

# CFMS FEMC



Canadian Federation of Medical Students



Fédération des étudiants et des étudiantes en médecine du Canada

## ANNUAL REVIEW 2014

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DR. JAMES TALBOT







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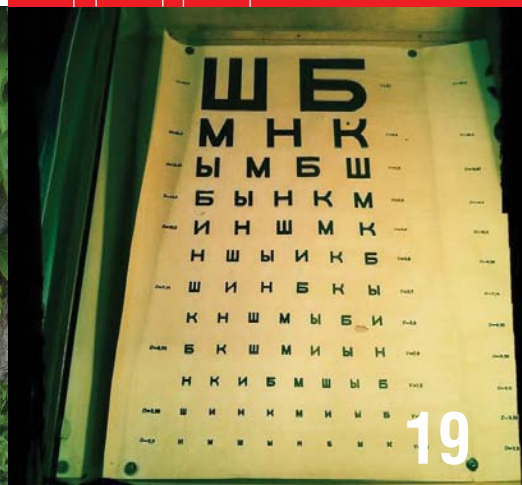


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**Description**  
Fear of the unknown, the disease that abandons logic and makes man inhuman.

**Artist**  
Haley Augustine  
Dalhousie University,  
Class of 2015

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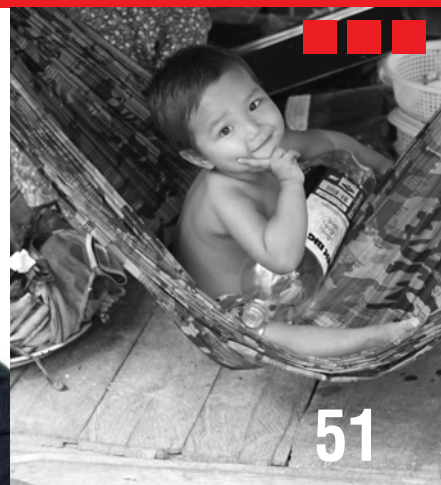
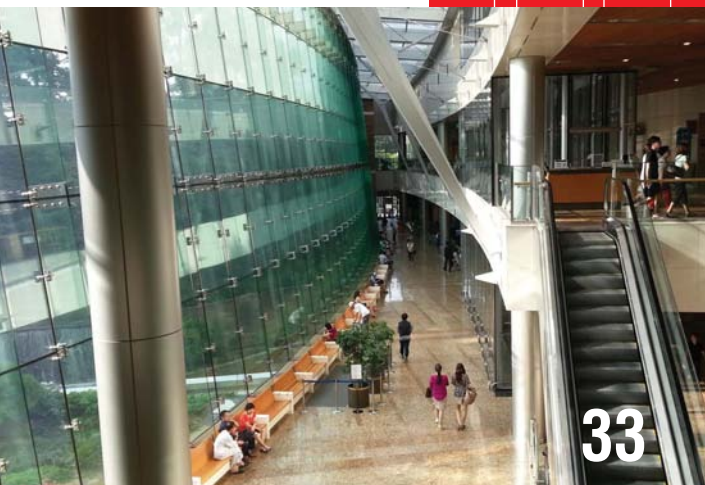
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# Letter from the editors



**Yin Hui**  
Annual Review Editor  
University of  
Western Ontario  
Class of 2015

Dear readers

It is with great pleasure that we present to you the 2014 issue of the *CFMS Annual Review*. Since its creation, the *Annual Review* has served as a venue for Canadian medical students to keep up-to-date with the CFMS team. As well, it has also served as a medium for Canadian medical students (and often practicing physicians) to show case their experiences and activities. This issue is no exception.

From the CFMS executive team comes activities and initiatives ongoing throughout the year to improve our members' academic experience and wellness, as well as advocacy efforts in support of the health and well-being of our patients. This year, our members far and wide and found experiences that enriched their education and expanded their horizons. Initiatives continue to demonstrate that patient advocacy begins the moment we enter medical school. You'll find thoughtful reflections from students in this issue. In the Alumni Affairs section, you'll find valuable insight and advice offered by our alumni on the great unknown beyond medical school. As usual, we have a section dedicated to recent marriages and births in the medical student and alumni community.



**Mimi Lerner**  
VP Communications  
University of  
British Columbia  
Class of 2014

This year, we had the pleasure of inviting Dr. James Talbot, Alberta's Chief Medical Officer of Health, for our featured interview. He expresses the importance of strong public health and a focus on prevention as significant components required for our patients' good health. Make sure to read this insightful piece and think about all the non-medical factors that impact on one's health.

Once again, this year we were happily overwhelmed by the large number of quality submissions. Due to space limitations, we unfortunately had the difficult task of selecting only a portion of the submissions we received for publication. Our sincerest thanks to those who submitted to the *Annual Review*. We would also like to encourage all of our members to share your experiences in the future!

The *Annual Review* 2014 editors

Yin Hui

Mimi Lerner

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# A letter from your CFMS president



Jesse Kancir, BSc,  
MSc  
President  
University of Toronto  
Class of 2014

Dear CFMS members, colleagues and friends

The Canadian Federation of Medical Students (CFMS) is proud once again to offer you our *Annual Review*. It has been a busy year for our organization as you will see from the various executive reports and articles that share the stories and activities of medical students from across our country. From my perspective, I have had the privilege of working with an executive that has demonstrated passion for their various responsibilities and, most importantly, for ensuring that the needs of medical students are met and that our voices are heard at many different levels.

Ultimately, we want to be an organization that serves its members and ameliorates the Canadian medical student experience while simultaneously translating these outcomes into better patient and population health. These aims are met by focusing on the three pillars of the CFMS: representation, services and communication.

On the front of representation, the CFMS has been particularly active this year being involved with the ongoing development of the Association of Faculties of Medicine of Canada's Student Portal that is looking to streamline the way in which Canadian medical students secure elective experiences. We've also been an active participant in the Physician Resource Planning Task Force, the national steering committee funded by Health Canada and composed of representatives from federal/provincial/territorial governments and from national medical organizations. This group has the aim of providing a pan-Canadian understanding of population physician needs (demand), working toward understanding and matching supply, and creating the resources to guide decision-making for medical trainees throughout their education.

In terms of services, not only has the CFMS been concerned with the quantity of physicians but also the quality. We were thrilled to learn in December 2013 that we had been awarded a grant from the Canadian Physician Health Institute to survey Canadian medical students and determine their relative levels of wellness. More of this is described in our VP Services report to which I refer you. In addition to the host of educational products and services available to CFMS members, we have taken the concept of "services" to mean ways in which we can help ameliorate student experience.

Finally, our communications have flourished this year with increased engagement through social media and progress on translating our website into French. Our aim is to reach every Canadian medical student with a variety of relevant information and opportunities in both of our official languages. The CFMS is on track to complete these changes throughout the year ahead and we are proud of these efforts.

The past few months have been incredibly busy ones for the many students who dedicate themselves to the CFMS and to their medical training. My sincere thanks to everyone who contributes to the work of this organization and to the production of this *Annual Review*. As always, please feel free to get in touch with any of the executive should you have any questions.

Sincerely

A handwritten signature in black ink, appearing to be 'JK' with a long horizontal flourish extending to the right.

Jesse Kancir



# Quebec update

Bryce Durafourt (McGill)

Quebec Regional Representative and Executive Vice-President  
CFMS

I WAS THRILLED TO HAVE BEEN re-elected as Quebec regional representative this year at our 2013 annual general meeting (AGM) in Vancouver and honoured to have been named the executive vice-president of the organization. I have spent the first half of my term continuing a number of projects and picking up new ones as well. One of my key roles as Quebec representative is to act as liaison with the Fédération médicale étudiante du Québec (FMEQ), and strengthen the relationship between our two organizations. In my capacity as Quebec representative, I regularly attend meetings of the FMEQ. Once again this year, the FMEQ sent a delegation to our AGM 2013, allowing for continued discussions and sharing of ideas, especially on the topic of student wellness. We have continued to collaborate since that meeting, and the CFMS and FMEQ submitted a joint proposal to the Canadian Physician Health Institute to fund a pan-Canadian medical student wellness survey. We were pleased to recently find out that we had been awarded the funding, and planning of the survey is now underway. This project exemplifies the results that can come from collaboration between our organizations. As another example of our collaborative efforts, we were happy to again invite a delegation from the FMEQ to the CFMS Lobby Day on Feb. 3 in Ottawa, which was deemed a success by both our organizations.

Among my responsibilities as an executive member, I oversee the CFMS travel funding, offered to support non-elected CFMS members attending a CFMS general meeting. Modifications I have made to the program include streamlining the process for applicants and reviewers by revamping the application form and introducing clear criteria for evaluation, as well as providing earlier decisions to applicants. We continue to receive an increasing number of applications for each meeting, demonstrating a growing interest in the CFMS! I also assisted with the recent review of our organizational bylaws, carried out to comply with the new Canada *Not-for-profit Corporations Act*. The updated bylaws will be submitted to our membership for approval at our next general meeting. Finally, I continue to act as external representative to the Canadian Association of Internes and Residents (CAIR), attending their meetings and offering opinions on issues relevant to medical students as they arise.

One of the largest projects I have been involved with over the past year is one that involves offering our services to all of our members in both official languages. To this end, I created the CFMS Bilingualism Task Force, comprised of bilingual medical student volunteers from across the country, to assist with document translation. As much of our interaction with our membership occurs through our website, the CFMS executive ranked

“This initiative will allow our information and services to be accessible to more students across the country...”

translation of the website as the number one priority in our strategic financial plan last year. Given the large volume of text available, funds were allocated in order to use professional services for the initial website translation. In order to reduce our costs, it was decided that once this initial translation was complete, we would ask our task force members to assist with ongoing translation of new items posted to the website. The most relevant and up-to-date sections of our website were compiled and have now been translated, and should be posted to our new French-language section of our website shortly. This initiative will allow the information and services to be accessible to more students across the country and should encourage increased interest in individual membership in the CFMS by students at the three non-CFMS member medical schools in Quebec. ■

# Uniting the West

Irfan Kherani  
 Western Regional Representative  
 University of Alberta, Class of 2015

Kimberly Williams  
 Western Regional Representative  
 University of Calgary, Class of 2014

**W**ESTERN CANADA, ALTHOUGH DIVERSE, IS IN MANY ways connected. We are excited to be the team working on uniting medical students from western Canada. Our role has been to meet with medical student society presidents frequently in order to better understand some of the strengths and concerns of our region. We are excited to keep working with medical students from western Canada and are trying to discover any cross-cutting factors that unite us.

We both love research and are excited to be tasked with setting up the first research arm of the CFMS. Over the next six months we will be laying the foundation of how CFMS can conduct research moving forward in order to best represent you — our members — to various external stakeholders. Our hope with this project is that we will not only create a solid foundation for how CFMS conducts its research but also open up new opportunities for you, our members, to get involved with some of the CFMS research projects. We need you!

If you have ideas on how to unite the West or want to get more involved in research please contact us ([western@cfms.org](mailto:western@cfms.org)).

Happy to be working with you this year! ■

“Over the next six months we will be laying the foundation of how CFMs can conduct research moving forward in order to best represent you — our members — to various external stakeholders.”

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# Ontario update

David Linton  
Ontario Regional Representative  
University of Western Ontario, Class of 2016

**T**HIS YEAR I HAVE HAD THE great privilege to serve as an Ontario regional representative for the CFMS. As a new member of the CFMS executive, the year so far has been both enlightening and humbling. The depth of experience and skills that medical students across Canada have to offer continue to amaze me, and I am proud to be representing such a fantastic group of people this year.

As I reflect on my experience so far, I realize how important it is to me to ensure that opportunities are open to all members of the CFMS, that the selection process is fair and transparent, and that we encourage people not to get discouraged if they are unsuccessful in an application.

I first became involved with the CFMS as a delegate from the University of Western Ontario to the federal Lobby Day in February last year. As a first-year medical student I had some idea of the role of the CFMS, but in the mix of acronymic organizations to which I had been introduced as a new medical student, the CFMS didn't initially stand

out in any special way. It wasn't until I was selected as a Lobby Day delegate and went to Ottawa and met with so many other people from the CFMS that I first saw the CFMS activities first hand. Later, I was fortunate enough to be one of the Political Advocacy Committee representatives to be awarded travel funding to the CFMS Annual General Meeting in Ottawa. When I reflect on this it really emphasizes for me how important it is to have as many opportunities as possible for students to get involved with the CFMS.

Without all these chances to apply to so many different opportunities, I would not be in the position I am now. In my work for the CFMS this year I've seen first hand how many people are trying to seize these opportunities. Together with Laura Butler, our Atlantic regional representative, I've had the chance to take the lead on the student initiative grants. The depth and variety of applications from across the country are truly remarkable, and it was a challenge selecting a small number of projects to fund from so many excellent applicants. We were thrilled

that we not only received a historic high number of applications, but we were also able to expand the funding available by 50% to fund more of the many excellent applications we would have otherwise had to reject.

As a member of the Nominations Committee I have also been exposed to the number of highly qualified medical students eager to help their colleagues across the country. Together with my experience working on the student initiative grants, I realize that it is essential that we not only continue to work to ensure that as many opportunities as possible are open to medical students across the country but also to encourage all medical students who have applied to continue to be active with the CFMS.

During the rest of my term as a CFMS regional representative, I hope to reaffirm these values and work to make sure that we continue to reach medical students across the country, and that medical students continue to see the value in playing an active role in our organization. ■



# Governmental affairs

Melanie Bechard

Vice-President Government Affairs  
University of Toronto, Class of 2015

**W**HAT IS THE ULTIMATE goal of our CFMS advocacy efforts? As is often the case with in medicine, this seemingly simple question requires a complex answer. This year, the Government Affairs and Advocacy Committee, which consists of student representatives from each of the 14 CFMS member schools, found ourselves grappling with this question.

Each year, the CFMS organizes a federal Lobby Day where approximately 70 delegates from across Canada gather in Ottawa to meet with members of Parliament and present a proposal relating to medical education or health policy. Selecting the specific “Ask” we bring to Parliament Hill is a task that demands much research, attention and discussion in order to maximize this exceedingly rare opportunity.

This past autumn, selecting the Lobby Day topic triggered an intriguing internal debate. The group had a sense that we should create an Ask that benefits our colleagues. After all, the three pillars of the CFMS include service, representation and communication. If we do not advocate for medical students, who will? Yet there was an equally strong sense of duty to our patients. As a whole, medical students tend to be a fairly privileged group. It is difficult to justify devoting our unique Ask opportunity to ourselves when there are much more vulnerable groups who struggle to access shelter or basic medical services. Everyone enters the medical profession for different reasons, but I do believe that we all have an underlying desire to serve those in need. By choosing to focus on issues specific to medical education, rather than the social determinants of health, would we eschew our commitment to our future patients?

Upon reflection, it strikes me that this debate is a scaled-up version of one that medical students face within our daily lives. We constantly find ourselves balancing the sometimes competing priorities of providing service to others and taking care of ourselves. We ask ourselves whether we should visit the gym after clinic or spend the evening reading about the conditions we encountered. We wonder whether our little sister would mind if we attended a conference instead of her birthday party. As medical students know, there is no single answer telling us where to devote our energies. The balance is constantly in flux. Providing excellent and compassionate care depends upon a commitment to the health of both patients and ourselves.

Perhaps our advocacy efforts can be most effective if we look toward adopting this balance. Sometimes, policy changes may place a group of patients at risk, and we need to leverage our resources to respond appropriately. At other times, there may be issues creating inequities in medical education that have a negative impact on medical students and require attention. It is very rare that the priorities of patients and medical students are not closely aligned — after all, happy patients make happy doctors, and vice versa.

