

CFMS FEMC

Canadian Federation of Medical Students



Fédération des étudiants et des étudiantes en médecine du Canada



ANNUAL REVIEW 2013

- 8 Communicating with medical students across the country
- 9 CFMS member services and discounts
- 11 Engaging medical students in government advocacy
- 20 The CFMS Global Health Program: a year in review
- 25 Diversity through student engagement
- 29 Conscientious donations
- 36 The conundrum in the Canadian medical system
- 39 Interview with Dr. Marla Shapiro

The rod of Asclepius, the symbol of healing and medicine, is depicted here as a serpent intertwined amongst the branches of a tree. It watches over the wolf as the latter cycles through life, represented by the lush greens above, and death, represented by the murky ground below.

Artist: Joanne Li
IT Officer Senior
McGill University, Class of 2014



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CFMS Letters

- 5 Letter from the editors
- 7 Letter from your CFMS president

CFMS Activities

- 8 Communicating with medical students across the country
- 9 CFMS member services and discounts
- 10 A banner year for the CFMS and medical education!
- 11 Engaging medical students in government advocacy
- 12 Reflections from the executive vice-president
- 13 We know you have it in you!
- 14 CFMS cancer fundraiser
- 15 Quebec update
- 16 Travel fund winners
- 16 Reflections
- 18 FM-CFS Canada essay competition winners

Global Health

- 20 The CFMS Global Health Program: a year in review
- 21 New national guidelines for global health concentrations
- 22 Adventures in reproductive and sexual health
- 24 A look inside the process and politics of public health policy at the international level

Initiatives

- 25 Diversity through student engagement
- 26 Birthing Babies Together
- 27 Kimmett Cup — The Lindsay Leigh Kimmett Memorial Foundation
- 28 On trees and refugees

Experiences

- 29 Conscientious donations
- 30 My first day in surgery
- 31 Living with Lafora Disease: a medical student's experience with the research of rare diseases
- 32 Finding perspective
- 33 Oncology in Teresina, Brazil
- 34 Kwanlin: water running through a narrow place

Opinions

- 35 Refocusing: a reflection on treatment vs. prevention
- 36 The conundrum in the Canadian medical system
- 37 The art in medicine

Featured Interview

- 39 Interview with Dr. Marla Shapiro — clinician, professor, TV host & medical consultant

Alumni Affairs

- 42 What's new with alumni affairs?
- 43 Alumni Q & A: How do you maintain your work-life balance?

Creative Works

- 46 Beautiful Wonder
- 46 An Old Rusty Cart
- 47 Lifeline Express
- 47 Living In Colour
- 47 Serendipitous Self
- 48 Lonely Fisherman
- 48 Road Closed
- 48 Serenity
- 49 Red. Blood Red.
- 49 Thunder
- 50 A transition to clerkship: planting the seeds

Artist Profiles

- 51 Balance
- 52 8 Friends, 12 Instruments and Q Weekly Music: Getting to Know UBC's Honourary MD
- 53 TLGLTP (topless) — The Glitter Brick Road

Photo Album

- 54 Weddings
- 55 Babies

Your CFMS Executive and Representatives

- 57 CFMS Executive 2012–13
- 57 Officers 2012–13
- 58 MEDSOC Presidents 2012–13
- 58 MEDSOC Senior and Junior CFMS Representatives 2012–13

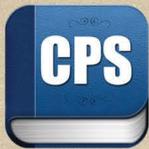


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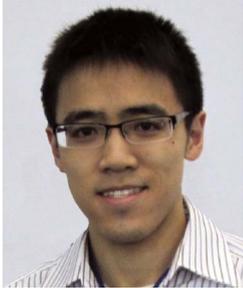
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Letter from the editors



Wilson Kwong
Editor
Queen's University
Class of 2015



Mimi Lerner
VP Communications
University of
British Columbia
Class of 2014

Dear readers

It is with great excitement that we are able to present the 2013 issue of the *CFMS Annual Review*. Over the years, the *Annual Review* has served as an outlet for Canadian medical students to showcase the amazing things they do.

In addition to bringing you updates from the CFMS executive team, all of whom have been involved with exciting projects over the year, we have also compiled an ensemble of excellent pieces submitted by medical students across the country. These pieces include artistic images, thoughtful commentaries and reflections on past experiences in medicine. As always, we have a section featuring great advice from various alumni, as well as photos from recent weddings and births in the medical student community.

New to the 2013 issue is a section titled "Artist Profile" where we highlight three medical students/groups who have continued to maintain a musical career while in school. These artists have taken the time to reflect on their musical experiences and how they've managed to fit music into their busy academic schedules.

Our featured interview this year is with Dr. Marla Shapiro, Canada's doctor, a figure that everyone is sure to recognize from her strong presence on television and in the media. She is truly an inspirational figure in the medical community and our interview with her was extremely insightful.

Every year we are overwhelmed by the number of stimulating and high-quality submissions, but unfortunately, due to space limitations, it is with regret that we are not able to include them all. Our online version of the Annual Review will also contain activity updates from our medical school members so make sure to check these out after enjoying your paper copy!

Thank you very much and we encourage you to continue contributing your experiences to the *CFMS Annual Review*!

The editors

Wilson Kwong

Mimi Lerner

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A letter from your CFMS president



Robin Clouston, BSc
Pharm
CFMS President
20–2013
Memorial University,
Class of 2013

Hello friends and colleagues

The Canadian Federation of Medical Students is your organization. The CFMS represents over 7800 undergraduate medical students at 14 campuses from coast to coast and we are proud to serve and represent you. It has been a great joy to be your president and I now have the honor of launching the *CFMS Annual Review 2013!* This magazine is an illustration of the hard work and dedication of our many student representatives. At the CFMS, it is our mission to offer representation, communications and services to our members.

Representation

We are sincere in our commitment to offer medical students quality representation — and it has been an eventful year! At the Canadian Medical Forum, we provide the medical student viewpoint in the important new project, The Future of the Medical Profession. We continue to represent students on the Association of Faculties of Medicine of Canada (AFMC)'s Visiting Elective Portal Project Steering Committee. On Feb. 4, 2013, we held our CFMS Lobby Day 2013 in Ottawa and enjoyed many successful discussions with Parliamentarians regarding physician resources and career planning. The Global Health Program represents medical students internationally, including the International Federation of Medical Students Associations (IFMSA) March Meeting held in Baltimore, USA.

Communication

We are always seeking to engage with our student members. Our cornerstone is www.cfms.org — the online home of CFMS. This year, we are undertaking a project to increase the amount of French content found on our website. As always, our biweekly member communiqués keep you up to date and our dedicated media team continues to communicate to the public with timely press releases on issues of importance. Those interested in Global Health can join the GH listserv as well as read a new book they've published titled *12 Stories: Narratives from New Canadians*.

Services

We know our members value the services offered by CFMS. We strive to deliver with great discounts including disability insurance, laser eye surgery, hotels, medical apps and much more. In addition, we provide online databases with reviews on electives and residency interviews. Our Student Initiative Grants program provides funding to students with great project ideas. Finally, the Global Health international exchanges continue to be very popular. Go to cfms.org to explore these great services!

This is your organization — *you* are the CFMS. If you have any comments, questions or would like to get involved, I encourage you to contact us online or get in touch via your CFMS Rep. If you're not already an online member, sign up today at cfms.org. I'm passionate about the CFMS and very proud of all that we offer. I hope you enjoy this issue of the *Annual Review!*

In solidarity

Robin Clouston

Communicating with medical students across the country

Mimi Lerner

VP Communications

University of British Columbia, Class of 2014

AT THE CFMS WE WORK hard to connect with the medical students we represent. We want to make sure students are aware of the services and support that the CFMS offers and the amazing opportunities that come up throughout the year, like student positions on national medical committees, scholarships, internships and conferences. Our CFMS representatives at each school are our lifelines and do a wonderful job connecting the CFMS with its student members.

Communiqué

Our communiqué goes out to students every two weeks through our CFMS reps. Students can also sign up to receive the communiqué directly through our website. This newsletter keeps students informed about services and opportunities offered by the CFMS and other organizations throughout the year.

Website

Last year the website grew substantially and this year we've been utilizing our new platform. Students can use the website to read up on the latest CFMS news and opportunities, stay up-to-date on media releases and position papers, as

well as take advantage of great discounts and services. This year, we encouraged students to register on the website to be eligible for prize draws of a Nexus 7 tablet and other fun swag! We've also focused our attention on creating a bilingual website. Students from across the country make up our Bilingualism Task Force and are working hard to provide important content in both French and English. This is an ongoing work-in-progress.

Social media

Facebook and Twitter have been a great way to connect not only with students, but also with journalists, physicians and health care groups across Canada. Our Social Media Committee works to engage students with current medical issues and news, student written articles and interesting opportunities to get involved with the CFMS and other medical bodies. Make sure to like us on Facebook (Canadian Federation of Medical Students) and follow us on Twitter (@CFMSFEMC).

Media relations

Our wonderful CFMS executive is always ready for interviews when media

interested in the medical student perspective comes knocking. We also create and distribute press releases when an important topic surfaces that warrants coordinated medical student input. This year we supported the Canadian Association of Internes and Residents (CAIR) when their representation on medical committees was jeopardized, we publicized an amazing book about refugee health in Canada titled *12 Stories*, put together by our VP Global Health and a University of Calgary student, and we teamed up with CAIR and the Canadian Medical Association (CMA) on a release focused on health human resources.

Lobby Day

National Lobby Day brings together students from across the country to collaborate on important medical education issues. This yearly event attracts a significant amount of media attention and we were eager to share our messages through print and radio outlets. Read about medical student efforts to lobby for better health human resources planning in *The Hill Times* or listen to VP Advocacy Tom McLaughlin's interview on CBC's *The Current!* ■

CFMS member services and discounts

Michael Cecchini

VP Services

Northern Ontario School of Medicine, Class of 2014

THE CFMS OFFERS YOU A variety of discounts and services! As VP Services, my main focus is to make sure that you have access to products and resources that will help you along your journey of becoming a physician.

Disability insurance

It's never too early to start thinking about how you can protect yourself with disability insurance. The CFMS via Kirkham & Jack, offers the most competitive plan that is specifically built for medical students. It is comprehensive, NO medical exam is required and it is guaranteed. Purchase now as a medical student and save 25%. This coverage will follow you for the rest of your career! Visit cfms.org for details.

Paying for your education

RBC Royal Bank® is a proud sponsor of the CFMS. As a medical student, finding the resources to pay for tuition and living costs requires careful planning. That's why we have developed customized banking solutions for Canadian medical students. Get up to \$250,000¹ in funding with the Royal Credit Line® for Students — Medical/Dental Studies. Learn more about our tailored solutions for medical students at rbc.com/cfms.

CFMS accommodations database

We are excited to promote this homegrown service, which allows you to search for temporary housing during electives, CaRMS interviews or to offer

your vacant living space to others and make some extra cash! Students from all years can use this service, including pre-clerkship students with extra space to rent out. This is the Craigslist equivalent for medical students.

Update on travel discounts

Efforts to re-establish our partnership with WestJet have not been successful. Financial stresses felt by airlines coupled with a change in discount policies are key factors in the cancellation of the CFMS discount. Discounts on travel are still available through the Canadian Medical Association as well as some provincial medical associations. Stay tuned for more information.

Student wellness

Medical training and clinical practice are both demanding and exhausting, so it's important to do things that will improve your own mental and physical health. The CFMS Wellness Committee has representation at each member school and they offer a variety of activities and resources for you. Ask your student society president to connect you with your rep!

Sweet website prizes!

