



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

## Annual Review 2012



The future of medical education

Town halls for transformation

Making time for your well-being

Lobby Day 2012

Interview with Dr. Samantha Nutt:  
War Child Founder and  
author of *Damned Nations*

Brink of a revolution

The social history

How to become a “great” physician

Literacy: Why we should care

Stepping outside the box



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Cover: Joanna Xuejiao Li, McGill University, class of 2014 and CFMS IT Officer Junior

This art work, titled "Growth of a Medical Student", depicts the transfer of wisdom from the experienced to the young. The old doctor presents a branch from his tree of knowledge to the medical student, in hopes that the student will grow it into a tree of his/her own and use the branches to help treat others.



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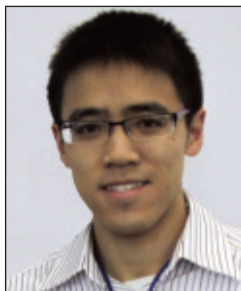
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## Letter from the editors



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Matthew Tenenbaum  
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Welcome to the 2012 edition of the *Annual Review*! This past year has been an exciting one for Canadian medical students, and the CFMS is proud to share the many accomplishments and creative aspirations of students from across the country.

This edition of the *Annual Review* will start off with updates from each of our CFMS Executive members and officers. Together, we've made great progress in each of our portfolios — including global health, political advocacy, student wellness and communications. You'll find the results of a 3-year CFMS study on distributed medical education, useful tips on discounts and services, a report from our annual Lobby Day and much more. Regardless of your interests, we're confident that this *Annual Review* will have something for you!

The Brief Updates section is new to this edition of the *Annual Review*, and its inclusion is meant to provide a brief overview of initiatives and updates from each medical school in the CFMS. There have also been some changes to our Alumni section this year, with an addition of a Studying Abroad section to highlight alumni who are currently pursuing post-graduate studies internationally.

Our Feature Interview this year is with Dr. Samantha Nutt, Founder and Executive Director of War Child Canada. Being one of the most prominent advocates for human rights in Canada, we are lucky that Dr. Nutt was able to take the time to talk with us.

To end off this edition of the *Annual Review*, we're also pleased to present the initiatives, experiences, opinions and creative works of medical students like you! The *Annual Review* also features a gallery of beautiful wedding and baby photos submitted by CFMS members. Creative art and photo pieces are also included, showing just how talented Canadian medical students are.

As always, we thank the Canadian Medical Association publishing staff and our advertisers for their invaluable support in creating this year's *Annual Review*. A special acknowledgement goes out to our General Manager, Rosemary Conliffe, who works tirelessly to make everything we do possible.

We hope you enjoy reading this edition of the *Annual Review*!

All editorial matter in *CFMS Annual Review 2011* represents the opinions of the authors and not necessarily those of the Canadian Federation of Medical Students (CFMS). The CFMS assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice herein.

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# A letter from your CFMS president



Noura Hassan  
CFMS President,  
2011–2012  
McGill University,  
Class of 2012

Greetings from your CFMS President

The Canadian Federation of Medical Students (CFMS) is a student-run, student-driven organization uniting over 7500 medical students from beautiful BC to the Rock. The CFMS is your organization. This year, I have the great pleasure and privilege of kicking off the *2012 CFMS Annual Review*. I trust that you will enjoy reading about the exciting projects and initiatives featured herein. You will quickly come to realize why I am so passionate about this organization; this *Review* is a tribute to our executive and general membership's hard work and dedication.

The foundation of our organization consists of 3 pillars: representation, communication and services.

## Representation

The CFMS continues to play an active role in medical education systems reform. We are particularly proud of the advances that have been made in the Association of Faculties of Medicine of Canada (AFMC)'s Visiting Electives Portal Project. Having been on the Governance Committee from the get-go, your CFMS representatives have been contributing to the development of a nation-wide electronic application system for visiting electives. On February 6, 2012 Parliament Hill welcomed medical students from across Canada for yet another successful Lobby Day. Our Global Health chapter brings valuable contributions to a number of international conferences. Finally, we continue to work on member-mandated projects to help improve your learning experiences.

## Communication

We are always looking for new ways to promote dialogue and fluid exchange of information with you. Our biweekly rep communiqués and global health listservs continue to help us keep in touch with our members. You can follow the CFMS on Facebook, Twitter and look for updates on our beautiful new website ([www.cfms.org](http://www.cfms.org)). Our dedicated team also produces press releases in a timely fashion, responding to issues of importance to Canadian medical students.

## Services

One of our top priorities is to help improve your experience in medical school. We continue to provide you with great discounts on services including textbooks, medical apps, hotel rooms, disability insurance and laser eye surgery. The CFMS Residency Interview Database is another highly valuable student-driven resource we encourage you to use and to contribute to. The Global Health Program's international exchange program remains extremely popular amongst our membership. Make sure to check our website to find out more about the numerous services we offer!

I can't help but get excited when I think about the great things the CFMS does and all the exceptional people who help make it happen. It is a great privilege to have been given the opportunity to lead this organization and to represent you within the Canadian medical community and to the world at large. Please feel free to contact us either via email or through your local CFMS representatives for any questions or suggestions.

Kindest regards,

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# Communications: Keeping you in the loop!

**Matthew Tenenbaum**  
**VP Communications**  
**McMaster University, Class of 2013**

**B**eyond providing services and political representation, the CFMS strives to articulate your voice as Canadian medical students. Communications — both internal and external — continue to be an important part of what we offer, and I'm pleased to say that this has been a very busy and productive year so far!

## CFMS website

Over the year, the CFMS website has undergone some major renovations, thanks to lots of hard work from our IT Officers Nima Kashani and Joanna Li. The layout is much more intuitive, and important goodies — such as member discounts — are easier than ever to find and use. We've also overhauled a lot of the content, and we've replaced text with images wherever possible. Improved versions of our CaRMS and Electives databases are back by popular demand. We're continuing to update and improve the website and, looking forward, we're investigating ways to present more useful, individualized information that will enhance your experience.

## Social media

After being introduced last year, Facebook and Twitter continue to be an important way to connect with students. In addition to sharing CFMS news items, social media has allowed us to engage students in discussions about timely medical issues. Going forward, the Social Media Committee will continue to discuss how medical students can best present themselves as young professionals when using social

media. If you haven't already, check us out on Facebook ("Canadian Federation of Medical Students (CFMS)") and Twitter (@CFMSFEMC)!

## Medical student spotlight

While the CFMS works to communicate to students, we also strive to be a means for students to share their experiences and accomplishments. Medical Student Spotlight is a new, online initiative that features the neat ideas and projects that students are working on across the country. Our database has amassed a number of academic, charitable and leadership projects — and it continues to grow! If you've been working on an inspirational initiative that you'd like to share, be sure to submit it!

## Media relations

Correspondence with the media is a huge component of the VP Communications portfolio. In addition to monitoring current health care and medical education news, we provide the "medical student voice" whenever an important issue comes up. In the fall, CFMS President Noura Hassan was interviewed by the Medical Post regarding rising tuition costs — an area of concern for students. The Canadian Medical Association has continued to be a valuable partner in our media relations strategy.

## PEI return-of-service

This January, the PEI government announced that it would require Island medical students studying at Memorial University to sign a mandatory, three-year return-of-service agree-

ment. This was identified as an area of great concern by MUN students, and we released a statement explaining our opposition to this proposed course of action. The story was picked up by a number of media outlets, including CBC Online and the National Post. Atlantic Regional Rep Will Stymiest and MUN PAC Rep Lindsay Ward each gave live interviews, and explained why return-of-service agreements are ultimately ineffective.

## Lobby Day

Our Lobby Day this year focused on how the federal government can enhance access to health care in rural and remote regions of Canada, and we were fortunate to have lots of interest from the media! Notably, we had many requests for radio interviews, including several from CBC Radio and many from local stations across the country. While President Noura Hassan and VP Advocacy Chloe Ward were our primary media contacts, many of our local PAC members stepped up and explained our proposals to the media. During our visit to Parliament Hill, we were also very pleased to have the support of MP Bruce Hyer, who supported us through his own press release and through a motion in the House of Commons.

This has been a very busy year so far, and there's still a lot of exciting news to look forward to. Don't forget to keep up-to-date through the biweekly Communiques, distributed to each school, the CFMS website, and our social media accounts. I look forward to staying in touch!

# Career planning and student wellness — re-emerging themes in medical education

**Renée Pang**  
**VP Education**  
**Queen's University, Class of 2013**

The last few years have produced a marked change in the landscape of health care and medical education. Emphasis of current discussions has shifted from the reported physician shortages to the limited availability of employment for residents trained in specific areas of subspecialization. As all stakeholders work together to better coordinate training of residents and students with societal needs, the CFMS works hard to provide students with the necessary tools and information to plan their future.

Career planning and student wellness are two themes that have resurfaced between various stakeholders in medical education. In the past six months, the CFMS has undertaken medical education projects that are looking for answers to your concerns. It is my pleasure to provide you with a brief update on this dynamic portfolio.

## Clerk work hours

Recent concern for physician wellness and patient safety has brought attention to duty hour policies for residents and attending physicians. Many studies have shown the negative correlation between sleep deprivation and information processing. Like physicians, medical students report a higher rate of depression than the general population. In response to the concern over common practices of duty hours among medical professionals, the CFMS began a large scale study in 2009 to assess the status of clerk work hour policies at Canadian medical schools. In 2009, we compiled clerk duty hour policies from

all 14 CFMS schools. Over the next two years, senior clerks and first year residents were surveyed to assess the number of hours they were required to work per rotation, and whether or not they were aware of the work hour policy at their schools for each rotation. The preliminary results of this large scale analysis were reported at the 2012 SGM in Banff.

To address the impact on wellness and performance among medical students in relation to work hours, Darrell Ginsberg (Queen's University, 2014) chairs a working group that will analyse the results for the CFMS-sponsored survey released in 2010 and 2011. Neil de Laplante (University of Western Ontario, 2015), a former engineer, has been helping with data-mining in the project.

## Career planning in Canadian medical schools

Health human resource planning has become the new hot topic in the dynamic political landscape of health care policy. The CFMS has called on appropriate stakeholders to make job trend data across different medical specialties available to the public, and more importantly, to medical students as they choose their future careers. The CFMS is also advocating for better communication between the training and the hiring arms of health human resources to ensure that Canadian medical graduates will be entering the workforce with sufficient information about job market demands across different disciplines.

Career planning during medical school training has become an emerging field of interest among a variety of stakeholders such as medical student societies, faculty, government and regulatory organizations – and rightfully so. In response to these concerns, the CFMS is conducting a literature review and survey regarding the career research tools available to medical students. Sameer Shaikh (McMaster, 2012) is chairing the working group on career planning this year. By the SGM in 2013, we hope to present results of our analysis and offer student-centred recommendations to ease the transition of medical students from career planning into residency.

## Future directions for the distributed medical education project

In May 2011, the CFMS published their recommendations from a student centred review, which was then presented and enthusiastically received by the Association of Faculties of Medicine of Canada at last year's Canadian Conference on Medical Education.

In response to the recommendations, the Distributed Medical Education working group, chaired by David Mikhail (University of Western Ontario, 2013) and Alkarim Velji (University of Alberta, 2015), was tasked with conducting a second study to assess the quality of medical education at such sites and correlation with match rates. Neil de Laplante is overseeing the results and data gleaned from both studies.

### Canadian electives portal management system

Since 2007, the CFMS has been advocating for a streamlined elective application process for Canadian medical students. We are excited to report that the final round of consultations was completed in November 2011, and work is now underway to start building the new application interface, currently known as the Canadian Electives Portal Management System (CEPMS).

Many senior medical students will attest that organizing electives can be a very time-consuming, expensive and frustrating process. Each school has unique requirements regarding immunizations and rotations. Although these factors continue to present some challenges in creating a unified application system, CEPMS is under con-

struction with full support from the Association of Faculties of Medicine of Canada and CFMS.

### CaRMS update and residency positions

Canadian Medical Graduates (CMGs) continue to do well in the CaRMS match. In 2011, 94.5% matched in the first iteration, with 63.1% matching to their first choice rank list. Moreover, 99.8% matched to one of their top 3 disciplines. This is comparable with last year's results, and the CFMS will continue to advocate for residency spaces for all CMGs. The 2012 Matchbook will continue to provide important information to all medical students about the matching process and the competitiveness of particular specialties.

### Right to research coalition

In January 2012, the CFMS Executive officially endorsed Open Access to promote equal access to quality research. Open Access is an alternative distribution and publishing model for scholarly literature that allows any individual, including medical students, to access research for free.

Thank you for reading this brief selection of some of the projects running this year at the CFMS under the Education portfolio. There are a myriad of other exciting projects and opportunities that you can find out about through your local representative. If you have any questions about any projects related to medical education, please do not hesitate to contact me at [renee.pang@cfms.org](mailto:renee.pang@cfms.org).



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# The future of medical education

**Renee Pang**  
**VP Education**  
**Queen's University, Class of 2013**

Faced with an increasing need for rural physicians, distributed medical education (DME) was introduced in Canada as a strategy to increase enrolment in medical schools. Since its inception, DME has explored a variety of creative innovations in medical education that have transformed clinical training opportunities in both undergraduate and post-graduate education in Canada. These include pre-clerkship electives in rural areas, rural core rotations, entire satellite campuses that are affiliated with medical faculties and horizontal clerkships in rural communities. In 2008, the CFMS initiated a three-year study across all member schools to look at the effects of DME on students, what

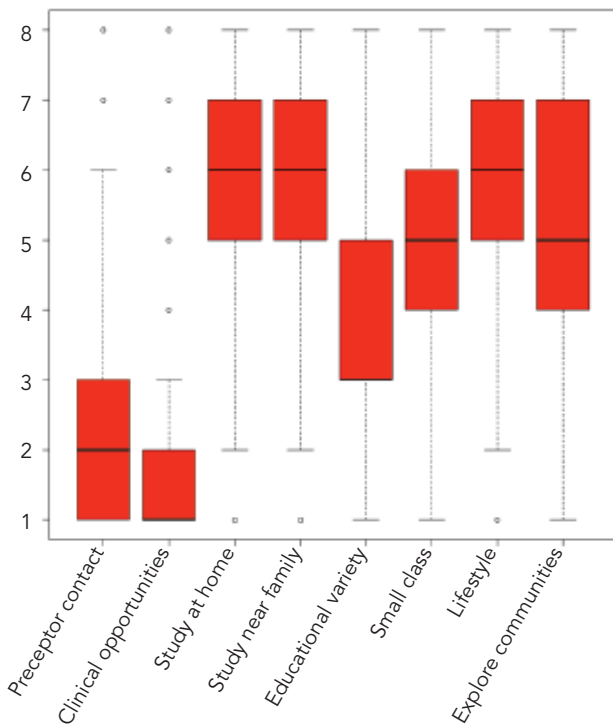
**Distributed medical education is no longer a dream, but a reality that affects most, if not all, Canadian medical faculties.**

they considered to be strengths and weaknesses in their education, and whether or not it has been effective in

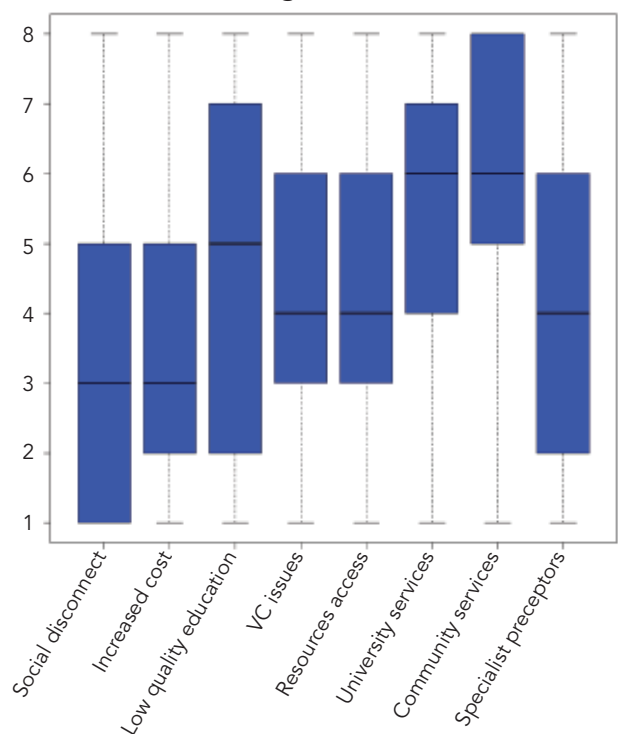
producing the intended primary outcome: to increase the likelihood of practising in a rural area. The following report will elaborate on some of the recommendations that the CFMS was able to make based on this study.

Some of the strengths identified in DME included clinical opportunities and preceptor contact, which were both ranked 1 and 2, respectively, in importance after aggregating the data collected from 484 participants. Educational variety was identified as the next most important strength in medical education. The smaller classes and the opportunities to explore communities were identified as another advantage. Overall, DME seems to offer rich educational experiences and

**Ranking of strengths**



**Ranking of weaknesses**



direct contact with attending physicians, which is perceived as both a benefit and advantage by students enrolled in these programs.

In terms of relative weaknesses of DME, social disconnect and increased cost were identified as top choices among the list of possible choices.

Other challenges included poor videoconferencing quality and resource access, as well as limited contact with specialist preceptors. Interestingly, fewer students felt that DME offered them a lower quality education, although the range of responses varied greatly for this question. The results show that in general, weaknesses were resource and network related. Both aspects can easily be improved by enhancing resources and ensuring that students have access to meaningful networks and support during their educational experience.

In terms of the efficacy of DME in exposing and inspiring students to pursue a career in rural medicine, of the students who did not want rural medicine before entering medical school, 20% now wanted to do rural medicine and 25% remained undecided at the end of the experience. Conversely, of the students who wanted to do rural medicine, 6% decided they did not want to pursue rural medicine and 12% became unsure at the end of the experience. Exposure generally seems to be conducive in encouraging students to practice in smaller communities.

Distributed medical education is no longer a dream, but a reality that affects most, if not all, Canadian medical faculties. Our study indicates that it offers great clinical training as well as good contact with preceptors. We hope that our recommendations based on the student-centred review will allow us to continue enhancing this educational model and bring benefits for future students and faculties alike.