This year, the Government Affairs and Advocacy Committee had the privilege of working with the National Officer of Human Rights and Peace as well as the global health advocates in the creation of the Lobby Day Ask. The global health team has extensive experience working with vulnerable populations and addressing the social determinants of health. Together, we decided upon a two-part Ask: one asked for continuing funding for social

“Everyone enters the medical profession for different reasons, but I do believe that we all have an underlying desire to serve those in need.”

housing facilities, and the other advocated for federal Canada Student Loan deferral during residency with the purpose of both relieving financial burden during medical training and enabling residents to participate in rural recruitment programs that provide federal loan forgiveness. It was intended to represent the needs of both medical students and vulnerable populations. Thankfully, we received an overwhelmingly positive response from the 65 policy-makers on Parliament Hill who agreed to meet with us. We look forward to building on these relationships over the next few months with the hopes of impacting policy.

As anticipated, defining the goal of our CFMS advocacy efforts has required a complicated answer. While this question continues to be discussed, it is hoped that this focus on balance and collaboration with Global Health can continue to produce successful Asks that create wellness for both medical students and the patients we are privileged to serve. ■

# Big questions

Ian Brasg

Vice-President Education

University of Toronto, Class of 2014

**T**HIS YEAR I'VE HAD THE PLEASURE of holding the education portfolio on the national CFMS executive for the second consecutive year. My work to date continues to touch on all three of the central pillars of the CFMS: representation, communication and service. Much of my role involves collaboration with our sister national medical education stakeholders on projects that seek to innovate and reform our collective enterprise. Instead of summarizing my activity to date, I'd like for you to consider the Big Questions that this portfolio regularly tackles.

How do we select the best possible candidates for admission to medical school? Are successful candidates demonstrably better than those who get bad news? Is the Medical College Admission Test a useful tool for differentiation, or does it select for homogenous thinkers of similar background? How can we create institutional levers that promote the matriculation of students of underserved backgrounds? Should class sizes increase, decrease or stay the same?

What is the right balance of lectures and small-group sessions for optimal learning? How can early clinical teaching and observership experiences be woven into curricula? Should pre-clerkship years focus on providing grounding in Medical Expert and Scholar teaching, or should pre-clerkship students also learn how to advocate, communicate, collaborate, manage and be professional? How can material from the social sciences and humanities be incorporated? Should it? Are emerging subjects — like leadership, handover of care and patient safety — emphasized enough in our coursework? What are best practices for integrating distributed medical

education sites? Even more fundamentally, how can our faculties keep curricula relevant in the era of Google, social media and point-of-care tools?

Which specialties should be offered as core-clerkship rotations? How much elective time should students have and where in the curriculum should it occur? What are longitudinal clerkships and how do they affect the learning of students? Should clerkship students experience overnight call or would they benefit more from consistent daily experiences? Should duty hours be restricted? How can medical student wellness be engendered and supported? Can we do a better job at helping students balance dual degrees and transition into and out of leaves of absence?

What means should be used to evaluate medical students during pre-clerkship and clerkship? Have pass-fail policies improved the well-being of students? Has competition for grades been replaced by competition for extracurricular activities, electives and letters of reference? What are best practices for the selection of medical students for residency? Which components of the application have the most predictive value for future residency and licensing performance? Is there a hidden component to residency selection? How transparent should programs be regarding their selection criteria?

How can we help medical students make informed choices regarding residency and careers? Is the R1 postgraduate match becoming more competitive for Canadian medical graduates? If so, what are some possible reasons? Should our system guarantee all Canadian medical graduates a postgraduate position? Should postgraduate positions be redistributed to reflect the projected balance of supply

“What is the benefit of pursuing bachelor’s coursework before starting medical training?”

and demand in the future? How can we make these projections, anyway? Under what circumstances, if any, should return-of-service agreements be used? Can curricular time that occurs after the Match be better used? Is the timing of the Match and licensing exam even optimized in the first place?

Finally, some bigger questions: What is the benefit of pursuing bachelor’s coursework before starting medical training? What is the optimal length of medical training for the flexible production of competent physicians who are prepared to meet societal expectations and needs? Should all medical students receive the same curriculum, or is there a role for streaming based on interest and/or aptitude? Similarly, how would our education system look if we pared down the 30 or so direct-entry specialties? How do you balance a desire for generalism, flexibility and wellness with the necessity of producing fully licensed physicians in a timely fashion?

I'd like to thank you for your interest in medical education and my portfolio, and hope that these questions have you thinking! Please contact me at [ian.brasg@mail.utoronto.ca](mailto:ian.brasg@mail.utoronto.ca) if you have any questions or concerns or would like to get involved! ■

# Bringing medical student mental health to light

Brandon Maser  
Vice-President Services  
Queen's University, Class of 2016

“Mental pain is less dramatic than physical pain, but it is more common and also more difficult to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say ‘My tooth is aching’ than to say ‘My heart is broken.’”

— C.S. Lewis, *The Problem of Pain*

**I**N THE WINTER OF 2009, I WAS diagnosed with major depressive disorder. Despite the illness being well behind me, this is not a fact about me that I often share with others and something that I attempted even harder to conceal during my depression. I suffered in the silence of my own choosing, secretly hoping someone would decipher my cryptic stares; thankfully someone did and encouraged me to finally reach out for help.

The reason I share this with you now is because when I read the statistics evidencing the struggles that medical students face with burnout and depression, when I see those cryptic stares in the faces of some of my colleagues, I can relate first hand to the silent burdens that are weighing them down. These burdens are not easily suffered through alone, yet so much effort is put into hiding our struggles and weaknesses as medical students.

I often reflect on my reasons for suffering silently during my depression and wonder if I had been in medical school when my depression first manifested, would I have still sought help? To accept that we are at the mercy of something we cannot conquer alone is frightening and humbling, especially when there are expectations on us, real or perceived, to

be successful and resilient. This fear of weakness is compounded by the stigma that exists towards those who suffer from mental health disorders, making seeking help even more challenging. It takes courage to confide in another that one's heart is broken, and even more courage to seek the help of others in fixing it.

However, despite how isolating burnout and depression are, we are not alone in our struggles and weaknesses. This is especially true for medical students. A recent study released in the US shows that medical students have higher rates of depression (58%) and burnout (50%) than their age-matched, college-graduate counterparts.<sup>1</sup> The frequency of suicidal ideation among medical students, although no different than the general population of the same age, is also alarmingly high (9%–11%).<sup>1,2</sup> Medical learner burnout and depression are not uncommon, nor are they new phenomena; they are systemic problems that require a systemic solution and a change in attitudes.

In an effort to catalyze this systemic change, the CFMS, in partnership with the Fédération médicale étudiante du Québec (FMEQ), is currently developing a national wellness survey to be implemented in all 17 Canadian medical schools over the next year. Along with this survey, we have plans to develop a national multimedia wellness campaign, in which we hope to highlight results from our survey, raise awareness for medical student mental health issues and resources, and advocate for changes within medical education that will be aimed at improving

medical student well-being. This campaign will also include the publication of a medical student wellness book, which will be a compilation of stories of medical students' and professionals' personal struggles and/or triumphs with mental health and wellness; creative pieces, such as art, poetry, short stories; data from the national wellness survey; information on wellness resources; and recommendations for the improvement of medical student well-being. Our hope is that both the survey and wellness book will serve as advocacy tools for the implementation of new medical learner wellness resources and curricula across the country.

The solution to this problem begins with us, with the advocacy we demonstrate, with the supportive environment we foster. I encourage those who are struggling to reach out to the supports around you and to share your story. The courage you demonstrate in doing so will motivate others to do the same and will contribute to an environment free from stigma and full of openness and support. ■

*If you or anyone you know is struggling with suicidal ideation, please visit <http://www.suicideprevention.ca/in-crisis-now/> find-a-crisis-centre-now/ for information on a crisis centre in your province.*

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# Keeping up with social media

Mimi Lerner  
VP Communications  
University of British Columbia, Class of 2014

IT HAS BEEN AN INCREDIBLE privilege working with the executive and members of the CFMS over the past several years. What I have enjoyed most is collaborating with students across the country on incredible projects aimed to better the experiences of the medical student body.

The most challenging aspect of the communications portfolio is effectively reaching out to all of our student members. In many cases we lack exposure and students spend their three or four years of medical school wondering what it is that the CFMS is or does for them. Every year the communications team, comprised of representatives and committee members across the country, works hard to convey to students the opportunities available to them through the CFMS, often in innovative ways. At the University of Manitoba, student reps are creating funny news reports posted through YouTube to

disseminate the information from our bi-weekly newsletters. Without this team we would be lost!

Social media has erupted over the past half decade and this year the CFMS has been working hard to keep pace. Our social media committee expanded and has worked incredibly hard to keep students up to date about opportunities to get involved, to get published, to win scholarships, to get internships and more. Not only that, but they post and tweet about exciting medical advances and controversial medical news to keep followers engaged and interested. Now medical students can contribute content to be posted on Facebook and Twitter by the social media team. Let us know what you'd like to read about!

The communications portfolio is ever evolving and several projects are on the go at any time. Currently our new Media Engagement Committee is working on

outlining their role going forward, to proactively engage stakeholders with the CFMS. The Social Media Committee is working on a branding project, along with several executive members, to create a cohesive image moving forward. Communications is actively involved with the government affairs, regional representative and services portfolios on new and exciting projects. The student-led *CMAJ* Humanities Blog is a new initiative that we are very excited to share with our members, the medical community and the public!

Thank you to all those students (and now residents) who have contributed so much time to supporting others through collaborative leadership and advocacy. It has been my pleasure working with all of you! I look forward to the rest of this year and to further teamwork efforts as I complete my term as VP Communications. ■

## Amanda Kelsall

**A**MANDA LEE KELSALL (Feb. 16, 1991–Jan. 5, 2014), from Horseshoe Valley, Ontario, was a second-year medical student (MD2016) at the University of Ottawa. She was distinguished throughout her high school and undergraduate studies for her academic and athletic excellence and known for her warmth and generosity.

Entering medical school at the University of Ottawa, she brought a brightness and enthusiasm to the MD Class of 2016. She had a joy for life that was contagious, sharing with others her passion for service through her involvement with the Refugee Health Initiative and as a leader of the Christian Medical and Dental Society, Ottawa chapter. Amanda loved to run and was often out training for her next half marathon — well before her classmates had hit their snooze buttons. Despite her dedication to these early morning runs, Amanda could always be found in the front row of lectures, engaged in her medical training and impeccably dressed.

On Jan. 5, Amanda passed away in a tragic accident returning to Ottawa following the holiday break. The MD Class of 2016 will forever feel the loss of one of its purest and humblest. Amanda represented all of the good in medicine and embodied the spirit of someone who would change the medical field. Amanda will be remembered by her family and friends as a woman of compassion, courage and faith. Her honest spirit will live on through all of the lives we will touch as future physicians.

In conjunction with the Kelsall family's wishes and to honour her memory and pay tribute to Amanda, a fund was created in her name. The Amanda Kelsall Fund will be used to financially support undergraduate MD students at the University of Ottawa.

The University of Ottawa Class of 2016 thanks the CFMS for their generous support of the Amanda Kelsall Fund



as well as for the outpouring of condolences and warm wishes from the national medical student community.

Anyone wishing to make a donation can do so by visiting the website below (the drop-down menu will bring up the Amanda Kelsall Fund name): [alumni.uottawa.ca/medicine](http://alumni.uottawa.ca/medicine) (note: there is no www. before alumni).

Alternatively, donations can be made by calling 613-562-5800 x3417. ■

*Written with contributions from Elise Azzi, Alexa Clark, Lindy Buzikievich, Amelia Wilkinson, Kayla Simms, Anthea Girdwood and the Kelsall family.*

# Vaccinations in 2013 — a global student perspective

Anthea Girdwood

Ontario Representative for the CFMS  
University of Ottawa, Class of 2017

Benjamin Veness

Past President of the Australian Medical Students' Association  
University of Sydney, Class of 2014

**T**HIS WEEK, 450 MEDICAL students from around the world are meeting in Santiago, Chile, to discuss global health. All would agree that, along with public sanitation, mass vaccination has undoubtedly been one of the most important factors behind reduced infant mortality and increased life expectancy. Nonetheless, the World Health Organization (WHO) still attributes 1.5 million deaths among children under five years of age (2008) to vaccine-preventable illnesses, like measles, for which American John Enders developed and released a vaccine in 1963.

Fifty years on, why are children still dying of this disease? In the developing world, access to essential medicines has been the greatest impediment. Canada, meanwhile, has a publicly funded immunization program that, along with the program in the United States, has included the measles vaccine since the 1960s. Despite the apparent interruption of endemic transmission in the late 1990s, the 2000s have seen a number of Canadian measles outbreaks, most notably that of 2011 in Quebec. No one would consider Quebec a developing nation and yet still we had hundreds of Canadian children suffering needlessly. We may have averted any deaths, but children infected with measles may still experience fever, diarrhea, pneumonia and infections of the brain.

Given the extensive debate over former centrefold Jenny McCarthy's participation on *The View* and her dangerous opposition to childhood vaccination, it was interesting to speak to a medical student, Martin Alpirez, from Panama,

about whether misinformation is also an issue in Central America.

After an awkward explanation of what *Playboy* was, and how on earth a nudie magazine was connected to public health, his response was refreshing.

"Why would anyone connect autism to vaccines? They're not at all related," Martin queried, genuinely perplexed.

"You know, your country should really put out a public education campaign to explain why vaccines are good."

According to the WHO, Canada had 759 cases of measles in 2011. Panama, a developing nation, had four. Even if you gross up Panama's population to compare like with like, the equivalent number of cases is only 37. Maybe he's right.

Australian medical students had heard of Ms. McCarthy but attributed any misinformation Down Under to a "crackpot" group duplicitously calling themselves the Australian Vaccination Network, a name that the New South Wales Office of Fair Trading recently demanded they change as it is "misleading." Australia had 190 cases of measles in 2011.

"The Australian Vaccination Network does not present a balanced case for vaccination, does not present medical evidence to back up its claims and therefore poses a serious risk of misleading the community," the New South Wales minister for fair trading said in December last year. Sound familiar?

In an interview with *TIME* magazine in 2009, Ms. McCarthy is quoted as saying, "If you ask a parent of an autistic child if they want the measles or the autism, we will stand in line for the [expletive] measles." She claimed that it was not vaccines that they were against, just "unsafe"

"Are we, in places like Canada and Australia, giving our citizens too much freedom when it comes to important matters of public health? Does the danger posed by those left unvaccinated necessitate mandatory immunization?"

vaccines, seemingly attributing autism to unnecessary "toxins." This type of lame pseudo-science has been thoroughly debunked and is widely criticized by the scientific and medical corps, yet somehow still persists. All vaccines are reviewed and approved by the Biologics and Genetic Therapies Directorate of Health Canada.

"Educate before you vaccinate" is the imploration on Ms. McCarthy's



Generation Rescue website. Good idea. Mike Kalmus-Elias, a medical student from London, reported that in his school, a common examination involves trying to convince a sceptical parent to vaccinate their child. “The scary thing is that sometimes you can’t convince the actor,” he says. The United Kingdom had 1,112 cases of measles infection in 2011.

The picture seems brighter in the Middle East. Lebanese student Joe Cherabie claimed not to know of any local equivalents to “what’s her name” (McCarthy). The WHO reports that Lebanon had nine cases of measles in 2011.