Want to win a Nexus 7 32GB tablet? Easy as pie! Simply ask your school's CFMS rep or email vpsservices@cfms.org to retrieve the sign up code. Our website — cfms.org, is an essential tool that allows us to share breaking news, services, product discounts, upcoming events and

more. In order to stay in the loop and have access to these perks, you must be registered to the website. Prizes to be won throughout the year. ■

SOME HOT DISCOUNTS

- McGraw-Hill — 25% off + FREE shipping
- PEPID Clinical Companion — up to 50% off
- CFMS Disability Insurance — 25% off
- Lasik MD — up to 50% off
- Choice Hotels — 20% off
- Skyscape PDA Software — 25% off

... and more!

Take advantage of these discounts and services by signing up to our website

1. Obtain the registration code from your school's CFMS representative
2. Visit cfms.org and use the code to register
3. Visit the *Resources and Benefits* tabs for discounts and services

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A banner year for the CFMS and medical education!

Ian Brasg
VP Education
University of Toronto, Class of 2014

THIS YEAR, I HAVE HAD THE pleasure of managing the education portfolio for the CFMS. My work to date has touched on all three of the central pillars of the CFMS: representation, communication and service.

Representation

As the CFMS education representative, I sit on a number of committees and organizational boards that allow me to represent and advocate for student interests. These roles include sitting on the Canadian Medical Association Committee on Education and Professional Development, the Royal College of Physicians and Surgeons of Canada's Education Committee and the Board of the Canadian Resident Matching Service. In conjunction with the CFMS president, Robin Clouston, we also have a seat on the steering committee for the development of the national electives portal. As you may know, the national electives portal will be a streamlined and centralized electronic way for our students to apply for elective rotations at all Canadian medical faculties. The close involvement of our organization in the development of this portal will allow us to ensure that it remains service-oriented and places student needs as a top priority.

We have also extended representation at educational organizations to the general student body by appointing selected students as external representatives to the AFMC Electives Interest Group and

AFMC Distributed Medical Education Resource Group. These students have joined the four other representatives holding positions under the education portfolio.

Guide to social media professionalism

As described in last year's Ontario representative portfolio update, the CFMS has begun the production of a *Guide to Social Media Professionalism* to complement the more general CanMEDS-based professionalism guide that was produced by our organization. This is a great tool for students as faculty professionalism leads have acknowledged that students are the best experts on social media etiquette and boundaries. More importantly, the faculty leads have indicated a strong willingness to consider our recommendations.

The guide is divided into two sections. The first attempts to synthesize clear guidelines for medical students regarding professionalism boundaries online. The second highlights best practices to ensure students who wish to present themselves online do so in the best possible light. All sections are being produced with the guidance of professional standards published by the Office of the Privacy Commissioner of Canada. The CFMS Social Media Committee and VP Communications are also involved in the production of the guidelines document. We anticipate that it

should be ready for student review at the CFMS Spring General Meeting in Quebec City. If you are interested in contributing to the guide please get in touch!

Medical student leadership survey

As you may recall, we have decided to survey the national student body on leadership attitudes and aptitudes. The first stage of the study — a pilot survey of CFMS student leaders, was completed last spring. The second stage — the national survey, is currently being finalized. The pilot study produced some interesting findings. Established leaders appear to endorse extracurricular activities rather than the formal academic curriculum as being most supportive of their growth as leaders. Respondents were also asked about barriers to leadership development and the top emerging themes were time constraints, the academic workload, lack of administrative support, perceptions of inadequacy and lack of professional recognition. Finally, established leaders endorsed character, self-management and communication skills as major strengths, while admitting that health-systems knowledge, quality improvement skills, socio-political navigation and resource management as major weaknesses. These results were presented to faculty at the Canadian Conference on Medical Education, Apr. 20–23, 2013. ■

Engaging medical students in government advocacy

Tom McLaughlin

VP Advocacy

University of Toronto, Class of 2013

ON MONDAY, FEB. 4, MORE than 70 medical students from across Canada assembled in Ottawa to meet with more than 65 MP's, Senators and other parliamentarians as part of the CFMS's annual Lobby Day. This year also marked the first time the CFMS was joined by delegates from the Fédération médicale étudiante du Québec (FMEQ), our sister organization representing Quebec's francophone medical schools, making this year's Lobby Day the first to represent every Canadian medical student.

On Lobby Day itself, students met with an MP or Senator as a group of two or three to discuss proposals — "The Ask" — to improve the health care system for Canadians. In order to be brought up to speed on the details of The Ask, delegates arrived the day before Lobby Day for a full day of training. The training day started out with some inspirational guest speakers, such as Dr. Joshua Tepper (a former CFMS president and assistant deputy minister of health in Ontario), Donald Boudria (a former MP and cabinet minister), and Irving Gold (government relationship VP at the Association of Faculties of Medicine of Canada). Delegates then received an in-depth briefing on the details of The Ask, and an opportunity to practice meeting with MP's as part of an advocacy training session developed by the Canadian Medical Association.

This year's Ask focused on health human resources (HHR) — essentially, how to ensure that the right doctors are in the right places to serve the needs of Canadian patients. It consisted of two specific proposals. First, we proposed

that the federal government defer repayment of Canada Student Loans until the end of residency. In addition to generally lowering the debt burden for Canadian graduates, this would optimize an existing federal incentive program that provides loan forgiveness for family doctors practicing in rural areas. The second proposal involved asking the federal government to use widely available statistics to project what the future physician needs will be. Such projections would be useful to provinces and medical schools interested in matching residency position spots to the health care needs of Canadians as well as assisting graduating medical students in knowing what their potential job prospects are in each specialty.

Both of these Asks received a positive reaction from MPs and they've agreed to forward a letter supporting our Ask to the ministers of health and of human resources. The media response to our Ask

was positive as well, with interviews being published in *The Hill Times* and *The Lobby Monitor*, and broadcast in English on CBC's *The Current* and in French on Radio-Canada.

Even though Lobby Day is an incredible day, gathering energetic and passionate medical students in Ottawa to advocate for an improved health care system, it is only one day. Truly affecting the political process will require much more ongoing effort. To this end, Political Advocacy Committee chairs are setting up local follow-up meetings with their MP's to foster longer-term relationships. We have also been in regular contact with several MP's who have been our strongest supporters so that we can continue to engage on Parliament Hill. Medical students bring such a unique perspective to advocacy that is so valuable in driving positive change for Canadian patients — let's not waste it! ■

CFMS Political Advocacy Committee

Chair	Tom McLaughlin (CFMS Vice-President Advocacy)
Memorial University	Carolyn Arbanas
Dalhousie University	Haley Augustine, Nada Ismael, Tara Jennings, Alison McIntyre
McGill University	Lynne Li
University of Ottawa	Jemy Joseph, Sana Rashid, Vidhi Thakkar
Queen's University	William Reginold
University of Toronto	Melanie Bechard
McMaster University	Stephanie Kwolek
University of Western Ontario	Matthew Lubanovic
Northern Ontario School of Medicine	Nicholas Fortino
University of Manitoba	Christopher Proctor
University of Saskatchewan	David Plemel
University of Alberta	Mila Luchak
University of Calgary	Michael Martyna, Yan Yu
University of British Columbia	May Kazem

Reflections from the executive vice-president

Jesse Kancir

Executive VP and Ontario Regional Representative
University of Toronto, Class of 2014

IN ADDITION TO MY ROLE AS Ontario Representative, I've had the privilege this year to take on the role of CFMS executive vice-president. In this role, I have focused my efforts on overseeing and improving the selection process of our representatives to external organizations. As I reflect back, I am reminded of my exchanges with Canadian medical students as we conversed about the richness of our collective experiences.

At its most obvious level, we're privileged to be able to engage with patients and hear people relate their struggles with the illness experience. This puts us in a position of trust that has often been described as a form of sacredness, but I want to suggest too, that the richness of our experiences reaches much wider than our clinical encounters. We represent a collection of cultural, educational, socio-economic and personal experiences. And it is with these nuances that as a body of medical students, we represent the Canadian identity.

While I see that as an important end in itself, I fundamentally believe it to be much more. Let me explain by drawing on a small piece of work, *Exit, Voice, and Loyalty* by Hirschman. Though short, the work has had one of the longest lasting impacts on me as I transitioned into medical school. Its thesis is that as people interact with systems in which they encounter dissatisfaction, they choose between two different reactions for bringing about change: exit or voice. A simple way to understand this is to use the example of a grocery store and how you might react if a supplier changes some

aspect of their product: do you 'exit' and switch to a different brand or do you instead write a letter to 'voice' your request for change?

The grocery store example is quite simplistic and you're probably wondering how this all connects. Relating it back to medical students — How do you as an individual engage in a system that has significant challenges, many of which are highlighted consistently in your national newspapers? How do you grapple with deficiencies in processes that you see as a clerk? Or gaps in education that you feel when your expectations of medical school fall short during your pre-clerkship years? Using Hirschman's concepts, exit holds very little promise here. Leaving our education and health care systems is unrealistic and misses the opportunity for 'voice' that can be so efficiently used by medical students.

The medical student voice: its tones are identifiably passionate, threaded with the narratives of our patients and informed by extensive education. We at the CFMS have it as one of our pillars embodied in the concept of representation. We pursue it at the national level as we lobby federal government to consider better health human resource planning. We also meet frequently with medical organizations to discuss problems and policy solutions to the breadth of issues facing Canada.

Polemical as it might sound, this article ultimately has as its goal to encourage you the reader, to inform yourself and then take pride in the work done by medical students in this country. I hope

“The richness of our experiences reaches much wider than our clinical encounters.”

that as you read our *Annual Review* you feel proud of the young Canadians who feel moved to sacrifice a few hours of leisure or study time to come voice their passion for topics such as biomedical ethics, health economics, distance medical education and global health advocacy. If you're a member, I would encourage you to request reports on the different meetings that we attend on your behalf and to consider applying to serve in some capacity. If you're interested in voicing an important challenge to medical students, then consider approaching your medical society to back a motion at our Annual General Meeting or Spring General Meeting in support of a stance or project. You can also contact me at jesse.kancir@mail.utoronto.ca to voice your issues or questions.

Overall, it has been my privilege this year to see the heartfelt work that many of you do, to learn from it and to ground myself in the belief that our energy and ability to translate this into meaningful action bodes well for our eventual stewardship of Canada's health care system. ■

We know you have it in you!

Maegan Springman
CFMS Blood Drive Officer
University of Manitoba, Class of 2015

THIS YEAR HAS BEEN AN amazing one for blood donations from Canadian medical schools. Together, we have saved up to 2931¹ lives! As the blood drive coordinator I am absolutely thrilled with medical student participation. As future doctors, we should make blood donation a part of our bi-monthly routine and encourage our patients to do the same. After all, you can have the most skilled surgeon, the brightest physicians, top-notch facilities and the best treatment plans, but without blood products, none of that matters.

CFMS and Canadian Blood Services (CBS) have been partners for years. We have assembled an amazing team of medical students — national champions — who are working tirelessly at their respective schools to get as many peers involved as possible. I would like to applaud and humbly thank each and every champion for their hard work.

If you would like to get involved, have any questions or want to find out when your next donation campaign is, please contact your school's champions listed in Table 1.

Please donate! To see if you are eligible, call the free hotline (1-888-2-DONATE) 24/7 and speak confidentially to a registered nurse or visit www.blood.ca. The need for blood is never-ending, so please book an appointment today! ■

1. The number of lives saved was calculated by multiplying the number of donations at each school by 3 as each donation saves up to 3 lives. Each donation is separated into platelets, plasma, and red blood cells to treat individual patients.

