CFMS FEMC

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

# ANNUAL REVIEW 2018

# INDIGENOUS HEALTH



# Our Mission

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

# Our Vision

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

THE CANADIAN FEDERATION OF MEDICAL STUDENTS (CFMS) WAS FOUNDED in 1977 in response to the recognized need for a national unifying body for medical students. Our membership has since grown to more than 8,000 students at 15 medical student societies across Canada. In addition, the CFMS welcomes individual members from non-member Canadian medical schools in Québec. At the CFMS, it is our mission to connect, support and represent our membership. As future physicians, we also advocate for the best health for all members of society.

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

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

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

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

The activities of the CFMS are diverse, relevant and member-driven. We invite you to learn more about our 2017-2022 Human Resources and Operations Strategic Plan,which will direct the CFMS to serve its members through its vision of tomorrow's physicians leading for health today. ■

Association Médicale Canadienne | Canadian Medical Association

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- Canada's opioid crisis
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## Cover art

**Title**
"Milgwija'sit puoin an'stawe'g wuguntew" (Apprehensive about the future of the spirit-healer's fragile stone)

**Materials/Medium**
*Acrylic paints on styrofoam, collaged and reshaped with a No. 10 scalpel, photographed with warm light and welcoming to shadows.*

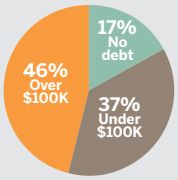
**Artist**
Jonny Oore,
Dalhousie University,
Class of 2019

# 4 FINANCIAL CHALLENGES OF MEDICAL SCHOOL

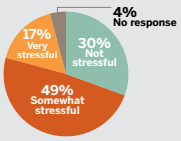
A career in medicine can be very rewarding. But during your training and as you begin practice, you could face some of these financial challenges.

## 1. CRUSHING DEBT

A large debt load can be a major source of stress and distract you from your studies.




*How much debt do you expect to have after medical school?*

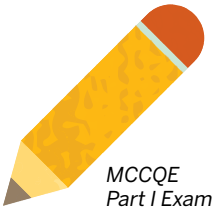



*How stressful do you find your financial situation?*

Sources: Debt figures from MD Physician Loyalty Survey December 2016; Stress figures from National Physician Survey 2012

## 2. EXTRA EXPENSES BEFORE RESIDENCY

As you finish your studies and begin residency, there are additional expenses to prepare for.



*MCCQE Part I Exam*

*Moving costs if your residency position is in another region*

*Travel expenses for CaRMS interviews*

## 3. CRITICAL DECISIONS DURING RESIDENCY

Once you start earning a salary, there are other financial decisions to make.

*Consolidate student loans or not?*

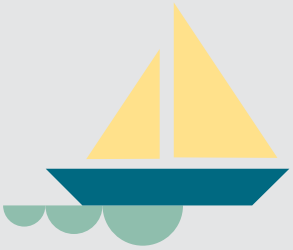
*Buy or rent?*

*Start a family or wait?*

*Pay down debt or start investing?*

## 4. JUMP IN INCOME

A dramatic increase in income when you transition to practice will be a welcome change. But beware the temptation to spend well beyond your means.



*Expensive vacations*

*Second homes*

*Luxury cars*

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# Letter from the editors

Darwin Chan
*Annual Review* Editor
McMaster University,
Class of 2018

Christina Schweitzer
CFMS VP
Communications
University of Calgary,
Class of 2019



Dear friends and colleagues,

In 2017, the Canadian Federation of Medical Students (CFMS) celebrated its 40th anniversary of *representing, connecting and supporting* medical students in Canada. At our anniversary celebrations in Ottawa at AGM 2017, and in last year's issue of the Annual Review, we reflected back on 40 years of medical student advocacy that has helped shaped medical education and Canada's health system today.

In this year's edition of the Annual Review, we pivot our focus to looking ahead at the next 40 years of medical education and healthcare in Canada. Close your eyes for a minute. Take a deep breath. Imagine it's 2057, 40 years from now. You're a senior physician, getting close to retirement. You run your own practice, or are a senior attending at your hospital. You manage medical students and residents on a daily basis and have hundreds of patients. What do you think the practice of medicine will look like in 40 years? How will our hospitals have changed? Will the core values we hold as physicians stay the same? Will physicians still be health advocates, scholars, professionals, communicators, collaborators, and leaders, as well as medical experts, as CanMEDS said you should be when you were in medical school in 2018? Will the residency match process look the same as when you went through it? What would be the advice you would give to the medical students you mentor?

This year's issue explores many of these questions, and includes a wide array of perspectives on what it means to be a physician from medical students from across the country. They are personal, they are philosophical, they are political. They are serious, sincere, entertaining and beautiful. We encourage you to read them all, and be as inspired as we have by the thoughtfulness, kindness, humility, artistic skill, advocacy and leadership of our colleagues, which reflects positively on us all as a national body of medical students. From mental health and wellness, to creating new models of policy making rooted in community consultation, to the opioid crisis, to maternal health around the world, medical students in Canada are tackling some of the most challenging issues in healthcare today head on. While we are all heavily invested in our journeys as medical students and that is undoubtedly a large part of our identity, we are people, first and foremost. The intensely personal stories and reflections in this issue also serve to remind us that we are human; it's ok to make mistakes and learn from them; to have patience, kindness and empathy for each other and for our patients; and to listen. To quote Dalia Karol & Hailey Newton's powerful piece in this issue on tackling mental health stigma in medical school: *"Let us remind our classmates that they are never alone. Each of us has our own personal struggles, but it is through our collective and mutual support that we will foster a stronger medical student community."*

Lastly, the theme of this issue of the Annual Review is "Indigenous Health," exploring both the health of Indigenous peoples in Canada and how this can be better supported and enabled, as well as the journeys of Indigenous medical students and physicians in shaping these journeys. Looking forward to the next 40 years of medicine in Canada would be remising without addressing this longstanding issue that has been neglected by our healthcare system for as long as it has formally existed.

Our feature interview with Dr. Nadine Caron explores her personal road to success as Canada's first female Indigenous surgeon, and what she environs for the future of Indigenous health. We also interview the CFMS National Officer of Indigenous Health, Willow Thickson, on the inclusion of Indigenous health in medical education and how medical students are working together to incorporate this important topic into our training across the country. This year's CFMS National Medical Student Day of Action (previously known as Lobby Day) was focused on Indigenous Mental Wellness, where over 70 medical students from across the country met with more than 60 MPs, senators, and policymakers to advocate for support for Indigenous Mental Wellness. The policy recommendations we proposed were developed through a groundbreaking community consultation process, which saw medical students take policies put forward by Indigenous communities themselves to Parliament Hill. The CFMS will continue to advocate on this and other public health topics of national importance and impact through the year, and through the next 40 years to come.

To all of the medical students who contributed to this edition of the Annual Review, thank you for your thoughtful and thought- provoking pieces. We hope you enjoy reading them as much as we have.

Here's to 40 wonderful years, and to many more to come.

Christina Schweitzer
CFMS VP Communications
University of Calgary, Class of 2019

Darwin Chan
CFMS *Annual Review* Editor
McMaster University, Class of 2018

# Letter from the president

Henry Annan
CFMS President
Dalhousie Medical School

Dear Friends,

I am thrilled to present the 2018 Annual Review from the Canadian Federation of Medical Students (CFMS). Here, you will find written works by many of the medical students I consider myself privileged to represent. This year, I have the absolute pleasure of welcoming over 150 Canadian medical students to my hometown of Halifax for our 2018 Spring General Meeting. The year 2018 marks the 200th anniversary of Dalhousie University, the 150th anniversary of Dalhousie Medical School, and the 60th anniversary of the Dalhousie Medical Alumni Association. There is indeed much for us to celebrate and the CFMS is so thankful to all three institutions for their generous sponsorship of our meeting which ensured its glowing success.

The CFMS also had its own reasons to celebrate this past year. Right on the heels of our 40th anniversary and buoyed by our recently passed five-year strategic plan, the CFMS Board of Directors made an unprecedented effort to build the organizational infrastructure to help us fulfill our mandate of connecting, supporting, and representing our members in a manner that is efficient and more transparent. In this vein, the board trialed a new dyad board model with great success. We look forward to officially implementing this new governance structure at our Annual General Meeting in 2018. We also created a governance committee whose primary purpose is to ensure that CFMS policy and activities are in keeping with organizational best practices. There was a renewed focus on strengthening our committees, decentralizing decision making, improving our position paper processes, and empowering Canadian medical students.

Aside from the work that the CFMS has been doing internally, the unmatched Canadian Medical Graduate (CMG) crisis continues to be our topmost concern. The CFMS is well represented on working groups and committees both nationally and provincially, advocating for greater supports for unmatched medical graduates and a restoration of the ratio of CMG applicants to post-graduate residency positions to 1:1.2. We are confident that many of our proposals will be adopted within the year and are encouraged by the positive response we are receiving from Canadian faculties of medicine.

This year, scores of medical students met with federal policy makers on Parliament Hill to advocate for indigenous mental wellness. In this year of reconciliation, I, as a settler, am reminded of our collective duty to ensure that indigenous wellness remains a top priority not only for governments, but also for educational institutions as well. The CFMS will continue to advocate for equitable medical school admissions policies, further training in culturally-safe care, and learning environments in which students from all backgrounds feel safe and respected.

During my tenure as president, I have embarked on a presidential tour, meeting with medical students at each of our member schools. I continue to be inspired by our members and have consequently reflected on what it means to be a medical student in Canada. A common theme emerged quickly—we are young (in spirit), vibrant and own our roles as tomorrow's health leaders with both humility and pointed purpose. I am confident that this generation of medical students will protect this spirit well into their careers.

What a blessing it is to be a part of this community of medical trainees. The future of Canadian healthcare is bright.

Stay fierce.

Sincerely,

Henry Annan

Henry Annan

2017-2018 CFMS President

# Reflections on the first 40 years as we fiercely go forward

FOUNDED IN 1977 TO support, connect and represent medical students from coast-to-coast, the Canadian Federation of Medical Students has transformed the medical education landscape over the past 40 years.

To celebrate our 40th anniversary, the CFMS hosted a celebration at its 2017 Annual General Meeting (AGM) back where it all started in Ottawa, ON. The celebration hosted Dr. Brian Goldman and centered around the theme of Disruptive Innovation in Medical Education, and the role medical students can play in leading change.

We concluded the day with a reception with some of our core stakeholders and past-presidents.

As the immediate past-president of the CFMS, I wish to thank our alumni, and specifically our board alumni, for their commitment to and engagement in medical education. Your service has laid the foundation for tomorrow's physicians who are leading for health today. ■

**CFMS Past Presidents** (Left to Right)
Dr. Sayeh Zielke 2003-4
Dr. Ashley Waddington 2004-5
Dr. Andre Bernard 2005-6
Dr.Tyler Johnston 2009-10
Dr. Matthew Sheppard 2010-11
Rosemary Conliffe General Manager since 2001
Dr. Robin Clouston 2012-13
Dr. Bryce Durafourt 2014-15
Dr. Anthea Lafreniere 2015-16
Dr. Franco Rizzuti 2016-17
Current President Henry Annan 2017-18

THE CANADIAN FEDERATION OF MEDICAL STUDENTS WOULD LIKE TO THANK OUR SPONSORS who so kindly supported our 40th Anniversary including our title sponsor **MD Financial Management**! Without their generous support we could not have made our 40th Anniversary such a special occasion. ■

# Approaching health advocacy with a new model for the 2018 National Day of Action

Yipeng Ge
CFMS VP Government Affairs
University of Ottawa, Class of 2020

Charles Yin
CFMS Day of Action Research Committee Chair
Western University, Class of 2021

## Introduction

THE ANNUAL CFMS National Day of Action, formerly known as Lobby Day, is a blockbuster event held by the organization that, each year, sees over 60 medical students from across the country converge on Parliament Hill in Ottawa to meet with policymakers and advocate for positive changes to our health care system.

The Day of Action is important not only because it allows medical students to engage directly with elected representatives on pressing health issues, but also because it is a chance for medical students to think critically about the systemic issues that affect the health of patients that we see in the clinic every day. Through engaging in political advocacy on health care, students begin to learn how to identify, diagnose, and treat these larger systems issues, which have deep impacts on the health of our society.

## Motivation

The 2018 Day of Action focused on Indigenous Mental Wellness. As an important and timely but sensitive issue that highlights perhaps some of the greatest inequities in the Canadian health care system, indigenous mental wellness necessitated careful thinking in developing our policy proposals.

From the start, the student committee that was tasked with developing the policy proposals (henceforth referred to as the "Research Committee") decided that any proposals brought forward must be aligned with the views of Indigenous communities in Canada. Better yet, these proposals should serve to amplify the voice of those communities.

As such, the 2018 Day of Action represented a departure from the traditional process through which the CFMS develops its policy proposals. Whereas in the past, the Research Committee focused on analyzing available literature and consulting with high-level experts and policymakers, this year the committee opted to adopt a "community consultation" model where the direction of our advocacy would be guided through direct consultation with Indigenous communities across the country.

## The Community Consultation Model

The community consultation model adopted by the Research Committee involved reaching out to community leaders in order to hear directly from Indigenous communities, organizations, and institutional leaders affected by the mental health crisis and asking what they believed were the most pressing needs for their communities.

To this end, a consultation subcommittee was formed, consisting primarily of the Research Committee, the Government Affairs and Advocacy Subcommittee, and the National Officer of Indigenous Health and Local Officers of Indigenous Health, to reach out to Indigenous community leaders and health experts from across the country and invite them to share their thoughts on how the CFMS could most effectively advocate for Indigenous mental wellness.

In just over four months of consultations, the subcommittee managed to obtain guidance and support from over 30 Indigenous community leaders and health experts that resulted in almost 40 pages of written material. In order to make sense of the consultation guidance and support, we utilized a rigorous qualitative approach to assign open codes to each sentence or bullet point from the collected feedback and then used an inductive approach to develop five overarching themes that we believed best encompassed the major messages convened through the consultations.

## Conclusions

The strength of the community consultation model is that it allows the population, the organizations, and the communities to help shape the direction of that advocacy and our own understanding of the issues. It is an acknowledgement that the community has a better grasp on their own needs than those in positions of relative power, such as medical students. This holds particularly true with Indigenous peoples of Canada, who historically and presently have been subject to racist and patriarchal policies that have sought to silence their voices.

Instead, medical students should seek to use our positions as future health care leaders to amplify the voices of our patients who are marginalized, oppressed, and discriminated against in society. The success of the consultations this year demonstrated that it is possible for the community consultation model to be incorporated into the Day of Action process moving forward. Indeed, the utility of community consultation spans beyond Indigenous health advocacy. It is our hope that the CMFS adopts the community consultation model in more of its advocacy work in the future. ■

*Authors' note: We would like to thank everyone involved in conducting the community consultation process for the 2018 CFMS National Day of Action. Without your immense dedication and hard work, none of this would have been possible.*

# 2018 CFMS National Day of Action on Indigenous mental wellness

Yipeng Ge
CFMS VP Government Affairs
University of Ottawa, Class of 2020

Charles Yin
CFMS Day of Action Research Committee Chair
Western University, Class of 2021

## Introduction

THE 2018 CFMS NATIONAL Day of Action on Indigenous Mental Wellness took place on February 12, 2018, bringing over 75 medical students from across Canada to discuss policy recommendations with Members of Parliament, Senators, and policy advisors in Ottawa.

## The Current Indigenous Mental Health Landscape

Indigenous mental health is a serious and long-standing issue in Canada that is rooted in a complex mixture of colonialism, historical and ongoing economic disenfranchisement, loss of cultural identity, and intergenerational trauma stemming from discriminatory legislation, practices, and institutions enacted upon the Indigenous peoples of Canada. Today, mental health problems amongst Indigenous communities have reached epidemic proportions, sparking suicide crises in multiple communities, especially amongst Indigenous youth.

Indigenous communities in Canada experience disproportionately high rates of mental health issues, with a suicide rate that is more than double that of the national average. The Indigenous peoples of Canada, including First Nations, Inuit, and Métis peoples, comprise 4.3% of the general population.[1] Despite representing a fraction of the population, the suicide rate among Indigenous youth aged 15-24 is five to six times the rate seen in the general population.[2] Suicide is especially prevalent among Inuit youth, at 11 times the rate of the general population. Suicide rates have reached crisis levels in many Indigenous communities in Canada.[3]

Despite a welcome recent announcement from the Government of Canada that it will allocate $69 million dollars over a period of three years towards Indigenous mental health and suicide, significant work remains to be done in ensuring this funding is used appropriately and effectively. We need to ensure that the funding targets the communities with the greatest need and that delivery of services is done in an effective and collaborative manner that promotes and facilitates Indigenous self-determination.