Are we, in places like Canada and Australia, giving our citizens too much freedom when it comes to important matters of public health? Does the danger posed by those left unvaccinated necessitate mandatory immunization?

Making sweeping assumptions about which countries just might have mandatory immunization, we sought out Calvin Liu of Hong Kong. “When it comes to vaccination for diseases such as

measles, there are no exemptions. There is less freedom when it comes to public health.” Chinese students Alex Wang and Nate Du agreed, but described the challenges facing health care providers when it comes to vaccinating a population of 1 billion people, especially those in remote regions. Despite this, China, a country with 40 times the population of Canada, had a per capita measles rate in 2011 that was only three times that of our own.

Interestingly, it was discovered that you can, in fact, refuse vaccinations in China — but in a paternalistic society where the distribution of information is highly controlled, it seems that even its medical students aren’t privy to that information. It’s doubtful that Canadians would appreciate such an approach.

Near the end of this conference, a number of students from African nations gathered to offer their thoughts on vaccination. Students from Kenya, Namibia and Ghana alike applauded the incredible efforts to support the vaccination

of their people, commending groups such as GAVI — the Global Alliance for Vaccines and Immunisation.

Are their patients concerned about the safety of vaccinations? No.

“It is an achievement to bring your child to be vaccinated. Mothers are proud to take care of their children this way.”

These students will practise medicine in areas of the world where infectious disease kills millions of children every year. They will see patients every day suffering without access to existing preventative care. In Canada, Australia and the UK, it would seem that we have forgotten what that looks like. ■

*Anthea Girdwood is a second-year medical student at The University of Ottawa and Ontario representative for the CFMS. Benjamin Veness is the past president of the Australian Medical Students’ Association. This piece was co-authored from the general assembly of the International Federation of Medical Students’ Associations in Santiago, Chile.*

Located on the shore of Lake Superior, Thunder Bay offers the perfect balance of a dynamic work environment and a vibrant community with many outstanding cultural, recreational, and performing arts venues.

**Thunder Bay Regional Health Sciences Centre (TBRHSC) is a state of the art, 375 bed Academic Health Sciences Centre, providing regional services to a population base of 250,000 people. We deliver all services with the exception of cardiac surgery and we are the Regional Trauma and Cancer Referral Centre(s) for Northwestern Ontario.**

Teaching, research and continuing professional development opportunities are offered through numerous institutions and we are affiliated with the Northern Ontario School of Medicine (NOSM) and the Thunder Bay Regional Research Institute (TBRI). Post graduate streams currently exist in Public Health and Preventative Medicine, Family Medicine, Internal Medicine, Obstetrics/Gynecology, Orthopedics, Pediatrics, Anesthesia, Psychiatry and Surgery. In addition, NOSM offers PGY3 Family Medicine programs in Emergency Medicine, Anesthesia and Enhanced Skills in Maternity Care, Care of the Elderly and a Self-Directed program.

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# Is our approach to patient care questionable?

Danielle Chard

National Officer of Reproductive and Sexual Health  
McGill University, Class of 2016

**O**R MORE IMPORTANTLY, are you an Askable Doctor? Why do we wait until the end of an appointment to ask “Do you have any questions?” What if, instead, we started our appointments with the patient asking the questions instead of the physician?

I can already hear the cynics. “What’s the point in a patient asking question I won’t have time to answer?” “I’m a specialist. I want to keep things focused on what I do best.” A quiet voice from the back row might ask, “What if they ask a question I don’t know the answer to?”

Consider this statement from Sir William Osler: “It is much more important to know what sort of a patient has a disease than what sort of disease a patient has.”

I had to read it twice myself; it seemed like a phrase that simply repeated itself. Go ahead, read it again. We are all familiar with protocols based on what “sort of disease” a patient has. What kind of training do we receive to figure out what “sort of a patient” has a disease? We’re taught to listen to what our patient has to say, but I feel like this generally only happens after we’ve asked a question, after we’ve delineated what “kind of thing” we want to hear.

The opportunity to make our interactions with patients less like transactions and more meaningful is in the way we

share information and contextualize a treatment with an understanding of the person as a whole. If you begin by listening, a patient’s questions crystallize important information for you. They can help you understand what your patient needs from you, their knowledge level and, importantly, what motivates them.

Letting a patient take the driver seat reaffirms that they are in control and you are simply a guide. By acting as their navigator you can point out which routes are the safest, places they might want to explore, while all the while allowing them to choose the direction they want to take. This trip is time limited, and perhaps you can’t explore everything this time around, but a navigator can only lay out your options; you make the decisions.

When the patient is asking the questions, you are able to customize the information you provide. Instead of getting an overwhelming information bomb we are so infamous for, your patient will receive a personalized package, tailored to their needs, appropriate to their level of knowledge.

Perhaps most importantly, an Askable Doctor approach allows you to create an open and safe space for all questions. When your patient feels safe and in control they are more likely to ask questions about topics that can leave one feeling exposed; questions about sexual health or mental health come to mind. By stepping

“It is much more important to know what sort of a patient has a disease than what sort of disease a patient has.” – Sir William Osler

outside your comfort zone, you give your patient the opportunity to be vulnerable.

So be brave and let let your patients help you to help them — that is, after all, why we’re here. Begin by listening to the parts of the story your patient wants you to hear. Create an openness that will leave patients knowing they are important and that you are committed to helping them find wellness. We don’t need to know all the answers and we don’t need to answer all the questions all at once, we’re just opening up the conversation, our minds and our patients to a lasting and trusting relationship with both their doctor and the health care system in general. ■

# Advocating for access to adequate and affordable housing

Ben Langer

National Officer for Human Rights and Peace  
University of Western Ontario, Class of 2015

**T**HE GLOBAL HEALTH Advocacy Program (GHAP) has gone through some major change this year, taking part in the CFMS Lobby Day for the first time and bringing our focus on health equity to the event. Our advocacy theme this year is Access to Adequate and Affordable Housing, and it was a whirlwind journey from November to February getting to know the political landscape around housing issues in time to bring a housing ask to Parliament Hill. With the help of incredible global health advocates, a savvy research team, strong partners in the CFMS Government Affairs and Advocacy Committee, and support from some great civil society partners,

we were able to narrow in on the issue of expiring federal social housing agreements. In Ottawa in February we made a strong case for reinvesting federal social housing subsidies back into programs that address the large and growing crisis in adequate and affordable housing in Canada and had many productive conversations with policy-makers around the issue. We look forward to being part of this crucial CFMS initiative in the future.

This spring the GHAP is going to be working on a few different aspects of housing nationally. Housing and health are inextricably linked, and we recognize that focusing upstream on this social determinant of health will help down the line in

terms of both human and health care costs. Recognizing that calls for federal leadership in housing are coming from municipal and provincial governments, as well as many prominent civil society groups, we're going to be joining these voices in pushing for a national housing strategy that would address both current and future housing needs, as well as continuing to push for reinvestment of federal housing subsidies. Look out in a few months for a CFMS housing advocacy video, as well as a clinical tool to help med students and other health professionals put housing on their radar. And before we know it, it will be time to head back to Ottawa for our new November Lobby Day! ■

## Montfort

### Recrutons psychiatres bilingues

Le département de psychiatrie est à la recherche de psychiatres pour son unité d'hospitalisation d'une capacité de 60 lits (40-44 lits ouverts présentement), ses services ambulatoires et ses services de consultation-liaison.

Montfort a reçu récemment sa désignation provinciale de centre hospitalier universitaire des sciences de la santé et s'implique activement dans l'enseignement.

La langue de travail et d'enseignement à Montfort est le français. Les soins et les services de l'Hôpital sont offerts dans les deux langues officielles. Tout médecin voulant œuvrer à l'hôpital doit démontrer une volonté d'apprendre à s'exprimer en français. La rémunération est excellente.

*Ottawa, 20 mars 2012, Ottawa encore une fois première au palmarès des meilleures villes canadiennes – Pour une troisième année consécutive, Ottawa a reçu l'insigne honneur d'être désignée ville canadienne où la qualité de vie est la meilleure par le magazine MoneySense<sup>1</sup>.*

Pour plus d'information, veuillez contacter le Dr Guy Moreau, médecin-chef et chef intérimaire de psychiatrie au 613.746.4621 poste 6201 ou par courriel à guymoreau@montfort.on.ca.

**Montfort. Mon choix. Mon avenir.**



<sup>1</sup> <http://www.jimwatsonottawa.ca/fr/nouvelles/ottawa-encore-une-fois-premiere-C3%A8re-au-palmar%C3%A8s-des-meilleures-villes-canadiennes>



# Searching for research in Siberia

Kayla Simms

MD Candidate

University of Ottawa, Class of 2016

IT STARTED ON THE PLANE.

Flying to Russia in the summer of 2013, an overwhelming excitement began to surface as I thought about *matryoshka dolls* and *ushankas*. I imagined the gourmet food new to my palate and the pristine facilities I would soon call my workplace in Yekaterinburg.

Through the International Federation of Medical Students' Associations lottery selection, I had been chosen to participate in a month-long ophthalmology research project 4,931 miles away.

It didn't take long before I realized how little I understood of the Russian culture or language. This weighty fact became apparent when ordering my in-flight meal by means of embarrassingly flapping my arms and chirping loudly. Needless to say, the stewardess served me beef. To my absolute pleasure, however, I was seated next to a curious young boy.

"Vy you go to Siberia," he asked.

At the word "Siberia," the nerves in my stomach threatened to send me searching for the nearest parachute; I could feel my heartbeat resonating the entire plane. Suddenly, just as I thought I would hurl, I felt a tap on my shoulder.

"Velcome," the boy said, beaming from ear to ear.

Smiling at this small but meaningful gesture, I removed the Canadian flag from my knapsack and pinned it on the boy's jacket.

It was then that the magnitude of this exchange began to sink in.

Upon arriving in Yekaterinburg and meeting my supervisor, Dr. B, he told me he was only made aware of my coming "vone week ago. So zere is no project for you, Kyla."

Before I even had time to react, a parakeet swooped over our heads right in the hospital lobby.



Shrieking, I frantically ducked and looked to Dr. B, who appeared surprisingly composed.

"Kyla, dis hospital bird. Make patients calm. Ve also have room of bunnies." And just like that, he opened a door to his left, revealing a room chock-full of live, frolicking bunnies.

By early afternoon, after being exposed to a series of obscenities and inexplicable mayhems, nothing fazed me. So when Dr. B asked if I would like to observe the afternoon's surgeries, I delightedly followed him through a big blue door.

Right before my eyes, in a tiny room with a window wide open (not to mention Russia's pigeon problem), three operations were being performed simultaneously. Three patients. Twelve doctors. No gloves, surgical masks, or even so much as a shoe-cover in sight.

I looked to my right and glared at a group of patients awaiting their turns. To my left, I found more patients, post-op.

I began to feel claustrophobic, overcome by practices incomparable to anything I knew. Gone were the countless

lectures on appropriate hygiene. Gone were the scrub nurses demanding students to step away from the surgical field.

But then it happened. They ran out of anesthetics.

And with their final operation to go, I watched as a physician whipped a bed sheet taut like a child playing with a homemade lasso. Except this wasn't playtime.

This was for tying the patient down.

And perhaps my interpretation of the exact events was misperceived by the overwhelming cultural and language barriers, but this is where a parachute on that flight seemed like a sweet alternative.

But I stayed for the month, and I loved it. I met fathers who smiled from toothless grins and mothers who touched my red hair in awe. I was greeted with an admiration that defied the bounds of verbal communication, all the while exploring a most intriguing medical community through the privilege of a lifetime.

And although my in-flight "research-project fantasy" never came to fruition, I am certain Russia enriched my life with more than any test tube ever could. ■

# Research in the Global Health Program

Stephanie Brown

National Officer of Global Health Education  
University of Calgary, Class of 2015

Irfan Kherani

National Officer of Global Health Education  
University of Alberta, Class of 2015

**I**N 2013, A MAJOR FOCUS OF THE global health program (GHP) was global health education research; the 2014 GHP looks forward to building on the excellent work carried out by five working groups and their student chairs.

## Pre-departure training (Ali Manning)

In 2007, the CFMS established the pre-departure training (PDT) program. This project was created in order to ensure that Canadian medical students were adequately prepared when participating in medical electives in low-resource settings. In 2008, the CFMS and the Global Health Interest Group of the Associations of Faculties of Medicine of Canada (AFMC-GHIG) co-published a set of guidelines for PDT programming. As PDT is further developed and incorporated into medical education, it is important to solicit feedback to ensure current programming is meeting the needs of students who wish to travel overseas to low-resource settings.

## Post-return debrief (Scott Hodgson)

In 2013, the CFMS global health program developed a study aimed at clarifying and recording qualitative information on existing post-return debrief programs (PRD) at medical schools across Canada. PRD is present in most medical schools across the country, though the method and timing vary considerably. Students who received debriefing were better at

adapting back into their settings and applying their knowledge. Despite recognizing the importance of PRD, students across the country requested a more systematic and evidence-based approach to the debrief program. The GHP looks forward to developing a plan to deliver better post-return debriefing to Canadian medical students!

## Global health concentrations

Recognizing that many schools do not sufficiently address global health within their core curricula, several schools have developed extracurricular programs to promote comprehensive global health education. These often take the form of a global health concentration program, though they lack consistent structure. A set of minimum national standards for these programs has been developed and will be made available in order to provide a template for schools wishing to expand their global health education offerings.

## Global health core competencies in medical school curricula (Rabia Bana)

Based on the expectation that all medical graduates should understand the major factors that influence the health of individuals and populations worldwide, a set of core competencies in global health was developed by the Global Health Education Consortium in 2008-2009. In conclusion it was agreed that students should have a basic understanding of the complexity of global health issues in

low-resource settings and should be able to identify sources of information concerning global health topics. Medical students also ought to appreciate the role of physicians as advocates for improving the health of patients and populations in their communities and globally. Since 2011, the Global Health Education Consortium competencies have been transposed into the CanMEDS roles to make the competencies more applicable to Canadian medical school curricula. The competencies are currently in for peer-review and will be made available after their presentation at Canadian Conference on Medical Education 2014 in Ottawa!

## Global health experiences database (Robynn Geier)

The evolving role of physicians in the domains of international development and advocacy has prompted Canadian medical students to report unprecedented demand for experiences in global health. Global health opportunities vary in scope, quality and availability, with many students expressing difficulty accessing the appropriate information to guide their pursuit of elective, volunteer and research experiences both locally and abroad. The current database includes detailed information on volunteer opportunities, exchanges, courses, summer schools, internships, conferences, assemblies, journals, newsletters and international electives, both in Canada and abroad. We will be posting a link to the database on the CFMS website in 2014! ■

# The CFMS Global Health Program: advancing health equity at home and abroad

Andrew Bresnahan  
Vice-President, Global Health  
McMaster University, Class of 2015

**E**ACH YEAR, THE CFMS global health program (GHP) unites medical students from every corner of Canada working to advance health equity at home and abroad. We are always looking for ways to welcome more medical students to the program and improve our communications, services and representation in Canada and around the world. This year, we have made great steps in this direction, thanks to a brilliant team from across Canada working to bring our program to life.

## Connecting across Canada

Supporting a team spread from coast to coast to coast is an inspiring challenge. This year we have continued using the CFMS website, Twitter account, Facebook pages, email lists and conference calls to communicate with students and colleagues at medical schools across Canada, sharing news, opportunities and reports to make our work as transparent and accessible as possible. Blog posts on housing and health, intimate partner violence and Indigenous health have helped build our organizing momentum, while reports from international meetings of medical students in Central America and North Africa helped highlight the strengths we bring to international efforts to build a more just and healthy world.