### **In brief: Recommendations to enhance distributed medical education**

#### **1. Satellite campuses:**

- a. Lecture content at various sites should be standardized if not identical
- b. Access to resources equivalent to those at main campus
- c. Involve students in UGME selection and application process
- d. Monitor match data to ensure that clinical education is on par with main campus
- e. Administration should help foster links between students to provide a social environment and encourage student leadership initiatives
- f. Make stipends available for out-of-pocket costs if applicable
- g. Allocate funds for campus integration initiatives

#### **2. Mandatory rural placements:**

- a. Expand offerings in various sites
- b. Ensure webcast relay for students in areas without videoconference technology
- c. Ensure preceptors are aware of the educational level and capabilities of medical students and provide them with learning objectives for the rotation
- d. Internet access if possible at accommodations
- e. Allow students to select preferred sites for mandatory placements
- f. Accommodate familial obligations if possible
- g. Encourage hosting site to organize social events
- h. Make placement cost-neutral

#### **3. Electives outside of academic centres:**

- a. Offer a formal introduction and orientation at all new sites
- b. Discuss goals and objectives for the placement with preceptor at beginning
- c. Recognize value of clinical electives
- d. Orientation material prior to departure
- e. Provide students with a support system
- f. Help improve access to accommodations and offer subsidies if possible
- g. Allocate for bursaries to alleviate anxiety over financial burden

# Changing how we're taught will lead to a better health care system

**Will Stymiest**  
**Atlantic Regional Representative**  
**Dalhousie University, Class of 2014**

The Canadian model of health care has become an essential element of Canadian life and a cultural symbol by which we identify ourselves to the world. More than a source of pride to some, our policy of not only equal, but equitable health care has become a dominant part of the Canadian ethos. However, it is apparent that our current structural framework for health care delivery is not meeting some of its basic goals. Namely, the ability of individuals to access an acceptable level of quality care, especially those living in rural and other underserved regions of the country, is currently inadequate.

Canadians in the Atlantic Provinces, like others across the country, have been affected by these shortfalls and over the past two decades governments have been searching for ways to address these issues. One method and perhaps the most basic approach, has been to increase the class sizes of medical schools in order to bolster the numbers of native physicians trained each year. This strategy comes with one key caveat: *it will only work if the increased number of medical graduates actually go on to practice in these areas of concern.*

In 2001, there were 1134 Canadian Medical Graduates (CMGs) who participated in the Canadian Residency Matching Service (CaRMS) match, and by 2011 there were 2496 CMGs applying to the match. While this is helping to address physician shortages, there are important ways in

which governments can improve their approaches!<sup>1,2</sup>

## Some examples of current strategies...

- 1) As part of their effort to increase undergraduate training capacity, Dalhousie University has partnered with the Government of New Brunswick to create a distributed medical education (DME) site in Saint John, NB. In addition to providing high-quality clinical experiences, DME sites and/or DME experiences have the ability to expose undergraduate students to rural/community practice. The CFMS, through student consultation, has highlighted this as an important factor for students who may otherwise not consider these areas of practice.
- 2) In recent years a greater emphasis has been placed on rural experience at the undergraduate level with at least 10 medical schools across the country (including both Dalhousie and Memorial) requiring students complete a rural medicine placement (either as pre-clerks or clerks).<sup>3</sup>
- 3) The establishment of a PEI Family Medicine Residency program allows for the expansion of residency training and clinical experience to more rural areas of Atlantic Canada.

## Where do we need to go...

Clinical training has classically taken place in large, university centres and as

a result this approach has contributed to increased specialization of practice. This type of training has produced more specialized physicians and has given rise to a centralized rather than a distributed health care system.

In order to address issues of patient access and quality of care in rural areas, it is important that we realize the role education and clinical experience can and should play. This type of educational shift is happening as evidenced above, but the paradigm shift has yet to take place. Traditional thinking about physician training, recruitment and retention will not serve us well if we want to create a system that meets the needs of all Canadians. The CFMS has been a voice in the push for change, and we as students must continue to be part of this discussion.

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# CFMS member services: Discounts are just the beginning!

**Robin Clouston**  
**VP Services**  
**Memorial University, Class of 2013**

**T**hrough pre-clerkship and clerkship, through studying hard and applying for electives, through your CaRMS tour and beyond, you have needs that are unique to medical student life. In my role at CFMS, it's my job to ensure that we support those needs with targeted member services — designed with you in mind!

## Discounts, discounts, discounts!

Medical students love CFMS discounts — in our most recent member survey in 2011, discounts were ranked as the most valuable CFMS service. Popular discounts include:

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- McGraw Hill Bookstore: 25% off over 500 titles
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- ... and more!

CFMS discounts save you money. But did you know there are more CFMS services to make medical student life easier?

## CFMS disability insurance

What would you do if you had an injury as a physician? Disability insurance is one of the most important things a physician will ever purchase. As a CFMS member, you have access to the only plan designed specifically for medical students: comprehensive, no medical exam, and will continue through your entire career with minimal changes. Plus, you get 25% off! This CFMS service, offered through Kirkham & Jack, helps you to plan for your future. See [cfms.org](http://cfms.org) for details on how to enroll.

## CFMS databases

In January 2012, through the dedication of the CFMS IT team, the new and improved CFMS Residency

Interview Database went online — just in time for CaRMS! Log on to get the scoop for your CaRMS tour. After CaRMS, log on again to post your own reviews! Clerkship students can now also take advantage of the Electives Database, where student post reviews of the electives they've been on. Don't forget to review the electives that you've completed!

## Medical resource reviews

This longstanding CFMS service, formerly known as the Textbook Review Committee, provides reviews of medical textbooks. This year has seen changes with the service expanding to include reviews of medical e-Resources. In addition, a review can now also be initiated by CFMS members themselves — *you* can recommend a textbook, website or medical app! This year's reviews, completed by the diverse CFMS Medical Resource Review Committee, will be available this Summer at [cfms.org](http://cfms.org).

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To access these CFMS services, go to [www.cfms.org](http://www.cfms.org) and click on "Member Benefits".

If you are a medical student but do not yet have an account, sign up at [www.cfms.org/signup.asp](http://www.cfms.org/signup.asp).

The sign up code is available to you through your school's CFMS representative.

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

### Changes to travel deals

This year there were unforeseen changes to CFMS travel discounts. In the past, members got 10% off at one of Canada's major airlines from Jan–April for CaRMS. Last year, discounts

were for regular fares only and no online bookings. Students expressed frustration and we tried to restore the deal, however the airline opted to discontinue their 10% discount altogether. This change was unexpected and understandably disappointing to many in 2011, students ranked travel discounts as the #1 most valuable service by CFMS. We are actively exploring options to find new airline discounts to suit the unique needs of medical students. In the meantime, the latest information on regular seat sales is available at [cfms.org](http://cfms.org).

### Financial wellness

Through a partnership with Royal Bank, the CFMS is delighted to offer 14 CFMS-Royal Bank scholarship, each worth \$2500. That's one scholarship at each member school! In addition, CFMS members have access to a

Royal Bank Line of Credit at prime interest rate along with sound financial advice. You can also check out the Canadian Medical Residency Guide, developed by medical students and brought to you by Royal Bank.

### Working together

At CFMS we recognize that member services go beyond discounts. The Global Health Program offers international exchanges, the Wellness Program provides resources for student health, the Residency Matchbook helps you to succeed in CaRMS, and more. In addition, there are fantastic products and services offered by the CMA which student members can access. This year, through working collaboratively, we've presented more services than ever before, highlighted in *CFMS Services Updates*, available from your CFMS Rep.

In a 2011 member survey, students told CFMS which services are most valuable to them:

1. Travel discounts
2. Residency Matchbook
3. Discounts on insurance
4. CFMS Electives Database
5. Textbook discounts

## Changing minds on Parliament Hill — one meeting at a time

Chloé Ward

VP Advocacy

University of Ottawa, Class of 2013

On Monday, February 6, members of the CFMS gathered in Ottawa for their annual Lobby Day on Parliament Hill. Over 60 students from across the country, divided in teams of two or three, sat down with Members of Parliament (MP) to discuss issues of importance to Canada's medical students.

This year, the agenda focused on improving service delivery in rural areas. Specifically, students presented their case on two matters: deferral of the repayment of the federal portion of students loans and the expansion of recruitment programs targeted at high

school students in rural areas. Students held more than 75 meetings to convey their point of view to key decision-makers.

"This year's Lobby Day was a great success," said Noura Hassan, CFMS President. "Our team did a fantastic job educating politicians about students' concerns and we had a lot of fun here in Ottawa."

The arguments made by students were well received by parliamentarians and their staff. One MP is even introducing a motion in the House of Commons to demonstrate Parliament's support for the proposal of the CFMS.

Students arrived in Ottawa for a weekend of advocacy training before their meetings with MPs. Preparations included presentations by

**The arguments  
made by students  
were well received  
by parliamentarians  
and their staff**



Dimitri Soudas, former director of communications for Prime Minister Stephen Harper; Joy Smith, Chair of the House of Commons Standing Committee on Health and MP for Kildonan-St. Paul; and a senior policy analysts from the Canadian Medical

Association. Moreover, students conducted mock meetings to practice their lobbying skills. “The CFMS’ Political Advocacy Committee did a spectacular job organizing the training session and lining up our meetings,” added Hassan.

Another Lobby Day should take place in 2013. Between now and then, the CFMS team will continue to work closely with MPs to try to improve the delivery of health services in rural areas.



Students participating in Lobby Day.

**CFMS Political Advocacy Committee Members**

Chair .....	Chloé Ward (CFMS Vice President Advocacy)
Memorial University .....	Lindsey Ward
Dalhousie University .....	Haley Augustine & Nada Ismaiel
McGill University .....	Douglas Slobad
University of Ottawa .....	Hana Alazem
Queen’s University .....	Wilson Kwong, Michelle Khan & Negine Nahiddi
University of Toronto .....	Thomas McLaughlin
McMaster University .....	Azim Kasmani & Lily Zhao
University of Western Ontario .....	Adam Papini
Northern Ontario School of Medicine .....	Jill Caines
University of Manitoba .....	Sarah van Gaalen
University of Saskatchewan .....	Jessica Lydiate & Sarah Miller
University of Alberta .....	Roshan Abraham
University of Calgary .....	Yan Yu
University of British Columbia .....	Trevor Skutezky

# Town halls for transformation

**Chloé Ward**  
**VP Advocacy**  
**University of Ottawa, Class of 2013**

As the 2004 Health Care Accord is set to expire in 2014, transformation in health care delivery is at the forefront of many policy discussions in meeting rooms across the country. The CFMS is also participating in the debates, after having launched a series of town hall meetings to consult members on the future of health care in Canada. As future health care leaders, the onus is on us to maintain and improve our current system to ensure the delivery of quality care for years to come.

Most medical schools across the country hosted a town hall during the winter of 2012. These sessions, to which CFMS members and some faculty were invited, were designed to generate debates about health care transformation.

The events were divided into two parts: a keynote address by a subject matter expert, followed by an open policy discussion. Among the many notable and well-spoken presenters were Dr. Haggie, President of the Canadian Medical Association; Dr. Roger Palmer, Alberta's former Deputy Minister of Health and Wellness; and the Honourable Dr. Carolyn Bennett, former Minister of State (Public Health).

"We had two very productive town halls at the University of Western Ontario," said Adam Papini, the chair of the CFMS Political

Advocacy Committee at the university. "A lot of good ideas came out of these sessions. As future physicians, medical students are entirely engaged in these discussions about the future of health care because it will impact their work later on."

Discussions focused around such topics as health system funding models, health human resources, national pharmacare programs, dental care strategies and other initiatives. "This is an exciting opportunity for medical students to voice their thoughts and opinions in a discussion that will have profound impacts for years to come," said Jemy Joseph, a medical student at the University of Ottawa.

**These sessions were designed to generate debates about health care transformation.**

The CFMS will compile a summary of the various town hall efforts and a corresponding report will be available in the spring.



Town hall event at the University of Ottawa with Dr. Carolyn Bennett as the keynote speaker.

# Taking care of student health and wellness

**Natalia Ng**  
**CFMS National Wellness Officer**  
**University of Ottawa, Class of 2013**

Now is an exciting time to be involved in medical student health and well-being! Why, you may ask? Because the wellness buzz is resonating throughout the medical community and capturing the attention of medical organizations nationwide. The Canadian Medical Association (CMA), the CFMS, and provincial Physician Health programs are all jumping on the wellness bandwagon.

In October 2011, the CMA hosted the 2nd Canadian Conference on Physician Health. This conference was uniquely different from past wellness conferences due to its focus on wellness issues within the medical student population. With a workshop stream highlighting medical student health in the academic setting, the CFMS had

the exciting opportunity to lead interactive workshops discussing pertinent wellness issues medical students currently face.

... students are in need of more support to balance their academic and personal lives.

Melanie Rodrigues, currently the CFMS Ontario Regional Representa-

tive, led a workshop that focused on how well undergraduate curricula are currently meeting their wellness objectives. She pointed out that the wellness curricula across schools is still widely variable, and advocated for a standardized baseline to ensure that all medical students are receiving adequate wellness support from their schools.

Helen Yang, a second year medical student and strong supporter of student wellness, provided an overview of causes leading to poor performance in the academic setting and ways of coping. Causes include a difficult workload, lack of sleep, mental health issues, preparing for CaRMS, and the stress of picking a specialty. She explained that student behaviours are often a reflection of the values modeled by senior clinicians, and that professional attitudes are best learned from reliable physician mentors. Yang also noted that it is important for students showing disruptive behaviours to receive unbiased, ongoing support from faculty to redirect them down a more constructive path.

As the current CFMS National Wellness Officer, I had the opportunity to focus my talk on medical students crossing boundaries in the non-clinical setting. A discussion by workshop participants on the topic of residents dating medical students showed that this is often an accepted and popular behavior in the medical school community. However, it becomes a boundary issue if there is a power imbalance between the two individuals. For example, if the resident is required to evaluate the



2nd Canadian Conference on Physician Health. Toronto, Ontario.  
 From left to right: Susan Ryan, Melanie Rodrigues, Helen Yang, Natalia Ng, Fran Carr, Amandeep Takhar, Lauren LaCaprara.



# Ontario regional update

Ian Brasg

Ontario Regional Representative  
University of Toronto, Class of 2014

This year I have had the pleasure of representing the 6 Ontario medical schools — and their students — on the CFMS executive. My work to date has consisted of addressing some regional issues while setting the groundwork for nation-wide initiatives. We are fortunate to have a close collaborative relationship with the Ontario Medical Student Association, which keeps close tabs on provincial happenings, that allows their CFMS counterparts to focus on wider-scope efforts.

## Rural elective-funding austerity measures

For many years now Ontario has been privileged to enjoy generous funding for rural medical electives and experiences in concordance with provincial campaign promises and concerns for equity and the just distribution of resources. However, recent slowed GDP growth and worsening debt have forced the government to adopt austerity measures — and tighten its belt — in most public service areas. There are concerns that such measures will harm the funding received for rural electives arranged by the various regional programs, including ERMEP, NOSM, ROMP and SWOMEN. The CFMS believes that the opportunities afforded by the various rural medicine programs to medical students are crucial components of a durable solution to the underrepresentation of health profes-

sionals in such areas. Exposing future physicians to the joys of rural practice as early as possible helps to maximize the likelihood that they will ultimately practice in these areas. The CFMS has advocated for the distribution of scarce rural elective resources in a way that acknowledges the important role of such medical student experiences.

## Online professionalism initiative

As many of you know, the CFMS recently produced an excellent guide to professionalism from the student perspective. This guide has been well received by faculty from medical schools across the country, who especially loved the CanMEDS framework adopted. While most of the feedback was positive, one criticism of the document was that it did not go far enough in addressing online professionalism and social media concerns. The faculty leads readily acknowledge that this may be an area in which students are best positioned to contribute to the discourse and help shape expectations. Students themselves have also been expressing widespread concerns regarding appropriate medical student behaviour on the internet. As such, the CFMS is pleased to begin undertaking the production of a practical guide to online professionalism and social media. We anticipate that this guide will build on the great work already being done in this area by student

leaders from across the country. Please let me know if you are interested in getting involved!

## Medical student leadership survey

Lastly, we are in the early stages of producing a national, REB-approved survey on medical student leadership. The study of leadership in medicine is becoming an important topic in academia, in part due to the current climate of fiscal restraint. Some studies, for instance, have shown that hospitals led by physician-CEOs are less wasteful and have better aggregated clinical outcomes than those managed by CEOs without clinical training. Despite these benefits, numerous investigations have found disincentives to physician involvement in leadership at many stages of professional development and advancement. We are interested in scoping the current range of medical student experiences and perspectives on leadership, as well as the effect of medical education on such involvement. We hope that the results of this study will help improve medical education for our members down the road.

I'd like to thank you for your interest in Ontario and my portfolio, and hope that the preceding summary of my involvement has been informative. Please contact me at [ian.brasg@utoronto.ca](mailto:ian.brasg@utoronto.ca) if you have any questions or concerns, or would like to get involved!



# Lifestyle checklist

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# The CFMS global health program: A year in review

**Paxton Bach**  
**VP Global Health**  
**Queen's University, Class of 2013**

2011 was an important year for the CFMS and the GHP was no exception. The development and implementation of our new strategic plan led to a period of introspection and provided the impetus for us to closely examine all of our existing programs and partnerships. It has also meant a chance to put forward a concrete vision for the future of the GHP, to ensure the effectiveness and longevity of the program. The new CFMS website is providing us with a valuable opportunity to improve our communication, transparency and institutional memory — we are also working hard to unveil several new online services, so continue to check back often! Overall the strategic plan has been more than just a helpful exercise and we feel confident in the continued growth and evolution of our projects.

Alongside our strategic planning, this remained a busy and productive year for our programs. We received an incredible 400 applications from Canadian students for clinical and research exchanges this fall, and in turn will be attempting to place nearly 50 international students this summer who are coming to experience the practice of medicine in Canada. Below are a few more of the highlights we have seen over the past year from other global health portfolios.

## Global Health Education

The theme of the 2012 Canadian Conference on Medical Education (CCME) is Global Health. This not only highlights the importance of this

topic to Canadian medical students, but also provides us with a golden opportunity to showcase the work done by the GHP. Front and centre will be our collaboration with the AFMC Global Health Resource Group and the Global Health Education Consortium to establish core competencies in Global Health for inclusion into undergraduate medical curricula. Covering a breadth of topics from the global burden of disease, to the social and economic determinants of health, this is an amazing opportunity to present our vision of the basic pillars of Global Health necessary for a comprehensive medical education. Also being presented at the CCME for the first time will be the work of the GHP on helping establish elective global health programs at Canadian medical schools. This meeting is a culmination of years of effort from several generations of National Officers of Global Health Education and a fantastic opportunity to applaud their diligence and hard work.