## Our Policy Recommendations

Through extensive consultation with Indigenous community leaders, Indigenous organization leaders, and Indigenous physician leaders, the CFMS calls upon the Government of Canada to:

1. Adopt the frameworks and strategies put forward by Indigenous communities and peoples in Canada to guide the federal response to the Indigenous suicide crisis:
   a. Adopt the First Nations Mental

Wellness Continuum Framework as a framework to address First Nations peoples' mental health and suicide
   b. Adopt the National Inuit Suicide Prevention Strategy as a framework to address Inuit peoples' mental health and suicide
2. Undertake a comprehensive review of the current distribution of funding through the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) in collaboration with Indigenous communities in order to ensure that every Indigenous community receives funding that is both sustainable and provided in accordance with need.
3. Direct Health Canada and Indigenous Services Canada to re-evaluate what programs and services are funded under the Non-Insured Health Benefits Program (NIHB), and:
   a. Increase funding for preventative and land-based mental wellness programs that create opportunities within the community
   b. Support and expand the list of approved service providers to include Indigenous traditional knowledge keepers

## Continuing the Conversation

It is imperative that we continue the conversation on Indigenous Mental Wellness, a significant area of importance in Canadian health care identified by the CFMS. Beyond our advocacy efforts during the 2018 CFMS National Day of Action, we will be continuing the conversation on Indigenous Mental Wellness with medical organizations and other partners in an effort to bring more attention to this topic within medical education. Additionally, we urge you as medical students to hold conversations and events at your school to raise awareness locally. We also encourage you to reach out to your local Members of Parliament to continue the dialogue on Indigenous mental wellness and our policy recommendations. For additional information and updates, please visit the CFMS website and our advocacy page! ■

*Authors' note: We would like to thank everyone involved in conducting the community consultation process and the members of the Research Committee for their hard work in drafting the backgrounder document and in deciding the final asks for the 2018 CFMS National Day of Action.*

**References**

1. Health Canada. A Report on Mental Illnesses in Canada. 2002. Available from: http://www.phac-aspc.gc.ca/publicat/miic- mmac/pdf/men_ill_e.pdf
2. Health Canada. Acting on What We Know: Preventing Youth Suicide in First Nations. 2003. Available from: http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/
3. Dyer O. Health workers sent to indigenous Canadian community beset by attempted suicides. BMJ. 2016;353:i2210.

# The CMA presidential debate in Ontario – how it affects medical students Canada-wide

Andrew Dawson
OMSA Chair
Queens University, Class of 2019

Maylynn Ding
CFMS Ontario Regional Representative
McMaster University, Class of 2019

Cory Lefebvre
CFMS Ontario Regional Representative
Western University, MD/PhD, Class of 2022

IN ONLY SEVERAL WEEKS AS OF writing this piece, the vote for the next Canadian Medical Association (CMA) president-elect will take place. For this round of elections, the CMA rotates to Ontario to look for qualified candidates to become the future president-elect. As many of us medical students are also CMA members, the individual who is elected as the CMA president for the 2019-2020 year will not only affect us in the present, but also will shape the healthcare and professional landscape within which we will one day practice. This article summarizes key aspects of the candidate platforms and highlights some of their answers to the questions posed in the Q&A session organized by the Ontario Medical Students' Association (OMSA).

Dr. Darren Larsen (larsen4cma.com), family physician from Thornhill, seeks to "bring #BoldLeadership … to the National level, from an Ontario perspective" through a three-pillared platform focused on building a culture of respect, supporting physicians, and healthcare advocacy. Having witnessed the public bullying of one of his student mentees last year, Dr. Larsen seeks to focus on professionalism and the fostering of a culture of inclusion for medical students and residents. He is a strong proponent for the maintenance of voting rights for medical learners within the association. His platform contains efforts in supporting physicians in career decisions and transitions while allowing them to find or re-find the joy of working in medicine.

Dr. Mamta Gautam (votemamtacma.ca) is a psychiatrist from Ottawa with significant previous experience advocating for physician wellness. Her platform, Care for the Self, Care for the System, Care for the Future, is geared towards reform on both individual and systems-wide levels. With regards to improving self-care of individual physicians and learners, Dr. Gautam proposes shifting from an onus on the individual to more organisational support, particularly when addressing the unique needs of members at different stages in their careers or members from different socio-demographic groups. Medical students are the future of the profession and Dr. Gautam wishes to ensure that there is proper career guidance, mentorship, and support of trainees, particularly with respect to the unique issues of increasing student debt and health human resource planning.

Dr. Atul Kapur (atulkapur.ca), emergency physician from Ottawa, seeks to make the CMA a more representative and responsive organization by focusing on The Physician, The Patient and The System. This three-point platform includes advocating for physician wellness, dealing with healthcare issues of specific patient populations, and working on improving workforce planning to ensure 1.2 residency spots per medical graduate. If elected, Dr. Kapur promises that he will personally visit all 17 Canadian medical schools to hear from medical students and create "communities of interest" for like-minded advocacy-focused members to connect and effectuate change.

Dr. Sandy Buchman (voteforsandy.ca), family physician with a focus in home-based palliative care, seeks to push for a more socially accountable medical system through his platform of CMA for Physicians, CMA for Trainees, and CMA with Patients. To address the issue of increasing burnout in the profession, Dr. Buchman proposes expanding the Triple Aim framework of healthcare optimization (health of population, patient experience, and cost-effectiveness) to a Quadruple Aim framework by adding a commitment to establishing better work-life balance for physicians. With regards to trainee issues, Dr. Buchman wishes to tackle the increasing tuition debt load, lack of socioeconomic diversity of medical school admissions, and the CaRMS mis-matching issue.

## Unmatched Canadian Medical Graduates

With regards to the growing number of unmatched Canadian medical graduates, Dr. Buchman believes a key issue is to correct the number of residency spots to better meet the needs of the system. Looking at human resource needs, Dr. Gautam proposes increasing the ratio of residency spots to medical graduates and tackling the increasing number of entry-level residency programs. Proposing a ratio of 1:1.2 medical graduates to spots, Dr. Kapur believes in making this issue relevant to the governments by working with allies in trainees, unmatched graduates, and patients. Using data models to help predict the needs of communities in the future, Dr. Larsen believes more leadership is required and that the CMA is well-positioned to support trainees and the system in tackling the issue.

## Indigenous Health

The candidates were asked for concrete plans of action that could rectify some of the challenges faced by Indigenous people seeking access to healthcare. Dr. Buchman proposed that every physician and trainee be required to participate in Indigenous Health educational online modules to raise awareness of these issues within the profession. Reiterating the need for more medical student education, Dr. Gautam also proposed tackling the issue of mental health care in Indigenous populations by understanding the systemic barriers and social determinants of health. Shaped by his placement in Thunder Bay during medical school, Dr. Kapur suggested addressing the issues in urban Indigenous populations along with rural Indigenous populations by focusing on social determinants of health, particularly through improved funding for on-reserve education. Echoing the focus on social determinants of health, Dr. Larsen focused on tackling skyrocketing food costs, improving home security, empowering youth with culturally-appropriate activities, and including Indigenous people in the decisions regarding their healthcare provision.

The candidates also discussed the issues of medical student intimidation, student disconnect with the CMA, and supporting student leadership. For more information, please consider the points proposed in the platforms of the candidates and watch the recorded debate on OMSA's Facebook page. The CFMS is looking forward to work with the newly-elected CMA president-elect and to engage with them on issues affecting medical students across the country. ■

# Emerging trends in medical education

Franco Rizzuti
Past-President & CFMS Board Chair
PGY-1 Public Health & Preventive Medicine, University of Calgary

AS THE CURRENT PAST-president of the Canadian Federation of Medical Students (CFMS), I have had the privilege of participating in medical education roundtables at the local and national level. Upon reflecting on these experiences and conversations, I wanted to share my thoughts on critical emerging themes which I feel will shape both the medical education and the healthcare professional environment(s) we will train and work in.

## 1. Innovation in Medical Education

When we think of medical education innovation, initiatives such as competency-based medical education (CBME), accreditation overhaul, licensing exam reform, and artificial intelligence often come to mind. However, I challenge learners that medical education innovation comes in a much larger variety of flavors. At TEDMED 2017, Lindee David, CEO of Joule, asked myself and a fellow medical student: "How can learners innovate from their seats?" To answer this question, we need not look further than Joule's 3D printing competition winners such as Bradley Prince, who suggested a 3D printable stethoscope, or Nicole Thompson who launched a transgender physical exam education component into Calgary's Medical School curriculum just this year. Across Canada, many of our members are also innovating at the ground floor. In the next decade, medical education innovation will take the form of large-scale transformative change, but more often it will be predominated by local grassroots evolutions and sometimes revolutions that sweep the medical education continuum. Often, these local innovators are the most connected with the patients and populations which they learn from and care for. Through close collaboration, they are ensuring medical education is training physicians for today's Canada and for tomorrow's healthcare needs, whilst providing better patient-centered care. I would encourage each member to never shy away from innovating with even the simplest or silliest of an idea.

> "In the next decade, medical education innovation will take the form of large-scale transformative change [...]"

## 2. Transitions to Residency

Learners at all levels of the medical education continuum, including staff physicians, are aware of the Canadian resident matching process. The current matching process has remained largely unchanged for almost 40 years. The current system utilizes a Nobel-winning equation designed to optimize the "stable matching problem." It is designed to match individuals with complete rank order lists in a closed system. While today's match shares many similarities to these origins, it is also significantly different. CFMS and others have commented that in the 2017 match cycle, Anglophone students had less than a 1 to 1 ratio for residency spots. Furthermore, the average number of applications is increasing every year and there is a growing number of unmatched Canadian medical graduates. These trends ought to make us pause and think. I suggest that this evolution requires a collaborative rethinking of the residency matching process by undergraduate deans, postgraduate deans, funders, and medical trainees to better meet the current realities and the needs of the Canadian public.

## 3. Big Data

It's almost impossible to pick up a newspaper, follow Twitter, or have a conversation without hearing the term big data. In 2018, big data is also an increasingly common term in medical education vernacular. Medical regulatory authorities, licensing bodies, medical schools, electronic medical records, health innovators, governments, and national entities are requesting more and more trainee, physician, and patient data to use for an increasing scope of activities. While this pursuit is noble and well justified, this ought to raise the following questions: Who has access to this data? Why is this data needed? Where is the oversight? What are the privacy principles surrounding collection access, storage, and utilization? I do not dare profess to have any brilliant insight into the answers of these questions, as these very questions will most likely be debated by ethical and legal scholars for many years. I would however encourage trainees to become astute, aware, and engaged in the conversation around data and its use. Enhanced data utilization will be a growing aspect of our clinical and professional practice. Developing a robust understanding and working comfort with it is imperative. ■

# Making waves – innovation on the east coast

Victoria Januszkiewicz
CFMS Atlantic Regional Representative
Memorial University of Newfoundland, Class of 2020

AT MY FIRST CANADIAN Federation of Medical Students (CFMS) meeting in Ottawa last year in September, I was in the presence of Dr. Brian Goldman, famous for his show on CBC, Black Art, White Coat. He was there to give a presentation on "disruptive innovation," which he defined as "transforming an existing market or sector by introducing simplicity, convenience, accessibility, and affordability where complication and high cost are the status quo." The talk focused on many of the ways that medicine is going to have to change and grow much like the way society and technology does. As Atlantic Regional Representative, I have been able to observe and experience just how innovative and cutting edge our four Atlantic Region schools are.

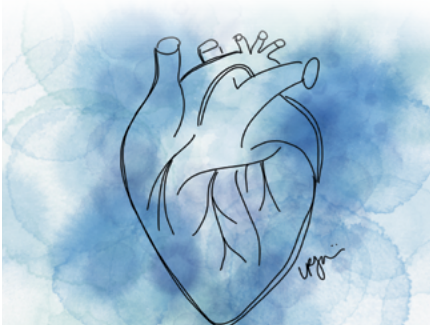
Historically, there have been separate conferences held between Dalhousie University and The Centre de Formation Medical du Nouveau-Brunswick (CFMNB) and between Memorial University of Newfoundland (MUN) and Dalhousie University. This year, organizers of these conferences decided to join and create the first annual Conference of Atlantic Canadian Medical Students (CoAMS), which will be held in Saint John, NB in April 2018. This is an exciting time for the region as it will be the first time bringing all four of the Atlantic campuses together, including students from all Atlantic provinces. This conference will feature sessions for Atlantic Canadian medical learners in ultrasound, trauma simulation, and "gray zone" sessions with experts on Addictions and Harm Reduction, MAiD, and Medical Innovation. The CFMS is thrilled to see this opportunity for development and collaboration.

Our Atlantic Canadian medical students also set the bar high with their innovative pursuits. This past fall, Dalhousie University and MUN congratulated two of their own winners of the Canadian Medical Hall of Fame Award. Michael Bartellas, from MUN, was the principal applicant on a successful grant to create Newfoundland and Labrador's first biomedical three-dimensional printing laboratory, MUN MED 3D. This initiative has supported three co-op engineering placements, and more than 40 biomedical projects! Brayden Connell, from Dalhousie University, was the co-executive director of HOPES in 2017, and he helped open the Health Centre – the first student-run-clinic in the Maritime provinces. Another Atlantic medical student of note is Melanie Johnson from MUN, who was selected by Joule as one of the 17 physicians/students who helped change the shape the future of health in 2017. Melanie was commended for her work in the Joule Innovation Challenge, which consisted of developing a 3D printed mug with flow control settings for patients with swallowing difficulties. 3D Printing and student-run healthcare are just two of many projects and initiatives here on the East Coast. These students are the embodiment of our CFMS vision: Tomorrow's physicians leading for health today.

Another way that Atlantic Canadian students will be making waves in 2018 is through political action and advocacy. Each province in the Atlantic Region sees medical students participate in Provincial Days of Action on a yearly basis (formerly known as Provincial Lobby Days). This spring, MUN medical students in Newfoundland will be advocating for the provincial government to cover the cost of the newly available Mifegysmo, which PEI saw medical students advocate for this past August. PEI will host another Provincial Day of Action for medical students in fall 2018. New Brunswick will see medical students advocate for better access to mental health services and Nova Scotia will see students put in an ask associated with family physician payment models this April.

The students at the Centre de Formation Medical du Nouveau-Brunswick should also receive credit for being innovative and creating change at their school. CFMNB is the newest school to join our CFMS family and they are soon celebrating their first anniversary for being a member school. They are continuing to build their CFMS portfolio at the school and are very excited to bring a delegation to the 2018 Spring General Meeting in Halifax.

We are so excited to host the CFMS General Membership here in the beautiful Atlantic Region. As Atlantic Regional Representative, I couldn't be happier to help share the wonder and charm of the City of Halifax with our members! When thinking about innovation, Dalhousie University in the heart of Halifax is the perfect example. Dalhousie University is celebrating its 200th year, and Dalhousie's Faculty of Medicine celebrates an amazing 150 years of excellence and innovation in medicine and teaching. The CFMS congratulates Dalhousie University on their sesquicentennial anniversary. ■



# What you need to know about the impacts of the new tax changes*

Lauren Griggs
CFMS VP Finance
University of Calgary, Class of 2019

**This information is current as of January 2018, and at the time of this writing, the government had yet to finalize this legislation in its 2018 budget and pass it into law.*

BY NOW, YOU HAVE PROBABLY heard about the proposed tax changes and are wondering, "What do these changes mean for me?" Until you are a practicing physician, they will have very little impact, but many medical students, residents, and new physicians are closely watching the private corporation issue to see what changes are enacted. Here you can find a few of the common questions being asked by young physicians about incorporation and what the tax changes may mean to anyone considering incorporating later in their career.

## 1. What is the purpose of incorporating a medical practice currently, without considering the proposed changes?

There are two primary advantages to incorporating a medical practice: income sprinkling and tax deferral.

Income sprinkling: Currently, incorporated physicians can reduce their family's overall tax bill by splitting their income with family members who are shareholders in their corporation and are in a lower personal tax bracket.

Note: The terms "income splitting" and "income sprinkling" are sometimes used interchangeably in the media. In fact, income splitting refers to the general strategy of splitting income to reduce taxes, whereas income sprinkling is a specific type of income splitting – it describes the payment of corporate dividends to various shareholders.

Tax deferral: Physicians with excess funds in their corporation (after paying the corporate tax and paying themselves) can allow the money to grow inside the corporation. The income generated within the corporation is called passive income. The advantage comes from deferring the personal tax payable until a future time when it's taken out, instead of paying personal tax on it in the year that the income is earned.

## 2. What's the difference between a public and a private corporation?

A public corporation is a company like a big bank, large insurance company, or food retailer whose shares are bought and sold on the stock market. Depending on their province or territory, public corporations pay a combined federal and provincial/territorial corporate tax of about 26% to 31%.

Any corporation that's not a public corporation is a private one. Private corporations can be owned by individuals such as physicians, dentists, lawyers, or farmers. Canadian-controlled private corporations often qualify for the small business tax rate, which is about 15%.

The federal government's proposed tax changes affect only private corporations.

## 3. If the proposed changes are enacted as written, will physicians still be able to incorporate?

Under the new rules, self-employed physicians will still be able to incorporate and access the small business tax rate on income they retain in their corporation. However, it is expected that the benefits of income splitting using dividends will be eliminated or constrained, as the payment of dividends to adult family members is proposed to be subject to a new reasonableness test.

> "[...] newly incorporated physicians may have many years to build their passive investments before any proposed changes would take effect, so incorporation may still be a strategy worth exploring down the road."

As for the deferral benefit that results in the build-up of passive investments in a private corporation, the government remains committed to developing a new framework for the taxation of passive income that would result in a much higher tax rate than is currently applied.

However, in October 2017, the government announced it would allow a new passive income threshold of $50,000 per

"About 60% of practicing physicians in Canada own a medical professional corporation, and would be affected by the changes."

year, suggesting that a private corporation could have $1 million in passive investments (based on a 5% return on investment) before being subjected to any proposed tax rules on passive income.

It means newly incorporated physicians may have many years to build their passive investments before any proposed changes would take effect, so incorporation may still be a strategy worth exploring down the road.

### 4. How many physicians would be affected by the proposed changes?

About 60% of practicing physicians in Canada own a medical professional corporation, and would be affected by the changes.

### 5. Will certain specialties be more affected than others by the proposed changes?

It's important to distinguish the business benefits of incorporating from the financial benefits. Specialty practices with high capital requirements, such as radiology, ophthalmology, and dermatology, should still get the existing business benefits of incorporating.