## Global leadership

CFMS is a member of the International Federation of Medical Students' Associations (IFMSA). Each year, we participate in bi-annual meetings of the IFMSA, meeting with medical students from over 100 countries around the world to share projects and learn

from each other's work. In February 2014, Emily Stewart (Toronto) and Scott Hodgeson (Manitoba) led the first Canadian delegation in many years to attend the Pan-American Medical Students' Association (PAMSA) meetings in Panama, where they led more than 36 hours of workshops on sexual health and Indigenous health. In March 2014, Danielle Chard (McGill), Zia Saleh (Alberta), Siqi Xue (Toronto) and I will be leading Canada's delegation to the IFMSA March Meeting in Tunisia, where we will be continue working with our international neighbours to shape the post-2015 sustainable development agenda to include measureable and effective action on the social determinants of health.

## Global health services — a focus on health equity

This year the GHP designed our first strategic plan, bringing a focus on health equity to each of our areas of service delivery, including our programs in global health education, reproductive and sexual health, international exchanges, partnerships, Aboriginal health and advocacy.

For the first time this year, our global health advocates (GHAs) worked with the CFMS Government Affairs portfolio from day one to design and implement our national Lobby Day, bringing a focus on social determinants of health to Parliament Hill. Over 80 students, representing every medical school in Canada, joined us for advocacy training at CMA House in Ottawa and met with nearly 70 MPs, senators and cabinet ministers to call for improved access to physicians in rural Canada, and better investment in social housing.

“... a commitment to ensuring that all people, regardless of where they are born or who they are born to, have a fair shot at a healthy life.”

The GHP is also leading efforts to improve CFMS's capacity to work alongside Aboriginal peoples to promote First Nations, Metis and Inuit health. Our 2014 Annual General Meeting will be the first to include representatives from Aboriginal health interest groups from medical schools across Canada, creating an opportunity to build lasting partnerships at a local level. At a national level, we are also in dialogue with Inuit Tapiriit Kanatami, the Métis National Council, the Assembly of First Nations and the Indigenous Physicians Association of Canada as we develop new CFMS policy papers on First Nations, Metis and Inuit health.

To highlight our shared commitment to health equity, medical students from the global health program have partnered with *Upstream* ([www.thinkupstream.ca](http://www.thinkupstream.ca)) to write a book celebrating Canadian physicians whose work offers practical examples of action to improve the social determinants of health. Like *12 Stories*, our book on

migrant and refugee health, we hope this new collection of student writing will be an inspiring tool for Canadian medical students working to build a more just and healthy society.

### Health for all

As I write, I am watching the snow fall on the town where I was born, an Inuit community on Labrador's north coast. Listening to my friends share stories of everyday life in the north, and thinking of our CFMS delegation to the IFMSA meetings in Tunisia, I am reminded that what links these areas of practice is our shared commitment to health equity — a commitment to ensuring that all people, regardless of where they are born or who they are born to, have a fair shot at a healthy life.

Beyond the busy pace of clinical work, early morning rounds and late night call, it's good to take time to remember what we are working toward. We can find these reminders every time we listen to our patients, accompany them through their suffering, and learn about the everyday conditions that shape their lives. Canadian physician and humanitarian James Orbinksi reminds us of this when he writes:

*In our choice to be with those who suffer, compassion leads not simply to pity but to solidarity.*

*Through pity, we respond to the other as a kind of object, and can assume a kind of apolitical stance on the causes of and the conditions that create such suffering, as though these lie somehow outside the responsibility of politics, and as though charity and philanthropy are adequate responses. In being with the victim, one refuses to accept what is an unacceptable assault on the dignity of the other, and thus on the self...Solidarity implies a willingness to confront the causes and conditions of suffering that persist in destroying dignity, and to demand a minimum respect for human life. Solidarity also means recognizing the dignity and autonomy of others, and asserting the rights of others to make choices about their own destiny. Humanitarianism is about the struggle to create the space to be fully human.*

What better work to share? Thanks to each of you who work to bring the GHP to life, and who bring it closer to contributing in practical ways to the struggle to ensure that all people, wherever they are born, have the space to be fully human. Over the next few pages, you will have the chance to hear

“Our GHAs worked with the CFMS Government Affairs portfolio from day one to design and implement our national Lobby Day, bringing a focus on social determinants of health to Parliament Hill.”

from other Canadian medical students involved in the GHP. Please feel free to contact us anytime with questions or ideas about we can work together to advance global health. ■



# IREACH — improving access to care for refugee and new immigrant populations

Danny Chan

University of Toronto, Class of 2016

Leora Branfield Day

University of Toronto, Class of 2016

Ayan Dey, MD, PhD

University of Toronto

**I**MMIGRANT AND REFUGEE Equitable Access to Community Healthcare (IREACH) began in 2012 as an initiative of University of Toronto medical students driven to make a positive difference in the community. Through their own academic fieldwork in the community, personal experiences and volunteer work, they realized that many new immigrants and refugees face several barriers to accessing care. This includes language, cultural, educational and social barriers, in addition to a lack of familiarity with social and health care services available to them. Recognizing this issue and motivated to help improve accessibility and empower refugees and new immigrants, medical students at the University of Toronto began IREACH — an initiative to connect new immigrants/refugees with community resources and facilitate communication with medical professionals through interpretation services.

Since its inception in early 2012, IREACH has won a project grant to support its operations and was recognized as an official student group within the Faculty of Medicine. Today, IREACH works in partnership with a number of community centres and services,

including St. Stephen's House, a community-based social service agency in downtown Toronto. This enables us to reach out to immigrant and refugee clients in the community. One of IREACH's main initiatives is the development of a wallet-sized medical history card for each client, created from a medical history taken by a volunteer medical student. Clients are then able to use this card when they are visiting a health care provider for the first time, in the emergency room or in an emergency scenario. This helps to overcome language barriers and facilitates the transmission of these individuals' most important health record information to health care providers, assisting in their treatment and management.

Over the past two years, the card-making clinics have received very positive feedback. Specifically, clients have described feelings of empowerment and confidence in seeking out health care services with the use of the card, as the cards act as an important resource to help facilitate communication with health care providers. Other clients have expressed that this initiative has reinforced their faith in the health care system as a whole, as they have been moved by the respect and care shown by medical student volunteers.

To create these cards, first and second year medical students gather a detailed medical history from clients, with or without an interpreter. In doing so, students are able to practise and improve their history-taking skills and learn how best to communicate with patients who speak limited English. Importantly, through this process, students gain exposure to working with vulnerable populations and learn first-hand about the clients' varied cultural backgrounds, beliefs and needs. As such, IREACH serves an important role not only in assisting immigrant and refugee populations, but also in providing valuable, hands-on opportunities for students to work with diverse and marginalized populations.

Overall IREACH's mandate is to oversee initiatives that improve access to health care for immigrant and refugee populations, while giving medical students the opportunity to work with unique populations and develop their communication skills. By sharing our story, we hope similar programs can become established at other universities across Canada.

Please contact us at [ireachuoft@gmail.com](mailto:ireachuoft@gmail.com) for more information. ■

# IHI Open School, Manitoba chapter: student-led initiatives

Kristina Joyal

University of Manitoba, Class of 2015

Cara Katz

University of Manitoba, Class of 2015

**I**N HEALTH CARE, THE CONCEPTS of interprofessional teamwork, patient-centred care and quality improvement are fundamental for an optimal system. The Institute for Healthcare Improvement (IHI) is an international non-profit organization that works towards these goals, and at the University of Manitoba we have a chapter of IHI that functions under the Manitoba Health Sciences Students' Association (MaHSSA). We want to highlight recent chapter activities, as well as our challenges and future directions, in hopes to inspire others to engage in activities related to health care improvement and interprofessional education and foster national dialogue in these regards.

## Activities of note

### *Nightmare Night Care (2011–2013)*

Nightmare Night Care (NMNC) is an overnight simulation shift that includes nursing, medicine and pharmacy. First-year nursing and medical students play the role of patients on a hospital ward while fourth-year nursing and pharmacy students, and second year medical students play their respective roles. Approximately 45 students are involved annually, including medical residents throughout the evenings as “attendings”. This simulation allows for insight into what our colleagues do and an appreciation of their skills and knowledge, as well as teamwork. “Patients” are given roles that they are expected to act out (e.g., requiring a wheelchair, trying to attract a nurse’s attention for help to the bathroom, etc). Students reported learning what it can feel like to be a patient, as well as some new insights into other



professional roles. We have since initiated a daytime simulation, and are looking to include occupational therapy and physiotherapy students in the future.

In 2013, an ethics-approved survey evaluated the ability of the NMNC event to improve inter-professional attitudes. From this, it was clear that, for some students, this was their first chance to work with other health care professionals.

#### *IHI Open School Workshop (2011–2013)*

This annual workshop introduces students to (and reminds them about) the IHI, the Open School, orientation regarding the certificate, and other ways to get involved. Approximately 40 students attend annually, with a few from outside of medicine. Students can receive recognition on their medical student performance record (MSPR or dean's letter) for completion of the IHI Basic Certificate. This acts as further motivation to complete the IHI Open School,

and we plan to expand this opportunity for recognition to other health care students outside of medicine.

#### *Other past activities include:*

Interprofessional Competition: Patient Safety Project (2006), Assessment of the Adoption of the World Health Organization Surgical Safety Checklist (2009), a case study (2013), poster presentation at Canadian Conference on Medical Education (CCME, 2013) and Student Quality Leadership Academy (2013)

### Challenges

There are numerous challenges to maintaining an active, inter-professional student group. The most glaring of our challenges is scheduling of events due to the physical separation between the two campuses and differing exam and holiday schedules. Additionally, we currently lack representatives from each program to coordinate with. Finally, there can be

a loss of momentum with the handover of leadership each year.

### Future directions

IHI is working with MaHSSA to improve inter-professional communication and representation. We have also changed the chapter leadership to two two-year positions, to reduce the loss of momentum from year to year. Ideally, the two positions would be held by students from different programs.

Finally, we are hoping to promote quality improvement projects by engaging with hospital and faculty quality improvement committees.

We hope that you have enjoyed reading about the University of Manitoba's IHI activities, and that it is helpful and inspiring for your own inter-professional, patient-centred or quality-improvement activities. Feel free to email us (IHI. Manitoaba@gmail.com) with any comments or questions! ■

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# Need for improved eye care among homeless Canadians

Christopher W. Noel  
University of Toronto, Class of 2016

**H**OMELESSNESS IMPACTS thousands of Canadians, and it has been linked to many important health implications, including greatly increased rates of morbidity and mortality.<sup>1</sup>

While there has been a significant amount of research conducted to identify the prevalence of some diseases within the homeless population, little is known about their ocular health. Given that the Ontario government does not cover the costs of primary eye care, the cost associated with receiving eye exams and prescription glasses is believed to be a major barrier for many people with limited financial resources, including those living on the street.

Our team's extensive literature search generated fewer than half a dozen articles related to the ocular status among homeless persons. Results from these papers are quite striking: one study conducted in Vancouver's inner city found that the prevalence of visual disability was approximately nine times more than the estimated Canadian rate.<sup>2</sup>

Under the supervision of Dr. Myrna Lichter, a staff ophthalmologist at St. Michael's Hospital, a student-led research team from the University of Toronto has launched an initiative to determine the prevalence of eye disease within Toronto's homeless community. This initiative involves administering surveys and vision screens to 100 homeless individuals across 10 randomly selected shelters in the city.

The hope is that our study will help not only to identify those with visual disabilities, but also to elucidate any access issues within our current eye care delivery system.

The project is well underway, and our preliminary data suggest that the majority of homeless individuals are dissatisfied with their vision. What I find particularly distressing is that over three-quarters of our participants have decreased visual acuity that could easily be corrected with prescription glasses. While many of our study participants qualify for Ontario Works, which helps subsidize prescription drugs, dental care and eye examinations, the cost of glasses is only partially funded and very few receive regular eye exams. In addition, despite our small sample size, our team has uncovered a number of sight-threatening findings, such as homonymous hemianopsia, elevated intraocular pressure, herpetic keratitis and retinopathy. In most cases, these eye problems were not being medically managed; Dr. Lichter has subsequently offered to provide ongoing eye care for these individuals.

Our preliminary results have motivated a group of ophthalmologists at St. Michael's Hospital to consider establishing a free eye clinic within Toronto's Central Local Health Integration Network. The belief among all members of our team is that vision is not luxury for those who can afford it, but rather a right to which all Canadians should be entitled. The

“The belief among all members of our team is that vision is not luxury for those who can afford it, but rather a right to which all Canadians should be entitled.”

homeless community's response to this initiative has been overwhelmingly positive, and the vast majority of our study participants have expressed interest in accessing these services. While the development of a free eye clinic is still in its early stages, our hope is that it will assist the disadvantaged in overcoming the hurdles they face when accessing eye care.

For more information about the study please contact Christopher Noel ([christopher.noel@mail.utoronto.ca](mailto:christopher.noel@mail.utoronto.ca)).

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# Medical humanities at the Schulich School of Medicine and Dentistry: integrated extracurricular pre-clerkship modules in narrative medicine, visual arts and history of medicine

Thomas Fear

University of Western Ontario, Class of 2015

Joshua Tobe

University of Western Ontario, Class of 2015

Jessica Truong

University of Western Ontario, Class of 2015

**T**HE STUDY OF HUMANITIES offers medical trainees both the opportunity to fortify their communication skills and a means to grow into reflective and introspective physicians. However, over the course of Schulich School of Medicine and Dentistry's (SSMD) pre-clerkship educational years, there is a lack of arts- and humanities-based learning offered to students. Considering both the rich academic milieu at Western University and the varying interests of SSMD medical students, there is an opportunity and demand for cross-faculty programs to be developed.

A small group of us have established a student-driven and faculty-facilitated subset of courses. These short courses function as a complement to the current pre-clerkship training; they include courses in the disciplines of visual art, narrative medicine/philosophy, and the history of medicine, each with distinct goals. The narrative medicine course aspires to impart a broader sense of oneself and others — what is often referred to as sensibility — while building moral insight and empathy. The visual arts stream strives to develop one's visual acuity and interpretation proficiency, skills essential to the art and practice of medicine. Finally, the history of medicine module assumes a more public health approach: a critical study of the history and modern practice of medicine, the

direction it's moving and how it can be refined.

The program is now in its second year. To date, we have run several sessions in each of the three streams and the informal feedback we have received from our fellow students has been tremendously positive. To formalize and characterize some of this feedback, we asked the students who attended one or more of a series of three visual art sessions to provide constructive criticism in the form of a questionnaire that followed each session. The majority of students felt that, although they had the desire to engage in artistic endeavours, their medical education did not provide the infrastructure, nor the encouragement, to do so. At the outset, we thought the chief impediment to student attendance and participation would be the workload of pre-clerkship education. As it turned out, many of the 40 first- and second-year medical students who attended felt that they could benefit from pre-readings and post-sessions assignments.

