicines (UAEM). I have never been one to attach my signature to anything lightly and my poor classmate had his work cut out for him. But, he made a good argument: to put it simply, the organization's goal is to improve global access to essential medicines by changing the way universities patent their research. I realized this "global access licensing" idea made sense. It could make a real difference without violating the mantra of medicine: first, do no harm. What began as skepticism on my part soon became enthusiasm. I signed the petition (the hardest-earned signature all day) and showed up to the next UAEM–Dalhousie meeting.

I spent the next 3 years leading a campaign toward launching a Global Access Licensing Initiative at Dalhousie and the associated hospitals. Under this initiative, the Dalhousie Industry Liaison and Innovation office will tailor global access strategies specific to each commercial agreement and each invention that has potential relevance to the developing world. We have held discussions with the key stakeholders and decision-makers among the Dalhousie administration and faculty, and thus far we have unanimous support.

But Dalhousie is not the first university to consider global access licensing, nor even the first in Canada. The University of British Columbia adopted extensive global access principles just a few years ago; the local UAEM chapter led the campaign there as well.

The difficult part in campaigning for global access licensing is not convincing people that it is a good idea. In fact, once explained, stakeholders are usually immediately supportive. The hard part is setting up the meetings with those key decision makers in the first place. I am not sure why, but medical students, deserved or not, have a legitimacy ascribed to them that allows them to access important stakeholders. We can, and should, take advantage of this to further our social justice efforts. Furthermore, medical students tend to be very enthusiastic and untiring in their extracurricular efforts, comprising an important human resource in this campaign.

This has led to a new partnership between the CFMS and UAEM–Canada. UAEM has knowledge and expertise regarding global access licensing and campaigning. The CFMS has a nation-wide network of enthusiastic medical students who can provide time, effort and the ever-so-crucial access to key decision makers. Moreover, the CFMS's network extends well beyond the established chapters of UAEM, and through the CFMS we can begin new global access campaigns at schools without a preexisting UAEM chapter.

As medical students, deserved or not, we have a legitimacy ascribed to us that allows us to access important stakeholders.

Global access licensing just makes sense and it is the way academic institutions are moving. Influential schools throughout the United States are already on board, as evidenced by the signing of the Statement of Principles and Strategies for the Equitable Dissemination of Medical Technologies by Harvard, Yale and many others. I am confident that Canadian universities will follow suit once their decision-makers learn about the benefits of global access licensing. I feel that this budding partnership between UAEM–Canada and the CFMS may be the avenue by which we, as medical students, can make this message heard.

Aboriginal health education

A philosophy for affecting change

Marcus Hancock
Aboriginal Health Liaison
University of Manitoba, Class of 2013

First as a high school teacher and now as a medical student, I have spent the past several years working and learning in the areas of education and health care. I am most passionate about Indigenous health education. As a member of an Aboriginal community and hailing from the east coast, I have used my unique experience and skill set to attempt to evoke change in how students, members of the community and First Nations, Métis and Inuit people view health and wellness. When the CFMS announced that they would be creating a new position dedicated to Indigenous health, I was very excited.

… we have become increasingly aware of the under representation of Indigenous peoples within our collective health care institutions.

As the Aboriginal Health Liaison (AHL) — a part of the CFMS Global Health Program, I continue to do my best to represent and connect both Aboriginal peoples and Canadian medical students. I feel privileged to be a member of both of these distinct and special groups of individuals.

The creation of the Aboriginal Health Liaison position is really about recognition. Like many of the CFMS's Global Health programs, the position represents recognition of our unique circumstances as medical students in a multicultural and diverse nation. Perhaps best summed in the global health programs statement of vision: "we are, as future physicians, uniquely and strategically placed to promote the values of health equity and social responsibility". We recognize that First Nations, Métis and Inuit people collectively represent a diverse subset of the population across this country and deserve our special attention. In addition to this, over the past several years we have become increasingly aware of the under representation of Indigenous peoples within our collective health care institutions.

While only in the job for a few months now, I have certainly glimpsed my share of challenges. Changing the status quo with regards to Aboriginal health education across Canada's medical schools will be a long term project. In many cases the perceptions of Aboriginal peoples are tied up within the complex and intricate hierarchy of society and culture — both within the medical community as well as the country at large.

My work as the AHL will be focused on creating partnerships and collaborating with relevant indigenous health stakeholders. I am also working to create a national and collaborative student approach to Aboriginal health interest group creation and administration at each of our member schools. Working closely with other medical students is a key part of this job. Together we are working toward the creation of national pre-departure training standards for students looking to participate in electives in Indigenous, remote and northern communities. We also hope to develop a scholarship open to students interested in Indigenous health electives. Establishing communication and collaboration among our member schools, to share and adopt the most effective and unique strategies for Indigenous health promotion and participation, is key to the success of this new program.

The Aboriginal population in Canada is infinitely diverse and merging traditional cultural teachings with modern medical faculty administration will remain an ongoing challenge. My hope, however, is that this work will help lead to the creation of healthy and vibrant Indigenous communities supported by well educated, culturally competent Aboriginal and multicultural physicians.

Please share your ideas and feedback: aboriginalhealthliaison@gmail.com.

Global health advocacy in action

A coast-to-coast initiative targeted toward immigrant and refugee health

Kamini Premkumar
National Officer of Human Rights and Peace
University of Saskatchewan, Class of 2012

The Global Health Advocacy Program (GHAP) unites Canadian medical schools behind a global health theme to train future physician advocates on behalf of underserved populations in their country and abroad. The theme for the 2010–11 academic year is "Immigrant and Refugee Health".

The year began with a high energy, inspirational weekend in October where our Global Health Advocates (GHA's) bonded in advocacy skills workshops, at team meetings and during evenings out in our beautiful nation's capital. Our goals were to provide the GHA's with advocacy training and build a strong team that would work effectively while distributed across a wide geographical area. It was hoped that the skills and tools the GHA's received would be disseminated to their respective student bodies. Training was provided in association with Results Canada, Dr. Kevin Pottie and the Canadian Conference on Global Health.

Results Canada is a grassroots organization that engages citizens to speak out against global poverty, hunger and suffering. They provided advocacy training to our GHA's and representatives from IFMSA–Quebec in the areas of political process insights and effective ways to create change by using the media and influencing politicians. The global tuberculosis crisis was the theme used in the training and will be targeted by the GHA's on World TB day.

Dr. Kevin Pottie is an expert in the field of immigrant and refugee health. He provided a scenario-based learning workshop about the barriers to health that refugees face. He also introduced us to the Health Advocacy for Refugees (HARP) program which trains medical students to work with newly arrived refugees by fostering competence in cultural issues.

The Canadian Conference on Global Health invited attendees to the keynote speaker presentation and a global health education workshop. Former Médecins Sans Frontières (MSF) President, Dr. James Orbinski set the perfect tone for this year's advocacy initiatives with an inspirational speech that motivated the GHA's to approach their projects with unmatched enthusiasm.

At the end of the weekend the GHA's were equipped to begin their local advocacy projects. Some chose to use awareness as a means of advocacy by inviting speakers to their schools. Others increased refugee and immigrant health teaching in their curriculums or partnered with local settlement officers to directly improve quality of care.

Many projects are worthy of elaboration, but these two highlight the vision and mandate of the GHAP particularly well. The cultural competency of physicians is a major barrier immigrants and refugees face in accessing health care and programs: HARP, in Ottawa, exemplify initiatives that directly address this barrier by integrating medical students into the refugee and immigrant community early in their training. Erica Lasher, GHA at Dalhousie University, partnered with Nova Scotia's Immigrant Settlement and Integration Services (ISIS) to assist in the development of a health clinic to serve the refugee and immigrant population of Halifax. She assembled a group of medical students that underwent training with the ISIS Refugee Coordinator. This training provided information about refugee health, addressed the settlement process and discussed the appropriate use of interpreters. The students plan to assess community needs through interviews with physicians who serve refugees as well as refugee families themselves. Their final report will be presented to the ISIS board members. Ultimately, they hope to hold a campus-wide letter writing campaign to advocate for this underserved population, request government funding for their clinic, and raise awareness of immigrant and refugee health issues amongst the student body and surrounding community.

This initiative reflects the goals of the GHAP: to teach medical students to be an advocate, to address the needs of an underserved population and to make lasting change in our communities. Through the leadership and advocacy efforts of the GHA's, changes are being made from coast to coast that will assist future physicians in improving immigrant and refugee health.

First, Do No Harm

Alyson and Timothy Holland
National Officer of Rights and Peace (Incoming) and Atlantic Regional Representative
Dalhousie, Class of 2011

Canadian medical students and physicians are increasingly interested in global health — seeking opportunities to participate in international electives and medical humanitarian and development work. However, responsible participation in global health experiences requires more than parachuting in and out of a community in a country perceived to be developing. Responsible and sustainable projects by medical students and health professionals in developing countries require a willingness to critically assess our motivations and goals. Why do we participate in projects in developing countries? Who benefits from overseas medical projects and electives, and how much do they benefit? Who bears the greatest burden of risk and cost in our initiatives, and how do we minimize that burden in the communities with which we work? How can we develop programs that ensure respectful collaboration with overseas partners? In short, are these projects in developing countries justified? If so, how do we ensure they are fair and sustainable?

Who benefits from overseas medical projects and electives, and how much do they benefit?

We have created a documentary, "First, Do No Harm," which explores these questions with the hope of encouraging critical thinking on the ethical issues pertaining to international medical volunteer projects and electives. Over the past three years, we have interviewed experts and global health providers from all over the world. We have travelled to conferences throughout North America and visited global health projects in Tanzania, Rwanda and Uganda where we were able to gain insight into the perspectives of visiting and local health providers.

The CFMS has been one of the primary financial supporters for the project, but has also been an incredible support in many other ways. The film premiered in April 2011 and the CFMS will be one of the primary avenues of distribution. We hope that the film will be a valuable aide to facilitators of pre-departure training as well as a valuable piece in the ever-evolving conversation on global health ethics.

Global health expert being interviewed for the documentary.


Filming the documentary.

Objective: A National Medical Equipment Recovery Program

National working group seeking representatives from every Canadian medical school

Achelle LeBlanc
Global Health Liaison Sr.
Dalhousie Medical School, Class of 2013

Rationale in brief

Millions of dollars worth of excess medical supplies are discarded in northern countries every year. The environmental and economic costs of landfill disposal or incineration are significant. Meanwhile, low-income countries struggle to acquire the most basic resources to provide care. Health care providers and students are forming community partnerships in an attempt to reduce such inequalities and environmental waste. Unused, serviceable supplies are collected and shipped to partner communities or sent along with travellers. This idea is not a new one — the Recovered Medical Equipment for the Developing World (REMEDY) program at Yale was pioneered in 1991 and sister projects have been emerging across North America ever since. REMEDY suggests their efforts have actually saved their hospital and patients a net $50,000 US annually since its inception.

Existing programs in Canadian medical schools

There are four existing medical equipment recovery programs in Canadian medical schools: Dalhousie University's Medical Equipment Recovery Initiative ('MERcI'), University of Alberta's 'MERcI', University of Western Ontario's 'Operation Green', and McMaster University's 'MED-P'. In addition, the University of Toronto and the University of Calgary are in the process of establishing their own programs. Operation Green is most similar to REMEDY in that its focus is collecting and distributing surgical equipment, while the remaining programs primarily deliver general and basic medical supplies.