The proposed changes affect the financial benefits, which include income sprinkling and the tax deferral on passive investments (as mentioned in Question 1). In general, medical practices that have higher levels of retained corporate earnings are going to be more affected by the changes to the passive investment rules. ■

*Content for this article is courtesy of MD Financial Management (md.cma.ca). As a member of the Canadian Medical Association, medical students have access to MD MedEd CounselTM – a team of MD Advisors and Early Career Specialists dedicated to medical students and residents.*

# IFMSA August Meeting 2018 – Montreal

Sarah Zahabi
CFMS Quebec Regional Representative
McGill University, Class of 2020


WE ARE PROUD TO announce that IFMSA-Québec, an organization that represents all medical students of Quebec, was elected to host the International Federation of Medical Students' Associations' (IFMSA) August Meeting General Assembly 2018. From August 2nd to August 8th, 2018, Montreal will welcome the world for a seven-day conference with the underlying theme of "Health Beyond the Hospital." In order not to miss out on this unique opportunity attracting 1000+ medical students from over 130 countries, we recommend you book the dates in your agenda today!

Our dynamic team is composed of students from all four medical faculties of Quebec, as well as CFMS members. We have been working on the August Meeting General Assembly for over two years, and have been receiving massive positive feedback from important stakeholders across the country, including our PM, Justin Trudeau! We have successfully signed the majority of our logistics contracts, and are currently working on planning our opening ceremony. We also have also assembled a team with expertise in visa applications. Our premier financial sponsors are the Quebec Medical Association and Tourisme Montréal. A pre-conference will be held in the historic Quebec City. We are also excited to announce that there will be a CFMS post General Assembly, a touristic and cultural experience geared towards promoting our national landmarks and Canadian culture.

> "[...] Medical students are the future of the profession [...]"

Please note that we will be organizing a Health Symposium for junior doctors and residents that will run parallel to the IFMSA General Assembly from August 2th to August 8th, 2018. More than 200 residents, junior doctors and IFMSA Alumni will be engaged in a symposium that will offer high quality trainings in professionalism, social accountability, wellness and mindfulness, as well multiple networking opportunities.

The Organising Committee is looking forward to welcoming you in Quebec. For any inquiries, please visit our website at am2018@ifmsa.qc.ca. ■

# STRIVE: Stress resilience in virtual environments

Stephanie Smith
CFMS VP Student Affairs
University of Calgary, Class of 2019

FOLLOWING TWO deployments to Afghanistan as a Critical Care Nursing Officer, I became very interested in the importance of resilience. I vividly recall caring for many traumatically injured soldiers and Afghan civilians and often not feeling prepared for the gravity of the situation or equipped to manage the emotions associated with such overwhelming exposure to traumatic injuries and loss of life. Fortunately, I developed strategies to cope with the stress to thrive in challenging situations based on a few key strategies. These experiences, coupled with many in the ER and ICU in Canadian hospitals, motivated me to develop the resiliency course STRIVE.

The goal of STRIVE is to improve resilience through the development of skills and strategies to approach traumatic events. Ideally, enhancing resilience and wellness will decrease the psychological complications associated with traumatic experiences.

The high incidence of burnout, compassion fatigue, PTSD, and suicide among health practitioners should be of paramount concern and a priority for understanding and intervention. Chaotic clinical environments impose continuous emotional and physical demands that create an environment for personal resilience to breakdown and as a result, many psychological issues can ensue. This threatens patient safety and outcomes as practitioner motivation, energy, empathy, and cognitive function can become compromised. Evidence indicates that improving resilience and decreasing burnout leads to improvements in (1) patient healthcare experience, (2) patient safety and outcomes, and (3) healthcare financial effectiveness.

We know that many health care providers must be prepared to treat patients who have been traumatically injured. Exposure to these situations is often unexpected and new, causing health care providers to experience additional stress. The literature indicates that sensory exposure through simulation to traumatic events is key in preventing negative long-term consequences associated with traumatic incident exposure. Therefore, the STRIVE course incorporated simulation experiences following didactic resiliency training.

A pilot course was conducted at University of Calgary in November 2017, where 12 people were selected to be trained as facilitators: six qualified physicians and nurses and six medical students who were nurses or mental health professionals prior to medical school. All completed a seven-hour course (four hours of didactic training covering the road to mental readiness, via the Big Four: tactical breathing/arousal control, visualization, self-talk, and goal setting, followed by three hours of medical simulation with mannequins). In addition, all were provided continual guidance for leading and debriefing simulations over the course of the sessions with participants.

Overall, the hope is for the training to translate over to patient care, where healthier providers will improve their patient's experience and outcomes in the future.

Prior to the course launch, all facilitators were asked to be involved with the simulation design. All agreed it would be challenging to develop scenarios for first-year medical students, third-year nursing students, and third-year social work students. However, roles were created to ensure all participants would be engaged. Overall, all of the facilitators indicated that the training was beneficial and should be provided early in students training. Many commented on how they were already using many of the Big Four strategies that they had developed over the years to help them manage the traumatic events they have experienced. They were keen to incorporate the skills they weren't currently using as they recognized the validity of the training throughout the sessions.

"The high incidence of burnout, compassion fatigue, PTSD, and suicide among health practitioners should be of paramount concern and a priority for understanding and intervention."

If you are interested in this training and would like a one-day course brought to your school, please contact vpstudentaffairs@cfms.org. I hope to conduct three to five courses across the country to continue receiving feedback about the simulation scenarios. Stay well and continue strengthening your resiliency toolkit! ■

# #HowWeAdvocate

Yipeng Ge
CFMS VP Government Affairs
University of Ottawa, Class of 2020

## Introduction

THE GOVERNMENT AFFAIRS and advocacy branch of the CFMS was the first immersive experience and interaction that I personally had with the organization. I was slightly overwhelmed and delightfully perplexed to learn of the tremendous efforts of medical students across the country in advocating for so many areas of importance. The value and importance of our collective voices as medical students and as effective advocates for our peers/colleagues, our profession, and most importantly, our future patients, cannot be overstated. It is sincerely humbling and exciting to be in this position of VP Government Affairs for the CFMS, to be able to work with so many passionate medical student advocates and build relationships for the continued strength and value of our work as an organization. This work is important to prepare us all as budding health professionals entering a changing world marked with ever-changing issues and inequities.

## 2018 National Day of Action on Indigenous Mental Wellness

A tremendous amount of work and preparation has gone into the 2018 National Day of Action on Indigenous Mental Wellness. Following the passing of the CFMS position paper entitled "Mental Health and Suicide in Indigenous Communities in Canada" in April 2017, the wheels were set in motion. An extensive effort from medical students across multiple portfolios contributed to the discussion and work in making this advocacy effort possible. A thorough community consultation process was implemented to gather guidance and support from indigenous community leaders, health experts, and institutional/organizational leads. With respect to our government relations, meetings were also held with advisers in the Prime Minister's Office, Office of the Minister of Indigenous Services, and the Office of the Minister of Health. This year marks a unique shift in our efforts to communicate extensively and build relationships with communities and the government in hopes of a strong, meaningful, and respectful effort to exercise our voices as medical students in a position of speaking from our own truths.

## The Opioids Crisis

We held our National Lobby Day, now re-branded as Day of Action, on the Opioids Crisis in February 2017, bringing medical students from across Canada to ask the federal government for the passing of Bill C-37, increased access to multidisciplinary chronic pain centres, and increasing investment in research investigating the interactions between mental illness and opioid misuse. We became a proud signatory on Health Canada's and the Canadian Centre for Substance Abuse's Joint Statement of Action in commitment to working on the opioid crisis collectively. Over the past year and a half, our local leaders at each medical school ran opioids crisis education and naloxone kit training events at nearly every school. We have also contributed to work on competency-based curricula in pain management, substance abuse, and addictions with the AFMC. As an organization, we have also funded two summer studentships to continue addressing the opioid crisis. Most recently, we have formed an Opioids Task Force of CFMS medical students to look at creating a formal position paper. We are proud to be part of the National Opioid Response Team meetings of organizations working on the issue at various levels.

## Committee on Health Policy

The guiding documents of the CFMS (discussion papers, position papers, and policy statements) typically adopted at the general meetings make the organization a strong and grounded advocacy group. The Committee on Health Policy, a group of articulate and policy-minded medical students, have been working tirelessly on proposing new papers, tracking and understanding existing papers, and revisiting/revamping the existing process from an idea to the adoption of a paper. The Position Paper Task Force has revisited and proposed a process to safeguard authors of papers and enhance the rigour and quality of papers, a process that has garnered extensive outreach for feedback from CFMS committees. From the development of a statement of intent to newly designed infographics and revitalizing the advocacy tracker to a video explaining the position paper process, we are well on our way to extraordinary changes to CFMS guiding documents and the implementation and follow-up of recommendations. Overall, we are strengthening our advocacy efforts and presence as an inherently political organization.

## Targeted Teams and Task Forces

Over the past few months, the development of the CFMS Rapid Response Team was established to fill a missing gap in the portfolio. The team will aim to rapidly address time-sensitive national political and health policy issues, as

well as rapidly analyzing, reporting, and responding to policy issues and events that affect Canadian medical trainees and their future patients. Furthermore, there exists many targeted task forces of passionate, experienced, and driven medical students working towards a common goal and interest area. One example previously mentioned is the Opioids Task Force. The Cannabis Task Force is well underway on an extensive review of literature and community concerns to create a position paper to be shared in the very near future. The Pharmacare Task Force is re-visiting our previous advocacy efforts on the topic (two prior consecutive CFMS Lobby Days focused on this very topic) and to continue our efforts in communicating the importance of this idea. The Health Research Task Force is looking at medical student ideas and input into the year-long study of the Standing Committee on Health on federally funded healthcare process and outcomes.

## Conclusion

It isn't hard to see that I am incredibly proud and humbled to be able to work with all the incredible individuals that put in their time and efforts into the government affairs and advocacy portfolio. I have the deepest gratitude and appreciation for these individuals and to be able to do this work. I am truly ecstatic to see where we go next. ■

# Views from the West

Odell Tan & Victor Do
CFMS Western Regional Representatives

THE WESTERN CANADIAN medical schools (UBC, Calgary, Alberta, Saskatchewan, and Manitoba) had an extremely exciting 2017! From the CFMS Spring General Meeting in Winnipeg to IceBowl in Vancouver, students and faculties have been hard at work creating opportunities for leadership and intercollegiate collaboration.

One of the most important parts of the Western Regional Representative portfolio is the Western Medical Schools Annual Meeting, which is a gathering of the various faculty administrators. At this meeting in Calgary, we presented a talk highlighting two key areas of importance for Western Canadian medical students: student wellness and the increasing number of unmatched Canadian Medical Graduates (uCMGs).

We encouraged innovative and strategic approaches to wellness with a renewed focus on clerkship support. While schools' preclerkship wellness programs have become more robust over the past few years, we still have significant work to do in developing more longitudinal, skill-building curricula for our students to prepare them for clerkship, residency, and careers. Since the meeting, the University of Calgary has begun work on a school-specific wellness survey and implementing a multidisciplinary simulation activity focused on developing wellness skills. At the preclerkship level, the University of Saskatchewan has responded to the needs and feedback of students and eliminated mandatory didactic wellness lectures in favour of facilitated self-directed wellness activities, such as yoga, cooking classes, and mindfulness sessions.

We would not be doing our duty as CFMS representatives if we did not address the issue of rising uCMG rates at the Annual Meeting. We emphasized the need for formal programs of support for uCMGs, such as the Year 5 program at University of Saskatchewan as well as University of Manitoba's work with the provincial healthcare ministry to fund additional family medicine residency positions for unmatched students. In response, students and faculty at the University of Alberta have created a Year 5 option tailored to their students' needs to be in place for the 2018 match.

Further, we highlighted the continued need for strong career planning support and student accessibility to health human resource projection data to inform decision-making. Support for uCMGs is not enough to combat this issue and we emphasized the need for faculties to work with provincial and national healthcare stakeholders to address this. The University of British Columbia faculty has made progress on this front by hiring a new Director of Career Advising and the student leadership is in the process of identifying specific student needs to ensure that development of their career advising program can address any gaps.

As we look further into 2018, we are excited by the support and responsiveness of our various administrations. Issues facing medical students today, such as wellness and the uCMG crisis, are not easily resolved, but we are hopeful that we can improve the current situations by working in close partnership with our faculties. Although each school has unique needs specific to their students and communities, we believe that further collaboration between the Western Canadian medical schools is possible and can contribute to improved innovation and student experiences at all five schools. We look forward to continuing to working with both student and faculty leaders. ■

# Indigenous health and the CFMS

Chris Biggs
CFMS VP Global Health
University of Manitoba, Class of 2019

MANY PEOPLE MAY ALREADY know this because I say it all the time, but the most amazing part about the Global Health portfolio is that many students who choose to become involved reside at this intersection of medical education and lived experience within disenfranchised and underrepresented populations. These students really "get it." I am so thankful to be surrounded by so many energized and passionate student leaders in Global Health.

For this reason, I have chosen to highlight one of the National Officers within the Global Health Portfolio. I sat down and had an e-interview with Willow Thickson, current National Officer of Indigenous Health (NOIH). Below you will find the transcript with a little insight into Willow's life, her views on Indigenous Health, and her ideas for the Indigenous Health and Global Health portfolios.

### Hi Willow. Thanks so much for chatting with me! To start, would you like to tell me a bit about your life before medical school? Where did you grow up? How has that shaped your perspective on Indigenous Health?

I grew up all over Alberta. I was on a tiny little reserve called Wabasca until I was 5, then Fort McMurray, and then when I was 10 we relocated to Edmonton where I spent the rest of my school years. My mother is Anishinaabe and Métis, and my father is Cree and Métis so I was constantly surrounded by relatives. For Indigenous people, this means blood related and non-blood related. Being surrounded by family from several nations in Treaty 8 and Treaty 6 gave me an understanding of the effects of colonization and extractive industry on my people's health. Specifically having family with diabetes, mental health issues, family who survived residential schools, family that has been in and out of jail, those with addictions issues, and pretty much every stereotypical Indigenous illness you can think of – all of this made me understand the effect of the western colonial system on my people. With many of these illnesses being directly caused by the removal of culture, language, and placehood of Indigenous people, I see them as preventable illnesses that we are able to address.

### Before becoming National Officer of Indigenous Health, what was your role in Indigenous Health at your medical school?

I did my undergrad at UBC in Kinesiology and Health Sciences and was a member of the club for Indigenous Students in Sciences and Health. I also did research on the cardiovascular health of Indigenous people and worked on several health initiatives throughout campus. Now since I have been in medical school, my role has shifted and I have been an advocate for Indigenous health curriculum in all health disciplines, specifically medicine. Last year, I was the Indigenous health representative for my class. I reported on areas for improvement within our education specifically relating to Indigenous health content. This year I sit on our main student board of government as the Vice President of Indigenous Health, where I work with school faculty on editing curriculum content. I also work with first and second year Indigenous Health Representatives on projects to supplement the Indigenous curriculum.

> "I think that the state of Indigenous health education in medical schools is dismal, but I don't think that it's just medical schools, I think that it's across all universities."

### What drew you to the Indigenous Health portfolio of the CFMS in particular?

The Indigenous health portfolio with the CFMS was something I had looked at in first year, but the seat was taken and I was curious as to what the position was doing from a national level. I didn't know that there was a Local Officer of Indigenous Health (LOIH) position within the school and probably missed the email as an incoming medical student as we get bombarded with emails during those first months. When second year came around and I received the email about being the Junior Local Officer of Indigenous Health for the UBC within the CFMS, I applied, interviewed, and received the position. Then the notice that the National Office of Indigenous Health (NOIH) position was available, and I thought that would better suit my ambitions and dreams to standardize Indigenous health content across Canada so that the work that I was

doing within UBC could be transferable to all universities. Big dreams required a more national position where I was able to network with students from all universities on their experiences with Indigenous curriculum within their school. This needs to happen to better the quality and delivery of health services to Indigenous patients across Canada, not just here in BC.

### What do you think of the state of Indigenous Health education at Canadian medical schools? Where do you see improvements?

I think that the state of Indigenous health education in medical schools is dismal, but I don't think that it's just medical schools, I think that it's across all universities. They are letting the students down by not mandating a certain level of Indigenous content. This also applies to all levels of education K-12 inclusive. It is a systemic problem within education. Specifically, as medical professionals we are being let down because we are expected to come from a place of empathy and compassion for individual experiences. If you don't know about residential schools, or the sixties scoop, or the many attempts of genocide on my people, how are you supposed to be compassionate to patients' experience, lack of compliance, or distrust in the medical system? I believe that there is starting to be a shift in understanding and that shift is necessitating a review of content to include Indigenous material.

> "I am at UBC because they are doing a lot within our curriculum to address the need to understand how to relate to Indigenous people [...]"

Improvements need to be made at all levels, we as medical students need not only to learn that these things happen, but also we need to know how best to help individual patients and advocate for equitable health care of Indigenous people; something that isn't happening right now. A singular blanket exercise does nothing in teaching advocacy or empowerment of Indigenous issues. I am grateful I am at UBC because they are doing a lot within our curriculum to address the need to understand how to relate to Indigenous people and I would like to see that happen at all universities across Canada. The problem is that there is no standardization of delivery of Indigenous content, so once we all leave medical school and enter residency we will all have differing levels of understanding of Indigenous topics and issues. Imagine that was the case for any other subject in medical school? Where some schools only get one week of lectures on the cardiovascular system and others spend a whole month, by the time you reach residency we will all see many patients with heart failure, MI, etc. and only the ones with the month's training will be able to properly address the situation.

### What are some goals or projects you may have planned for the year for the Indigenous Health portfolio? What opportunities do you see to collaborate with other Global Health portfolios of the CFMS (Sexual and Reproductive Health, Human Rights and Peace, Global Health Education, Partnerships)?

A major goal for the Indigenous health portfolio includes designing a report card on Indigenous health content and delivery for every Local Officer of Indigenous Health to complete every year, so that each school is graded by the students on the level of education we expect versus what is actually delivered. This can happen annually, and it is a way for students to hold their faculties accountable for progress.