## Global Health Advocacy

The Global Health Advocacy Program theme for 2012 is once again “Immigrant and Refugee Health”. Since this theme was chosen one year ago, educational and advocacy programs have been established all across the country. Existing projects include the creation of or placement of students into immigrant and refugee health clinics, the development of immigrant and refugee cases for use in clinical skills programs, and the arrangement of cultural competency lectures for medical stu-

dents. On a national level the GHAs have begun a coordinated campaign to bring attention to Bill C-4, an amendment to the Immigration and Refugee Protection Act that threatens to have a significant negative impact on the manner in which we treat refugees arriving in Canada. Lastly, work has now begun on “The Book of Refugee & Immigrant Stories”, a publication that will contain a collection of stories describing real-life interactions of these at risk populations with the Canadian medical system. This promises to be a useful educational and advocacy tool, and will be widely distributed upon its completion later this spring.

## Aboriginal Health

The position of Aboriginal Health Liaison was created by the CFMS in Saskatoon at the 2010 CFMS Annual General Meeting. From the outset the goals of the position were to promote the incorporation of Aboriginal Health content in Canadian medical schools, to work in collaboration with Aboriginal Health interest groups at medical schools across Canada, and to serve as a conduit for communication with the Indigenous Physicians Association of Canada (IPAC). To this end the AHL has built strong ties with IPAC and is coordinating with them on a number of initiatives directed at improving Aboriginal health in Canada. A key goal for the following months will be to examine the extent which Aboriginal health is included in Canadian medical school curricula and to advocate for the adoption of the core com-

petencies in Aboriginal Health (as outlined in the document “First Nations, Inuit, Métis Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education”) as mandatory components of undergraduate medical education in Canada. The AHL has also begun a partnership with STOP TB Canada, calling for improved funding for tuberculosis research and treatment worldwide, and increasing awareness of the high burden of tuberculosis in the indigenous Canadian population.

**Reproductive and Sexual Health**

The focus of the GHP in the realm of

reproductive and sexual health this year was once again organizing campaigns and providing resources to help schools mark World AIDS Day. On an international level, the CFMS participated in the International Federation of Medical Students “Get to Zero” campaign against HIV, collaborating on a video with 23 other member countries. Sights are now set on building up resources to help observe other important WHO dates including International Women’s Day and the International Day against Homophobia. These will be accessible by all on the new GHP section of the CFMS website. Additionally, HIV electives are taking off at many Canadian

schools and this project has now merited publication by the Ontario HIV/AIDS Treatment Network, the OMA’s Scrub-In, and will be presented at the IFMSA General Assembly in Accra, Ghana this March.

I would finally like to take this opportunity to recognize each of the 2011 Global Health Program National Officers for the countless hours of hard work spent on overseeing their individual programs, and for all of their contributions to the GHP strategic plan. The amount of effort each of them has put in is commendable, yet often underappreciated. Congratulations, and thanks to each of you for a successful year!



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The **Cumberland Health Authority (CHA)** provides health care services to this northern-most part of Nova Scotia. The District’s services range from acute to long-term care and include public health, addiction, mental health and primary care programs. From five health care facilities and several community-based sites, a total staffing complement of nearly 800 health professionals and support staff provide quality care to Cumberland County’s 33,000 citizens.

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# Global health certificates: Expanding access to global health education in Canada

David Matthews, National Officer of Global Health Education (outgoing), University of Toronto, Class of 2014  
Mary Halpine, National Officer of Global Health Education (incoming), Dalhousie University, Class of 2014

In recent years, there has been growing demand for global health education at Canadian medical schools. Despite sustained student advocacy for increased global health teaching, medical schools often struggle to address this need. A survey of graduating Canadian medical students in 2011 showed that 44.8% of students felt that instruction in global health was inadequate.<sup>1</sup> As a result, many students participate in informal or extracurricular global health learning opportunities, including international clinical placements, global health lecture series and volunteer opportunities with marginalized communities in their local area. However, these programs often lack the structure and supports necessary to provide students with adequate training in global health.

Recognizing the need for more comprehensive global health education, several Canadian medical schools have begun to offer elective global health certificate programs. These programs combine a number of different global health learning opportunities into a cohesive program. The best developed of these certificates is the “Making the Links” program at the University of Saskatchewan.<sup>2</sup> This program combines in-depth coursework in global health with community placements in a remote community in Northern Saskatchewan and at a

partner site in Mozambique. In addition, students complete a longitudinal placement in the context of an urban underserved community at the SWITCH clinic in Saskatoon. By participating in this type of program, students are able to experience the local, national and international aspects of global health, while gaining a solid academic foundation in the field.

Inspired by the success of “Making the Links,” the CFMS Global Health Program is working with our faculty partners to create a set of National Guidelines for Elective Global Health Certificates. It is hoped that these certificate guidelines will provide greater recognition for students participating in extracurricular global health learning activities, and will serve as a template for schools that are looking to develop similar programs. Key elements of the guidelines include:

- a. **Local community engagement** through clinical and/or research experience with community-based organizations.
- b. **Global health coursework** either within the school’s curriculum, through extracurricular events or self-directed learning.
- c. **Low-resource setting elective** in a community within or outside of Canada, for a minimum duration of 4–6 weeks.
- d. **Pre-departure training and post-return debriefing** before and after the low-resource setting elective.
- e. **Student evaluation** with fellow students and faculty. This may include methods like portfolios or written reports.

These guidelines are intended to be flexible and adaptable to the global health opportunities available at different medical schools. An initial draft was presented at the CFMS Annual General Meeting in September 2011 and generated lots of discussion. We are hoping to present a finalized draft of the guidelines at the CFMS Spring General Meeting in Banff. The next article describes the efforts by students at the University of Calgary to establish a Global Health Certificate. If you are interested in establishing a similar program at your school, please contact [noghe@cfms.org](mailto:noghe@cfms.org) or your school’s Global Health Liaison.

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# University of Calgary's global health concentration pilot

Rita Watterson, Global Health Liaison Sr., University of Calgary, Class of 2013

Kimberly Williams, Global Health Liaison Jr., University of Calgary, Class of 2014

In our current globalized society, there is an urgent need to prepare future physicians to face pressing global health issues. It is well recognized that the “immediate need for global health medical education has not been adequately addressed by medical schools.” Currently, medical education regarding global health allows students only a glimpse into this burgeoning field, and is elementary and sparse in nature. In an effort to shift this tide, undergraduate medical education train future doctors to meet the diverse range of health conditions we face as a global community.

## Program development

The Global Health Concentration (GHC) pilot program was developed in an effort to provide hands-on learning experiences for future medical students. Inspired by the ‘Making the Links’ program developed at the University of Saskatchewan, the GHC was envisioned and implemented over a 10-month period as a student-run program with support from faculty and staff. Working with the Undergraduate Medical Education office and the Global Health Department we developed the concentration to fit as closely as possible within the existing curriculum. Currently, practical opportunities to apply curriculum knowledge and theory in the community are limited. Thus, current medical graduates may lack the necessary

skill sets to work with these patient populations.

Students participate in three inner city clinics within a service-learning model in order to understand the unique challenges of underserved populations in Calgary. During pre-clerkship electives, they go to Tanzania to work alongside fellow students through our partnership with the Bugando University. Throughout their undergraduate training they are involved in monthly journal clubs and seminars under physician mentorship and evaluation.

As a student-led program working with current undergraduate medical curriculum, we have realized the importance of faculty involvement and support. Recently, the Global Health Department appointed a faculty consultant, a big step forward in ensuring the permanency of this program. With a combined effort across the country we hope more medical students will engage in working with underserved populations during their training and in their future practice.

## To be or not to be a ‘globie’, now that is the question!

Not every medical student is as interested in doing a Médecins Sans Frontières mission, but based on the diversity of the country that we will practice in, we will not be sheltered from a rich array of patients. At the University of Calgary, there are quite

a number of students who are interested in global health. The ‘global health’ that I believe in includes the idea that globalization has created legal, political and cultural interactions that impact the health of every country in innumerable ways. Globalization has made the nationally defined world more intricate, by defining the world as a complex of nations and regions as well as a single social space.

The creation of the GHC has given us students the opportunity to explore ‘global health’ as we learn to become clinicians. It is allowing us to explore the supraterritorial nature of our globe in hopes that no matter where we practice, we will be prepared to be the most effective physician that we can be. It is through this program that we hope to act as physician advocates both inside and outside of the health system.

Submitted on behalf of the University of Calgary GHC Student Led Group: Giselle De Vetten, Cherie Nicholson, Adam Thomas and Adam Wiebe

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# What will you be wearing on April 11?

## *The Day of Pink and the International Day Against Homophobia and Transphobia 2012*

**Joshua Dias**

**National Officer of Reproductive and Sexual Health  
Northern Ontario School of Medicine, Class of 2014**

2011 brought many highs when it comes to lesbian, gay, bisexual, transgender and queer (LGBTQ) rights. US Secretary of State Hilary Clinton gave a speech to the UN stating it should never be a crime to be gay. Zimbabwe's Prime Minister said he hoped for a new constitution with freedom of sexual orientation. Argentina passed a comprehensive law on transsexual equality. However, for LGBTQ people living in one of 76 countries where homosexuality is criminalized, the situation is not getting better — there was a new wave of arrests and convictions for being gay in Cameroon, political leaders in Ghana threatened to get rid of gays from society, people were executed in Iran for their sexual orientation and there were reports of arrests and detention of LGBTQ individuals in countries like Iraq, Bahrain, Saudi Arabia and Tanzania.<sup>1</sup>

Here in Canada, we are proud to be leaders when it comes to gay rights. However, while we have made a lot of progress when it comes to laws (transsexual rights being the last major front), we still haven't ended discrimination against sexual minorities. The results from the first national climate survey on LGBTQ discrimination in Canadian schools were shocking: 55% of sexual minority students reported verbal harassment and 21% physical harassment because of their sexual orientation; and almost two thirds felt unsafe at school.<sup>2</sup> According to Statistics Canada, hate crimes based on

sexual orientation more than doubled in 2008, and increased another 18% in 2009; three-quarters of these crimes were violent and most resulted in physical injury to the victim.<sup>3</sup>

Health and human rights are closely linked and the impact of homophobia and transphobia on health has been well studied. Some LGBTQ individuals avoid seeking health care or withhold personal information for fear of discrimination. Many develop emotional, psychological and substance abuse problems due to prejudice and violence. Increased rates of some STIs, cardiovascular disease and some cancers have also been reported. Sexual minorities are also two and a half times more likely than heterosexuals to attempt suicide<sup>4,5,6</sup>. This statistic took a human face last

year when 15 year old Jamie Hubley from Ottawa, who after years of battling depression and bullying because of his sexual orientation, took his own life.

While the picture may appear bleak, many organizations are stepping in to fight discrimination, and promote inclusivity and diversity. The CFMS's Global Health Program is proud to count themselves as one of the organizations who believe it's essential to promote human rights for all people, including sexual orientation and gender identity, in order to solidify our commitment to global health. Thus, this year we will be teaming up with a leader in anti-bullying and anti-discrimination, charity Jer's Vision, to host events for the International Day of Pink.



Northern Ontario School of Medicine celebrates their first Day of Pink in 2011 and is looking forward to participating again in 2012!



The Day of Pink was created after a Nova Scotia high school student was bullied for his sexual orientation and for wearing pink. Two of his straight peers intervened to support the student. They purchased pink t-shirts and encouraged everyone at their school to arrive wearing pink — showing solidarity in stopping homophobic and transphobic bullying.<sup>7</sup>

This year, the CFMS's team of Local Officers of Reproductive and Sexual Health (LORSH) are going to bring that message to medical schools across Canada and we're inviting you to participate! Simply wear pink on April 11th to show your support for fighting bullying and discrimination and promoting diversity. In addition, the LORSH team will be putting on various presentations and events to cel-

... wear pink on  
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promoting diversity.

ebate the upcoming 2012 International Day Against Homophobia and Transphobia. We at the CFMS look forward to playing our role in promoting equality with the hope of improving the health of LGBTQ people in Canada and around the world.

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### University of British Columbia

This year, UBC has seen a great number of students from all four years get involved in ongoing initiatives and starting up new ones! Arts in medicine groups have solidified their place in our program. Students, residents, faculty and friends enjoy attending the Medplay, coffeehouses, art shows and *Medicina: the Arts and Healing Conference* each year.

Wellness is important as we work hard through medical school and our Wellness Initiative is a student-run group that offers yoga and medfit workouts weekly, nutrition seminars and a Wellness Newsletter to help maintain work-life balance.

Students interested in politics and advocacy are involved with UBC's Political Advocacy Committee, which is building toward a provincial lobby day.

Community outreach and education remain popular volunteer opportunities for students who want to get involved with the many different populations in BC. A Special Olympics health fair runs each year, as well as multiple aboriginal health outreach programs, including in the Downtown Eastside. Run for Rural Medicine is hosted at each of UBC's distributed sites annually to raise awareness about rural medicine, as well as to keep our students in shape!

UBC's Global Health Initiative sends students to communities across the globe each summer to implement education and building projects.

We can't forget our many interest groups, clubs, sports and social events that keep us busy throughout the year! With too many initiatives to highlight, every student at UBC has the opportunity to get involved in something that motivates them.

### University of Alberta

At the University of Alberta, we have a number of exciting projects and initiatives on the go including our student-

led Professionalism Committee, the Health Advocacy Leadership Program and our intra-faculty collaboration initiative with the dentistry, dental hygiene and medical laboratory science student associations.

One of our goals is increasing student engagement both with the MSA and the CFMS. Last September we were able to send more delegates to the CFMS Annual General Meeting. Increased interest and attendance resulted in the development of a new student wellness initiative sparked by two first-year students who attended the meeting in Calgary.

September 2011 also included the opening of the Edmonton Clinic Health Academy, a student-focused health sciences centre designed to promote interdisciplinary collaboration. The new building is home to 12 health science research and education groups including medicine, dentistry, nursing, public health, pharmacy, rehabilitation medicine and nutrition. We hope that sharing the facility will encourage more partnerships between the MSA and our health care colleagues.

In other projects, we are currently conducting a review of the MSA constitution, our Political Advocacy Committee and Alberta Medical Association Reps are collaborating on a Health care Symposium, and arranged a student forum with the CMA Presidential Nominees.

Some of our future projects include the major task of preparing for accreditation in 2014. Finally, we look forward to continuing to improve the experience of medical students at the U of A. The class of 2011 were #1 on the LMCC exams, and we hope that we can continue to expand the good work being done by students at the U of A.

### University of Calgary

It has been yet another exciting year at the University of Calgary Medical

School. Each year in early February, the U of C joins forces with the University of Alberta medical school for a fun-filled weekend conference in Banff. AMSCAR (Alberta Medical Students Conference and Retreat) offers a wide array of learning opportunities, including sessions on suturing and basic airway skills, as well as yoga, photography and hiking. This annual event is organized by both U of C and U of A students and is consistently one of the best "conferences" of the year!

In February 2011, the CMSA organized the annual U of C Head Shave fundraiser, raising over \$18,000 to support Brain Cancer research via the Canadian Cancer Society. In response to the Japan Earthquake disaster, the U of C organized a Japan Earthquake Relief Fundraiser and collected over \$9,000 to support the Red Cross.

Members of the Class of 2013 CMSA council participated in the CFMS Spring General Meeting. The CMSA was heavily involved in organizing the CFMS AGM, which was hosted in Calgary in September. The Class of 2013 CMSA council also organized Orientation Week for the Class of 2014, a week-long introduction to both the academic and extra-curricular lifestyle of the U of C medical school. O-week entails an Amazing Race event, Med Olympics, fun practice OSCEs and peripatetics, and many social events.

The Global Health Interest Group and CMSA VPs of Global Health organized the Rich Man Poor Man dinner, an annual event designed to raise funds for both local and international charities. This year the Rich Man Poor Man dinner raised over \$20,000.

Along with the Professional Association of Resident Physicians of Alberta (PARA), the CMSA participated in the third annual PARADime Backpack Drive. This event entails

recycling our medical school backpacks by collecting non-perishable food items, clothing and other daily necessities in these backpacks and donating them to local drop-in centres and homeless shelters.

Other activities planned include the 2012 Cancer Head Shave, Atrophy Cup (a hockey tournament for both current students and alumni) and participating in the upcoming Interview Weekend MMI & Orientation. As Calgary is hosting the next IceBowl in September 2012, a hockey tournament for all western Canadian medical schools, the CMSA is heavily involved in fundraising and organizing this highly anticipated event.

## University of Saskatchewan

For yet another year, the U of S has maintained an active student body. Our student council, the SMSS, continues to spearhead initiatives that address the needs of our students. Specifically, the inclusion of IMGs in the first round of Saskatchewan's CaRMs has led to countless discussions and a Town Hall meeting.

Creating a positive impact on our community is another goal of the SMSS, with male students participating in Movember, the annual Blood Drive, Adopt-a-Family at Christmas to support under-privileged families at Christmas, and Miles for Smiles a 5 km and half marathon runs to raise funds for the construction of a children's hospital in Saskatchewan.

The Political Advocacy Committee has lobbied the government regarding issues of medical education in our province.

The Physician Wellness Initiative continues to influence the student body to maintain a balanced lifestyle. Activities in this area include an inter-professional Wellness Week, dance classes, stress reduction seminars and providing healthy snacks to stressed exam writers.

Our Global Health Committee — Health Everywhere — consistently provides educational and experiential opportunities for medical students to address health issues throughout the world. Making the Links is a longitudinal rural and global program designed to introduce students to the social determinants of health. Along with this program, participants receive a university accredited certificate in global health, which is the first school in Canada to offer this distinction. In the fall of 2012, the global health committee will be hosting its first global health conference titled “Local Steps—Global Strides: building momentum for global health at the University of Saskatchewan”.

The University of Saskatchewan continues to grow and change. We are currently in the pursuit of a new Dean, expanding our class size and moving to a 2x2 curriculum as per the rest of Canada.