What can you do?

The Canadian Federation of Medical Students Global Health Program (CFMS–GHP) is an ideal avenue for the student leaders of these initiatives to share resources on how to develop or improve the programs at your medical school. A national working group has been created for this purpose. We are seeking representatives from every Canadian medical school to participate in the design and implementation of a national medical equipment recovery initiative. This will involve researching and discussing the risks, benefits and ethics of medical equipment recovery in order to design a national set of guidelines. Collaboration via the CFMS–GHP will ensure the quality and sustainability of this program.

We are seeking representatives from every Canadian medical school to participate in the design and implementation of a national medical equipment recovery initiative.

Please contact the author if interested in contributing to these discussions and developments.

Challenges in conducting qualitative research in an international low-resource setting

Jennifer Baxter
Queen's University, Class of 2012

The United Nations Population Fund (UNFPA) Reproductive Health Campaign of Nexos Voluntarios (NeVo) was developed in 2008 as a means of addressing significant reproductive health concerns in the community of Urubamba, a town of approximately 12,000 in the Peruvian *sierra* (mountains). The vision was to empower youth with the knowledge needed to take greater control of their futures. I was the first volunteer to work on this project, meeting with the local branch of UNFPA, local experts in women's health, other NGOs working in this field, community leaders, the local office of the Ministry of Health and the local Health Centre, to develop a curriculum for a comprehensive sexual health education program to be delivered by international volunteers. Over the next 2 years, the program had been implemented in five schools (integrated into core curriculum in one) reaching nearly five hundred adolescents, addressing themes of gender, self-esteem, rights, puberty, anatomy, contraceptives and family planning, teenage pregnancy and STIs. This summer, I returned to the community to evaluate the effects of the sessions on communication within schools and families through focus groups with students, structured interviews with parents, and semi-structured interviews with educators.

Addressing sexual health, in a community where this is largely considered taboo, is an intimidating challenge. Ensuring research methodology and interview guides are culturally sensitive and appropriate without compromising the integrity of the results obtained is a constant consideration, compounded by the reality that I am, and always will be, an *extranjero* (foreigner) in the community. The importance of consulting with community members to determine how best to interview students and parents was recognized, as cultural perceptions and norms surrounding sexual health are highly individualized for a community. Ultimately, a combination of qualitative methodology was used to best access the varied populations of interest; single-gender focus groups afforded the opportunity for group discussion and were considered potentially less threatening for adolescents whereas individual interviews ensured confidentiality regarding a taboo topic for parents and presumably encouraged more open, honest responses.

The vision was to empower youth with the knowledge needed to take greater control of their futures.

Also challenging is applying North American research standards to a context for which they were not directly intended. While striving to ensure that this research involving a marginalized population was conducted ethically, modifications were made to accommodate the local sociocultural context. The research protocol was continuously modified throughout the project to ensure it was culturally sensitive and relevant, meeting the needs of both a research credit-course as well as an NGO seeking an evaluation and needs assessments to direct future efforts. Interview guides were finalized on-site where they could be reviewed by NeVo staff. Letters of Information and Consent were significantly modified to be appropriate for the level of literacy of participants (particularly parents). Consent for student participation in focus groups was provided by the principal and students themselves without directly informing parents to ensure that the continuation of the initiative in the community was not compromised (in the event that parents were unhappy that their children had received such sessions and forced the school to cease involvement). Ultimately this required acceptance of the needs of the local community and a constant reminder of the ultimate intent of the research: to assist the NGO in assessing and developing projects aimed at addressing the needs of the local community. Inappropriate restrictions potentially compromising this goal had to be eliminated.

Language was also a significant

barrier. As an Anglophone with minimal- to moderate- Spanish-language skills, I required assistance with translating interview guides, conducting interviews, and with transcribing and translating audio-recorded interviews. This required interview schedules to accommodate not only myself and the interviewees, but also the NeVo staff member accompanying me, thereby delaying data collection and modifying research protocol. It required recognition of personal limitations and seeking significant assistance from dedicated volunteers. It meant that I was not present for seven of eight interviews with parents such that semi-structured interviews became structured with paraphrased written transcripts (as opposed to transcription verbatim) sent to me following my departure from the community.

The physical distance of the community from research supervisors and research supports was a considerable challenge, forcing reliance on technology (primarily email) in a low-resource setting for project development, data analysis, transcription, translation and follow-up. This challenge was compounded when internet access was slow or failed.

Research conducted in low-resource settings required extensive cultural humility, including a genuine integration into the way of life of the local community, accepting local culture and realities and working within them. In this instance there was a different perception of time that became the norm for research efforts, accepting the implications on data collection given the relatively firm timeline of the project. The word "delay" would more appropriately be replaced with "modified" to reflect this reality; the timeline and schedule for interviews were continuously modified based on community factors and other demands on the time of NeVo staff. Significant patience was a requirement. One needed to recognize the differing priorities, compared to one's own cultural norms in such settings, such as the luxuries of electricity and running water. The local political climate was also a significant factor, causing numerous community-wide strikes and holidays, thus preventing interviews on numerous days.

These challenges all add to the inherent limitations of the data collected. These challenges, however, should not be used as justification for discrediting evaluation efforts or discouraging their use in international low-resource settings. Potential challenges should be recognized early and addressed as best as possible in local contexts to ensure that critical analysis for the continued development and implementation of effective efforts is used in low-resource settings worldwide.

Research conducted in low-resource settings required extensive cultural humility.

Footnote: *I would like to profoundly thank all those who assisted my efforts and helped me to overcome the challenges I have faced over the past ten months. These include Dr. Carpenter, my research supervisor; Wilma Hopman, Elaine van Melle and Hilary Delver for their research support and guidance; the volunteers and staff of Nexos Voluntarios, without whom I would have been truly lost and there would have been no project to evaluate; my transcription/translation team of ever-giving volunteers; my friends and family at home for their support; all research participants; the school teachers and administration for facilitating the project; and the community of Urubamba, who so graciously welcomed me back to my Peruvian home.*

The Healthy Young Minds Project at UBC

Kristy Williams, Alex Butskiy, Maryam Dosani, Disha Mehta and Taylor Swanson
University of British Columbia, Class of 2013

The Healthy Young Minds (HYM) Project was created by five medical students at the University of British Columbia who believe that health advocacy is a powerful tool for improving youth mental health. Mental well-being has recently been identified as a priority health concern by key health promotion bodies, such as the Mental Health Commission of Canada. The particular vulnerability of youth is demonstrated by a number of facts:

- The estimated prevalence of child and youth mental health disorders in British Columbia is 15%
- For more than 70% of Canadian adults living with a mental illness, onset occurred before 18 years of age, highlighting the importance of early intervention in promoting mental well-being
- Less than one third of children under age 18, who have a serious mental health problem, will access mental health services
- Youth are poorly equipped to recognize mental health disorders, yet are most likely to seek help from peers

HYM student leaders were inspired early in their medical training by a common passion for reducing these disparities and providing young people with the tools to not only access mental health resources, but also to emphasize the importance of addressing mental health through self-care practices. The project's mission statement is "to establish a sustainable framework for engaging youth in the discussion of mental health with the aims of reducing stigma and facilitating access to mental health care". This is being achieved through the creation and delivery of workshops in Vancouver high schools.

An important feature of the project is the focus on integrating expert knowledge about mental health with what students already know. The project is currently compiling and evaluating results from four focus groups with local high school students. The team wants to ensure that the project is informed by youth and values their personal and collective experiences while involving them in a discussion about mental health. Feedback from focus groups thus far indicate that youth appreciate and have a desire to learn about a number of mental health related topics, which HYM hopes to address in the development of their workshops. This input complements other pre-existing programs and resources that HYM will use to engage with youth.

HYM team leaders: Kristy Williams, Taylor Swanson, Maryam Dosani, Disha Mehta, Alex Butskiy (from left to right)

Since the beginning of the project in 2009, HYM leaders have cultivated skills important for professional development in their role as future health care providers. When asked about the impact of the project in their education, the team is quick to describe how the project complements the CanMEDS core competencies, particularly as Health Advocates, Communicators and Collaborators; roles that are difficult to teach and learn through traditional education modalities. Their ability to engage with communities and populations with a considerable health burden that is under-addressed has been a valuable experience. It has not only allowed the team to build on important skills, but to also realize that partnering with community champions with common goals is a practical and mutually beneficial way to energize projects.

The next steps for HYM include the creation of youth and expert informed workshops which will stimulate discussion with youth about mental health and the importance of self-care practices. HYM leaders hope that youth will benefit from not only the workshops themselves, but also the interaction with positive role-models. The program will be evaluated following the workshops and the group will be recruiting UBC volunteers to ensure the sustainability of the project in subsequent years.

National Geriatrics Interest Group

A new Canadian medical student initiative

Katrin Dolganova
Queen's University, Class of 2013

The National Geriatrics Interest Group (NGIG) is a student driven initiative created by medical students in Canada to address the gap created in the medical community between high societal demands for and the relative lack of supply of physicians with geriatric interest and training.

The aging population of "baby boomers" has been a popular news item in the past decade. As adults aged 80 and older become the fastest growing segment of the population in North America[1], the structure and functioning of social institutions will face many challenges. Pension distribution, limited health care resources, unaffordable seniors-friendly accommodations are just a few of the more controversial considerations.

The provision of accessible and quality health care, in particular, is an important concern for medical students who will soon come face-to-face with the obstacles in hospitals and clinics. With a ratio of 0.57 geriatricians per 10,000 individuals over 65, Canada lags behind most other developed nations. A ratio of 1.25 is the target, if we want to ensure adequate patient care and student training.[2]

Clerks and residents need to feel comfortable and prepared to look after geriatric patients, who more often than not present with numerous and a complex mix of both medical and social problems that affect their health and quality of life.

Geriatric education should be an important component of undergraduate medical training, because, regardless of the specialty, most medical professionals will provide care to geriatric patients. Unfortunately, Canadian medical schools are hardly uniform in this respect. In 2006, mandatory geriatric content varied between a total of 7 to 196 hours (with the average being 78 hours) in undergraduate curriculum, which included both pre-clerkship and clerkship years.[3]

Relying on individuals' motivation to learn through electives or self-directed learning is not an effective solution[4], likely due to the low level of student interest in and negative perceptions of geriatrics as a specialty.[2] Although opportunities for geriatrics electives are plentiful, less than 50% of students take advantage of them. In the long term, this affects the delivery of quality health care to elderly individuals – too often wrong medications are prescribed, delirium is misdiagnosed and issues important to geriatric patients and their families are not addressed by physicians.[3]

NGIG aims to address these gaps in education and establish a more positive portrayal of geriatric medicine. NGIG is a branch of the Canadian Geriatrics Society (CGS). It provides a national student forum for networking, sharing of ideas and resources, and development of new initiatives to improve interest, awareness and perceptions of geriatrics. In addition, students can access funding, participate in interesting research initiatives and attend conferences provided by the CGS.

NGIG is currently recruiting members from each medical school in Canada for a number of executive positions and liaison roles. For more information and to become involved in this new initiative, please contact Katrin Dolganova (Communications, External) at edolganova@qmed.ca.