Table 1: Donations, potential lives saved and the champions for each school

School	Champions	Donations	Potential lives saved
University of Alberta	Chris Novak – co-Junior Champion Pearl Tan – co-Junior Champion Karina Arnesen – co-Senior Champion Kristen Hemrick – co-Senior Champion	147	441
University of British Columbia	Divjot Kumar – co-Junior Champion Lu Qiao – co-Junior Champion Selina Li – co-Senior Champion Edward Choi – co-Senior Champion	5	15
University of British Columbia – Island Medical Program	Michelle Lamarche – co-Junior Champion Bethany Hildebrand – co-Junior Champion Kalun Boudreau – Senior Champion	2	6
University of Calgary	Andrea Mosher – Junior Champion Elizabeth Digby – Senior Champion	91	273
Dalhousie Medicine New Brunswick	Fraser MacKay – Junior Champion Michael Bone – Senior Champion	56	168
Dalhousie University	Shannon Murphy Jillian Smith Erin Westby	46	138
University of Manitoba	Rebekah Rittberg – Junior Champion Maegan Springman – Senior Champion	44	132
McMaster University	Mallory Fox – Senior Champion	19	57
Memorial University	Tiffany Aylward – Junior Champion Jamila Belhadjsalah – Senior Champion	22	66
University of Northern British Columbia	Trina Fyfe	18	54
Northern Ontario School of Medicine	Stephanie Sackaney – Senior Champion	18	54
University of Ottawa	Omar Abdel-Razek Apoorva Bollu Vince Dinculescu Patrick Lavoie	47	141
Queen's University	Cody Li – Junior Champion Peng You – co-Senior Champion Shelly Xu – co-Senior Champion	99	297
University of Saskatchewan	Lena Xiao – Junior Champion Lindsay Anderson – Senior Champion	49	147
University of Toronto	Katie Bies – co-Senior Champion Humara Edell – co-Senior Champion	222	666
University of Western Ontario	Adrienne Elbert – Senior Champion	92	276
Potential total lives saved thanks to Canadian medical students			2931

CFMS cancer fundraiser

Peter Bettle

Atlantic Regional Representative
Dalhousie University, Class of 2015

CANCER IS A DISEASE THAT affects people all across Canada. According to the Canadian Cancer Society, an estimated 186,400 new cases of cancer and 75,700 deaths from cancer will occur in Canada in 2012. However, Canadians pride themselves on being strong, hardworking people who do not give up and the fight against cancer is no exception to this.

People across our country come together every year to raise money and awareness in the battle to end cancer and so do Canadian medical students. The CFMS coordinates an annual nationwide cancer fundraiser across its 14 member schools. Each school organizes or participates in a fundraiser of their choice, with all the proceeds going to cancer charities. The CFMS member schools have risen to the challenge and have not only met the goal of the initiative, but have far exceeded expectations. When we looked at what each school was doing we were pleased to discover that many schools not only participate in our CFMS mandated cancer fundraiser, but also do several other fundraisers as well. Memorial, Ottawa and Manitoba each have two fundraisers that they participate

in, while Dalhousie University participates in three fundraisers. The University of British Columbia has the most, with six fundraisers across the school's four sites. Examples of the various cancer fundraisers include The Relay for Life, The Run for the Cure, Movember, Shave for the Cure, bake sales, music nights, coffee houses and more! This just goes to show how passionate and hardworking medical students are about contributing to cancer awareness and research.

In the past, we have asked the schools to give a summary of their CFMS fundraiser so that the results of the student's hard work could be recognized. However, we have realized that schools are participating in much more than just the CFMS fundraiser and that this work also deserves to be recognised. To that end, we are hoping to put together a more complete cancer fundraiser summary in the coming years to fully recognise the wonderful projects and initiatives that our member schools are undertaking. We are very proud of all the efforts put forth by our members and would like to say congratulations to everyone involved with the cancer fundraisers and we encourage you to keep up the excellent work! ■

“CFMS member schools have not only risen to the challenge, but have far exceeded expectations.”

Quebec update

Bryce Durafourt
 Québec Regional Representative,
 McGill University, Class of 2015

IT HAS BEEN A BUSY, BUT EXCITING year working on the Québec portfolio. One of my key priorities for the year was to strengthen our relationship with the Fédération médicale étudiante du Québec (FMEQ) and to collaborate wherever possible. A number of executives from the FMEQ, including FMEQ president Valérie Martel, attended our CFMS 2012 Annual Meeting in Winnipeg as observers and this allowed us to get off to a great start. Following my election, I was invited to attend FMEQ general meetings as an observer. At the general meeting in Sherbrooke I had a chance to meet the entire FMEQ executive and present my duties and projects as the CFMS Quebec regional representative. I am looking forward to upcoming FMEQ meetings in Montréal and Québec City, where updates and discussions will take place, fostering further collaboration that will greatly benefit both organizations.

A second priority for my portfolio was to make joining the CFMS as an individual member more accessible. Currently, 14 of Canada's 17 medical schools are institutional members of the CFMS, meaning that all students at those schools are automatically members of the CFMS. The 3 remaining schools, Université de Montréal (U of M), Université Laval and Université de Sherbrooke, are members of the FMEQ. The fourth medical school in Quebec, McGill University, is an

institutional member of both the CFMS and FMEQ. Currently, medical students from U of M, Laval and Sherbrooke can join the CFMS as individual members, but to do so they must write a letter and mail a cheque to pay their membership dues. We are working to make this process easier by offering an online membership application and payment form.

As we strive toward offering this easy membership application process, we want to ensure that our information and services are offered in both official languages. To this end, we have established the CFMS Bilingualism Task Force, comprised of bilingual medical student volunteers from across the country to assist with the translation of key areas of the website. This project is a major undertaking as there is a significant amount of content on the CFMS website which must be translated into French. The goal of this project is to offer our services in both English and French to both attract individual membership from U of M, Laval and Sherbrooke, and to offer quality services to all of our student members across Canada. I believe that by having the ability to be members of both the CFMS and the FMEQ, Quebec medical students will be best represented by both organizations and that our two organizations will continue to work closely together in the years to come. ■

“Fostering collaboration that will greatly benefit both the CFMS and FMEQ.”

Travel fund winners

THE FOLLOWING STUDENTS received Travel Fund awards in 2012 to enable them able to attend either the Annual or Spring General Meeting. Their personal reflections follow.

AGM 2012

Michael Yang	University of British Columbia (reflection online)
Rujung Zhang	University of Ottawa
Bryce Durafourt	McGill University

Jessica Jackson	University of Western
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Jocelyn Stairs	Dalhousie University (reflection online)
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SGM 2012

Michael Cecchini	Northern Ontario School of Medicine
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Howard Meng	University of Toronto (reflection online)
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Aisha Ghare	Queen's University (reflection online)
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Colin Ellis	University of Saskatchewan
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Ben Taylor	Memorial University
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Reflections

Aisha Gha

CFMS SGM, April 2012

Queen's University, Class of 2015

Being back in class at Queen's, it's hard to believe I was in beautiful Banff just days ago. Throughout the weekend, I kept finding myself very grateful to the travel grant that allowed me to experience CFMS' Spring General Meeting.

Even before the conference officially started on Friday morning, I had met so many of the executives and officers, and everyone was so friendly that I truly felt welcome. Initially I was worried that I would only be allowed to quietly observe, but everyone encouraged me to actively participate and so, throughout the conference, I found myself most engaged when I got to contribute to the discussions.

I think one of the most insightful aspects of the conference was the pan-national updates. We are so often in a "medical school bubble" in our respective schools and provinces, we are rarely aware of the issues and successes of medical schools across the country. Becoming cognizant of the issues at each

school has led me to be more active in now seeking out news and information on my own and persuading my classmates to do the same. Furthermore, I found the "small working group" session to be one of the best parts of the conference because we actually got to discuss the relevant issues such as those concerning the CFMS' mandates (such as services), job market, CaRMS and Lobby Day. If I had any recommendations for next year's meetings, it would be to include more small group sessions that enable active contribution from executives, officers and non-executive members alike.

I also sat in on the Global Health meetings and found those to be very educational, particularly with regards to the Global Health curriculum at Queen's compares with that of other schools and how ours can be improved. Furthermore, because there are fewer students in the Global Health committee, I found they had more discussions and planning than the GM. Taking full advantage of being at SGM, I also volunteered for the Resolution Committee.

"I think one of the most insightful aspects of the conference was the pan-national updates. We are so often in a 'medical school bubble' ... we are rarely aware of the issues and successes of medical schools across the country."

My past involvement in Model UN was a bonus as I helped edit and rephrase clauses. Seeing the voting process the next day on those resolutions was quite fun. I was also quite surprised to see

how much influence the CFMS has on undergraduate medical education, such as ensuring Pre-departure training is a part of the accreditation of a school, working to regulate clerkship hours and giving input on Distributed Medical Education.

Both my inherent interest in political advocacy and the wonderful experience from this weekend have helped me realize that I very much want to be involved with the CFMS next year. I could not be more grateful for the experience, which has not only permitted me to see the hard work of proactive students in shaping our medical education, but has introduced me to new friends and future colleagues.

Howard Meng

CFMS SGM, April 2012

University of Toronto, Class of 2014

I had the opportunity to attend the CFMS SGM in Banff, Alberta from April 12 to April 14, which would not have been possible without the generous support of the travel funding I received from the CFMS. While at the conference, I gained a wealth of exposure to the workings of the CFMS — its function and mandate, and the various positions, the networking opportunities, and potential for future collaborations.

As I wrote in my original statement, I have a strong interest in being an active member of the CFMS and this conference really reaffirmed my desire to work with and be active among a group of outstanding medical student leaders. Everyone I spoke with from the CFMS was passionate about the work they do at their respective schools, as well as the work they do at the national level. Moreover, being in an environment with like-minded individuals made the conference exciting and worthwhile.

As U of T is undergoing accreditation this year, and I as student accreditation leader, this conference was an excellent place for me to get a glimpse of the work that has taken place across the country. The discussion topics for the breakout

sessions were very fruitful as I had the chance to learn about the IMG/CSA problem that was occurring in B.C. and the residency training position imbalances. The debates that occurred during resolution period were very lively and I was impressed by the variety of contributions from each delegation.

All in all, I truly enjoyed the CFMS SGM. Not only was the site strikingly gorgeous, but the people at the conference were so easy and fun to talk to. This definitely ranks among the top of my medical school experiences and I will definitely maintain a connection with the CFMS in the future.

Michael Yang

CFMS AGM, September 2012

Queen's University, Class of 2016

The Winnipeg AGM was my fourth CFMS meeting, but hopefully not my last. Attending these CFMS meetings has been one of the highlights of my medical school career. I have developed professionally, met life-long friends and I hope contributed positively to medical students nationally as well as locally in British Columbia. During this time, I created and administered a national career's survey to get an understanding of the various careers resources offered at each school. The results from this survey were used to convince the University of BC's Administration to run a 2-day Career Conference where Program Directors, Faculty and residents showcased their specialty. I was also involved in composing two resolutions related to International Medical Graduate of Canadian Origin access to an open CaRMs match, which was passed at the Banff SGM. These resolutions provide the basis for CFMS to create a working group to take this ever relevant issue.

During the President's Round Table discussion, I actively contributed to the discussions regarding the Sponsorship Policy the University of Toronto was trying to impose on their medical society.

Because of my positive experience

“Attending these CFMS meetings has been one of the highlights of my medical school career. I have developed professionally, met life-long friends and I hope contributed positively to medical students nationally as well as locally ...”

and my passion for the issues CFMS deals with on behalf of medical students, I decided to run for a position on the Executive. Although I did not win, I feel the candidates who won are very qualified and I am happy to see that the CFMS has such strong student advocates on their team. I plan to keep my eye out for other opportunities in which I can contribute to this organization and I hope to keep coming back to these meetings if possible.

I want to say thanks for the Travel Bursary Committee for funding my trip and I look forward to working with you in the future.

Jocelyn Stairs

CFMS AGM, September 2012

Dalhousie University, Class of 2015

I'd like to begin by thanking the CFMS again for their generous support. It was both an honour to be chosen to receive funding for the conference and incredibly useful to be able to attend. It is always both amazing and inspiring to

see the dedication of and projects undertaken by medical students across the country. The meeting ended up being useful on a personal level and will hopefully be useful to both the Global Health Initiative and the Medical Equipment Recovery Initiative underway at Dal.