These courses have succeeded in making studies in the humanities more accessible to medical students, and they have proven to be well-liked by participants. However, varying levels of attendance suggest the programs are not as appealing as other extracurricular activities. One reason we have hypothesized for this is the lack of transcript recognition. To improve attendance and increase the value of the course

“These courses have succeeded in making studies in the humanities more accessible to medical students, and they have proven to be well-liked by participants.”

for students, it is the long-term goal of the program organizers to confer a certificate of completion for full participation, which would be recognized on students' transcripts. Furthermore, we hope to create a website to publish student work derived from these courses in order to increase awareness of fellow students and faculty. We are very proud of this initiative and are excited to finally see SSMD join the ranks of other Canadian medical schools on the medical humanities forefront. ■

# The best-kept secret: an unforgettable summer clinical studentship in radiation oncology

Wei Ning (Will) Jiang

University of British Columbia, Class of 2015

**T**HE BEST HALF-HOUR I SPENT aimlessly browsing the internet last year was when I chanced upon the Canadian Association of Radiation Oncology/Canadian Radiation Oncology Foundation clinical summer studentship in radiation oncology. I had high hopes about experiencing all aspects of radiation oncology to inform my career decision, high hopes of verifying that the patient interaction speaks to my heart, and high hopes for developing clinical skills for all the years to come. It exceeded all my expectations and gifted me with an unforgettable summer.

For the clinical component, the experience is similar to a third-year radiation oncology elective: I was assigned to a different radiation oncologist and resident each day, so I was exposed to all treatment sites, from pediatric to gynecological, from head and neck to sarcoma. As I have an interest in palliative radiotherapy, I spent each Friday at the rapid access palliative lung clinic. I saw patients through the whole spectrum of care, from new patient consultation, to patient review during treatment, to follow-up after treatment. On top of that, I had a chance to attempt contouring and treatment planning. Reflecting on the experience, it painted a realistic picture of life as a radiation oncologist.

For the optional research component, I had six half days set aside to assist in an ongoing research project. The resident and

radiation oncologist primary investigator were so supportive that I did not hesitate to continue my work into my third year!

Throughout the six weeks, Dr. Carolan and the coordinator accommodated my every request. For instance, when I reflected that I lacked exposure to pediatric and gynecological cancers, they scheduled more sessions for me in these areas. The radiation oncologists and residents were consistently helpful and patient to answer my questions. The environment at BC Cancer Agency was collegial and supportive.

By far the most memorable experiences, though, were the interactions with patients. I fondly remember one patient who came into the clinic angry, repeatedly complaining about the wait time to see his cardiologist and frustrated about his painful bloody diarrhea after his prostate radiotherapy. What remained with me, though, is not his radiation colitis, or the long discussion we had — it was his son's comment that his father had not looked so relieved or so understood in weeks. Two days later, a handmade card landed on my desk. In it, with large, rough handwriting, was "To the student doc: Thank you." That card now has a permanent home on my window sill. Certainly, not all experiences ended well. I recall a pediatric follow-up patient who confessed that she always feels one step behind in her classes, at her work, or with friends. My worries

"A handmade card landed on my desk. In it, with large, rough handwriting, was 'To the student doc: Thank you.'"

gnawed at me: Did we do this to her? Is this the neurocognitive sequelae of pediatric whole brain radiation? In another instance, I can still taste the profound sadness when I heard about the death of a patient I saw in clinic just a day ago, but I can also reminisce about the satisfaction blooming in my heart when I realized that the changes we made to his pain medication helped him to be comfortable during his last hours. From the highs and the lows, I found working with the patient population fulfilling.

In these six weeks, there were times of joy, times of empathy, times of curiosity and times of learning. Whether in the clinical or the research component, with the support of residents and radiation oncologists, I was blessed with this opportunity. It was the best first clinical rotation I could ever ask for. ■

# These first times

Nina Nguyen

Université de Sherbrooke, Class of 2016

**T**HE FOUR BOXES WERE FINALLY lying in the middle of the empty room after spending so many hours in the car. After endless days spent day-dreaming about medical school, I finally got to unpack my ambitions. I plastered the walls of my new home with nostalgia and stared at pictures of old friendships. Medical school marked the start of something new, and expectations kept me awake before the first day of class.

*It was the first time I moved away.*

Memories blinded me when I sat down in the lecture hall. Butterflies, again, were flying in my stomach, just like when I had stepped into the kindergarten's schoolyard years ago, not knowing even one word of French. I smiled quietly, wondering how great all my classmates must also be if I myself made it so far.

It was the first time I attended university. I felt a little naïve to be so proud to be sitting there. It was just school, after all.

*Wrong — it was the first time I attended medical school.*

The warmth of the freshly ironed white coat on my shoulders did not stop me from shivering. It seemed that the spotless linen, embracing every curve of the body lying on the hospital bed, as white as the season's first snow, was mocking my uniform. Maybe this is why superheroes never wear white.

*It was the first time I witnessed a Code Blue fail.*

The faint hum of the coffee machine pouring into my stained cup and the spring rain gently knocking on the library's windows were stopped by a shy cough. A classmate was waiting in line for the coffee machine, but his gaze was directed at me.

"Nina, do you still have these pills? For anxiety. I've heard you had some. For depression. Anything will do."

I remembered speaking to him once or twice, but I did not know his full name. During the past few months, I thought that I was the only one for whom the sun never rose. For a moment, I mourned these classmates who were also trapped in the dusk.

"I don't know where I can get help."

*It was the first time that I suffered.*

As soon as the resident slit the uterus I was on my tiptoes, trying to catch a glimpse of that baby girl, but streams of blood blurred my view. The attending pulled a wailing baby out of this mess, and then nurses quickly wrapped her and laid her in the incubator. I was adjusting her knitted cap when the baby seized my pinky finger. Her lips, still blue, curled up.

*It was the first time that I made someone smile, her very first smile.*

His strained breathing was slicing his sentences in half. His bony hand on my left shoulder felt as heavy as hope despite the ravages of disease in his body. He took a deep breath to thank me

for listening to him, for writing down his regrets. He thanked me for studying medicine while the monitor faintly beeped, reminding me that his face will not feel the autumn's winds.

*It was the first time that I felt like I belonged here.*

"I think I know you. I've seen you somewhere."

I did not expect anyone to talk to me when I exited the press box. I should have remembered someone with such a radiant smile, but months of cramming muddled my memory.

She knew who I was, despite my business attire, despite the steno pad I was holding, despite the masquerade.

"You're a medical student."

I stopped walking. She knew.

"And you write. A lot. And well.

Thanks for showing me how medical school is incredible. I'm applying soon."

*It was the first time that I was proud to be a medical student.*

Medical school feels like growing up, once again. Dreams bruised my idealism and stained my white coat while silently watering the physician-in-training sprouting in me. Next time you meet me at the hospital, you will recognize my genuine smile, but my darkened eyes will betray who I have become.

Don't be afraid.

*It will be the first time that I will truly feel like a doctor. ■*

# Appreciation

Kevin Dueck  
University of Western Ontario, Class of 2016

**S**HE CAME INTO THE CLINIC STRUGGLING to carry all she had brought. A purse over one shoulder, a plastic bag slung at the crook of her arm and both hands holding something delicately covered in foil. The nurse greeted her and checked her in, and she was directed into one of the small consultation rooms.

When we entered the room the object in foil was sitting on the counter, the plastic bag beside it. She lit up seeing the surgeon. Through her thick accent she thanked the doctor for what he had done and proudly removed the foil. It was a cake, made from scratch. She had baked it for the doctor and the staff. From the plastic bag came paper plates and cutlery. I had seen patients express gratitude before, but this was something more.

What had the surgeon done? I expected it to be emergency surgery saving her life. No, her diabetic foot had been amputated.

Removing a part of someone's body and having them thank you for it, this is where I start to struggle. Receiving not only thanks, but a cake for cutting off a part of this woman's body, it was hard to wrap my head around. Despite easily being able to list benefits of such a surgery (no further foot ulcers, worry of infection, wound care, etc.) it still does not feel quite right. Removing a cancer is like dealing with an invader, something foreign, and thus different than removing a still functional part of the body. This part of medicine is going to take some getting used to. ■



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# Summer woes: child malnutrition in Nepal

Laura Stratton

University of Toronto, Class of 2016

**O**NE OF THE MANY THINGS my classmates and I worried about during our first year of medicine was what to do during the summer. Should the summer be spent doing something “productive,” such as research or work? Or do you escape from the whirlwind that is first year and travel to exotic destinations? Or perhaps it should be left empty, so as to enjoy the luxuries of an unscheduled day?

On a break from making Excel charts analyzing the pros and cons of these options, I stumbled across an information session for the non-profit organization Bringing About Better Understanding (BABU; [www.thebabuproject.com](http://www.thebabuproject.com)). I learned that BABU was co-founded by University of Toronto medicine graduate Hamid Izadi in 2009, with the mission to improve child health through preventative and curative medicine in Nepal. Since then, more than 50 Canadian medical students have volunteered with BABU in programs that combine clinical experience, public health initiatives, research and adventure in Nepal. I was sold. Gone were my Excel files, replaced with a plane ticket to Kathmandu.

Having recently completed a master’s in nutrition, I was thrilled to be assigned to the Nutrition Centre at the International Friendship Children’s Hospital (IFCH). Nepal has some of the highest rates of malnutrition in the world and the Nutrition Centre was recently opened in response to the overwhelming need in Nepal’s most densely populated city, Kathmandu. The Centre functions to provide nutritional rehabilitation to

severely malnourished children, as well as education for their families.

My role was to identify evidence-based ways for BABU to help improve the nutrition program offered by IFCH. Despite the extraordinary dedication and passion of the interdisciplinary team of dietitians, nurses and physicians at the centre, its future was uncertain due to lack of sustained funding. There simply were not enough human and material resources available to care for all the malnourished children admitted to IFCH.

Although I helped implement practice improvements to the Nutrition Centre, I left Nepal feeling as though the real issue of resource scarcity facing the centre had not been addressed. Coincidentally, shortly after returning I received a call for charity nominations for EarthTones — an annual benefit concert put on by University of Toronto students to raise money for child health around the world. I applied on behalf of the Nutrition Centre and was overjoyed to learn that it had been selected as a recipient of donations from the 2013 concert. I know these funds will make an immense difference for children at the Nutrition Centre; however, this is the first of many steps needed to ensure long-term sustainability.

Research to evaluate the treatment program at IFCH is critical. To achieve these goals, I am collaborating with the BABU research director, University of Toronto MD/PhD student Natasha Lane, to plan a series of research projects for future students. These projects will focus on examining the cost-effectiveness

“There simply were not enough human and material resources available to care for all the malnourished children admitted to IFCH.”

of different food supplementation options available at the centre, as well as the impact of existing education and outreach programs. We hope that through this work, we will lay a foundation for long-term success of the Nutrition Centre.

I am immensely grateful for the opportunity I had to learn and work alongside the clinicians I met at IFCH. Continuing this work since returning to Canada has been an unexpected additional bonus, which wouldn’t have been possible without the dedicated staff at BABU. I encourage anyone looking for an adventurous and rewarding summer to consider volunteering with BABU, or any international program that exposes you to novel clinical settings. Delete that Excel sheet! Buy a plane ticket! You will be grateful you did! ■

# Good kaRMSa

Ameer Farooq

University of Alberta, Class of 2014

I HAVE JUST FINISHED PUTTING in all my CaRMS applications. For any first years reading who don't yet know, CaRMS stands for Canadian Resident Matching Service, and it is the central online system through which applications for residency are submitted. It has also been the bane of my existence for the last few months.

CaRMS applications are no fun. You have to somehow convince residency directors that you are different than the dozens of other smart, organized, well-qualified applicants. You have to convince them that you are 100% committed to program X at location Y. This is despite the fact that you are not entirely sure that you are making a wise move by committing five years of your life in a somewhat unknown city and even less sure about (finally) choosing a career for the rest of your life. You scrutinize the inner recesses of your mind for anything to put on your resume (what was that volunteer activity I did in first year?). You write and re-write your personal letters, and each version sounds more and more like a Rob Ford rant, minus the hilarity.

The application deadlines coincided with my two-week elective in general surgery. On a particularly busy night of call, we had a major trauma come into the ER. It was a young man who had sustained horrible injuries through a motor vehicle accident. In the ICU, I looked at the man's fractured face and realized that he was not so different from me.

Throughout the process of preparing my CaRMS applications, I was focused on my future prospects, as I have been my whole life. I have always focused on the road ahead, the next challenge. There is always the sense that if I can just clear this hurdle, it will be smooth sailing and clear skies. Yet there is always a fresh anxiety at the next hurdle and the familiar manoeuvre of ignoring family, friends, and cheesecake to concentrate on hustling.

What I often fail to do is appreciate where I have been and how I have gone about navigating the journey. I don't mean that I fail to do this in the very obvious "reflective" style we are asked to use in medical school assignments, but to really be grateful for all the things that had to go right for me to get here. I have never been in a major accident. I wasn't born in a wartorn country and haven't had to flee as a refugee, as the millions of Syrian children are doing right now. I wasn't born into a poor family that couldn't afford to send me to taekwondo or needed someone to finish high school and go out and get a job. I was born — perhaps the greatest miracle of all.

For all of us medical students, we have had incredibly good karma, though probably not through any action of our own. This is not to diminish the struggle many medical students have gone through to get here. What I can say is that a lot of people who struggle their whole lives never succeed in making headway.

“You have to somehow convince residency directors that you are different than the dozens of other smart, organized, well-qualified applicants.”

It always used to annoy me when my father, a general surgeon, would come home and regale us with tales of woe and sadness. My siblings and I would get irritated — why would he always tell us these sad stories of good people getting sick? Now, I begin to understand what my father was getting at. I have realized medicine is often not a series of serendipitous, transcendental experiences and profound achievements, but a hard slog, a disciplined effort to measure twice, cut once. For me, CaRMS was a hard process, but I have at least realized that in spite of everything, in spite of all the other roads I could have traveled, here I am at the crossroads. And for that, I am grateful. ■

# Medical student elective experience in Seoul, South Korea: gangnam style

Loretta Cheung

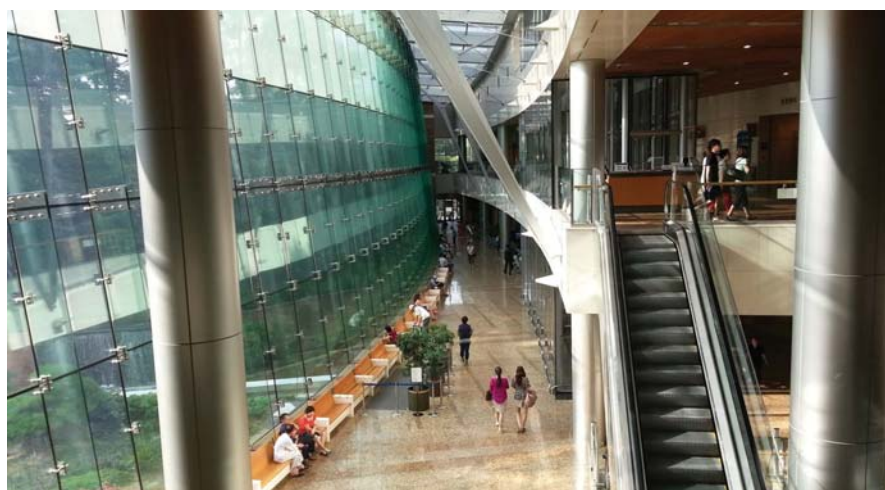
MD Candidate

University of Ottawa, Class of 2016

**S**AMSUNG MEDICAL CENTER (SMC) is one of the largest hospitals in South Korea, with the latest medical equipment and one of the best patient-centred medical services. Located in the Gangnam region within Seoul, the capital of South Korea, the centre includes the main hospital and the cancer centre, with over 40 medical departments, 10 specialist centres, and 120 special clinics. With SMC being one of the best hospitals in Asia, I chose to go on a two-week elective in the department of dermatology during the summer of 2013. While I had visited Korea before and understood some spoken and written language, this was my first “business” trip to Korea and I was excited to experience the medical work environment.