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Healthy and Proud

Julie Nguyen
McGill University, Class of 2012

Healthy and Proud is an adolescent health care promotion and prevention initiative started in 2007 by Julie Nguyen (McGill) and Rania Gosselin-Papadopoulos (Université de Montréal). Workshops, led by university students, promote a positive body image as a novel approach to preventing eating disorders, obesity and high-risk sexual behaviour within the adolescent community. In 2010, we were awarded the Residency Advocacy Grant from the Canadian Paediatric Society. We have also presented our project at the Canadian Association for Adolescent Health's 14th Annual National Conference and at the IFMSA conferences held in Montreal and Bolivia.

As of November 2010, the team has 39 workshop leaders: university students from McGill, Montreal, Sherbrooke and Laval, studying at the Faculties of Medicine, Nutrition, Communications, Psychology and Pharmacy. Healthy and Proud is part of the IFMSA and its Standing Committee on Public Health.

The interactive workshop was created to encourage youth to speak up, give their opinion and have an open debate. Its content, developed from a thorough scientific literature review, has been revised and approved by physicians, nutritionists, a psychologist and all specialists in adolescent eating disorders. In addition, a tool kit including a multi-media presentation and a training workbook to ensure homogenous training for workshop leaders has been developed.

Workshop discussion topics include the following.

1) **Body image versus self-esteem:** What cultural and societal influences impact on how adolescents feel about their body? What influences what they find good looking?
2) **Puberty and body shapes:** What determines your height and your body shape? We identify and describe different body shapes and find people in pop culture that they can identify with. What can you do about your acne? Can you tell if your body, curves, height and muscle will develop more?
3) **How to develop a more positive body image:** We help participants find solutions through positive attitude, nutrition and exercise that will help them improve their body image.

Our message is simple and based on balance: *it is possible to eat foods that you like and exercise for your enjoyment, while being empowered and responsible for your health and you should be proud of it!* Emphasis is put on the dangers and inefficiency of dieting and excessive training. We recommend simple steps, such as eating when you're hungry, sleeping 8–9 hours a night and eating with family. In fact, eating with your family has been linked to higher quality nutrition and less eating disorder patterns.

Many studies show that it is possible to integrate the prevention of eating disorders and obesity, as they share many risk factors. Large prospective studies have shown that dieting behaviors are associated with long-term weight gain. For example, it was shown that girls and boys were much more likely to binge eat while dieting. Neumark-Sztainer, who has done ample research on the link between body image and health behaviors in adolescents commented, "After adjusting for BMI, association

Healthly and Proud workshop leaders.

between body satisfaction and dieting, unhealthy weight control behavior and binge eating remained statistically significant." For example, in adolescents with diabetes mellitus type 1, it was shown that poor glycemic control was found in adolescents who had poor body image; a significant percentage of them had admitted to insulin dosage omission or reduction as a means to lose weight.

Healthy and Proud workshops are presently available in high schools and group homes in Quebec. We have also made contact with physicians and multidisciplinary teams within pediatric hospitals and clinics. They can provide patients that they identify at high-risk for unhealthy weight control behavior with information on our workshops. Planned for March 2011 was a parent and teacher evening to discuss attitudes that encourage a positive body image in adolescents.

The goal is to promote positive body image, as a novel approach to prevent eating disorders, obesity and high-risk sexual behaviour within the adolescent community

We hope to spread these workshops as far as we can, and help as many adolescents feel proud and empowered about their health.

For information or if you would like to create a team within your university, please contact us at info@healthyandproud.com or visit our website at www.healthyandproud.com.

Valentine's Global Heart Hour

You can change the world on Valentine's Day

Vanessa Rambihar
University of Toronto, Class of 2012

Join us and be part of a global collaboration that is making a difference. Started by an enterprising and creative team of medical students at the University of Toronto, this year marks our third annual Valentine's Global Heart Hour. This Valentine's celebration is meant to share ideas, celebrate student involvement in charitable and volunteer work, and inspire each other to sustain humanitarianism.

Global Heart Hour organizers from the University of Toronto.

The 2009 launch focused on heart health since the world was in the midst of a global food, financial and climate crises. The link of cardiovascular health to poverty and development was noted and the community was invited to promote heart health.

In 2010, the theme was "Think Haiti and Rethink the World", in response to the Haiti earthquake. A January 2010 editorial in the Lancet considered it scandalous that it took a seismic shift in tectonic plates for Haiti to earn its place in the international spotlight. Humanitarianism remains the most crucial motivation and means for intervention globally.

This year, Global Heart Hour celebrations at the University of Toronto include an interprofessional Red Party and fundraising in support of Right to Play. Join us by taking an hour next Valentine's Day to do something similar or to create your own Global Heart Hour and start changing your world.

Be part of Global Heart Hour on Valentine's. By yourself, with friends, families or colleagues, take an hour to think global heart and make a difference in your own way. Share your thoughts, blog, Facebook, tweet, use You Tube to share with the world and see what others are doing. Be part of taking this global — just as we turn the lights off for Earth Hour, let's turn hearts on for Global Heart Hour. For more information please contact Vanessa.rambihar@utoronto.ca or see www.facebook.com/globalhearthour

Act Aware, Be Aware

World AIDS Day 2010

Christa Aubrey
University of Alberta, Class of 2011

Christine Osborne
University of Ottawa, Class of 2013

On the day of Louis Turpin's death, his family and friends all gathered together to celebrate his life. At this moment he knew how lucky he was to be surrounded and supported by friends and family — he also knew too well how many others with HIV are not quite as fortunate as him. After Louis death, the Turpin family funded photographers Jacqueline Turpin and Michelle Valberg to travelled across Canada in search of people willing to share their faces and stories. In 1997, they published the book "Look Beyond—The Faces and Stories of people living with HIV/AIDS." Lise Turpin founded the Snowy Owl AIDS Foundation in memory of her brother. She also serves as its Executive Director. Lise explained to the University of Ottawa medical student audience that although we now know a lot about treating the HIV virus, there is still stigma surrounding HIV in Canada and around the world.

PHOTOGRAPHY: SARAH BRASCOUPÉ FUNNELL, UNIVERSITY OF OTTAWA, CLASS OF 2013

Most of this stigma is as a result of judgments being made about people living with HIV, fear due to lack of knowledge about how HIV is transmitted, and ignorance to what it is like to live with HIV. Stigma about HIV or fear of stigma makes it more difficult for people living with HIV to live healthy lifestyles. As future physicians, it is crucial that medical students recognize this stigma and work against it as health advocates for their patients.

Thus, this year World AIDS Day (WAD) was once again celebrated by medical students across Canada on and around December 1. Medical schools took part in film screenings, speaker panels, art presentations, concerts, open mic nights, candlelight vigils, letter-writing campaigns, bake sales and much more. Donations were also collected for various organizations, including Give A Day and Dignitas International.

The CFMS Global Health Program is involved in organizing several WAD events. Traditionally it has been a collaboration between the National Officer of Reproductive and Sexual Health (NORSH) and the Global Health Liaisons (GHLs) at each medical school. This year, Local Officers of Reproductive and Sexual Health (LORSHs) were also involved.

The local officers and all the medical students across Canada made this event a success. It is hoped that their efforts on December 1st gave all medical students across the country an opportunity to reflect on the AIDS epidemic and raise public awareness. Mainly, it is hoped that all medical students will continue for the 364 other days of the year to fight the stigma that surrounds HIV. We can no longer just be aware anymore. We need to act aware.

Acknowledgement

Lise D. Turpin: The Snowy Owl AIDS Foundation/La Fondation Harfang des Neiges pour le SIDA www.snowyowl.org

Being a resident and mother

Mary McHenry
PGY-2 Pediatrics, Dalhousie University (VP Communications, 2008–09)

Dr. McHenry and her daughter Eleanor.

My decision to become a parent during residency wasn't an easy one. I didn't know whether to wait until I was finished or to start my family during my 4 years as a pediatric resident. But I am happy I didn't decide to wait! Finishing medical school was a huge accomplishment, but having a baby was even better. I feel strongly that being a parent makes you a better physician, especially in the pediatric world.

In the 5 months that I have been a mother, I have learnt so much. Going back to work will be a challenge, especially with night call, but I don't regret my decision. I have always believed that everything happens for a reason (including the CaRMS match!) and I am extremely happy with my decision to become a resident and a mother. I hope as CFMS members, you never forget that each life experience you have only makes you a better person and physician!

Juggling babies and books

Alexandra Maher
Memorial University, Class of 2013

Medical students with children are quick to point out that their lives are enriched by the fulfilling and wonderful experience of being a parent! However, those of us without children wonder how these students keep up with the pressures of juggling a difficult academic program with childcare, family celebrations and all of the other activities and responsibilities of parenthood.

In 2008, at the same time the Wellness Committee at Memorial University of Newfoundland (MUN) completed a needs assessment, the CFMS began to express interest in exploring what services and policies were available to support student parents and what their needs may be. In response, the MUN Wellness Committee established a Family Support sub-committee and Matthew Sheppard, CFMS Atlantic Regional Representative, was hired as a Family Support Coordinator. Matthew conducted an informal survey of medical undergraduate student parents across Canada to collect information, thoughts and opinions regarding the parental supports and policies pertinent to medical student parents as they progress through their program. There was an overwhelming response and it became clear that there was a lot of variability in what is being offered from school to school. Overall, the report found that parents' needs vary widely and this must be taken into consideration in any future policy development.

Tracy Hussey and Alexandra Maher, the 2010–11 MUN Family Support Coordinators, are trying to connect with the student parents on a more personal level to assess needs and to garner resources. Recently, all undergraduate, postgraduate, Masters and PhD students with children interested in joining a Family Support network were asked to identify themselves to the Coordinators. After making contact with these parents, the Coordinators sought input from them about their experiences and needs, and invited them to family-oriented events to facilitate community development.

The first event was an October Pumpkin Party. The response was great, with about 10 families of pirates, ghouls and superheroes in attendance! It was an opportunity for the parents to meet each other and for the coordinators to meet parents and their families. In the new year, there are plans for another family event as well as a parent focus group to learn more about the specific challenges they face and how medical school can better support them in their scholastic endeavors.

Medical school presents challenges to all students and at MUN we want to support students so that everyone can achieve their highest potential. This committee is just in its infancy, but we have high hopes that it will become a great resource and advocacy group for our parents, as well as a known part of our medical school.

Come walk in our moccasins

Aboriginal students at the University of Ottawa provide a mini-medical school

Sarah Brascoupé Funnell
University of Ottawa, Class of 2013

On Saturday, January 22, 2011, the Aboriginal medical students at the University of Ottawa launched their third Aboriginal Mini-Medical School. In consultation with the Aboriginal Program Director, Dr. Darlene Kitty, the day's events were designed by the Aboriginal medical students with the aim of demonstrating to other Aboriginal people what a day in the life of a medical student is like. The over arching purpose of the mini-medical school is to recruit more Aboriginal people to apply to the Faculty of Medicine's Aboriginal Program at U of O to reduce the health disparity amongst Aboriginal people by graduating more Aboriginal doctors.

For over a decade now, the Francophone medical program at the U of O has offered mini-medical school as a way to recruit Francophone applicants. Due to the great success in this recruitment effort, the 2009–10 academic year saw the Aboriginal program launch a similar strategy. Receiving guidance from the Francophone program in the form of relevant educational material, medical students Ana Blake (2012) and Sarah Brascoupé Funnell (2013) designed a program addressing issues related to diabetes. With the support of Dr. Arlington Dungy (former Aboriginal Program Director) and Rachèle Prud'homme, this program was offered to Aboriginal post-secondary and mature students in January 2010 and was then offered to high school students in April 2010. Due to the excellent feedback, it was decided to hold two more such events in 2011.