There are several areas of overlap within the global health portfolios. Something I am passionate about is Sexual and Reproductive Health and Global Health Education. I believe that collaboration on position papers in these two areas is critical. Indigenous sexual health is critical, and there as so many topics such as disproportionate cancer and HIV rates within Indigenous communities, STI testing, pregnancy, and birth control delivery in remote communities, the effects of environmental destruction on women of child bearing age, the effects of global warming on Indigenous peoples' way of life and what that means for health; the list feels never ending as there is so much inequity for Indigenous people.

A friend of mine once said that she stopped working with Medicins Sans Frontier because she realized that the same conditions she was treating overseas were just as prevalent in Indigenous communities. She realized that she could do third-world work in our own backyard. That really stuck with me, and I think should stick with everyone who is interested in global health. No running water, no homes, tuberculosis, HIV, etc. it is all here in Canada, but most people don't see the same kind of glory working with Indigenous communities as they do in working in Africa. Change needs to happen and we all need to work together to make it happen. My hope is that through this portfolio I can elicit some change within our medical curriculum and system that will better my people or at least the delivery of health services to my people.

### Thanks so much Willow! Keep up the great work!

To learn more about the CFMS Global Health portfolio or to contact myself or any of our National Officers, please visit https://www.cfms.org/what-we-do/global-health/our-team.html ■

# A cry for HELLP in Uganda

Rachel Loebach
Western University, Class of 2018

Adriana Cappelletti
Western University, Class of 2018

WHEN WE FIRST WALKED into the stuffy, closet-sized assessment room on the maternity ward, Nyimbo's blood pressure monitor was flashing 210/150. The 26-year-old, 34-weeks pregnant mother-to-be had arrived at the hospital two hours earlier, seizing and hypertensive. The call team diagnosed a slam-dunk case of eclampsia.

Now Nyimbo lay on the gurney, naked and writhing. She was begging for help in Swahili, her hands wrapped around her neck – 'choka', she pleaded. She was suffocating. As she labored to breathe, the ward's sole oxygen machine sat on the ground adjacent to the gurney, broken and non-functional. In the midst of a nationwide physician's strike, it was impossible to tell who, if anyone, was in charge. Her catheter bag was filled with dark red urine. She was beginning to slide in and out of consciousness.

The risk to Nyimbo's life and the life of her unborn child were climbing with every passing minute. She had progressed into full-blown HELLP Syndrome. She needed a Caesarean section and she needed it two hours ago. But it would be another four hours before the proper medical supplies, blood work, surgeons, anesthesiologist, and operating room were ready. And of course, it would be far too late.

The sequence that followed is impossible to forget; intubation, incision, delivery of a lifeless baby girl. Nyimbo was transferred to the last free bed equipped with a ventilator - one of four - in the ICU. And that is where Nyimbo's story ends. The damage was irreversible. Two innocent lives lost, mother and child, at the hands of a completely preventable and treatable condition.

Tragically, stories like Nyimbo's are far too common in many developing nations. Every day, 830 women worldwide die in childbirth. That is the equivalent of two jumbo jets filled with predominantly healthy pregnant women and girls crashing every single day. Ninety-nine percent of these deaths occur in developing nations, mostly in Sub-Saharan Africa.[1]

Sadly, women are dying and families are losing their loved ones due to preventable causes: distance to hospitals, limited healthcare resources, shortages in trained birth attendants, lack of education on the importance of antenatal care, and cultural practices of early marriage and pregnancy before full reproductive development.[1,2] All of these contributors to maternal death are underscored by the most influential social determinant of health: poverty.

In order to witness this health inequity for ourselves, we traveled to Mbarara, Uganda in November 2017 to complete an Obstetrics and Gynaecology elective. This is where we met Nyimbo and countless other women who had been abandoned by their corrupt government and left with a broken healthcare system.

At the time of our elective, Uganda's physicians were on strike due to inadequate pay and poor working conditions. Hospitals were providing emergency services only, and resources were critically depleted. Under normal circumstances in Uganda, labouring women's relatives are expected to leave the hospital to buy supplies such as surgical gloves and sutures, which tends to delay emergent surgeries by up to an hour. Hand sanitizer and personal protective equipment are often unavailable; nurses and physicians must improvise, using gauze as a mask or the end of a latex glove as an umbilical cord tie. The physician strike magnified the lack of resources and shortage of healthcare providers in Uganda. One anesthesiology resident was managing up to three simultaneous operations (!), all of which were emergency cases given the conditions of the strike. We took in our surroundings in stunned disbelief.

> "Every day, 830 women worldwide die in childbirth. [...] Ninety-nine percent of these deaths occur in developing nations, mostly in Sub-Saharan Africa."

In Uganda, a country with a comparable population to Canada, at least 16 women die in childbirth every day. Can you imagine if that same number, nearly 6,000 women in one year, died during childbirth in Canada? It seems unfathomable that Canadians would support such tragedy in their own country; so why does humanity remain so tolerant

and/or ignorant towards this tragedy abroad?

If you, like us, are upset and unsettled by these preventable deaths of over 300,000 pregnant women every year, we are calling on you to take action. The following simple steps are only a few suggestions towards creating change. This is not a hopeless cause.

> "In Uganda, a country with a comparable population to Canada, at least 16 women die in childbirth every day."

1. Share this article or other resources with your friends and family. (See Box 1 for recommendations)
2. Donate to grassroots initiatives that empower local leaders to advocate for improved maternal health. Check out 'Save the Mothers,' a Ugandan-Canadian collaboration with this exact goal.
3. Advocate for reciprocal partnerships between your medical school and those of developing nations. Crossing international boundaries is a vital step toward developing sustainable and long-term solutions.

Please join us in advocating for better care of pregnant women and their infants, and help spread awareness about this tragic and largely ignored global health disparity.

## Box 1. Resources on Maternal Mortality and Morbidity

- WHO online Fact Sheet on 'Maternal Mortality'
- Half the Sky: Turning Oppression into Opportunity for Women Worldwide by Nicholas Kristof and Sheryl WuDunn
- The Game Changers by Jean Chamberlain Froese and Patricia Paddey
- Savethemothers.org ■

**References**

1. World Health Organization [Internet]. WHO Media Centre; c2017. Maternal mortality: Fact sheet; 2015 [cited 2017 Nov 22]. Available from: http://www.who.int/mediacentre/factsheets/fs348/en/.
2. Kristof ND, WuDunn S. Half the sky: Turning oppression into opportunity for women worldwide. New York: Alfred A. Knopf; 2009.

# EmBRAcing breast reconstruction

Yaeesh Sardiwalla
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BREAST CANCER HAS WIDE-reaching impacts on the lives of many Canadians. Providing breast cancer survivors with reconstructive options following their treatments can be important to restoring confidence with body image, physical well-being, and improving their quality of life. Breast Reconstruction Awareness (BRA) day is an annual event where surgeons provide education to and answer questions from the general public on the topic. Dr. Mitchell Brown of Toronto was instrumental to developing BRA day and defining the objectives of the event. The event has subsequently been replicated nationally across Canada in 28 different cities and has also expanded internationally to over 35 countries. The success of these events is largely due to the involvement of local surgeons and organizers who utilize their charisma to lead the event in order to share a comprehensive but balanced message of hope for these patients. The Halifax event has been spearheaded by local volunteer organizer Noelle Brown since inception. Breast reconstruction occurs at an emotionally charged point in individual's lives and the passion associated with the process resonates with all involved.

BRA day allows participants to develop realistic expectations of what reconstruction can achieve and for them to hear the first-hand stories of women who have been through the process. Each BRA day around the country has variations in style, but follow the same basic format. This year's Halifax BRA Day event, for example, was held on the 18th of October 2017 at the Royal Bank Theatre in the Halifax Infirmary. Reconstructive surgeons (Drs. Morris, Williams, LeBlanc and Wheelock) were in attendance as well as some of their past patients and many prospective patients. This creates a unique environment where the close bonds demonstrated between past patients and surgeons facilitates a warm starting relationship that future patients can build on when beginning to explore their options. A sense of hope is fostered through these informal aspects of the event. The planned programming starts with surgeons comprising the expert panel discussing the history of breast reconstruction, the various techniques (implant versus tissue) available, and an honest evaluation of the risk and benefits associated with the procedures. The highlight of the night and conclusion is the Show and Tell Lounge, an innovative idea where volunteers show attendees the real-life results of their breast reconstruction in a safe and comfortable environment.

BRA day's success has also been validated through surveying participants. 96% found the breast reconstruction information provided by surgeons and pamphlets useful. This would intuitively be expected since all the resources (surgeons, nurses, device companies etc.) congregate in one location to answer questions for a multi-faceted procedure. Furthermore, 97% had a better understanding of breast reconstruction after visiting the Show & Tell Lounge. This emphasizes the value of learning and empathizing with others who have been through a similar situation. Finally, 85% of participants felt better about their options after the event.

There are two main ways to create a new breast: Using an implant or transferring skin, fat and/or muscle from another part of the body. Both are potentially appropriate options and the solution needs to be individualized depending on the cancer surgery, radiation therapy, desired cosmetic outcome, and patient's physical factors. The surgery can be completed immediately after the breast is removed (immediate reconstruction) or delayed for some time after. The complexity of this choice and the nuanced factors that exist in the decision-making matrix are what necessitates a consultation with a plastic surgeon. For more information, please see the resources provided below.

It is interesting to note that breast reconstruction surgery was not always a covered procedure in Canada. Health care coverage for reconstructive breast surgery only began in 2006 in Nova Scotia (each province is different), meaning that many patients may be unaware of the reconstructive options available to them as a provincially insured service. Primary care providers and medical trainees who interact with patients on the front line of medicine can use this information to counsel patients about their choices. It should be noted that wait times to see plastic surgeons in Canada is considerable (up to two years in Nova Scotia), and is something that needs to be rectified. Understanding the available options and resources for survivors of breast cancer can help empower women and improve quality of life issues being faced.

For further information on breast reconstruction and BRA day, please see: https://www.dalbreast.com/

Dr. Sarah Al-Youha, a breast reconstruction fellow at Dalhousie University, has created this accessible and easy to understand website for patients and physicians wishing to know more about reconstructive options and services offered: http://www.bra-day.com/ ■

# 4th annual McMaster Health Advocacy Symposium

Claire Bodkin & Nikita Singhal
McMaster University, Class of 2019
McMaster Health Advocacy Symposium Co-Chairs

THE 4TH ANNUAL McMaster Health Advocacy Symposium – held on Saturday, September 23rd, 2017 – drew over 100 attendees from students in various health professions at universities across Ontario. Dr. Andrew Pinto and Deena Ladd from the Decent Work and Health Network opened the day with a keynote discussing working conditions as a social determinant of health; their presentation highlighted how collective advocacy by healthcare providers has been essential in the fight for workers' rights and improved labour laws in Ontario. Participants then attended two breakout sessions, choosing from a selection of workshops focusing on art and activism, eating disorders, digital and social media organizing, medico-legal partnerships, supervised injections sites in Hamilton, and building a health advocacy toolkit. At The Table, a social enterprise initiative at YWCA Hamilton, catered a light breakfast and delicious hot lunch. The day closed with Dr. Carys Massarella's keynote on the importance of health advocacy in supporting transgender people and communities.

Feedback from attendees indicated that the symposium provided an accessible, low-barrier opportunity to network with other students and current healthcare practitioners engaged in health advocacy work. Attendees said they also considered new ideas and was able to better understand major health issues like the opioid crisis, and most importantly, developed their personal health advocacy skills. They appreciated that we were able to bring in content experts who also had lived experience related to their area of expertise. As a conference team, we worked diligently to ensure our conference was physically, socially, and financially accessible while offering high quality speakers and workshops. This was only possible by fundraising to cover the majority of the associated costs. We're so grateful that the CFMS was our title sponsor — financial support via the Student Initiative Grant was absolutely essential for hosting the symposium.

To learn more, please visit our website at https://mhasymposium.wix.com/2017. And don't forget to save the date for next year's event… we hope to see you at the 5th Annual McMaster Health Advocacy Symposium on Saturday, September 22nd, 2018! ■

# Stand up for Indigenous health

Adriana Cappelletti
Western University, Class of 2018

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YOU ARE PROBABLY AWARE that First Nations, Métis, and Inuit Peoples, collectively known as Indigenous people, face significant health disparities largely attributed to the historical and ongoing colonization and systemic racism that Indigenous people experience.[1] Compared with non-Indigenous Canadians, Indigenous people experience poorer health outcomes in nearly all areas of health, including chronic disease, accidental death, mental health, and overall mortality.[2,3]

Our project, entitled 'Stand Up for Indigenous Health' (SU4IH), is a simulation-based tool for teaching the Indigenous social determinants of health. We introduced it to you briefly in 2017's *Annual Review* in the early phases of its creation. We wanted to create a tool where medical students immerse themselves in scenarios that reflect the lived experiences of Indigenous people in Canada. To do so, we used a community-based participatory research (CBPR) model. CBPR is an approach that values community members as active participants throughout the research process.[4] By placing community voice at the forefront of this process, CBPR can facilitate change that is informed by those who are directly affected and knowledgeable about the specific social determinants that impact their health.[5]

Since last year's publication, we have partnered with four additional Indigenous communities and gained a wealth of knowledge from those who shared their stories with us. This year, we would like to share with you the insights we have gained from these partnerships and the value of community-based projects.

## Community-Gatherings

The narratives that inspired the scenarios for SU4IH are the result of collaboration with Indigenous communities in urban, rural, and remote Ontario, both on and off-reserve. During gatherings, we elicited community experiences with health and healthcare by facilitating sharing circles, where participants were asked questions and invited to share their experiences by taking turns passing a speakers' feather around the circle. This practice is generally considered as a comforting and healing one among Indigenous groups.[6] Prior to sharing circles, rapport was first established over a meal, and gatherings were opened in a traditional manner including a prayer by an Elder, or with a smudge.

It has been a privilege to be welcomed to join community members and learn from their stories. Being present in the circle with people who are opening their hearts and sharing vulnerable moments is humbling. The human connection, trust, and emotions established in the circle through narrative sharing makes it unlike any other learning experience. When you can put a face to the story and feel a human connection with the person who lived that experience, you feel a motivation to be part of the change and a duty to advocate for culturally safe healthcare. Despite this new learning, we must continue to practice humility and recognize that there is still so much to learn if we are going to be part of meaningful improvements in healthcare informed by Indigenous communities.

## Insights from Sharing Circles

Significant insight gained on how to be better future physicians has come from the responses to our question: *If you could tell a medical student one thing to improve the care for your community, what would it be?* Several recurrent themes emerged, providing recommendations for future physicians working with Indigenous patients:

- Genuinely LISTEN to patients.
- Be upfront and honest about medical diagnoses.
- Provide patients with understandable information about diagnosed medical conditions, and allow for patient involvement in making decisions regarding management.
- Recognize the knowledge within communities, such as the importance of spirituality, land, and traditional medicine to Indigenous peoples' wellbeing.
- Approach encounters with Indigenous patients without bias or stereotypes.
- Be partners in care who patients trust.

"Compared with non-Indigenous Canadians, Indigenous people experience poorer health outcomes in nearly all areas of health [...]"

## Ongoing Partnership

In the process of developing SU4IH we continue to ensure community input.

"Being present in the circle with people who are opening their hearts and sharing vulnerable moments is humbling."

Following transcription of recorded focus groups to generate case-based scenarios for our simulation, we sought feedback from focus group participants, Indigenous physicians, and leaders from the Ontario Indigenous Cultural Safety Training Program. This review process ensures that communities remained involved and informed throughout the process of developing SU4IH and that scenarios are truly reflective of lived experiences.

## Implementing SU4IH

As we move forward with piloting SU4IH, we intend to continue promoting community involvement and representation in several ways: promoting Indigenous medical student leadership through the role of 'Change Agent' facilitators, and inviting Indigenous community members to share knowledge and experiences during post-simulation facilitated discussions.

## Concluding Remarks

In piloting SU4IH, Ontario medical students will simulate the same narrative stories that have inspired us. Our hope is that these real-life scenarios are more compelling than statistics in promoting interest in and knowledge of social factors influencing Indigenous Health. In turn, we hope to see a larger number of students join those of us who are motivated to advocate for improved care of Indigenous populations in Canada. Look out for 'Stand Up for Indigenous Health' in 2018 and join the movement towards change! ■


**References**

1. Browne, A. Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. Soc Sci & Med [Internet]. 2017;184:23-6. Available from: https://doi.org/10.1016/j.socscimed.2017.04.045
2. Statistics Canada. Select health indicators of First Nations people living off reserve, Métis and Inuit. Statistics Canada: 2013 [cited 2015 July 15]. Available from: http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11763-eng.htm.
3. Arkle M et al. Indigenous Peoples and Health in Canadian Medical Education. CFMS: 2015 [cited 2018 Jan 5]. Available from: https://www.cfms.org/files/position-papers/2015_indigenous_people_in_canadian_med_ed.pdf
4. Holkup PA, Tripp-Reimer, T, Salois, EM, Weinert, C. Community-based Participatory Research: An Approach to Intervention Research With a Native American Community. ANS. 2004;27(3), 162–75.
5. Horowitz, CR, Mimsie Robinson, R, Seifer, S. Community-Based Participatory Research from the Margin to the Mainstream: Are Researchers Prepared? Circulation. 2009;119(19), 2633–42. Available from: http://doi.org/10.1161/CIRCULATIONAHA.107.729863
6. Stevenson J. The Circle of Healing. Native Social Work Journal. 1999;2(1), 8-21.

