

# CFMS FEMC



Canadian Federation of Medical Students  Fédération des étudiants et des étudiantes en médecine du Canada

## ANNUAL REVIEW 2016

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## Our Mission

**T**HE CANADIAN FEDERATION OF MEDICAL STUDENTS IS THE NATIONAL voice of Canadian Medical Students. We **connect, support and represent** our membership as they learn to serve patients and society.

## Our Vision

### Tomorrow's physicians leading for health today.

**T**HE CANADIAN FEDERATION OF MEDICAL STUDENTS (CFMS) WAS FOUNDED in 1977 in response to the recognized need for a national unifying body for medical students. Our membership has since grown to more than 8000 students at 14 medical student societies across Canada. In addition, the CFMS welcomes individual members from non-member Canadian medical schools in Québec. At the CFMS, it is our mission to connect, support and represent our membership. As future physicians, we also advocate for the best health for all members of society.

The CFMS **connects** Canadian medical students and we seek to engage with our student members. Our cornerstone is [www.cfms.org](http://www.cfms.org) – the online home of CFMS, available in both English and French. We also publish the *CFMS Annual Review*, a yearly magazine highlighting CFMS and medical student activities. Beyond connecting members to CFMS, we connect Canadian medical student with each other, through bi-annual meetings, numerous committees, programs and events. These student-to-student connections facilitate the sharing of local best practices across schools and create a sense of camaraderie among medical students.

The CFMS **supports** medical students through a wide variety of services and programs. We know our members value savings as they undertake costly medical training, and our discounts program includes disability insurance, laser eye surgery, hotels, medical apps for smartphones and more. We also host online databases with reviews on Medical Electives and Residency Interviews. Our Student Initiative Grants support and enhance local initiatives undertaken by Canadian medical students. Our Global Health international exchanges provide opportunities for members to experience medical learning in diverse global environments. Finally, in recent years we have taken a renewed focus in supporting the wellness of our members via wellness resources, a wellness member survey, and advocacy efforts.

The CFMS **represents** our membership at multiple forums. We provide the Canadian medical student perspective to our sister medical organizations, government and other partners that are helping to shape the future of medical education, medical practice and health care. Within Canada, we are proud of our work in medical education on projects such as the *Future of Medical Education in Canada*, The Royal College's *CanMEDS 2015*, and the *AFMC Student Portal*. Our advocacy work includes a national Lobby Day in Ottawa where we discuss health policy topics with parliamentarians in an effort to bring about positive change, both for Canadian medical students and the patients we serve. Internationally, our Global Health Program represents the Canadian medical student voice abroad.

Our CFMS Global Health Program (GHP) is vital within the CFMS. Focused on promoting health equity at home and abroad, the GHP represents Canadian medical students at the International Federation of Medical Students' Associations (IFMSA), and at the Pan-American Medical Students' Association (PAMSA). Our Global Health Program also connects medical students for health equity initiatives across Canada. The CFMS Global Health Program works toward globally minded education and coordinates national projects related to global health.

The activities of the CFMS are diverse, relevant and member-driven. We invite you to learn more about the creation of our new Mission and Vision and how the 2014-2017 Strategic Plan will direct the CFMS to serve its members through its vision of tomorrow's physicians leading for health today. ■



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**Dr. Bryce Durafourt,**  
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Past President, CFMS

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## Cover art

### Description

*"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."*

-Dr. William Osler

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Linda Chang Qu,  
Queen's University,  
Class of 2018

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Justin Hall  
Medical student  
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## Letter from the editors

Dear friends, dear colleagues,

As we write these thoughts down in unknown airport terminals, alone among a crowd of strangers, we feel a certain relief to both be graduating this year. The relief of finally parting ways with what feels like luck. Just like many of our graduating classmates across the country, after successfully making it through years of post-secondary schooling, we were finally getting a shot at our future careers, the one that we worked for since our teenage years. Or even earlier, for some whose childhood dream was to become a doctor.

The 2,500 of us were finally going to become doctors: every year sees a new crowd of budding doctors interviewing for their choice of specialty in the heart of winter. And this year, we were fortunate enough to be one of them. To quote a past executive member of the CFMS, it is a sign that, despite feeling like there is a fair share of luck in that decision-making process, “everything has gone right.” Everything has gone right because we made it to medical school, we made it through clerkship and, more importantly, we met the people who supported us throughout that decade-long journey.

We were lucky – and thankful – to have either family or friends who were supportive of our goals, but many of our most meaningful encounters were during medical school. New like-minded friends, inspiring mentors, future colleagues, or even a partner: medical school is about encounters. Encounters with life, encounters with death, but also with challenges, inspiration, deception, and successes. Joining the CFMS forced these encounters to happen much quicker, as if we were trying to push the luck that we already had: in a matter of weeks and months, we knew we had like-minded supporters wherever we would go in the country.

These encounters happen when luck allows it, and even if we expected to foster new friendships, we unexpectedly reconnected with old ones too. From newfound project partners to old elementary school friends, CFMS allowed Canadian medical students to not only to fulfill their passion in student leadership, health advocacy, and medical education, but also to develop a growing professional network.

The *Annual Review*, this year, is a testimony of the luck that we have to meet all of these inspiring and supportive people that would support our professional and personal goals in medical school. People from all walks of life, of all ages, of all schools of thought who, ultimately, shape the luck that we seek for by going into a field that owes so much to uncertainty. All of us worked hard, all of us dedicated the best years of adulthood to our professional goals, and yet everyone would hold their breath after all these interviews, uncertain of how their hard work would be rewarded.

The road to uncertainty, though, is less fearful when not alone. May it be family, friends, classmates, CFMS peers, but find someone to help you go through the bumpy road that medicine is. The *Annual Review* is a summary of all these encounters that we collectively had during the year, and the thoughts that arose following some of them.

Canadian medical students from coast to coast confidently shared the results of their reflections and their creativity in words and pictures, and we believe that they are setting an admirable example. Medical school leaves little time to think about ourselves, our experiences, and our encounters, but reflection is essential for our wellbeing. The *Annual Review*, published annually by our Federation, strives to foster reflective and creative work by publishing the best of them. If you, too, wish to share your best encounters with your Canadian peers next year, please do not hesitate to contact us at [annualreview@cfms.org](mailto:annualreview@cfms.org).

Thank you for your support, your trust, your friendship.



Nina Nguyen



Carl White-Ulysse

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**Nina Nguyen**  
Annual Review Editor  
Université de Sherbrooke,  
Class of 2016



**Carl White-Ulysse**  
Executive VP and VP  
Communications  
McGill University,  
Class of 2016



## Letter from the president



**Anthea Lafreniere**  
President  
University of Ottawa  
Class of 2016

Dear CFMS members, organizational partners, and friends,

Inside the pages of the 2016 *CFMS Annual Review*, you will get just a glimpse of the incredible year in the lives of Canada's medical students. It has been a privilege to serve the Canadian Federation of Medical Students (CFMS) and all of its members this year as CFMS President. I have endeavoured over the past year to further our mission to connect, support, and represent our membership at the national level and am proud of an Executive Board and a broader organization that has strived to do the same.

In an effort to better connect to not only our members, but the medical and Canadian community at large, we are very excited to have launched a new and improved CFMS website ([cfms.org](http://cfms.org)). Thanks to the hard work of our Communications and Information Technology team, the new website is more accessible and more engaging than ever before. You will be able to check out our live social media feed, get the latest news, access resources including our CFMS Matchbook, CFMS Annual Review, several CFMS databases, and financial resources from our partner MD Financial Management. If you haven't seen it yet, check it out!

The CFMS has made great strides this year in its efforts to support its members. After two years of development, the CFMS-FMEQ Wellness Survey was administered this winter across Canada. Having been awarded a Canadian Physician Health Institute grant in 2013, this project represents the culmination of the work of countless medical students and residents, consultation with physician wellness experts in Canada and the United States, and collaboration with several partner organizations. Thousands of Canada's medical students participated, providing insight into the challenges that can be faced during undergraduate medical education. With robust analysis of the survey data, we hope this information can be used to improve the Canadian medical student experience in years to come.

Numerous individuals represent the CFMS both nationally and internationally, advocating in the best interest of Canada's medical students as well as the patients we serve. This year, there have been two representation opportunities that have stood out to me as being particularly exciting for the CFMS. Over the past three years, the CFMS has been strongly represented on the Physician Resource Planning Task Force (PRPTF), a national steering committee funded by Health Canada and composed of representatives from federal/provincial territorial governments and from national medical organizations whose aim is to provide pan-Canadian understanding of population physician needs. In the fall, the CFMS actively participated in the first-ever PRPTF summit to test its consultative process by looking at the important topic of the unmatched Canadian medical graduate. Secondly, I am personally excited to be working alongside Dr. Thomas McLaughlin, President of Resident Doctors of Canada, to co-chair a new Canadian Medical Association Working Group looking at engagement of medical students, residents, and new-to-practice physicians – individuals representing the "First Fifteen" years in the field of medicine. These examples and more are indicative of the active representation of medical students in Canada.

As I have met medical students from coast to coast, I have been inspired by the incredible things they accomplish each and every day. Medical students advocate for patient health, they perform world-class research, they teach and create curriculum, and they practice wellness and support their classmates in doing so also, all while vigorously tackling their medical studies with the goal of providing the best patient care for Canadians. I want to thank all of Canada's medical students who volunteer their time in so many different ways – I am humbled to be counted among you.

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthea Lafreniere'.

Anthea Lafreniere

# Declaring an illness and physician identity debate: a trainee perspective

Marie-Pier Bastrash  
VP Student Affairs  
McGill University, Class of 2017

**A**S VP STUDENT AFFAIRS AND past National Wellness Officer, I helped organize and attended the 4th Annual Canadian Conference on Physician Health, held in Winnipeg in October 2015.

I was asked to debate “for” the following motion: “Be it resolved that declaring an illness erodes a physician’s personal and professional identity.” Here are some excerpts of my speech.

*First of all, to make the conscious decision to declare an illness goes against the physician’s traditional portrait that is taught in medical school.*

Declaring yourself as ill goes against the image of the deeply knowledgeable and compassionate healer whose primary role is to help others, and not to be helped.

*Second of all, to make the conscious decision to declare an illness goes against the ingrained personality traits that has led many trainees to be accepted into medical school in the first place.*

As outlined by the CMA’s Mental Health and Stigma in the Medical Profession report, candidates with certain personality traits tend to be disproportionately accepted into medical school. The compulsive triad, outlined in a 1985 JAMA article, consists of doubt, guilt, and an exaggerated sense of responsibility. To me, these traits could possibly deter a trainee from declaring any personal illness:

- 1) In fear of instilling doubt in themselves, in their personal capacity to take on the challenge of medical school and residency training;
- 2) In experiencing personal guilt from decreasing their productivity or failing to meet their own expectations of performance;
- 3) In being overwhelmed by an exaggerated sense of responsibility towards their families, their peers and also their patients with who they interact day in and day out.

There are still many feared consequences that can impact the decision to declare an illness or not.

*First, the fear of non-confidentiality.*

Students facing a situation where they must declare an illness must often turn to their deans of student affairs or undergraduate medical education for direction and assistance. Despite our UGME’s absolute best intentions and efforts at ensuring confidentiality to its students who need it most, many students have stressed how fearful they are of speaking truthfully to these professors. Some report suboptimal office locations in close proximity to other student services.

*Second, the fear of discrimination from peer and superiors in the classroom and clinical environment.*

Even in the best circumstance where a student does declare an illness and gets adequately accommodated, the risk of being the subject of stigma or discrimination remains. As outlined in the

CanMEDS Physician Health Guide, “although attitudes are changing, the medical profession must continue to address the stigmatization of mental illness as an essential aspect of promoting mental health for all.”

*Third, the potential delay in a student’s progression through the stages of medical training.*

“If I need x days off from school or a reduced workload in the clinical environment, will I be asked to repeat my rotation? If need a few weeks off, will I be asked to join the next cohort? Importantly, will the reason behind these documented leaves appear on my transcript?”

*Fourth, the fear of reduced competitiveness and non-acceptance in residency of choice.*

Many fear that declaring an illness during medical school might hinder their important track record or put a blemish on their stellar applications.

In this context, isn’t it hard to expect students to be upfront about the challenges they may be facing? In that context, isn’t it logical that some students wait and wait and wait before finally asking for help, much later than would have been beneficial for their health?

What do you think?

Share your opinion on the CFMS Wellness page forum, accessible through the CFMS home page! ■

# Budgeting for clerkship

Franco Rizzuti

VP Finance

University of Calgary, Class of 2016

**C**LERKSHIP – REFERRING TO the practice of medicine by medical students during their final year(s) of study. Clerkship is exciting, intense, impactful, at times scary and full of new experiences.

One of the new experiences of clerkship is the rapid change of lifestyle, and change in budget.

Sure, tuition remains the same, and some schools provide students marginal stipends, however talking with clerks, many were unprepared for the volume of costs associated with clerkship.

So let's look at what changes. As a prelude, I won't discuss exact figures as it varies tremendously from school to school; rather I'm going to give a broad overview of things to consider. I'll also try to give some budgeting tips and trips.

## Transportation

As a pre-clerk, it is easy to get around the city via transit. As a clerk, in many cities, a car will be required, and at some programs cars are a must for distributed medical education sites.

When budgeting for a car, it's not just the cost of the car; be sure to also budget for:

- Gas;
- Insurance;
- Parking;
- Maintenance;
- If an older vehicle, a repair budget.

Some tips:

- Use Car2Go, Zipcar or any other car-sharing service if available in your city;
- Carpool where possible;
- Join rideshare posting websites, such as Kangaride, and Facebook groups (each major travel corridor has one!)

And Craigslist works well if you're fearless.

## Lifestyle

A typical day as a clerk can be 12 to 14 hours, not including call. This can make getting to the grocery store, or staying on top of meal prep, and household chores a bit harder.

Try to plan ahead, try to prepare a week of lunches on the weekend (and freeze/refrigerate some), so you're not buying (expensive) hospital food every day.

Try to have snacks handy as a clerk, it's not always easy to fit in lunch, but you can always fit in a granola bar or fruit between consults.

Start a coffee/tea fund and use coffee cards – every 10th coffee free (when you're drinking three a day) adds up! Bring a to-go mug (environmentally friendly and helps you save).

## Other Clerkship Costs

Budget for a few new wardrobe items. Budget to have some professional photos taken (for electives and interview applications).

## ... and now onto Electives, Licensing Exams, and Interviews.

When budgeting for electives plan for:

- The AFMC Portal registration fee;
- Individual elective application fees (these vary and most are not refundable);
- Travel and accommodation costs (check out the various CFMS resources).

In final year, budget about \$1000 to \$1500 to write your licensing exam (MCCQE Part I).

Now for CaRMS and the Interview process, budget for:

- CaRMS registration fee PLUS additional fees for each additional program you're applying to;
- Notary fees in some jurisdictions (check with your school to see what free/low costs options are available).

Once you get interview offers:

- Flights and trains (try to look for seat sales, or student discounts – CMA as well as regional bodies (OMSA, FMEQ and, of course, the CFMS have many member discounts);
- Join loyalty programs and sign-up for reward heavy credit cards;
- Accommodations:
  - o Try to buddy up with colleagues across the country;
  - o Look at Interview accommodation databases;
  - o Utilize AirBnB;
  - o Hostels with member status;
  - o Join Facebook groups for accommodations.
- Budget for cab fares (to and from the airport/train, to and from interviews, etc.).

## Other Clerkship Tips:

- Find budget-friendly and low-cost date night or friend night ideas that appeal to you;
- Always look for sales wherever possible;
- Plan ahead;
- Buy in bulk whenever possible.

Clerkship is busy, has additional costs, but should not preclude students from living life and having a good time. Budget ahead – it's never too early to start thinking about clerkship. ■

# Catching up with the GAAC: highlights from the Government Affairs and Advocacy Committee

Jessica Harris

VP Government Affairs

University of Saskatchewan, Class of 2017

IT'S BEEN AN EVENTFUL YEAR for the Government Affairs portfolio, both on the provincial and the national scale. From the dynamic federal election to the ever-growing dialogue on Pharmacare to the imminent legislation on physician-assisted dying, it's safe to say that CFMS advocates have been busy. Included below are a few highlights from what we've been up to.

## Election Toolbox

First up was the federal election last October. The CFMS Election Toolkit was a collaborative effort with the intent of helping medical students navigate the election process. The toolkit included a how-to voting guide tailored to medical students, a template letter on Pharmacare to use in reaching out to candidates, and a summary of health care highlights from each political party's platform. Finally, we encouraged medical students to connect on social media using the hashtags #elxn42 and #medvote. It was a great way to get out the "med" vote!

## Local Initiatives

One of my goals at the outset of my term as VP Government Affairs was to foster our local advocacy efforts. I'm happy to see that goal becoming a reality, although I'm not sure how much I've had to do with it. The local GAAC representatives work tirelessly to communicate, coordinate efforts, and share best practices so to bring fantastic advocacy events to medical students from coast to coast.

While there are far too many excellent events to name each individually, a few that come to mind include refugee health clinics in Atlantic Canada, an advocacy event focused on transgender patients at McGill, a student-run Health Advocacy Symposium at McMaster, provincial Lobby Days in Manitoba, Alberta, and British Columbia, as well as a physician-assisted dying panel discussion in Saskatchewan with CMA president Dr. Cindy Forbes. All have been wonderful opportunities for students to get involved and experience first-hand the impact that health advocacy can have in their future careers.