What sets this past January's Aboriginal mini-medical school apart from the earlier ones was that the entire program was designed solely by the Aboriginal medical students based on the chosen theme of the respiratory system. The day's events began bright and early with a ceremonial prayer by Aboriginal Elder Albert Dumont, which included some words on traditional uses of tobacco. This was followed by a lecture designed and presented by Madeleine Woods (2013) on the respiratory system, which included epidemiological statistics regarding Aboriginal people's respiratory health. The participants were then split up into case-based learning (CBL) groups and taken through a typical CBL case, designed by Sarah Brascoupé Funnell (2013). Following a break, the participants remained in small groups to attend workshops on radiology (designed by Erin Peltier and Kevin Hogan, both 2014) and the physical exam (designed by Renee Vachon and Sabrina Squires, both 2014). The latter allowed the partici-

U of O Aboriginal Program medical student Renee Vachon (class of 2014) offers her arm to teach participants how to cast.

U of O Aboriginal Program Director, Dr. Darlene Kitty, teaching mini-med school participants how to suture.

pants to auscultate and percuss "standardized patients" (other Aboriginal program medical student volunteers). Over lunch, participants and volunteers were treated to a PowerPoint presentation by Dr. Kitty illustrating her work experience in Chisasibi. The afternoon sessions included a smoking cessation lecture by Dr. Andrew Pipe, a tour of the anatomy lab and fun-filled workshops on how to cast and suture.

The highlight of the day was Madeleine Woods' presentation entitled, "So You Want to go to Medical School" in which she explained that "those rumours you heard about needing good grades to get into medical school are true" and then proceeded to offer practical advice on how to achieve such grades.

Their ultimate goal is to reduce the health disparity amongst Aboriginal people by graduating more Aboriginal doctors.

This was followed up by heartfelt testimonies given by Aboriginal medical students Sabrina Squires and Renee Vachon on their journey to medical school.

The success of the day's events was evident by the positive feedback that was received from the participants. Their overall impression was that the Aboriginal medical students inspired them by illustrating that medical school is "doable" and that the rewards are well worth the effort. By being introduced to what a day in the life of a medical student is like, the participants left feeling more comfortable and confident in applying to medical school! This program will be offered again in April 2011 to Aboriginal high school students.

U of O Aboriginal Program medical student volunteers: Ben Carrier (class of 2011), Eric McGillis (class of 2012), Madeleine Woods (class of 2013) and Owen Gagne (class of 2012).

U of O Aboriginal Program medical students Dominique Babin-Muise (class of 2013) and Joe Scanlon (class of 2013) demonstrate with participant how to percuss.

The clerkship chameleon

A tale of blending in and standing out

Laura Hinz
University of Western Ontario, Class of 2011

In clerkship, you need to be a chameleon. Every few weeks, we arrive on a new service, with a new preceptor and new expectations. The first few days are a blur of figuring out how the charts are organized, who to ask for help, and how your consultant would like assessments structured. Our job is to be the clerk they want us to be. Or so it seemed in the beginning.

It is not surprising that medical students enter clerkship striving to be chameleons. The system is set up to emphasize uniformity and standardization. We are issued the same teal scrubs as every other clerk; we study the same clinical guidelines and practice gold standards. Yet medicine is not a homogenous entity, neither in the way patients present nor the way physicians practice.

Once we realize that medicine is not comprised of hard and fast rules, the need to be a chameleon is lessened. Toward the midpoint of clerkship, the clerks began to shed their chameleon skins. Part of this shift was simply a result of gaining familiarity with the system. We were no longer lost on a daily basis, or spending 2 hours on a dictation, or secretly looking up every drug on our smart phones. Having mastered (or at least grasped) the basics, it became time to ask more questions, to make suggestions based on our reading and to voice our own goals for the rotation.

However, we could not completely forget our former chameleon ways. Preceptors still required notes to be ordered in a certain way, diagnostic protocols to be followed, and daily schedules adhered to. Thus there was a certain amount of blending in left to do, but it was not as all-encompassing as the beginning of clerkship. Instead, I began to hear my classmates making comments like "When I'm an attending, I'm going to structure rounds like Dr. So-and-So," or "that resident always has time for teaching, I hope I can do that in a few years."

These overheard comments were encouraging not only in that they implied an increasing comfort level with clerkship, but in their use of the pronoun "I". Clerkship is an ideal place to lose yourself — we dress in identical scrubs, identify ourselves with numbers, and put up with having our names mispronounced and forgotten. I knew things had reached a breaking point when I introduced myself to an OR scrub nurse as "clerk". Somehow in 12 months of clerkship, I had gone from an individual to just another teal-clad clinical clerk.

It was time for a change and first on the list were the scrubs that were three inches too short. One-size-fits-all was no way to practice medicine, nor was it an ideal way to clothe clinical clerks. To bridge the distance between scrub pants and rubber OR shoes, I chose pink leopard print socks. With this choice, I declared my chameleon days officially over. It was time to bring a bit of my own personality into the practice of medicine. The socks were, albeit, a small stand, but they were a crucial link to who I was before I became "clerk".

I knew things had reached a breaking point when I introduced myself to an OR scrub nurse as "clerk".

As clerkship drew to a close, I began to see more examples of both clerks and consultants refusing to practice as chameleons, at least for parts of their day. There was the Internist who only wrote in green ink, the elective student with the Olympic lanyard, and the resident who threaded his reflex hammer through his button holes. These quirks were a daily reminder that between fitting in and standing out, there was still room to be yourself.

The sweat lodge at Pic River

Heather Reid
Northern Ontario School of Medicine, Class of 2013

Inspired by her experience in a Sweat Lodge during her "In Community Experience" on the Ojibways of Pic River First Nation near Marathon

Elder Prody gives the guidance, and the ceremony commences,
With skirted legs and naked feet, I strip off my defenses.
A ribbon is split to share with me, in a southern fire red,
To give protection to the wearer, when bound about your head.
Offerings are made, I kiss the earth, I am down on hand and knee,
Crawling clockwise into the lodge, showing my humility.
Wiikeh for protection and bear grease for your pains
Later, a cup of warm medicine, to help as your strength wanes.
Skaabe brings the grandfathers in, places them in the centre,
Elder Prody smokes his pipe and prays, inviting the spirits to enter.
The sweetgrass sprinkles diamonds, when drawn across Grandfathers' backs,
These sprinkles illuminate the cedar, which jumps as it pops and cracks.
The warm womb of Mother Earth, envelopes me with her heat,
And the pounding of the rawhide drum, reproduces Her own heart beat.
The circle joins their voices; I get shivers as the sacred songs are sung,
The lodge fills with pride and strength; echoing a chorus in Native tongue.
The rattle shakes the rhythm; footsteps of a thousand dancers,
The Creator works in mysterious ways, you must listen for your answers.
There are twinkles in the eyes of the Grandfathers, as each person begins to share,
They serve to remind each attendee, of the spirit presence there.
The courage of the bear helps people when they share, and the wisdom of the beaver abounds,
The turtle speaks our truths; the sabe shows our proofs, while the eagle's love surrounds.
The wolf guides us to humility, we humble ourselves, our pride in check,
While the buffalo joins our circle, to teach us all respect.
A closing song and the sweat is done, we crawl out with smoldering skin,
We kiss the cold, share some fruit, and revel in a cleanse within.
And as I depart, I'm reminded that "the ceremony isn't done,"
These words will guide me, for it's easy to see;
I've only just begun.

Patient perspective

Alexandra Choi
McMaster University, Class of 2013

As I lay on the gurney, I was surprised at how calm I felt. It wasn't as though I was silently reassuring myself or had put on a mask of tranquility. For one reason or another, I was just completely comfortable with the idea of a stranger cutting into my chest. When the resident came in to explain the procedure, I responded so cheerfully that he was a little taken back and when one of the doctors approached me with a rather large needle, I peppered him enthusiastically with questions about medicine. What can I say? I was pre-med. What happened next is a bit of a blur, but I remember two things. The first is the doctor in charge loudly telling me that I would feel "a bit of pressure." The second is the worst pain I have ever felt in my life.

That was when I panicked. The sensation of having a lung re-expanded is an interesting one — a little like being sat on by a rhino while a grizzly bear rips your muscles to shreds. Not that I would actually know of course. At the time I was "reassured" that it might be more painful for me because a) my lungs were in a more severe state of collapse than they were used to seeing, b) my gymnastics had given me a surprising amount of chest and back musculature, and c) I had been walking around with a collapsed lung for about four days. Nevertheless, I contend that few people having a chest tube inserted would describe the sensation as "a bit of pressure."

As pain ripped through my chest and I dissolved into an extremely uncomfortable coughing fit, I instinctively reached for someone's hand to hold. The resident in front of me stared down at the death grip I had on his hand with a mixture of surprise, uncertainty and impatience before quickly shaking himself loose. Meanwhile the doctors proceeded as they had before, quizzing the residents as they discussed my case. Soon enough the ER team swept out of the room and the doctor in charge called out to me in the same loud, calm and vaguely condescending tone that I should just relax, and that I would be transferred to cardiothoracic surgery shortly. As you can probably tell, I did not find my first hospital admission particularly enjoyable.

When I was moved to the thoracic surgery ward, I found that most of the doctors and nurses there behaved similarly to the team I had already encountered. They weren't unconcerned per se, but they were certainly busy and they always spoke to patients as though the patients were a little bit deaf and a little bit dim.

Of course, not every doctor and not every nurse was like that. One doctor in particular stopped by to check on me regularly, taking a few minutes to ask me how I was doing between surgeries. I also know that even the doctors who seemed detached probably weren't indifferent, but I think physicians sometimes forget that patients can't always see that. I'm sure all of the doctors looking after my care assumed that they did an excellent job — and by all medical measures they did. My chest tube went in smoothly. My surgery went well. I eventually made a full recovery. But I have no recollection of the surgery and at the time I had no idea how to gauge my own health. All I knew was that I was in pain, and that no one really seemed to care.

After a few months in medical school, I can see why my doctors seemed less concerned than I. The fact is that physicians spend their days surrounded by sick and, in certain wards, potentially dying people. You become desensitized. After a few weeks in family medicine, I began to think that bronchitis was no big deal. After a few weeks in vascular surgery, I saw abdominal aortic aneurysms as commonplace. For doctors, pain, surgeries and constant injections are just the makings of another ordinary day. But I think we need to remember that, for most patients, an extended hospital stay is extraordinary. Bronchitis can be debilitating. Abdominal aortic aneurysms are life threatening. We can memorize as many drug mechanisms, differential diagnoses and complicated procedures as we like, but in the end patients don't see any of that. What they see is how they are treated, how we talk to them and whether we seem like we actually care.

I instinctively reached for someone's hand to hold.

As I go through my electives, I can see myself starting to become like the doctors that first admitted me. I talk about "slight pressures" and "small burning sensations" and I have begun to speak in disturbingly similar tones. But I hope that as I move forward I can remember my own patient experience and the types of things that made a difference to me. And you know what? If someone ever reaches for my hand, I won't pull it away.

Beyond the rash

Geeta Yadav
University of Ottawa, PGY-1 Dermatology, Ontario Regional Representative 2007–08

It was 3 o'clock in the morning in mid-July, just a few weeks into my residency and I was working the emergency department night shift. I picked up a chart and read the chief complaint: rash. What I encountered, however, was much more complicated.