## University of Manitoba

With our recent successful accreditation process and current curriculum renewal project, students and staff at the University of Manitoba Faculty of Medicine have been busy! We still managed to find time for a wide variety of outreach initiatives on and around campus. Some are cemented traditions like the Jacob Penner Park and the Children's Hospital programs. Both regularly bring students and youth from our nearby community or paediatric wards together to interact and take part in wellness activities. Other programs, like the Winnipeg Interprofessional Student-Run Health (WISH) Clinic, continue to grow each year. WISH allows students from a number of disciplines the opportunity to develop their professional skills under mentor guidance, while providing an entirely free health care service to a population in need. Another growing tradition is our Movember

month that culminates in a coffee-house fundraiser for prostate cancer, featuring a number of moustached performers and audience members. Because of our limitless supply of musical talent, we hold a second coffeehouse fundraiser in the spring. Money raised will help support the United Way.

There is a growing presence of CFMS on campus. Following a successful Health Care Symposium that featured Dr. Michael Rachlis, PAC is now organizing our second annual Provincial Lobby Day. Though we have held a number of blood drives in the past, our first CFMS-affiliated Blood Services Council is leading the way for this year's events. Finally, our Global Health program will be holding its inaugural Rich Man Poor Man fundraising dinner in April in support of the Winnipeg Harvest, a local food donation program. We look forward to continuing this trend when we host the CFMS AGM in September 2012!

## University of Western Ontario

It has been a very exciting time at Western these past couple months. This is the first year we welcome the 4th-years back to our Windsor Campus, they are the first class to complete 100% of their medical education in Windsor.

The month of December was busy with social events, including our winter formal “Trapped in a Snowglobe” and FENdWIC, the Festive Non-Denominational Winter Celebration. We also held two day long clinical skills days, one in Family Medicine and one in Surgery. We have over 90 clubs at Schulich so there is something of interest for every student, with events taking place daily.

This term we plan to continue partying — at the Schulich Classic, Schulichpalooza, Spring Formal in Windsor and culminating in our annual musical production Tachycardia!

## McMaster University

McMaster's Michael G. DeGroot School of Medicine has been working on a number of exciting projects this past year. The medical students' lounge and the study space are being renovated to ensure our medical students can work, relax and socialize. We are also working to make sure students have access to internet at all the Hamilton Health Sciences hospitals, optimizing the Distributed Medical Education (DEM) technology for our two regional campuses in Kitchener/Waterloo and Niagara, and mobilizing more funds for electives and conference travel. As our online portal — MedPortal — plays a very important role in student education, our IT Team is working on optimizing and improving the system for maximum user-friendliness and accessibility with the help of a newly appointed committee.

## University of Toronto

Overall, the past year has been one of important change for the University of Toronto. The Faculty of Medicine officially welcomed its first incoming class of Distributed Medical Education undergraduate medical students in August 2011 with 54 new students beginning their studies at the new Mississauga Academy of Medicine. By 2015, the campus will be home to 216 students, adding to the already wide interaction of learners with the health networks of Credit Valley Hospital and the Trillium Health Centre. Warmly welcomed by all students, this expansion also has allowed students to expand extracurricular programming and engagement with additional populations and communities in the greater Toronto area.

In May 2012, the Faculty of Medicine will be undergoing accreditation by CACMS and LCME, and much work by both students and staff over the past year has been spent preparing for these visits. Through self-evaluations and appropriate con-

figuration around needed changes, the process has been a positive one and the Medical Society anticipates the outcome to be similar.

## Queen's University

There has been a lot happening at Queen's since we last updated everyone! In November, students ranging from 1st to 4th year organized and performed at the 42nd Medical Variety Night, a spectacular production featuring singing, short plays, dancing and musical talent. All proceeds from this highly success event are donated to local Kingston charities.

Currently, the Aesculapian Society is busy re-vamping our highly valued Mentorship program in which students from all years are organized into groups with a pair of faculty members. This program allows students and faculty to interact socially and enjoy various planned events such as formal dinners, trivia nights and competitions, in addition to other informal plans made by groups throughout the year. Queen's students are also in the process of planning the annual Global Health Gala, which features drinks, dancing and a silent auction. The gala seeks to raise funds for a selected charity that supports global health initiatives.

The start of the 2011–2012 school year also saw the opening of Queen's New Medical Building — a new building dedicated specifically to Queen's School of Medicine. The building is a state-of-the-art teaching and learning facility, with fully equipped surgical and technical skills labs, leading edge classrooms, clinical teaching space and everything else a medical student needs!

## University of Ottawa

**OMSW:** The University of Ottawa has the privilege and honor of hosting the Ontario Medical Students Weekend (OMSW) in October 2012 — the largest annual medical student conference in Canada. Having already com-

pleted 8 months of planning, our team is still hard at work. With committees and subcommittees totalling more than twenty individuals, we hope to make this the largest OMSW to date, inviting up to 800 delegates. Our theme this year will be "Shaping Health Care on the Hill". Being in the nation's capital and just a few steps from Parliament Hill, this conference will allow medical students to practice clinical skills as well as become politically engaged and develop advocacy skills needed to become health care leaders.

**TedxOttawa:** Who hasn't heard of the award winning Technology, Entertainment and Design (TED) conferences? Through their world renowned conferences they have successfully enriched the creativity of millions and have spread ideas that inspire throughout the world. This fall at the University of Ottawa Medical School we hope to draw from this success with our own TedxOttawa (where x= independently organized) rendition. Emphasizing the importance of International Health and exploring specific yet broad arenas including refugee/immigration health and maternal health we are beginning to plan a fantastic line up of diverse speakers. Email [tedxuottawagh@gmail.com](mailto:tedxuottawagh@gmail.com) if you have questions.

## Northern Ontario School of Medicine

**Lights, Camera, Action!** In December, it was announced that a new medical drama — loosely inspired by NOSM — will soon begin production in Northern Ontario. *Hard Rock Medical* is an offbeat half-hour drama that follows a diverse group of medical students navigating their way through a fictional school's four-year program. Appearing on both TVOntario and the Aboriginal Peoples Television Network, *Hard Rock Medical* promises to provide engaging insight into some of the unique features and challenges

of delivering health care in Northern Ontario.

**Here we go again!** In March, NOSM will host its second MD program accreditation site visit since gaining full accreditation in 2009. NOSM is very different from all other medical schools, with a unique organization and curriculum. Administration, faculty, staff and students at both campuses are busy preparing to receive the accreditors and ensure that they understand our great school and are persuaded that, in our own way, we are in compliance with all 130+ standards.

**Rendez-Vous 2012!** Next October, NOSM will be hosting five world conferences in one — Rendez-Vous 2012. This conference will bring together the Wonca World Rural Health Conference, the Network: Towards Unity for Health Conference, the NOSM/Flinders Conference on Community Engaged Medical Education, the Consortium for Longitudinal Curricula, and the Training for Health Equity Network. The whole world of innovation in health professional education will be coming to Northern Ontario. Check out the conference website ([www.rendez-vous2012.ca](http://www.rendez-vous2012.ca)) for more information and the call for abstracts.

### **Dalhousie University**

Dalhousie University Medical School is going through a period a change and transformation. With the creation of a new Distributed Medical Education site in Saint John, New Brunswick, students at Dalhousie have been working to overcome new challenges as well as old. The increase in undergraduate seats that the Dalhousie Medicine

New Brunswick (DMNB) campus created has made more relevant the discussion about residency opportunities in Atlantic Canada and how students need to become involved in the discussion.

The Dalhousie Medical Students Society (DMSS) is continuing a remodeling process begun last year with the reworking of its constitution. In an effort to infuse our governing document with greater institutional memory and internal consistency, the DMSS has developed a framework for a constitution that better suites its purpose. Now we have a document that works better to support students, instead of existing as a perpetual annoyance to them.

Looking forward, students at Dalhousie are excited to explore ways through which our newfound presence in a second province can help expand the reach of medical students' influence in Atlantic Canada, as well as solidifying our current endeavors at the level of the DMSS, both internally and externally.

### **Memorial University of Newfoundland**

The 2010–2011 school year has been busy for MUN Medicine and several new student-led program initiatives were launched!

Memorial was awarded the CMA Leadership Innovation Fund to start a Rural Medicine Interest Group (RMIG). Heidi Wells (RMIG President, 2014) has organized outreach to students in rural NL through presentations in high schools and housing for rural applicants interviewing at MUN Med.

The Gateway program (est. 2006) through the ANC facilitates first medical contact with refugees and immigrants arriving in NL. Our Gateway coordinators, Paul Crocker and Catherine Winsor (2014), have integrated a physical examination component for a higher quality of care for patients.

Zack Warren (2014) started the Emergency Medicine Interest Group including clinical case presentations by ER physicians and Paramedic ride-alongs. This allows MUN Med students an opportunity to appreciate what happens before the patient arrives in the ER.

MUN MSS and the CFMS are lobbying against a proposed PEI Return of Service contract, to be implemented in 2013. Lindsey Ward (PAC Rep, 2014) is leading this initiative, completing interviews and drafting media releases to make the public aware of this topic. We are working towards a solution that addresses the recruitment issues for physicians returning to PEI.

Memorial's Global Health Interest Group has continued involvement with 12 loans through the KIVA lending program, raised money for numerous charities on World AIDS Day and plans to have a documentary screenings for students.

Other interest groups have continued to grow in the 2010–2011 school year, including: the Family Medicine Interest Group, Pediatrics Interest Group and Surgery Club.

As always, MUN Med has put an emphasis on Student Wellness and the MSS has arranged many social events for students.



# Brink of a revolution — From chocolates and roses to social responsibility and humanitarianism

*Students from the University of Toronto challenge community to change?*

**Gautam Goel**

**University of Toronto, Class of 2014**

As thoughts of chocolates, roses and other greeting card-esque clichés wistfully meander through people’s minds around Feb. 14, the current state of world affairs was hardly so rosy. A tumultuous 2011 — littered with the devastating earthquake in Japan and ensuing nuclear crisis, the horrendous drought in East Africa and continued strife despite the fall of Libyan leader Col. Muammar Gaddafi — was far from a distant memory. Despite all of this happening around the world, students from the Faculty of Medicine at the University of Toronto saw an opportunity in its midst. Working over the past four years as active proponents of social responsibility and humanitarianism, students were looking towards Valentine’s Day as a chance for change as they work feverishly to host their annual Global Heart Hour event.

“Our goal is to refocus Valentine’s Day from its materialistic nature to one that concentrates on humanitarianism and encouraging social responsibility,” said Hussein Jaffer, a second-year medical student at U of T and the current director of Global Heart Hour. “That’s why my good friend and colleague, Vanessa Rambihar, first started this initiative in 2009; we see the potential to redefine Valentine’s Day into something that could be the force

for positive actions and change. This change can only happen if we all participate, so we encourage all members of the community to join us.”

A grass-roots student-run initiative, Global Heart Hour emerged from a 25-year Valentine’s Day heart health promotion project. The 2009 launch focused on heart health, occurring in the midst of the global food, financial and climate crises. The link between cardiovascular health and poverty and development was noted, and the community was invited to promote heart health to make a better world. The event seeks to inspire and sustain humanitarianism in the face of decline and inspire communities to collaborate to continue to make a difference. Global Heart Hour believes that humanitarianism remains the most crucial motivation and means for intervention globally.

This year marked the fourth Annual Valentine’s Global Heart Hour, which was started by an enterprising and creative team of medical students at the University of Toronto and involves a large part of the university community. Featuring a panel of distinguished leaders and speakers, the event used a student-run open concept approach and is a Valentine’s celebration to share ideas, celebrate student involvement in charitable and volunteer work, and inspire

one another to sustain humanitarianism. Global Heart Hour included an audience-driven discussion to encourage collaboration and inspire each other to continue to do more for the world.

The celebrations included an interprofessional Red Party in support of Global Heart Hour and fundraised for a charity of choice. This year’s charity, Borderless World Volunteers, an organization active in health, education and economic development projects. Last year, the Red Party raised over \$1500 for Right To Play.

*Be part of Global Heart Hour and use the sentiment of heart on Valentine’s Day as inspiration and focus to change your world.* Whether by yourself, with friends, families or colleagues, we encourage you to join us and be part of a global collaboration. We encourage you to take an hour to do something similar, or create your own Global Heart Hour to make a difference. Share your thoughts, blog, Facebook, tweet, use YouTube, etc. to share with the world and see what others are doing. Be part of taking this global — just as we turn lights off for Earth Hour, let’s turn our hearts on for Global Heart Hour. For more information please contact [Vanessa.rambihar@utoronto.ca](mailto:Vanessa.rambihar@utoronto.ca) or [h.jaffer@utoronto.ca](mailto:h.jaffer@utoronto.ca) or see [www.facebook.com/globalhearthour](http://www.facebook.com/globalhearthour).

# Memorial's Rural Medicine Interest Group

**Fady Kamel and Heidi Wells**  
**Memorial University, Class of 2014**

The shortage of rural family physicians is a critical issue across Canada. The latest available StatsCanada survey suggests that up to 10% of people in Newfoundland and Labrador (NL) do not have a regular doctor.<sup>1</sup> Furthermore, studies show that medical students from rural origins are more likely to pursue family medicine and practice in rural areas.<sup>2,3,4</sup>

To tackle this problem, Memorial University started the Rural Medicine Interest Group (RMIG) as part of a grassroots effort to combat NL's rural physician shortages by increasing the number of rural students applying to medical school. This program has a two-pronged approach: 1) mentoring rural students already attending university and 2) motivating high school students to attend university and ultimately medical school.

To mentor students already attending university, we are currently hosting a series of Lunch & Learn seminars where students have the opportunity to gain knowledge about the positive and negative aspects of rural medicine. Each seminar has a general presentation where a physician or resident presents their knowledge, experiences and thoughts on practicing medicine in rural NL. Following this, there are small group sessions where the attendees have an opportunity to discuss with medical students

the process and challenges of applying to medical school. So far, we have had great success with the seminars.

To motivate high schools students, we have set up an advertisement campaign that targets high schools across

## Memorial University started RMIG ... to combat NL's rural physician shortages

the province to educate guidance counselors and students on the feasibility of medical school as a career option. We will also be doing a series of schools visits to encourage students to attend university. One of the greatest barriers for rural area students is the cost associated with going to university. On our visits we will educate them on the numerous sources of funding and support available to those who attend university. One advantage of RMIG is that many of the medical students participating in the program have rural backgrounds and can use this to show the rural students that it is actually possible to get a post-secondary education. Also, by exposing the students to medicine as a career option so

early, we hope to increase the number of rural students applying to and entering medical school in the long term.

To track the progress of RMIG's efforts, we are conducting a prospective study to determine how effective this approach will be and hope to publish the results in the coming years. We also hope that in the future, this effort will be replicated in other medical schools across the country.

### Acknowledgments

This project has been made possible by funding from the Canadian Medical Association, Memorial University's Faculty of Medicine and Memorial University's Office of the President.

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# Vancouver Native Health Society Clinic — a student directed initiative

**Nathan Wong, University of British Columbia, Class of 2013**

**Roveena Sequeira, University of British Columbia, Class of 2014**

It has been previously reported by various groups that the Aboriginal population are overrepresented in the lower health demographics.<sup>1,2</sup> Compared to the general population, Aboriginal people have higher rates of diabetes, HIV/AIDS, alcohol related deaths, hospitalizations and preventable admissions.<sup>2</sup> In Canada, there are approximately 1.4 million Aboriginal people, of which 150,000 are in British Columbia.<sup>2</sup> In addition, over 50% of Aboriginal communities live in urban settings such as Vancouver.<sup>2</sup> Community Health Initiative by University Students (CHIUS) is a student directed group that recognized the importance of addressing these disparities and offering this vulnerable community specialized health care services. In 2007, CHIUS initiated a cooperative student directed clinic with the Vancouver Native Health Society (VNH) Clinic. The VNH Clinic is one of three major health care clinics situated in Vancouver's Downtown Eastside that provides its services to over 9000 Aboriginal people with the goals to promote and improve the physical, mental, emotional and spiritual health of its patients.<sup>3</sup>

It is generally agreed upon that Aboriginal health has been negatively affected by many external and social factors. In order to truly improve health

status, social determinants of health would need to be addressed.<sup>1,2</sup> Aboriginal people face many social issues including, but not limited to a loss of traditional lifestyles/culture, homelessness, unemployment, discrimination, violence, sexual exploitation and substance use.<sup>2</sup> At the VNH Clinic, under the guidance of a physician and nurse practitioner, volunteer UBC medical and nursing students facilitate a comforting and respectful environment, and provide after hours health care to this vulnerable population.

The guiding principles of the VNH Clinic are service, learning, inter-professionalism, reflection and student leadership. Students apply their studies to a clinical environment and are responsible for taking a complete history and systems-focused physical exam, as well as formulating a differential diagnosis and management plan. Students then present the patient case to the staff physician and nurse practitioner, discuss the case and then see the patient together. At the end of each 3-hour shift, interesting cases are reviewed, successes and difficulties are addressed and further learning ensues. Educational seminars are also arranged to further educate students about issues such as Aboriginal health, addiction and street drugs. Experts in the community and volunteer patients

serve as guest speakers to talk about their related experiences and engage the group in discussion.

The VNH Clinic provides students with the opportunity to develop an understanding of inner city health and Aboriginal populations, as well as gaining some hands on interdisciplinary experience. Students learn about the challenges and rewards of practicing Aboriginal and inner city health care. In providing such experiences early in training, it is hoped that more future health care providers will be attracted to practice in these areas.

## Acknowledgements

We thank Dr. Aida Sadr, VNH physician and Sarah-Jane Crossen, VNH nurse practitioner, for their continued support of this program.

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# Bone marrow stem cell donation project at UBC

Ying Yao, Merry Gong, Rui Chen, Donald Yung, Celeste Loewe  
University of British Columbia, Class of 2013

Various life-threatening disorders (e.g., leukemia and lymphoma) can be treated with allergenic hematopoietic stem cell transplants, which involve transplanting the donor's healthy stem cells to the patient's bone marrow to replace diseased cells. Allogeneic donors and recipients must share compatible tissue markers (HLA) to minimize complications such as graft-versus-host disease. Contrary to common belief, the majority of patients (>70%) are unable to find a match within their families and must rely on the OneMatch Stem Cell and Marrow Network to search for an unrelated donor.