## Advocacy Tracker

Another task I wanted to tackle upon taking on this role was to develop a way of better measuring the reach of our advocacy efforts. The CFMS is so fortunate to have active and engaged members who devote considerable time and effort into researching, drafting, and passing position papers at our bi-annual general meetings. However, the question of what comes after the papers are passed is one that continues to surface amongst our membership.

In 2013, the Government Affairs portfolio expanded to include the Committee on Health Policy (COHP). The overall aim of the COHP is to keep position papers current while also helping to propose future directions for new ones. Well the COHP has been a great addition, it is now time to work on applying

“The local GAAC representatives work tirelessly to communicate, coordinate efforts, and share best practices [...]”

metrics to those position papers so we can track our advocacy efforts well in to the future. Under the direction and leadership of our National Officer of Health Policy (NOHP), Tamara Ibrahim, the Committee on Health Policy has made great strides to this end. Look out for exciting changes in the near future!

## Federal Lobby Day

Finally, on February 22nd, the CFMS held its annual flagship event, the Federal Lobby Day. Over 65 medical students from across Canada met with Members of Parliament to discuss strategies for cost-effective and equitable access to necessary medications. Canada is the only developed nation in the world with universal health care but no corresponding pharmaceutical coverage. This is an important issue for the CFMS and

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## CFMS Government Affairs & Advocacy Committee, 2015-2016

CFMS Vice-President, Government Affairs.....	Jessica Harris
Memorial University.....	Mark Hewitt (Sr), Burton Ward (Jr)
Dalhousie University – Nova Scotia.....	Lucy Soudek (Sr), Natasa Zatezalo (Jr)
Dalhousie University – New Brunswick.....	Christy Stephenson (Sr), Joe Sanford (Jr)
McGill University.....	David Benrimoh
University of Ottawa.....	Olivia Lee (Sr), Raphael Nahar Rivière (Jr)
Queen’s University.....	Michael Kroeker
University of Toronto.....	Sarah Silverberg (Sr), Haniya Khan (Jr)
McMaster University.....	Vivian Tam (Sr), Nick Parle (Jr)
University of Western Ontario.....	Charles Yin
Northern Ontario School of Medicine.....	Ken Euler (Sr), Sam Nordlund (Jr)
University of Manitoba.....	Sara Matyas (Sr), Camille Glidden (Jr)
University of Saskatchewan.....	Paul Robinson (Sr), Jacqueline Carverhill (Jr)
University of Alberta.....	Justin Khunkhun
University of Calgary.....	John Van Tuyl (Sr), Amy Li (Jr)
University of British Columbia.....	Claire Schiller (Sr), Emma Mitchell (Jr)

through a variety of measures over the past few years we have shared our support as an organization for a comprehensive pharmacare strategy that would help address our economic inefficiencies and health inequities.

As you can see, it’s been an exciting year for the Government Affairs portfolio and it’s still far from over! Stay tuned for more exciting initiatives that are sure to come in the months ahead. ■

# Medical education: the world of acronyms can be fun, after all

Nebras Warsi  
VP Education  
McGill University, Class of 2017

“IT MIGHT TAKE A WHILE to get used to them.” My predecessor, Irfan, chuckled as he handed me my transition package. It certainly did.

Medical education is often described as a world of acronyms. From the AFMC to CACMS to the CFPC, a huge number of organizations are involved in the education of students and residents. But, within this world of acronyms and pedagogic theories, there is ample room for advocacy, research, and new projects that continue to connect and support our membership. After all, medical education is what brings us all together.

We have a lot of exciting updates from the Education Portfolio this year. To me, its strength derives from the Education Committee, composed of 16 members from across Canada. I've outlined some of our major priorities for this year below:

- **The National Electives Portal.** From its inception, the CFMS has worked closely with the Association of Faculties of Medicine of Canada (AFMC) for continued development of the Electives Portal. This year, we are working on standardizing immunization requirements across schools, further enhancing online functionality, and continuing responsiveness to student inquiries and feedback.

- **Advocacy.** The Education Committee this year has focused on many important advocacy projects. First, we launched an awareness campaign of how to respond to and prevent mistreatment in clinical settings. Furthermore, we worked to ensure that changes in residency positions did not disadvantage Canadian medical students in the residency match. Another important project has been advocating to restore funding to Canadian clinician-scientist training programs. Finally, we are really excited to be working a Medical Education Advocacy Toolkit to support local, grassroots, advocacy by our members.
- **The Match Book.** The Match Book is the CFMS's main resource for students in terms of demystifying the matching process. In addition to developing an updated resource, we are proud to offer our first French Match Book this year.
- **Research.** The Education Committee is actively involved in presenting research at the Canadian Conference on Medical Education each year. In particular, this year we focused on enhancing the peer-reviewed research output of the CFMS. With a wealth of data across our position papers and surveys, we hope to enhance our ability to publish and disseminate this important information through peer-reviewed sources.

“[...] within this world of acronyms and pedagogic theories, there is ample room for advocacy, research, and new projects [...]”

The Education Portfolio of the CFMS is broad, but it is also extremely rewarding. I am honoured to have been able to work with an exceptional Education Committee and CFMS Executive, whose combined work has made many of these projects possible.

Looking ahead, there are major changes in Canadian Medical Education on the horizon. From competency-based residency training programs to new curricula and changes to our accreditation systems, many exciting developments lie ahead for our medical students. We hope to continue bringing your voice to the table as these and other new projects develop. ■

# The CFMS National Blood Drive: medical students already saving lives!

Salima Abdulla

CFMS National Blood Drive Officer

University of British Columbia, Class of 2017

**O**NE IN 10 CANADIAN patients admitted to the hospital receive blood products and, in most cases, blood from more than just one generous blood donor. That's one of the reasons why the Canadian Federation of Medical Students (CFMS) entered into a partnership with the Canadian Blood Services over 10 years ago.

The CFMS represents over 7,500 medical students across Canada, who are committed to helping others in every way possible. The CFMS is a Canadian Blood Services *Partners for Life* organization and pledges an annual goal for blood donations, as the need for blood is constant. Our 2015 goal of 1,225 units was surpassed, as we collected 1,326 units! Next year, our goal is therefore to reach 1,350 units of blood.

To encourage blood donations and raise awareness, the CFMS runs a friendly six-month-long (September to February) competition between medical schools to track which school accumulates the most donations and first-time blood donors. This competition, appropriately named the Phlebotomy Bowl, pits medical schools against one another, regardless of student population size. Students register as donors through their school's *Partners for Life* number. Donations are tracked by Canadian Blood Services at local blood clinics. Results are then converted from absolute numbers into a per capita rate. At the end of the Bowl, Canadian Blood Services presents engraved plaques to the winning schools.

Our 2014-15 Phlebotomy Bowl was a great success, resulting in a total of 751 life-saving donations and 105

new blood donors. Congratulations to Dalhousie Medicine New Brunswick for the Most Donations Per Capita and to the University of British Columbia Vancouver Fraser Medical Program for the Most New Donors. The third Annual Phlebotomy Bowl concluded on February 29, 2016. We look forward to the results from this year's Bowl!

The CFMS sincerely thanks the Junior and Senior Blood Champions at each medical school across Canada for their voluntary time and dedication to this important cause. Blood Champions are medical students who work hand in hand with their respective local Territory Managers to plan blood drives at their school year round. They go above and beyond in encouraging their peers to donate blood, while helping at blood typing events (called "What's Your Type?") and stem cell cheek swabbing events held on campus.

The CFMS thanks the Canadian Blood Services for their continued support and engagement with our organization as it offers practical, hands-on experience to student volunteers while "Giving Life." Tobias Keogh is Canadian Blood Services' manager for Partnership Development and has been instrumental in helping organize the Phlebotomy Bowl and annual pledge goals. He's in constant communication with local Territory Managers to ensure that donations are being tracked, and targets are being met.

CFMS is looking into actively participating in stem cell registration events. The national stem cell network matches donors to patients who need stem cell transplants. Stem cells are used to treat

"[...] Less than 4% of eligible Canadians give blood yet half of Canadians have either needed blood or know someone who has"

more than 80 blood-related diseases and disorders, and less than 25% of patients who need transplants will find a match in their family. If you are between 17 and 35 years old, you can "Give Life" by donating stem cells.

Please register today at <https://www.blood.ca/stem-cells>.

It's important to know that less than 4% of eligible Canadians give blood yet half of Canadians have either needed blood or know someone who has. We all have the power to "Give Life" so please consider joining the movement. Contact me at [blood@cfms.org](mailto:blood@cfms.org) to find out how you can help your local medical school win the coveted Phlebotomy Bowl while "Giving Life!" ■

# Foreword: as citizens of the global community

Golden Gao

VP Global Health

University of British Columbia, Class of 2017

**T**HE CFMS GLOBAL HEALTH Program has long been a proponent of health equity, an advocate of population health, and a champion of global health issues. We understand that, as future physicians, we will not only be leaders within our communities, but also citizens responsible for the global community. In December 2015,

the world gathered at the Conference of Parties (COP 21) in Paris, France, to discuss strategies to address climate changes. To add to the discussion, the International Federation of Medical Students Associations (IFMSA), of which the CFMS is a member organization, sent a delegation of medical students from around the world, among which

were two Canadian medical students, Kit Moran, from Dalhousie University, and Anne-Lou McNeil-Gauthier, from the Université de Sherbrooke. In the following two articles, Kit elucidates the connection between climate change and health, while Anne-Lou enlightens us with the achievements of COP 21. ■

## A medical student's experience at the COP21

Anne-Lou McNeil-Gauthier

Université de Sherbrooke, Class of 2018

**L**AST DECEMBER, THE Conference of the Parties on Climate Change 21 (COP21) – one of the most newsworthy events of 2015 – took place in Paris, France. The stakes were high: the 195 parties were to agree on a treaty to take concrete actions to counter climate change. Two weeks of intense negotiations, with its victories and disappointments, unfolded before the eyes of a medical student.

The climate change negotiations have been considered by some to be the greatest opportunity for public health intervention in the 21st century. This conclusion, published by the Lancet Commission on Climate Change and Health, was endorsed by the World Health Organization (WHO) as well as the Global Climate and Health Alliance, the World Medical Association's Doctors for Climate Action and the International Federation of Medical Students' Associations (IFMSA). There is an intrinsic link between the environment in which we live, the water that we drink, the air that we breathe, the food we eat

and our health. I am happy to say that this conclusion, which has been consistently repeated to the ears of leaders, finally bore fruit. In the final text, it was mentioned that fundamental right to health was threatened by climate change. This was a small victory that was not obtained with much work. Imagine the difficulty in coming to a text adopted unanimously by 195 countries, each with different priorities, economic stakes and varied agendas. But they all committed to stay at the table to negotiate on CO<sub>2</sub> emissions and economic concerns while maintaining protection for health. It was not an easy thing to do, but they did it.

Another remarkable achievement from the COP was agreeing to limit temperature rise due to climate change to 1.5°C. Along with the promise of US \$100 million to the Green Climate Fund to help finance projects of resilience and adaptation in developing nations, wasn't this a beautiful achievement? What filled me with optimism was seeing all the engagement from the media, political leaders, all of those who came to Le Bourget despite the recent terror attacks

and, above all, the civil societies both inside and outside the conference. Not to forget the climate marches, which spanned the globe. 60,000 people united in Melbourne; 50,000 in London; and another 50,000 in Paris where all gatherings were prohibited. Despite the restriction, a chain of humanity of 10,000 persons formed, and this was one of the greatest displays of humanity in which I have taken part.

More than a month after the adoption of the treaty, the dust has settled down, the media interest has faded. Now, what remains of the demonstrations? Do the flames still burn? The treaty has been adopted and signed, certainly, but for it to take effect it must be ratified by at least 55 countries representing at least 55% of global emissions of greenhouse gases. The objectives are ambitious, but to realizing the implementation of the agreement requires not only a clear roadmap and a political will, but also the continuous involvement of citizens, non-governmental organizations and health professionals. ■



# Let's talk about the future

Kit Moran

Dalhousie University, Class of 2019

**W**HEN IT COMES TO TALKING about the future, most medical trainees are accustomed to conversations with an amount of inherent uncertainty: In what specialty will I train? Where will I be spending the next two-to-five years? Will I be any good as a doctor?

But let's switch gears for a moment and visualize the future for our patients. Let's ask a different set of questions: Will they be sicker? Healthier? What will their care be like? Will our interventions be more successful? Will our care be more holistic? Hopefully you are visualizing a bright future for your patients.

Would that change if you knew we are at the beginning of an unprecedented public health event: a crisis the World Health Organization (WHO) expects to contribute to the deaths of 250,000 people a year between 2030 and 2050? Should this not also be a conversation to have about the future?

In fact, world leaders were talking about that exact future in Paris in December 2015. After more than 20 years of negotiations, the United Nations Framework Convention on Climate Change finally resulted in an agreement. Their message was loud and clear: climate change is a looming and imminent threat for our planet.

While the concept of climate change is likely familiar to most, the links to health may not be apparent at first. Nonetheless, climate change should hold

significant meaning for all physicians, and in particularly medical trainees. When the effects on the climate become apparent by the mid-century, we will all be in the middle of our careers. We will be the body of doctors facing the health legacy of climate change.

Climate change impacts health in many ways: directly, through mortality and morbidity due to heat waves and other extreme weather events; and indirectly, through pathways such as food insecurity, ecosystem collapse, and migration due to climate displacement. Together these pathways account for the WHO's estimate of the 250,000 deaths a year, mostly of malnutrition, malaria, diarrhoea and heat stress. Furthermore, these effects are unlikely to be evenly distributed, with most of the burden of harm from climate change falling upon those who contributed least to the problem; it is expected that the Global South will bear the brunt of the effects.

This does not, however, excuse Canadian physicians and students from a duty to address this issue. Climate change will lead to displacement and migration, which will inevitably reach North America. In addition, Canadian physicians face the health impacts due to the processes that drive climate change, such as the thousands of deaths per year in some major cities due to air pollution from combustion engines.

However, talking about climate change does not have to be entirely negative. The Lancet Commission on Health and Climate Change determined that it could be the greatest opportunity for public health in the 21st century. In fact, although the economic costs of acting are high, climate actions benefit society not only in health but also in net financial savings on long-run health costs. It actually makes economic sense to act on climate change. This is important to us as future physicians: we can push for climate action as prudent from both a health and financial standpoint.

As medical learners, we are in a unique position to also advocate for the inclusion of climate change literacy in our medical education. The White House administration in the United States has announced commitment from the deans of more than 70 schools of health to integrate climate literacy in their curriculums. As socially responsible medical trainees in Canada, we have to push to ensure the implementation of these commitments in our own schools. Having a formal climate change education will better prepare us to face the healthcare challenges ahead.

It is our duty as medical trainees and future physicians to act and advocate on behalf of our future patients, ensuring for them the possibility of a healthy world. So let's start talking about the future. ■

# Responding to rural health needs through medical education

Kelly Aminian  
Memorial University, Class of 2018

“ONE OF THE MAJOR problems of rural health is the chronic shortage of health-care practitioners in rural, remote and northern areas,” said Dr. Raymond Pong, founder of the Centre for Rural and Northern Health Research.

In Canada, 31.4% of the population lives in predominantly rural regions. Since rural areas tend to be underserved, strategies have been examined to meet the needs of these communities.

*“So far, the most effective and lasting strategy seems to be the rural education strategy: training healthcare providers in rural areas, in smaller towns, exposing them to smaller environments, as well as recruiting trainees from rural areas,”* said Pong.

The University of Calgary Cumming School of Medicine developed an initiative which allowed students to take a pre-clerkship course in a rural community through video conferencing and podcasting. Clinical skills and focus groups were led locally by generalist preceptors. No differences in academic performance were demonstrated between students in rural and urban settings.

This was part of the longitudinal integrated clerkship at the Cumming School of Medicine, wherein students live and complete clerkship requirements in a rural community. Interest in this model has been high and Dr. Doug Myhre, associate dean of rural medicine, said they have roughly twice as many applicants as available spots each year.

Myhre stated that 76% of students who completed the longitudinal integrated clerkship went into family medicine, versus 32% of a matched cohort of students in the rotation-based model.

Again, there was no difference in academic performance between the groups. Of the students who went into family medicine from the longitudinal integrated clerkship, about 85% went into rural practice.

*“Some communities have now completely reversed their physician shortages and have waiting lists of doctors,”* said Myhre.

There have been long-term studies on rural retention of resident physicians, as well. The Family Medicine Tracking Study, initiated in 1999, surveyed graduates of the Northeastern Ontario Family Medicine Program. While 63% of people in the program were from small communities, 88% practiced in communities with populations under 100,000 after graduation. Though only one third of entrants had grown up in northeastern Ontario, two thirds stayed there to practice.

There is also a need for specialists in rural communities. The Northern Ontario School of Medicine offers a Northeastern Ontario Postgraduate Specialty program.

Pong and his colleagues tracked the practice locations of graduates over six years. They found a strong positive association between participation in the program and practicing specialty medicine in northeastern Ontario.

*“In terms of rural medicine as a whole, what you’re getting is an experience that allows you to see a more holistic view of the patient,”* said Myhre. He added that learners in rural settings develop better clinical and procedural skills, and are less reliant on technology and specialist consultation.

While Myhre was initially concerned that students learning in rural areas might feel isolated, students formed tighter bonds with their small groups and took more responsibility for each other’s learning.

Pong added that the nature of collaboration is different in rural settings. Members of different professions work more closely together than in cities where patients are typically referred. *“Rural training helps you establish a rural network so that you work with not only other physicians but also other professionals in other disciplines,”* said Pong.