When I walked into the patient's room, I saw a 13-year old girl, sitting on the bed, furiously scratching her legs with a look of severe discomfort on her face. Her mother, who was standing near the bed, seemed more focused on a book she was studying than she was on her unhappy daughter. In a chair in the corner sat the patient's father and younger sister. I introduced myself to the family and launched into my routine of collecting the history of her presentation. After just my first question I realized the reason for the book: it was a dictionary. This patient and her whole family had recently emigrated from Guatemala and spoke virtually no English. I spoke even less Spanish.

Stumped, I used awkward hand gestures and an unnecessarily loud voice to let the family know I'd be right back. I retreated to the nursing station to see if anyone in the department could help with translation. But, given the hour, I was out of luck — there was no one available who spoke Spanish, not even by phone. My staff suggested I do the best I could and report back afterwards.

Hesitantly, I returned to the room to see if I could glean any clues from the presentation itself. What I saw were erythematous, monomorphic-looking papules that were generalized on the patient's extremities, face and buttocks. All of this was on what appeared to be a base of chronic eczematous changes. Just months out of medical school, I had never seen anything similar before and felt I needed a health history to help understand what I was seeing. But what to do about the language barrier?

Then a solution occurred to me. I pulled out my iPad and opened up Google's free, online translation webpage. I had frequently used it when traveling abroad for more mundane purposes: to order vegetarian food in Turkish or direct a taxi in Slovak. "How long have you had this rash for?" I typed in. "*¿Por cuánto tiempo ha tenido esta erupción de?*", the iPad displayed.

When I showed them the screen, my patient and her mother beamed. Together, they composed an answer. Within seconds, I had it in front of me in translated English. After a few minutes, I learned that the young patient had a medical history of eczema, she developed this new rash two weeks prior to coming to hospital, she had never had this before, she had been ill three weeks prior with cold like symptoms and a fever and still had a mild sore throat. Finally, things were becoming clearer.

I left the room and reported to my staff who said the history was suggestive of a post-viral exanthem. We returned together to see the patient and her family and, after some more questioning and repeat examination, my staff suggested a diagnosis of Gianotii-Crosti syndrome — the exam and the history seemed to fit. We took out the iPad again and used it to explain the diagnosis to our patient and her family. She had a benign, self-limited, post viral exanthem (or as we put it to them: *benigh exantema post-virales autolimitadas*). We were able to explain the expected course of this rash, how to manage symptoms, and answered the parents' many questions. We wrote down our suggested diagnosis on a piece of paper and explained that they could look on Spanish websites for more information. We were even able to find out more about the underlying eczema, which was not well-controlled and suggested a follow-up with her family doctor and a dermatologist for further help.

We are a country rightly proud of our multicultural and multi-linguistic character; according to Statistics Canada, one in every six Canadians has a mother tongue other than English or French. Yet for those citizens who cannot communicate well in either official language, visiting a doctor can be a challenging, even frustrating experience. And it can lead to sub-optimal medicine: as much in dermatology as in any specialty, diagnosis is difficult without a thorough history and a treatment regimen is useless if not understood.

Thankfully, technology presents an opportunity to address this challenge. By putting existing and easy-to-use technology in the hands of physicians, we can facilitate communication and make medicine more effective. We could even do this by piggy-backing on the shift toward electronic health records and pushing for hospitals to include broad functionality in any new technology they adapt. The end result will not only be better treatment for patients but also more effective doctors.

As the family left the emergency room, they all looked relieved and satisfied and kept saying "Gracias!" as they walked out. I didn't need my iPad to translate that.

Inhumanity in the humane doctor

Magbule Doko
University of Western Ontario, Class of 2011

It was my first autopsy. We walked down the stairs to get to the morgue. The basement of the hospital was cold and quiet. My pathology supervisor entered in his code and opened the door — within were two small rooms. The inside of my nose tickled as we walked in. The smell was different from anatomy lab. Was it because death was fresh here? "We got one last night" the pathologist said with a bit of a grin on his face. Even I got excited.

I changed into sterile attire and put on white rubber boots. My heart was racing. Could I handle this? I walked into the autopsy room to find our patient on the table. The naked body lay there with the head resting on a slab. The pathologist began with the classic cut down the chest. I stood across from him and watched with amazement in my eyes. The human organs in situ were a splendid sight. I knew I was going to learn today. But then I glanced at our patient's face. It was something I was avoiding. Looking into those eyes made me wonder about this patient's story. Who were they? What was their life like? Then my hands felt dirty. What was this inhumanity? I took a step back. Was I capable of this? As doctors, we are told to be compassionate and caring, but here I was dehumanizing death. For the rest of the autopsy my thoughts and emotions bounced back and forth. I was devastated by our inhumanity as we opened the skull. Yet, as I held a human brain in my hands I was genuinely amazed and appreciated this way of learning. We removed the heart from the chest — the anatomy of the valves was exquisite. But who had this heart loved?

Here I was dehumanizing death.

William Hunter, an eighteenth century physician, spoke of a *necessary inhumanity*.[1] A quality that every physician inherits through his or her years of training. Reflecting on my experience of the autopsy, I determined that as doctors we must possess this *necessary inhumanity*. As Richardson states in her argumentative paper titled *A Necessary Inhumanity*, this quality is protective for both the patient and doctor.[1] It allows the doctor to treat the patient effectively by not being completely blinded or distracted by the patient's story. It allows us to do our best in the face of another human's unfortunate circumstances. It seems so contradictory that for us to effectively help another human being we must contain an element of inhumanity. This process of becoming a doctor creates inhumanity in the humane doctor.

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False fear: Boomers will cripple health care system

Jillian Alston
University of Toronto, Class of 2012

A survey conducted by the CMA in the fall, found that our generation fears that boomers will cripple the health care system. Being intimately involved with the health care system, it is hard to grasp why so many younger Canadians are quick to solve a 'so-called' health care crisis with private insurance to cover provincially-funded services. Yes, our system has plenty of room for improvement; however, the group I am writing on behalf of — Students for Medicare, believes that the solutions to its sustainability lie within our one-tiered system. In fact, according to the *Commission on the Future of Health Care in Canada,* Roy Romanow suggests that medicare be expanded to include home care and a national drug strategy. We believe in his message: our system is as sustainable as we want it to be.

To relieve the fear that "the Boomers are going to put our system in crisis", we point to a recent report titled *The Sustainability of Medicare*, prepared for the Federation of Nurses Unions, by Hugh MacKenzie and Dr. Michael Rachlis, a renowned economic consultant and an expert health policy analyst, respectively. Using Statistics Canada population projections and data from the Canadian Institute for Health Information on health services utilization, they estimated that over the next 25 years, the increase in health care costs will be close to 1% per year. This is only 0.2% higher than the yearly cost increase between 2001 and 2010. Bottom line: a crisis isn't in our forecast.

While 44% of people under the age of 46 said they were willing to buy private health insurance to supplement the publicly funded system, we wonder whether the survey-takers understand the implications of this option and the cons of introducing private financing of medically necessary services. While insurance companies claim that this option may be more efficient and cheaper (in terms of taxes), private health insurance is an extremely wasteful way to provide health care. For example, for every health care dollar the US spends, 30 cents goes directly to administration costs. In Canada, our single-payer system limits insurance overhead and so we spend much less on administration — just 17 cents per dollar. Private insurance may mean governments spend less on health care, but it doesn't mean it costs any less. In fact, in order for insurance companies to exist, they must also find a way to factor their profits into the cost of health care. Since the implementation of the *Canadian Health Act*, we are somewhat protected from insurance companies profiting from the health or ill health of Canadians. Wouldn't you rather have ALL money spent on health care (through taxes or insurance premiums) be put toward care?

As Anne Doig, CMA president, said of the results of the survey, "Canadians are not giving up on medicare, but they're recognizing that medicare needs to be transformed to deal with current realities, demographic and otherwise." Yes, our system needs major repairs, but unless we actually change our system to increase capacity, purchasing private insurance will still create the same or even more demand on health resources. Instead of looking at private solutions that puts money into the pocket of companies, the answer lies in innovating our health care system to make better use of health care spending. To structure our system to reduce wastes and meet the demands of our evolving health problems and changing population requires strong leadership. Dr. Rachlis and Hugh Mackenzie say it well: "The key to controlling costs and improving quality in the health care system, as unexciting as it sounds, is better management of the system in the public interest."

Students for Medicare advocates for maintaining and strengthening a publicly funded, not-for-profit health care system. We are students and practitioners of nursing, midwifery, medicine, public policy, other disciplines and allies.

Med school HOT

Taylor Lougheed
Ontario Regional Representative, Queen's University, Class of 2012

Definition

"Being attracted to someone that you normally would not even glance at because they are in your med school class with you. The main cause of this attraction is being cooped up with the same people day after day. This makes you look at people in a different way."

— urbandictionary.com

Case study

Classmate #1: "Oh that Taylor is so hot right now."

Classmate #2: "I find him hotter each year we have class together and I have limited interaction with other people!"

Non-classmate: "Sorry, who?! I don't see it. He's probably just *med school hot*."

Despite not being aware of the term "med school hot" until now, you have likely all experienced it at some point and to some extent. For better or for worse, the majority of medical students will end up living/working/studying/socializing with the same group of folks for a number of years.

I have conveniently compiled a list of five handy ways to bust out of the med school social bubble.

1) Say hello to other people*

It is a bold first step, but you will be required to meet people that are not in your medical class for this to work and this is the way to do it. Everyone will end up developing their own approach, but I find leading off with your name is generally an acceptable start. A word of caution, however, as contrary to what is often taught in clinical skills courses your surname is not necessary.

Bonus tip: Remove your hospital nametag before social encounters. This may require you to preemptively remove it *before* leaving the hospital/clinical skills instead of always "forgetting."

2) Have hobbies outside of medicine‡

Incomprehensibly, not everyone is as excited to talk about the wild and wonderful medical conditions you and your colleagues are inevitably learning about. You will need to branch out into other topics of conversation, if only briefly. Pursuing hobbies outside of your textbook/class/hospital is a great way to ensure the conversation flows (relatively) smoothly and that your conversation partner does not always feel slightly nauseated.

3) Resist the urge to diagnose

As medical students' knowledge grows, their ability to identify or diagnose various ailments in public settings increases. This is natural and entirely appropriate in a clinical setting.

Social setting warning: Diagnosing often leads to staring. Staring can lead to awkwardness. This is counter to your aim and should be avoided.

4) Magic

Science has not yet fully elucidated the intricate workings of friendship between meds and non-meds.

5) Find time to spend with your new found friends

Research ongoing…

Following these five handy tips will ensure that you are well on your way to either making new friends outside of med school or appreciating the ones that put up with you in it. Good luck!

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* Confirmed. It works surprisingly well.

‡ Unconfirmed. Insufficient research.

A reflection on the need for self-care

Ania Van Meer
McMaster University, Class of 2013

A core component of the curriculum at McMaster is "Professional Competencies," in which we explore effective communication skills, ethics and moral reasoning, social determinants of health, population health, professionalism, lifelong learning and — everybody's favourite — how to exercise self-care. This latter topic is part of "ProComp" because it was felt that medical students are inclined to neglect their physical, mental, social and spiritual well-being and form unhealthy habits that persist into their professional lives. As students, we are encouraged to tend to all aspects of our health regularly and it has become routine in my group of nine students and two facilitators to share what we have been doing in the effort to remain healthy, balanced people.