On a personal level, I really appreciated the opportunity to be exposed to the climate nationally on issues such as International Medical Graduates and match rates. It is also interesting to discuss the challenges being faced and the curriculum with other students. Finally, it was exciting to have the opportunity to be involved with the election of individuals that will shape the CFMS in the year to come.

With respect to the Global Health Portfolio, where I spent most of my time, several interesting ideas emerged. First, we had the opportunity to speak about per-departure training prior to international electives, which I will bring back to the Global Health Office at Dal for comment, as I think that this is an area with large room for improvement at Dal. Second, the global health speaker, a First

Nations internal medicine specialist from the University of Manitoba, was one of the best speakers I have ever heard with regards to social determinants of health, the role of non-Aboriginal physicians in advocating for Aboriginal peoples, the political climate in Canada with regards to the health of Aboriginal peoples, and the importance of making the links between local and international under the umbrella of global health. Third, though discussions about anti-oppression training and the need for education behind the CFMS' new initiative to add Positive Space symbols to clipboards, an "offensive language" awareness campaign was launched to include more anti-oppression training in the medical curriculum to ensure that medical students are truly capable of creating the positive spaces that they promise.

During the global health meetings, I also had the opportunity to make a presentation on Dalhousie's Medical Equipment Recovery Initiative. The opportunity to hear from the other schools that have similar initiatives and to get both contact information and hear

“... I really appreciated the opportunity to be exposed to the climate nationally on issues such as International Medical Graduates and match rates.”

about ways they have overcome ethical and logistical issues was very useful. I will be meeting with other members of the Medical Equipment Recovery Initiative to determine how these new ideas might fit within the Dalhousie framework.

In all, this was an incredibly useful and inspiring meeting. I continue to be impressed with the CFMS as an organization and am grateful that they provide the opportunity for non-executive members to attend.

FM–CFS Canada essay competition winners

IN THE SPRING OF 2011 MEMBERS of the Board of Directors of Fibromyalgia-Chronic Fatigue Syndrome (FM–CFS) Canada worked with Rosemary Conliffe, general manager of the CFMS to design and offer a competition to medical students in Canadian teaching hospitals to write about Fibromyalgia. In 2012, FM–CFS Canada decided to run another essay competition, this time focusing on the illnesses known as Myalgic Encephalomyelitis and Chronic Fatigue Syndrome. The award winners for this competition are as follows:

Female medical students			
First prize	Natalja Tchajkova	University of British Columbia	\$1000.00
Second prize	Paula Tchen	University of Ottawa	\$500.00
Male medical students			
First prize	Robert Lavers	Dalhousie University	\$1000.00
Second prize	Thach Lam	University of Western Ontario	\$500.00
Seven other entrants will receive an award of \$100			
	Aaron Lau	McMaster University	
	Mohammad AlNajjar	University of Calgary	
	Zachery Hynes	Memorial University	
	Paul Szelemej	University of Manitoba	
	Sophie Flor-Henry	University of Calgary	
	Aliya Nurmohamed	Queen's University	
	Soraya Mehdizadeh	University of Ottawa	

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The CFMS Global Health Program: a year in review

Kimberly Williams

VP Global Health

University of Calgary, Class of 2014

EACH YEAR THE GLOBAL health program run by the CFMS attempts to expand the services, representation and communication that it can provide to members. We are constantly looking at ways to get more medical students involved in global health activities and I believe in the past year we have done just that!

Increasing our communication

We have continued to use the CFMS website as a way of communicating transparently to our membership. A blog post on homophobia brought insight into the negative impact that homophobia can have on the health of some Canadians. A post on federal policy that created Designated Countries of Origin (DCOs) and how this policy will affect those seeking asylum in Canada, especially the Roma, explained some of the potential health impacts of the change.

Global Health Services — a focus on advocacy

We have tried to improve services that the global health program provides to medical students by adjusting some of our programs, starting with Global Health Advocacy (GHA). Being a health advocate is not only one of the canMEDs roles that we are required to fulfill, but it is also an area of medicine that recently has become more prominent. Health care expenditures make up a large portion of any government budget, whether provincial or federal, and with the current economy finding many

governments running a deficit, this is always a topic for discussion.

As part of the GHA program, representatives participated in a training session to learn how to conduct a lobby meeting, how to speak to the media, identify some of the key issues surrounding refugee health in Canada, and learn skills that will enable them to facilitate peer-training sessions back at their respective schools. We have also been working at building closer ties with the medical students from the CFMS Political Advocacy Committee (PAC). This February, we had representatives from the global health program participate in the CFMS Lobby Day with PAC members and other medical students.

We have also tried to create tools to help medical students become better advocates. One such initiative was the book *12 Stories. Narratives from New Canadians*. Written by students, the book is a compilation of stories from immigrant and refugees about their experiences in the Canadian health care system. Lynn Peterson (University of Calgary) and I compiled these stories and came up with recommendations for improved care based on their major themes. Medical students are using the book when meeting with key policy makers, health officials and politicians to lobby for health improvements.

Increased international representation

CFMS is a member of the International Federation of Medical

Students' Associations (IFMSA). We attend bi-annual meetings and bring CFMS members to participate in these discussions, present projects and meet medical students from over 100 countries around the world. In the past year, we have had an increasing number of participants in IFMSA activities. William Stokes (Memorial University) was a member of the IFMSA delegation at the International AIDS Conference in Washington, DC — check out his blog post on the CFMS website! Neil de Laplante travelled to Brazil as a member of the IFMSA delegation to the Rio+20 United Nations conference on sustainable development — check out the article he co-authored called *Health at the Rio+20 Negotiations* in the Lancet. At the IFMSA meeting in India, Sabrina Nurmohamed promoted Toronto Notes and received international praise, and Leena Desai shared her microfinance project and is now partnering with medical students from other countries to move the project further.

As you will see from the following pieces written by medical students — we are actively engaging in the debate over human rights issues, we continue to build our global health education presence, we are working toward engaging more medical students in aboriginal health and global health activities continue to flourish at individual medical schools. ■

New national guidelines for global health concentrations

Mary Halpine, National Officer of Global Health Education, Dalhousie University, Class of 2014

Irfan Nizarali Kherani, National Officer of Global Health Education, University of Alberta, Class of 2015

GLOBAL HEALTH IS RAPIDLY becoming a hot topic among medical students with great strides being taken in curriculum integration, improved standards and the inclusion of pre-departure training in LCME accreditation guidelines effective the 2013–14 academic year. Students have been major drivers in many of these initiatives and continue to work with faculty to offer more comprehensive programs at their schools. Following the creation of the first global health concentration elective at the University of Saskatchewan in 2005, numerous medical schools across Canada have begun to expand their extracurricular global health offerings.

Making The Links program at the University of Saskatchewan has the stated goal of equipping students with the knowledge and the will to spend their careers working with marginalized

populations both locally and globally. The program is structured over two years and includes both course work and practical experience in underserved rural, urban and international settings. Several other concentration programs are now offered across Canada; however, they are variable in nature and focus.

To provide a framework for schools wishing to develop their own programs or enhance existing ones, the Canadian Federation of Medical Students Global Health Program set out to assess the concentrations across the country and develop a set of guidelines on which future programs could be structured. Through consultation with student and faculty leaders across Canada, a set of consensus guidelines was initially drafted, outlining the theoretical pillars of such elective global health tracks. Drawing on these guidelines, formal

surveying of faculty members at each of the 17 Canadian medical schools was carried out this past summer to examine the components of each existing program, identify common themes and compare them to the drafted guidelines.

Preliminary survey results indicate that certain components are consistent among programs, including didactic teaching on core global health themes, service learning and clinical electives in low-resource settings. The guidelines are currently being finalized and will be released at the 2013 CFMS Spring General Meeting in Quebec City. It is hoped that they will encourage universities to provide enhanced global health education opportunities and ensure medical students acquire the adequate knowledge and skills to advance the health of marginalized communities both locally and internationally. ■

MAJOR CRITERIA	
Global health coursework	Covering the core competencies recommended by GHEC
Local community engagement	Community partnership in service learning model for 1 year
Low-resource setting elective	Immersion for 4–6 weeks
Pre-departure training & post-return debriefing	Training as described in AFMC and CFMS guidelines
Student evaluation	May include portfolio or written reports
MINOR CRITERIA	
Extracurricular global health	Including lecture series, journal clubs, etc.
Language training	In preparation for electives
Global health mentorship	Mentors provide career guidance
Knowledge translation project	Synthesize learning to larger scale project

Adventures in reproductive and sexual health

Joshua Dias

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

THIS YEAR, I WAS EXCITED TO renew my position as national officer of reproductive and sexual health (NORSH), giving me the opportunity to finish ongoing projects and better solidify the role within the CFMS. While I am passionate about the position, balancing it with third-year clerkship hasn't been easy, so when winter holidays rolled around, I looked forward to taking a break from both med school and NORSH tasks, and took a Caribbean cruise with my family. What I was not expecting was how reproductive and sexual health issues would shape my vacation.

Alternative medicines in Grenada

Our cruise began with an island tour of our first port, Grenada. We visited one of the island's oldest spice plants where we learned about the processing of spices like cocoa and nutmeg. However, I wasn't expecting to learn about two other interesting plants. The calabash is a fruit commonly used on the island as its dried rind is strong enough to be made into instruments, tool handles and bowls. While the pulp is often discarded because of its toxic properties, our guide mentioned that women sometimes used it to induce abortion, which is illegal in Grenada.^{1,2} Women have to be very careful though, as too much is lethal. In addition, we learned about the island's "under the counter drink" which is made from a combination of alcohol, spices and the extract from the Bois Bande tree's bark. The bark is thought to increase sexual power, desire and ability to perform sexually.^{3,4} It was at this point in the tour that a guest asked where this drink could be purchased, much to the guide's amusement.

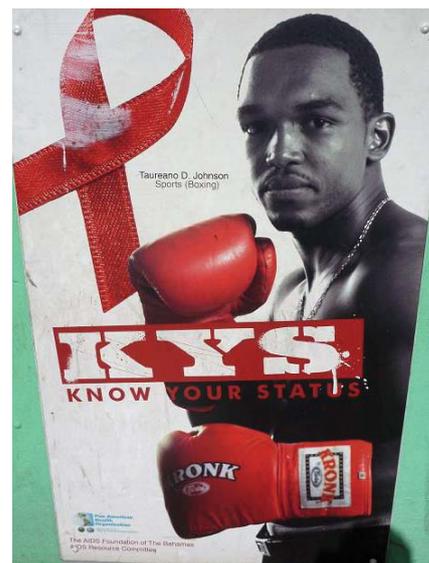
Gay rights and homophobia in the Caribbean

Our guide was fairly open and encouraged us to ask questions, and since I consider myself an advocate for gay rights, I asked him what the views were like on the island regarding homosexuality. He said that while homosexuality was illegal in Grenada (penalty up to 10 years in prison), it was rarely enforced and that there aren't many openly gay people because of homophobic views.^{5,6,7}

Interestingly, same-sex sexual activity is illegal in half of the ports we visited, while all eight ports don't recognize same sex unions and don't have anti-discrimination laws. I was surprised this wasn't mentioned by the cruise in order to protect/warn LGBTQ passengers, though I have to admit, the ship itself wasn't very LGBTQ-friendly either. One gay couple we ran into said they made several complaints because of homophobic comments and behaviors of other guests. They felt the environment to be so discriminatory that they were reluctant to even dance together. Even gay staff on board said they couldn't be themselves.