The problem of maldistribution of doctors is complex, but several initiatives influenced by a growing body of research have shown success by meeting the needs of rural communities. *“You need to push the envelope and you need to have a very long horizon of at least 10 years to see your efforts come to fruition,”* said Myhre. ■

*A version of this article previously appeared on in-Training, the online magazine for medical students (in-training.org).*

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# Through the eyes of the tigers: establishing a Canadian Doctors for Medicare student chapter at Dalhousie

Mark Maclean

Co-Chair, CDM: Dalhousie Chapter  
Dalhousie University, Class of 2018

**M**EDICARE REPRESENTS Canada's commitment to equitable and accessible care for all Canadian residents. While many Canadians proudly stand behind our universal, publicly-funded health care system, it has been challenged by advocates of a parallel private insurance plan. The Canadian Doctors for Medicare (CDM) and associated student chapters, support Medicare and raise awareness around issues with privatization. CDM envisions a high-quality, equitable, sustainable health care system built on the best available evidence as the highest expression of Canadians caring for one another.

Governed by the Canada Health Act (CHA) of 1984, the Canadian health care system operates on the principles of public administration, comprehensiveness, universality, portability, and accessibility. The CHA supports Canada's commitment to accessible and equitable care. Indeed, the CHA states, "the primary objective of the Canadian health care policy is to protect, promote, and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health care services without financial or other barriers."<sup>1</sup>

For years, health care expenditures have outpaced the annual rate of inflation. With an aging population, we can expect further increases in health care expenditures and a reduction in GDP growth as the ratio of working Canadians declines as a percentage of the total population. Indeed, the supply of physicians must increase by at least 46% over the next quarter of a century to meet the increased demand for services as a result of an aging and growing population.<sup>2</sup> In order to preserve

the sustainability of Medicare, innovative solutions to either reduce costs or increase GDP must be sought.

The CDM seeks to strengthen and improve Medicare by advocating for innovative solutions in treatment and prevention services that are evidence-based and improve access, equity, and sustainability. Last year, medical students at Dalhousie University wished to support the CDM: in their mission and established the CDM: Dalhousie Chapter. They set out to learn more about the current state of Medicare and the challenges to the health care system that will be faced.

## The Dalhousie Chapter Goals:

- 1) Inform medical students of CDM's vision and goals;
- 2) Foster improved education around health system issues for all Canadian medical students;
- 3) Recruit medical students and retain their support as they move forward into residency and clinical practice;
- 4) Build CDM's capacity by engaging student members in health care projects that are mutually beneficial to both CDM and students;
- 5) Provide training and mentorship to students who show a passion for health policy and health systems management in line with CDM's goals.

Currently in its second year of operation, the Dalhousie Chapter executives have recruited classmates, hosted several educational presentations with guest speakers, and have started lobbying to our municipal government in support of a national Pharmacare program. Dr. Monika Dutt, Chair of CDM (see interview page 45), recently attended a Dalhousie

Chapter discussion, featuring topics such as the need for government action on a Pharmacare program. Insufficient funding for prescription drugs is a barrier to care, forcing patients to reach into their own pockets or use private insurance. To this end, Canadians pay prices 30% higher than the OECD average and the gap continues to widen.<sup>3</sup> Many patients would support such a plan – especially since 10% of Canadians cannot fill a prescription.<sup>4</sup> The Dalhousie Chapter seeks to raise awareness around topics such as this, particularly by disseminating information to students studying in health care related fields at Dalhousie.

As the Dalhousie Chapter continues to make its voice heard in the Maritimes, the executives are working toward a strategic plan. They envision a plan that aligns with the Chapter's goals, a plan with measurable goals that will carry the chapter forward in the coming years. Through coordination with the CDM National Student Advisory board and assistance from leaders such as Dr. Dutt, they are preparing for their own sustainable growth. ■

Sign-up to become a member of CDM (free for students): <http://www.helpforcharities.com/CDM/index.php>

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# The need for STARS in medical education

Anand Lakhani

University of Toronto, Class of 2018

Elliot Lass

University of Toronto, Class of 2017

William Silverstein

University of Toronto, Class of 2017

**A** MEDICAL STUDENT IS winding down her first shift of emergency medicine when she sees a gentleman who has seemingly broken his nose after “running into his friend’s fist.” The medical student is confident that she made her first diagnosis as a clinician – a broken nose. The staff agrees that it should be reduced, but believes X-rays are needed to confirm the fracture, contradicting best practices. The student wants to question this unnecessary use of X-rays, but is extremely hesitant to do so. This is due to the current culture of medical education that rewards students for over-ordering diagnostic and therapeutic interventions, and chastises those who show restraint. Our purpose is to help transform this culture of medical education and promote the dogma where “less is more.”

Choosing Wisely Canada (CWC) was launched in April 2014 to help physicians and patients engage in conversations about unnecessary tests, treatments, and procedures, with the aim of reducing them. Unnecessary care leads to adverse patient outcomes, including false positives, patient anxiety, further invasive workup of incidental findings, cumulative radiation, and antibiotic resistance. CWC partners with over 45 medical and surgical specialty societies to develop evidence-based recommendations of clinical decisions that should be questioned (see interview page 41).

## A Grassroots Campaign by Medical Students

Overuse in healthcare is rampant; the Institute of Medicine reports that unnecessary care accounts for 30% of healthcare costs in the United States. Medical students face many barriers that prevent them from providing high-value care to patients. These challenges include being taught and assimilated into a culture of overuse, attempting to appease preceptors and improving clinical acumen by over-ordering unnecessary interventions, and inconsistent role-modelling of cost-conscious behavior from supervising physicians. Drivers of overuse include an inability to question the care being provided due to hierarchy in health care teams, uncertainty in diagnostic capabilities, and an aspiration to be praised for thoroughness. CWC recognizes that the only manner to achieve a sustainable culture shift is to target students.

The CWC Students and Trainees Advocating for Resource Stewardship (STARS) campaign was launched in September 2015 and is funded by a grant from the American Board of Internal Medicine Foundation. It is a multi-pronged campaign, consisting of a leadership summit, where two medical students from each Canadian medical school traveled to Toronto to sharpen their leadership, advocacy, and communication skills needed to launch local, grassroots campaigns. The hope is these STARS will work with their local colleagues and faculty to foster an environment where

“Our purpose is to help transform this culture of medical education and promote the dogma where ‘less is more’”

students understand the importance of resource stewardship.

## Recommendations for Medical Students

The crux of STARS was the development of the first list of recommendations for medical students. This list focuses on behaviours rather than clinical practices, since behaviours in medical training play a critical role in shaping future practices, coupled with the fact that students do not order therapeutic interventions and lack the expertise to focus on a small subset of diseases. A preliminary list of 12 recommendations was developed by a student-led taskforce, and refined to 10 items after consultation with the two national medical student governing bodies. In a subsequent consultation process, nearly 2,000 Canadian medical students studying gave feedback on the candidate recommendations.



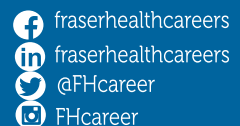
This feedback informed the final list of “Six Things Medical Students Should Question” during their training. Examples of list recommendations include suggesting the least invasive therapeutic intervention and initiating conversations with patients about whether a test, treatment, or procedure is necessary. We hope that the recommendations

will support students in initiating difficult conversations about finite resource stewardship. Physicians have already taken up this call to arms to combat unnecessary care. It is now our turn as medical students to contribute to this movement and to ensure the quality and sustainability of our healthcare systems. ■

The full list of recommendations can be found here: <http://www.choosingwiselycanada.org/recommendations/medical-students-and-trainees/>. For more information, please visit [www.choosingwiselycanada.org](http://www.choosingwiselycanada.org) or tweet us @ChooseWiselyCa.



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# The Stem Cell Club: expansion to medical schools across Ontario

Ari Cuperfain

University of Toronto, Class of 2019

Alexander Tigert

University of Toronto, Class of 2019

Joseph Aziz

University of Ottawa, Class of 2018

Menachem Benzaquen

University of Ottawa, Class of 2018

Navot Kantor

University of Ottawa, Class of 2018

Christopher Welsh

University of Ottawa, Class of 2018

Neha Arora

McMaster University, Class of 2017

Jessica Shanahan

McMaster University, Class of 2017

Amanda Yaworksi

McMaster University, Class of 2016

Janice Yu

McMaster University, Class of 2018

Thomas Henderson

Western University, Class of 2018

George Wang

Western University, Class of 2017

Warren Fingrut

University of British Columbia, Class of 2015

**T**HE STEM CELL CLUB IS A student-run non-profit organization that works to recruit Canadians as stem cell/bone marrow donors. We are a community partner of Canadian Blood Services, and we are accredited through them to run our own stem cell donor-recruitment drives. At these drives, we guide potential donors to provide informed consent and a tissue sample (cheek swab) – this information is then inputted onto Canada’s stem cell donor database, the OneMatch Stem Cell and Marrow Registry. These donors can then find out if they are a match to a patient in need of a stem cell transplant who cannot find a genetic match in their family.

In last year’s *CFMS Annual Review*, we outlined our initiative’s successful launch at the University of British Columbia’s medical school, and our subsequent expansion to all of its distributed sites.<sup>1</sup> We are pleased to report that we have successfully launched five Stem Cell Club chapters at medical schools across Ontario: University of Toronto (St. George Campus), University of Ottawa, University of Western Ontario, and McMaster University (Hamilton

and Niagara Campuses). We have also launched our website ([stemcellclub.ca](http://stemcellclub.ca)), on which we have published our volunteer and club leader training program, informed consent diagrams, and stem cell drive checklists.

To date, we have recruited 4020 potential stem cell donors (representing 1% of all donors on Canada’s current donor database). Our recruitment strategy focuses on the most-needed donors according to the literature: young and ethnically diverse males.<sup>2,3</sup> From November 2012 to December 2015, 65% of 2870 recruited registrants were male. From October 2013 to December 2015, of the 1067 males recruited, 57% self-reported as non-Caucasian and 71% were age 17-25. We have recruited 62 young Aboriginal males, increasing this demographic group’s representation on Canada’s registry by ~7%.

Our initiative enables medical students to realize the CanMEDS roles. We empower students to become leaders in Canadian healthcare and health advocates for patients in need of stem cell transplants. We hone student communication skills to recruit registrants without

“Through targeted recruitment of the most-needed donors, we guide students to be stewards of limited healthcare resources.”

compromising informed consent, and to sensitively and professionally redirect ineligible donors to help in other ways. Through targeted recruitment of the most-needed donors, we guide students to be stewards of limited healthcare resources. We develop students’ quality control skillsets by instructing them to use our checklists and to maintain good-documentation practices. At our drives, students act as scholars, teaching

other students about stem cell science and the principles of stem cell donation. Medical students at each chapter of our club work collaboratively with each other and with students from other disciplines across the university to recruit donors. Through tracking outcomes at every drive we run, we emphasize continuous quality improvement.


We invite other medical students across Canada to partner with us and establish stem cell clubs at their respective schools. We offer our support, guidance, and mentorship to any individuals or groups of students interested in starting up their

own stem cell clubs. We will share our evidence-based training modules, experience running drives, and other resources. We will connect you directly with Canadian Blood Services and Héma-Québec, and work to accredit your group to run stem cell drives independently. We can, together, dramatically increase the number of individuals we recruit to become stem cell donors, and save lives of patients who cannot find a match today. ■

Interested students can email Dr. Warren Fingrut at [wfingrut@gmail.com](mailto:wfingrut@gmail.com) to discuss the next steps.

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# A letter to a patient

Pauline Kosalka  
McMaster University, Class of 2017

**Y**OU CAME TO THE Emergency Department one day. It was not the first time. I was warned even before I read your chart that you kept coming back, just like the cat in that old song. “Take your time,” my preceptor told me.

The chart branded you as “syncope,” but I knew things were never so simple. I took the few steps to your room. There it was – C8 – the bed separated from everything else by that enchanted curtain that would hide all details of our conversation from the outside world. I drew it aside and made my introductions.

You were not “sick” – at least not in the “impending doom” sort of way we are taught to classify patients in the ED. But you were by no means well. I could see that by the unkempt state of your graying hair, the alarm in your eyes, the tears in your voice.

The chart had lied to me – at the very least, it left out much of the truth. You had indeed fainted earlier during the day, but there was so much more. You had your share of health problems in the past, even once ending up under the surgeon’s knife, and you had never really returned to yourself. Nowadays, you are beset daily by vague discomforts, feelings of electricity coursing through your limbs. It scares

you and you have already looked to other physicians for help, but nobody was able to take your pain away. It has come to the point where you feel that some doctors do not take your condition seriously. My heart trembled as you said that you had thought today would be the last day of your life and that you would rather go through another surgery if it could take away the symptoms you suffer every day.

I was vaguely aware of the time and tried to move on as the words kept flowing from your lips, as if a dam had burst and all of your concerns had to be unleashed upon the world that very moment. I was almost hoping that I could find something unusual as I did the physical exam. Maybe if I found something, it would help some brilliant physician diagnose what was wrong.

Then, a corner of that impenetrable curtain was pulled back and my preceptor summoned me to present my findings. I listed your concerns, knowing there was not much we could do at that moment. I didn’t know whether the core of your condition was “organic” or “psychogenic” or a mix of the two. Either way, your suffering was real.

My preceptor was kind to you. She did what was indicated to check for any red flags regarding your syncope and she

“We could not give you the answers you wanted and I do not think that the ED was the right place to find these answers”

did her best to arrange a follow-up with a specialist for your other concerns. It wasn’t enough. You told me there was a good chance you would die if we discharged you and that you would file complaints against the hospital. None of this was new for you.

Looking back, I have no ill will. You have serious concerns that cause you great fear and suffering. We could not give you the answers you wanted and I do not think that the ED was the right place to find these answers. What would I have done if I were in your place?

I do not know. ■



# Delusional

Mim Fatmi

University of Alberta, Class of 2016

“NO, YOU’RE NOT,” WE inform her. She looks at us imploringly, repeating what she knows to be true. *“I am! I’m in the navy, my husband is a marine, and he’s on a mission right now and I just want to be able to talk to him!”*

My preceptor stands his ground. I try to tell her gently, *“Caitlyn, you’re not in the army. You’re in the hospital.”* I pause to assess her reaction, then push further. *“We’re not sure if you have a husband.”*

She turns to fix her gaze on me. She’s been through this argument before, and knows what her line of defense will be. *“Oh yeah? I don’t have a husband? Then what are these?”* She reaches down the neck of her shirt and pulls out a chain with two dog tags and one bullet, with the chain threaded through it.

*“So where did I get these if not from my husband, huh?”* She continues glaring.

My preceptor’s had enough. We’ve been through this discussion too many times in the days since her admission. *“You probably bought them off some guy in a pawn shop, Caitlyn. Look, we’ve gotta go, we have other patients to see.”* Curt. Direct. Dismissive.

*“No, please, doctor – wait! Please!”* This evokes a different kind of desperation in her, knowing that the less she gets to say, the less chance she’ll convince us of her truth. *“Please, just let me out on a pass this weekend! I have to feed my kitty, no one has seen her for the past week! Please, doctor!”*

I realized something in that moment. That she is as lost as any of us, hoping to make sense of the few facts and concrete evidence provided to her, and

her disordered brain has put together those clues in a more intricate and elaborate fashion than most other people. Where most minds implement Occam’s razor, hers jumps to conclusions that involve complex plots and backstories. Ultimately, she operates in a fantasy realm in which things don’t necessarily need to line up with the reality that exists in physical space around her.

We have a term for this – or rather, a diagnosis: delusional disorder. Delusional disorder: the presence of one or more non-bizarre delusions for a duration of one month or longer. Her multiple delusions include that of a husband that no family member has ever seen or meet, a Russian gang out to get her, a neighbour who is stalking her, a history of being an elementary school teacher, an artist, a musician, and apparently, a marine. While all of these things may sound somewhat ludicrous from the outside, I couldn’t help but imagine what life is like for her.

Caitlyn, how does it feel to see and interpret innocuous stimuli as part of a dark plan where someone is out to get you? How taxing is it constantly being your own lawyer, preparing arguments for every conversation you have? How disorienting is it to wake up to a new day and have to fill in the gaps? Most importantly, how hard is it to eternally question what’s real and what isn’t, to weigh the facts others present you with the reality you experience in your own mind, to see how the pieces best fit together?

I’m sorry, Caitlyn, for the poor job we do in validating what’s true for you.

“I’m sorry for being rigid and inflexible in our interpretations of the universe, and expecting everyone to conform to the same.”

I’m sorry for being rigid and inflexible in our interpretations of the universe, and expecting everyone to conform to the same. I’m sorry that we take the term for your illness and use it in place of outdated words like “hysterical”, that we lump you into the same category as attention-seeking histrionics when I know that you cannot help how differently your brain operates.

This life is confusing enough for the best of us; I’m sorry that we add to your confusion when I can see that you are truly just trying to make sense of the world around you. ■

# Does the learning ever stop?

Marina Abdel Malak  
MD Candidate  
University of Toronto, Class of 2019

“GETTING INTO MEDICAL school is the first step. You may think that once you’re in, you’ll learn and know everything. But trust me, the learning never stops.” These words are my father’s, a physician himself. When I first received news that I had been accepted to study medicine, I was overjoyed. Then the real work started, and I realized exactly what he was talking about.

During lectures, there were concepts that I didn’t fully understand, and I began taking the time to research answers. When I spoke to faculty and heard an exciting patient story, my curiosity motivated me to ask for more information so that I could learn practical applications. When a health story came on the news, I instantly found myself debating whether or not this was relevant to my future practice.