From the start, I was warmly welcomed by everyone in the department. I was placed in the outpatient dermatology clinic and the laser clinic at the hospital and observed many treatment procedures performed by the residents.

Seeing over 50 patients in the morning alone, I was able to see a variety of cases presented in a fairly homogeneous population, including atopic dermatitis, alopecia, vitiligo, skin tumours, onychomycosis, pityriasis alba and prurigo. Foreign patients from many countries, including Russia, Iran, Germany and the United States, were seen in the afternoon clinics. I learned about many skin diseases that are more prevalent in Asia than North America, such as Behçet’s disease and non-HIV associated Kaposi’s sarcoma. It was fascinating to see the different skin manifestations among various ethnicities. Although the patients mainly conversed in Korean with the doctors and residents, they were



very kind to explain the cases in English. I had the opportunity to practise my Korean with the nurses and patients and I certainly improved upon my knowledge of the language for both conversational and medical terms. Additionally, it was interesting to discuss the similarities in medical education, including the incorporation of the problem-based learning (PBL) system.

There were many cultural differences in patient care between Korea and Canada. In Korea, the doctors are more reserved and efficient when taking care of patients, with some departments seeing over 90 patients per day. Patients always show their respect toward their doctors by bowing and thanking them. Similarly, the residents and medical staff show great courtesy toward their professors. I found the more open and liberal student–teacher relationships in North America was not seen in the Asian culture, as there were strict and clear divisions between students and professors. The doctors were often very rigorous in teaching the residents, who worked hard and were on call every other night.

In addition, I met many other foreign doctors and medical students training at SMC from many countries, including China, Germany, Myanmar, Ecuador and India. I often had insightful conversations with many of them about the differences in our health care system and patient care.

The hospital environment and resources provided for the doctors and patients were excellent. Patients were often entertained well in the waiting rooms with new television shows and evening concerts performed by musicians. Also, I enjoyed the Korean meals in the staff cafeteria that I ate together with the doctors and residents, as it is within Korean culture for the senior residents and doctors to buy meals for their junior colleagues and to make sure my stay at SMC was pleasant and memorable.

Having a more multicultural and global view of medicine has allowed me to understand patients from different countries better. I highly recommend doing an elective at SMC for a global view of health care. ■

# Say it like you mean it

James Yan

University of Western Ontario, Class of 2015

...“Exactly so,” said Alice.  
“Then you should say what you mean,” the March Hare went on.  
“I do,” Alice hastily replied; “at least — at least I mean what I say — that’s the same thing, you know.”

“Not the same thing a bit!” said the Hatter. “You might just as well say that ‘I see what I eat’ is the same thing as ‘I eat what I see!’”  
— Lewis Carroll’s, *Alice’s Adventures in Wonderland*

**A**NOTHER THURSDAY AFTERNOON on my clinical teaching unit (CTU) rotation. Afternoons all a similar routine: see patients, teaching sessions, team rounds, and then finish up leftover tasks. Aside from Fridays which had an extra clerk teaching sessions, there was not too much of a variation. Thus, when we met for rounds that afternoon, I was not expecting anything unusual to occur as I began to report on my patients.

This was to be my first, but not my last, mistake.

I had reached my last patient, Mr. W. Casually, as I had done dozens of times over my five weeks of CTU, I began.

“Mr. W. A 60-year-old male presenting to our ER with shortness of breath from a COPD exacerbation ...” Mistake number two.

Honestly, I did not even realize

the slip, but my attending immediately noticed. Before my next word, he interjected, with a small smirk, “Well, COPD cases can *feel exasperating* but I think you should try again.”

Embarrassed, I fumbled for a response. “Sorry, *exacerbation*. You know what I meant, right?”

The third, and most cringe-worthy, mistake.

“That’s beside the point. You have to be careful with the words you choose,” he snapped, shaking his head, “The lines of communication are so fragile.”

And that should have been the end of it. Medical student screws up, doc corrects him. Roll the credits. But my attending’s last line really stuck with me.

I remembered a game in elementary school, Broken Telephone, in which a sentence was spoken down a line of children and then recalled, often erroneously, by the last person. Simple misunderstandings were funny; however, errors due to misinterpretations in medicine are not humorous at all.

There are no “simple misunderstandings” to ignore regarding patient care. Communication breakdowns have the potential for very serious consequences. A 2006 *Annals of Internal Medicine* article by Gandhi et al. revealed that communication factors were a major reason behind process breakdowns leading to missed

or delayed diagnoses. Unfortunately, the hospital has many opportunities for such breakdowns, ranging from unclear orders, vague charting and illegible writing, to overly casual handovers. A common motif behind these is the assumption that the receiver will intuitively be able to interpret what the sender meant. Alice’s conversation with the March Hare highlights that the “simple” act of interpreting meaning from another’s remarks is not a clear and easy process in the slightest.

It was a sobering realization that I was an example of the problem. Yet, I am still grateful for having this encounter, in particular toward my attending who was willing to bring this deficiency to my attention, and that it was done at a time in clerkship where I was still relatively fresh and able to address this issue sooner rather than later. Reflecting on the whole event also brought a deeper appreciation of the CanMEDS Communicator competency. Like Alice, I had initially thought communication was natural and straightforward. But delving beyond the surface revealed it to be a complex and inconsistent process. As medicine becomes increasingly inter-professional, communication is a skill “that it is essential that we develop properly.

And I do truly mean that. ■



# The truth — a physician’s most powerful weapon?

Mark Hewitt, BMSc  
Memorial University of Newfoundland, Class of 2017

**A** PHYSICIAN MAY POSSESS enormous amounts of medical knowledge; they may have the technical skills to suture a heart back together or to excise a pancreatic tumour or a world-renowned reputation. However, the truth of the matter is that a physician’s profession is rooted in their ability to connect to each and every patient as an individual, to show compassion and concern. Every detail the patient tells us is a clue to their diagnosis. Without those clues, the physical symptoms are useless. It is this dialogue that allows us to truly help individuals and it is this communication upon which the foundations of patient-doctor trust are built.

At some point within our careers as physicians, we will be faced with a situation in which disclosing the full truth of a diagnosis may be earth shattering. One could certainly think of many situations where the whole truth may not be relevant to the patient’s needs, and certainly where it may cause more harm than good — a principle that contradicts our training and oaths as physicians. The patient may be a terminally ill elderly individual and be found to have a slow-growing cancer. You may be the family physician

for an entire family and within this family the parents may not want to tell their young child that they are dying.

One could argue that it would be easier to tell the elderly patient that all the tests were normal, reasoning a non-essential diagnosis could potentially exacerbate current conditions and reduce the quality of their remaining life. In the care of the child it would be easily justifiable to believe they don’t understand the magnitude of the situation. However, usually it is the parents’ disbelief and inability to face reality that drives this request. Despite the personal turmoil, the upset families, it remains that the biggest consideration of truth telling has to lie with the best interest of the patient. Lies only perpetuate lies; if one test is lied about, the next one will have to be. Once this trust is gone, the connection between a patient and the physician is severed, leaving the physician in the dark.

A physician has a moral obligation to tell their patients the truth, barring any deemed incompetency. From a legal standpoint, withholding information regarding a diagnosis can lead to lawsuits; however, this belief is built on more than

“The patient has put their absolute trust in us to help.”

just legality. The physician, no matter how “well” they know the patient, cannot fully understand how the patient would want their information or what they would want to do with this information unless explicitly told beforehand. The patient has put their absolute trust in us to help, and even if it is easing concern with a fatal diagnosis, that is a small measure of help we can offer.

Overall, the act of truth telling is far from black and white. Pros and cons can be created for not fully disclosing the extent of a diagnosis. However, above all, we as physicians owe it to our patients to allow them autonomy over their health care, to provide guidance and beneficence yet not paternalism, and to give them the same trust and respect for their own decisions that they give to us by stepping into our clinics. ■

# Temples

Kyra Harris, BHSc  
McGill University, Class of 2016

**M**OST DAYS IN THE GROSS anatomy lab, I stand next to the same cadaver. He has no name, just a number: Slab 20, Body 1719. I watch as my colleagues delve deeply into him. I have tried to make peace with this practice of mining the dead for knowledge. For most, it offers the chance to colonize the human body in the name of medicine. For me, it has become the most spiritual aspect of my medical education, masquerading as a simple anatomy lesson.

Most days, when I stand before my cadaver, I want to clean his body, wash his feet and comb his hair; my instinct is to take care of him. I stare at his hands: hands that once pressed into the palms of loved ones, I now find balled in cold, rigid fists. I want to unfurl them the way my mother unfurled my own hands while reminding me that the only things kept in the tiny cages of closed fists are the things that haunt us. With my fearful hands, I want to suture up the signs of our exploration. More than anything, I desperately want to make my cadaver whole again. Instead, at the end of each lab, I tenderly replace each of his organs and lay him to rest under his green shroud.

But today, we did not pull back his green shroud. Instead, we learned from prosections: bodies dissembled and sorted into labelled buckets. As I looked into the buckets, the spirituality the

gross anatomy lab once inspired in me quickly vanished. I was now innately aware that our bodies are flesh. The moment I saw the body broken into parts I was unable to continue to see it as a temple. I began to ask: does a temple still hold the same spiritual meaning when the candles have been blown out? When the scriptures have all been read? Or when all the chants have been recited? When believers have vacated the holiest of all holy places, then is it still holy? Or does it just become bricks and mortar, holding up the roof of a place where people once found god? This is what I wondered when I looked into that bucket of prosections. How simple it is to distill a body that once held so much life into unrecognizable remnants.

Today, the will I once had to make my cadaver whole again has vanished. I have no desire to piece together these prosections because I would have nowhere to begin. There is no way to draw life back into these abandoned bodies. I now realize that a human being is much more than just the sum of their parts. It is not just the beating heart or breathing lungs that constitute our existence. It is each person's story, echoing within their bodily temple, which makes them uniquely human; it is our physical, emotional and spiritual

“In the practice of medicine, I am not only responsible for the maintenance of the temple, but also the health of the soul that resides within it.”

wholeness that makes each and every one of us alive.

Today, I will leave the gross anatomy lab with a crucial lesson: in the practice of medicine, I am not only responsible for the maintenance of the temple, but also the health of the soul that resides within it. If I am only to treat the parts, then I am but a carpenter. Only when I treat the patient as a whole, will I truly be able to practice the sacred art of healing. For this invaluable lesson, I kneel beside Slab 20 and whisper “thank you” to Body 1719, hoping that wherever his spirit may be he knows the depths of my gratitude. ■

# What it means to be a medical student: a reflection

Alyssa Lip  
Queen's University, Class of 2017

IT WAS ABOUT SEVEN MONTHS ago when I was an undergraduate student, eagerly anticipating the moment that I would get into medical school, not knowing exactly what it meant.

And then it happened. Luck, hard work, and other mysterious (but evidently important) elements all contributed to that one life-changing email from the Queen's School of Medicine Admissions Office.

One of the first things I recall doing was setting up my line of credit. I went to my bank's local branch and explained my new situation. Immediately, I was set up with my own financial advisor and a credit of \$250,000. Absolutely nothing about me had changed — I had not grown any older, more responsible, or added a dime of worth to my name — and yet here was the bank, treating me with much more deference than any normal 20-year-old would receive. I was suddenly someone you could entrust a loan of a quarter of a million dollars to. All this was because I added two little words to my name — medical student.

I'd been working in a research laboratory at the time. Even there, I felt my co-workers' shift in recognition of my education. It wasn't just about how others perceived me though — I reacted the same way. I felt different, now as a medical student. And yet, I hadn't actually been educated as a medical student. That wouldn't come for at least another three months, and it wouldn't be completed for another four years.

What I now know is that it was naïve to think that being a medical student simply meant changing schools, and being one step closer to my final goal of becoming a doctor. Getting into medical school meant so much more. It's more than being one step closer — it's a giant leap, it's crossing that invisible threshold.

Here, in Canada, the selection process for incoming medical students is meticulous, demanding and highly critical. What results is a trust in our country's medical professionals.

From my perspective, it makes being a medical student a privilege.

Time and time again, it amazes me just how much of a privilege it is.

With a simple email, we can attend surgeries, clinics and rounds. Patients confide in us, knowing we're medical students. We have a voice, and people actually listen. We, ourselves, can change our curriculum. We have a say in the future of medical classes. We have countless opportunities that I don't think there's quite an equivalent to in many other faculties and levels of study. For example, in a few weeks time, my colleagues will be meeting with members of Parliament to discuss issues of importance to medical students.

There is no far-off reality, where it's years before you're a licensed doctor with all the responsibilities. It all started from when you clicked "accept" on that offer of admission. It's no coincidence that a big part of the emphasis in the

“It's no coincidence that a big part of the emphasis in the medical curriculum, right from the very beginning, focuses on professionalism. It's here and it's now.”

medical curriculum, right from the very beginning, focuses on professionalism. It's here and it's now.

Upon receiving and accepting that admissions letter, you gain a certain respect. In my personal experience, I felt it instantaneously and it is a wonderful feeling. But with that respect comes responsibility. Herein lies the proverbial double-edged sword: there is an assumed trust in you, paired with an expected accountability. This inherent trust, from colleagues, superiors and especially the public, is a privilege that we, as medical students, cannot take for granted. ■

# Top 10 things to know before starting residency

Robin Clouston

Past President

Dalhousie Family Medicine Integrated Emergency Medicine, PGY1

**N**OW THAT I'VE GRADUATED medical school and started my residency, there is so much that I wish I had known beforehand! I started in Family Medicine integrated Emergency Medicine at Dalhousie at Saint John, NB, on July 1, 2013, and I'm now over half-way through my PGY1 year — a busy, educational, daunting but very fun year. Now that Match Day 2014 has come and gone (congratulations Class of 2014!), there is plenty that I've reflected on — here are the top 10 things I wish I had known before starting residency:

- 1) **The level of responsibility is daunting at first.** I really thought I knew what I was getting into; I passed the Licentiate of the Medical Council of Canada exams and did advanced cardiac life support training, right? But the first time you write a prescription and no one cosigns it, you realize how important it is to check and recheck, and look it up again that your treatment is correct (amoxicillin is 500 mg TID, right?). The code pager is a whole other level of unease. But once you've been through the code and written those first few orders, a new sense of confidence will bloom.
- 2) **You will wonder what to call yourself.** Getting that medical degree was one of the best feelings ever, but I still stumbled how to introduce myself to patients. Was I really going to call myself "Doctor?" The answer is yes — mostly. I've settled into a pattern of "Dr. Clouston," or "Robin" or even "Dr. Robin," depending on

the circumstance. You can figure out what works for you.

- 3) **At first, your clerks may know more than you know.** As residency is starting, third year of clerkship is still going and you will have seasoned clerks. In many ways, this is great (i.e., if they save your behind) but also a reality check! It's important in these circumstances to recognize your knowledge gaps and work to fix them, and also recognize that there is still plenty of knowledge you can share with your clerk colleagues.
- 4) **At first, you will feel like you are in transition.** Because you will be. You will feel more experienced than a medical student, but not quite like a resident — for me this transition felt about three months long. More and more, medical educators are acknowledging the existence of this transition<sup>1</sup> and implementing steps to ease the transition from medical school to residency.
- 5) **Residency can be socially isolating.** Often, we move away from our friends and families, into a place where our new job can consume us. Unlike medical school, we aren't surrounded by our classmates all day. It's easy to lose touch with old friends and difficult to make new ones. It will take more effort, but it is more important than ever to actively make time for both medical and non-medical friends and family.
- 6) **All the other residents will feel just like you do** — sometimes confident, sometimes overwhelmed, sometimes really smart and sometimes idiotic.