Since a patient's best chance of finding a non-related donor match is within the same ethnic group, it is important to have adequate representation for all ethnicities in the stem cell registry. Unfortunately, for reasons unknown, Chinese individuals are quite underrepresented in the global stem cell registry. Out of the 13 million registered donors in the Bone Marrow Donors Worldwide database, less than 4% are of Chinese origin. Chinese-Canadians make up only 2% of the Canadian registry. Furthermore, young adults, whose stem cells are healthiest and most suitable for donation, have relatively low registration rates in the OneMatch Stem Cell and Marrow Network.

To address these issues, we created the Bone Marrow Stem Cell Donation Project at the University of British Columbia (UBC). Our project consist-

**Contrary to common belief, the majority of patients are unable to find a match within their families**

ed of three phases. During the first phase, UBC students aged 19–30 and of Chinese descent were surveyed to investigate common barriers or misconceptions that help to explain why Chinese-Canadian young adults are underrepresented in the OneMatch Network. Phase two involved holding a workshop to raise awareness and educate UBC students regarding hematopoietic stem cell donation process. Finally, we held two on-campus stem cell drives to increase donor registration in this age group.

Preliminary survey results show a lack of understanding of the process involved in hematopoietic stem cell transplants. For example, even among the 10% of respondents who are already registered as potential donors, 70% of them were not aware that hematopoietic stem cells can be collected from peripheral blood. It is hoped that the results of this project will be a valuable resource to contribute to the success of future stem cell campaigns and the

recruitment of potential donors.

We also successfully held two on-campus stem cell drives at UBC with the help of volunteers. Our final tally of newly recruited donors was 460 — many more than we had expected! Through our efforts, we also encouraged some of our first-year colleagues to continue these drives in the coming year.

Over the course of the project, we were able to fulfill many of the CanMEDS competencies. Forming an understanding of the barriers to stem cell donor registration is much like assessing our future patients' pre-formed notions and core values required for any effective medical consultation. We also learned to assess people's attitudes in an effective, culturally-sensitive, and client-centred approach, which is an important component of the "Medical Expert" competency. The project enabled us to collaborate extensively amongst ourselves, external organizations (OneMatch and the OtherHalf Chinese Stem Cell Initiative), other medical experts, as well as the media. Excellent communication, resource management, organization, and timely decision-making are all essential for an effective collaboration — in turn developing our skills which are integral to the "Collaborator", "Communicator", "Manager", and "Professional" competencies. As our project has been committed to raising public awareness, we have also developed our competency as "Health Advocates."

# Teach me how to doctor

**Srimal Ranasinghe**  
 Husband of Carolyn Wong-Ranasinghe  
 University of Calgary, Class of 2013

I feel like being married to a medical student is making me linguistically smarter. This is probably partly because I have no friends of my own, and thus attempt to leach off my wife's social circle. So I end up spending an inordinate amount of time around medical-types. I am frequently part of vocabulary-expanding conversations such as the following:

**Med student A:** "Have you taken a look at the CaRMS website yet... sounds like things are getting pretty brutal for the 3rd years."

**Wife:** "I'm only a first year...I hear arranging pre-CaRMS electives is pretty intense for the second years, though."

**Doctor Person:** "Which section are you guys in? MSK?"

**Med student B:** "Yeah, MSK/Rheum/Derm. But I'm finding this new TBL approach to be a bit painful. All those G-RATS and I-RATS..."

**3rd-year student:** Oh TBL! By the way, which class are you guys in? Blobfish or Aye-Ayes?

**2nd-year student:** I'm a Blobfish. Hey, nice nametag. Which class was the Shree-Malls?

**Me:** Umm...that's actually the phonetic pronunciation of my name.

Over the course of the year I discovered that TBL stands for Team Based Learning and doesn't involve anal probes. G-RATS and I-RATS are not a new species of furry rodents specially created to run around mazes, press levers or generate electricity by running on large wheels. Apparently

## Medicalese ... I dub thee the language of love.

they are groundbreaking methods of learning, testing and evaluating all rolled into one.

MSK turns out to be short for "musculoskeletal" as opposed to a covert government agency overseeing super-secret testing. "Rheum" and "Derm" aren't new passwords being used by the CIA, but are short for Rheumatology and Dermatology respectively. Look them up on Google/Encyclopedia Britannica/microfiche at your local library sometime.

"Blobfish" and "Aye-Ayes"... I'm yet to figure out the reasoning behind naming one's med-class after ugly creatures. Google informs me that the latter is a spectacularly ugly creature that belongs to the lemur family. Try to imagine the offspring of a meerkat mating with a rabid hyena that indulged a cocaine habit for most of her life, and you may just see an Aye-Aye in your mind's eye. The Blobfish is an even more hideous creature. Given that it resembles Mick Jagger's shrunken head after being run over by a steam-roller and dipped in a vat of boiling oil, I understand its recalcitrance to appear in the public spotlight.

I have also discovered that medical students think in radically different ways than the rest of us. We were play-

ing *FunGLISH* with a group of friends involving two teams — med students versus non-med students. The objective of *FunGLISH* is to lay out various pre-set adjectives that describe words to be guessed by your team.

Here's a brief excerpt from the game:

**Team NMS 1 (Non-med students):** "What's 'Large', 'Grey', 'Non-human', 'Living', 'Heavy'?"

**NMS 2:** "umm...a rock?"

**NMS 3:** "Iron Man...or Woman?"

**NMS 4:** "an elephant?"

**NMS 1:** "Yes!"

**Team MS 1 (Med students):** "What's 'Big', 'Yellow', and 'Dangerous'?"

**MS 2:** "Ah...Cholesterol?"

**MS 3:** "No no...adipose tissue?"

**MS 4:** "Actually \*giggle\* I think it's an adenocarcinoma."

**MS 3:** "Ha! That's genius ... but I think it's most probably a mesenchymal tumor."

**MS 1:** "No no ... guys, come on. Seriously!"

What really stumped me was that I never would have thought of "Cholesterol" as "Big, yellow, and dangerous"! Silly me, I was thinking of things like "a large bonfire", "the sun", or "Yao Ming"!

Needless to say, the non-medical students won the game by a large margin.

But what's really important is that I finally feel I can communicate with my wife as an equal. Aaah *Medicalese* ... I dub thee the language of love.

# You're WHAT?!

Joshua Lai

University of British Columbia, Class of 2014

“The next one’s interesting,” the nurse called out to me as she passed by. “70-year-old woman, thinks she’s pregnant. Probably dementia, if you ask me.”

My eyebrows shot up incredulously as I turned to thank her. Recomposing my face into the neutrally friendly, calm demeanor I was learning to associate with professionalism, I knocked and entered. Across the room sat Meredith, wearing copious amounts of make-up, large flashy rings on her wrinkled hands and a wig of dark red hair that nearly hid her age.

I introduced myself and began the interview. “What brings you to the office today, Meredith?”

She replied, “I think I must be pregnant because I’ve been having all the symptoms of pregnancy. And just so you know, I have five children, so I know what it feels like.” She paused, daring this young first-year medical student to challenge her. I asked her to describe her symptoms.

“I feel bloated, and I’m always nauseous, and I threw up a few times,” she rattled off. “I’m also getting lots of cramps in my uterus and I have to pee a lot too. I’m telling you, I don’t know how, but I’m pregnant!”

I paused, caught in the moment between trying to remain engaged in the conversation, thinking about what could possibly be going on and pressuring myself to ask an intelligent next question. Was this dementia? Did she just want to become pregnant? Or was I about to witness a new world record? As the confused pause got longer and

longer, I blurted out the first thing that came to mind, “Ok, so when’s the last time you had, er, intercourse?” “Three days ago,” she said.

My eyebrows shot up again before I could stop them. She continued, “About six months ago, I met my current boyfriend and we’ve been madly in love ever since.”

“That’s great!” I offered weakly. “When do you think you got pregnant?” “Well, all my symptoms started about a month ago,” she replied. “My boyfriend and I also had sex around then, so maybe that’s when it happened.”

“Maybe,” I replied. After confirming that she was indeed post-menopausal, I glanced up at the clock, surprised to see that more than five minutes had passed. Anxious to gather more information before my preceptor came back, I asked in rapid succession, “Did anything else change a month ago? Your diet? Your bowel habits? The color of your urine?”

“No,” she replied curtly each time. “I took a pregnancy test, which was negative, but I want the doctor to give me another one.”

“Ok, I’m sure we can arrange that,” I replied quickly. “Do you have any previous medical conditions and are you on any medications?”

“I have diabetes and hypertension. I’m taking pills for both but I don’t remember what they are. Isn’t the doctor coming in soon?”

Right on cue, my preceptor strode in. Meredith immediately turned her attention away from me and greeted her doctor, a note of relief in her voice. My

**“I’m telling you,  
I don’t know how,  
but I’m pregnant!”**

preceptor glanced down at the chart, turned to me and asked me to present my patient.

Tentatively, I began, “Meredith is a 70-year-old woman who has 1 month history of nausea and vomiting, uterine cramps, bloating and urinary frequency. She believes she’s pregnant.” I paused, searching my preceptor’s face for any clue.

Glancing up from the chart, my preceptor asked, “Did you ask her whether she’s on any medications?”

Meredith answered for me, “Yes, I’m on two high blood pressure medications, one diabetes medication and the cancer medication you gave me last month.” “Oh, what’s the cancer medication for?” I interjected. “My breast cancer,” she replied.

My preceptor explained to both of us that Tamoxifen, the medication prescribed for Meredith’s recent recurrence of breast cancer, was the likeliest cause of her symptoms.

Afterwards, my preceptor turned to reassure me, “Meredith probably doesn’t share her breast cancer diagnosis with everyone, so don’t feel bad.” I nodded, wondering if she might have chosen to confide in me, if I had focused less on solving the clinical puzzle and more on the confused, near-panicked woman who thought she was going to have to give birth again.

# McGill's new satellite campus: The Gatineau experience

**Nicholas Chadi**  
McGill University, Class of 2012

**A**ugust 2, 2010. It was a hot and sticky summer day in Gatineau, Quebec. I was about to begin the most frightening, yet exhilarating part of my medical studies: clerkship. However, unlike most of my classmates, I was also about to take part in a second new beginning — I was one of the 9 students who had chosen to spend their 3rd year of medical school as part of McGill's new integrated clerkship program.

For many months, the faculty of medicine had been promoting its new Gatineau teaching site which was meant to offer a semi-rural and francophone learning environment to a group of students interested in completing all of their mandatory rotations in a new 11 month semi-longitudinal clerkship. The promises were numerous: a high level of clinical exposure and access to teaching staff, a friendly and welcoming environment with very few residents, enviable schedules and a generous financial compensation for living and travelling expenses, and a fourth year of medical school almost entirely devoted to elective rotations (in Gatineau or not). All that and only a few minutes away from the charming city of Ottawa. The decision for me had been an easy one. From the first time I had heard about the program, I knew I wanted to be part of it. The more independent, flexible and integrated structure of the program, offering more autonomy and an opportunity to become “medically bilingual”

were undeniable advantages that had lured me toward Gatineau.

Six months after the end of my year in Gatineau, I can now reflect on what was definitely an incredibly positive experience. However, while I was not disappointed by any of the initial promises of the program, my fellow Gatineau clerks will certainly agree that there were still a fair number of ups and downs during the year. As might be expected with a new teaching program, many adjustments had to be made all through the year to correct some situations where students felt that they weren't necessarily getting equivalent patient exposure and teaching time as students at McGill's main campus. On many occasions, energy and mood was often low among the group. Nevertheless, the teaching and administrative staff in Montreal and Gatineau were extremely understanding and proactive and succeeded in promptly addressing most of our issues. At this point, I personally believe that the program has evolved and improved a great deal, offering an outstanding opportunity for medical students looking for a more tranquil and personalized type of clerkship, away from the hierarchical structure of big teaching hospitals.

Distributed medical education in Canada certainly isn't limited to McGill's new integrated clerkship program. Having been part of the CFMS



Students from the Gatineau satellite campus.

Distributed Medical Education Taskforce last year, I was able to appreciate the quality and solidity of similar programs in other universities across the country. While research comparing distributed medical education with traditional clerkship programs is still scarce, the literature seems to agree that both options offer different advantages and that medical graduates coming from satellite campuses are certainly not at a disadvantage when it comes to applying for residency. As I prepare for my CaRMS interviews and enjoy six consecutive months of elective rotations, my last few words go to students considering getting a taste of distributed medical education: while you might never actually know for sure if your education was truly better or worse, you will most definitely gain from an experience away from your university's main campus. Don't hesitate to ask questions, investigate your options and remember, regardless of your decision, clerkship is by far the best part of medical school!

# The social history

Tanu Sharma

University of Toronto, Class of 2012

“What is the patient’s diagnosis?” demanded Dr. X during my practical examination. “Hepatic encephalopathy secondary to liver cirrhosis,” I replied confidently. “Liver cirrhosis?” she mocked. “How many types of cirrhosis are there?” “One?” I answered with embarrassment. What came next caught me off guard.

“You don’t seem to care about your patient,” said Dr. X quite bluntly. “Medical students nowadays get into medical school by virtue of their grades but they lack the bedside manner that is required to be a good physician,” she stated. When I protested that she had misinterpreted my nervousness as indifference, she glared at me and asked sternly, “Did you or did you not ask the patient about his occupation?” “No,” I mumbled.

“Then you didn’t take a proper social history did you? And by not asking him, you don’t know if he is working, you don’t understand his financial circumstances, whether he can afford his medication, support his family or pay for transportation to his appointments. If you don’t take a proper social history, you don’t understand the disease in the context of the patient.”

I was confused. I had meticulously gathered all the medical details relevant to the patient’s diagnosis yet Dr. X remained fixated on my limited social history. Her harsh feedback was unrelenting and when I finally stumbled out of her office, I was angry and tearful.

In the coming weeks, I tried to justify my poor performance on the examination. My history was limited because my patient was encephalopathic from his liver disease and could not recall the details resulting in his admission. Furthermore, he had *C. difficile* diarrhea and spent much of the

“Did you or did you not ask the patient about his occupation?”  
“No,” I mumbled.

designated exam time in the bathroom. My physical exam was limited by contact precautions and I fumbled to find my stethoscope under my yellow gown. The over-sized latex gloves hindered my ability to accurately percuss the liver span and appreciate the dullness in Traube’s space. When I protested my case Dr. X was unimpressed. I believed at that time that her expectations were exceedingly high for a third-year medical student. Until that point my clinical evaluations had been nothing short of exceptional and Dr. X’s feedback was a slap across the face that stung for the rest of my clinical training.

Still, I considered her harsh teaching points in all of my clinical encounters thereafter. By that point in clerkship, history-taking was second nature as was the anatomical placement of my stethoscope. Yet I found myself questioning if my algorithmic information gathering was allowing me to manage each patient appropriately given their specific clinical problem. I questioned if my physical examination was relevant and if I really understood the sounds of the organs underlying my instruments. With all this uncertainty, I went back to the basics of clinical medicine and re-learned my history taking and physical examination, considering the value of each and how I could personalize these to meet patient needs.

Today my social histories might even be considered too extensive. I pull my stethoscope out of my gown before entering a room with contact precautions and I know how to distinguish dullness from tympany through the ruffle of my gloves. I no longer resent Dr. X because I finally recognize the invaluable message that resonates through her harsh manner. What Dr. X was teaching me so early in my training was that the same disease will affect two patients in very distinct ways. Understanding the psychosocial impact of disease on a patient can help optimize their care and this crucial information can easily be elicited through one commonly neglected aspect of history-taking — the social history.



# How to become a “great” physician

Yan Yu

CFMS Political Advocacy Representative  
University of Calgary, Class of 2014

As medical students, most of us are keen to become great doctors in the future. But what exactly does it mean for a physician to be “great”?

I’ve thought about this question off and on throughout my first year of medicine at the University of Calgary. The last time I asked this question was when I was trying to fall asleep in my Ottawa hotel room at the 2012 CFMS National Lobby Day. The light was still on, but I had pulled the pillowcase off one of the pillows and was using that as a make-shift eye-shade. Clever, eh?

I was dozing off in this fake, but comfortable, darkness when I suddenly realized something. By going to sleep like this, I was doing exactly what much of medicine is doing today, something that may prevent me from becoming a “great” doctor!

I can cover my eyes, ostrich-like, with as many pillowcases as I want. But the light will still be on. Similarly, medicine can cover itself with pillowcases of symptom-management and temporizing fixes. But for many diseases, the underlying causes will still be there. Nitroglycerin and fibrinolytics in acute coronary syndromes don’t eliminate the underlying, preventable atherosclerosis. Inhaling buckets of anti-cholinergics can’t stop the preventable, but irreversible progression of COPD. Giving diuretics to congested patients with PND doesn’t reduce the salt content in prepared foods — a major, preventable trigger of heart failure.

Don’t get me wrong. Medicine’s current sickness-care mandate is definitely necessary. I just happen to believe that physicians must also address the underlying causes of diseases if we are truly serious about improving people’s health. By “underlying”, I mean more than individual preventable factors like obesity, tobacco use or lack of physical activity. I’m talking about the constellation of environmental, social and economic factors that determine the health of whole populations. This involves looking at whether or not folks have a stable source of income to buy healthy foods or whether they are empowered to improve their own social circumstances.

Encouragingly, the importance of these “social determinants of health” is gaining more than just a foothold in 21st-century medicine. Today, more and more primary care physicians are incorporating some degree of social activism into their daily practice, ranging from advising patients on lifestyle change to working for the government itself. Organizations like the Canadian Medical Association (CMA) are already helping to facilitate such political activism. Physicians have the advantage of being non-partisan, with a mandate to enhance the health of all citizens. As a result, we hold a privileged position: we are trusted. What we believe carries a lot of weight in society. Thus, physicians have a moral obligation to live up to this reputation and do what they can to improve societal health.

For medical students, medical school should be, and often is, the ideal place to learn about effective health and social advocacy. Initiatives like the annual CFMS National Lobby Day demonstrate that students can make a positive difference on improving the social determinants of health. With our current national prognosis of graying baby boomers and limited health care resources, Canada needs its current doctors and those in training as well, to take up the role as stewards of the health care system.

Being a sharp-minded, trustworthy and compassionate clinician is not enough. To be a “great” physician, you must simultaneously work for the health of society as a whole: in research, in politics, in health care policy or in other fields that contribute to solving the underlying causes of diseases. In other words, a “great” doctor puts the “health” back into “health care”.