But the learning didn’t stop there. When taking histories, there was the art of trying to incorporate empathy and support into our interactions. When presenting a case history to the group, I had to learn how to be concise and clear at the same time. When preparing a presentation for a school initiative, I had to think about whether activities were developmentally-appropriate, if the children would learn something new, and how I could use this opportunity to promote health in the community.

There was always more learning. At times, I felt overwhelmed. I spoke to others around me, and they were experiencing the same thing. I decided to ask those who had travelled the road before me. The responses were eye-opening, comforting, and reassuring.

*“Medicine is rapidly changing – so there is always going to be something you don’t know. Everyday, there is a new research study, a new guideline, an indication for a medication, and more. Try to find ways to get the information ‘quick’ – and then search for details later.”*

*“We all learn something new everyday in medicine. You can never learn it all. Sometimes, you need to pick and choose between what is a priority now, and what you can catch up with later. It is good to be curious, but remember that you can’t learn everything in one day!”*

*“Don’t be hard on yourself when you find that you don’t have all the skills perfected right away, or when you realize that the information you thought was right last month has changed today. That is a part of medicine. Instead, find out how you can stay updated. Attending rounds, conferences, and meetings is a great way to stay social and stay informed!”*

To feel that I wasn’t alone, that this was a part of medicine, was extremely reassuring. I felt calmed by the fact that practicing and experienced physicians also felt the pressure of constantly having to learn new knowledge and skills. In a paradox, the lifelong learning in medicine – although challenging – is what keeps me loving medicine. The fact that I need to be flexible and adapt to new knowledge makes me realize how worthwhile this career is.

“While I accept that I cannot learn everything in one day, and that I will never know everything, I also realize that this is what makes me love medicine”

My passion for medicine is not weakened by this learning; I feel more motivated and inspired to work my hardest, to seek out learning opportunities, and to satisfy my curiosities. While I accept that I cannot learn everything in one day, and that I will never know everything, I also realize that this is what makes me love medicine. With all the resources available, it is our responsibility to ensure that we remain current with knowledge and skills that will enable us to contribute to positive patient outcomes.

So, will I ever know everything there is to know about medicine? No. Will the learning ever stop? No. Knowledge is definitely power... But the process of learning in itself is just as, if not more, powerful. ■

# The business of medicine

Larissa Padayachee  
University of Saskatchewan, Class of 2018

**A**MONGST OTHER THINGS, physicians are stereotyped as having illegible handwriting, being notoriously late and, despite years of medical training, being deficient in the ability to manage the business side of medicine.

It's the last of the above stereotypes that motivated me to enroll in the MD/MBA program at the University of Saskatchewan. Through the MBA portion of this program, I became better informed on many topics such as financial management, human resources execution, and marketing strategies. Once I started medical school, however, I began to see similarities between my business training and my medical education.

## Understanding Products and Patients

PESTEL analysis is a business tool used in marketing and product development. "PESTEL" is an acronym for political, economic, social, technological, environmental and legal – all different areas that can impact an idea, strategy or product. It's essential to explore various perspectives within these areas to best predict the outcomes of any given situation.

Physicians use a similar tool; investigating a patient's background to best derive a probable differential. We refer to this as a 'history.' Recognizing how aspects of family health, current medications, lifestyle, and presenting symptoms affect the patient are essential to appropriate assessment and management.

In both business and medicine we assess the influence that extrinsic factors have on product uptake and patient health.

## Projections and Prognostications

The ability to forecast revenues and expenses are fundamental in any business seeking long-term growth, investment, and success. Conducting these projections is based on past experiences of the company, current environmental factors (PESTEL analysis) and predictions of future growth and opportunities. Innately, there will be discrepancies between projections and actual outcomes, due to variable factors that impact a business (loss of resources, new competitors entering the market, competing products, etc.). Ultimately it becomes a risk-benefit analysis of which path to follow based on predictions (defined as something that may or may not happen in the future).

In medicine, we make many predictions as well. Physicians treat the patients based on past experiences, currently available resources, and new medical research. However, each patient is different; different genetic make-up, hormonal balances, psychological tolerance etc. These all impact the progression of disease, adherence to medication, and overall quality of life. Options are provided to the patient, based on risks, side effects, complications, and potential curability. It then becomes the patient's decision – and the patient must recognize the costs and benefits of each option to make an informed decision about their care.

As with business, in medicine, there is no guarantee. The path taken is based on statistics, ratios and hope of a positive outcome.

## Collaboration and Interdisciplinary Teamwork

As I learned in business school, there are many moving parts when running a com-

“Once I started medical school, however, I began to see similarities between my business training and my medical education.”

pany; human resource management, marketing, stakeholder relations, investments etc. These require unique knowledge and expertise. Collaboration between departments is necessary to ensure efficiency and success.

The same can be said for health care – each health profession has unique knowledge and skill sets to assist in patient and community care. It is important that we utilize this expertise to its fullest potential to ensure an efficient healthcare system. To achieve this, health professionals need to collaborate and work as a team.

Essentially, in business and in health care, the whole is greater than the sum of its individual parts.

In summary, I was pleasantly surprised by the degree of theoretical overlap between the two disciplines. Analyzing situations using both business and medical lenses has given me a unique perspective – one I hope to share with my colleagues as I journey through my academic career. ■

# Numbness

Kevin Dueck

Western University, Class of 2016

**E**NTERING MY FINAL YEAR, I was contacted by a third-year colleague. He was feeling over-whelmed during his family medicine rotation and was looking for advice. In medical training, even a year more of experience is seen to impart substantial wisdom, an interesting phenomenon. I listened and tried to calm his anxiety addressing his concerns and giving advice to improve his efficiency without sacrificing patient care. I also told a story.

When I was in my family medicine rotation, part of my evaluation involved observed encounters with patients. Early in my rotation my preceptor sat in on a visit by a middle-aged gentleman accompanied by his wife. His concern was

numbness in his left leg.

As a diligent medical student I delved into his history and explored his concern. Acute or chronic? Had it occurred before? Asking all the standard questions related to such a concern. I was careful to make sure I ruled out more sinister causes asking about recent trauma, previous cancer history, changes to bowel or bladder function and more. Following a detailed history, I performed a thorough physical exam, finding decreased sensation in the lateral aspect of the patient's left lower leg, but no other significant findings.

I began to wrap up the visit by presenting a summary to my preceptor going over my findings and assessment. Most likely it was caused by him being a long

haul trucker and resting his leg against the door leading to nerve compression.

My preceptor listened graciously and, after a pause, asked if the patient was bothered by the numbness. In my efforts to find the cause for the numbness I had failed to ask, so I did. "No, I was just curious." I thought of all the potential causes I had inquired about during his appointment when in reality all he wanted was to satisfy a curiosity and reassurance. In my attempt to show my skills, I had passed over questions essential to patient-centered care and failed to connect his concern with his life and wellbeing.

My young colleague laughed. He understood. ■



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# Accessing justice

Annie M. Wang

University of Toronto, Class of 2018

IT WAS MY FIRST TIME SHADOWING at the clinic. A lady in a white coat walked into the office and began speaking to the staff physician I was following. She sounded like she could be another doctor or a nurse.

“There’s one other thing I want to ask you,” said the white coat lady to my staff, “do you know Dr. X at Hospital Y?”

“I know of him, but we’ve never worked together. Terrific surgeon,” my staff replied.

“Oh great; my sister is scheduled to have surgery with him next month.” She then told him her sister was recently diagnosed with colorectal cancer. Although it’s early stage, she wanted her sister to have the best treatment.

“When she told me she got a colonoscopy referral, I was so worried I called a gastroenterologist friend to make sure she could be scheduled right away.” Hearing this, I was bothered.

I was bothered because my own mother passed away from gastric cancer when I was seventeen. For as long as I can remember, she was my source of strength and insight. When she became sick, I watched, terrified, as this rock of a woman was first unable to finish her meals, then became so nauseous she spent hours in the bathroom. I worried for months as she waited for her endoscopy. When she finally got it and was diagnosed with stomach cancer, I anxiously

waited some more for her surgery.

On the morning my mom passed away, I remember thinking how strange it was that the sky could be so brilliantly blue when my world just collapsed. Although it’s been years, I still wonder sometimes: if my mom got the endoscopy earlier, would she have been there for my high school graduation? If she was able to see the specialist sooner, would she have been there to watch my little sister ride her bike for the first time? If she was operated on earlier, would she still be with us – be with me – here today?

Now here I was, listening to a health-care worker talk about how she was able to schedule her sister in sooner because of a personal connection. Just the other day, a classmate told us a radiologist he did research with was able to help his mom get imaging sooner for a breast lump. I more than anyone understand the desire to give our loved one the best care possible. It’s what I desperately wanted for my mom. Yet I can’t help thinking, when my mom was waiting for a procedure, did another patient with some inner connection to the system jump the queue? Even if these favors were done outside normal working hours and didn’t push her back, they still represent privileged access my mom didn’t have. If she had such access, would that have made a difference? Would I still have a mother?

“How would I draw the line between preferential access and professional courtesy? Or are they one of the same?”

As I advance in my training through medical school and then residency, I will no doubt encounter many brilliant colleagues and mentors on the way. If I’m ever approached by a colleague to urgently see them or their spouse or their friend for a problem, what would I do? How would I draw the line between preferential access and professional courtesy? Or are they one of the same? On the other hand, if one day someone close to me was in need of medical care, would I also approach a colleague for a favor? Would I try to provide them with privileged access to the system my mom didn’t have?

One of the four pillars of medical ethics is justice. Yet what exactly are the rules of equality and equity? When it comes down to it, I don’t have an answer. ■

# A reflective letter from a first-year medical student to his future self

Anish Naidu

Western University, Class of 2019

**H**EY DOC,

I am sure that you have become an accomplished doctor by now. But, between the lack of sleep and the mountain of paperwork, even you probably occasionally need a refresher on what being a great doctor is really all about. Do you remember the drive you had that made you work hard through all of your high school, undergraduate and graduate training, and eventually got you into medical school? You should strive to maintain that drive for the rest of your life, and I know that you can do it.

When you were a first-year medical student, you had a willingness to learn about anything and everything that you came across. Your thirst for knowledge drove you to talk to new people, attend talks, and follow the latest trends in science and technology. I hope that you still endeavour to keep up-to-date, because it is crucial to provide the best care to your patients. You have been given a strong foundation in both the technical knowledge and the soft skills required to be a good doctor, and you have to keep building up on both grounds, never sacrificing one for the other.

Your goal has always been to help people, but helping people does not mean simply fixing a sick person and moving to the next. Your patients are human beings who want a human to interact with. You should always be empathetic

towards your patients and their family, because only that enables you to understand their pain and to comfort them. I understand that the frequent exposure to pain and death can result in compassion fatigue, but it is extremely important that you remain empathetic; so take a break and relax if you have to, but never be callous towards a patient. Never rush your patients to make difficult decisions, instead guide them through the process and they will always be thankful to you for that. Remember that there are various social determinants that can impact the life choices and health of your patient, so you are in no position to judge your patient without living the life that your patient has.

When interacting with your colleagues, always maintain your utmost respect for them. Their expertise is indispensable to you. Without their help, you can never provide the best care to your patient, which is your ultimate goal. So take the time to get to know them and earn their trust. Also keep in mind that you have a responsibility towards your profession and towards society. Advocacy and public education play a key role in fulfilling these responsibilities. Advocacy is how you can make yourself heard, it is how you can gain support, and it is how you can drive society towards positive change.

Lastly, do not ever forget to take care of yourself. A good work-life balance is

“You can help your patients and society get healthier in the long run only if you stay healthy yourself.”

crucial for you to stay mentally, physically and emotionally healthy, and to be productive for a long time. It is very important that you set aside time to spend with your friends and family, and to reset your burn-out meter. You will depend on them to carry you through the difficult times, so never forget about them. Make time for regular exercise, don't give up on sports, and even develop some new hobbies to entertain yourself. You can help your patients and society get healthier in the long run only if you stay healthy yourself.

I know that all this is a lot to ask for, but your role is to try to do the best you can. Don't get discouraged if things don't always go according to your plan. I believe in you; I believe that you will continue to be a great doctor!

Yours truly,  
Yourself ■

# Arthritis, or becoming a good Doctor

Fatemeh Ramazani  
Western Regional Representative  
University of Alberta, Class of 2018

“**M**R. N?”  
“Hello.”  
“My name is Dr. R and this is one of our medical students, Fatemeh. Would it be alright with you if she joins us today?”

“Sure, no problem.”

“Students, welcome back to anatomy lab. Today we will begin the musculoskeletal block with dissection of the knee joint. Before we begin, let’s brush up on our clinical knowledge of the knee.”

“So what brings you in today?”

“Well doctor...”

“Who can tell me the pathophysiology of a clinical diagnosis of arthritis?”

“My knee has been flaring up lately. It only takes 30 minutes of walking for it to get red and swollen. It’s better today but, trust me doctor, it’s bad. The last doc I saw told me it was “something-it is” but I couldn’t care less. I just want to know how I can make it stop.”

“Fatemeh.”

He pointed to a student in the back of the class, consumed by her friends’ conversation around her. Every head in the room turned to look towards the back. Radio silence.

“If I’m not interrupting your conversation, would you mind telling me the pathophysiology of a clinical diagnosis of arthritis?”

“Would you mind if Fatemeh takes a quick look at your knee?”

“Not at all.”

## Inspection:

Patient’s left knee is slightly swollen medially. No discolouration. Patient looks generally comfortable.

Student’s face is pale, and cheeks are flushed. She looks visibly uncomfortable.

## Palpation:

Patient’s knee temperature is symmetrical and normal. No fluid appreciated on palpation of the joint.

Student’s skin temperature is unusually warm. Palms are symmetrically sweaty.

## Range of motion:

Patient’s active and passive range of motion of the knee is normal and unremarkable.

Student’s knees are locked and rigid. Range of motion is noticeably limited.

## Neurologic:

Patient’s sensation and reflexes, along the lower extremity, are normal.

Student’s fight or flight mode is activated.

“What do you suspect is the diagnosis, Fatemeh?”

“Um...”

“I’m waiting for the answer, Ms. Ramazani.”

“Um...”

“Inflammation of the bursa?”

The instructor’s eyes widened as he began walking across the room, arms crossed. He passed the other students, frozen in their white coats, one by one.

“Tell me, Ms. Ramazani, what do we call inflammation of the tendons?”

“Tendonitis.”

The physician looked at her as she stood frozen, staring at the patient’s knee.

“Could it be a problem with the tendons?”

Tendonitis. Unlikely.

“And what do we call, say inflammation of the sinuses?”

“Sinusitis”

“Could it be a problem with the joint itself?”

“Student’s skin temperature is unusually warm. Palms are symmetrically sweaty.”

Arthritis. Unlikely.

“So, by that logic, what do we call inflammation of the bursa?”

He was now standing right in front of her in the classroom. No longer angry, but amused.

She averted eye contact.

“Bursitis.”

“Could it be a problem with the bursa?”

Bursitis. Bingo.

“So class, let’s all enlighten your colleague. What do we call inflammation of the joint?”

The usually disjointed class suddenly came together in perfect harmony:

Arthritis. Bingo.

“Yeah, yeah, bursitis! That’s what the other doctors told me as well. Way to go kid!”

My preceptor looked at me, visibly content. We closed the encounter and headed towards the door of the examination room. As I was about the step out, I felt a hand on my shoulder.

“Be a good doctor kid, we need more of those.”

My preceptor looked back from the doorway.

“She will be.” ■

# Miracles

Shannon Chun  
Queen's University, Class of 2017

**B**ELEAVE MEDICAL SCHOOL curricula attempt to prepare students for when they finally encounter death, but it is an impossibly endless subject to broach. Witnessing one fellow human spirit gradually flicker out is simultaneously harrowing and yet an enormous privilege. But how do we teach students to cope when the experience is so intensely personal and unique? Oftentimes it delves into the realm of spirituality and religion; domains that are largely avoided in the classroom for their polarizing nature.

He was a 78-year-old gentleman, collapsed in his hospital bed with a protruding abdomen. His soft blue eyes were glazed with a look that was difficult to differentiate between dementia and delirium. His heavy breathing was distinctly audible despite the crowded room, and his complexion was as pallid as the hospital sheet he now clutched in his hand. A circle of family members framed his bedside, dabbing their swollen, red eyes or holding onto the guardrail to stop their own tremors of grief.

His frail habitus belied a steadfast resolve that was either hopeful or deluded. He had been informed that his cancer had recently progressed, and his body would certainly not withstand the onslaught of additional therapy. Beautiful and stirring words were shared by the son as he rushed to his ailing father's side,

weeping openly. Warm embraces were held, and tearful kisses were exchanged. And yet, this gentleman's blank expression suggested that perhaps he did not quite comprehend the solemnity of the occasion. His wife had described him as "hopelessly hopeful", never willing to admit any pain or discomfort despite whatever injurious agent his body was battling.

The physician awaited his turn and advanced towards the patient. He clearly and carefully explained the most recent blood work that indicated his liver and kidneys were slowly but surely failing. Apologetically, he concluded by saying that he simply had no more "tools in his toolbox" for this man. As I looked expectantly onward, I could have sworn an expression of clarity dawned on his weathered face, as if he was registering what was being said to him at long last.