"Getting that medical degree was one of the best feelings ever, but I still stumbled how to introduce myself to patients. Was I really going to call myself 'Doctor?'"

This is normal. Remember that all of your residency colleagues are in the same boat. Reach out and talk to them, even when you are knees deep in that tough rotation, because you will get each other through the lowest and highest points of residency.

- 7) **Time is short.** There are rounds to get through, consults waiting and your pager is ringing again. Sometimes your ability to see each patient and get to know his or her full story may feel compromised. However, it is at these times that it is most important to remember that the patient comes first — and this may mean staying late. I have found that organization is key at these busy times. Particularly, you can strive for efficiency in the aspects of your day that are not spent in front of



the patient — writing notes, entering orders, etc.

- 8) **Listen to your patients.** We all know — at least cognitively — how important it is to listen to our patients on their medical care — that is patient-centred care, after all. But further, I've found that particularly some of my older patients have been some of the wisest people I've ever met. At the times when I've taken the time to really listen, I've learned a lot about life and this has really enriched my year.
- 9) **Learning is self-directed.** You know that feeling you have in medical school, like you should probably be studying right now? I have come to the conclusion that this feeling might never go away. Definitely in residency there is plenty of reading and studying to be done — for that far-away College of Family Physicians or Royal College exam, so that you don't sound like a fool on rounds, and most importantly so

you can actually take care of patients. But I'm noticing even for practising physicians, the need for continuing medical education in order to stay current never goes away, but perhaps balloons. So for all of us, for the rest of our careers, there will always be something medical that we could be reading *right now*. Once I accepted the above, it was also possible to accept that it is unreasonable to study at all hours, and the best approach was to create goals for my learning. I continue to struggle to meet all those goals, but I think the exercise of planning one's learning is invaluable for a medical career.

- 10) **Residency is the perfect time to figure out your wellness routine.** Finally, I'm in one city, and the nomad life of clerkship is behind. Never has my own wellness seemed more important. Particularly, never has sleep seemed more important. It is possible to get enough sleep during residency

— but you need to work really hard at it. (My favorite saying: Respect your bedtime.) I even cook — and healthy stuff. I'm still working on getting to the gym, but the point is, wellness is within reach. You can do it!

My medical school experience is filled with wonderful memories with wonderful people. I always get excited when I see an old classmate in the halls of my hospital. But now I also have a new group of residency colleagues with whom to share this journey of medicine, and patients that enrich the experience. So, Class of 2014, (and 2015, 2016 and 2017), as you complete medical school, get that MD and prepare for residency, believe me when I say: the best is yet to come.

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# Montfort

## Recruiting bilingual psychiatrists

The Department of Psychiatry is currently recruiting psychiatrists for its 60-bed capacity inpatient services (currently 40-44 active beds), its outpatient services and consultation-liaison services.

Montfort recently obtained its provincial designation as an Academic Health Science Centre and is actively involved in teaching medical students, family medicine and psychiatry residents.


The working and teaching language at Montfort is French. Health care and services are provided in both official languages. Any physician interested in practicing at the Montfort Hospital will have to demonstrate a willingness to learn and work in both French and English. There is an excellent earning potential at the Montfort Hospital.

*Ottawa, March 20, 2012 – Ottawa again tops list of Best Places to Live in Canada For the third year in a row, Ottawa has taken top honours as the best city to live in Canada by MoneySense magazine's annual Best Places to Live survey<sup>1</sup>.*

For more information, please contact Dr. Guy Moreau, Chief of Staff and Interim Head of Psychiatry at 613.746.4621 ext. 6201 or by email at [guymoreau@montfort.on.ca](mailto:guymoreau@montfort.on.ca).

**Montfort. Mon choix. Mon avenir.**

<sup>1</sup> <http://www.jimwatsonottawa.ca/en/news/ottawa-again-tops-list-best-places-live-canada>

 **Hôpital Montfort**  
Ottawa, Ontario

# Challenges of life as a military medical officer

Lieutenant-Colonel Nick Withers, MD, CCFP(EM), FCFP  
CFMS President, 1995–96

**F**EBRUARY 28, 2014, 2:45 AM — phone rings: “Sir, the Admiral needs you to come. The PROTECTEUR is on fire with 298 personnel on board.” I would like to say that interesting calls like these have been rare during my 20+ year career in the Canadian Armed Forces but I would be lying. Having lived and worked around the world, I have many memories of unique challenges that I had never dreamed of when I started medical school some 22 years ago. Whether it be planning medical care for Her Majesty, Queen Elizabeth II on her 2010 Canadian tour or planning the closing of the Canadian medical facilities in Kandahar, there have been a plethora of interesting experiences during my career. While opportunities to deliver health care in unique and often austere places are plentiful in uniform, there are many aspects of the job that are very challenging.

## Clinical competence

Maintenance of clinical skills is a significant challenge for uniformed physicians (called medical officers (MOs)). I often remind new MOs that it takes 10 years to gain 10 years experience ... unless you are in the Forces — then it takes 30 years as we see fewer patients and they are generally healthy. Opportunities for provision of urgent or emergent care are limited except on operations or remote training locations. The Canadian Forces Health Services sponsors a program to allow its doctors to work in an acute care setting four weeks per year but this needs to be



Taken outside of the medical clinic at the Airbase in Kandahar, Afghanistan. Lieutenant-Colonel Withers had just returned from donating medical material to a local military hospital.

“Work–life balance is a catch phrase bandied around loosely in many circles. Whereas we all recognize its importance, very few of us are able to achieve it effectively.”

supplemented by “moonlighting” if one has any hope to maintain clinical competence. I have taken this as a personal challenge and continued a rural ER practice throughout my career, successfully challenging the CCFP(EM) last year. These extra hours have been at the cost of family time, leading me to the next point.

### Maintaining work–life balance

Work–life balance is a catch phrase bandied around loosely in many circles. Whereas we all recognize its importance, very few of us are able to achieve it effectively. Although routine days are 7:30 am to 4 pm, there are times when you may be sent away on short notice. Deployments can last six or more months and are often accompanied by an intense training cycle that is geo-

graphically dislocated from family, making the absence from home more like nine or more months. Throw in a few ER shifts a month and regular relocations to new places and you need a really supportive family! That said, I am able to retire with a sizeable pension at age 42, which does a whole lot for work–life balance!

### Physical fitness

While the day-to-day humdrum of seeing patients is not terribly demanding on the body, a military career can provide a significant physical fitness challenge if you embrace it. For some, fitness testing and standards can be discouraging but for those who recognize the health benefits of activity, this is a welcome addition to the daily routine. The Canadian Armed Forces

strongly supports physical fitness. Our Special Operations Forces demand that even their physicians maintain the same fitness standards as the operators. Although you may end your career with an additional ache or pain, generally your body thanks you for decades of activity. This has certainly been a positive challenge from my perspective and has helped ward off those extra pounds.

These represent just a few of the challenges of life in uniform. Representing both the patient and the employer is another unique aspect that requires you to ensure all your patients are actually fit enough to safely do their jobs anywhere in the world. I have embraced these challenges and with the support of an amazing family have enjoyed immensely my years serving in the Canadian Armed Forces. ■

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# Fibromyalgia–Chronic Fatigue Syndrome Canada essay winners

**E**STABLISHED IN THE SPRING OF 2011, THE FM-CFS CANADA ESSAY COMPETITION HAS BEEN organized collaboratively between the board of directors of Fibromyalgia–Chronic Fatigue Syndrome Canada and the CFMS general manager, Rosemary Conliffe. This year, Canadian medical students were asked to answer the question “If a diagnosis is made (fibromyalgia, chronic fatigue syndrome or myalgic encephalomyelitis), what can we learn from patients?” Congratulations to this year’s award winners, listed below:

<b>First Prize</b>	Chelsea Wharfasky	Queen’s University	\$1000.00
<b>Second prize</b>	Paula Tchen	University of Ottawa	\$500.00
<b>Second prize</b>	Sheila Wang	University of Toronto	\$500.00
<b>Second prize</b>	Natalie Lidster	McMaster University	\$500.00
<b>Three other entrants will receive a prize of \$250</b>	Haley Augustine	Dalhousie University	
	Joanne Reid	Dalhousie University	
	Kelly Fenn	Dalhousie University	



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## A date in the rain

Nina Nguyen

Université de Sherbrooke, Class of 2016

**W**HEN I INTERRUPTED THE buzz in the hotel lobby with the clicking of my heels, I felt uneasy.

I was usually comfortable around strangers but this time, I felt like I was out of place.

“So you’re from Sherbrooke, right?”

I turned around to find a pair of eyes locked on my nametag.

“*Bonjour.*”

Your eyebrows greeted me with their surprise. I untied the knot in my stomach, and then introduced myself. “Yes. Nina. From Quebec. Yes, I speak French. You too? I’m impressed!” Everyone wanted to know why I was here, and the answer is still probably somewhere between the sea and the mountains of the West Coast.

On my way to downtown Vancouver, I worried about fitting in, about making friends, about deserving to be there. At the crossroads of success and happiness. The doors of the SkyTrain swung open, and I mindlessly wandered to Coal Harbour.

The pouring rain washed my worries away, and the sky remained blue.

—

Only a few hours later, two bowls of steamy ramen were already framing our conversations about refugee health and medical humanities.

Medicine never tasted so good.

Medicine never felt so warm.

—

You spoke a lot. Between sips of black coffee, you moved motions, you proposed position papers, and you debated on issues that were important to us. I was surprised that we shared so many interests: medicine, of course, but also that same desire to break down borders.

Medical education, global health, mental health: these topics, not often discussed by our mentors, occupied our minds for three days. I, too, forgot that there was another world beyond the walls of my classroom.

From the moment I stepped on the

plane bound somewhere West, I shivered at the immensity of the world of medicine. You showed me how united we, the Canadian medical students, are in front of pressing issues such as health human resources management and wait times in the emergency room.

But, most of all, you showed me how we, twentysomething students, can shape the world of medicine.

—

When I sat down on the Canada Line carrying my new knowledge and my new, unexpected friendships toward the East Coast, I was not sad to leave you; I was hopeful because it was not an *adieu*, but rather an *au revoir*.

It was a pleasure meeting you, CFMS. Let us have a date over a bowl of hot chocolate in Ottawa this spring, shall we?

See you again. *À bientôt.* ■

## Reconnecting with my peers, passion and purpose

Danielle Chard

McGill University, Class of 2016

**I**AM GRATEFUL TO HAVE HAD the opportunity to attend the CFMS AGM this fall through travel funding. Being able to share ideas, resources and goals has impacted the work I want to do as I finish my medical degree and beyond. I feel excited to pursue involvement with my community outside my studies and my passion for advocacy has, again, been sparked.

On a professional level I left this meeting feeling connected and supported. Realizing that many medical students are facing the same challenges brought us together with common goals for the future.

I was delighted to see that there was recognition that this work is a continuation of work often already being done and that there was active sharing of resources.

On an advocacy level I was encouraged to see a focus on sexual health. This often-forgotten aspect of health was addressed from the perspective of improving medical school curricula, providing support to members through position papers (sexual health education and induced abortion), and work being done by the national officer of reproductive and sexual health (Joshua Dias) along with the

sexual health officers at medical schools across Canada.

I spent my first year of medical school consumed by books and lectures. Attending this meeting has reminded me of why I want to be a doctor and that knowledge is an important, but small, tool of my trade. I want to look back on my last years of medical school as a time when I grew as an advocate for better education, better patient care and better health care policy. Being at the CFMS AGM has provided me with the inspiration, connections and tools to start this work. ■

# Reflections from a first timer: CFMS annual general meeting

Emily Milko

McMaster University, Class of 2016

**A**S A VERY NEW MEDICAL student, having only been in medical school for a couple of weeks, I learned an incredible amount at this year's CFMS AGM. The meeting was incredibly well organized and rarely strayed from the agenda, an impressive feat in itself, but what was even more impressive, and evident throughout the meeting, was the level of dedication shown by all the individuals in attendance, particularly the CFMS executive members. As a new medical student it was both intimidating and inspiring to witness a room full of young leaders who positively impact health at a

national and international level, and I kept having to remind myself that on top of all the work each individual was contributing towards the CFMS, they were also working to complete their medical education! It was incredible to witness the passion that every member had for the CFMS and how this passion fueled their actions.

In addition to leaving the meeting feeling absolutely inspired by these individuals, a personal highlight included hearing the interesting thoughts and opinions of Dr. Louis Francescutti, current CMA president, during his presentation to the global health program,

which made me quite excited to follow the actions of the CMA this year. I was very pleased to see that in addition to the CFMS' very strong global health program, they are placing more emphasis on national health policy than in the past, and I look forward to seeing this arm of the CFMS develop.

To sum up my experience at the CFMS AGM in a few words, I would say: inspiring, promising and exciting. It was a privilege to sit among so many health leaders for the weekend, and I cannot wait to continue to follow, and hopefully in some way contribute to, the incredible work of the CFMS. ■

## Exposure and awareness at the CFMS AGM

Krystyna Ediger

University of Calgary, Class of 2015

**I**CONSIDER MYSELF TO BE VERY fortunate to have been a recipient of a travel award to attend this year's CFMS AGM. I had never attended a CFMS event before, and the weekend provided me with great insight into the workings and processes of our national student body.

Since June 2013, I have been working with the CFMS vice-president global health and the national officer of partnerships as a member of a number of global health small working groups. Because of this involvement, I attended the global health portion of the CFMS meeting, where I got to meet and learn

from some of the best and brightest medical students in the nation. One theme that seemed to arise from the global health program was national student interest in the development of student-led clinics. As a clinic manager at the University of Calgary's student-run clinic, one of the few functioning student clinics in Canada, I was approached to chair a working group on student-run clinic development under the national officer of global health education. It is an honor to be able to work with this portfolio and representatives from member schools to develop and foster information sharing regarding student-led

clinics. It is my hope that this group will serve to benefit schools that want to start these types of initiatives, as well as those who are seeking to foster and improve active clinics.

In addition to this new role, my attendance at the meeting will allow me to bring knowledge and information about medical education, student wellness, advocacy and global health back to my colleagues at the University of Calgary. Being part of my school's delegation to the AGM will allow me to help increase University of Calgary student awareness about the important work of CFMS. ■

# Connecting across Canada

Ryan Chard

University of Manitoba, Class of 2015

I WOULD LIKE TO THANK THE CFMS for the opportunity to attend the AGM in Vancouver, BC. The conference really emphasized how many student leaders across Canada come together to advocate for health and rights of people worldwide, Canadians and medical students. The highlight of the conference for me was seeing rapid exchange of ideas shared in small working group sessions on topics ranging from use of electronic tablets/phones in clinic to wellness and many, many others. Every person at the table brought

forth a unique perspective and fully engaged the topic. The respect and instant partnerships formed between students coming from very different places was exciting.

One big message I took from this conference is that student wellness is a rapidly growing concern across Canada. All Canadian students have the opportunity to engage with this topic and a lot of what can be accomplished through the CFMS can be anticipated from the trailblazing work the FMEQ has done in establishing this as a necessary part of

every student's education. Most schools have some framework to be involved with wellness as a student and I would encourage everyone to take that opportunity and ensure that wellness is a part of your curriculum.