Tackling HIV through public health

Throughout the cruise, I was excited to see numerous HIV campaigns. In almost every port, signs encouraging testing and safe sex were prominent. In St. Lucia, the hospital had a sign saying "Be a man, get tested" with an HIV ribbon and in downtown Nassau, pictures of celebrities were used to promote a "Know Your Status" campaign. I even passed by a man wearing an AIDS 2012 shirt saying "Condomize!". Unfortunately, the prevalence of HIV in the Caribbean (~1%) is



higher than any other world region outside sub-Saharan Africa, but it would appear that strategies targeting the issue are working as there have been sharp declines in new HIV infections and AIDS related deaths.^{8,9}

Making a pro-choice statement on vacation

I'm a pretty impassioned activist when it comes to abortion, so when I was packing my suitcase for the trip, it wasn't unusual for me to include a few pro-choice t-shirts. Most of them were fairly incon-



spicuous, but one in particular had a fairly prominent message “Abortion is healthcare. Trust women.” I knew it would be controversial and I was expecting dirty looks or whispered comments, but I was not prepared for what would happen one evening in the dining room.

While seated for dinner a guest heading for her table next to ours, read my t-shirt in passing. It must have made her quite upset because the next words I heard were “I can’t believe that Indian trash is wearing that shirt.” The words flooded my head with past memories of being a victim of racism. With my own blood boiling, I decided not to be confrontational when she said it a second time, but instead leave the table to inform guest relations. To my disappointment, the staff said it would take a while to respond as they had a protocol to follow and suggested I head back to dinner and inform them if it happens again. When I returned to dinner, my family asked why I had run off. After I informed them of what happened, a shouting match erupted between my family and the other table. While I felt extremely supported that my family would come to my defense, I felt compelled to diffuse the situation.

I turned to the woman and with palpitations said “You made an extremely offensive and racist comment and that’s why we’re upset. You have the right to disagree with what’s on my t-shirt and the right to think differently on the issue

of abortion. I encourage debate, but you don’t have the right to verbally abuse people. When you called me trash you resorted to insults and by prefixing the word Indian you are not only being insulting you are also being racist.”

It was at this point that the restaurant manager intervened and moved the couple to another table. Two days later we sat down with a guest relations manager who apologized for the incident saying their protocol was obviously not practical and should have responded sooner. In addition, they said they warned the couple that if another incident should happen they would be removed from the ship.

Reflection at sea

Over the next few days, I had the chance to reflect on how pro-choice and pro-life groups interact. I thought back to marches and demonstrations I took part in where both sides engaged in shouting matches without accomplishing anything. I do think that the visual support of demonstrations is important, but it’s the calmer discussions that help us move forward on the issue. Perhaps if my fellow guest hadn’t reacted so intensely we could have had a productive discussion. Toward the end of the cruise I ran into the woman’s husband who ended up apologizing for her behavior, saying that while he didn’t agree with abortion she shouldn’t have made those comments.

As we disembarked from the ship, I felt reinvigorated. Over the course of two weeks, I had encountered important issues including homophobia, reproductive rights and racism – issues that need a voice. Although I’m still debating what

path of medicine to pursue, I do know that no matter where I end up, I will continue to fight for inequality and discrimination, while promoting diversity.

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A look inside the process and politics of public health policy at the international level

Neil de Laplante

University of Western Ontario, Class of 2015

THE HIGHLIGHT OF MY TERM as National Officer of Partnerships in the Global Health Program was a trip to Brazil for the Rio+20 UN Conference on Sustainable Development. Rio+20 was intended to reinvigorate the development policy agenda in advance of the end of the Millennium Development Goals (MDGs) in 2015. I was part of a seven member delegation from the International Federation of Medical Students' Associations (IFMSA), which I heard about through the CFMS Global Health listserv.

About 50,000 delegates and 100 heads of state attended Rio+20. Development policy is expansive, so after a few days it seemed weirdly natural to be in a negotiating session that transitioned from discussing forests to finances to gender equality without a hitch. Outside the negotiating sessions, many governments and civil society groups hosted a series of fantastic panel discussions. Reaching a consensus statement on something so broad is unsurprisingly difficult and the outcome document was widely derided in the media as a weak patchwork.

Health is a key cross-cutting issue in sustainable development. When we take the broad view of policy and the social determinants of health, even a seemingly arcane negotiation about fishing can be as relevant as progress on HIV and malaria funding. Our delegation worked closely with the World Health Organization (WHO) as their eyes and ears, covering a lot of ground to track the many-threaded negotiations. It was a fascinating and rewarding look inside the process and politics of public health policy at the highest levels.

Despite the overall weakness of the text, Director-General Dr. Margaret Chan declared the conference a success for health. I have to agree with her and took away a bit more optimistic outlook than the media reported. We had the opportunity to meet Dr. Chan toward the end of the conference and had an animated hour of wide-ranging discussion. She was genuinely excited to hear from medical students as she was a long-time educator before going to the WHO. It was an inspiring session.

Implementation is where many brilliant and ambitious multilateral agreements have collapsed, but the Rio+20 document contains some concrete steps for implementation. There are ongoing consultations and a summary of the post-2015 sustainable development goals process is available at www.worldwewant2015.org. If you're interested in learning more, don't hesitate to contact me.

I will leave you with three key messages:

1. Diplomacy is very hard. Consensus is elusive because, as Tip O'Neill famously said, all politics is local. However, success is worth the headache.
2. Canada is no longer a positive actor on the international stage. We obstruct on the environment, climate and financing. Even our own diplomats seemed a bit disheartened.
3. Politicians feel little urgency to solve global health and development problems because they are under no pressure from their citizens. We can and must change this. ■

“Health is a key cross-cutting issue in sustainable development. When we take the broad view of policy and the social determinants of health, even a seemingly arcane negotiation about fishing can be as relevant as progress on HIV and malaria funding.”

Diversity through student engagement

Howard Meng

University of Toronto, Class of 2014

THE FACULTY OF MEDICINE, University of Toronto, recognizes the importance of training a diverse population of physicians as part of its commitment to fulfill our social responsibility — enabling our physicians to meet the health needs of the diverse populations they serve, especially in the multi-cultural city of Toronto. The Summer Mentorship Program (SMP) is a grassroots program established in 1994 at the University of Toronto by the Faculty of Medicine in partnership with the Faculties of Dentistry, Nursing, Social Work, Pharmacy, Kinesiology and Physical Education and various other programs. One of its primary goals is to expose high school students with Aboriginal and African-Canadian ancestry to various healthcare professions. Students enrolled have the opportunity to participate in a 4-week intensive summer curriculum to improve their critical thinking, creativity, presentation and teamwork skills through a plethora of activities.

The Morning Report, initiated in 2011, arose as an extension of the SMP. Under the guidance of Dr. Lisa Richardson and support from the Office of Health Professions Student Affairs, medical students spearheaded the development of the Morning Report program for recent graduates of the SMP program. By offering this longitudinal post-SMP program, our aim is to provide students with the opportunity to expand on what they learned during SMP and further their career prospects through mentorship.

We directed our efforts in two themes: 1) the medical history and clinical examination, and 2) inter-professional collaboration in health care.

Students were involved in an

interactive patient encounter, facilitated by Dr. Tarek Abdelhalim. In simulated patient interviews, students had a first-hand opportunity to ask questions for a history taking experience. They also had the chance to perform cardiac and respiratory exams where the importance of relevant clinical findings was discussed. This hands-on experience gave these students a realistic impression of the clinical physician role, and we hope, provided further inspiration to pursue a medical career.

In the second session, students from the Faculties of Medicine, Nursing, Pharmacy, Radiation Sciences and Social Work collaborated to deliver another equally interactive session that focused on the importance of inter-professional collaboration. It is our belief that the high school students were able to deepen their understanding specific to each health professional's role. They were extremely keen in asking questions relevant to each profession and even sought advice from these student mentors afterwards.

The mentorship in Morning Report takes the clinical skills and knowledge learned to the next level. The senior high school years are crucial for students to inquire about and begin planning their future careers. Medical students, in

collaboration with students from other health professions, facilitated sessions to help students navigate through potential barriers. From a realistic experience of what being a medical professional is like to facilitating the planning process of how to get there, Morning Report helps high school students realize their career aspirations in the medical profession.

Feedback from participating students was exceptionally positive throughout. It remains a challenge for organizers to come up with novel activities for SMP students. To broaden the experience that this program can offer, we are partnering with the Division of Teaching Labs so that students can be involved in the laboratory research setting.

Moving forward, we hope to continue to expand the SMP program, involving more students, increasing health professional experiences, and developing our longitudinal follow-up programs. Our goal is for high school students from underserved populations to be stimulated with realistic profession-specific experiences, invoking career aspirations to drive a positive transition into post-secondary education and eventually, become the health care professionals of tomorrow. ■



A group of students who took part in the Morning Report at the University of Toronto.

Birthing Babies Together

Bailey Adams, University of Alberta, Class of 2014

Danielle Lewis, University of Alberta, Class of 2015

Katie Stringer, University of Alberta, Class of 2015

THIS PAST SUMMER, THREE medical students from the University of Alberta (U of A) came together to create an educational initiative called *Birthing Babies Together*. Danielle Lewis, Katie Stringer and Bailey Adams have produced a film documentary about what it means to provide woman-centred maternity care in a system that offers choice for birthing families.

The film takes a very unique perspective as Lewis and Stringer are both mothers and current learners. It was their contrasting maternity care experiences — Lewis having had midwifery care and Stringer having a family physician — that spurred their desire to create this documentary. Initially, the project explored the roles of physicians and allied healthcare professionals in providing maternity care with a focus on inter-professional collaboration. However, as filming commenced, it became clear that the scope of the initiative was expanding. With support and encouragement from the maternal health community, the team traveled to British Columbia and throughout Alberta to learn from the leaders in the field. Interviewees included obstetricians, family doctors, midwives, doulas, registered nurses, neonatologists, maternity health researchers and families. They had the opportunity to take a detailed look into the world of normal childbirth and the many facets of maternal health and neonatal care.

As the practice of medicine is continually evolving and innovative research guides us through this process, this film is a creative opportunity to provide supplemental learning

to medical students. With the continual support of the Undergraduate Medical Education Department at the University of Alberta, the team has been able to incorporate *A Mother is Born* into the second year curriculum with an accompanying panel discussion led by cast members and a local obstetrician. After watching the film, a second year student reported “Not only did the movie and panel inform me on midwifery and doulas but it really lifted pregnancy back to being something normal and beautiful in a woman’s life”. The team is working to have the film distributed to midwifery and medical programs across Canada so that it can be seen by our future health care innovators. Lewis, Stringer and Adams hope that the film will inspire future physicians to advocate for women’s choices and inform their patients with evidence-based maternity care.

The team has also hosted an Edmonton public premiere with over 300 people in attendance, with additional screenings occurring across the country. *A Mother is Born* was also presented this February at the Western Perinatal Research Meeting, as well as at the Creating Space III Conference in Québec City in April. One well-known midwife, Carolyn Hastie, has commented “What a fantastic project. Interprofessional collaboration is crucial for optimal health care for women and their babies.” The team hopes to impart the view that “birth in most cases is a physiological event and should be a celebrated milestone in a woman’s life.”

You can learn more about the Birthing Babies Together project and the women behind the scenes at www.birthingbabies.ca. The team can be contacted at birthingbabiestogether@gmail.com. ■



BIRTHING BABIES TOGETHER
a university of alberta medical student initiative

Kimmett Cup — The Lindsay Leigh Kimmett Memorial Foundation

Jason Baserman, University of Calgary, Class of 2014

Joe MacLellan, University of Calgary, Class of 2009

Reid Kimmett — Submitted on behalf of Dianne and Kelly Kimmett

THE KIMMETT CUP, HELD ON January 19 and organized by members of the Lindsay Leigh Kimmett Memorial Foundation Committee (Jason Baserman, Joe MacLellan and Reid Kimmett), was a resounding success on so many levels. Standing at Mitford Park under a cool Alberta sky listening to the skate blades of the players carving the ice, the laughter of the participants, families playing together and spectators in carriers, strollers and even on leashes, is an exhilarating experience.