After a momentary pause, he turned his head upwards, looking directly at the doctor. With a quick wink he said, "Well, if you think of anything, let me know!" Although we all chuckled fondly at his statement, I strangely felt exasperated. Did we get to him? Does he know his time is now? As medical students, we are instructed of the importance of effective communication. Does this not entail the responsibility to inform our patients of the severity and gravity of their illness? I nearly felt it was my duty to ensure that

"Perhaps the ones that can educate us most about death are our patients."

this man not go blithely unaware of his impending death. He needed to tidy up his things, he needed to say his farewells, he needed to know! And so, his delusion, his hopefulness – whatever you call it – frustrated me.

As I was lost in my thoughts, he calmly and lucidly spoke these final words: "For I am a man of faith, and I believe in miracles". I was dumbstruck. This almost childlike statement resonated so deeply within me. Instantaneously my feelings of irritation dissipated, and I found myself immensely humbled by this man's outlook. Perhaps the ones that can educate us most about death are our patients. How often do we self-importantly rely on our imaging modalities and serum levels and calculations? In the rigid, categorical, and definitive lines drawn in medicine, is there any room for miracles?

At the brink of life, staring death in the face, this man certainly seemed to think so. ■



# Code Blue... Room 1501A...

Yousif Atwan

Ontario Regional Representative  
Western University, Class of 2017

I WAS SITTING IN AFTERNOON Clinical Teaching Unit (CTU) rounds when that announcement took over the PA system. Usually, it's either a silly jingle or a code in the emergency department. Never was it something pertinent to our team. This time, it was different. Did she just say 1501A? That's one of our patients.

We looked at one another with stunned gazes. Our attending calmly let a senior resident run upstairs to run the code while we continue reviewing. For those twenty minutes, my mind was elsewhere. When I finally did leave the room, the code squad was conducting CPR on a lifeless body. As I looked around, my senior resident yelled out to me, "Jump in there for compressions!" About ten people in the room were looking my way – I couldn't look like an idiot. I couldn't show them that I've never been involved in a code before.

Without pausing, I took over for the fatigued nurse. I knew all eyes were on me. I kept my head down and pushed harder. I turned red, I began to sweat. My stethoscope fell off my shoulder. I take a look at the monitor... No rhythm. I finally turn right and look at the patient's neck... I see something flickering. My senior checks for a femoral pulse and doesn't respond. I stop compressions and reach for the carotid. Am I sure that's a pulse? What if this is something normal?

"I feel a pulse at the carotid!" I yell. My resident confirms and soon enough, a nurse confirms a femoral pulse. We stop compressions.

The nursing staff takes over care of the patient while I step aside to the back of the room. I couldn't believe what had just happened. My very first code... I didn't expect to be thrown in there... I wasn't efficient at compressions... Yet the patient regained a pulse during that time period. He's still not responding neurologically, but we regained a pulse. Feelings of fear, anguish and excitement left me stunned.

I had looked after this patient on occasions over the past couple of weeks. We were managing a mild medical condition and the patient seemed ready to go home in a couple of days. Never did I think this patient would end up in such a situation. And now, I may have been part of saving that patient's life. I was left stunned – no words can describe.

After leaving the room, my attending joins us and lets us know that ICU will be coming by to transfer the patient for better care. He then looks at me and tells me to go home. I wanted to stay and follow up on this patient's care, but he insisted that I've done my part and that it's best for me to go and rest. He was genuinely looking after me. I reluctantly went back to our meeting room to gather my belongings.

"A rollercoaster ride would be a severe understatement to describe the sequence of events"

I had so many thoughts rush through my head with no time to appreciate any of them. I was so glad that my resident trusted me enough to jump in and help. I was ashamed that I wasn't initially performing sufficient compressions. Yet I was proud of regaining a pulse for my patient. A rollercoaster ride would be a severe understatement to describe the sequence of events. The thrill of the situation made me love medicine more than ever. It reminded me how sacred life is and why we all do what we do in the field of medicine.

I packed and headed to the elevator. I reached the first floor and began heading to the back exit.

"Code Blue... Room 1501A..." was overheard again.

And that was how I left on the last day of my internal medicine rotation. ■

# Medical professionalism matters to me

Bryce Durafourt  
CFMS Past President 2014-2015  
McGill University, Class of 2015

**F**OUR YEARS AGO, I HAD JUST embarked on my journey to becoming a physician. As a medical student at McGill University, I was guided in the transition from layperson to physician in part through participation in McGill's longitudinal physicianship and physician apprenticeship courses. These courses explored the roles of the physician as a healer and a professional. We learned about the importance of understanding the patient's perspective and to differentiate a disease process from the illness and its impact on the patient's life. At monthly meetings we informally discussed issues such as medical aid in dying and challenging situations we encountered during our clinical rotations.

My learning about medical professionalism went beyond this curriculum. As president of the Canadian Federation of Medical Students (CFMS) for 2014-2015, I had the opportunity to represent more than 8,000 Canadian medical students. Through my interaction with CFMS members, I witnessed the dedication of many passionate future physicians who are helping to define professionalism. One consistent area of concern was physician mental health and work-life balance. CFMS members often highlighted the need for us to do more to end the stigma around mental illness, be it among physicians or the general public. Medical professionalism to the next generation of physicians means recognizing that physicians cannot work in isolation to improve the health of our patients. Rather, we must identify the social determinants of health and be champions of public policy



that often will have a greater impact on health than any medication. Climate change matters to my peers, and the choices we make as a society will influence the health of future generations. The CFMS advocated for a comprehensive national Pharmacare strategy, recognizing that our interventions can be futile if a patient cannot afford to pay for his or her medication. We supported improved access to care in rural and remote areas of Canada and recognized the need to do more for our Aboriginal patients.

As I started my residency training in Neurology at Queen's University earlier this year, my sense of responsibility was at first overwhelming. Patients expect their physicians to be knowledgeable, courteous, punctual and understanding. We must thoroughly care for each patient while exercising good resource stewardship. I saw the importance of good communication with patients, other physicians and our allied health partners.

I was impressed with some of the technologies available but frustrated with the lack of progress in other areas. I saw the challenges of maintaining patient privacy and confidentiality while recognizing that problems can arise when patient information is not transferred seamlessly between institutions.

The meaning of medical professionalism is rapidly evolving. As physicians, we must earn the trust of the public rather than take it for granted. Being a medical professional means more than investigating, diagnosing or treating – it means living up to our end of the social contract we implicitly agree to when we become a physician. ■

*A version of this blog post, written by CFMS Past-President Dr. Bryce Durafourt, appeared on the [cma.ca/gooddoctors](http://cma.ca/gooddoctors) website as part of the CMA's Medical Professionalism #GoodDoctors campaign.*

## Book review: *How We Do Harm*

Anthony Maher  
Atlantic Regional Representative  
Memorial University, Class of 2018

**H**OW WE DO HARM ENCOURAGES questioning. Written by an astute American oncologist, Dr. Otis Brawley, this 2012 book prompts health care consumers and providers alike to question their assumptions about the nature of the United States health care system: how it works, for whom it works, and who it leaves behind. It delivers an unapologetic appraisal of the influence of “medical politics, self-interest, and self-delusion” in health care.

In many passages, Dr. Brawley’s writing has poetic overtones. Describing the process of trying to save the life of a critically ill man, he views himself as “orchestrating a macabre dance.” He masterfully shows the tangible impacts of abstract concepts. Thus in the case of his patient Edna Briggs, he observes that the concept of “health disparities” acquired the very real smell of a rotting breast.

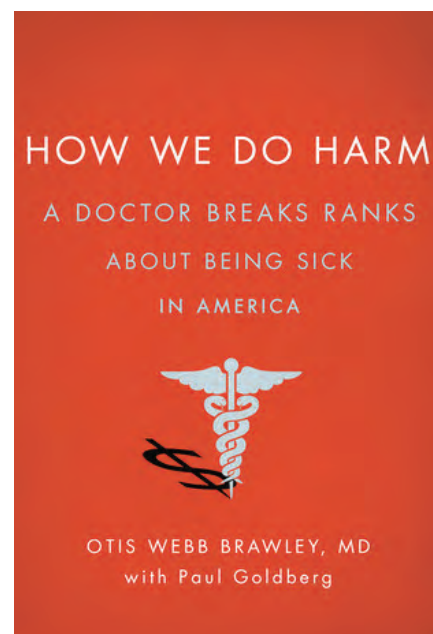
Dr. Brawley uses sales analogies to describe the actions of many of his colleagues. He writes, for instance, that “[if you have more money, doctors sell you more of what they sell, and they just might kill you.” I found this unfiltered approach to the role of profit in medicine to be refreshing. If these kinds of motives exist to the extent that the author claims, it is incumbent upon the profession itself to step forward and spark a wider discussion about the potential impacts.

Another issue on which this book is insightful is the issue of death and dying. Reflecting on his patient Debbie’s decision to pursue aggressive cancer treatment despite his recommendations to the contrary, he asks: “Where does Debbie get the idea that more is better and that some treatment – any treatment, even toxic treatment – is safer than nothing?”

Elsewhere he labels this approach “death by the cure.” Death, he writes, is a “basic part of our humanity”, and yet we often shy away from accepting its inevitability and choose instead to demand treatment. These observations prompt the reader to trace the limits of medicine and confront the interplay between cure and mortality.

My main critique pertains to the author’s understanding of scientific evidence. Dr. Brawley does not engage with the question of how “science” differs from “non-science.” He seems to imply that simply educating the general public about the merits of the scientific method will result in better outcomes. But there are many competing narratives about how to behave in society and how to respond when things go wrong. As seen in recent debates surrounding Aboriginal midwifery, for instance, many indigenous peoples have begun to contest the position of Western science and promote the benefits of indigenous knowledge. How would Dr. Brawley respond to the suggestion that differing ways of knowing might not be hierarchically ordered? How would he approach the idea that Western scientific knowledge co-exists with other forms, such as indigenous knowledge? The book does not provide an answer to these questions.

Finally, it is noteworthy that the author draws comparisons with Canada at several points throughout the book. He cites evidence that Canada spends half of what the United States spends per capita on health care and that an American patient could save 60 per cent on branded drugs simply by travelling to Canada. There are undoubtedly many positive aspects to Canada’s health care system and Dr. Brawley is wise to invoke some



of them in order to convince American readers that an alternative system is indeed possible. But Canada’s system also has flaws of its own. In particular, I would have appreciated more discussion of the health care challenges that cross the Canada-United States border, such as those associated with an aging population.

In conclusion, *How We Do Harm* offers a thought-provoking plea for transformation in health care. It is grounded in real-life experiences and delivered in a way that evokes the powerlessness felt by far too many Americans when interacting with their health care system. For these reasons, I would recommend this book to a wide audience. While the Obama administration in the United States has introduced important reforms since this book’s publication, its overarching messages – on death, humanity, and profit – remain widely relevant. ■

# Accepting the error of my ways

Emily Hodgson  
Québec Regional Representative  
McGill University, Class of 2018

**A**S A LONG-TIME PERFECTIONIST, being faced with my own shortcomings, however big or small, has always made me very uncomfortable. I have often attempted to forget experiences of failure as quickly as possible and, in many cases, I have forgotten too quickly to learn from the initial mistakes.

When it comes to human error, medicine is not a very forgiving field. The shortcomings of physicians can profoundly affect the lives of patients. Thus, our profession is held to very high standards. Despite what some might believe, physicians are not above the errors that are inherent to the human experience. I was well aware of this when I embarked on my medical school journey, but a recent read has highlighted the importance of recognizing and accepting my errors in this field.

*Monday Mornings* is a novel by American neurosurgeon and CNN chief

medical correspondent Sanjay Gupta. The book describes the experiences of five surgeons at the Chelsea General Hospital, where M&M (morbidity and mortality) meetings are known to be particularly harsh. These are scheduled on Monday mornings, giving the book its title. Each of the main characters is faced with their own shortcomings at one moment or another and there are great contrasts in their reactions. Some are profoundly affected by the consequences of their mistakes, while others accept their limitations more readily. Although the accusatory format of the hospital's meetings is at times quite brutal, it assures that no surgeon can hide from their mistakes and each is forced to come to terms with the consequences of their errors.

Apart from being a very enjoyable read, this book marked me as it served as a clear reminder to embrace and accept one's failures rather than attempting to ignore them. As physicians-in-training,

we will be making a great number of mistakes. Understanding our shortcomings is an important part of learning and growing in our profession.

Perhaps medical students have the advantage of making a large number of small mistakes while we grow into full-fledged physicians; it may be easier for us to learn to accept failure since it is a more familiar concept. What this novel has highlighted, however is the ease with which we can forget this ability once we are fully qualified. When mistakes are no longer common in the workplace, it is easier to see oneself as being "above them" or "past them." One of the many lessons I hope to retain from medical school is that no matter how many degrees I might possess, I will always be fallible. Embracing my shortcomings, however uncomfortable it may be, is an essential part of moving forward and putting the patient's well-being first. ■

## A manifesto to a future MD

Kaylynn Purdy  
Northern Ontario School of Medicine, Class of 2018

1. Remember what it feels like to be a patient.
2. Do what is right and in the best interest of your patients, even if it means going against the grain.
3. Medicine is filled with brilliant people with all sorts of incredible life experiences. Never let your accomplishments cloud your pursuit for selflessness.
4. Remember who and what got you here.
5. Draw. Write. Create.
6. Centre yourself in the present moment.
7. Acknowledge your pain and use it to better the lives of the people around you.
8. Make personal connections with patients; take the time to ask non-medical questions.
9. Run towards hard things and hard problems, not away from them.
10. Even when you are exhausted, remember that the simple act of waking up each day is beautiful. ■

# Going upstream: the switch to public health

Jordyn Lerner

University of Manitoba, Class of 2016

IT'S HARD TO CHANGE FROM one clerkship rotation to the next. Just when you get comfortable being an internist, you're suddenly dealing with a different group of diseases as a surgeon. The most difficult switch for me was when I finished my core clerkship rotations, and started electives in public health and preventive medicine.

The upstream mentality and office-based skills or public and health and preventive medicine were different than those in any other rotation. A few days into the rotation, I realized that medical school did not prepare me for public and health and preventive medicine.

Medical school largely caters to the future clinician cohort. After all, half of the class will pursue further training as generalist clinicians in their family medicine residencies, while the other half will be clinicians in Royal College specialties. Preclerkship goes organ system by organ system, detailing the pathophysiology of disease. Clerkship focuses on clinical skills like history, physical, and differential diagnosis.

It's not that the clinical content in medical school is irrelevant to a practice in public health and preventive medicine. Quite the contrary, actually. While auscultation techniques don't come into play when assessing the health of a population, an understanding of disease process is necessary when working on health promotion and disease prevention strategies. As well, some public health and preventive medicine physicians run clinics in areas like sexual health, and communicable diseases.

Technically, medical school taught about public health and preventive medicine. Accreditation standards demand its inclusion in undergraduate programs. Specifically, they require the curriculum to include preventive care, determinants of health, health promotion, illness prevention, and the impact of socioeconomic factors.

Medical school taught several public health and preventive medicine competencies. It covered biostatistics, literature appraisal, and the social determinants of health, among other topics. Medical school gave me all the public health and preventive medicine skills and knowledge that an undergraduate student would be reasonably expected to have. The problem is that when they taught these things, I didn't care to learn.

The hidden curriculum tells medical students that preventive care is not as important as acute and chronic care. Sessions on cultural competency are seen as fluff that distract from "real" medical subjects like pharmacology. Preceptors write letters of reference based on clinical acumen, not on understanding of the Ottawa Charter for Health Promotion. Even as a student interested in public health and preventive medicine, it was hard to care when I knew that the NBMEs would focus on mechanisms of disease more than upstream prevention.

It's no secret that public health and preventive medicine education is a challenge. In 2009, the Association of Faculties of Medicine of Canada (AFMC) commissioned an environmental scan of undergraduate public health and

“The hidden curriculum tells medical students that preventive care is not as important as acute and chronic care.”

preventive medicine education. Some course directors reported negative feedback from students along the lines that public health and preventive medicine had little content, and was too “touchy feely.” One course director said that students hate anything that they do not see as clinically relevant.

While public health and preventive medicine education has its challenges, things are improving. The AFMC's environmental scan identified best practices public health education. The members of the Public Health Educators' Network are doing incredible work, including developing free open-access resources like the AFMC Primer on Population Health.

I don't know how to change the hidden curriculum and make students care about public health and preventive medicine. But if public health and preventive medicine has taught me one thing, the answer is probably upstream. ■

# Medical minority

William Caron

McMaster University, Class of 2016

**F**EELING LIKE AN OUTSIDER IS never a pleasant experience. For some people and groups, exclusion is a part of everyday life. Being of a certain race, class, or gender (among others) gives us strength in identity, but also assigns us to a position in the social hierarchy. As a white man, I'm privileged to not belong to a "visible minority".

However, I am a member of a non-visible minority – I self-identify as a gay male. I am also a member of one of the most respected professions in the world.

This juxtaposition sometimes hits me when I think about the future. Will I be respected for my profession? Or will I be stigmatized and discriminated against by patients and colleagues alike for my minority status? As a member of a "non-visible" minority, I can choose to hide my status if I feel like doing so. For many others in my profession, this is not an option. Racism and sexism continue to persist in my workplace. While we educate our students on these issues in a patient-specific context, we are not always provided with information on discrimination that occurs intra-professionally.

While I have not felt discriminated against thus far in my medical career, I can't help but wonder if this is due to the fact that I am a private person. What microaggressions would I encounter if every one of my colleagues were cognizant

of my minority status? This thought often makes me hesitant to reveal my sexual orientation to my peers.