# The Stem Cell Club – over 10,000 stem cell donors recruited at campuses across Canada

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THE STEM CELL CLUB IS A student-run non-profit organization that works to recruit Canadians as stem cell/bone marrow donors.[1] We are a community partner of Canadian Blood Services, and we are accredited through them to run our own stem cell donor-recruitment drives. At these drives, we guide potential donors to provide informed consent and a tissue sample (cheek swab) – this information is then inputted onto Canada's stem cell donor database, the OneMatch Stem Cell and Marrow Registry. Transplant physicians use this database to find matches for their patients who need a stem cell transplant and who cannot find a genetic match in their family. Since 2011, we have recruited over 10,000 potential stem cell donors (representing 2.4% of all donors on Canada's current donor database). Our recruitment strategy focuses on the most-needed donors according to the literature: young and ethnically diverse males.[2-4]

We have reported on our initiative in the past three issues of the CFMS *Annual Review*. In 2015, we outlined our initiative's successful launch at the University of British Columbia's medical school, and our subsequent expansion to all of its distributed sites.[5] In 2016, we reported our successful expansion to five medical campuses across Ontario.[6] In 2017, we reported on the launch of stem cell club chapters at two additional Ontario campuses, as well as at University of Saskatchewan and University of Manitoba.[7] In the present issue, we are pleased to report that we have developed a capacity to recruit over 4000 potential donors annually, of which the majority are males with a high degree of ethnic diversity. Of note, 53 of these registrants were Indigenous males, allowing us to increase representation of this needed demographic group by 4.5%. We also developed and published a multimedia library to support our efforts to recruit

potential donors (available at http://stemcellclub.ca/promo.html), and improved our training program for volunteers and club leaders (available at http://stemcellclub.ca/training/index.html).

Our initiative provides medical students with experiential learning opportunities, allowing them to develop across CanMEDS roles. We empower students to become leaders in Canadian healthcare and health advocates for patients in need of stem cell transplants. We hone student communication skills to recruit registrants without compromising informed consent, and to sensitively and professionally redirect ineligible donors to help in other ways. Through targeted recruitment of the most-needed donors, we guide students to be stewards of limited healthcare resources. We develop students' quality control skillsets by instructing them to use our checklists and to maintain good documentation practices. At our drives, students act as scholars, teaching other students about stem cell science and the principles of stem cell donation. Medical students at each chapter of our club work collaboratively with each other and with students from other disciplines across their university to recruit donors. Through tracking outcomes at every drive we run, we emphasize continuous quality improvement.

We invite other medical students across Canada to partner with us and establish stem cell clubs at their respective schools. We offer our support, guidance, and mentorship to any individuals or groups of students interested in starting up their own stem cell clubs. We will share our evidence-based training modules, experience running drives, and other useful resources. We will connect you directly with Canadian Blood Services and Héma-Québec, and work to accredit your group to run stem cell drives independently. We can, together, dramatically increase the number of individuals we recruit to become stem cell donors, and save the lives of patients who cannot find a match today. Interested students can email Dr. Warren Fingrut at warren.fingrut@utoronto.ca to discuss the next steps. ■

**References**

1. Fingrut W, Parmar S, Cuperfain A, Rikhraj K, Charman E, Ptak E, et al. The Stem Cell Club: A Model for Unrelated Stem Cell Donor Recruitment. Transfusion 2017; 57 (12): 2928–2936. Doi 10.1111/trf.14327
2. Fingrut W, Rikhraj K, Allan D. Targeted Recruitment of Male Donors for Allogeneic Hematopoietic Cell Transplantation: A Review of the Evidence. Vox Sanguinis: in press. doi:10.1111/vox.12632
3. Kollman C, Howe C, Anasetti C, Antin JH, Davies SM, Filipovich AH et al. Donor characteristics as risk factors in recipients after transplantation of bone marrow from unrelated donors: the effect of donor age. Blood. 2001 Oct 1;98:2043-2051.
4. Beatty PG, Mori M, Milford E. Impact of racial genetic polymorphism on the probability of finding an HLA-matched donor. Transplantation. 1995 Oct 27;60:778-78
5. Fingrut W and Wang X. The UBC Stem Cell Club: strengthening Canada's stem cell donor database. CMFS Annual Review 2015, 2015; 23.
6. Cuperfain A, Tigert A, Welsh C, Aziz J, Kantor N, Benzaquen M, et al. The Stem Cell Club: Expansion to Medical Schools across Ontario. CFMS Annual Review 2016, 2016, 20.
7. Parmar S, Rikhraj K, Hartsook S, Afford M, Longmuir C, Brar R, et al. The Stem Cell Club – Spearheading Stem Cell Donor Recruitment at Medical Schools Across Canada. 2017 CFMS Annual Review, 39.

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# Tackling mental health stigma in medical school

Dalia Karol & Hailey Newton
University of Ottawa, Class of 2020

AS MANY OF US KNOW, medical school can be a time of significant stress and can quickly become overwhelming. It has been well established that medical students face high levels of depression, anxiety, and burnout with one in four medical students experiencing symptoms of depression in their medical education.[1] Despite this startling statistic and the high prevalence of mental health issues amongst medical students, mental health is still not a topic that is widely discussed. For students, opening up about their own mental health struggles is associated with a fear of judgment, the false association with weakness, the fear of going unmatched, amongst many other factors that silence our voice. Despite our efforts to de-stigmatize mental health, the stigma still exists. At the University of Ottawa, the Student Wellness Committee (SWC) has made de-stigmatizing mental health one of its top priorities. Many of us have experienced moments where we have struggled with our own mental health, but have been hesitant to reach out or seek support. With this in mind, we have made it our committee's goal to help create an open and supportive community within our school, and hopefully across Canada as well.

So, how can we, as medical students, begin to tackle such a large and pervasive problem? Our approach has been to run a continuous and longitudinal wellness program, run exclusively by the students for the students, that aims to promote open discussion, provide adequate resources, and promote wellness year-round. We have started a new initiative this year called "Wide Open," which is a series of bi-monthly small group sessions that encourage open discussion of important wellness themes such as mental health and coping with some of the stressors of medical school. We aim to normalize the shared feelings we all have in medical school through open discussion and we use a set of prompts to encourage students to share while at the same time inviting other students to be active listeners to help foster a supportive environment. These "Wide Open" sessions help to set the stage for one of our most successful and highly anticipated events of the year, "Our Stories." Our Stories is a mental health open mic night that encourages medical students to share stories about their own experiences with mental health. Only medical students are allowed to attend to ensure confidentiality, and students are encouraged to tell their own stories at the event or to submit their stories anonymously. Last spring was the event's premiere, and it sparked the start of a welcomed trend towards solidarity, openness, and judgment-free discussion amongst our peers. This event created a unique and empowering atmosphere where support was demonstrated across students of all years of study. It was inspiring to see an entire room of students there to support each other, to share their stories, to grow, and to help de-stigmatize mental health.

Understanding that not all students will feel comfortable sharing in a larger group setting, we have introduced several other events in the hopes of fostering a more casual environment to encourage the process of opening up about mental health and wellness. We run a "Wellness De-Stressing Room" before major exams where students can come to de-stress, enjoy healthy snacks, participate in de-stressing activities, as well as seek advice or just hang out with their peers or students in other years. This wellness room helps to remind students and reassure them that they are never alone. They are not alone when it comes to feeling the stress and pressure of exams, but also not alone in the sense that there will always be students and resources available along their journey in medical school. Prior to the first exam for the first year class, we also ran a "wellness on-call" program where SWC members were available to speak to any first years seeking advice, companionship, or just to talk. The SWC also offers weekly wellness workouts that encourage and emphasize the importance of exercise in maintaining one's physical and mental health.

Despite the many advances that have been made to open the discussion about mental health, there is still a lot more work to do, and we are very fortunate to have strong support from our SWC members, our Aesculapian Society, and Student Affairs Office. We hope that some of our events and initiatives will inspire other medical schools to take the initiative to break the stigma surrounding mental health in medical school. Let us remind our classmates that they are never alone. Each of us has our own personal struggles, but it is through our collective and mutual support that we will foster a stronger medical student community. ■

**References**

1. Rotenstein, L. S., Ramos, M. A., Torre, M., Segal, J. B., Peluso, M. J., Guille, C., … Mata, D. A. (2016). Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. JAMA, 316(21), 2214–2236. https://doi.org/10.1001/jama.2016.17324

# *Brain on Fire* - a journey of finding the lost self

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*BRAIN ON FIRE* (2016) IS A movie adaptation based on New York Post reporter Susannah Cahalan's memoir of her terrifying descent into insanity from autoimmune encephalitis-induced psychosis and her eventual journey to recovery. This movie really resonated with me because of its similarities with my own patient encounters during my psychiatry rotation. Most importantly, it made me think critically of my experiences on psychiatry as a health care provider.

One recurrent theme of *Brain on Fire*, which was apparent in the psychiatric patients' daily struggles, is the degree of functional impairment these illnesses have on people's lives. Prior to the onset of her condition, Susannah was a promising young journalist who seemed to have it all: a dream job, loving boyfriend and parents, and supportive co-workers. However, when her illness came on knocking on her door, she lost everything that once defined who she was. She was not able to concentrate at work, experienced frequent insomnia, cycled rapidly between high and low moods, suffered from auditory hallucinations, and felt tortured by changes in her personality. She could hardly work, let alone function, on a daily basis. She moved back home with her parents, but her erratic mood swings and destructive behaviors put a lot of strain on her relationship with her family.

This element of Susannah's disease made me reflect on a middle age lady on the ward – Ms. M with psychosis/depression secondary to a brain tumor resection. When I first met Ms. M, I immediately picked up on her flat affect, prolonged speech latency, and psychomotor retardation. She endorsed anhedonia and felt utterly alone. She even made up a "boyfriend" who lived in the U.S. and only visited her infrequently, but later confessed that it was a lie to make herself "feel better." Even though she had family living in Toronto, she insisted on not contacting them because they called her stupid and hated her. When describing these traumatic events, Ms. M did not display any emotions outside of her baseline; yet when questioned about her life before her brain tumor resection, she lit up. She described herself as "highly functional" prior to the surgery and worked 4 different jobs simultaneously at times. She also enjoyed reading comic books and frequently posted her own artwork online as a blogger. Her speech was fast and coherent, and excitement and pride shone in her eyes. This contrast in her behaviour showed me that just like Susannah, her life was supremely derailed by her debilitating mental illness.

Unfortunately, unlike Susannah's story, Ms. M did not have the same strong social support system Susannah had. Despite the multitude of misdiagnoses provided by different healthcare providers along her journey, Susannah's family never gave up on her. Instead of settling on the "convenient diagnosis" that their daughter was just "partying too much," they insisted on chasing after the truth. Eventually their efforts and perseverance helped to confirm Susannah's diagnosis and led to her final recovery. In contrast, Ms. M described her family as her main stressor in life. Ms. M's mother in Korea would often call her to criticize her impulsive behaviors and ridicule her with offensive names; her dad frequently called her stupid and "hated" her; and her sister had apparently kicked her out. I will never forget the tears she tried to hold up in her eyes and how hurt she seemed when she told me about her family. She couldn't look me in the eyes afterwards and had poor sleep the following night. With a lack of social support, Ms. M felt enshrouded by loneliness whenever returning to her home to be reminded of the "emptiness" in her life. I believe it was for this reason that despite previous admissions to the psychiatric ward, Ms. M's depression and suicidal ideations immediately returned after her initial discharge.

"One recurrent theme of *Brain on Fire*, which was apparent in the psychiatric patients' daily struggles, is the degree of functional impairment these illnesses have on people's lives."

Susannah's battle allowed me to gain better insight into Ms. M's illness and allowed me to appreciate the significance of functional impairment and social support on patients' self-esteem and illness relapse. It made me reflect on my experiences on Sunnybrook's psychiatric ward as a medical student, and how to better approach psychiatric patients with empathy and compassion in my future practice. ■

# "You are a valuable part of the team!" – the role of a clinical clerk

Anish Naidu
Western University, Class of 2019

IT WAS MY SECOND MONTH OF clerkship, and I was in my Paediatrics rotation when my most memorable patient encounter to date took place. It was a new consultation for the assessment of an adorable five-year-old boy with query Autism Spectrum Disorder and intellectual disability, who was accompanied by his single young mother.

The assessment started with me and my preceptor obtaining a history from the mother. While chatting with the mother, she admitted to being a bit depressed lately as she worried about her son's future. However, I had a feeling that there was something else going on besides the boy, but nothing concerning came up during the interview. Interacting with the boy quite clearly elicited many features of autism. At the conclusion of the appointment, we explained the follow-up plan, and I accompanied them back downstairs to the waiting area. She seemed reassured that would be organizing good care for her boy. As I called out for the next patient, she received a call on her cellphone. I overheard the tone of her voice getting sadder… almost sobbing. I was growing suspicious that the call might be related to the feeling I had earlier about something else going on in her life.

I directed the next family upstairs to the assessment room and asked them to tell my preceptor that I will be up shortly. I then built up the courage to confront the mother about the call, while apologizing for eavesdropping. I took the mother and the boy to a private room, and she broke down crying. She confessed that she has not been coping well at all, and that she was trying to keep herself together and withhold information during the appointment because she was worried about being identified as unable to care for her boy, and that Children's Aid would get involved. With the boy's father out of the picture, she had no reliable support. Her younger sister had depression and had completed suicide a month ago, leaving her parents with their own grief to cope with, and unable to provide much support to her. The phone call was from her mother that reminded her of her sister's death.

I was a bit stunned and felt that I was in uncharted territory, as I never had such an experience before. I fell back onto the basics of being empathetic and a patient listener. I consoled her by reassuring her that we were working to provide the best care for not only her son, but also for her as well. I told her that the potential involvement of Children's Aid would not necessarily mean that she will be separated from her son, but rather that we will all work together to ensure that they are well supported. I convinced her to return to the office upstairs with me. I apologetically interrupted the ongoing session with the next family and requested my preceptor to talk to the mother in another room. I briefed him on what happened downstairs. We spent a half-hour exploring the social situation in great detail, and planned a follow-up in a week to talk further and develop a comprehensive plan. By the end, the mother thanked the both of us with tears of relief, and I felt really happy that we were able to make such a huge positive difference in her life.

After the mother left, my preceptor smiled at me and said, "I would have completely missed that… that's why you are a valuable part of the team!" At this moment, it hit me that we would not have discovered any of this had I not gone down to the waiting area with the mother and confronted her about the phone call. If I was not around, the secretary seated downstairs would have simply directed the next family up.

"I then built up the courage to confront the mother about the call, while apologizing for eavesdropping."

I am sure that I am not alone when I say that as a fresh clerk, I used to feel that I was not really contributing much towards patient care. I felt more like a burden to the team because I was there to learn, and they had to take time to teach me and answer my questions. After this encounter, I realized that even as a novice clerk, I can be a valuable part of the team if I stay diligent, observant, and responsible. Completing even the basic history and physical exam as thoroughly as possible can go a long way. Quite frequently, clerks have the privilege of being able to spend a lot more time with patients than a resident or staff physician can. Using this time to develop good rapport with patients and to explore their social history in sufficient detail will help improve their care.

*"If you cannot do great things [yet], do small things in a great way."*
*– Napoleon Hill* ■

# Doorway of understanding

Sarah Hanafi
University of Alberta, Class of 2018

CANADA RECENTLY introduced legislation to legalize medical assistance in dying (MAID). When this issue entered into the sphere of public discourse, there was much debate within our society regarding the moral dangers and slippery slopes of this precedent, with a concomitant examination of our nation's values. At the centre of this process lay Canadian physicians - amongst them, some of the staunchest advocates, but perhaps even more so, some of the strongest disavowers of the proposed legislation. Around that time, I distinctly remember meeting a patient in the emergency room who shook me from a place of complete disconnect on this issue, and invited me to the doorways of sympathy and understanding.

I was shadowing a geriatrician who was asked to see an 80-year-old gentleman in the emergency department that was requesting MAID. This man was perfectly healthy - surprisingly so for his age - and yet he expressed very real suffering at the thought that he may reach an age where, due to medical reasons, he could no longer express his wishes adequately as a "vegetable," as he put it. This prospect of loss of dignity and agency caused him great distress, so much so that he came to us that day requesting assistance to end his life while it was "still good." Ultimately, we couldn't offer him much at that moment as MAID was but a point of debate and was nowhere near passing the House of Commons. But in that interaction, I felt something shift inside me; whereas I had formerly thought I would never understand the desire to seek MAID, I found familiarity in the very real suffering he bore, and I felt true sympathy.

> "During this elective I am learning what it means to be patient centred: to set aside one's own values, beliefs, and biases."

Fast forward more than two years, and after only four days on my palliative care elective, I've been involved in three conversations with patients seeking MAID. To be frank, I perhaps foolishly did not anticipate the magnitude of this reality and its gravity. During this elective I am learning what it means to be patient centred: to set aside one's own values, beliefs, and biases. What it means to try to understand the whole person in front of you: their highest of hopes, their wildest of dreams, and their darkest of fears. And to come to know their loves, their hurts, their needs, and their wants.

I listened to a terminally ill patient with cancer describe how his illness has robbed him of the enjoyment of fresh Italian pasta, the vitality of championing the many sports he mastered, the ability to relieve himself of his insufferably itchy scalp, and, most tragically, the appreciation of the sight of his beautifully devoted children.

As he put it, "I'm just existing rather than living."

I also listened to three adult children impart with teary eyes a binder titled "Super Dad," the energetic, passionate man who infected all with a love for life, family, and God.

As we discussed the path ahead, we talked about what brought meaning into his life. I watched my preceptor's mind whirl, analyzing the room's dynamics,

> "[...] I can certainly grow to rise above these differences and to honour every patient with the same compassion and understanding [...]"

when asked what options were available. As we discussed the goals of care, and the ability to prioritize comfort over the prolongation of life, we waited for the patient and his family to finally name the elephant in the room: MAID.