There are playoffs in the competitive and recreational divisions, but really this day is just about playing hockey for the love of hockey. Said one participant “It’s no wonder people get so excited for pond hockey! It was unlike any experience I have ever been a part of. I know Saturday will be a day I’ll never forget. I loved volunteering years previously and being a spectator, but to be able to lace up was so cool! I feel like I was more a part of the day! There were so many memories made. Not only does my entire body hurt (a good kind of hurt), but my cheeks hurt from all the smiling and laughing! My team had a blast and they will all be back next year.”

At the local arena 375 players laced on full equipment to participate in 10 minute shifts setting a Guinness World Record for the most participants in a recreational hockey game. What a heart warming experience it was to watch new hockey players, some as young as four years old, playing alongside grown men and women. One of the hockey Moms sent this note: “I just wanted to extend a HUGE thank you from our

entire team (The Cochrane Dragons) and all of the parents. This was quite the experience for all of our children and we are so very grateful that we were able to be part of such an event! Our little ones were mixed in with adults and by the end of their 10-minute interval, they all felt like superstars.”

A favourite memory of everyone there was watching a very young player playing his heart out in a red Kimmett Cup jersey that reached his skates!

As players gathered to celebrate at the end of this monumental event there was joy in the air and so many stories of goodness from this day. A local minor hockey team sold 50/50 tickets and donated their share of the proceeds back to the foundation. A local church group spent 6 hours baking and donated the proceeds as well. Local citizens who weren’t on the volunteer list showed up and asked what they could do to help. A young child decided he would like to donate so counted 39 cents from his piggy bank.

We as parents of Lindsay know that this is a day that she would have loved. It is an incredible tribute to her fun loving nature and love of hockey. She threw 100% of her efforts into a cause that she believed in, just as Jason, Joe and Reid do. She would so strongly support the cause of Right to Play in giving less fortunate the opportunity to discover and learn through the joy of sport. We are so very proud of her accomplishments in life and of all that is being done in her memory now!

As long-time volunteer and participant John Webb so aptly summed up

“Standing ... under a cool Alberta sky listening to the skate blades of the players carving the ice, the laughter of the participants, families playing together and spectators in carriers, strollers and even on leashes, is an exhilarating experience.”

the event: “It’s absolutely incredible. You stand at the edge of Mitford Pond, surrounded by a Cochrane winter in January, and Lindsay Kimmett is on the ice. She’s on the ice then and she’s on the ice now. She’s in the stands, she’s volunteering behind the scenes, she’s bringing energy, excitement and enthusiasm to the day. Her day. Our day. The Kimmett Cup.”

At the time of writing this article we are close to our goal of raising \$100,000 for Right to Play. If you would like to be a part of this winning venture, donations can still be made by visiting: <http://righttoplay.akaraisin.com/Common/Event/Home.aspx?seid=6129&mid=8>. ■

On trees and refugees

Students at the University of Toronto challenge the local community to redefine Valentine's Day

Chrystal Chan

University of Toronto, Class of 2015

DURING EARTH HOUR, WE turn off our lights for the environment. During Global Heart Hour, we ask you to you turn your hearts on for humanity.

The beginning of February traditionally heralds thoughts of flowers, jewelry and chocolates. As warm ideas for Valentine's Day fill our minds, the current state of the world's affairs is hardly so rosy. This holds especially true for refugees and immigrants in Canada, in light of the recent drastic political changes that have caused this group of individuals to lose their medical coverage.

Students from the Faculty of Medicine at the University of Toronto (U of T) saw a need for help and found a way to do it. Global Heart Hour (GHH) is an annual interdisciplinary grassroots initiative started by U of T medical students in 2009. This year they focused their efforts on promoting refugee and immigrant health, with all proceeds raised sent to a volunteer clinic for medically uninsured immigrants and refugees.

"Our goal is to foster care and concern for the vulnerable by refocusing our attention on Valentine's Day from material goods to humanitarianism and social responsibility," says Chrystal Chan, a second-year medical student and GHH co-chair. "We see the potential to redefine Valentine's Day into something that

could be the force for positive actions and change. Every year we encourage all members of the university and community to stop by and join us."

GHH emerged from a 25 year Valentine's Day heart health promotion project. The 2009 launch focused on heart health, occurring in the midst of the global food, financial and climate crises. We believe that humanitarianism remains the most crucial motivation and means for intervention locally and globally.

Feb. 11, 2013 marked the fifth annual GHH. Every year, the GHH team invites a panel of distinguished leaders and speakers for an audience-led discussion. The event uses a student-run open concept approach and is a Valentine's celebration to share ideas, celebrate student involvement and inspire one another to sustain humanitarianism. This year's event included some remarkable guest speakers: Dr. Tatiana Freire-Lizama, high risk obstetrician; Maureen Silcoff, refugee lawyer; Vanessa Wright, Médecins sans Frontières nurse; and Lishai Peel, award-winning spoken word poet. The event also featured a silent auction, a hot lunch and poster presentations showcasing international health projects from U of T medical students.

"Too often we criticize ourselves for not doing enough humanitarian work.

"Inspiring one another to sustain humanitarianism."

We think that instead we should celebrate what we have already done and use that celebration as motivation to do even more," says Rohan Kothari, second-year medical student and GHH co-chair. The celebrations included the Red Party on February 25th, which is an interprofessional fundraising collaboration in support of GHH.

This year's event was an incredible success, raising over \$3000 for the Scarborough Volunteer Clinic. Nevertheless, the GHH team will need the university and local community to get involved again next year, and the year after that, and the year after that. Here is the team's message:

"We encourage you to be part of a global collaboration and use the sentiment of Valentine's Day as an inspiration and focus to help your world. Take an hour to write to an MP, donate to a fundraising effort, share your thoughts, see what others are doing or at the very least ... drop by Global Heart Hour 2014! Let's give an hour to humanity." ■

Conscientious donations

Haley Augustine

Dalhousie University, Class of 2015

TWO WEEKS INTO MY ELECTIVE at the Comprehensive Community-Based Rehabilitation Therapy Centre (CCBRT), I had already familiarized myself with my new surroundings. I had gotten accustomed to the bumpy hour-long bus ride to the clinic in Moshi town and the endless amount of ugali* served at every meal. Tanzania is a country with abundant wildlife, fresh produce, vibrant beauty and culture, and I felt privileged to be there. CCBRT prides itself on reaching out to rural and underserved communities with a multidisciplinary team of doctors, teachers, wheelchair technicians, social workers, occupational and physiotherapists. The health model at CCBRT is seen as the future of innovative care in Tanzania.

One morning, a mother came into the clinic with her eight-year-old daughter. The child was hypotonic and immobile because of her cerebral palsy and had grown so big that her mother laboured to carry her. Her mother was seeking a wheelchair to ease her own back and allow her child to experience more in life. She was told by the occupational therapist Neophita that it would be months before the next shipment of wheelchairs arrived from India.

This perplexed me. There were several bike factories, tire shops and metal shops in the area and I knew there was capacity to make wheelchairs locally. As it was, children who received a wheelchair were advised to go to the local bicycle repair

shop if there were any problems. With the technology and the infrastructure already in place to repair wheelchairs, I could not understand why there were no local manufacturers.

With curiosity, I asked, “Neo, why do all the children have to wait so long for their wheelchairs?” Neophita explained that there used to be a local wheelchair shop which had been doing quite well employing local Tanzanians. The shop, however, was put out of business by a big donation of wheelchairs sponsored by a charitable group. After that, CCBRT stopped getting their wheelchairs from the local company since they were receiving wheelchairs free of charge. This seemed logical and cut down on costs, but eventually became quite problematic when donations were not meeting the local demand and the clinic was continuously backlogged with children waiting for wheelchairs.

Prior to this, I hadn’t realized that donations might hinder development. The reality is that health systems are very intricate and complex. We have to be very conscientious of what we give — whether it is medical care, valuable goods or even wheelchairs! In this situation, the charitable donations had limited the centre’s effectiveness and ability to be locally self-sufficient.

I recently attended a global health discussion series put on by the department of Anesthesia in Halifax. I was

“I hadn’t realized that donations might hinder development.”

pleased to note that many of the panelists focused on the teaching and training component of international medical work. The alternative quick-fix tour around developing countries to provide treatment or medical care offers limited capacity building. Rather, it may present barriers to strengthening a country’s own health program and may increase its reliance on external expertise to perform work for them. During the discussion series, there was an emphasis on sustainability, capacity building and knowledge translation so that the proposed medical treatments could be carried on well after international experts had left.

Globalization of health and health care is a reality today. We have to be conscientious of our donations and consider their impact on the development of health systems globally. The age-old saying “give a man a fish and he will eat for a day, teach a man to fish and he will eat for a lifetime” rings true when we think of how we can contribute to the development of global health. ■

*Ugali is a cornmeal dish cooked with water to give it a porridge-like consistency.

My first day in surgery

Ryan Figueroa

University of Toronto, Class of 2014

AFTER SPENDING FIVE DAYS in a cramped classroom learning about common cases and procedures in surgery, I anxiously anticipated starting this monster of a rotation. Candid confessions from upper-year medical students described their surgery experiences with ghastly statements such as, “the hours are insanely long,” “sunlight will become a distant memory,” “you are going to feel useless,” “the scrub nurses can be mean to you” and “you won’t even have time to eat, drink or pee.” Now, of course there were positive comments being whispered in between the cacophony of negative parables. However, the depressing remarks seemed to echo louder in my hippocampus.

The night before my first day, instead of sugar plums dancing in my head, endless mnemonics like SOAP, AD DAVIIID, and PPP SAFE DISC scrolled through my mind. Determined to be punctual, I rushed out into a dark, rainy morning and pondered, “Is this bad weather a pathetic fallacy for what the day will bring?”

In my crisp blue scrubs, I took the elevators up to the surgical ward to meet my assigned team. Fifteen minutes passed by ... then 30 minutes ... still, no sign of my team. At this point, I had already introduced myself to all the nurses, PA’s and pharmacists, and I was

running out of small talk. The other teams had started their rounds, and I was left alone feeling like a fly on the wall while the rest of the hive buzzed to life. At this point I felt discouraged and unappreciated.

Feeling mildly discouraged from the morning’s events, I did not expect to be of any use in the OR either. While waiting, I imagined my supervisor to show up with an army of residents and fellows behind him. Shockingly, he showed up *alone*. He proceeded to tell me there were four surgeries scheduled and I was to be his first assist. Naturally, I felt elated at the sudden turn of events!

After a couple of newbie clerk mishaps in the OR involving tearing the sleeve of my surgical gown after being overzealous with pulling on gloves and forgetting to twirl to tie up the back, the rest of my scrubbing-in experience was *unremarkable*. Surprisingly, the scrub nurses were accommodating, albeit strict when it came to ensuring a sterile field. At first, I felt anxious being in this unfamiliar place. To my surprise, a kind scrub nurse told me, “Relax. You are here to learn and not to be blamed.”

One of the cases involved a 48-year-old woman with a previous history of recurrent right breast cancer and had already undergone three surgeries to rid the cancer. Unfortunately, her cancer

“Relax. You are here to learn and not to be blamed.”

returned by angrily manifesting itself on the skin of her breast. I did not get to talk to her much, but her facial expressions revealed anxiety, pain and uncertainty. I could only imagine her rollercoaster of emotions. Fear after her first diagnosis, followed by joy thinking the first surgery took care of the cancer. Next, frustration when the cancer came back. Then, modest hope after the second and third surgeries failed to offer sanctity from this ruthless disease. I kept these thoughts in my mind, while I assisted the surgeon with simple tasks such as retraction and cutting sutures. It was not until the final close that I had an epiphany. I realized that although my responsibilities in the OR seemed menial, they were still very important in ensuring a successful surgery.