Perhaps this quote from Chinese medicine puts it best:

下医医已病之病，  
中医医欲病之病，  
上医医未病之病。

When translated, it is less poetic, but its meaning nonetheless resonates: Average doctors treat diseases.

Good doctors treat diseases and prevent their complications.

Great doctors prevent diseases from happening in the first place.

# Pfizer and continuing medical education: The ethics of collaboration

Adam Dmytriw, MSc (Oxon)  
Dalhousie University Faculty of Medicine  
Class of 2014

Contributions from Pfizer and other pharmaceutical corporations to the development of continuing medical education resources continue to provoke strong criticism in Canada. In 2009, Pfizer and the Canadian Medical Association (CMA) reached an agreement to develop an online CME resource for physicians across the country.<sup>1</sup> It was somewhat unsurprising when the first module to be released from the online resource on Parkinson's disease focused on pharmaceutical treatment options primarily produced by Pfizer. The Continuing Medical Education program administrative board currently seats two staff members from Pfizer; a board that seats only six members in total.<sup>2</sup>

Given that the CMA is the self-described voice for Canadian physicians, its partnership with Pfizer sends a tacit message of permissibility for fraternization with large pharmaceutical companies. In 2009, the CMA accepted \$780,000 from Pfizer for the creation of the CME resource, not including future contributions, which according to the founding press release will be a continual source of funding for research and development<sup>3</sup>. Another equally resounding message communicated to Canadian physicians is that it is ethically sound to allow industry to fund continuing education, which has no precedent in nearly any other collegiate profession

**It has long been clear that donation from the pharmaceutical industry to organizations performing research or providing continuing medical education can have a significant impact on physician behaviour and particularly prescription habits.**

in the country.

Importantly, Pfizer cannot be solely implicated in an inherently mutual collaboration with the CMA. Ultimately, the result may be the loss of confidence in one of Canada's most venerated medical associations. Former

Senior Editor of the *New England Journal of Medicine*, Arnold Relman, relates that any major benefactor expects something in return for an investment. During his tenure with the *NEJM*, he felt that the pharmaceutical industry had 'no business educating physicians at all'.<sup>3</sup> This idea of CME with industrial support has been increasing in the United States since 1984. At the time, contributions from industry were approximately US\$302 million, but now exceed US\$1.036 billion. An ongoing Cochrane Review tracing these contributions to CME and medical practice suggests that resources resulting from these collaborations contribute to 'moderately large changes in clinical practice'.<sup>5</sup>

Despite claims that 2009 represents an unprecedented downturn into practices typically only seen in the United States, one need only look a decade earlier. In 1999, Rx&D and the Medical Research Council (predecessor to the CIHR) engaged in a lasting partnership which has since been updated in name to the Rx&D/CIHR Research Collaboration.<sup>6</sup> Stipulated in the agreement was that certain CME programs would not necessarily be met with equal funding from the CIHR, but simply receive a 'seal of approval' as the resource went on to be funded by industrial partners such as AstraZeneca and Pfizer.<sup>7</sup> It is further stipulated that industry partners will 'support where

possible the principles and practices of CME programs', with no indication of what constitutes such a possibility. It is further introduced that both educational content and instructors may come from industry if a consensus for approval can be met.<sup>7</sup> Moreover, the criteria for conflict of interest violations are defined by Rx&D itself to be enforced only upon three previous violations in the same year.

It has long been clear that donation from the pharmaceutical industry to organizations performing research or providing continuing medical education can have a significant impact on physician behaviour and particularly prescription habits.<sup>8</sup> Now that indus-

try is feigning an attempt to appear at an arm's length away from academic and government institutions, it remains to be seen whether its effect will remain as strong. What is clear is that indirect contributions to CME at the level of policy development can have a marked impact on the commercial uptake of pharmaceutical goods and physician bias. Our generation may have to be even more wary than those who have come before us.

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# Literacy: Why we should care

Danny Guo

University of Calgary, Class of 2014

*D*eun aut yew zinn chille durin un dert wellve. You probably don't understand what that last sentence means. But let me reassure you that it is plain English, simply written in a way that is difficult to understand by reading it. Now I want you to remember that feeling of confusion — or perhaps even irritation — that you experienced while attempting to read that line of apparent gibberish. This frustration is what many Albertans feel almost every day because 4 out of 10 Albertans struggle with literacy, which the Oxford Dictionary defines as “the ability to read and write”. This means that roughly half of the people you run into on the street, train, bus or any other public place will struggle with a doctor's instruction on treatment plans and reading directions on the back of medications. Imagine the frustration and anxiety that a mother would feel if she was unable to give the proper amount of acetaminophen to her feverish 6 year old, not because she could not afford it, but because she simply could not read English.

There are many reasons why one might struggle with literacy, including immigration to inadequate education. Most of the time, it isn't the individual's fault that their literacy is not up to par. Instead, it is usually because the environment they grew up in either downplayed the importance of literacy and education, or made access to these

resources very difficult. Whatever the reason, a study by Statistics Canada (International Adult Literacy and Skills Survey) demonstrated that “those with low levels of literacy work fewer weeks, experience more and longer periods of unemployment, and

... ‘education and literacy’ is defined by Health Canada as the third determinant of health ...

earn lower wages when they are working”. Statistics Canada stated that roughly 43% of Canadians between ages 16–65 have minimal or low levels of literacy skills and that this percentage hasn't changed since 1994. Considering that ‘education and literacy’ is defined by Health Canada as the third determinant of health, I would say this is problematic.

As medical students, we are surrounded by literate colleagues and classmates, and as a result, can often forget about the literacy issue. The primary reason why we are in medical

school is to attain medical education so that we may serve the community as a physician who promotes the overall health and wellness of society. On that note, it only makes sense to lend our attention to those with low literacy.

The Government of Alberta sets an excellent example by contributing significant funding for non-profit organizations that provide free tutoring for those with low literacy. However, the funding is still considerably short, forcing many of these institutions to rely on the cheapest form of student recruitment: print. That's right, as ironic as it sounds, non-profit literacy organizations use newspapers and posters as their primary means of advocacy. The posters might as well say “If you can read this ... then never mind”. This is exactly why medical students, who are future doctors and health educators, are the perfect vessels for advocating the importance of literacy and education to future generations. If enough of us take a step in this direction, we can make a dent in the persistent trend of low literacy in Canada and progress toward a more educated and healthier society.

Now, back to the quote at the beginning of this article. The gibberish is actually the instructions on the back of an acetaminophen bottle, as perceived by a mother struggling with literacy. Ironically, it says: “Do not use in children under 12.”

# Interview with Dr. Samantha Nutt — War Child founder and author of *Damned Nations*

**Matthew Tenenbaum**  
VP Communications  
McMaster University, Class of 2013

Dr. Samantha Nutt is an award-winning humanitarian, acclaimed public speaker and a leading authority on the impact of war on civilians. She is the founder and executive director of War Child Canada, an international organization that empowers young people to overcome the challenges of living with conflict. Her new book, *Damned Nations*, chronicles her 15 years of experience in some of the most devastated regions of the world.

Dr. Nutt sat down with the *Annual Review* to speak about her experiences and her advice for current medical students.

**AR: Looking back, why did you decide to pursue a career in medicine?**

SN: While I was an undergraduate at McMaster University, I became increasingly interested in the relationship between health and human rights. I became very involved in a number of global health and aboriginal health groups on campus, and this led me to apply to medical school. It also shaped my choice of Public Health as a specialty.

**AR: After graduating, you travelled to Somalia as a volunteer with UNICEF. How did you find that experience? Did it connect at all with what you had learned in medical school?**

SN: In many ways it did, but it was much more about the broader determinants of health. The social, political and economic situation there produced violence and uncertainty,

which had a tremendously negative impact upon peoples' health. For me, it was more an extension of what I was learning from a public health perspective.

Confronting that kind of injustice head on, the one thing that I wasn't prepared for was the extent to which foreign policy can actually influence health outcomes in different corners of the world. One of the things that astonished me in Somalia was the rabid proliferation of arms. It wasn't the only cause of instability, but it certainly had a tremendous negative impact on well-being on the well-being of Somalians.

**AR: Was this a big transition, coming out of medical school to do humanitarian work?**

SN: I think it was a big transition, to find yourself in the middle of a desert community coming under fire because you are participating in an assessment.



Dr. Samantha Nutt

Photo by Dustin Rabin

Nothing really prepares you to confront the level of violence and injustice that you see. After experiencing it, you don't really become desensitized to it. It is still just as shocking to see a 10-year-old wielding an AK-47 and to lead that kind of unstable existence. I think that this shock is a good thing and it's a part of the reason why I continue to work in this area.

**AR: Would you say that this was what motivated you to start War Child?**

SN: There were a number of factors that motivated me. For me, it was primarily after spending five years in the field and seeing where the gaps are. The overwhelming focus is often on short-term humanitarian relief, yet many of these communities have been experiencing conflict for generations. It became apparent that, unless you're invested in breaking that cycle — by empowering training and providing opportunities for local community-based organizations — the process of rebuilding and creating a safer, more stable environment for children will never happen.

War Child's programming tries to fill the gap between short-term humanitarian endeavours and longer-term development, which does not usually take place without a greater level of security. We're talking about countries like Sudan, which has experienced more than 30 years of war or eastern Congo, which has experienced 15 years of war. If you're constantly just focusing on food, water and shelter, but children don't have the opportunity to go to school, then violence simply continues. We try to tackle these structural deficits with local partners.

**AR: Is our understanding of how best to help inaccurate?**

SN: I wouldn't say it's inaccurate, but we don't always have access to all the information. Relief plays an important role in saving lives during very difficult times, and there is certainly a role for it. But there needs to be a balance so that we are not constantly applying band-aids without addressing the structural deficits. I believe that there is room for Canadians to raise their level of development literacy and to better understand how our actions have positive and negative impacts elsewhere in the world.

**AR: Have we gotten any better in our understanding of these conflicts over the past 15–20 years?**

SN: It's hard to call it better or worse. It has transformed, both in terms of our personal decision-making as well as our foreign policy. Trade has displaced aid when it comes to our foreign funding decisions. We aren't basing these decisions on need and there is much greater focus on what is good for Canadian companies. The question that is rarely asked is whether this is an appropriate purpose for our aid. I believe that aid should be for helping the most vulnerable, and that it should not be primarily about our interests. We're accessing much more information and engaging in the issues in new ways, but we're not necessarily making better decisions.

**AR: In your new book *Damned Nations*, one of the things you talk about is how our actions here can fuel or enable conflicts abroad. What should we know about this?**

SN: War is in literally everything we do every day, from conflict minerals in our computers to pension funds that invest in landmines. There are deeply rooted political and economic reasons for these conflicts, but in many instances our exploitation augments an already unstable environment.

For me, it is about making sound ethical choices, and demanding accountability from Canadian industry. Seventy-five percent of the world's mining companies are headquartered in Canada and we are implicated in four times as many human rights transgressions as the next two biggest offenders. Yet, we have no active legislation that governs the behaviour of these corporations in other parts of the world. We can make different choices and, though this may not change the outcome of conflicts, it at least increases the likelihood that we are not exacerbating them.

**AR: A significant proportion of Canadian medical students are interested in the health of people around the globe. What is the best way for them to help? How can they have the greatest impact?**

SN: Medical students frequently ask if they can travel overseas to work in one of War Child's programs. While there is certainly value to firsthand experience, we also need to understand the limitations of our training and knowledge. We need to understand when it is the right time to engage on that level.

Donating is extremely important. Students often think that they don't have the resources to have an impact, but even small amounts of money add up and make a tremendous difference to our programming. For students

who are interested in these issues, I also recommend getting as broadly-based an education as possible. Undergraduate or post-graduate work related to international development, international relations or foreign policy is extremely useful.

If you do want to volunteer, do so with international organizations here in Canada. Many organizations, including War Child, will take students in our offices for about a month. Students expect to learn something, but if you're here for only a week it is difficult to involve you in something meaningful. If you're prepared to commit for a longer period of time, we can involve you in more significant projects. Once you've been in that sort of

role, you are much better prepared to go overseas and to make sustainable contributions.

**AR: As a modern leader in both health care and humanitarian work, do you have any final words of wisdom for medical students looking to become the leaders of tomorrow?**

SN: There's a tremendous amount of pressure to conform and go in the same direction as everyone else before you. The choices laid out before you are all very clinically based. You're asked if you want to be a surgeon, an internist, an OB/GYN, a family doctor ... and end up with labels. I didn't feel like I fit properly in any one of

these. I had a better sense of what I wanted to be doing, and less of a sense of how to get there.

If you are prepared to speak to your mentors and program heads, and to chart a path that is somewhat non-traditional, it is amazing how flexible people often are. Thanks to people who were willing to make exceptions for me based upon my interests, I was able to do what I did and still be working in this field. Students face tremendous pressure, and it poses false choices. You can do this sort of work and still have a meaningful career. The trick is to seek out the people who can help you with these alternative choices, and help get you the education you need to set you on this path.

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# 2011–12: Another year, more alumni

**Cait Champion**  
**Alumni Officer**  
**University of Toronto, Class of 2012**

**N**ow in its second year, the CFMS Alumni Affairs program continues to grow and connect our alumni in the support of medical students and medical student initiatives.

We've begun a tradition of holding alumni lunches at our General Meetings, starting with the 2011 Spring General Meeting in Toronto and again at our 2011 Annual General Meeting in Calgary. At the Spring General Meeting, several past executive members and recent graduates were able to join us in celebrating medical student achievements through our CFMS/RBC Medical Student Leadership Awards. It was made even more special by the attendance of several alumni who played a role in selecting the award winners. At our Annual General Meeting, our alumni shared their CFMS experiences and touched not only on the organization's important milestones (the creation of CaRMS and the start of Lobby Day),

but on personal milestones as well. Our alumni elaborated on the role the CFMS has played in their lives in terms of finding life partners and developing a passion for medical education that continues to drive their careers today. To learn more about the CFMS's accomplishments over our more than 30-year history, visit our Organizational Timeline under About Us on the CFMS website.

In addition to participating in General Meetings, this is the second year that alumni have contributed to the Alumni Q&A section of the *Annual Review*. This is just one of the ways that alumni can share their experiences with current medical students to help us navigate the transition from medical school to residency, and eventually clinical practice. We are also featuring a new Studying Abroad section this year to highlight alumni who are currently pursuing training internationally.

The CFMS Alumni Affairs program will continue to grow as we head

into 2012–13 with more alumni participating in the selection committee for the CFMS/RBC Student Leadership Awards. We're also hoping to build opportunities for mentorship and leadership skills development for students from the expertise of our alumni.

In keeping with tradition, we plan to continue our alumni lunches at our General Meetings. Please let us know if you will be close by to either of our next stops; Winnipeg, MB in the Fall, and Quebec City, QC in the Spring of 2013!

*Are you a former Canadian Medical Graduate? Interested in supporting current CFMS/FEMC projects and connecting with other alumni? If so, we want to hear from you!*

*Contact our Alumni Officer, Cait Champion ([cait.champion@utoronto.ca](mailto:cait.champion@utoronto.ca)) or our General Manager, Rosemary Conliffe ([office@cfms.org](mailto:office@cfms.org))*

## Alumni Q&amp;A

# What do you love the most about your career and what do you like the least?

**Cait Champion**  
**Alumni Officer**  
**University of Toronto, Class of 2012**

**Dr. Tara Mastracci (University of Ottawa), Vascular Surgeon**

Vascular Surgery is a wonderful specialty because it combines the best of both Surgery and Internal Medicine. In the OR and in outpatient clinic, vascular surgeons deal with disease in all areas of the body, in patients of all ages and with different severity of illnesses. Thus, vascular training prepares you to be comfortable operating on extremities, in the neck, and in the thoracoabdominal cavity — and as such, no two operations are exactly alike. Commonly, the patients also have a very heavy burden of other comorbidities — cardiac, renal, neurological — so their perioperative care can be very complex — and a vascular surgeon gets to practice critical care medicine, as well as long term preventative internal medicine, cardiology, neurology, etc. This also means working in a multidisciplinary team with many different specialties in the hospital. Vascular disease is a relatively chronic illness, so over time vascular surgeons do get to develop a long-term relationship with the patients undergoing treatment, which is not always the case in surgical subspecialties. Also, the technological advances in endovascular surgery in the last 15 years have completely revolutionized the field, which makes it a very excit-

ing time to be a Vascular surgeon. It has always surprised me why everyone doesn't want to become a Vascular Surgeon!!

**Dr. Jason Kur (University of Alberta), Rheumatologist**

Favourite aspects of Rheumatology: Diagnostic challenges and the spectrum of diseases. Rheumatology has some of the most interesting systemic diseases to diagnose and manage from sarcoid, to ankylosing spondylitis to the vasculitides. It's a constant intellectual exercise.

Least favourite aspects of Rheumatology: Dealing with the large volume of referrals to my practice. Rheumatology is an underserved specialty. More and more patients are waiting for assessments because of physician shortages.

**Dr. Matthew Erskine (McGill University), Emergency Medicine**

I love Emergency Medicine, because we work at the “front line” of health care delivery. We get to actually diagnose, stabilize and definitively treat many of the patients before they are seen by anyone else, which is exciting and intellectually challenging. The variety of patients that we see and the fact that we are never on-call and have

a great deal of control and flexibility over our work schedules is a bonus!

With increasing volumes of patients using the emergency department as a substitute for a family physician, we are seeing more patients with chronic complaints. It can be difficult to deal with these patients, because the ED is not designed to treat and follow chronic illnesses and we are limited in what we can offer them, which is frustrating to both the patients and the emergency physician. As emergency physicians, we like to diagnose and fix problems quickly (or at least get patients admitted to hospital quickly so they can be “fixed” by someone else) — and we can't do that with patients with chronic, but stable illness.

**Dr. Danielle Martin (University of Western Ontario), Family Medicine**

My favourite part of my chosen profession is the ongoing relationship I have with my patients. As a family doctor, I really get to know them over time, and that relationship makes my work incredibly rewarding. It also allows me to be a better clinician because my growing understanding of the family, work and community factors that contribute to their health help me to support them in finding solutions to their challenges that will actually work. My

least favourite part of my day is trying to hunt down the results of investigations that have occurred in other hospitals and trying to bridge the gap between specialists and primary care when notes are not available. I hope that as we move toward a comprehensive electronic health record our patients' information will be more easily accessible to them as well as their entire health care team.