When many think of Palliative Care, they think of lessons on prescribing opioids, managing shortness of breath, and intractable nausea. And while I've learned some aspects of this, the greater lessons I've been privy to have been the tacit teachings in patient-centred care. Each day I've been challenged to confront my deepest held beliefs and values, in the name of honouring my patient's own ethos. And while my creed may never permit me to be directly involved in MAID, I can certainly grow to rise above these differences and to honour every patient with the same compassion and understanding, irrespective of whether we kneel together in prayer.

For these opportunities to grow personally, I am ever grateful to the patients and families who, in their time of tremendous vulnerability, have invited me into the doorways of understanding. ■

# From learning to doing: the transition to clerkship in medical school

Marina Abdel Malak
University of Toronto, Class of 2019

THE MAJORITY OF MY FIRST two years of medical school were spent sitting in lectures and small-groups where we learned about important concepts around illnesses and their management. Our clinical skills courses allowed us to practice physical examinations on one another and on standardized patients, thereby giving us the opportunity to hone our techniques before working with real patients.

Without a doubt, these two years were essential to my development as a clinical clerk. In September 2017, I entered my first year of clerkship, where I would be rotating through a variety of clinical specialities – and working with real patients. If it were not for the first two years of medical school, I would not have the knowledge or skills to even fathom doing so!

Entering clerkship was like starting medical school all over again: the feelings of excitement and fear filled my soul. I wanted to be a 'good' clinical clerk – a medical student who could take an adequate history, perform a relevant physical examination, and formulate a diagnosis and treatment plan. The idea of being part of a patient's team and working with other professionals made me feel important: I realized that contrary to the first two years of medical school, I now had a critical role to play in the care of my patients. I was no longer simply practicing my skills on standardized patients – in clerkship, I would be dealing with real patients with real illnesses.

As excited as I was to enter this new experience, I was also quite nervous. What if I forgot to ask an important question during a history? What if I performed a physical exam manoeuvre incorrectly? Would my attending physicians think I was incompetent? Would patients lose their trust and respect for me? Would I be made to feel inferior to other medical students?

In addition, the increased responsibility and time constraints made me anxious. How would I find time to see my patients and care for them, document my interventions, return home, and study for exams…and still have time to enjoy myself? Where would I find the time to engage in self-care, spend time with my family and friends, and continue my extra-curricular activities? It seemed to me that once one entered clerkship, life ceased to exist. From the stories I heard, students in clerkship didn't have any time for themselves. They left for their rotations, returned home, studied, and slept. And then repeated this every day for the next two years…and the years after that in residency.

With all these feelings and thoughts rushing into my head, I began to wonder whether I would actually enjoy clerkship. Deep in my heart, I knew that working with real patients is what I had been waiting for. My passion for helping others and incorporating my knowledge and skills made me feel motivated to be the best medical clerk I could be. But at the same time, my worries about not being 'good enough' and not finding time for the non-medical aspects of my life made me feel uncertain of what would come.

I was not alone. Many of my peers felt the same way. This reassured me greatly – my thoughts and emotions around entering clerkship was 'normal.' But, what could I do about it? I shared my feelings with my family, who reminded me why I started this path in the first place. I knew that entering a medical career would be time-consuming and challenging. But this continuous learning, coupled with new experiences and opportunities to help patients, is what drove me to pursue medicine.

"Entering clerkship was like starting medical school all over again: the feelings of excitement and fear filled my soul."

The more I reflected, the more I realized that my fears about clerkship were understandable, but need not limit my passion and excitement for what was to come. Yes, I was nervous about not being the best medical clerk, forgetting something important, and not finding time for myself. But after careful reflection, I realized that there were solutions. Firstly, no one is perfect. I might forget to ask patients questions, but I can always return to them and acquire this information. In fact, I noticed that during clerkship, each time I forgot to ask a question, I was more likely to remember that question in future encounters! Next, I reminded myself that medicine is a continuous journey of learning. I might not master every physical exam immediately, and I may not know all the answers instantly. But that is what I love about

"Now, about four months into clerkship, I can honestly say that this has been the best time in my medical education."

medicine – delving into a world where one can always learn new things, attain greater knowledge about illnesses and their management, and become increasingly comfortable with uncertainty!

In terms of self-care, I understood that clerkship was a busy time. In fact, many days, I return from my rotations and can do nothing but relax. However, not all days are the same. There are times when I return home and study for my exams. There are weekends where I am able to go to the mall, spend time with my friends and family, and engage in my hobbies. Of course, my time is not as 'open' as it was prior to clerkship, but this is part of my medical journey. And I am thankful for it, because this has taught me many valuable lessons. I have learned to be more organized with my time, and to prioritize what is truly important to me in life. I have discovered what my inherent beliefs and values are, and I strive to maximize my time and energy into things that nourish my body, mind, and soul.

Now, about four months into clerkship, I can honestly say that this has been the best time in my medical education. I am working with a variety of outstanding healthcare professionals who contribute to the needs of patients. I have various opportunities each day to speak with patients, learn about their stories, and use my skills and knowledge to promote their health. I am blessed to be part of a profession that assists others in attaining wellness and comfort. Yes, I am busier, No, I don't always have all the answers. But I am learning to be comfortable with that. Clerkship has given me the chance to apply the foundations I acquired in my first two years of medical school to 'real life.' It has motivated me to continuously nurture my academic and non-academic development in order to be an effective physician. In simple terms, clerkship has revitalized my passion for medicine. It has allowed me to embrace new experiences as I work with diverse patients who have numerous medical conditions. It has enabled me to return to the basics of physical examination, history-taking, and empathetic conversations in order to be a leader, medical expert, and health advocate.

Yes, clerkship is a new – and frightening – experience. Just like any other moment when we enter a new stage in our lives. These feelings are normal. With each day that passes, I am becoming more comfortable and confident in my abilities as a clinical clerk. I am embracing opportunities to grow, learn, and use my skills and knowledge. I am contributing to the wellness of patients. I am becoming more responsible for health outcomes, my own learning, and my time-management. I am appreciating the simple treasures and beauties in life. Clerkship has allowed me to become a stronger, wiser, and more confident healthcare provider and individual. As my medical career continues, I am certain that this will only increase. Every new opportunity – even those which may seem daunting and scary at first – can only make us grow and rediscover our talents, values, and blessings. In short, clerkship has inspired me to embrace life in a new way: one with an open mind and heart that is prepared to be uncertain…knowing that this uncertainty is what leads to personal and professional development, an appreciation for life, and an unquenchable desire to learn, laugh, live, and love. ■

# The place of beautiful skies

Sharon Yeung
Queen's University, Class of 2021

THE SKY WAS IDYLLIC, AS always: a canvas of clarity, of infinite depth. Though rain and lightning would, on occasion, burst forth from its deepest enclaves, the sky would always find its way back to a solitude even more beautiful than before, as if in apology for the commotion it had caused.

That was what Kas was to me – the place of beautiful skies.

I was perched on a picket fence, one late afternoon in August, watching a makeshift game of baseball, on a makeshift baseball diamond, with mounds of dirt as makeshift bases. I didn't know anyone who was playing, nor did I really know how the game worked. In the sweetness of the summer air and the warmth of the caressing sunlight, I counted in my head the number of days I had been away from home. Forty-one, I think. It had felt infinitely longer.

I was a stranger, in a strange place that only I found strange, and surrounded by strange people who certainly weren't strange to one another. You don't think about what it means to be different, until you are, in every way conceivable. Until you look different, sound different, and have no idea where you are going. I didn't drive a pickup truck or a four-wheeler, and I didn't know how to fish or shuffle dance or read the clouds. The kids told me that I wore funny clothes and talked weird, with an honesty that made me laugh in spite of myself. In my first days there, they taught me to take winding shortcuts that would cut across backyards and fields, some emptying right onto soft, sandy beaches. When I tried to go for a run, they gave me crazy looks that made me think I should know better – because they knew I would end up being chased by a pack of res dogs. I loved those kids dearly, because they possessed a quiet wisdom that always made a fool of me.

Amid the radical strangeness, fragments of familiarity would come and go. Dodgeball was played by the kids with a religiosity I knew from back home, as was Carly Rae Jepsen. There was Doritos, and Coca-Cola, packaged in that familiar, full-luminescent glory that made me thankful, for once, for the wide reaches of commercialization. And then, importantly, there were the people. People who privileged me with their time and their stories even though I was noticeably different – even though I couldn't tell First Beach from Third Beach, or east from west. We occupied dramatically different realities: I had never picked my own strawberries, or built my own home, or lived in such deep, intimate relations with my friends and family. Likewise, though my stories of surviving university dormitories and navigating an upbringing in an immigrant family fell upon the most compassionate of ears, a mutual acknowledgment of our differences persisted – differences in who we are and where we come from.

Such a thought jarred me, because the complacent comfort of my home environment never challenged me to consider a reality outside my own, or confront the norms of society that I took for granted as true norms, if such a thing even exists. Yet, as I teetered on the picket fence on that August afternoon – with the baseball game and the sky and the sunlight before me – I experienced an overwhelming sense of connection to the people and to the place, in spite of our differences. Or perhaps, it was because of our differences that I had been challenged to recognize that the threads stitching people to one another, and to place, and to time, are perhaps not shared appearances or lifestyles or even experiences, but a shared humanity. Within our different realities, we pursue purpose, knowledge, joy, and human connection. We pursue freedom and safety, justice, and reward. We aspire to live lives that have worth; we desire to love and to be loved. And though our pursuits manifest in ways unique to our realities, be that in the objects we deem worthy to pursue or the avenues through which we achieve them, the commonality of our human spirits connect us. I learned, that day, of the privilege I have of standing in solidarity with my friends and colleagues in Kas on this very basis.

The day I left was a sombre one – a cold morning so early that it felt as if the reserve hadn't yet woken. I promised that I would one day return, and though I haven't yet, a week rarely passes that I do not look skyward and remind myself to approach people and places beyond my reality with deep humility, kindness, and a good sense of humour.

Thank you, Kas, for the ways in which you welcomed me, loved me, and taught me. ■

# Welcome to the club

Charles Gillis
Memorial University of Newfoundland, Class of 2020

THEY STAND AROUND THE drape-encircled hole of a patient, gloved hands rooting messily around, touching things that were never meant to be touched, much less see the light of day. The smell of cauterized flesh hits my olfactory nerve, a smell both familiar yet forbidden, not entirely unpleasant. Like an exotic bacon. As I'm admonishing myself for this thought, the scrub nurse whose domain I have invaded waddles over and starts mumbling at me.

"M'love what's your glove size?" Except this comes out in kind of a strange, accent-heavy porridge that hits my ears all at once.

"Um. What?" I say over the din of beeping that is coming from what seems to be a transplanted chunk of aircraft cockpit, full of displays and switches. We manage to establish communication through a series of intricate hand gestures. She stands, somehow matronly, on a stool surrounded by the tools of her trade, metal instruments with so many names. Hooks, claws, holders, scissors. I'm terrible with names. I realize I'm probably more terrified of her austerity than the three surgeons in the room, masks underneath kind eyes.

I look into the operating field, a mess of orange and pink and red that the surgeons are seemingly hacking into willy-nilly. I'm stuck between being terrified I'll have to identify some piece of this mess and a desire to know what the heck is actually going on. I wish I had eaten just a bit more breakfast. No, actually, that's wrong, I wish I had eaten just a little less. I get the sweats and have weird thoughts about hypoglycemia. Whipple's triad in a Whipple procedure. What a guy.

I'm entranced by the way the surgeons move and interact, fluidly maneuvering around each other, entirely on the same page as one word muttered between them results in their hands dancing about the field. The gaping hole of the patient's abdomen is like an octopus, four sets of hands gesticulating wildly at its borders. The resident is hand tying a suture so fast I can't even see what she's doing; she's a looney tunes cartoon come to life and her hands are windmilling around the sutures. Abruptly she stops and sticks a hand out towards the towering scrub nurse, narrowly missing my protruding face. As I mutter an apology and retract my nose from the field, the surgeon's eyes speak volumes despite the lack of facial expression underneath the surgical mask.

The moment happens as I'm asked offhandedly about the gastric arterial supply. Trying desperately to call my mind back to remember one single anatomy slide which happened many weeks and many weekends ago, I precociously stammer out something about a gastric artery and am rewarded with an enthusiastic, "Yep!" I fail to remember anything else and the questions dry up in favour of a more one-sided learning opportunity. The anesthesia team is peering out at me, heads just barely visible above their drape like a castle rampart they are firmly entrenched behind.

During a lull in the activity, I replace the position of one of the surgeons and I'm encouraged to feel part of what's going on. I'm immediately alarmed at how different it looks from up close as opposed to eight feet away, like I'm staring into some terrible whirlpool right beside my wayward vessel. This person's guts are in my hands and I think about how strange it is, how strange it all is, that people stab each other all the time but we get a license to slice, we give you enough drugs to put you in a coma, and then haul out your intestines. I picture everyone's guts as a little trap door in their skin, there's a trap door in my own skin and I can pull it open and my small bowel, loops on loops, plops out and I squeeze it and poke it and sling it around my neck like a squishy boa. "Can you feel the pulse?" I felt around a bit, unsure if the beat I was feeling was my own index finger. "Yeah, totally!"

"This person's guts are in my hands and I think about how strange it is, how strange it all is, that people stab each other all the time but we get a license to slice, we give you enough drugs to put you in a coma, and then haul out your intestines."

Apparently at some point in our abdominal foray, we finished what we were meant to do there and began closing the patient up. I thought about the fact that I didn't pee for 6 hours straight and congratulated my bladder. I tallied up in my head how many times I responded, "Oh, cool!" when the procedure was being explained to me, a number which I'm now too ashamed to repeat to another living soul.

The patient woke up, confused, and I shrugged my shoulders at her. Welcome to the club. ■

# Working on the geriatrics unit the day my grandfather died

Christina Schweitzer
CFMS VP Communications
University of Calgary, Class of 2019

TODAY WAS MY FIRST DAY on the Geriatrics Unit. Today was also the day my grandfather died.

Grandpa had been ill for quite some time. He had severe dementia, but the last time I last saw him, three months ago, he recognized me still. I hadn't seen him for several years, so I was glad when on the long drive from Toronto to Ottawa for a CFMS meeting, we passed through Kingston and stopped in to spend some time with him. I'm glad I had a chance to tell him I loved him, to introduce him to my boyfriend John, to hold his hand, to give him one last hug.

On December 28th, I woke up to a text message from Mum:

*"Prayers for Grandpa please. He is in the hospital."*

Oh boy.

He was given the Last Rites, but the next day he responded to the medications and was discharged a few days later. But then he took a turn for the worse. Mum booked a flight to Kingston, to be with Grandpa, Grandma, and her brothers and sisters.

I knew it was coming. Days went by with no news.

This morning, I woke up to another message from Mum:

*"Grandpa passed this morning."*

Everything is still. I think about Grandpa and his humour, his music, his gentle teasing, his quirks, his ability to improvise the most beautiful piano music without ever having had a lesson, the way he loved us grandkids.

Grandpa was a romantic soul, and loved my grandmother through 63 years of marriage. They have 5 children, 12 grandchildren and 2 great-grandchildren who have lifetimes of happy memories of him.

Dad says we are flying to Kingston tomorrow for the funeral. I put on a pot of coffee and check my calendar.

I am supposed to be doing my first day of clinical core in Psychiatry this afternoon, our last course before clerkship starts next month. I open the email containing the details.

*"Please meet on the Geriatrics Unit."*

Oh boy.

There are lots of different types of psychiatry… it had to be geriatrics?

I consider re-scheduling and joining another group next week, but the logistics are challenging and I really just want to get it over with. I'll be ok. I think.

When I arrive on the unit, I'm glad to see the friendly faces of my classmates. Everyone has been so kind and supportive today.

The doctor walks into the room, and I'm grateful it's someone I know.

*"Hey Christina! Happy New Year. How's it going?"*

I don't have the heart to tell her.

Later on, we are split into pairs and are assigned a patient to interview.

"This is an odd question, but of the patients we're interviewing, could I please be assigned to a younger patient, who doesn't have dementia?" I explain why, and the doctor is very kind.

My patient is a physically healthy woman in her 70s, in hospital to treat her depression. We discuss the events that led to her being in hospital, and she tells us of how many of the people close to her have died recently.

*"You don't realize how important it is to spend time with them until they're gone."*

I could see her eyes well up, as I'm sure she could see mine.

We both make it through and move on to discuss her grandchildren, and she lights up. She looks forward to their weekly visits, and I think she finds great purpose in her life in loving them.

Her husband arrives, and our interview comes to an end. I think she enjoyed it. There's something healing about just being given the space and opportunity to tell your story.

That's something I cherish about being a medical student – we might not have a prescription pad, but we can listen.

She doesn't know it, but I think she helped me heal too.

At the store on my way home, I pick up some of Grandpa's favourite sweets: liquorice allsorts and jellybeans from the bowl in the living room, and Scotch mints from the jar in the glovebox of his truck.

I open the bag of mints, put on an Oscar Peterson album he loved, and flip through photo albums looking for pictures to scan for the visitation.

I think of happy summer days at the cottage with Grandpa, and of the kind words a colleague and friend wrote to me today –

*"I am with you."* ■

# A journey around the medicine wheel

Kaylynn Purdy
CFMS VP Medical Education
NOSM, Class of 2018

CANMEDS IS OFTEN SEEN AS the wheel of medical education, but the Medicine Wheel itself holds four of the most important virtues, and struggles, on our journey to becoming physicians.