At the end of this long first day, I felt optimistic and I understood the impact of my role as a clinical clerk in surgery. ■

Living with Lafora Disease: a medical student's experience with the research of rare diseases

Tony Wang

University of Toronto, Class of 2016

WORKING WITH CHILDREN has always been an interest of mine. It motivated me to work as a camp counsellor during my summers in high school and to volunteer at Bloorview Kids Rehabilitation Hospital throughout my undergrad. When I first entered university, I sought a compromise between my involvement with youth and the scientific research community. This search led me to Lafora disease, a fatal paediatric neurodegenerative epilepsy and to Dr. Berge Minassian, a neurologist who has dedicated his life's work to unravelling its mysteries.

Lafora disease is an extremely rare genetic disorder affecting fewer than 10 individuals out of every million worldwide. With no present treatment or cure, this disorder destroys lives in a ruthless and systematic progression. Teenage onset of Lafora Disease produces myoclonic (jerk-like) and intractable tonic-clonic seizures. The failure of medications to stall deteriorating speech and movement foreshadows imminent depression and anger. These psychological disturbances progress to dementia and psychosis as the mind wastes away. Patients inevitably spend their last days bedridden and in agony. A decade after initial onset, Lafora disease will shatter a young life.

Research conducted by Dr. Minassian at the Hospital for SickKids in Toronto has shed new light on the pathophysiology of Lafora disease in that insoluble glycogen deposits in neurons disrupt normal electrical signals.¹ These deposits of abnormally branched glycogen, called

Lafora bodies, arise from glycogen hyperphosphorylation when a carbohydrate phosphatase is absent.²

For the Minassian lab, the challenge of studying rare genetic diseases stems primarily from a lack of funding. I cannot recall a single day at the bench when I did not sheepishly ask to borrow another lab's apparatus, usually a centrifuge or an analytical balance. Thankfully, I cannot recall a time when someone said no.

This shortage in funding results from a constellation of issues — a lack of public awareness to fundraise for research, a scarcity of private donors and large pharmaceuticals hesitant to invest in disorders that affect a handful of patients and offer little prospect of financial return. Ultimately, researchers studying rare diseases face more than the conundrum presented by the science itself. They must also contend with ultra-tight budgets hampering scientific headway.

Scientists such as Dr. Minassian, who work in smaller labs and persevere despite these unique challenges, are true champions of translational medicine. Instead of self-pity or frustration, Dr. Minassian acknowledges these challenges with good humour and humility. He frequently jokes that our lab is deliberately “going slow to go steady.” Despite his easy-going personality, Dr. Minassian possesses an unparalleled and infectious work ethic. As a summer student, late Friday afternoon meetings to discuss the week's progress and future work were a regularity. I admire him and his research team at

“I'm inspired to advocate for researchers who study rare diseases.”

SickKids for their determination to better the lives of some of medicine's most vulnerable patients. Since joining his lab, he has inspired me to advocate for researchers who study rare diseases and receive a disproportionate amount of funding.

I believe righting this inequality is possible. Our responsibility begins with raising awareness of less common, but no less crippling illnesses. Only then can we hope for increased funding from public and private sectors for research into rare diseases. Our legacy to patients suffering from disorders such as Lafora disease need not require us to make advances at the forefront of the scientific literature, but rather, to facilitate this advancement.

Join me and help usher in the promise of translational medicine.

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Finding perspective

Emily Hildebrand and Casey Wong
University of Manitoba, Class of 2015

THERE WAS A FLURRY OF excitement that day at the nursing station when Elliott refused to come in for treatment. No matter how many health care staff made the three-minute walk to his place, he refused to come in for treatment. Elliott was an elderly gentleman who had recently been suffering from recurrent episodes of bowel obstruction. He was a pillar in the community and this outburst was uncharacteristic. It seems, with reason, Elliott thought being carried on a stretcher to the nursing station was too demeaning and didn't want everyone in the community to think he was dying. Privately, Elliott probably also knew he didn't have a lot of time and being treated would mean being sent off the reserve and the possibility of dying far from home. His story is just one of many we brought home with us this summer and these stories will shape how we practice in the future.

As Elliott's story illustrates, it's frustrating from a health care perspective when you and the patient have different ideas about what's in their best interest. This was further illustrated by Mark, who was known to the health care system as an addict, a pathological liar and a general annoyance. At a sweat lodge we unknowingly met Mark, who was introduced to us as a genuine, loving man trying to overcome his struggles

with alcohol. The stories of Elliott and Mark show how easy it is to misconstrue someone. It's difficult to gain a balanced perspective of people when you see them solely through the lens of medicine and prejudices can easily be formed, preventing equality of care and relationships with patients. In other words, when attempting to control a person's disease the individual can be lost which sacrifices a patient's right to self-determination.

We mentioned control in the context of a specific situation, but the value of control itself is more far-reaching. As medical students we have scheduled, busy lives that revolve around a medical system that values high achievement and dedication to learning. In our context, being able to work hard for long hours is an admirable quality that many of us strive to achieve. In contrast, in the Aboriginal culture we witnessed, it is accepted that many things are not within human control. On the reserve, people didn't rush anywhere and everything was perpetually two hours late. This clash in values was the bane of the nursing station with its specific appointment times and scheduled hours. It's easy to perceive this relaxed lifestyle as a weakness, especially from a health care context. However, we found that this slower pace of life can allow one to be more present in the moment, decreasing daily stress.

“Prejudices can easily be formed when you see people solely through the lens of medicine.”

Being open to different perspectives allowed us to learn so much more this summer than we might have otherwise. Challenging the core beliefs we hold yields a more balanced persona, but it can be hard to recognize our unconscious assumptions unless we are placed in situations where the value system is different. Control is a fundamental assertion of our Western system that we recognized this summer and have come to challenge. One way this manifests itself is in patients who come to terms with their illnesses, yet continue their treatment only to appease their doctor. It's something to think about as future physicians — when our desire to heal becomes a need to control the uncontrollable versus knowing when it's best to just let go. ■

Oncology in Teresina, Brazil

Timothy Roche

University of Ottawa, Class of 2014

IHAD THE INCREDIBLE OPPORTUNITY this past summer to spend one month on a medical exchange in northern Brazil. I was placed in the capital city of the state of Piaui, Teresina. Having never left North America before I was very apprehensive about travelling to a nation known for tourist muggings and drugs, but was excited to see medical practice outside of Canada. I ended up with an amazing view of a less-developed nation's medicine.

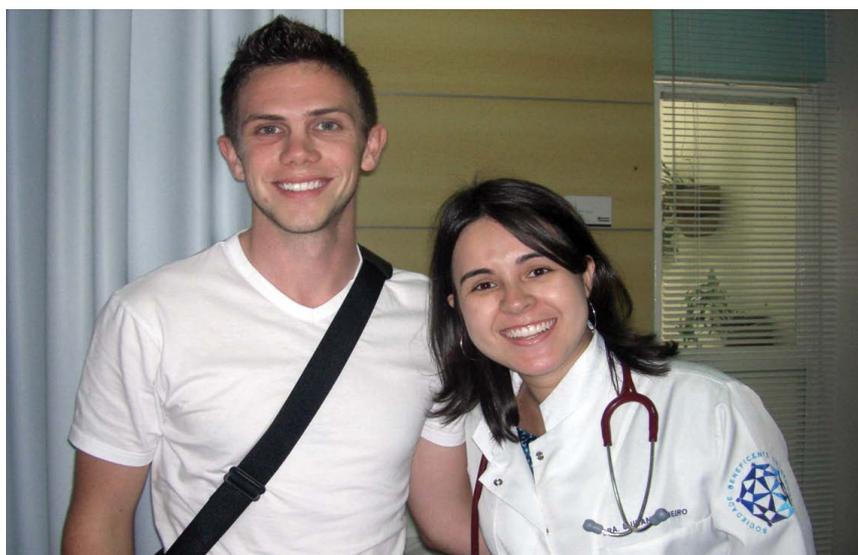
My primary preceptor was a well-known medical oncologist trained in Sao Paulo and Paris, but I also worked with the chief oncologist, a gynecology surgeon and an emergency doctor. My preceptor informed me that many of the doctors in Brazil work for both private and public health facilities because they receive more money from private hospitals, but gain occupational benefits and stability in the public sector. Brazil is a developing nation with increasing revenue, but a very corrupt government and police system prevent the growth and development that could be achieved. Health care seemed to be on the back burner, both from what I observed and discussed with the doctors. The contrast between the severely underfunded, stripped-down public hospitals and private care in beautiful, clean, modern hospitals on the same street in downtown Teresina was astounding. Canadians have so much privilege with our health care system. Before this elective I saw 8-hour wait times in the ER and month long waits for surgery and MRIs. In Teresina people die in the overcrowded ER waiting rooms, receive cheaper, but less safe surgeries and have severely limited drug

choices, which is compounded if you have little disposable income.

I was able to discuss patients, clinical choices and experiences with the doctors I worked with given they all spoke English, but couldn't communicate with a single patient. Having very few people to talk to while on exchange in Brazil was both a personal challenge and a clinical limitation. I was able to read most of the charts, x-rays and prescriptions, even attended some lectures. I was able to follow along having prior knowledge and similar medical terminology, but zero patient discussion meant no view of cancer from their point of view, something I would have really liked to experience in a foreign country. The young patients were the toughest to see, it hit very close to home to see a 28 year-old patient with terminal osteosarcoma. I became frustrated for the doctors who were routinely advocating for patients or

subverting insurance limitations, just for basic treatment options. It was an inefficient system driven by lack of money and, as one doctor told me, insurance auditors who have no knowledge of oncology.

My medical training thus far prepared me for my clinical experience in Brazil; however, culturally and linguistically I had many more challenges. I survived my exchange solely due to the help of the amazing hosts I had in Teresina, who showed me the ropes of getting around and touring their beautiful country. Teresina was a significantly less safe city than any I've been to in Canada, but I managed to make it through without incident and great memories of a wonderful people and culture. It was an amazing exchange experience that expanded my view of the world outside my bubble and the immense medical privilege we have in Canada. ■



Kwanlin: water running through a narrow place

Megan MacGillivray
Queen's University, Class of 2015

KWANLIN DÜN FIRST NATION (KDFN) is rooted in the land and waters of Whitehorse and its surrounding area. Their health centre is the only First Nation operated medical centre north of the 60th parallel. It is fenced by a community garden along one side and an expansive Yukon forest on the other — a spectacular display of nature's remarkable tranquility.

I undertook an observership at KDFN this past summer. At the onset of the observership, I had some preconceived ideas about what I would experience. As medical students, we are inundated with information about barriers to medicine in rural and northern regions of the country. In addition, many of us are aware of the medical and, to a greater degree, societal strife engulfing Aboriginal communities. These include suicide, diabetes, substance abuse and trauma, to name only a few. This perspective is important and valid, and these real issues should never be neglected. Yet, was it really fair of me to embark on this new experience with a biased viewpoint?

During this observership, I bore witness to many of the established health concerns facing Aboriginal people. I performed a physical exam on an obese man with Type II Diabetes. I took histories from patients that smelled of alcohol and tried to ascertain if they were intoxicated as I spoke with them. Perhaps the most challenging of all, I listened and sympathized with the tragic story of a patient living in a sexually abusive home. These

problems are not unique to Aboriginal communities, but during my short time at the KDFN Health Centre I experienced them at an outstanding frequency.

With such a vast array of challenging scenarios, one might be tempted to conclude that the experience did indeed conform to my initial expectations, but those experiences are not what resonated with me afterwards. Instead, my most lasting impressions were from the kindhearted people I met, and the warm and inviting community that I was welcomed into.

The patients at the clinic had humble dispositions and I was moved by their willingness to share their stories with me — an inexperienced medical student from Queen's. Time and again, I was struck by their ability to openly share painful pieces of their past or admit bad habits of their present; skeletons that many are unlikely to admit.