I'm proud of who I am, and I am proud of all of my accomplishments. However, this pride doesn't stop me from fearing how I will be treated if I revealed an aspect of myself that people might irrationally hate. Where does this fear come from? The answer is historical context. Past leaders in medicine and other respected professions were often heterosexual and homophobic men who actively discriminated against those who identify as LGBTQ+. Stories about older physicians who were shunned by their colleagues once their sexual orientation was made public are not uncommon.

In the medical profession today, overt discrimination has been replaced by microaggression. Colleagues who remark "I never would have guessed!" when someone discloses their sexual orientation, and preceptors who ask invasive questions about a transgendered student's surgical status, are both examples of microaggressions that discourage LGBTQ+ physicians and students from being open about their sexual orientation or gender identity.

Discrimination and microaggression in the workplace are problems without an immediate solution – people are resistant to change by nature, and even those who insist that they are open-minded may still

**“ In the medical profession today, overt discrimination has been replaced by microaggression.”**

perpetuate a hostile environment.

I'm fortunate that I've landed in an environment where I am accepted and loved for who I am, regardless of my sexual orientation. This isn't the case for many medical students and physicians around the world. These people entered medicine to help their fellow human being, only to find themselves mentally (and sometimes physically) abused by their colleagues.

We, as physicians, need to recognize our prejudices so that we can ensure a safe and supportive work environment for all of our colleagues.

"First do no harm" – it applies not only to our patients, but to our colleagues as well. ■

*Previously published on the CMAJ Student Humanities Blog.*

# Words create worlds: implications of the Medicine-Psychiatry divide

Emily Macphail

Western Regional Representative  
University of Calgary, Class of 2017

**A**LTHOUGH THE SITUATION is improving, a significant amount of stigma still exists around mental illness, and by extension around psychiatry – as it relates to psychiatric disorders, treatment, and to the profession as a whole. Unfortunately, despite the fact that we now have extensive evidence that psychiatric illness is as biologically-based as any other condition, this stigma is reinforced rather than reduced by the categorical divisions physicians impose on healthcare: medical, surgical, and, psychiatric. This compartmentalized thinking has negative effects on our patients, not just in their interpretation of our words, but also via indirect effects on the care that they receive.

As physicians, we aren't always aware of how our language will affect our patients. However inadvertent miscommunication may be though, that doesn't make it benign, as one patient I saw in a family medicine clinic illustrated. She had recently been inpatient at an eating disorder program whose allocated beds were on an acute medical unit, and she shared with me one of her experiences there.

Admitted one month prior with a BMI below 14, a heart rate of 42, and at risk of refeeding syndrome, she was still dealing with significant orthostatic hypotension and on telemetry at the time. Psychiatric diagnosis aside, she was as physically ill as many others on that unit. But when making small talk with a hospitalist one morning, she inquired how many patients the physician was seeing on the unit, and received a somewhat jarring response: "Well, I have you guys, and then I have four of the sick patients."

Taken aback, this young woman repeated, "Sick patients?", to which she received clarification.

"Sorry, I meant the medical patients."

As in many psychiatric conditions, patients with eating disorders are often reluctant to seek treatment. While this can be due to the anxiety or fear around what it inevitably entails, it is also due in large part to the fact that many eating disorder sufferers do not feel they are "sick enough" nor believe their illness is severe enough to deserve treatment.

As the patient relayed to me, the wording of her condition as "non-medical" created turmoil for her. "I had struggled every second of that admission to believe that I should be there and that I was a) actually sick, and b) worth the resources being spent on me. In that moment, the hospitalist confirmed what I knew deep down – that I wasn't ill, that this was all stupid, and that I was wasting everyone's time and money. Had I not been under threat of involuntary admission if I didn't agree to stay, I would have left treatment immediately."

This is only one instance of the division of "psychiatry" from "medicine", but the negative implications are far from uncommon, and emphasize how "doing no harm" extends further than ensuring we aren't physically injuring people. Beyond the language used with patients, the separation of psychiatry from pure "medicine" has further lasting effects on patient care. It tacitly limits psychiatrists' scope of practice, encouraging the idea that psychiatry is responsible for an abbreviated understanding of the human body: neck up only. Conversely,

"[...] A separation between "medicine" and "psychiatry" in our language and views creates one in reality"

it suggests that "medical" specialties need pay little to no attention to the mind. It helps to create an atmosphere where mainstays of medical assessment and care, such as the physical exam, are handled with caution, because, seen as non-essential in a "non-medical", "hands off" specialty, they begin to approach the realm of being seen as potentially inappropriate. Subsequently, patients' legitimate physical symptoms may be ignored and recommended monitoring may not be done.

The way we see things, the way we categorize things, the distinctions we hold, and the words that we use all act to create our reality. Not only do our words form our sentences – they also structure the world that we and our patients inhabit. Subsequently, a separation between "medicine" and "psychiatry" in our language and views creates one in reality. Unfortunately, this separation is a dangerous divide, and we must be careful that patients not be lost and harmed by falling down the gap that it creates. ■

# Ontario's health care cutbacks are affecting medical students

Andrew Micieli

University of Ottawa, Class of 2016

Robert Micieli

University of Toronto, Class of 2019

**A** “PERFECT STORM” IS AN expression that is often used when a combination of many events – no one of which alone is particularly devastating – creates an overwhelming force.

Two rounds of unilateral fee cuts, with the most recent on October 1st, 2015, saw Ontario physician fees cut by 1.3 percent. Physicians are leaving the province, clinics have been forced to close down and patients are suffering. A perfect storm.

What is often lost or forgotten is how medical students are affected and what role they may play in these discussions. The physicians of this province need our support and the Ontario government and Eric Hoskins, the current Minister of Health and Long-Term Care, and need to realize how these cuts will affect the next generation of doctors.

Will this be the last time unilateral cuts occur? Inevitably, utilization of our health care will increase each year, and even with the current cuts, cost will still be a major issue for the government. In the race to balance the expense of caring for an aging population with the relentless focus on a budget, physicians are too easy a target.

These cuts may deter medical students from choosing specialties such as family medicine, or at least may push them to complete their residencies elsewhere. A recent online survey was conducted in Ontario which asked residents in family medicine where they were planning on practicing given these recent cuts. Prior to the cuts 89 percent anticipated setting up

practice in Ontario, compared to 33 percent after the cuts. Ontario should expect to lose a significant number of newly trained physicians in the coming years.

If physicians are so well paid how is it that such a small cut in fees is resulting in clinic closures across the province? What is hidden in the discussion of physician incomes is the amount of debt Ontario medical students graduate with that must be paid off and, more importantly, the hushed-up reality of mental illness among medical students. Medical students are at significantly higher risk for burnout, depression and mental illness compared to the general population.

These cutbacks are affecting vulnerable patients. For example, the new Humber hospital in Toronto has cut down cystoscopies to 12 per day rather than the 40 they were completing at the old site. Patients are now waiting 4 months for a cystoscopy for fairly urgent reasons and are being forced to make multiple trips to the emergency department while waiting. Lobbying by urologists has been unsuccessful. This is just one example of many.

To counter, medical students, residents and physicians have taken to social media to campaign using hashtags on Twitter such as #CareNotCuts, #OnCall4ON and #CodeBlue to raise public awareness. Unfortunately, there has been very little success – it would appear the public cannot be swayed.

How can medical students calm the perfect storm?

“What is often lost or forgotten is how medical students are affected and what role they may play in these discussions.”

We need to emphasize to the public how the quality of care will decrease, wait times will increase to see a family physician/specialist or to have surgery, there will be less doctors practicing in Ontario, and certain – formerly essential – services will no longer be available. Too often the emphasis on social media has been on highlighting hard work and decreased income. This has proven to have little effect, and so it is necessary to try a different approach.

Hopefully in the near future we can be a part of a system where the Ontario Medical Association and the government work together to ensure that there is a health system in place that provides quality care for the patients and fairness to physicians; that is, of course, if we still decide to practice within Ontario. ■



# Inspired by student leadership

Henry Annan

Dalhousie University, Class of 2018

IT IS NOT COMMONPLACE TO find an organization that is led by a team of highly qualified, highly dedicated individuals. Yet, here I was at the 2015 CFMS Spring General Meeting, surrounded by so many of such medical students. Networking with and speaking to the numerous attendees, each proudly representing their respective medical schools, was nothing short of inspirational. By participating in spirited debates and discussion, I began to realize just how much influence we as Canadian medical students can have on the national stage.

At a leadership session organized by the Canadian Medical Association, President-Elect Dr. Cindy Forbes, while

offering advice on honing leadership skills among medical students, stated, “One of the greatest steps you can take in leadership is just showing up.” I can confidently say that “showing up” to the 2015 SGM was indeed one of the greatest steps in honing my own leadership skills. I know that experiences like the ones I had during my weekend in Vancouver will prove invaluable as I aspire to be not just a great physician, but a great physician leader as well.

As the saying goes, “a candle loses nothing by lighting another candle.” What excited me the most is the fact that the stories I shared with my classmates upon my return to Halifax, have

encouraged more students at my university to become more interested in the CFMS and seek out more opportunities to get involved with the organization. I believe that the strength of the CFMS is rooted in membership participation. I hope that student involvement with the CFMS will continue to grow and that positive stories like the ones I have shared will inspire more students nationwide to join the organization in its endeavours. I am truly grateful for receiving the CFMS Travel Award and look forward to helping this great organization continue to expand its reach. ■



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**medical\_affairs@bluewaterhealth.ca** 519-464-4400 ext. 4534

## Furthering student leadership

Venus Valbuena

University of Toronto, Class of 2017

**T**HIS PAST APRIL, I WAS HONoured to be one of the Travel Award recipients at this year's Canadian Federation of Medical Students' Spring General Meeting. It was an incredible opportunity to visit the beautiful city of Vancouver and meet equally involved and passionate medical students from across the country.

My current involvements with wellness and student government on a provincial level made a lot of the workshop – and personal – discussions relevant to the work I have been doing in the past year. I helped co-chair a Wellness Retreat for medical students across Ontario and it was exhilarating talking to other interested students about the planning, execution and impact of this event and other wellness activities that are going on at my own school,

University of Toronto. Medical student wellness is not where it should be yet but knowing that it is progressively gaining attention on the national level gives me great hope that the future landscape of medical school will be more positive for future cohorts of medical students.

Among the many events that I enjoyed that weekend, my favourite had to be the conflict management workshop hosted by the Canadian Medical Association. We had a married duo from Toronto engage us in a conversation about very pertinent topics in medicine – conflict management and negotiation in the workplace. They gave us necessary tools and guidelines for how to approach difficult conversations, which are skills that are absolutely necessary for our field of work. As medical students, our mindset can become

insular since we are often surrounded by medically-minded people; in that sense, it was refreshing this kind of education from a lawyer and professor of business.

Other highlights of the weekend included the resolutions meeting, presidential elections, and of course, exploring Vancouver! I was inspired during the resolutions meeting by all the advocacy work being done by medical students across the province – all these individuals were so passionate about their causes and it truly reflected in the quality of their position papers. I just wanted to end off by paying my sincerest thanks to the CFMS and organizers of this event for the opportunity to travel and network with medical students and the Deans of our school. I had a great time and I hope to join you again in the future! ■

## Not “just” medical students

Madalena Dearden

University of Alberta, Class of 2017

**T**HIS YEAR I WAS FORTUNATE to be a recipient of one of the Canadian Federation of Medical Students' (CFMS) travel grants to attend the Annual General Meeting (AGM), which took place September 18 to 20 in Windsor, Ontario. I understood the CFMS to be an organization representing the concerns and interests of medical students across Canada, and I wanted to attend the AGM to network with other medical students and learn about their involvement in public health initiatives such as advocating for indigenous health as well as tackling health promotion in a broad sense. The issues discussed at this year's AGM were, as it turned out, very well aligned with my interests in public health. I learned just how extensive CFMS

advocacy efforts have been and how capable this organization is in this regard, doubtless owing to the fact that the CFMS has an intelligent, passionate, and compassionate team of devoted students who ensure continuity of established successful programs and who heedlessly seek new opportunities to enhance the Canadian medical education experience.

I believe that many Canadian medical students who are members of the CFMS have a relationship with it that starts with paying their member dues, putters along with occasional awareness of some of the opportunities the CFMS provides – maybe a global health exchange in clerkship or access to an online resource in clerkship – and ends without even realizing the spirit the CFMS embodies. Yes, while

it is a great source for accessing tangible benefits, it is also a fountainhead of novel ideas, alternative perspectives, and gumption, promoting progressive cultural shifts that require years of advocating, networking, and believing that even we, as “just” medical students, have the capacity to be key players in effecting positive change on a societal level. The ignition of these sentiments, despite a culture of cynicism that often brews when discussing real political change, is, in my opinion, a rarity and something worth nurturing. ■

*“Scratch any cynic and you will find a disappointed idealist.”*

*- George Carlin*

# Less medicine, more care: how Choosing Wisely Canada started the conversation with students

Nina Nguyen

*Annual Review* Editor

Université de Sherbrooke, Class of 2016



**D**R. WENDY LEVINSON RECEIVED HER MD DEGREE from McMaster University before pursuing her training in internal medicine at McGill University. Prior to her return to Toronto in 2001 as appointed faculty, she had a fulfilling career in the United States as faculty of various medical schools and as a renowned expert in patient-doctor communication. Aside from patient safety and quality, she researched and taught about related topics as well, such as disclosure of medical errors to patients and informed decision-making. Dr. Levinson was the female Chair of the Department of Medicine of the University of Toronto, a position that she occupied until 2014, the year she was appointed to the Order of Canada. Dr. Levinson currently serves as the Chair of Choosing Wisely Canada.



**D**R. KAREN BORN HOLDS A PHD IN HEALTH SERVICE Research from the University of Toronto and holds an MSc in International Health Policy from the London School of Economics. Her research work focuses on public engagement and education around the health care system, interest that she furthered by co-founding Healthy Debate, a blog providing unbiased information about a variety of topics in health care. She was recently appointed as an Assistant Professor at the Institute for Health Policy, Management and Evaluation, University of Toronto. Dr. Born currently serves as the Knowledge Translation Lead at Choosing Wisely Canada.

**C**HOOSING WISELY CANADA (CWC) is a grassroots, physician-led campaign targeting both clinicians and patients. Modeled after the Choosing Wisely campaign launched by the American Board of Internal Medicine (ABIM) Foundation in April 2012, CWC was officially launched in April 2014 in partnership with the Canadian Medical Association. The campaign, supported by all provincial and territorial medical associations, and partnered with many medical specialty societies aims to help clinicians and patients engage in conversations about unnecessary tests and treatments. Ever since its inception, CWC has been active in medical education and been active on national and medical media. In November 2015, CWC successfully launched a list of recommendations tailored to medical students in partnership with the Canadian Federation of Medical Students (CFMS) and the Fédération médicale étudiante du Québec (FMEQ): “Six Things Medical Students and Trainees Should Question (see article page 18).” This list was developed with input from nearly 2000 medical students from across Canada. Efforts to engage medical students in CWC are being sustained by the creation of Students and Trainees Advocating for Resource Stewardship (STARS), a campaign designed to raise awareness among medical trainees.

### **How does the CWC campaign differ from the American campaign that it was modelled after?**

Wendy Levinson (WL): At the time that the campaign was conceptualized by the American Board of Internal Medicine (ABIM) Foundation, I was the chair. That organization is dedicated to advancing professionalism in medicine: it was felt that the physicians were not fully taking responsibility for the stewardship of finite resources. That transcends any country borders, so it’s equally relevant in Canada. As I mentioned at the Family Medicine Forum 2015, the Choosing

Wisely campaign has spread across sixteen countries all over the world. What that tells you is that the campaign in its essence is about what it means to be a doctor and what the interactions between patients and doctors should be. That is actually universal. It is not surprising that a campaign might begin in the United States and still be highly relevant to Canada and other countries.

Now that said, it does differ in that in a number of ways. Number one: the societies in Canada have created their own lists, and most of those societies might have used one or two recommendations off the American list. The recommendations themselves are different in Canada, based on our reality. Secondly, we have the ability in Canada – that is not present in the US – to really work with the provinces in a population-based way. We have a less fragmented system: even if we have many challenges in our health care system, we do have the capability of working province-wide, measuring province-wide. For example, in Ontario, we can work with the Institute for Clinical Evaluative Sciences (ICES), and look at all preoperative tests done in the province. That is something that is much harder to do in the United States, except through the Medicare dataset, which is only for people 65 years old and older.

### **How differently does this campaign approach doctors and patients?**

WL: We have always believed, as conceptualized in the campaign, that its core mission is actually about engaging in conversations about unnecessary tests and treatments. We live in our North American society that believes that “more is better” and doctors and patients alike have the same underlying belief. We rarely have the conversation that, sometimes, more is not always better. Maybe more can sometimes be harmful? The goal of this campaign is to stimulate the conversation. The real change is the culture change, and it has to happen ultimately in the interactions between



doctors and patients, here decisions are made. You cannot have that unless you educate both sides of the exam table. We have to create information on both sides so we can stimulate the dialogue and have a different type of conversation. If patients come in thinking they need an MRI for their low back pain, that they need antibiotics for their child who has an ear ache, and that they think that good care requires a prescription or a test, then it will make it a difficult conversation for doctors to explain why that is not necessary.

Aside from patient expectations, there are other reasons why doctors over-order: fear of litigation, harder explanations to patients, lack of time to have that conversation... all leading to the thought “So why not just order it?” Conversations between specialists and family physicians often mention that some patients cannot access specialist care unless certain tests are ordered, even if not needed. Of course, there are also financial incentives. The most important factor is that we learn how to practice in medical school, and we keep those patterns of practice throughout our career. If we learn that we always order that test for a particular condition, we set a practice that way, and it stays with us.