The philosophy of self-care is directly related to the care we are able to offer patients and that is why it inspires me so much. In fact, I see myself as a self-care advocate of sorts, which is why I am ashamed to admit that I recently realized I am *still* taunted by an image of the archetypal "real" medical student. Established years ago and derived from various sources (mostly television and seasoned physicians I've met through my medical family), this image continues to influence my self-expectations even though I have been convinced it is not the best model. You see, the "real" medical student does not observe self-care. This is because it would take her eye off the prize of being the best doctor she can be. For example, the "real" medical student spends most of her day in the library or hunched over a cadaver. She lives on coffee and granola bars if she remembers to stuff any in the pockets of her white coat (I might add that hunger has little power over her, if she notices it at all). She does not develop any hobbies, especially ones that are particularly time-consuming, like knitting or bread-baking. Nor does she read anything but textbooks (novels are a waste of time and she is saving up for Harrison's anyway). She denies her bodily needs and limits, and sets aside most of her personal (read: trivial) interests because that is what a medical student simply must do to be any good.

Why have I remained so troubled and unable to shrug her off as a Hollywood construct or a relic from times past? Is it because I cannot match her dedication or her commitment to medicine and that makes me feel inadequate or undeserving? Possibly. But some reflection has elucidated another explanation, which is that the image of a person who has transcended life's basic necessities and become super- (or sub-?) human is a considerably disturbing thing. The "real" medical student concerns me not because I cannot *be* her, but because I fear *becoming* her. To be a good physician, I cannot lose touch with my needs — for faith, friendships, hobbies, healthy food, exercise, sleep, recreation outside of medicine, and all the other things that make me a whole person. Though I believe I must pour almost all my energy into learning how to be a physician, it is so important that I do not forget to be my full self. I fear the day I deny the needs of my body and soul, because that could be the day I overlook similar needs in my patients.

To be a good physician, I cannot lose touch with my needs — for faith, friendships, hobbies, healthy food, exercise, sleep, recreation outside of medicine, and all the other things that make me a whole person.

Interview with Dr. Brian Goldman — ER physician, radio host, author

Kathleen Newmarch
University of British Columbia
Class of 2013

Dr. Brian Goldman is an emergency physician at Toronto's Mount Sinai Hospital. In his spare time, he hosts the popular CBC radio show *White Coat, Black Art*. Dr. Goldman is known for pulling back the curtain and getting up close and personal with Canada's health care. His recently published book, *The Night Shift: Real Life in the Heart of the ER* is a compilation of his experiences working at one of Toronto's busiest hospitals.

Dr. Goldman took a few minutes out of his busy schedule to answer some questions.

AR: Why did you choose medicine and specifically why emergency medicine?

BG: I believe some people are born to do medicine and some people kind of fall into it. When I was going into university I didn't really know what I wanted to do with the rest of my life. A number of my friends applied for medicine, so I applied as well. I kind of fell into it.

Emergency medicine was a very different story. I was gearing toward a career in neurology. I had it so finely tuned, I had planned my career from the top down. The other thing is that I was a chronic insomniac. All except the one morning that I was supposed to give rounds at the weekly neurology conference room. I remember running up the steps to the room, my malevolent senior resident saying, "It's ok Brian, you're too late". That was the worst day of my life, the most embarrassing day of my life and the best day of my life. Although, I didn't know it at the time. I did 1 year of pediatrics and another year of internal medicine. During this time, I had my first article published in *The Globe and Mail*. I started my writing, but I also thought, "How am I going to earn a living?" A few of my friends in residency were doing emergency medicine and they said why don't you give it a try? And I did and I liked it from the start, so I started doing emergency medicine not as a career, but as a way of working in a field that was stimulating and intense, and one that also gave me time to write. I've been writing and practicing emergency medicine in tandem ever since.

AR: You've been in the public's eye for a few years now; as a medical reporter on *The National*, on CBC Radio One as *The House Doctor* and now with your successful radio show *White Coat, Black Art*. How did you go

PHOTO COURTESY OF CBC

Dr. Brian Goldman

from being a physician to being a radio show host?

BG: Well, in the 80s I did a number of magazine and newspaper articles. Then I took a course at Ryerson Polytechnique University in radio documentary writing. At the time, I was working on a series of articles on drug diversion. I decided to go back and interview all the people I had interviewed for print articles on a broadcast quality recorder and sent it to the CBC. Luckily for me, the executive producer liked that tape so much that he gave me a shot on the air back in 1987. That was the beginning of my career at CBC. I lasted in private broadcasting for a year and I was laid off. I promised myself that if I ever had another chance in broadcasting I wanted to do something really special. I had noticed for years that nurses, physicians, paramedics said the most amazing things to each other when they thought patients weren't listening. I thought what a wild idea it would be to bring those stories to the public. That was really the genesis of *White Coat, Black Art*. It was originally a book that was going to be called *Medical BS*. None of [the publishers] wanted the book because they thought it was too negative. Luckily for me I had friends at CBC. It was a very happy day when the program developer called me up and said "We're not saying yes to this proposal and we're not saying no". That's how *White Coat, Black Art* was born. My broadcasting career is divided into two. Before *White Coat, Black Art* I was simply known for appearing on the air, but after *White Coat, Black Art* I started to be known for what I have to say and that is the most amazing part of getting to do what I do.

AR: You say that at *White Coat, Black Art* it's your aim to get health care professionals to speak candidly about the experiences that go on behind sliding doors. Have you found most professionals are eager and willing to share their experiences or have you had difficulties?

I had noticed for years that nurses, physicians, paramedics said the most amazing things to each other when they thought patients weren't listening.

BG: I wouldn't be doing my job if I didn't have difficulty. I have a gift for interviewing and people like to talk to me, primarily because I show them I'm interested and that I'm listening. Some of that is my long experience in emergency medicine where you have to size up people very quickly and you have to gain rapport very quickly. I would say that I was immediately gratified when I started working on the show by just how much my colleagues wanted to talk. I found that once I started asking the right questions they spoke and they said the most amazing things. I've had colleagues talk to me about burn out, moral distress, about boundaries they've violated. It's a signature of the show. Does that mean everyone wants to talk? No, but it continues to be a satisfying part of the show that I have people, real people, who have interesting things to say that reveal a side of health care that listeners would not otherwise be able to get.

AR: How do you think your show has impacted the public's view of our health care professionals and our health care system?

BG: This is the obligatory moment that I must say my show is transcendent and important and it will change the way we think about health care. I would be fooling myself if I thought that. I believe the show has provided a wonderful sounding board for people to know how doctors think and behave, so they can perhaps make better choices about their health. I think that the show has provided a kind of cathartic release for the people that work in the system and also for patients who feel there have been mistakes in the system. Certainly on a personal level, *White Coat, Black Art* has made me much more informed and has given me a much more balanced, and rounded view of health care in Canada. I had a show producer Quade Hermann, she's now working as the director of UN radio in Sudan, who forced me to reveal parts of myself, including the mistakes that I've made. By putting myself out there, I've been able to reach other audiences of health professionals. When I speak people come back and talk to me quietly about the mistakes they've made and I see that it resonates with them and that's very satisfying.

AR: You have recently published a book *The Night Shift, Real Life in the Heart of the ER*. What inspired you to write a book about your experiences in the ER? What are you trying to convey to your readers?

BG: What inspired me to write a book is that over a long career, I have amazing experiences to tell and I also have an interesting look on medicine.

Memoirs about my career in emergency medicine provides a springboard to talk about my view of who should be doing what in health care, whether health care needs to be reformed, medical errors and making the system safer. What I want to be able to do is pull back the curtain and help people who are going to use the emergency department now and in the future understand how people like me tick. The statistics state that 40% of people will require the services of the Emergency department over the next year — that's an astonishing number of people. I want to make it easier for them to understand what it's like.

AR: You mentioned that along with medicine you always kept writing. What is your view on the importance of maintaining those interests outside of medicine for the developing physicians as well as the practicing physician?

BG: I think that it's terribly important for physicians, med students and residents to develop their abilities in writing. I'm a big believer in narrative medicine, the whole concept of understanding patients by helping them to develop their stories even as healers develop their own stories. I think we lost a lot of that as we started to expand the scope of technological and scientific medicine and I think we've begun to see the limits of that approach. If you really want to understand patients you have to understand their stories. When I say their stories I mean in terms of the archetypal stories by which they view their lives. If you want to understand a patient with chronic pain, you want to know the impact of that pain on a patient's life and very few of us ever ask that question. In addition to [writing], at McMaster University they are teaching art appreciation and they are showing that teaching art appreciation can help develop a surgeon's eye. I believe very passionately that we need to develop our abilities in the arts to be well-rounded physicians.

I'm a big believer in narrative medicine, the whole concept of understanding patients by helping them to develop their stories even as healers develop their own stories.

AR: As a final question, what advice do you have to our up and coming physicians?

BG: Well, learn your lessons and study hard, but leave time to do other stuff. I've had the best of both worlds. On my darkest days as a physician I remember that I'm a broadcaster and on my darkest days as a broadcaster I remember that I'm an emergency physician. A very wise person once said to me "If you can't be the best, be different". I'm certainly different and my message is to find what makes you unique, find what you love doing. Leave yourself open to evaluating, pinch yourself every once in while, "Am I enjoying this? Am I jazzed by this? Do I have this feeling that I can't wait to get out of bed in the morning and get started?" If you do — run with it, if you don't — look for something else.

What's new with Alumni Affairs

Cait Champion
Alumni Officer
University of Toronto, Class of 2012

In an article for last year's Annual Review I wrote about the importance of the CFMS/FEMC alumni in building the foundation for all of our current successes in medical education and student advocacy, and it has never been more true.

Over the past year with the help of our alumni, we have created a timeline of the organization, our successes and our challenges. The Organizational Timeline project serves not only as a neat reminder of our history, but shows the development of several key components of our organization, such as our relationship with CaRMS and our hugely successful and ever-growing Global Health Program. Check it out at www.cfms.org.

It's because of the enthusiasm of over 30 years of CFMS/FEMC alumni, that in 2010–11 we've created an official Alumni Affairs portfolio. Starting with dedicating an Alumni Officer to work with our alumni, we're finding new ways to engage with former CFMS/FEMC members who have since moved on to exciting careers in all areas of medicine. One new addition you'll see in this edition of the Annual Review is our Alumni Q & A section, helping current Canadian medical students benefit from the knowledge and experience of those who have come before us. Several alumni have also volunteered their time and energy to be part of the 2010–11 CFMS/FEMC Leadership Awards selection process, bringing the insights they've gained throughout their medical careers to support leaders within the medical student community.

As we move towards 2011–12, our Alumni Affairs portfolio will continue to grow and develop. Starting with an Alumni Appreciation Lunch at our 2011 Spring General Meeting in Toronto, we hope to create even more opportunities to learn from our amazing and inspiring alumni, as well as increase support for Canadian medical student issues within the medical community. We also hope to provide an opportunity for CFMS/FEMC alumni to reconnect with each other, both to rekindle past friendships as well as forge new connections with physicians and students across the country.

More than anything I want to say a huge thank-you to all of the alumni who helped build and continue to support medical student initiatives across the country; you are invaluable and help make our work even more successful and far-reaching than it would otherwise be!