In Oji-cree teachings, the four colours of the medicine wheel represent many things, including four virtues corresponding to each colour and direction. Over the past four years of medical school I have come to understand how the medicine wheel represents the lessons I have learned and the struggles I have had in medical school and during my time as the CFMS VP Medical Education. The four virtues of the medicine wheel (much simpler than the CanMEDs wheel) are Wisdom, Generosity, Fortitude, and Bravery.

As a student at the Northern Ontario School of Medicine, I think it is apt to start with a reflection on the first direction corresponding to the colour White, the direction North, and the virtue of Wisdom.

## Wisdom

Miriam-Webster Definition: "accumulated philosophical or scientific learning."

We enter medical school with knowledge gained from our past lives and experiences, but most of us enter with little understanding of what life is; to hold the life another person in our hands, to bring life into the world, and in many cases, to watch it slip away. Over time we build our understanding of the human body in health and disease, we gain skill in treating illness and pain, and we gain confidence in diagnosis. We build our knowledge so that when the time comes when we are the only person available to help another human being, we will be able to make the best and the right decision. Carrying the medical knowledge of all generations before us is a wisdom that is both an honour, and a heavy weight to bear. I have gained an immense understanding of the medical education world, which is at times exhilarating, but also terrifying. There are things that I would have wished to live my life without knowing, yet at the same time, that knowledge has provided the opportunity to improve medical education for every student that comes after me. To hold Wisdom is one of the greatest privileges. Wisdom is both part of the art of medicine, but also the burden.

Now moving onto colour Red, corresponding with the direction East, and the virtue of Generosity.


## Generosity

Miriam-Webster Definition: "liberal in giving."

I think many of us enter medicine because we have "generous hearts," for we wish to give ourselves and our lives to healing of others. Yet, this is the one virtue that I sometimes fear I may have lost more of than I have gained. The culture of medicine hardens you, it changes you. You begin to realize that many peers, colleagues, and mentors are out more for themselves than for others. Very few start this way. Our careers and goals begin to shape more of our decisions than the idea of making the world a better place. The goal of our top choice residency, then our top choice fellowship, and then our desired job drive us to make choices that may not be the best for us, our families, our communities, or even our patients. Generosity is the one virtue I find myself fighting to cling to the most, and is perhaps the most important one to fight for. Generosity is the foundation on which the medical profession is built, and I try to remind myself each day that I am here to give, not take.

Continuing our journey around the medicine wheel to the colour Yellow, corresponding to the direction South, and the virtue of Fortitude.

## Fortitude

Miriam-Webster Definition: "strength of mind that enables a person to encounter danger or bear pain or adversity with courage."

Medical school is not for the faint of heart, those with weak stomachs or those afraid to challenge adversity head on. Like many medical students' past, present, and future, my third year was the hardest year of medical school. I didn't find that patient care was overwhelming,

or the volume of studying too much, or challenge of being inserted into the lives of others emotionally distressing; it was the combination of these factors in addition to being 2600 km from my family while we went through a time of loss and grief. The last four months of my third year, were the worst four months of my life. There were many days when I contemplated dropping out of medicine and moving back home, and on my lowest days, I even contemplated ending my life. What Miriam-Webster failed to include in their definition of Fortitude was that one does not need to encounter adversity on their own, that strength of mind isn't about facing life alone. Fortitude is reinforced by asking for help. What I learned from my third year was that strength of mind is asking for support when you need it, not trudging onwards in isolation. Fortitude is inexplicably linked to connection. Connection to others around us is what allows us to bear the heavy burden of our lives, and of medicine.

The final direction returns me to my roots of where I was born and raised – Western Canada. The last colour on our trip around the medicine wheel is Black, corresponding to the direction West, and the virtue of Bravery.

## Bravery

Miriam-Webster Definition: "the quality or state of having or showing mental or moral strength to face danger, fear, or difficulty: the quality or state of being."

Bravery and Fortitude at first glance appear to be the same virtue, but when I reflected on these definitions, I came to understand that bravery is a state of being, and fortitude is an element of character. We don't need to be brave all the time, but more often than not we do. Almost daily we enact a state of bravery when we admit our mistakes to the people we look up to and who hold our futures in their hands, when we look patients' in the eye and deliver bad news, and when we go out of our comfort zones to provide care to people when they need it most. We often need to do things we don't want to do, things that have grave consequences, but we do it because it is right and it is necessary. However, just because you must be brave, doesn't mean you aren't allowed to be scared or that you aren't allowed to be human. I see my stethoscope as armor. When it is on, I am brave, but at the end of the day, I can take it off, go home, and just be me. Remember, bravery is a temporary state, don't forget to take off the armor at the end of the day.

The Medicine Wheel is a tool of many devices. It is a spiritual guide. It is a way to understand the seasons of the world and of life, it lays the foundations for a holistic view of health, and it is a teacher. The four virtues can be used as a way to guide your development as a physician and as a leader, and also as a means to reflect on your journey.

Go forward and lead the future of medicine: Be Wise; be Generous; be Fortitudinous; and be Brave. ■

# The opioid overdose crisis: what can we do?

Perneet Sekhon
University of British Columbia, Class of 2020

LOSS OF CONSCIOUSNESS, respiratory depression, and pinpoint pupils. These are the triad of symptoms seen in an opioid overdose. According to the BC Coroners Service, 978 people in 2016 died due to an illicit drug overdose. Currently, we are seeing a rise in these numbers. For example, July 2017 saw a 30% increase in suspected drug overdoses compared to July 2016. The vast majority of these victims were males aged 30-59. Overdoses are widespread occurring throughout our province. There are a wide range of drugs being consumed, such as fentanyl and heroin. And importantly, close to 90% of these overdoses occurred indoors (private residences leading the way). There is no doubt that this is a public health emergency and interventions are needed. The problem can be approached in several ways but needs to incorporate at least three foundational principles:

"People that suffer from addictions generally have comorbid mental health conditions. This can include depression, anxiety, post-traumatic stress disorder, and suicidality."

evidenced-based harm reduction and addictions treatment, reducing stigma within mental health, and cross-disciplinary collaboration. By applying these principles, we can actively be a part of the solution to the opioid overdose crisis.

Addressing the opioid overdose crisis is difficult due to the fact that substance users are in various stages on the addictions spectrum. This ranges from first-time users to those in active detox and long-term opiate agonist therapy. Fortunately, an intervention that can be applied anywhere on this spectrum is harm reduction. Examples of harm reduction include needle and syringe distribution programs, education on safe injection practices, and take-home naloxone kit programs. These are proven strategies that work to connect users to the healthcare system, reduce rates of HIV and Hepatitis C, and prevent overdoses. By increasing funding for harm reduction we can reach more substance users and improve their health outcomes. It is also worth mentioning that increased resources aimed at promoting addictions research, treatment services, and related community services will also be beneficial.

People that suffer from addictions generally have comorbid mental health conditions. This can include depression, anxiety, post-traumatic stress disorder, and suicidality. Along with other psychosocial stressors, these are the root causes for addiction. Unfortunately, existing stigma associated with mental health makes it difficult to address this situation. Instead of seeking mental health treatment, there is greater likelihood for negative coping behaviours such as consumption of street drugs. This is a risk factor for addiction. By reducing the stigma associated with mental health, we can hopefully mitigate these outcomes.

"[...] existing stigma associated with mental health makes it difficult to address this situation. Instead of seeking mental health treatment, there is greater likelihood for negative coping behaviours such as consumption of street drugs."

There is no one solution to the current opioid overdose crisis. However, an interesting potential piece to the puzzle is currently in the works. I am part of a team of medical students, designers, and engineers working on an opioid overdose detection device. This is a technological solution that came about through collaboration between different professions with a common goal. Working together and bringing in different expert opinions, we have demonstrated that you can discover creative solutions to difficult problems. ■

# Dr. Nadine Caron: A legacy of resilience for the Indigenous Peoples

Darwin Chan
*McMaster University, Class of 2018*

DR. NADINE CARON IS NO ORDINARY GENERAL surgeon. She was the first Canadian female general surgeon of First Nations descent, as well as the first female First Nations medical student to graduate from the University of British Columbia (UBC). After medical school, she completed her surgical residency at UBC and her Masters in Public Health at Harvard. She then went on to complete a fellowship in Endocrine Surgical Oncology at the University of California, San Francisco. Here, we talk to her about her upbringing and heritage, the power of basketball and sport, and her life's aim to help unveil and celebrate the resiliency of Indigenous communities and individuals in Canada.

## Can you tell us about your heritage?

My mom is Anishnawbe from the Sagamok First Nation. I am a member of this First Nation in Northern Ontario, which is about an hour west of Sudbury. My dad is of Italian heritage. He emigrated from Italy, so it's an interesting combination of my mom being indigenous and my dad being an immigrant. It's been very insightful to see the perspectives of both sides.

## Where did you grow up and can you tell us about your upbringing?

I was born and raised in Kamloops, BC. I grew up with my three brothers; two older, one younger; the only girl nestled within three brothers. I often joke that I was in a school of hard knocks with respect to "putting up with the boys," but at the same time was really protected by my brothers who I grew up quite closely with. I grew up in an incredibly supportive family environment, which I know is a huge factor for where I am today. It really set me up for understanding what was important in my life.

My mom went to residential school. She was the first from her reserve to graduate from residential school. She stuck it out all the way through and I hope I've learnt from her resilience, her determination, her optimism. I've certainly respected those traits my entire life.

While we hear a lot about intergenerational trauma and the challenges of next generations of residential school survivors, I grew up in a family that was supportive and an integral part of my success. I consider myself infinitely fortunate.

## How did you find out about your mother's history in the residential school?

Interestingly enough, I learned a lot about residential schools by asking a lot of questions from other members of my family, including my aunt, grandma and other residential school survivors. My mom has shared stories with me, some history. She's an incredibly positive person - a real believer that you focus on what you want to define you, what you want to remember.

That's how she's chosen to share most of her residential school stories with me and I respect that. With all residential school survivors that I know, meet, or work with, I think that every story they share has a reason, has power to help us understand. No doubt there are incredible, egregious issues with the policies and the background of this residential school system that the government created, implemented, sustained and endorsed. My mom readily acknowledges it but focuses on the education she took from that institution; she took away the ability to get out and to survive, and to be happy, to be able to have what she wanted in life through hard work and determination, regardless of the trials and tribulations that may come across her path.

She left residential school after graduation and went on as the first person from her reserve to actually go on to postsecondary education when she went to teacher's college. She was there only a few days when she was told: "You may have graduated from residential school, but you don't have a grade 12 education. You're never going to make it." For my mom, that's the best message someone could have given her. It's the ultimate guarantee that she'll be successful. No one could keep her down. She went on to become a teacher – thousands of lives are better because she became the type of teacher that she wanted to be.

## What led you to medicine?

I didn't grow up wanting to be a doctor. There's no one in my family that was in medicine. I had minimal exposure to physicians. They were this untouchable group of people that seemed like they had power, knowledge, and expertise.

It didn't cross my mind as something that I really wanted to do until much later. It was also intimidating to know whether I could do it, once it became a possibility of a dream. Both my mom and dad made it very clear that postsecondary education was going to be a vital step to make sure that regardless of what I decided to do, that I would be able to do it. Education would keep my doors open… lead me to doors in the future I might not even know about currently.

They were very supportive in that message, but very clear that if you decided to do something but didn't go on to postsecondary, that doors would close. If you were in school, gaining an education, the world would keep its doors open for you while you figured it out. It was no surprise that my goal from very early on was to go to university but perhaps surprising that I actually chose Simon Fraser University for my undergraduate degree almost exclusively because of basketball.

There was a coach who was an inspiring, talented and insightful leader, Allison McNeill. She and I had crossed paths when she was the provincial basketball team coach that I had the incredible honour of playing under her for about three years leading up to my grade 12 year.

When Allison got the head coaching job at SFU it was a chance of a lifetime to play basketball at university under a coach that believed in you and that you had deeply rooted respect for. It was incredibly fortunate timing for me, so I went on to SFU. I soon realized SFU had a great kinesiology program, and with time it became evident that this area of study was a perfect fit for me.

I did my undergraduate degree in kinesiology and I truly loved it. I started looking towards the health field, not really knowing which direction to go, and then I had this amazing opportunity, completely because of basketball.

We were at national championships in Jackson, Tennessee, in my senior year of basketball. The organizing committee made it so that every varsity team that went to nationals got a corporate "sponsor," a corporation or business in the community that actually came and

cheered you on when you were thousands of kilometres away from home.

Ours was "HCA" or Hospital Corporation of America, a healthcare organization. When we left Jackson, Tennessee after the tournament that year they said, "If anyone's interested in going into medicine, give us a call and we can set you up to shadow a physician for the summer, and you can try it out."

I came back to SFU and was back for about a week when I realized how could I *not* take that opportunity? So I called them up. About ten days later I was on a plane going back to Tennessee for three months. The health care administrator, Jimmy Anderson, set me up with a physician who agreed to let me shadow him for the summer.

The physician was a gentleman by the name of Tom Edwards who happened to be a general and vascular surgeon. It was just unbelievable luck, unbelievable support, at a time in my life where I was really looking to figure out what my next step was going to be. This mentor walked into my life and had this incredible job, this career, where every day his entire role was to take people's symptoms and make them go away, take people's pain and make it better, take people's questions and get a diagnosis.

It was just so inspiring and I was at a point in my life where I needed inspiration; I needed something to replace the basketball court and to me I saw pretty much immediately that the operating room would be my next 'basketball court.'

## It's amazing how basketball really led you on a path serendipitously to medicine and surgery.

Absolutely. Without basketball I don't know where I would be right now. I really believe in the power of sport, and almost every year I do a camp with Johns Hopkins University. I have an associate faculty position at their Centre for American Indian Health and every June there is a camp called Native Vision. It is  a sports and life skills camp for Native American youth. It is a perfect merger of exactly what I got out of sport in the end. In the end it doesn't really matter what your three point shot percentage is or the number of rebounds you get.  The score board really isn't the story at all.  It's interesting; all of a sudden your capacity to make a stellar shot with no time left on the clock isn't really about the game, it's about believing in yourself in a situation that's stressful. When your team is down by 15 early in the first half, it's about teamwork in terms of getting that time out, figuring out how you're going to work together as a team because not one person can make up that difference.

It's teamwork, it's determination, it's commitment, it's hard work, it's self-confidence. And that's what Allison McNeill was so good about.  When she taught you the game of basketball, you thought that was her job as head coach at SFU, but then you realise years later that she was doing so much more than that. She was setting you up for life because eventually everyone hangs up their basketball shoes.

Everyone hangs up whatever equipment you need in sport and it's the transferable skill set that got you to that next level of sport that actually gets you to that next level in life.

## Can you tell me about your efforts and initiatives to train other healthcare professionals on how to prevent racism within the profession?

That's something that's certainly evolved and I think indigenous people in Canada who are exposed to the medical system see that.

I don't think ones' exposure to the medical system as a physican is as representative as the exposure to the medical system when you're a patient or a family member of a patient because people don't hide that racism from you as much as when you have a white coat on or "MD" after your name. As a health care provider, you start to become responsible for keeping an eye out and seeing it, listening for it, acknowledging it and making it your responsibility to make sure that when you hear it or see it or feel it, that you do something about it and try to make sure that it doesn't happen again.

With more and more indigenous healthcare providers, not just doctors but the full scope of healthcare providers, I think that we're really working on addressing this. At UBC now, with the Centre for Excellence in Indigenous Health, we've launched  "UBC 23-24" in the 2017-18 academic year.

UBC 23-24 is actually a curriculum that we call an "experience," not a course, and 23-24 refers to the Truth and Reconciliation Commission (TRC) Calls to Action numbers 23 and 24. They call it cultural competency in the TRC, but we know that that language has since evolved and now we're looking at cultural safety and humility. At UBC's Centre for Excellence in Indigenous Health, we're really pushing for the responsibility of postsecondary institutions to ensure that the healthcare professionals they train leave with that skill set, just as much as they leave with the ability to use a stethoscope, read an ECG or a use a scalpel, suture or syringe.

We are also hoping to work with the government and the regulatory colleges to make sure that professionals that are actually out in the field also accept that responsibility.  We can move this whole agenda of cultural safety and humility from a point where five years ago it was something really ambitious, it was something impressive, it was something inspirational if a university was taking it on… to something that's non-negotiable, something that's mandatory, something that's necessary.

As faculty at UBC I think that our Centre for Excellence in Indigenous Health is having an impact and we're hoping that more universities take that on and make that shift from something that you cheer when it happens to something you acknowledge that it's about time. As a country we can set our goals higher.

## Can you tell us about your goal of training more indigenous health or medical professionals to bring that cultural competency to the table?

I think that's an incredibly important goal to strive for. It is vital to recognize the need to increase the number of indigenous healthcare providers, not just in medicine or in nursing, but across the spectrum of health care. The TRC Calls to Action include this outcome. First of all, it is recognizing that our people can set their goals on any career and have the ability of achieving it – based on merit, skill, experience and capacity. As we have more and more indigenous healthcare providers, indigenous patients have a health care system that has options – and they have advocates within the system that may understand their story more clearly. We have seen this transition in medicine in other areas already – if a female patient would like a female physician this choice is more likely to be possible as more and more women have gone into all areas of medicine.

I think an indigenous patient being able to seek out an indigenous healthcare provider is really key. But at the same time you want to make sure that cultural competency, cultural safety, cultural humility is present across healthcare professions – regardless of cultural background or ethnicity of the provider, or patient.

Indigenous healthcare providers must be at the table. We must be sitting at these department meetings or board meetings and be a voice in decisions made. We can be visible, we can hear things and keep the conversation honest, transparent. If health care organizations or academic institutions are trying to pass things over or pass things that are not supportive of the TRC initiatives, there are indigenous people with the same degrees, same titles, same position as them that are saying, "You can't do that anymore."