Fear of litigation is one of the many reasons that physicians might order tests that are unnecessary. Specifically about that, we have talked to the CMPA (Canadian Medical Protective Association). They do not ever endorse campaigns, but they have been really supportive of us and actually feel that these recommendations will help protect doctors if they were ever sued, because they are basically saying that the standard of care is to not give certain tests or

treatments when they are not necessary. They are quite positive about the impact they could have, but to date, we are not aware of any case law, both in the United States and in Canada, that has brought Choosing Wisely into legal arguments.

### **Aside from applying their specialty-specific lists of recommendations, how can medical students get engaged in that conversation?**

Karen Born (KB): It is always exciting to engage students. To inspire our medical education work we looked for inspiration to large scale mobilization efforts to engage students and to change the culture of medicine and healthcare. We have seen this in quality and patient safety, which is now much more present in the medical education curriculum than it was ten years ago. There are still gaps in the curriculum across Canada right now around resource stewardship. Getting this into medical school curriculum by taking a top down approach is not what we wanted to do. We think it should be from the bottom up, where students themselves would be endorsing and working towards changing medical education and local culture on a large scale. We have seen change work from the bottom up. For example, at the University of Toronto, we have worked with a number of students over the years. For example, we had summer students from two years ago were responsible for identifying places in the curriculum at the University of Toronto where stewardship can be integrated. We saw from their initiative that students could increase awareness about the campaign amongst faculty and students.

There are so many ways that medical students can get involved at their local schools, for example by simply going to our website and looking at the list of recommendations, learning what is applicable to the rotation they are on during clerkship. They can also refer to the lists

specific for each specialty, download our mobile application. The essential component of this campaign is knowledge and awareness of the recommendations themselves. That is the first thing that they can do as individuals. They can also connect with local student leaders and contribute to their efforts. At each school, we now have two Students and Trainees Advocating for Resource Stewardship (STARS) students leading local CWC initiatives. We are in ongoing communication with these students who are leading local initiatives such as conferences, speaker talks, and quality improvement projects. Students can also use recommendations as starting points for their research projects.

WL: We find that a lot of students, medical students and residents, want to do some quality improvement research or a small study. A medicine resident at the University of Toronto noticed there were a lot of people who got urine cultures at the hospital, but the results were never used. He made that the focus of a very interesting study on how this test was overused and not relevant to the patient. There are often opportunities for students and faculty members at each of the schools to get involved in Choosing Wisely. So if a student wants to do a small project using something they observed in their own clinical work, here is another thing that they can do. There is a series in the Journal of the American Medical Association (JAMA), called “Teachable Moments”: if a student noticed, for example, noticed that some patients are getting worked up with a lot of X-rays in the emergency room that are potentially not needed, he or she can write it up. They need a faculty member to help them, but these “Teachable Moments” are about overuse. There is also a column in the Canadian Family Physician (CFP), called “Too Much Medicine,” which is a series about Choosing Wisely. Those are all ways medical students can get informed.

### **Are there any tips and tricks for medical students who might be working with preceptors who do not agree with the Choosing Wisely approach?**

KB: One of the reasons why the campaign has resonated so much with medical students and in medical education is that such a huge component of undergraduate medical education is supporting learning through questioning. And in many ways, we see that there are so many opportunities for students to really question the status quo. This was very much the basis of the development of our list of recommendations that really targets the culture and environment of medical education as well as the behavior of students in this environment. Rather than students feeling that they can't speak up, that they can't question the authority or the knowledge of preceptors, residents or other professionals they are working with, students should feel empowered to question as learners.

Students shouldn't feel that, by asking if it's necessary, are they challenging the authority, but that they're rather demonstrating their knowledge and engaging into a conversation that helps forward their own education. The list of recommendations really provides the platform for students to think about ways that they can question and engage with their peers, residents, faculty or patients, in addition to their formal learning. I think it really provides a positive platform for students to ask questions and to use these moments as learning opportunities, rather than be seen as challenging the authority or being disrespectful.

### **What are the next steps for CWC?**

WL: We are holding our first ever National Meeting on March 30th in Toronto and are expecting nearly 300 people to attend! The National Meeting will showcase the student work, as well as

examples of how groups around Canada are implementing the Choosing Wisely recommendations and making changes. At the meeting we plan to officially announce our “Ten Million Campaign” which aims to prevent ten million unnecessary tests and treatments by 2020. What we are going to ask our supporters to do, including individual practitioners and students, is to register with the campaign and to pick a target they want to work on. For example, maybe they want to work on decreasing the use of blood transfusions in the hospital that are not needed. Then, they would get a toolkit from us that would help them implement that change, and they would measure their baseline and report to us the change from it to contribute to the collective measurement of ten millions tests and treatment avoided.

Second, we will shortly launch our new patient education campaign called “More is not always better.” That will have a number of components. One is a brand-new website specifically for patients that has information divided into

women’s health, men’s health and kids’ health. To raise awareness about unnecessary care among patients we are working hard to provide family physicians with materials to post in their offices that help to foster conversations about unnecessary care. This includes posters for patients with questions that they can ask doctors. For example, “Do I really need this?”, “What are the options?”, “What are the downsides?” and “What happens if I do nothing?”. We provided a lot of material to family doctors because we feel that the best way to reach patients is in the family doctors’ offices. Then there is possible continued work with STARS. Those are the three next whole bodies of work.

**For closing words, how can medical students that are interested in initiatives like this develop their ability to educate patients and peers during their medical training?**

WL: Understanding the many drivers of unnecessary care is key, and so is learning about how to talk to patients.

It’s sometimes difficult when a patient comes in with expectations. How do you tell those parents that they don’t need antibiotics for her child’s ear ache? There are skills for that which comes with empathy. So you empathize, but then you need to bring up the correct information. Students work in all those clinical settings, and they should practice having these conversations. Or they ask their supervisors, “How would you best communicate with this patient?” when it’s relevant. I think it’s the lived experience of having these conversations with patients that will make students feel that they understand how important this work is. You learn practice patterns early in your training and you carry them with you, so these first few years in medicine are the most important ones. ■



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Phone. 780-757-7999 Fax. 780-757-7991 email us at [mdgroupclinic@gmail.com](mailto:mdgroupclinic@gmail.com)

Thank you for your interest, Dr. S Tomi.

# Renewing Canada's commitment to Medicare: an interview with Dr. Monika Dutt, Chair of Canadian Doctors for Medicare

Mark Maclean  
Co-Chair, CDM: Dalhousie Chapter  
Dalhousie University, Class of 2018



**D**R. MONIKA DUTT HAS BEEN THE CHAIR OF Canadian Doctors for Medicare (CDM) since June 2013 and has been on the Board since 2010. She is a family physician and public health and preventive medicine specialist. She holds an MPH and an MBA from Johns Hopkins University and is currently completing an MFA degree in creative writing at the University of British Columbia. She has previously worked in Northern Canada and inner city Toronto, as well as in India. She is currently the Medical Officer of Health for Cape Breton, Guysborough and Antigonish in Nova Scotia, and a family doctor in Wagmatcook First Nation. She is an adjunct professor at Cape Breton University and Dalhousie University, and is also on the board of several organizations, including the Cape Breton YMCA and the Broadbent Institute. She is interested in policy areas such as healthcare, income inequality, poverty, and climate change. She is the mother of a four-year-old and enjoys running, biking and swimming.

**How does CDM influence policy through work with doctors, governments, and others? Do you have any advice for medical students who wish to gain experience and knowledge on important Medicare related topics?**

CDM works with many groups, including healthcare allies and all levels of government, as well as with medical trainees and physician colleagues with the goal of maintaining and strengthening our single-payer healthcare system. We do this in many ways, such as through grand rounds and student sessions, and research, such as on ways to evaluate models of care. Our advocacy work can range from meetings with government decision-makers, to national campaigns, to collaboration with physicians at the local level.

Medical students are welcome to participate with CDM directly as we have many active student chapters across the country, as well as Student Board member positions. There are also research opportunities. Students can seek opportunities during their training to work with physicians who make connections between their daily work and improving the system they work in. They can participate in student organizations like the CFMS, and focus on Medicare-specific issues.

**Why should medical students take interest in the current state of Medicare? What does Medicare require from the next generation of physicians?**

As trainees and physicians, every action we take as we care for our patients is shaped by the state of Medicare. We see the good and the bad, the aspects that flow smoothly, and the aspects that frustrate patients and providers. We know what it is like to have a patient who can't afford to pay for their medications or is waiting longer than they should be for surgery. As we've seen through CDM, our voice as healthcare advocates is effective because of our lived experiences.

Healthcare is valuable to all of us, and thus there will always be debates

about the best way to design our system. Medicare requires the next generation of physicians to be actively involved in ensuring healthcare remains accessible to all based on need, not on the ability to pay for healthcare. It requires physicians to be proactive in advancing evidence-informed models of care, such as centralized referral systems for specialists, e-consultation methods or universal Pharmacare. It requires us to acknowledge that there are gaps in care and that we can be part of addressing them.

**Why is universal Pharmacare important?**

Universal Pharmacare is an unfinished piece of Medicare, a missing link in our current system. Pharmacare has long been a priority for CDM, and we have worked in partnership on this issue with many others, including the CFMS.

A recent open letter to Prime Minister Trudeau published in the Toronto Star, signed by over three hundred health professionals and academics, outlined why Pharmacare is essential. Currently, Canada is the only developed country with a universal healthcare system that does not provide universal coverage for medically necessary prescription drugs. This weakness harms our patients – one quarter of Canadians report that they or someone in their household has not been able to take their medications due to cost. Millions in Canada lack drug coverage or have inadequate coverage.

Additionally, Pharmacare would save money – anywhere from \$4 billion to \$11 billion. A recent survey showed it is also desired by the vast majority of people in Canada. Most importantly, Pharmacare would improve the lives of our patients.

**What factors influenced your decision to pursue family practice and work as a Medical Officer of health? Have you encountered unique challenges, or lessons, through your practice in Cape Breton, Nova Scotia?**

Combining family medicine and public health creates a diverse practice: as

a family doctor, I interact with patients at the individual level. As a public health doctor, I work to improve health at a community level, for example through initiatives related to climate change, housing and poverty.

Cape Breton is an island of approximately one hundred thousand people, with a mix of urban and rural settings, and several Mi'kmaq communities. Challenges are similar to many other places where major industrial bases, in this case coal mining and steel production, has ended. Health issues are often connected to poverty. There are also many positives that come with work in smaller communities – resilience, creativity and sense of culture and history are vital components of life here. As a physician, it is fulfilling to be immersed in local issues, but to also have opportunities to interact provincially, nationally and even internationally, as I can through CDM.

**You recently attended a presentation and discussion held by medical students at the CDM - Dalhousie University Chapter. Were you excited by the student interest and engagement? Should other schools consider student CDM chapters?**

I was thrilled to watch the students lead the presentation and discussion – their knowledge, excitement, critical analysis and dedication were evident. Several schools across Canada have student chapters that would welcome increased student involvement. New chapters would be useful additions at other schools. CDM student chapters are one way in which students can influence the future of Medicare. ■



# Clinical potpourri

Linda Jingyan Pan  
University of Manitoba, Class of 2017

## Resuscitation

He lay there,  
Life spirals and dances,  
At times embracing him,  
Other times turning her back.  
We learn:  
“He’s an important man.”  
Not by power, status, or affiliation.  
But because he farms.  
He does chores for the elderly.  
He’s a father, husband, brother, son.  
A fellow human being.

## Healing

Bravely baring their souls,  
Exposing the trauma, failed coping, struggles faced.  
We listen:  
Trying to understand, sympathize, empathize, wanting to help.  
But how?  
Medications can only do so much... take one so far...  
Toning down the symptoms doesn’t end the pain  
That’s the beginning of the journey, the formation of scars.  
To forgive – both oneself and the world.  
That is the process to existence, to life.  
In the words of a wise patient:  
“It’s alright... we will all heal together”  
Entwined in this common connection of humanity. ■

# The biopsy

Kaylynn Purdy  
Northern Ontario School of Medicine, Class of 2018

## ■ WAS FIFTEEN, SCARED

I wanted to yell “stop,”  
Wanted to say “no,”  
I wanted to run.  
Too sick to move,  
too tired to flinch.  
I was too small to stand  
up for myself and speak.

## Power of the white coat.

A piece of me  
I wanted to keep was  
cut out. It was placed  
in a sample container  
and sent away.  
This small piece of me  
bore my name.

My identity given  
to a sterile pair of  
blue gloves.

I was examined  
under the microscope.

I cried over its loss  
and mourned over its absence.

The void filled with  
pain and little relief.

The pain brought many lessons,  
many sorrows.

This small piece of flesh  
would change my life.  
It would take so much  
from me, yet  
give so much back.

Time slipped by,  
transcripts amassed,  
I waited.

A letter came for me,  
and called me north.

I was twenty-two, scared.

Wanted to yell “stop,”  
Wanted to say “no,”

I wanted to run.

Too amazed to move,  
too nervous to sit.  
I felt too small to fulfill  
my duty and responsibility.

Power of the white coat.

A piece of her  
she wanted to keep was  
cut out. It was placed  
in a sample container  
and given to me.  
This small piece of her  
bore her name.

She gave her identity  
to my sterile  
blue gloves.  
I examined her  
under the microscope.

I wondered about her loss  
and thought about her life.

The void filled with  
questions and little answers.

The questions brought many lessons,  
many sorrows.

This small piece of flesh  
would change my life.  
It would take so much,  
from me, yet  
give so much back. ■



# Thunderstruck

Gerhard Dashi

Queen's University, Class of 2017

*"Thunder..."*

The student rushes into the OR. His last few bites from lunch barely swallowed. Nervous because he's late. Nobody notices.

*"Thunder..."*

He looks around. Three groups have formed; one with males, one with females, one man sits alone. The men are new, their foreign names on the white board. Must be the harvesting team, from the big city. The women are local, nurses and anesthesia.

*"Thunder..."*

He approaches the women, introduces himself, asks if it's OK to observe, he has permission. They look at his nametag. "Sure", looking at each for approval. "Stay at the head of the bed. We'll be running."

*"Thunder..."*

He builds enough courage, asks when the patient will come. "He has to be in asystole for five minutes." Two people open the OR doors, hold them open. He's never seen that before. "We'll pause for one minute of silence when we're cooling, a way to say thanks," says one of the foreigners. Everyone nods. The doors are still open.

*"I was caught..."*

"Here they come." Everyone perks up. A timer is started.

*"In the middle of a railroad track..."*

Between a human train, one nurse pulling, another pushing, a child on a stretcher. Eyes closed. Looks the same as any other, except the hair is wet. He wonders why.

*"I looked round..."*

He looks around. The doors have closed, black cardboard is taped over the windows.

*"And I knew there was no turning back..."*

The anesthesiologist prepares to intubate. "Why?" "We need to recruit the lungs before removal."

*"My mind raced..."*

Surgeons race to the body, transfer it to the operating table. They take their positions, two at the thorax, two at the abdomen. The empty stretcher leaves the room.

*"And I thought what could I do..."*

A nurse rolls buckets of ice behind each surgeon.

*"And I knew..."*

Another hangs large, cooled IV bags.

*"There was no help, no help from you..."*

He doesn't know how to help.

*"Sound of the drums..."*

Sound of an electric guitar. Then chanting. Then drums. Then "Thunder, thunder..."

*"Beating in my heart..."*

His heart pounds, he's gone mad. No one else reacts. He definitely hears music.

*"The thunder of guns..."*

The thunder of metal in the corner. One nurse with an iPad and a speaker.

*"Tore me apart..."*

Two surgeons tear ribs apart, two split the abdomen. The callousness tears him apart. Is the music for timing?

Motivation? Boredom?

*"You've been, Thunderstruck..."*

He is disgusted. These people are heartless.

*"Rode down the highway, Broke the limit, we hit the town..."*

They'd hit a car.

*"Broke all the rules..."*

Broke all the surgical rules.

*"Played all the fools..."*

Playing death for a fool, saving others instead.

*"They blew our minds..."*

They blow up the lungs. Alveoli inflate, contusions remain.

*"And I was shaking at the knees..."*

He slowly walks around, sees mostly anatomy. Tries to get the best view, he needs to learn after all.

*"Could I come again please..."*

"Could I change the song, please", asks a nurse. "Let it finish. It was his favorite song", answers another.

*"Yeah, them ladies were too kind..."*

Things make a lot more sense now. These people are human. The body is cooled, packed with ice and cold fluid.

*"It's alright, we're doin' fine..."*

"We're doing well. Let's stop for that minute of silence." No one pauses the music, a different song now. How long has it been?

*"Thunderstruck! Yeah, yeah, yeah..."*

The organs come out, one by one. Soon they'll be closing. "Do you want to scrub in?"

*"Thunderstruck! Baby, baby..."*

He's conflicted. He needs to practice, he never says no. But this is a donor, a child, now is not the time.

*"You've been, Thunderstruck..."*

He goes to scrub, hating every second. Decides to do his best. This child's memory deserves it. His gift, his family's gift, deserves honor.

*"Thunderstruck! Thunderstruck!..."*

He's soon left alone, the last person suturing. The surgeons rush out, new organs in hand. Nurses clean the hair and wounds. He closes the abdomen, with no contents inside.