Are you a former Canadian medical graduate? Interested in supporting current CFMS/FEMC projects and connecting with other Alumni? If so, we want to hear from you! Contact our Alumni Officer, Cait Champion (cait.champion@utoronto.ca) or our General Manager, Rosemary Conliffe (office@cfms.org)

Alumni Q & A

What's the best advice you've received during your medical career?

Cait Champion
Alumni Officer, University of Toronto 2012

Endure the challenges of medical education, work to remove them for the next generation, and celebrate rather than begrudge them when you are successful.

Dr. Jonathan DellaVedova
PGY-2 Pediatrics

"There's more to life than just medicine." In medicine more than most professions, it's easy for your career to become your life, rather than a part of your life. It's never easy, but always remember to make time for family and for hobbies.

Dr. Ben Hoyt
Otolaryngology

1) On picking a CaRMS specialty: You won't love every single second of your job. Just make sure you can tolerate the most mundane/commonplace aspects because there are interesting/fascinating parts to every specialty in medicine.
2) Patients lie. Seriously. At the very least, they tell you something different than your attending. Don't sweat it.

Dr. Gillian Shiau
PGY-1 Diagnostic Radiology

The best advice I have received is that 75% of your energy should go into mentoring activities. Never pass up the opportunity to mentor someone, answer a question, or assist them in their path. It is the best way to be an effective leader.

Dr. Danielle Martin
Family Medicine

The best advice I received, especially in terms of choosing a specialty — look at the people in any given specialty, not just the specialty itself. Look at their attitudes, their personalities, their interests - find a specialty where you not only see yourself enjoying the work in that field, but also where you see yourself fitting in with the people who already work in that area. That's probably a good indication of where your own interests and strengths might find synergy with the type of work in that specialty.

Dr. Nawaaz Nathoo
PGY-2 Opthalmology

I believe as a medical student, being involved with codes was probably the most stressful situation and I/we had the misperception that we should be able to save everyone. Then a thoughtful senior resident (the name of whom I cannot recall) reminded me that in the setting of a cardiac arrest, you are starting with dead so you can't make the situation any worse. In a morbid way, this was reassuring and allowed me to focus on the task at hand — saving those that could be saved.

The second piece of advice was again from a resident who I cannot remember. As a clinical clerk at Memorial in 1994, you were the "scut monkey", performing all IV starts and drawing blood after normal working hours. Early in my clerkship, I had significant anxiety over starting IVs and my success rate was low. I was so concerned about hurting the patient that it distracted me from this relatively straight forward procedure. After a few weeks of blood, sweat, and tears (mostly mine) and ultimately lack-lustre performance, one of my residents stated quite matter-of-factly, "starting an IV doesn't hurt you at all — get on with it." I initially assessed this as a cruel and callous position but then saw the wisdom in this statement. After that, I became much less anxious about IV starts and my proficiency improved significantly and the number of second, third and fourth attempts were minimal!

Dr. Nick Withers
CO/Task Force Surgeon, Canadian Forces

The best advice I received was to go after the specialty I wanted — never worry that it's competitive or 5 years as opposed to 2 or not the highest paid. This is your career and you have to be happy — never settle because it's the easier or quickest route to just being done.

Dr. Allie Meiwald
PGY-4 Emergency Medicine

When I was a third year medical student, my mother (who is a retired physiotherapist now), told me that the best thing I could do was to "be nice to the nurses"! This has been extremely helpful to me not only as a medical student, but now as a resident. You quickly realize, especially in pediatrics, that nurses are not only experienced, but they know the patients very well, and often have control over most things on the floor. So be honest and nice to the

nurses, and it will take you very far in your medical career, I promise!

Dr. Mary (Jamieson) McHenry
PGY-2 Pediatrics

I think it was a nephrologist in Hamilton who told me that although it is important to find an area of practice which may have conditions or aspects that fascinate you — you must also make sure you enjoy the daily "bread and butter" aspects of that area of medicine as well — as that is what you will spend the majority of your day doing!

Dr. Phil Doiron
PGY-2 Dermatology

As part of my internal medicine residency training I spent a month in Nanaimo, Vancouver Island working with a very skilled group of internists. It was in this setting that much of the practical aspects of office medicine came to light.

Dr. Hector Baillie gave me very insightful and useful advice about establishing a well working office environment. One of the most important decisions that a new physician can make in terms of a good functioning practice rests with whom you hire as your office staff. The individual that you hire becomes the public face of your practice, and she or he has influence over nearly every aspect of your professional career. The process of selecting this individual requires considerable time and reflection. If you are fortunate to have such a prized member of staff it is important to reward them appropriately for their skills. Physicians who try to save on staffing expenses often pay for it in the long run in other ways, such as reduced productivity, unhappy patients and reduced leisure time.

Dr. Jason Kur
Rheumatology

1. It's called "lunch hour" for a reason.
2. If you see a chair, sit in it. If you see a bed, lie in it.
3. Learn how to talk to your patients; 90% of the diagnosis is in the history.

Dr. Brad Dibble
Cardiology

Distributed medical education down under

Jonathan DellaVedova
PGY-2 Pediatrics, McMaster University
CFMS President 2008–09

The tide is finally turning on our nation-wide physician shortage. Though we still lag behind most industrialized countries and millions of Canadians are still without primary care physicians, the Canadian Institute for Health Information (CIHI) reported a steady increase in the number of practicing physicians in 2009. Initiatives implemented nearly 10 years ago, such as increases to medical school enrollment, are finally beginning to produce results. However, the shortage always was and continues to be asymmetric, with rural communities suffering the worst from limited access to physicians and other health care resources.

Back then, distributed medical education (DME) was the white

knight designed to address physician undersupply, overcapacity in the medical education system, and the care needs of rural communities in one fell swoop by placing learners outside our handful of academic health science centres and into uncharted educational territory.

In 2008–09, former CFMS Vice-President of Education (and later President) Tyler Johnston led a comprehensive initiative to capture the medical student experience of DME. Of course, there are no white knights in medical education, but the data gathered painted a picture of the conditions under which DME could be even more eagerly accepted and valued by Canadian medical students and future patients. These concepts served the basis for further CFMS advocacy, putting our organization on the national map.

In October 2010, I had the opportunity to make that map international at the Global Community-Engaged Medical Education Muster in Adelaide, South Australia. Along with my colleague Tracey Ross from the Northern Ontario School of Medicine (NOSM), I was invited to Australia to share my experiences as a former rural medical student and part of NOSM's Charter Class. As the former CFMS President, I was also able to provide a Canadian national perspective on DME for the audience of educators from around the world.

This relatively new annual conference was designed to foster collaboration between medical educators in many different countries who had been initially implementing DME in parallel. Australia in particular shares many features with Canada including a small population spread over a vast area, a great deal of uninhabitable territory, a significant minority of indigenous people, and the need to improve health care access for all.

The shortage always was and continues to be asymmetric, with rural communities suffering the worst from limited access to physicians and other health care resources.

Not surprisingly, the challenges students and educators face in Australia are similar to those in Canada: travel in poor conditions, educational expenses, faculty development, social isolation and upheaval, teleconferencing fidelity, access to resources, ethical issues, and more. However, the successes are also shared: many learner testimonials (including my own) lauded the irreplaceable academic, professional and personal development experienced in the community setting. How to maximize the experience and mitigate the challenges was the focus of most of the discussion.

In an inspiring plenary session, a guest educator and DME pioneer from Nepal outlined the challenges he was facing developing a medical school to serve Nepal's mostly rural population. Though only 1.5% of Canada's land mass, the majority of Nepal is completely unreachable by road. Nepal's pioneering rural medical students are discovering a total lack of healthcare resources and personal supports but are finding inspiration in building a future for some of the world's most underserviced people.

In Canada DME is here to stay and we should continue to advocate for the conditions that will ensure its enduring success. Congratulations to the CFMS for achieving an enviable international position as a leader in education innovation. Keep punching above your weight and keep up the inspiring work.

Photo album

Bev Wudel, CFMS VP Global Health 2009–11 and Mark Taylor, U of A Class of 2010.

Chris Brown, current Queen's med student, and Sarah Onufer (now Brown). Married on Aug. 7, 2010. Wedding was at the family farm.

Peter Gill, a U of A medical student currently completing his Rhodes Scholarship, and Jayme McColl Married at Magdalen College and Rhodes House, Oxford, UK, on Sept. 18, 2010

Shawn Mondoux, CFMS VP Education 2009–11 and Bronwyn Hammell Married in May 2010 in Ottawa.

Alyson and Tim Holland. Married on Aug. 7, 2010 in Sambro Head, Nova Scotia. Both are students at Dalhousie in the Class of 2011.

Brett and Brittany Graham. Married on June 6 2009. Brett is a student at U of S, Class of 2011.

Colin Brown and Sacha Craig. Married July 16, 2010 in Cape Traverse, PEI. Colin is a Memorial medical student, Class of 2013.

Marc Kawaja and Shelly Hobbs. Married July 2010. Marc is a Memorial medical student, Class of 2013. Marc and Shelly are happy to announce the arrival of their daughter, Claire Brianne. Congratulations!

Sheila Klassen, McMaster University class of 2011, Hamilton campus, and Mikhail Klassen. Married in Montreal, August 2009.

Ania and Ryan Van Meer. Married on Aug. 7, 2010 in Beamsville, Ont. Both are medical students at McMaster.

Mohamad Hussain and Fareena Shabbir. Married in Oct. 2010. Mohamad is a McMaster student in the class of 2012.

Jamie Szabo, a student at Dalhousie in the class of 2013, and Geoff Bishop. Married July 31, 2010.

Kim Krueger, a 3rd year medical student at the University of Alberta, is also a proud new mom of adorable 6-month-old twins! Her son Calvin Christopher and daughter Quincey Lillian, were born on July 13, 2010.

Trapped inside

Michael Corbo
McMaster University, Class of 2012

There you are, sitting in your usual spot in front of the TV. It has been a while since my last visit, but the change that you have undergone since then is apparent at first glance. The energy that once ran through your body like an electric current has been prematurely sucked out, leaving you limp and lifeless; a shadow of your former self. It hurts to see my friend utterly transformed into something I can barely recognize … but who am I to speak about pain.

I have seen enough tragically ill patients in my medical training to be comfortable with the presentations of terminal disease; this is different. I have spent countless hours with you in the past few years and there exists a bond that took a great deal of time to develop. I regard you as family.

As I sit beside you and talk, the flicker in your eye speaks back to me. It lets me know that you are still present, even though you can no longer verbally communicate. I cannot imagine how hard this must be for you: the knowledge that your muscles are getting weaker each day; the feeling of looking into the eyes of a loved one and not being able to say what you want to; and the utter lack of control associated with your disease. You are trapped, a prisoner inside your own body.

With all of the hardships that you have endured, I often wonder if you ever feel sorry for yourself. You will never have the opportunity to get married, have a family and live life the way you intended. Despite all this, I have never heard you complain once. I do not know if I would have handled this in the same manner.

Life is quite the journey and fate has a way of bringing people together for reasons we cannot fully comprehend. You have had an impact on my life that words cannot describe and I can only hope that I have had the slightest impact on yours. I resent the fact that you must go through so much emotional pain, but I hope it comforts you to know that I will be there as you embark upon your final journey.

The necessary drive

Richa Sharma
University of Western Ontario, Class of 2013

Before the medical school classroom, the clinical skills suite, the hospital and the anatomy lab, each of us came from somewhere else. Many medical students live away from home — whether near or far, we have all, on occasion found ourselves on a lone road, in an empty bus or staring into the abyss of the dark night from high above the ground as we await arrival at our destination.