On the whole, this conference really highlights the power of medical students when we share ideas and unite nationally. I would also like to thank UBC for hosting this event in beautiful British Columbia and the many speakers that came from far and wide to help provide students and the CFMS with direction. ■

## Society of Rural Physicians of Canada



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# “*We need to change society*” — an interview with the province of Alberta’s chief medical officer, Dr. James Talbot

Kimberly Williams  
University of Calgary, Class of 2014  
Western Canadian representative



**D**R. JAMES TALBOT IS THE CHIEF MEDICAL OFFICER of Health for the province of Alberta. He is tasked on behalf of the minister of health to monitor the health of all Albertans. In this role, he offers recommendations to the minister of health and Alberta Health Services on how to protect and promote the health of the public through disease and injury prevention. Prior to his appointment, Dr. Talbot served as the senior provincial medical officer of health for Alberta and was responsible for strategic planning surveillance, health assessment and other special projects.

Dr. Talbot has a BSc, a PhD in biochemistry from the University of Alberta, and as an MD from the University of Toronto. He is Royal College certified as a medical microbiologist. He has worked in public health since 1991 as director of the Provincial Laboratory for Northern Alberta, chief medical officer for Nunavut and associate medical officer of health for Alberta Health Services.

He most recently served as Medical Director for the Alberta Real-Time Syndromic Surveillance Net, a system he developed to monitor and act on emerging infections and injuries. Dr. Talbot is also an associate professor cross appointed in the School of Public Health and the Faculty of Medicine at the University of Alberta.



## What were your reasons for going into public health?

During my training and work, I came to realize that you can help more people if you help more than one person at a time. I am lucky to work with wonderful family physicians and specialists who help individual patients and families on a daily basis. As a medical officer of health, I can help to prevent suffering in those that I have not even met; this concept to me is profound.

## Why is public health so important to the health care system?

Public health has an unbroken track record of decreasing disease, improving health and prolonging life. It really has the longest record of success within medicine measured by hard outcomes like decreasing disease incidence and increasing life expectancy. Public health recognizes the difference between wellness or true health and health care. It acknowledges that in the past few decades the balance in society has changed — there are many more things that conspire against people's health than promote it. Public health, however, understands that there are real factors that help or hinder both individuals and society from being healthy; we appreciate that not all of these factors are under the control of the health care system.

## What do you see as challenges to the health care system that we, as medical students, will face during our career?

The short-term problem is that our health care system is always struggling to move upstream. We are not focusing enough on chronic disease prevention, and this is causing our health system to be overwhelmed by disease. We need to create the right coalitions to deliver and build health in our communities. We need a health approach that emphasizes chronic disease prevention and not just acute care. These coalitions must bring together not just those in the health care system; they must be supported by city planners, architects, farmers, dieticians,

developers, landscape architects and politicians. These coalitions will be key to creating a health system that results in wellness and healthy society.

In major cities across Canada, we are building suburban neighborhoods that do not catalyze healthy living. Rather, they facilitate obesity, hypertension and diabetes. *We need to change society.* We need the cooperation of large groups of people including academics, business owners and faith-based organizations to design communities that will result in health, not disease. Access to healthy foods from local farms, reducing vending machines in schools and convincing the public that fresh food prepared by you for you are the types of changes that will help us move upstream.

Acute care, based on diagnosis, treatment and cure, is an ever-growing part of health care. Unfortunately, it has and will continue to eat away the budget of governments, thereby minimizing the budget available for targeting the social determinants of health. In Alberta, 45% of the budget currently goes to illness. As a result, less money is allotted to other ministries in charge of the social determinants of health, ministries such as parks and recreation. If we build fewer parks, people have less space to be well and survive in our complicated world. They are less mentally fit and more likely obese leading to an increased need for acute care in turn reducing the budget available for prevention.

The solution: to recognize that wellness is not just about the absence of illness; to recognize that those outside the health system are those who really contribute to everyday wellness. It's not just physicians, but people like minor league hockey coaches who cause communities to be well. Farmers' markets are engines for health, they help to increase the income of local farmers, while at the same time supplying the community with healthy foods. Benefit comes from a recognition of the importance of what goes on outside hospitals and then using that momentum to act and incite change.

## You have been highly involved in surveillance including developing the Alberta Real-Time Syndromic Surveillance Net. Do you think that infectious disease outbreaks such as the case of avian flu seen in Alberta this year is something we should worry about as future physicians?

When it came to infectious disease outbreaks, 20 years ago we had more gaps in Canada than plans. We did not have access to creating vaccines rapidly; we did not have a method to relay messages to the public and we did not have an antiretroviral stock. Today, all of those concerns have been rectified. We have a global reporting system sending us information from even the remotest parts of China. We have contracts in Canada that ensure the expedited production of vaccines for Canadians. We have antiretroviral medications stock piled, those that have been proven to work in specific situations such as outbreaks within continuing care facilities. We have clear lines of communication and coordination. We have improved our techniques — the public is more aware of respiratory hygiene and hand hygiene than ever before. That being said, if a mutation to a current virus occurred resulting in a high infection rate and high mortality, all of our plans would be put to the test.

## What role do you believe medical students play in regards to public health?

Medical students should recognize that the future belongs to them. They need the insight to realize that it takes lots of people to create health outside of the health care system. The factors that you learn about in medical school — the social determinants of health — are important!

A family physician I know recently told me a story about a diabetic patient she saw in clinic to whom she described the importance of exercise and eating healthy foods.

The patient subsequently replied, “How do I do that?” The physician explained more specifically the cardiovascular exercise one needs in a week including other options such as yoga or walking to work. She discussed how to shop the outer edge of the grocery store where they stock the fresh fruits and vegetables and to stay away from the high fat, high salt and high sugar food-like products in the interior of the store. When she finished the patient once again asked, “But how do I do that?” The patient described her community, an environment where there were no stores offering healthy foods and where her work limited any purposeful exercise. It was at this moment that

my friend realized that so many of her patients were simply unable to adopt healthier lifestyles due to systemic challenges out of their control. The physician realized that she was wasting her breath. It was the social determinants of health that were affecting her patients and no amount of education was going to help them to achieve the interventions that she described. Medical students need to be aware of these type of situations; they need to remember that they work as part of a wellness system in addition to the illness treatment system.

As Spider-Man’s Uncle Ben once said, “With great power comes great responsibility.” Medical students have a responsibility

to be role models of wellness. They need to speak out for the creation of healthy cities made for pedestrians and cyclists. They can donate their time or money to charitable organizations that bring these ideas to fruition. Physicians are respected and people will listen.

After all, what was Hippocrates talking about? He is the father of medicine for a reason. He was talking about an ideal where healthy relationships create real health: relationships between individuals, between individuals and society and between society and their environment. Medical students have a responsibility to society and this responsibility is more important right now than ever before. ■



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Member of the Altima Healthcare Group

# Once upon a September

Noor Amily

University of Ottawa, Class of 2014

Once upon a September ... I became a real hospital member  
 My Ob/Gyne rotation started ... and I knew inside that this is what I hearted  
 The nurse called my pager ... as that woman in room two was in labour  
 Everyone rushed and I was pushed to find myself in room two all squished  
 I heard that baby's first cry ... as another nurse came rushing by  
 As I wiped my tears of joy ... I saw that it was a baby boy  
 Blood covering my scrubs ... nothing helped even with all my rubs  
 I smiled and wanted to hold ... that bloody placenta that sure wasn't cold  
 I moved closer as the resident stitched ... that tear which with blood was enriched  
 I wanted to do that hand tie I knew ... but I wasn't sure what to do  
 I knew then that all along ... this is the place where I belong  
 A speciality that filled me with joy ... and I would, till the last of my days enjoy



## ◀ Anatomy cupcakes

Karen Willoughby

McGill University, Class of 2015

In my first year of medical school for my 30th birthday I made anatomy lab-inspired cupcakes depicting different organs using gum paste. In order from top-->bottom, Left --> right: the kidney and adrenal gland (in yellow) with vessels, an eyeball with the four rectus muscles, the heart, the liver and gallbladder (in green), the small and large intestines with mesentery (in yellow), the cortex/brain, the knee joint (between the femur and tibia) with the fibula bone, patella and patellar ligament on top, the lungs, trachea and bronchi, and half of a breast showing the mammary glands.

# Day in the life of Mary: a short story

Esther Kitai Rosenthal

University of Toronto, Class of 2015

It takes me a minute to realize what is waking me: the screaming lady is at it again. “*Go to sleep,*” my daughter’s voice says. Can’t she hear the screaming lady? How does she expect me to sleep? I know, somehow, that there is no-one with me, and that the voices are not real. “*Get up. You are so dirty. Go and wash.*” He is always criticizing me and telling me what to do. I oblige, go to the wash-room, lie back down, and wonder what the voices will let me do today. Why did the voices come? They were not with me in China, or for the first years in Canada.

The loudspeaker announces breakfast, and I sit up, waiting for the voices’ reaction. I hear ... nothing. For the first time in three days they are letting me go to breakfast. I walk to the dining hall and stand in line; as always, I feel bad for the other patients, and scared of some of them. They all seem so bizarre. It is hard to believe that, until three years ago, I had barely heard of “psychiatry”— but here I am surrounded by “crazy people.” I guess that my voices make me one of them.

I get my food tray and bring it back to my room. My sister says, “*You cannot eat. They are poisoning you.*” I pick up the bagel and bring it toward my lips. “*DO NOT EAT.*” I put it back down. Silence, so I pick it up again. “*STOP TRYING TO EAT.*” I give up, put it back and lie down. I listen to my stomach grumble and my roommate scream.

I spend hours listening to the loud voices, while my roommate yells. I should probably do something, but cannot think what. I pull up the covers and hope that sleep will take away the noisy emptiness. Finally, the doctors come. The questioning begins: How are you today? How did you sleep? Did you take your medications? How are the voices? Are they better, worse or the same? Why have you not eaten anything? Is it the voices? Can you try to eat with us here? I perform the same routine for them as I did alone, moving food toward and away from my mouth, paralyzed by the voices. I can tell they are not happy with my inability to eat. Neither am I. Neither is anyone (except maybe the voices).

The ending of my meeting with the doctors is the same as always: “We are worried about you, Mary.”  
I am worried too.

Over the next few hours, the voices become quiet and I can take my medications and even eat lunch. The rest of the day is the same as always. Nurses come and go, encouraging me to attend group activities. The voices do not let me, so I stay in bed. Pretty soon, through the window of my room, I can see the sun setting. I think about my husband and children and wonder what they are doing and if they think about me. Are they ashamed of me? Saliva builds up inside my mouth, and I hear the common “*Do not swallow that saliva. Do not swallow. You may not swallow.*” I must have fallen asleep before deciding whether to swallow, because the next thing I remember is waking up to the screaming lady. Another day is here ...





## ◀ The ruins of Ta Prohm Cambodia

Elaine Tang  
University of Western Ontario, Class of 2015

The temple of Ta Prohm shows the force of nature against the power of mankind. Amongst solid rock temples built by man, ancient trees dig their roots deep into the walls, climb over roofs and undermine the foundations.

## Kulen Mountain ▶ Cambodia

Elaine Tang  
University of Western Ontario  
Class of 2015

Cambodia is a country that has been torn apart by civil unrest and political upheaval in recent times.

Due to widespread poverty, many adults utilize children as part of begging rings to get money from travellers and wealthier locals. Despite this, many of the children retain their innocence and are content with remarkable little in their lives. They always have a smile for you.





# Weddings



◀ Daria Zajac and Robert Peeters  
August 24, 2013  
Windsor, Ont.

Allison Meiwald and Rob Davis ▶  
August 10, 2013  
Corner Brook, NL





◀ Christopher Proctor and Sarah Lefley  
July 6, 2013  
Grosse Isle, Man.

Angela Bell and Rory Cavanagh ▶  
July 21, 2012  
Lucknow, Ont.





# Babies



◀ Erin Aurora Cavanagh  
Born June 1, 2013  
Parents Angela and  
Rory Cavanagh

▶ Arya Taylor Graham  
Born January 30, 2014  
Parents Geeta Yadav and  
Andrew Graham



◀ Layan Sabalbal  
Born August 2, 2013  
Parents Maher Sabalbal and  
Samah Rafehi



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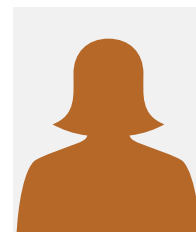
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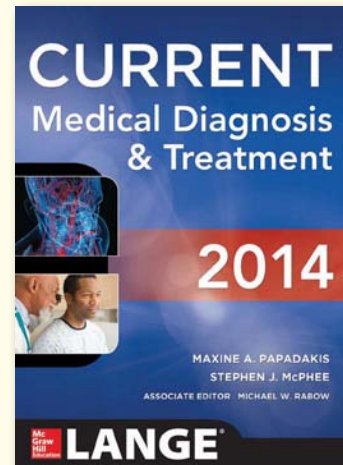
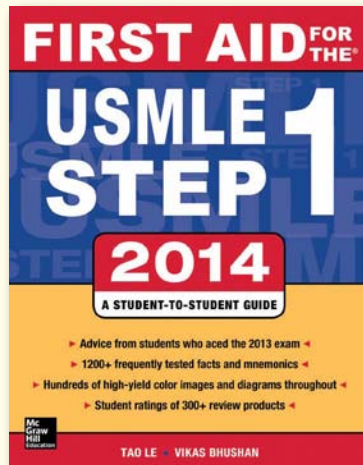
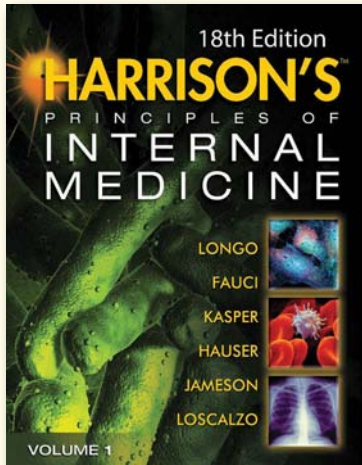
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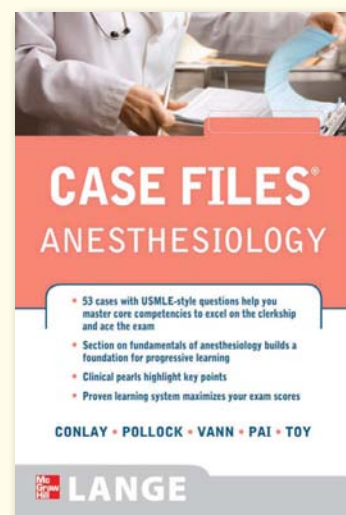
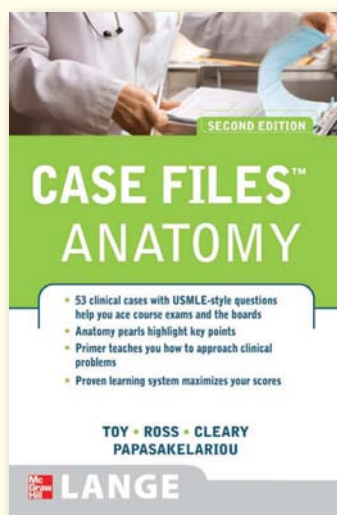
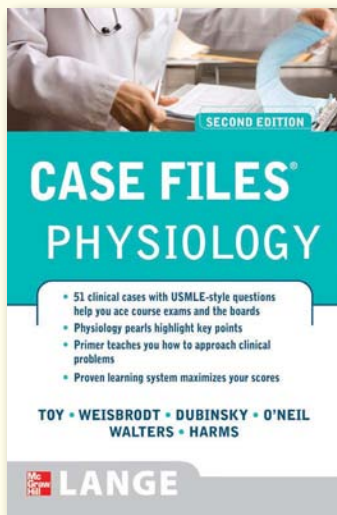
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