*"You've been, Thunderstruck!"* ■

# If Dr. Seuss were my Doctor

Katie Simms

University of Ottawa, Class of 2017

If Dr. Seuss were my doctor  
Oh, what a script he would write  
Surely more than a drug  
Or some metabolite

He would tell me to wonder  
To marvel and pause  
To feel good about “me”  
With a round of applause

“Look where you are  
My, how far you have grown  
From tying your shoes  
To a big student loan”

He would look in my ears  
Say “stick out your tongue”  
He would stretch my extensors  
Examine each lung

He’d use words like “Glarbish”  
And “Sniffer” and “Bluck”  
And “Puffly” and “Huffly”  
And “Flomber McRuck”

His office would be covered  
In posters galore  
Of cats and green eggs  
The tales we adore

His Nurse would be Thing  
Not One nor not Two  
But the Third of its kind  
And would be just as blue

“The doctor is in!  
He lives in your heart  
Everyone is a healer  
You can all play the part”

Dr. Seuss is my doctor  
Yes, surely he’s me  
The child I was  
The doctor I’ll be

He’s more than a story  
Or a book or a rhyme  
He’s my childhood self  
And a healer, with time

Dr. Seuss is my doctor  
He’s the doctor within  
Oh, the places you’ll go  
When the doctor is in! ■

*Previously published on the CMAJ Student  
Humanities Blog.*

# Coated with compassion

Sarpreet Singh Sekhon

University of British Columbia, Class of 2019

I rest in a place that is not my own  
I quiver in silence about a time I’ve known  
I am no longer the same as today has shown  
I am struck with illness and am all alone

I am approached by new faces, each with their own stride  
In them, they say, I can confide  
Do they not know I have lost my pride?  
By my own body, have I been defied

I am visited by loved ones who share my grief  
“It’ll all get better,” is their belief  
Can you really mend two halves of a broken leaf?  
I do not know. If only the tree would speak

Another individual gently comes inside  
He is coated anew; perhaps, bona fide  
There is no rush, I feel not denied  
Through compassion he is able to bridge my own divide

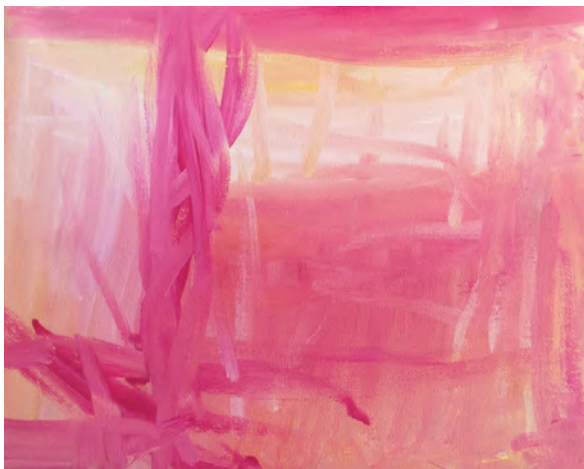
I speak his language and he speaks mine  
It seems as though our paths were to intertwine  
To him I say, “Thank you for spending your time  
I am still broken, but reconnected to my vine”

With warmth, he shares with me two lines  
“I have not spent but I am affined  
to all that you are. This is a great privilege of mine” ■

## Umbilicus ▼

Grace Yi Wan  
University of Calgary, Class of 2017

This abstract piece explores the fragility and strength of a newborn's attachment to his or her mother. Medicine is seldom seen in hazy, softened tones – the starkness of hospital lighting frames everything clearly and sharply; our profession seeks to understand things objectively. This is my way of capturing the warmth and dimension of new life.



## Political chess ▼

Linda Chang Qu  
Queen's University, Class of 2018



## While we are here ▲

Annie Wang  
University of Toronto, Class of 2018



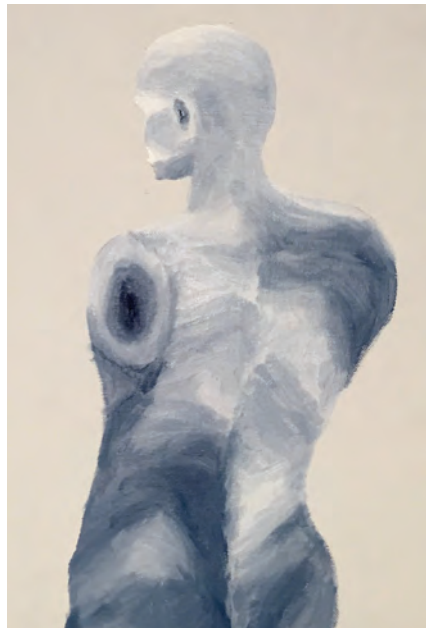
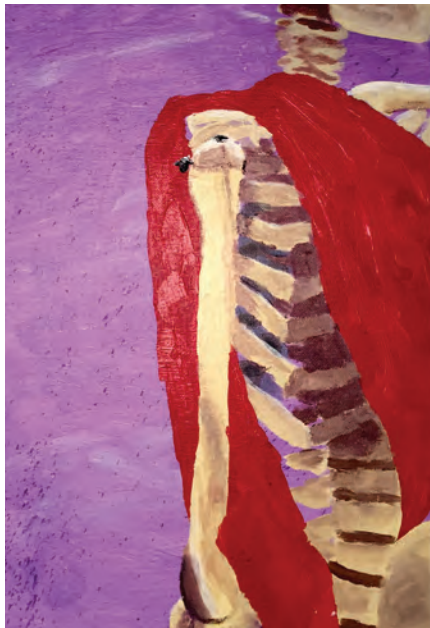
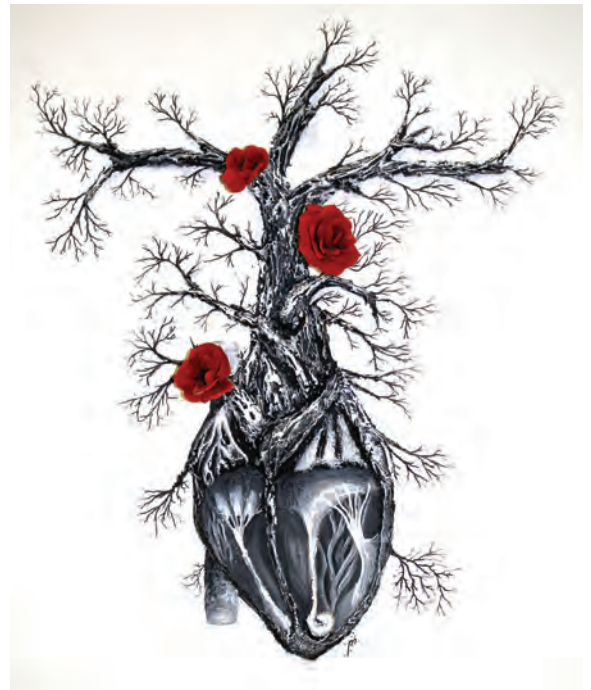
## Jigsaw ▲

Grace Yi Wan  
University of Calgary, Class of 2017

In medicine, even with the same diagnosis, each patient tells a unique story. This painting captures how pieces of different stories can never quite fit together – the story the next patient weaves is always slightly different, the presentation a different color, a different tempo of paint, spattered with a different hand onto the canvas.

# Untitled ▼

Agata Dzwonek  
University of Ottawa, Class of 2017



## ◀ The duality of the role

Anna Whalen-Brown  
University of Alberta, Class of 2018

These paintings symbolize the duality of a medical student as they transition into their role within the healthcare sphere. The colourful painting (1) depicts a skeleton draped by a traditional garment, representing passion and belief. The more subdued painting (2) depicts soft contours of whites and blues, representing a consistent and phlegmatic outer persona. The figures face each other, highlighting the dichotomy between inner and outer identities.

## ▼ Adaptation of Waterfall Pines

Laila Nasser  
McMaster University, Class of 2017

This is an acrylic palette-knife painting adapted from 'Waterfall Pines' by Deanne Flouton.



## Gulliver ▲

Chien-Shun Chen  
University of Toronto, Class of 2016

Gulliver's Travels, a familiar story from many of our childhoods, lends itself to highlight the significance of cultural psychiatry. Do we – as the tiny people of Lilliput were so quick to bind the shipwrecked Gulliver – similarly evaluate the patient in front of us with a reflexive comfort of our own sociocultural experiences? In view of such juxtaposition of a superficial conformity and a naked vulnerability, a culturally sensitive approach to psychiatry allows for the often desperate opportunity in which hidden assumptions and practice limitations can be made aware. Or, the irony of how easily the reference of this Anglo-Irish tale can be lost.



## Zermatt, Switzerland ▶

Florentina Teodescu  
University of Toronto, Class of 2017



# Weddings



◀ Anthea Lafreniere and Matthew Lafreniere  
July 18, 2015  
Woodview, Ontario

Anthea Lafreniere, University of Ottawa, Class of 2016



Sudha Ayalasangamayajula and Anirudh Ganti ▼  
December 23, 2015  
Visakhapatnam, India

Sudha Ayalasangamayajula, Western University, Class of 2019





# Babies



◀ **Makai Lopez**  
Born October 22, 2015  
London, Ontario  
Parents Kailey Minnings and  
Kervin Lopez

Kailey Minnings  
University of Toronto, Class of 2017

**Aria Mai Nedeljkovic** ▶  
Born April 1, 2015  
Toronto, Ontario  
Parents Alex and Linda  
Nedeljkovic

Alex Nedeljkovic  
Schulich School of Medicine and Dentistry at the  
Western University, Class of 2019





# CFMS executive and representatives 2015-2016

## EXECUTIVE



Anthea Lafreniere  
President  
president@cfms.org



Bryce Durafourt  
Past President  
pastpresident@cfms.org



Carl White Ulysse  
Executive VP and VP  
Communications  
vpcommunications@  
cfms.org



Franco Rizzuti  
VP Finance  
vpfinance@cfms.org



Nebras Warsi  
VP Education  
vpeducation@cfms.org



Jessica Harris  
VP Government Affairs  
vpgovtaffairs@cfms.org



Golden Gao  
VP Global Health  
vpglobalhealth@cfms.org



Marie-Pier Bastrash  
VP Student Affairs  
vpstudentaffairs@  
cfms.org



Emily Macphail  
Western Regional  
Representative  
western@cfms.org



Fatemeh Ramazani  
Western Regional  
Representative  
western@cfms.org



Han Yan  
Ontario Regional  
Representative  
ontario@cfms.org



Yousif Atwan  
Ontario Regional  
Representative  
ontario@cfms.org



Emily Hodgson  
Québec Regional  
Representative  
quebec@cfms.org



Anthony Maher  
Atlantic Regional  
Representative  
atlantic@cfms.org



Rosemary Conliffe  
General Manager  
office@cfms.org

## NATIONAL OFFICERS

Kevan Lu	Information Technology (Sr.)	it@cfms.org
Stephen Leung	Information Technology (Jr.)	it@cfms.org
Tamara Ibrahim	Health Policy	nohp@cfms.org
Alyssa Lip	Wellness	wellness@cfms.org
Salima Abdulla	Blood Drive	blood@cfms.org
Dr. Cait Champion	Alumni Affairs	alumni@cfms.org

## NATIONAL OFFICERS OF GLOBAL HEALTH

Scott Hodgson	Partnerships	nop@cfms.org
Antonio Lee	Exchanges	exchanges@cfms.org
Kelly Ma	Exchanges	exchanges@cfms.org
Marguerite Heyns	Education	noghe@cfms.org
Jenna Webber	Reproductive and Sexual Health	norsh@cfms.org
Koray Demir	Human Rights and Peace	norp@cfms.org
Ryan Giroux	Aboriginal Health	ahl@cfms.org

## MEDICAL SOCIETY PRESIDENTS

Eric Zhao	UBC	eyzhao@alumni.ubc.ca
Fatemeh Ramazani	UofA	msapres@ualberta.ca
Bradley Prince	UofC	bradley.prince@ucalgary.ca
Larissa Padayachee	UofS	smss.president@usask.ca
Robert Schmidt	UofM	umschmir@myumanitoba.ca
Meaghan Donnelly-Perras	NOSM	mdonnelyperras@nosm.ca
Noah Stern	UWO	nstern2018@meds.uwo.ca
Hrishikesh Suresh	McMaster	hrishikesh.suresh@medportal.ca
Roland Xu	UofT	shuzhengrong.xu@mail.utoronto.ca
Jonathan Krett	Queen's	president@qmed.ca
Kristin Ambacher	UofO	kristin.ambacher@uottawa.ca
Doulia Hamad	McGill	president.mss@mail.mcgill.ca
Meghan Mahoney	MUN	c55mem@mun.ca
Mike MacGillivray	Dal	michael.macgillivray@dal.ca

## VP EXTERNALS/CFMS REPRESENTATIVES

Tiffany Lam	UBC Sr.	tiff.lam@alumni.ubc.ca
Kingsley Shih	UBC Jr.	kingsley.shih@alumni.ubc.ca
Ashlee Yang	UofA Sr.	msavpext@ualberta.ca
Brendan Morgan	UofA Jr.	msavpext@ualberta.ca
Luxey Sirisegaram	UofC Sr.	luxey.sirisegaram@ucalgary.ca
Chantal Badger	UofC Jr.	chantal.badger@ucalgary.ca
Jeffrey Poon	UofS Sr.	jep322@mail.usask.ca
Bonnie Liu	UofS Jr.	bol716@mail.usask.ca
Bryce Barr	UofM Sr.	brycebarr00@gmail.com
Gurmeet Sohi	UofM Jr.	sohig@myumanitoba.ca
Kristen Zahn	NOSM Sr.	kzahn@nosm.ca
Talia Ryan	NOSM Jr.	talia.ryan@nosm.ca
Justin Cottrell	UWO Sr.	jcottrell2017@meds.uwo.ca
Brandon Chau	UWO Jr.	bchau2018@meds.uwo.ca
Cameron Lam	McMaster Sr.	cameron.lam@medportal.ca
Vivian Ng	McMaster Jr.	vivian.ng@medportal.ca
Claudia Frankfurter	UofT Sr.	claudia.frankfurter@mail.utoronto.ca
Sujen Saravanabavan	UofT Jr.	sujen.saravanabavan@mail.utoronto.ca
Graham Skelhorne-Gross	Queen's Sr.	vpexternal@qmed.ca
Andrew Dawson	Queen's Jr.	vpexternal@qmed.ca
Jonathan Gravel	UofO Sr.	vpexternal.sr.aesc@uottawa.ca
Max Deschner	UofO Jr.	vpexternal.jr.aesc@uottawa.ca
Ivan Serwadda-Luwega	McGill Sr.	externalcanada@mcgillmed.com
John Jeddore	MUN Sr.	d64jnj@mun.ca
Courtney Manuel	MUN Jr.	cam024@mun.ca
Matt Ernst	Dal Sr.	matt.ernst@dal.ca
Alexandra Taylor	Dal Jr.	al.taylor@dal.ca

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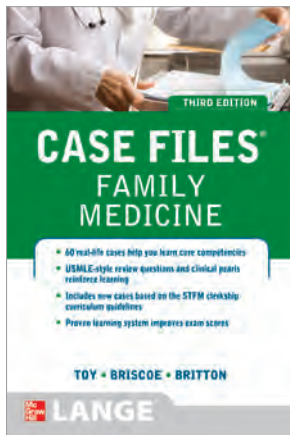


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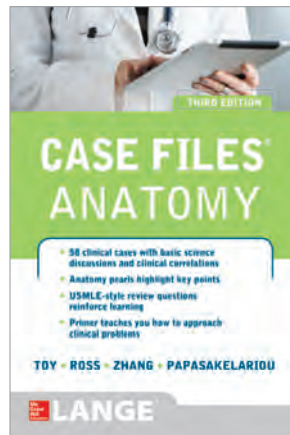
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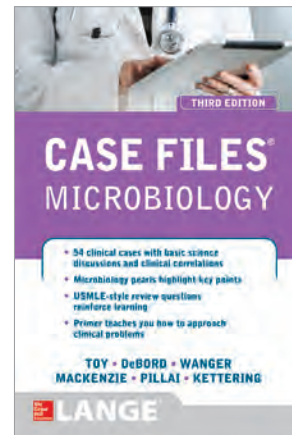
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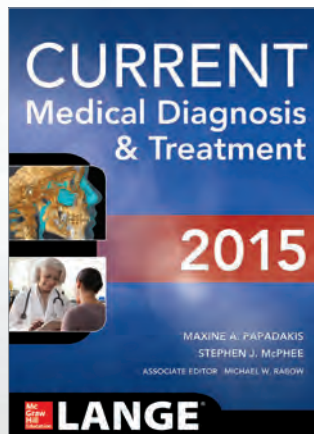
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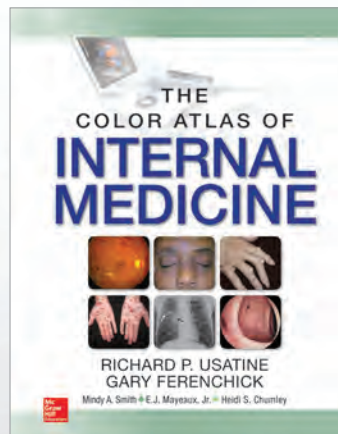
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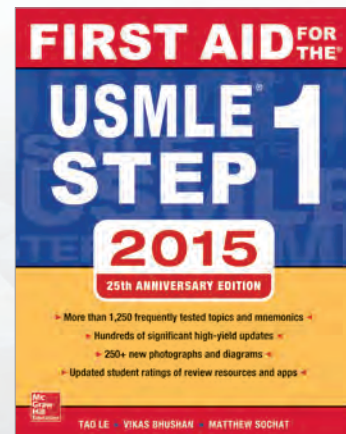
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