We all have important people in our lives who have supported us through thick and thin, shown us unconditional love and compassion and encouraged us to strive for our goals. Without them perhaps we would not survive those lonely moments. They are helping us to become not only caring physicians, but also responsible and conscientious human beings.

Through our endless study of the physiology texts, all night revision sessions before the anatomy exam and diligent attention in the pathology lab, undoubtedly we will all grasp the scientific knowledge necessary for the practice of medicine. But what of becoming the type of doctor who truly understands when our patient says, "I need your help doc"?

This is why we have to make the drives, even the ones we despise. The long drive, the short drive, the icy drive, the dark drive, even the wanted-one-more-night-at-home drive. Not only to maintain our connections to the people that we love and the places that comfort us, but also to give our patients the kind of doctor that can reply "I understand".

I like to think of medicine as the 401 West and myself as a Nissan Versa. Hugging the curves, loving the road and recognizing rest stops as opportunities to fill up the tank.

White coat, Warm art

Dr. Carol Ann Courneya
Associate Professor, Faculty of Medicine UBC

Dr. Pamela Brett-McLean
Director Arts & Humanities in Health & Medicine Program, Faculty of Medicine & Dentistry, University of Alberta

White Coat, Warm Art is an exhibit of art by medical students, residents, faculty and health care practitioners. Over 60 submissions were received from across Canada and a jury selected 25 to be shown at the White Coat, Warm Art Exhibit in conjunction with the Canadian Conference on Medical Education Meeting (May 2011). These images are some of the 25 to be shown at the exhibit.

The art selected for the exhibit is a mixture of "medically related" images as well as art that has nothing to do with the practice of medicine; but acts as an escape by the student or practitioner into a world of creativity and expression. Many of the artists said that the creation of art keeps them grounded and refreshes their spirit.

Daily Doodles
Mickiko Maruyama
UBC Medicine Northern Medical Program, 1st year

Self Portrait
Alfred Lam
U of T Michener Institute (Med Radiation Science), Faculty

Light Headed
Cyrus McEachern, UBC Medicine Vancouver Fraser Medical Program, 3rd year

Still Life
Daria Manos
Dalhousie QEII HSC Thoracic Radiology, Staff

Hands, David Walker
UBC Department of Pathology, Faculty

My Grandfather
Liu Liu
McGill University, 2nd year

Grandma, Matthew Kennedy
University of Toronto, 1st year

Handinhand, Jenna Creaser
Dalhousie University, 3rd year

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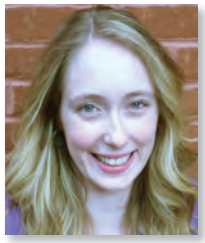
CFMS Executive 2010–11

Matthew Sheppard
President
msheppard@munmed.ca

Tyler Johnston
Past President
tyler.johnston@medportal.ca

Noura Hassan
VP Education
noura.hassan@mail.mcgill.ca

Sarah Fung
VP Global Health
swfung@gmail.com



Robin Clouston
VP Communications
robinc@mun.ca

Jesse Kancir
VP Finance
jesse.kancir@utoronto.ca

Ashley Miller
VP Advocacy
amill083@uottawa.ca

Steve Hawrylyshyn
VP Services
steve.Hawrylyshyn@medportal.ca

Serena Siow
Western Regional Rep.
shsiow@interchange.ubc.ca

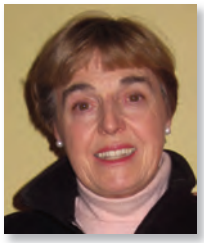
Shawna Pandya
Western Regional Rep.
pandya@ualberta.ca

Phil Vourtzoumis
Quebec Regional Rep.
phil.vourtzoumis@mail.mcgill.ca

Bourne Auguste
Ontario Regional Rep.
bourne.auguste@medportal.ca

Taylor Lougheed
Ontario Regional Rep.
8tpjl@queensu.ca

Tim Holland
Atlantic Regional Rep.
Timothy.Holland@dal.ca



Rosemary Conliffe
General Manager
office@cfms.org

Officers 2010–11

Natalia Ng . . . . . .Wellness . . . . . .nng026@uottawa.ca
Pamela Verma . . . . . .Annual Review Editor (Publications) . . . . . .pamverma@interchange.ubc.ca
Crystal Sin Yi Cheung . . . . . .Blood Drive . . . . . .CCHEU009@uottawa.ca
Michael Li . . . . . .Information Technology . . . . . .cfms.ito@gmail.com
Daniel Rosenfield . . . . . .IPE Officer . . . . . .daniel.rosenfield@utoronto.ca
Cait Champion . . . . . .Alumni Affairs . . . . . .cait.champion@utoronto.ca

MEDSOC Presidents 2010–11		
Diane Wu	University of British Columbia	wudiane@interchange.ubc.ca
Alyssa Cruz	University of Alberta	avcruz@ualberta.ca
Catherine Bereznicki	University of Calgary	cbereznicki@gmail.com
Alyson Thompson	University of Saskatchewan	adt314@mail.usask.ca
Jessica Cudmore	University of Manitoba	umcudmoj@cc.umanitoba.ca
Zac Veitch	Northern Ontario School of Medicine	zachary.veitch@normed.ca
Mike Verbora	University of Western Ontario	mverbora2013@meds.uwo.ca
Koyelle Papneja	McMaster University	koyelle.papneja@medportal.ca
Tom McLaughlin	University of Toronto	tom.mclaughlin@utoronto.ca
Thurarshen Jeyalingam	Queen's University	5tj3@queensu.ca OR president@qmed.ca
Andrew Boozary	University of Ottawa	president.aesc@uottawa.ca
Louis-Charles Moreau	McGill University	msspres.med@mcgill.ca
Aris Lavranos	Dalhousie University	hlavrano@dal.ca
Bolu Ogunyemi	Memorial University	b.ogunyemi@mun.ca

MEDSOC Senior and Junior CFMS Representatives 2010–11		
Vy Nguyen–Sr. Kate Milne–Jr.	University of British Columbia	vynguyen@interchange.ubc.ca kmmilne@interchange.ubc.ca
Ryan Gallagher–Sr. Rannie Tao–Jr.	University of Alberta	rdgallag@ualberta.ca rtao@ualberta.ca
Regan Taylor–Sr. Urooj Chaudry–Jr.	University of Calgary	rctaylor@ucalgary.ca utchaudr@ucalgary.ca
Ashley Oleniuk–Sr. Allison Finningley–Jr.	University of Saskatchewan	ajo565@mail.usask.ca amf774@mail.usask.ca
Rebecca MacLean–Sr. Marcus Hancock–Jr.	University of Manitoba	ummacl13@cc.umanitoba.ca umhanco3@cc.umanitoba.ca
Allison Sweeney–Sr. Dana Zoratto–Jr.	Northern Ontario School of Medicine	allison.sweeney@normed.ca dana.zoratto@normed.ca
Tony Di Labio–Sr. David Mikhailv–Jr.	University of Western Ontario	tonydilabio@gmail.com dmikhail2013@gmail.com
Siraj Mithoowani–Sr. Marko Erak–Jr.	McMaster University	siraj.mithoowani@medportal.ca marko.erak@medportal.ca
Jaisy Yang–Sr. Jesse Kancir–Jr.	University of Toronto	jaisy.yang@utoronto.ca jesse.kancir@utoronto.ca
Renee Pang–Sr. Fahima Dossa–Jr.	Queen's University	vpexternal@qmed.ca vpexternaljr@qmed.ca OR fdossa@qmed.ca
Austin Gagné–Sr. Stephanie Kenny–Jr.	University of Ottawa	vpexternal.sr.aesc@uottawa.ca vpexternal.jr.aesc@uottawa.ca
Leigh Chantal Pharand–Sr. Marina Ibrahim–Jr.	McGill University	leigh.pharand@mail.mcgill.ca marina.ibrahim@mail.mcgill.ca
Adam Harris–Sr. Jennifer Gillis–Jr.	Dalhousie University	Adam.Harris@dal.ca jegillis@dal.ca
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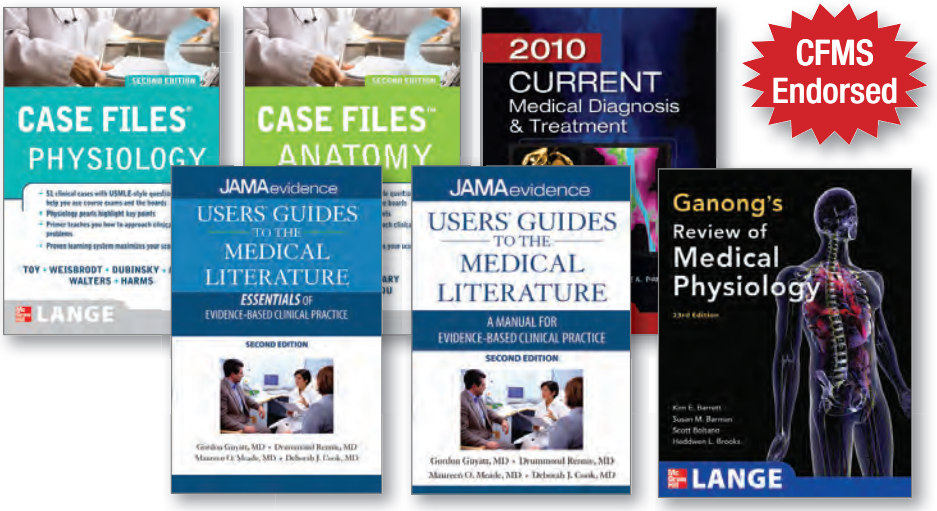

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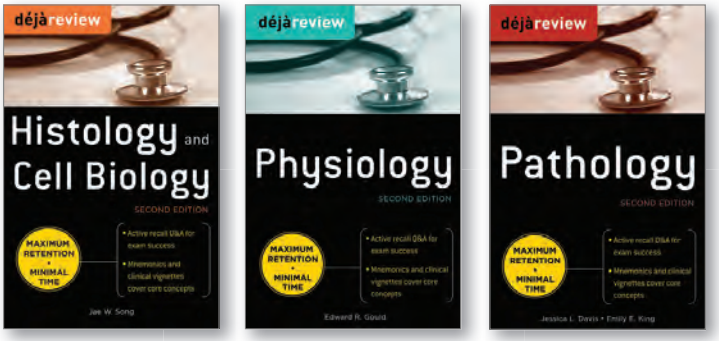

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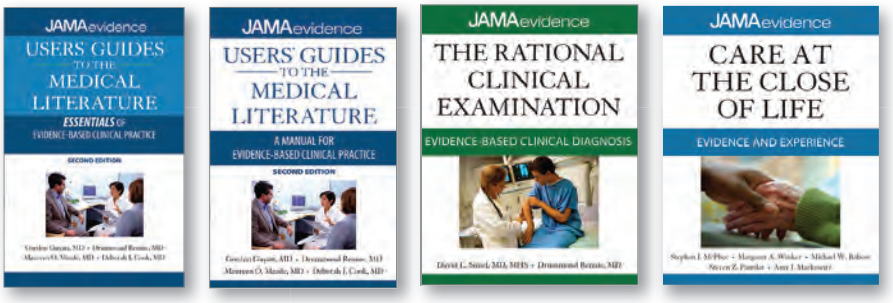

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