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**Dr. Mary McHenry (Dalhousie University), Pediatrics**

My favourite part about pediatrics is working with such a diverse population, from newborns to adolescents, and all the ages in between! What I find most difficult about working with children is keeping your emotions separate from your work when a child has a life-threatening illness. Fortunately, children are amazing and resilient so this is very rare.

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**Dr. Brad Dibble (University of Western Ontario), Cardiology**

There's no way I can pick just one favourite thing because there were many factors about cardiology that drew me to it as a subspecialty. First of all, it's simple conceptually because the bulk of the diseases I deal with are due to either pump, electrical, or plumbing problems, but within each of those categories there are enough complexities I face to keep it interesting and challenging. Secondly, although it's unfortunate that cardiovascular disease affects so many people worldwide, it has resulted in many clinical trials that have answered a lot of important questions as to how best to treat these

patients, with new trials coming out all the time helping to refine and modify my practice approach. There's never a dull moment!

I find that most physicians who have any degree of unhappiness in their careers feel that it's primarily due to excessive workload and I am no exception. My community is underserved with too few cardiologists and there simply aren't enough hours in the day to see the patients that need to be seen, making for very long days away from home and not enough time for family or sleep. It can be difficult to balance and maintain control of my time on occasion.

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**Dr. Allie Meiwald (Memorial University), Emergency Medicine**

I love the variety. Knowing that every patient I see on shift is going to be different keeps me intrigued. Never knowing when a trauma, MI or severely ill patient is going to arrive always keeps me on my toes.

What I don't like. Shift work has its ups and downs. Working nights and weekends can sometimes take a toll; however, having days off in the middle of the week for regular life activities — dentist appointments, car appointments, banking, etc. does help to make up for it.

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**Dr. Kevin Busche (University of Western Ontario), Neurology**

I spend about 75% of my time doing clinical neurology, and I very much enjoy it. At least once every couple of days, I see a patient who 'blows my mind'; it's almost unbelievable how many different ways the nervous sys-

tem can malfunction and how that can present clinically. I also treasure the relationship that I have developed with many of my long-term patients. As is the case with many branches of medicine, we don't 'cure' many patients, however, we often treat people actively and ameliorate discomfort. At the very least, we can listen to people and offer advice, which is sometimes undervalued as a therapeutic intervention.

The rest of my time is spent in medical education. I really enjoy my interactions with the medical students and find that it keeps me fresh. Sharing my interest in neurology with interested students revitalizes my own interest in my clinical work. I also spend time working with faculty and residents in the Office of Faculty Development, assisting people who are interested in becoming better teachers. This allows me to interact with other people, who, like myself, are fascinated by medical education.

The one thing I dislike about my job is the administrative work. I am site leader for neurology at my hospital and also the program leader for general neurology in Calgary. I have to say, I find it a lot easier to work with patients and students than administrators! I suspect that I find it challenging largely because I'm not passionate about it the way that I am about clinical work and education.

I think that's the underlying message: if you want to design a great career, you need to find the things you are passionate about and pursue them. I think it's especially valuable to find one thing outside of your day-to-day clinical work that gives you a change in perspective, whether its education, research or administrative work. A change is as good as a rest, as they say.

# The LMCC part 1. Just how hard is it?

**Matthew Sheppard**  
**PGY1 Anesthesia, University of Ottawa**  
**CFMS Past President**

So now that I've graduated medical school and moved on to greener pastures, I can tell you the tale of the MCCQE Part 1. A lot of my friends from the year behind me are asking questions about this dreaded hoop in the quest to become a physician, so I thought I'd share my thoughts in the Annual Review.

My advice for studying for the LMCC is simple: do not spend too much time studying and definitely do not spend extra money on more medical review books and practice exams specifically for the LMCC.

You have been writing tests in medical school for four years now and if you've done well up until this point (i.e., you've passed), then there is no reason why this kick at the can should be any different. Unless you've completely slept through the last four years (including the examinations) and played hockey during clerkship, you should have nothing to worry about. At graduation, the school has conferred upon you its confidence that you are safe to enter residency — that's kind of a big deal.

Having said that, if you're like most self-respecting medical students, 'winging' an exam is probably not your idea of a stress-free day. So, I've outlined my simple strategy below.

The LMCC multiple choice section is made up of 6 equal parts: Psychiatry, Internal Medicine, Pediatrics, General Surgery, Ob/Gyn and

Population Health/Legal/Ethical/Organizational Aspects of Medicine. A quick glimpse at Toronto Notes or any other review book will tell you that reading through the entire section on Psychiatry only takes an afternoon whereas reading through all the subspecialties of Medicine to the same depth will easily take a week. So, I prioritized.

**Take the exam seriously, but don't study too much for it.**

I read over every page of the Psychiatry (twice, because I like Psych and it was the shortest section) and Ob/Gyn sections of Toronto Notes. Next on my list was Legal/Ethical/Organizational Aspects of Medicine. Do yourself a favour and read Chapter 15 of Shaw's *Public Health and Preventive Medicine in Canada* (no need to buy, just check it out from your friendly medical school library). I wish I had read it twice. It might seem a little bland for some people (although I thought it was really interesting), but it provided an excellent background for numerous questions on the LMCC. I did a month of Gen Surg before the

LMCC and I didn't think Internal Medicine or Peds would be high yield so I didn't review any of those sections. The last thing I did was spend about 4 hours doing multiple choice questions for all specialties because that's how it is presented on the exam. I think all my studying could have been condensed into 20 hours.

This strategy might not work well for you, but it did for me. Sure, some of the multiple choice questions were out of this world, and a lot of the clinical decision making questions were like those 'read my mind' questions you got pimped on in clerkship, but everyone found the exam weird so I didn't fret.

Bottom line: take the exam seriously, but don't study too much for it. If you were consistently near the bottom of your class in medical school, spend some more time than usual on this test — while failing the MCCQE Part 1 is not the end of the world, it is a pain to have to rewrite. But if you're in the top 95%, most residents say they regret studying too hard for this exam versus not studying enough.

Study a few hours a week the month before the exam and don't stress yourself out. You'll miss out on the last few opportunities to hang out and enjoy the company of your classmates. It's been a long four years and your class has come far together, take some time to celebrate, because you won't have such luxury in residency.

# Studying abroad

## Stepping outside the box ...

**Tyler Johnston**  
**PGY2 Emergency Medicine,**  
**Dalhousie University**  
**CFMS President 2009–10**

As health care gets increasingly complex and as trainees try to tailor their careers to their interests, medical students and residents are increasingly choosing to go beyond traditional medical pathways and pursue training in a complimentary field.

In the US, many medical students are now taking a year out of their core studies to pursue training in research, public health and management. A number of combined degrees (e.g. MD/MPH, MD/MBA, MD/Msc.) are also springing up in addition to existing MD/PhD programs. Residents also have a variety of options including master's programs and clinical investigator programs that can be a great way to start a career in medical research.

These forms of additional training are not exclusively for people interested in research anymore and they can prove enriching and enlightening.

Still, in order to make sure you get the most out of additional training there are some things to consider:

### 1) Why?

Why are you considering additional training? Are you pursuing a passion? What *specifically* are your interests? What do you hope to gain and how will it help you in your future career?

Make sure you're doing the training because you want to and not because someone else thinks it's a good

idea. This is probably the most important consideration, so take some time to think this through.

### 2) Talk to as many people as you can ...

The experience of others can help you figure out exactly what you want to do and which program best fits your needs. Make sure you do your homework and speak with people who've actually done the program because what transpires in practice can be different than what appears on websites and in advertisements.

... additional training are not exclusively for people interested in research anymore ...

### 3) A word about research ...

If research is a major goal, make sure the program you choose provides good research training and seriously consider choosing a program that is at least two years in duration to allow for acclimatization and the time to conduct meaningful research.

### 4) Assessing the investment ...

This type of training often involves a considerable investment of money and



Tyler Johnston

time. Be sure that the additional training will help meet your goals, that you can reasonably afford the program and that you maximize your search for funding (e.g. scholarships, home department, research councils, fellowships).

### 5) It's a long career so do what's right for you ...

This is similar to the first point, but it's also more than that and worth repeating. Pick the right time in your career to do this type of training; it could be in medical school, residency or after many years in practice. Similarly, some people complete this type of training online so they can stay home with loved ones and new children, while others want to live in interesting places (i.e., the UK, etc.). All of these reasons are valid — it's your life, so make this training work for you.

### Examples of Common Programs

Master's of Community Health and Epidemiology  
 Master's of Medical Education

Master's of Public Health  
Clinician Investigator Programs  
MBA/Master's of Health Administration

### **PhD medical science**

When I made my choice to do additional training at Harvard University in Boston, it was because I wanted to get back to global health, a field I had worked in before medical school and

one that I found I wasn't getting enough of in my medical training. I knew I wanted to make global health a significant part of my future career, but I also wanted to maintain my commitment to clinical medicine so I enrolled in a one-year MPH in Global Health. It's a multidisciplinary degree including training in epidemiology, biostatistics, management, global health, refugee studies and humanitar-

ian relief. The breadth is exciting and suits me well, but I'm having to work a little harder in it to reach my research goals. All in all, I hope that my MPH will help me better understand health systems, medical research and how to look after my patients both at home and abroad. I am also having a great time checking out my new city and sleeping in my own bed ... every night of the week (i.e., there is no call).

## Choices and opportunities

**Mark Preston**  
**Urologist**  
**University of Ottawa, Class of 2006**

I completed medical school and my urology residency at the University of Ottawa, graduating in 2011. During this time, I was actively involved with the CFMS before spending four years on the Board of Directors at PAIRO. These experiences taught me a tremendous amount about medical education, health policy and leadership, which has, and will continue to serve me well throughout my career. In addition, I had the opportunity to meet and work with incredibly interesting and fun people from all over Canada.

I am now in Boston completing a Fellowship in Urologic Oncology at Massachusetts General Hospital (MGH). I chose this position due to its very large clinical volume, exceptional research possibilities and



Mark Preston

**You are limited only  
by your ideas and  
your energy level**

mentors. Concurrently, I am studying toward a Masters in Public Health at the Harvard School of Public Health

with a concentration in Clinical Effectiveness. This program is geared toward providing physicians with the methodology and skills required to be an effective clinical researcher while providing opportunities for other interests. I have been involved in global surgical development for years now and am currently working on a collaboration between MGH and a university hospital in Uganda for improving research (burden of surgical disease, surgical outcomes) and educational capacity. Boston is an epicenter for education or research endeavors and the wealth of opportunities is staggering. You are limited only by your ideas and your energy level.

My long term plan is to return to an academic center in Canada where I can continue my clinical, educational, research and surgical development pursuits. I hope this training will allow me to make a unique contribution.

## Beyond the CFMS: Exploring health policy, planning and financing at the LSE and LSHTM

**André Bernard**  
**Anesthesiologist, Dalhousie University**  
**CFMS President 2006–07**

**H**ello CFMSers from coast-to-coast! My name is André Bernard. I'm currently on staff as an anesthesiologist at Dalhousie University in Halifax, Nova Scotia. Having just completed residency training, I've remained grateful to my CFMS experience from 2002–2007 when I served as VP International Programs and Partnerships, VP Finance, President (and Past President). The CFMS remains the most dynamic and engaging organization with which I've ever worked. I think of it (and you) often and I'm pleased to see your continued growth and strengthening.

The CFMS set me on a path in which health policy has become central to how I see my role in medicine. It has enhanced and complemented my work as a clinical anesthesiologist. It has enabled me to serve as an instrument working for change for our health system. Beyond the CFMS, in 2009–10 I had the opportunity to undertake my Master of Science in Health Policy, Planning and Financing jointly between the London School of Economics and Political Science (LSE) and the London School of Hygiene and Tropical Medicine (LSHTM) in London, UK. This 1-year degree provided an incredibly rich opportunity

to learn the fundamentals of health policy engagement and research, with a specific focus on how health systems are built, financed and sustained from innumerable perspectives. I was a member of a class of nearly 55 people just like me: clinicians and policy people, NGO workers and government officials, feeding a passion for facilitating health transformation in each person's context.

My time in London was transformative. I had the distinct opportunity to live at Goodenough College, a post-graduate residence (and much more)

**Identify your interests and pursue your goals both within and outside of clinical training over these coming years.**

in Bloomsbury, Central London. In addition to my year of rigorous academic study, Goodenough provided a world of opportunities that I could never have had living anywhere else — from having access to a private box at Royal Albert Hall, to tickets to



André Bernard

Wimbledon, to living and learning with people from 100 different countries — it is a place I would recommend to anyone wishing to study and live in London for a year.

I think in medicine we can often feel trapped into following a single and direct course to our ultimate clinical destination. I would encourage you to identify your interests and pursue your goals both within and outside of clinical training over the coming years. My residency program provided me with a leave of absence and, ultimately, six months of credit toward my residency.

There are countless former CFMSers who have followed a similar path. If you're interested in hearing more, don't hesitate to get in touch with me or any other previous alumni! In the meantime I remain a proud alumnus wishing you success now and in the future.

Good luck and all the best.

## Biking around Oxford's dreaming spires

**Sayeh Zielke**  
**Fellowship, Adult Congenital**  
**Heart Disease, Royal Brompton**  
**Hospital, London**  
**CFMS President 2003–04**

**T**oday I made it up the hill. I did! I did! It took six months, but guess what, I made it up that hill.

Oxford is not particularly a hilly town. But the University of Oxford's John Radcliffe Hospital sits on top of one of the steepest hills in the city, the infamous "Heddington Hill". The latter is not really a big deal for true Oxonians bike masters of this land. But for me, with my suboptimal athletic skills, lack of dexterity, and heels that I wear to work, this represented a true challenge. I had to work hard to convince my loving husband to let me loose on a bike. The rules were clear: I shall wear a snowboarding helmet; wear a florescent construction vest and only bike during day light hours. This limited the frequency of the 30-minute bike trips to the hospital, given my work day typically begins and ends before sunrise and sunset during the fall and winter.

The first time I biked to work, I dismounted at the sight of the hill. I just did not know how to even begin to challenge this little mountain. We had driven up that hill everyday to get to the hospital. I knew how steep it was. I watched every day half a dozens bikers huff and puff their way up, most walking up with their bikes, with selected few pushing through to the top.

It took the last entire six months, mostly leisurely bike trips on the week-



Sayeh Zielke

**It took ... six months  
 ... to finally make it up  
 the hill ... and it  
 paralleled my medical  
 training in many ways**

ends to the hospital to finally make it up the hill without dismounting. And today, there it was — I got to the hospital in my heels and snowboarding helmet without getting off my bike.

I learned a lot through the process and it paralleled my medical training in many ways. First, I believed that I could and must make it up the hill. And then I surrendered to the fact that it will take weeks and months to get there. I committed to going one meter longer each time. Red faced and short of breath, I watched Oxonians whip by me day after day. I learned that I needed to keep a minimum critical speed while biking up the hill or I would lose balance and fall. So I

learned to dismount my bike without shame, knowing I had done my best for that day. Some days were better than others, and I had to accept that.

Medical training is the same as learning to climb the hill. It takes a long time to develop the required skill sets and expertise. One must not get discouraged, but learn to maintain a critical learning momentum to grow and develop as a clinician. It is also important to know when to "dismount" and ask for help. There were lovely periods through my training and there were weeks and months that I would rather forget, but what stands out are the incredible teachers and mentors that invested heavily in my formation and the patients that made it all worthwhile. Six years of one-in-four call in internal medicine and cardiology training was tough. Old grumpy profes-

sors to work around were tougher. The internal medicine and cardiology Royal College exam each took a good year of my life to study for and successfully pass.

I am now thrilled to be wrapping up my training at University of Oxford John Radcliffe's Hospital. Four years at University of Ottawa Medical School, six years at University of Calgary in the Internal Medicine and Cardiology residency program, it is time for this long training period to come to an end. But not before I could realize a childhood dream.

I remember naively emailing the University of Oxford Medical School to ask to spend some time on an elec-



tive, the week I received my acceptance letter from University of Ottawa Medical School. I didn't really know what an elective was, but as long as I can remember I wanted to go to Oxford.

The elective plan at Oxford did not pan out. Neither could I find time during my internal medicine and cardiology training to get to Oxford. However, I decided to apply for a fellowship in echocardiography and adult congenital heart disease in the United Kingdom. It was not easy to come for training to the United Kingdom. The visa process and medical licensing issues were quite burdensome. It took months and a great amount of perseverance and energy to navigate the bureaucratic layers for a cross-continental training. But here I am, biking through Oxford's glorious architecture, up the Heddington Hill and to the hospital. And my colleagues are exactly as I imagined them to be: academic, intelligent, reserved and lovely.

If I could sum up my echo fellowship in one sentence it would be this: Training in a postcard. I love the quaint house with squeaky floors that we rent, the beautiful meadows that inspired Alice in Wonderland are just a block away, the little coffee shops, the lively and historic pubs the likes of which were frequented by C.S. Lewis and J.R. Tolkien and, more history and academic legacy than one could absorb in a lifetime.

The Heddington Hill won't be my last climb in life. I am sure there will be steeper ones yet to come. But I am sure glad today I finally made it up the hill.

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# Photo album



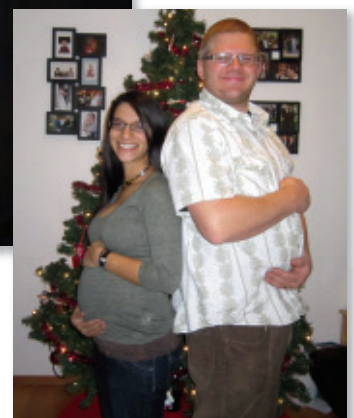
Geeta Yadav, Northern Ontario School of Medicine, class of 2010, CFMS Ontario Regional rep 2007-08 and Andrew Graham. Married on July 2, 2011 inside Hart House at the University of Toronto



Gil Eamer, University of British Columbia, class of 2012 and Erin Eamer were married on August 9, 2009 in Edmonton



Janis Friesen, University of Manitoba, class of 2012 married Mohamed Abaza on July 11, 2010. Mohamed is from Cairo, Egypt.