I think that's really key and even indigenous students can have this. I would call it a responsibility, an opportunity, that I hope they feel supported enough that it's not a burden. I hope indigenous students that are in the medical schools or in the nursing schools, in the physiotherapy schools or midwifery schools - that they can say: "wait a second…" and have those present truly hear their perspectives. This is really important and I think we should talk about this.

## What words of wisdom or advice would you impart to aspiring indigenous health professionals if you had the chance?

If someone aspires to be a healthcare professional, I love sharing with them just what an honour it is to be part of this profession. The challenges can be so rewarding to overcome and the barriers can be fought through in order to have a career where your goal everyday is to help those who share their stories with you.

I think I would tell them that whatever health career they want to pursue, that they can do it and to not let to the voices that don't know them, that don't know who they are, that don't know the resilience of where we come from, to tell them anything different.

## In retrospect, what do you feel most proud of?

I think that there have been a lot of challenges in my career, and in a bizarre way some of them I look back on and I can't believe that I got up after being knocked down. And I'm really lucky due to the fact that I look back at those times now saying: You know what? I am a better person because of what I went through. I am stronger. I think I'm wiser. I think I've learnt from those experiences. Every day we can learn something new.

But what am I most proud of? I am proud that when I look at my daughter I know that at least so far, I have tried my best, in my own little way, one day at a time, to make this world a better place for the next generation. ■

# 60 minutes

Tharshika Thangarasa
University of Ottawa, Class of 2019

You wait,
And enter.

You have 60 minutes to speak.

To expose the intricate framework of your mind,
The context to your predicaments,
The emotional underpinnings of your life.
To a figure donned in a white lab coat,
Concealing his own sorrows,
Masking his own vulnerabilities.

You have 60 minutes to speak.

A finite amount of time to explore a turbulent sea of emotions,
That reach impenetrable depths.
That engulf the unspoken secrets you have kept, so carefully concealed.
An enclosed space to release a stampede of your most violent memories,
That will pierce through the walls of this institution,
Wreaking havoc on the serene oblivion that once ensued.

You have 60 minutes to speak.

But you sit, in utter silence. ■

# Human/kind

Ricarda Konder
Dalhousie University, Class of 2020

"You're only human"
she says, with her hand on my shoulder,
using that last word
to insinuate flaw
as we look at the damage before us.

How humbling indeed
that, despite our burning desire to succeed,
our species somehow agreed
to let its own label
be synonymous
with failure. ■

# Bouquet

Matthew Lee
Dalhousie University, Class of 2019

i am imagining a photo i have yet to take
composing it in my mind's eye
titled: 'bouquet'
there's a deep drop
a shock of vivid violet
behind a simple white wooden table
upon which sits
in the centre, a plain and clear glass vase
with a curve like something clay
dug up in a cloud of dust

spilling out as a weeping willow
there is a stethoscope hanging
a reflex hammer prim and proper
with measuring tape coiled and tangled

folded paper flowers stained
from lines of black pen
overwriting the names of patients
there are some paper clips
bent here and there amongst
wooden tongue depressors glued
craft-like as popsicle sticks
at the bottom a transparent orange container
filled with pills and covered
with more paper and tiny stickers and ink
censoring the name
of the artist

click ■

# First patient

Kate Morrison
University of Saskatchewan, Class of 2021

Fresh faced
Bright lights
Cold air
Sterile
Pristine white coats
They said to us
*"This is your first patient"*
*"You will check on your patient each day"*
I stand there, humbled, my first patient.
I've waited my whole life to take care of patients. Today begins that journey.
*"This will be the easiest patient you ever have"*
*"Your patient will not speak, have demands, or questions. This will be your easiest patient"*
*"Respect your patient, their right to confidentiality, their privacy"*
An air of responsibility settles over the room.
Hands in lab coat, fiddling with pens and notebooks, it stops for a moment, the room nods
A sign of understanding
*"You will drape your patient as you will do all your patients. Preserve their modesty. Only expose what you must see."*

*"This individual, with the support of their family, decided to be your patient.*
*They did not have to do this.*
*But because they did, you will learn from them"*
*"You must realize this, spend great time with your patient. With time, you will come to understand much more.*
*And always remember, you will learn from each patient.*
*Each patient.*
*You will learn."*

Our patient does not have a pulse. No audible breath sounds. We do not know our patients name. However, we know they have consented to our ways.

And with the introductions over, like all things in medicine, we dive right in. Not a moment to waste.

101 persons.
Groups around our patients.
Instructed on what to do, but what to expect, that we would have to experience on our own.
That day I did not know I would have dreams about my patient.
Wonder about my patient's life.
What did my patient do for fun?
What did my patient's laugh sound like?
What were my patient's fears?
Why did this person decide to be my patient? Maybe if they had known they would be my first patient they would have thought otherwise. Oh, how I am glad they didn't. I needed this patient.

101 persons.
Grouped around our patients.
We dawn our gloves.
First we look. We do not touch. Just look.
What stories can be found with our eyes.
Scars
Burns
Discolouration
Fingers
Toes
Our patients face.
A face we will not forget.

We start the patient chart
Record our findings

101 persons.
Grouped around our patients.
Gloved.
With the confidence of a child uttering her first words
A croak
A sheepish whisper
A few with some gusto
One mutters to the other
*"Scalpel please"*

Our first cut

101 persons
Grouped around our patients
Gloved.
We will see inside of our patients
Yet, we will never know what ignited their spirit.
What stories, moments, and ideas they kept inside
We will see, but we will not know

Time goes on
Fresh faces begin to fade as winter settles in
We may check on you first thing in the morning, before heading to our next class, or before heading home for the day.
A busy day, my mind filled with list of things to do, red lipstick on, I check on you before heading to a holiday party.
We check on you. We see you.
But
There is an emotional toll to seeing you this way.
You do not look like the patient I first knew
We are still with you
We still check on you each day
But you do not look the way you did that first day.

Coats no longer new
Chart in hand
We attempt our first diagnosis
Cause of death

You were our first patient.
101 persons
Grouped around our patients
Gloved
We will never know you
But we will never forget you
Our first patient
You may be gone
Yet, you still spread your wisdom around.
You let us learn from you.
Thank you
We will never know you, but we needed you. ■

# Faded memories

Michael Taylor
University of Alberta, Class of 2020

The Whistle of far windy notes, painting the halls as if afloate.
Seat firm and wide, I lean to hear: each breath – one, two – become less clear.
Your room is grim, ravaged by age; matte-paint preserved… thrives in this cage.
My empty stare – toward the cracks, while blankets rise with lacking gasps.
I listen to the stories made – within these walls – they fill this space.
The beeps, each tear, the fallen cries; I slowly numb, nil thoughts survive.
Our past, of which you don't recall… I wish for thoughts you knew at all.
I try to grasp what brought you here, to understand your distant fears…

Peruse your face – compare to mine – read wrinkles soaked with sands of time.
I reach to touch your throbbing neck – half-wrap my palm, eyes closed – to check.
Feel every peak blend into valleys; your heart beats slow as it does rally.
Still calm, at peace, silent, and cold; shackled with sick – excessive toll.
Nostalgia stout, I yearn to find: the stories that you've left behind.
I scheme to write, perform our dreams – where weak days few, and far between.
I wander through the beaten paths, of memories lost – guarded by laths.
Garner each (the lessons plenty): the untruths told… I listen gently…

I foster thoughts of versions old, of versions lost, of stories bold.
With time, I cite the plots between: the person who I could have been.
I wait for differences to peak, as you lay there and I may speak.
These thoughts, which push your soul from mine – they all but quash our bond, divine.
Mimicked souls – you and I – we dream the same blue-tainted sky.
Cast from cloths woven together… we reach the ground like mirrored feathers.
We stumble through our fathomed woes; yet, near the end we match our foes.
I think of you as part of me; once twined as one, now far you be…

I learn from this – the pain you cause… now search these walls for simple pause.
Grown far from tainted tears I've cried, when anger flowed from deep inside.
I hated you for what you left – for leaving me inside this cleft.
So many frills now left untied; you've pushed me to adjust and thrive.
I rise to expectations fraught, to tie the ends with limber knots.
The man I choose to break and be…the man I wish that you could see.
When all is said – completely gone, my own two feet I'll stand upon.
"Make me proud," you said to me, as death was but a certainty…

But lies were what they came to be, as death escaped so carelessly.
Outsiders flocked to see you through; but months drew by without one clue.
Faint hopes that you will resurrect – became deceit, in retrospect.
I wished that you would simply die; my complex hopes thrust me to cry.
A heartless man I may not be; yet, callous soul you cannot see.
I hate you for the blame I lay – on you – without a thought or say.
It's no one's fault you live as silent; this sick is crude, brazen, and violent.
I cannot fight this one for you – dear Da, hear me? I'm here for you…

My little one is sixteen months; my heart – it swells each time he jumps.

His nose is small; some say 'petit' – it curves like yours… I say repeat.
I named him John (you would have loathed); grandson like Da, he soon will know.
I keep him framed, right here with me… in case you wake to lastly see.
The boy who is, the man he'll be; his father, who wed happily.
I miss you more than sons should bear… as I may leave while you halt there.
This room is grim, and yes, a cage, but comfort creeps in subtle waves.
Your hand in mind – I will not leave, 'til bitter ends force my belief…

Dear Da, I hope you soon will hear: the laughing song of sunlight's cheer.
You're far from home, so surely true; but, love is close – I'm here with you… ■

# Medical jargon

Yasmin Jajarmi
McMaster University, Class of 2018

"code blue," noun, or
a braille, or
a running
of fingers against
milled ribs as
a reading
a conversation, or
a blue
without un-blue, or
in adulthood, teething,
chewing our hands,
awaiting milk, or
the peeling a pale orange,
its disrobed flesh
waiting,
compressed
by fingers
at a rate of
thirty to two. ■

# Reminisce the loved

Hsin Yun (Ruby) Yang
University of Ottawa, Class of 2020

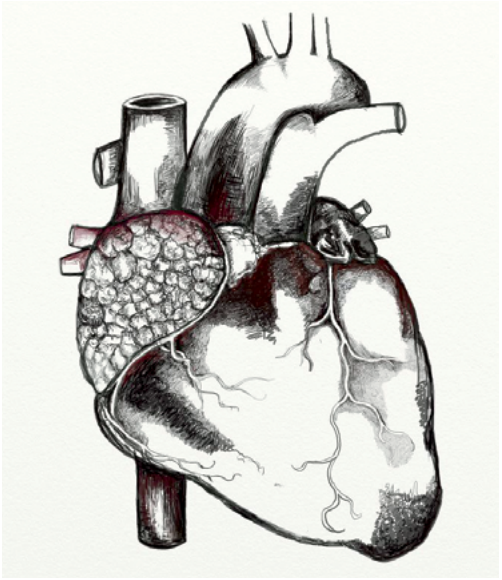
Early calls rarely come with good news
as reality slaps with unforgiving cruelty.
A sudden gasp matched by a crushing heart drop.
Muffled whimpers and uncontrolled shivers
with silent tears flowing endlessly.
Face buried in a pillow hard as concrete,
feeling stone cold in the peering sunlight.
The loving has become the loved.

There is much to say,
but little comes out.
What could have been
- should have been
can no longer be.
The unspoken words hurt the most.
Afraid to look around, afraid to feel.
Must put up a front but cracks still emerge,
playing a bluffing game as the day remains.
Classes continue with peers unaware
studying away, still learning,
hoping to change future cases,
but not for the one yesterday.
Yesterday has already gone away.

Yet, the promises and memories
drive the shakeable but unbreakable will.
What becomes lost from the sight
does not disappear from the heart.
In the one place, it still resides
the love that I claim, by my side.
Because of "you", my aspirations to be
I will never forget.
So, for others with the time now, still together
find it in your resolve to ask
- ask for their untold stories.
Remember who they once were,
who they currently are,
and who they can be for you. ■

# Camp

Alice Wang
McMaster University, Class of 2018

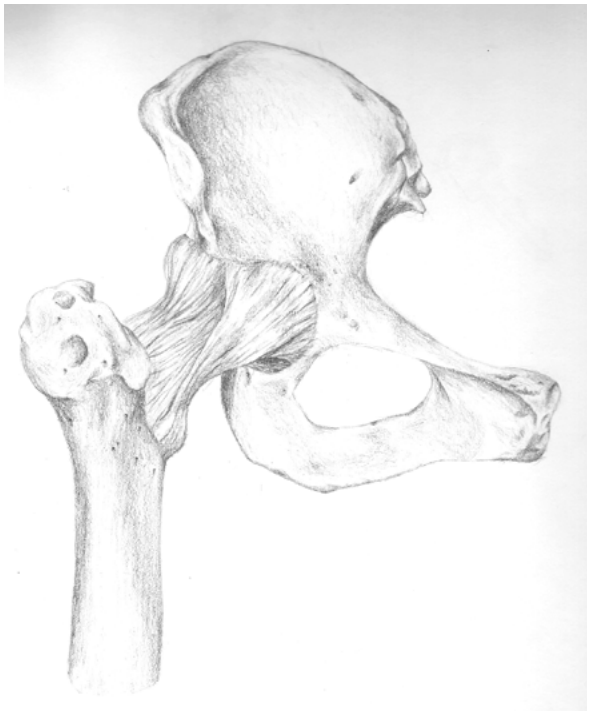


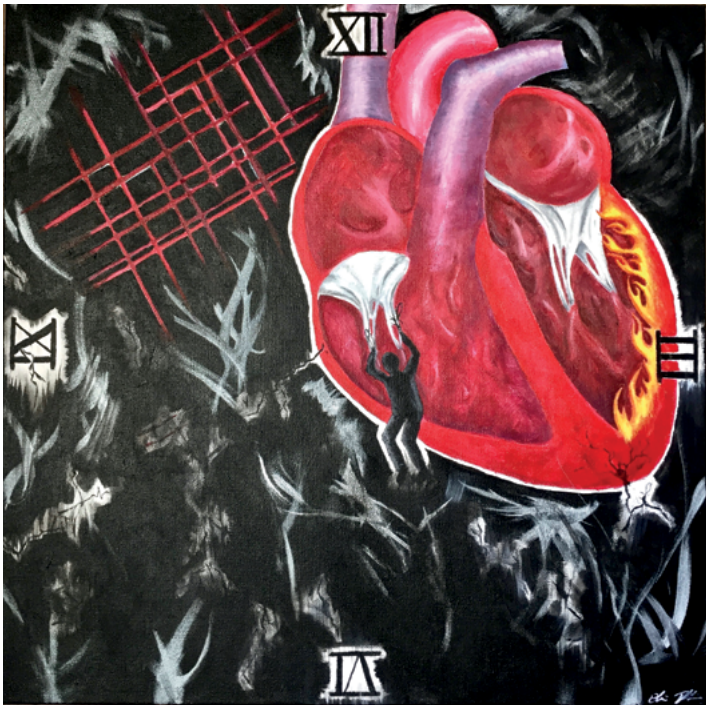
# Heart

Alice Wang
McMaster University, Class of 2018

# Untitled

Beerpal Plaha
McMaster University, Class of 2018





# Heart Strings

Olivia Philippon
University of Saskatchewan, Class of 2019

# Babies

Zoe Penelope Chan
Born December 2, 2017
Parents Darwin Chan and Joanna Chan

Maximilan van Oosten
Born July 14, 2017
Parents Erik van Oosten and Renee Pang

# Weddings

Cait Champion & Graham Clark
July 29, 2017

Avital Sternin & Tavis Apramian
St. Catharines, August 6, 2017

Olivia Philippon
University of Saskatchewan, Class of 2019

Bryce Durafourt & Emily Reynen
Montreal, June 3, 2017

Brandon Maser & Kristen Reipas
Langdon Hall, Cambridge, ON, August 5, 2017

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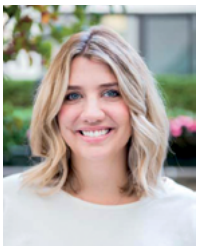

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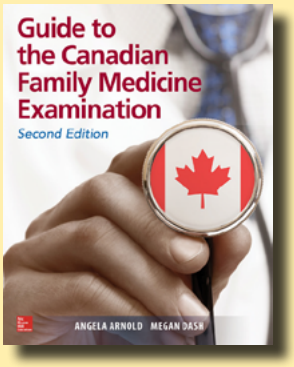


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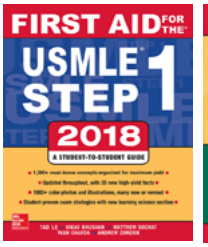


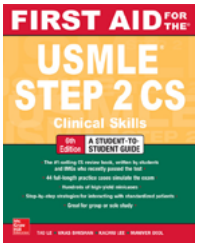


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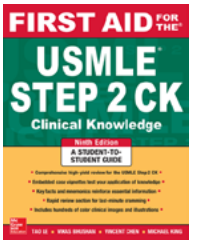


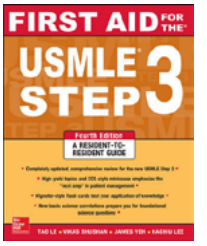


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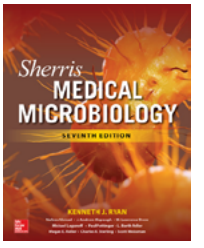


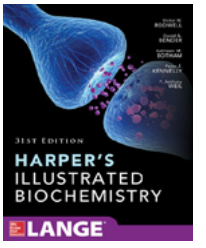


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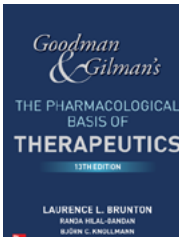


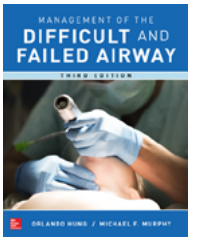


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