Meira Louis, University of Calgary, class of 2009 and CFMS Western Regional rep 2007-08 married Tyrell Doig on May 21, 2011



Michelle van Walraven, University of Ottawa class of 2012, CFMS rep to CFPC and Neil Leicester. Married at the cottage in Muskoka, Ont. on July 24, 2010



... and Michelle with girl friends from med school: Ashley Macdonald, Melanie Waite and Erin Gallagher



Natasha and Rodney Gaudet were married on July 2, 2011 in Stanley Bridge, PEI. Natasha is a Memorial medical student, class of 2014



Piotr (Peter) Wtorek, University of Manitoba, class of 2015 and Amy Wood. Married October 8, 2011



Rachell and Mark So were married July 30, 2011. Rachell is a UBC medical student, class of 2014



Danny Guo, University of Calgary class of 2014, CFMS Political Advocacy Committee, married Belle Zou on December 24, 2011 in Shen Zhen (city), China.



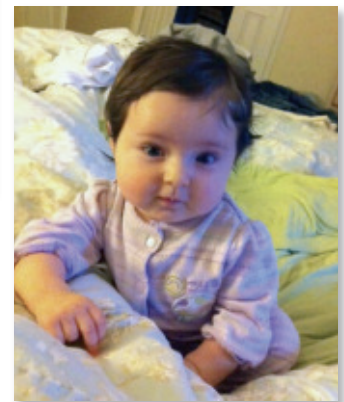
Bryson Alexander Wettig born May 27, 2011 to Kara Wettig, University of Manitoba medical student, class of 2012



Emma Galya Preston, born January 20, 2012. Daughter of Diane Belder-Preston, University of Ottawa, class of 2007 and Mark Preston, University of Ottawa, class of 2006 and CFMS rep to CAIR 2004–06



Lalina Dorais Ram, daughter of Rithesh Ram, University of Calgary, class of 2013 and Veronique Ram. Born August 29, 2010



Georgia Avalyn Mondoux was born on August 10, 2011. She is the daughter of Shawn Mondoux, PGY-1 University of Ottawa and CFMS VP Education 2009–10 and Bronwyn Hammel

# Endocrine detective story

Jessica van der Sloot  
University of Alberta, Class of 2014

The dusty, squeaky ceiling fan spun lazily in the sweltering afternoon heat. The 3 o'clock sun filtered through even dustier blinds, painting the scene a golden sepia tone. The man in the black fedora tipped his hat up to wipe the sweat from under it. That's typical Chicago body heat for you.

Black Fedora's name was Private Detective Jonathan Carter, according to the tarnished nameplate on the oak desk. Said desk was covered in mounds of newspapers, notes, and records piled haphazardly to form his own paper mountain range. Carter sat behind his desk, feet upon it, browsing that day's paper (later to join its fellows on *Mount News*). The headline read, "IMMUNE SQUAD FAILS IN TB STING."

"Damn lazy neutrophils," Carter muttered.

Heavy footsteps down the hall alerted Carter to the approach of his long-time, thick-necked partner. Moments later the brick-like figure that was Jeremy Friedman wandered through the door (labelled in gold block letters "Carter and Friedman, P.I."), buried in his own copy of the newspaper.

"Carter," Friedman said, without looking up and sat down across the desk from him.

"Friedman." Carter did likewise.

There then followed their customary ten minutes of silence, interrupted only by the scratching of paper-on-paper and the rhythmic squeaking of the ceiling fan. Friedman finally put down his paper and sighed.

"Gonna be a long day, Carter. I can just tell."

"How's that?" Carter asked from behind his shoes.

"Remember Ricky? Guy from Central? Says he's got an unsolvable case for us."

Carter lowered his paper. "Unsolvable? Central's got good fellas to deal with."

"Not like this. They've only got one lead and most of Central's busy just with maintenance. The brain boys ain't got time for this."

Carter pulled his feet off the desk. Unsolvable? If Central's busy picking up the pieces ... then this must be an inside job. There's no other reason to call in joe's like Carter and Friedman — an infection or toxin they'd hand off to another system. The problem must be in the belly of the beast somewhere. Literally.

"What's the lead?"

Friedman leaned over the desk. "Fatigue."

Carter's eyebrows disappeared into the brim of his fedora. "That's it? Fatigue?"

Friedman shrugged and leaned back. "That's it. Fatigue."

Carter's mind ground into action — fatigue ... fatigue ... Holy Hippocrates that could be anything. Hematology, the neuro boys, the endocrine gang ... Where would they even start?

"So what's the plan, boss?"

Carter stood up and stretched. "You're right, definitely gonna be a long day." He grabbed his coat from the wobbly rack next to him. "We'll

hit up the regulars first. You take the bone marrow, check in with RBC, I'll talk to Bobby up in the hypothalamus. Maybe it's just a sleep issue."

Friedman shook his head. "Sleep. We should be so lucky it's just sleep."

The next afternoon found Carter and Friedman wilting once again under the crummy ceiling fan. This time, the desk had been cleared of everything except a handful of reports and pocketbook of handwritten notes.

Friedman's bristly hair stood out at a hundred different angles from running his hands through it in frustration. He repeated the gesture and threw down the report he was reading.

"Nothing. God almighty, absolutely nothing."

Carter looked up from the hematology report. "So the bone boys had nothing for you?"

"Nah. Bit of structural weakness, bit of achiness, but 65 years'll do that to ya. My guy tells me WBC and RBC are both out of the DX — they're starting a bakery, you know that? Walking the straight and narrow, sounds like."

Carter made a peculiar "harumph" sound under his breath. "We'll see how long that lasts. One URTI and WBC will be high as a kite."

"I'm optimistic. So sue me. What'd Central have to say?"

"Everything seems to be all right ... I talked to Bobby, he said everything was on the up and up. TSH, GH, FSH, LH, even sleep pattern ... everything's okay. Straight up fatigue, though — I've got a hunch it's those endocrine hooligans."

“Great.” Friedman threw his hands up dramatically. “Now we’ve gotta do house calls.”

“We’ve gotta hit the target organs if we want to figure out what’s going on,” Carter said with an edge of annoyance. “Got a better plan?”

“Yeah. I think I’ll retire.”

Some time later, Carter and Friedman arrived at their first stop, the pancreas. The trip along the main arteries had been rougher than usual, to which Friedman complained bitterly. Carter, however, took notes in his pocketbook...and promptly whacked Friedman across the head with it to shut him up.

At the head of the pancreas, they began the tedious job of seeking out the Islets of Langerhans. It took them a full half hour to find the beta cell they were looking for.

“Manny, good to see you.” Carter greeted his old informant and introduced his partner. “We need some information.”

Manny grinned good-naturedly. “Figures. You come down here once every thousand cardiac cycles, not to see how I’m doin’, but what I can do for you. Nice.”

Carter wouldn’t be deterred. “We’re lookin’ for the idiot with the nerve to mess with energy levels. Don’t tell me you haven’t noticed — hell, you and alphie here are the go-to guys for glucose metabolism.”

Manny’s grin disappeared in an instant. “What?! Carter ... you — you and I been pals for a long time, right? You know I’d never mess with big stuff like that. Never.”

Friedman scrutinized him closely. “You’re not tellin’ us everything. Ain’t ya?”

Manny’s anxiety rose visibly, his

voice dropping to a low whisper: “I’m telling you, it ain’t me. But ...” He leaned in closer. “... I’ve got contacts in the kidney. Pretty close quarters, you know? There’s a rumour going around that there’s been electrolyte deals.”

Carter sighed. He’d been afraid of this. Tracking down the electrolytes getting passed around was going to be tough. “Anything else?”

## Carter’s mind ground into action — fatigue ... fatigue ... Holy Hippocrates that could be anything.

Manny shrugged. “Lots of rumours, but none of them really seem solid.”

If there had been a light bulb above Carter’s head at that moment, it would have just switched on.

Solid.

Solid. Or rather, less solid.

Carter hurriedly shook Manny’s hand and shouted a farewell over his shoulder as he sprinted to the superior mesenteric vein. As usual, Friedman objected loudly to Carter’s pace. And as usual, Carter forcibly (and cheerfully) shut Friedman up.

A quick check with the nephrons confirmed what Carter already knew. Some of the cells were completely out of it and covered in fine crystals. There

were even the beginnings of what looked like tiny crystallized snowballs floating through the tubules, bumping into others, clumping together ...

Friedman ran his hands through his thoroughly dishevelled hair. “This isn’t good. Definitely not good.”

It was a long trip back to the neck, and traffic was congested at the heart. But not even Friedman complained that it took them three beats to get through the pulmonary artery. They knew what was at stake.

After calling in backup from the thymus and cervical lymph nodes, Carter and Friedman took their exit at the thyroid. But that wasn’t their destination. A little beyond and posterior to it, they arrived at one of the parathyroid lobes.

It was impossible to miss. There was a big commotion on the medial aspect of the lobe — overgrown vasculature, parathyroid hormone spewing in every direction ... And right in the middle of it all was Richard Trevor. Or rather, several hundred Trevors.

“Trevor!” Carter, Friedman, and the Immune Squad advanced on the growing number of Trevors. “Hands and hormones where I can see them!”

The Trevors turned in unison. One stepped ahead of the others — the original Trevor. “What do you want? I’m expanding my business, nothing malignant.”

Friedman shouted, “Save it! We know you’ve been dealing in calcium!” “You’ve got no proof.”

“Actually, we do.” Carter held up a report from Central. “Hypercalcemia, fatigue, bone weakness and pain ... Everything’s pointed at you, your PTH, and your little adenoma operation you’ve got here.”

The original Trevor laughed nastily. “Ooh, ya got me! Chain me up and take me to county!” The Trevor clones shuffled restlessly. Original Trevor turned to them and gave a single command:

“Sic ’em.”

Back in the office, Carter and Friedman both perused their papers contentedly. The headline announced “PARATHYROID ADENOMA FOUND — HELP COM-

ING,” and featured an action shot of the ongoing fight.

“You think they’ll win?” Friedman asked.

“The Immune Squad?” Carter folded up his paper. “Nah. This adenoma’s too big for them to handle. Probably have to wait for the ... what’s-his-name, the knife-guy. The surgeon.”

Friedman shuddered. “Man, I hate those guys. Cutting stuff out, dic- ing stuff up ...”

Carter raised an eyebrow. “You know our ... generous host is a neurosurgeon, right?”

Friedman went to argue, then thought better of it. “Ah well. At least he’s not an anaesthetist, am I right? Now those folks are creepy! With the needles and the stabbing and the poking ...”

Carter rolled his eyes and went back to his paper.

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# Shadow of you

Ahmad Abdullah

University of British Columbia, Class of 2015

Just as the alarm went off, Eva swiftly leapt out of her bed and splashed her face with ice-cold water before running downstairs. The fear of being late yet again was looming over her head, so she bolted through the doors and into her car to head for Riverview Hospital. Today was her last day of volunteering in the psychiatry unit.

Her mind was overflowing with mixed feelings. There was the excitement of returning home to Ottawa. There was a peculiar sadness about saying goodbye. But one thought that continuously overwhelmed her was whether or not she had treated Michael, the 20-year-old male psychosis patient in bed #18, properly.

She was not sure what to think of him. Michael was definitely the most unusual, most interesting and most frightening patient she had met over the last 3 years of volunteering. He would frequently be found talking to himself about his gold mountain somewhere in the Arabian desert, his alien friends and his collection of 50 thousand replicas of King Tut's mask. He would rarely notice anyone else around him. And then his piercing-yet-soft stare, mixed with a peculiar hint of affection, would make Eva feel even more uncomfortable. Once, he even passionately said "I love you" to her during a spontaneous attempt at conversation. Thinking he was just a

"psycho" she didn't take him seriously — but still firmly said "no." She even tried explaining herself as best she could. Often times though, she would wonder what was really going on inside his head. No one could ever know.

**She instantly  
realized  
these spots  
were Michael's  
dried tears.**

Late in the evening, Eva and a team of medical students came to Michael's bed. This was the last time she would see him, and she wondered if Michael was aware of this. Everything seemed normal, until she noticed that he was no longer staring into her eyes. Instead, he had his gaze fixed on her slender, dark shadow on the ground. The shadow had formed as the glistening rays of the setting sun came through the window and shone on Eva's delicate body.

But then something very strange occurred. Michael pulled a pad of paper out from underneath his pillow

and quickly started to scribble something down, taking a peek at Eva's shadow every now and then. The group of medical students discussed Michael's condition, unaware of what he was doing, while Eva could not take her eyes off of him. She was extremely curious as to what he was writing. His face was red, as if he was on the verge of exploding with anger. His hand moved quickly across the pad as he wrote. One could almost hear it from yards away. When he reached half way on the page, Eva noticed his expressions had softened up quite a bit and something was dripping onto his pad. She stood still for a while wondering what to do. Confused and unsure, she went on with her normal routine for the day until it came time for her to leave.

Eva had one step out the door when she noticed Michael coming toward her. She was terrified, but kept composed and forced out a smile. Michael ripped the front page off the writing pad, handed it to Eva and silently left. Not a single word. Eva stood still for a while. She did not feel the courage to read the page there and then, so she put it into her bag.

A few hours later, Eva was enjoying her snack on her return flight home when she remembered the paper that Michael had given her. She took it out and opened it. It looked like a poem. It read:



“The rebellious rays of light  
Escaping the sun’s fierce might  
Piercing through the clear sky  
With a zeal quite high  
Come falling down upon you  
And brighten everything around you

And so I am born  
I have nothing to adorn  
Dark, black, faceless  
But existing with some strange blissfulness  
I have no control whatsoever  
But I would rather stay this way forever

As long as the sun shines in its full glory  
And the clouds stay away from this story  
I follow you everywhere you go  
Mark your every step and so  
You sing and run and boisterously frolic  
And I enjoy your presence like an alcoholic

Nothing can separate us I boastfully bet  
Until sadly it’s time for the sun to set  
Alas it’s how the world works  
It doesn’t ever have regrets  
The sun slowly drifts away into the sky’s wilderness  
And I painfully begin to fade away into nothingness

As the darkness dissolves me into itself  
I curse the setting sun over the continental shelf  
And then begins the endless wait  
For the next dawn to break  
So I can be born anew  
And spend the next bright day with you

This is what I think every lonely night  
This is what a day in my life would be like  
Yes every night would be a dark storm  
And since you turned me down in my human form  
O my love wish I was a shadow of you  
My very existence would be because of you”

She noticed smudging of the ink at some spots on the paper. It appeared as if something had dripped on it. She instantly realized these

spots were Michael’s dried tears. Not knowing what to do or how to feel, she burst into tears. Her teardrops fell onto the paper ... perhaps onto some

of the same spots that Michael had shed his own tears earlier.





**Scarred**

Mark Lipson  
University of Manitoba, class of 2012



**UBC Camp**

Alia Dharamsi, University of British Columbia, class of 2014  
(counterclockwise from bottom)  
Alia Dharamsi, Devon Rasmussen, Harpreet Ghuman, Candace Pearson, Gavin Wilson, Matthew Miles, Andrew Hurlburt, Lawrance Chow, Thomas De Los Reyes  
Camp Makefriends was a weekend away for new UBC MD and DMDs to get to know each other, relax after their first week of classes, and make some lifelong memories.



**Greece**

Sarah Blowers, Memorial University, class of 2013  
Summer vacation in Greece with 5 of my best friends, fellow MUN class of 2013 classmates. We have all seen each other through the thick and thin over the past three years of medical school ... and I figure that's worth celebrating!  
(l to r: Meighan Kelly, Jessica Downing, Kayla Churchill, Kelly Au, Sarah Blowers, Sarah Hann)



### View

Tanu Sharma, University of Toronto, class of 2012  
This photograph was taken in Mbeya, Tanzania from the back of a pick-up truck where I sat with a dying Maasai woman whom we were transporting to hospital.



### Satellite on mud hut

Tanu Sharma, University of Toronto, class of 2012



### Health card

Tanu Sharma, University of Toronto, class of 2012

This is a photograph of the old version of the health card. Although a dying breed, this card is still in use and this photograph suggests that our current health care system may “crack” under the current model.



### Septra Tanzania

Tanu Sharma, University of Toronto, class of 2012

This is a photograph of the packaging process of TMP/SMX for distribution to patients with HIV/AIDS in rural Tanzania. We spent hours counting and hand packaging hundreds of sachets for distribution.



### Stormy Unveil

Yingwei Liu, University of Ottawa, class of 2013



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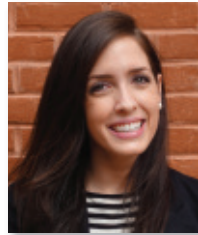
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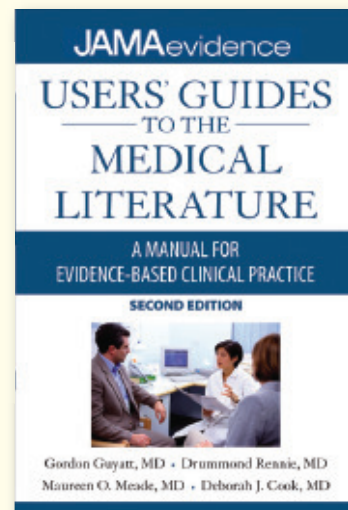
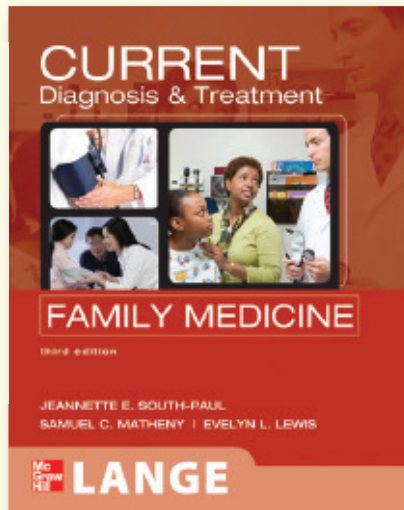
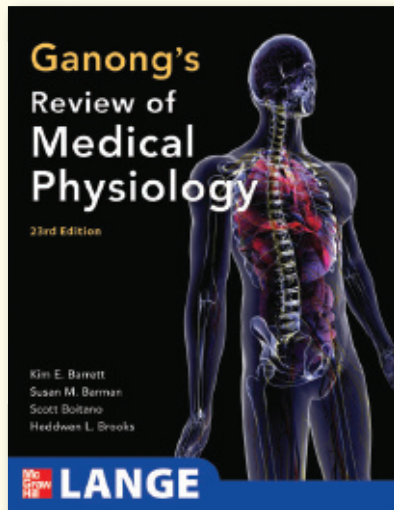
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