Their community at large was highly involved with nature. Posters demonstrating local plants and berries used as traditional medicines lined the halls of the clinic. Programs existed to pass knowledge of the natural world from Elders to younger generations. Members of the community who tended to the community garden left vegetable baskets in the clinic. Patients were welcome to take these vegetable baskets home following their appointments, in what I have now come to realize was an extension of the healing process.

Ultimately, my experience at the KDFN reshaped my expectations of

“Kwanlin promoted a holistic view of health incorporating tradition, nature and a supportive community.”

health care in an Aboriginal community. I now know that while many of these communities face barriers to health care and struggle with serious medical inequalities, one must not let these issues obscure the rather important lessons that can be learned from these areas. KDFN promoted a holistic view of health incorporating tradition, nature and a supportive community. At the onset of my observership, a limited understanding of Aboriginal health precluded me from fully realizing the potential of the experience. For many of you who have spent time in an Aboriginal community, this may not be new information. However, for others who have not yet had this opportunity, I encourage you to consider my learned perspective for any future encounters you might have. ■

Refocusing: a reflection on treatment vs. prevention

Michael Benusic

University of British Columbia, Class of 2014

SECOND YEAR, TYPICAL Vancouver GP office. First patient walks in — typical GP patient.

Open the EMR and 15 current medications pop up — mostly the usual suspects that are becoming increasingly familiar to me. A diuretic, Metformin, Statin, ACE inhibitor, SSRI, Beta blocker. Before med school, a list such as this would have floored me, but now I barely bat an eye.

I feel myself already beginning to become compliant to prescribing — all it takes is one signature to solve nearly any medical problem walking into the office. Diabetes? Hypertension? Heart failure? Depression? No problem.

Well, at least from my side of the prescription pad. I see the patient for minutes — they live with the condition. Side effects of the medication? Cost of the medication? Interactions of the medications? If anything's really bad, perhaps they'll come back — we'll switch them onto another. There has to be a better alternative. Fortunately, there is.

Massive epidemiological studies have outlined for us what needs to be done to curb a large portion of the 'lifestyle diseases', especially the big ones like cardiovascular disease and type II diabetes. Prevention is simple — eat a healthy diet, exercise and stop smoking. But how often does this actually translate into effective physician-facilitated primary prevention?

I've yet to see a preceptor engage in primary prevention. Secondary prevention, yes — but never primary. It seems it's human (or societal) nature to deal only with an issue when it's present.

Science has given us the rational

causation. Epidemiology has shown us the relative risks, but physicians have failed to effectively and convincingly translate this information to patients. I'd wager that the media, as biased and overly simplistic as it is when reporting on epidemiological studies, has accomplished more for primary prevention than physicians.

Who's to blame? It's a vicious cycle. Physicians are too swamped with disease treatment to focus on prevention, but by not focusing on prevention, extra work is created for future physicians. Extra work for physicians is leading to increased health costs (translating to perhaps less focus on prevention, depending on the political environment), and when we take a step back and look at the real bottom line — lost quality and quantity of life for patients.

Is the health care system then to blame? The system is superficially focused on immediate treatments with immediate results. People are trying to change this, but just like human shortsightedness on the economy and the environment, it's a hard sell. Health care is already a primary component of provincial budgets — convincing policy makers, politicians and voters that more investment into prevention now will mean a bigger payoff in the future is, shall we say, a bitter pill to swallow?

There is a gap between financial and political support, and the evidence that primary prevention needs to be a priority. Physicians need to be given a reason to act. As it stands, altruism — spending more time with patients without extra billing — is not working.

Epidemiological studies have done a

“I feel myself already beginning to become compliant to prescribing — all it takes is one signature to solve nearly any medical problem walking into the office. Diabetes? Hypertension? Heart failure? Depression? No problem.”

terrific job in telling us what needs to be done. We just need to do it. The health care system lacks malleability — strong public policy advocates are needed to ensure we incorporate evidence-based medicine from the statisticians into our practices.

As for my patient, it's not acceptable that he's on 10 'lifestyle' medications. Somewhere, the system has failed. I can blame the physicians, the politicians, the drug companies, the patient's own motivation — regardless, band-aids in the forms of pills are being applied to the problem. We need to refocus! ■

The conundrum in the Canadian medical system

Lisa Li

McGill University, Class of 2014

IT IS ENOUGH TO MAKE ANYONE do a double take — fledgling doctors equipped with years' worth of extensive training are being turned away across Canada. At a time when navigating the daunting queues into physicians' offices is no easy feat, it seems that graduating residents should be waltzing effortlessly into a struggling medical system. What explains the frustrating and perplexing roadblock that some of them encounter?

The conundrum in the Canadian medical system lies in a paradoxical supply-demand disparity. Although figures published by the Organization for Economic Co-operation and Development (OECD) reveal an increasing trend in physician numbers since 2004¹, it is debatable whether this new workforce is being channeled into the right medical disciplines. Although it seems that most specialties are straining under insufficient manpower and long wait times², only some have the openings to alleviate their understaffing woes. Certain fields, such as orthopedic surgery, cardiac surgery, neurosurgery and nephrology, are essentially jobless.² Implicated culprits are various, including poor government budgeting and hospital fiscal crises preventing the hiring of new staff, but underlying these issues is essentially a failure to keep medical students abreast of the economical ebb and flow. The fluctuating realities of the health care job market clash jarringly with students' expectations of an impoverished health system clamoring for experts in all trades. A lack of appropriate guidance relegates career path selection to whim. The tendency of many debt-saddled students to

aim toward the more lucrative, higher-paid specialties without much knowledge of marketability exacerbates the incongruity. The resulting influx of unbalanced and unusable professional skills is counter-productive to the edification of the system.

To subvert this problem, a goal of educational institutions should be to help funnel professional competencies into areas where there is the capacity and need to accommodate them. Academic centers should collaborate with professional organizations to respond optimally to a dynamic health human resource environment.³ Informed decision making is pivotal to shaping wise, market-appropriate vocational paths for medical trainees and career planning resources offered by organizations such as the Canadian Medical Association (CMA) and promoted by schools are an essential part of the equation. As of now, easily accessible, up-to-date resources on Canadian job market trends are limited and incomplete.² The CMA offers specialty pages which present extensive job profiles, but lacks job-trend data reports. In contrast, implementation of such measures by the Association of American Medical Colleges (AAMC) has resulted in the comprehensive Careers in Medicine (CiM) pages. This user-friendly resource offers previous match data and workforce statistics for a wide variety of specialties in the U.S. By keeping medical students well-informed, CiM is a potentially powerful tool in guiding graduates into the areas that are in highest demand. It is worth contemplating that the advantages of establishing such a career planning initiative in Canada would far outweigh the cost of lengthy,

“The goal of educational institutions should be to funnel professional competencies into areas where there is the capacity and need.”

highly technical training that is now being spurned from the workforce. For our future medical graduates and education policymakers, it is certainly food for thought.

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The art in medicine

Anthony Vo

University of Ottawa, Class of 2015

MEDICINE HAS LONG diverged as an art form. Medical trainees these days are taught to think objectively. We look at the scientific facts presented to us and we make decisions based on these facts. Our decisions, whether they are subjective or abstract, and our feelings rarely play a role. We are slowly evolving into a profession where the emphasis is placed on the lab values and diagnostic images than what we perceive. As this appears to be the trend, it is important to not forget that medicine in itself is a form of art. We are taught basic skills and techniques that through time we master. Our ability to understand patients and their problems rest on how sharpened these skills are and our own approach to the problem. We use evidence-based algorithms as only guidelines for how we treat patients. Each patient is a canvas that we are given to make our own mark and like any artists, how we create perfection is different than any other. This is the art of medicine.

Arguably the most basic and essential skill found in medicine and art is observation, the ability to critically view a reference to critique its features. From the moment the patient walks into the room, a lot can be elicited from just observation. Harvard Medical School has found that training students in formal observation exercises in art demonstrated better visual diagnostic skills when viewing skin lesions than students who didn't.

This appears to be a useful skill especially when skin lesions are increasingly common in this era. This artistic skillset is especially important in surgery too. Surgeons depend on observation skills to understand how each feature relates to all others before performing a procedure. How one surgeon sees and approaches a problem can be completely different from another surgeon, but the goal is the same.

The first skill medical trainees learn in medical school is history taking, a relatively simple skill, but grossly underestimated. History taking isn't simply surveying the patients with a fixed set of questions. If the patient is not prompted sufficiently, the patient will remain a stranger to the medical trainee and the care is no longer optimized. Prompting too much, the medical trainee may appear disorganized or incompetent. It is a fine art of asking the right questions in the right amount. This can easily be seen when observing an attending physician and a medical student. The Mayo Medical School understood that history taking is an artistic skill that can be developed. They used different forms of art (storytelling and theatre) as a means to teach medical students how to effectively take patients' medical history.

In a realm of medical technology advances, the physical exam seems to be a dying art. The once revered skills of touching, listening and looking are slowly

“The once revered skills of touching, listening and looking are slowly being replaced with lab tests, ultrasounds and MRIs.”

being replaced with lab tests, ultrasounds and MRIs. The physical exam is highly dependent on the skills of a medical trainee. What a medical trainee hears as a normal heart beat, a cardiologist can appreciate the subtlety. What a medical trainee can use to diagnose carpal tunnel syndrome can range from Tinel's sign to Phalen's test.

Like any art form, how one artist approaches a problem and how skillful his artistic abilities are, determines the results. Medicine can never fully be what science intends it to be. There is no formulated procedure to approach a problem, just like there is no procedure to paint a canvas. No matter how objective and scientific medicine is becoming in this era that demands perfection, medicine remains to be an art. ■

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Interview with Dr. Marla Shapiro — clinician, professor, TV host & medical consultant

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

Wilson Kwong, *CFMS Annual Review* Editor, Queen's University, Class of 2015

DR. MARLA SHAPIRO IS A practicing clinician in Toronto who is certified by the College of Family Physicians of Canada and holds a fellowship in community medicine from the Royal College of Physicians and Surgeons of Canada. She is an associate professor in the Department of Family and Community Medicine at the University of Toronto, medical consultant for CTV National News and Canada AM, and host of Dr. Marla & Friends on CTV's News Channel.



AR: What were your reasons for going into medicine?

MS: I honestly can't remember a time when I didn't want to do medicine. I think that, when you look back, how is it that you know that you want to be a doctor? I don't think you know you want to be a doctor, rather you imagine you want to be a doctor and you have a view of what medicine will be like. I didn't come from a medical family and so didn't have that kind of exposure, but I always loved science and people.

I really consider myself lucky because here I am so many years later and I still get up in the morning and love what I do. Medicine is an entry to so many career paths — there are so many opportunities for people with a medical degree other than just clinical practice. I've been so fortunate to have medicine in my life to open up so many other career paths.

AR: What made you decide to explore journalism while already in medicine?

MS: It was actually an accident, not something I was proactive about. My clinical post-graduate training was family medicine, followed by a Master of Community Health and Epidemiology and Royal College program in what is now called Preventative Medicine and Public Health. This gave me the best training in medicine as it affects the population at large, versus the family, which is much more one to one.

One day, I was in the office seeing a family. I was explaining to the father what was wrong with his child and why we were doing what we were doing. I ended the conversation, as I often do, by saying 'did you get it?' He asked "what do you mean?" and I explained, "I need to give you something you can take home and explain to your wife. So if you didn't get it, I didn't give it right." He laughed and said he got exactly what I said and that I should do it on TV. I jokingly said 'make me an offer'. It turns out he worked at a television program

and called me the next day to come do the show.

From there, I started doing medical segments on the news and at that time there was no one in Canada who was the American equivalent of what Dr. Kim was doing on Good Morning America or what Sanjay Gupta does now. No one in Canada had that kind of identity. Eventually I moved to CTV, the national platform, where we created this go to person for applicable medical news. So I cultivated the career, but getting into the career was total happenstance.

AR: What was it about medical journalism and television that you enjoyed?

MS: My favorite thing about family medicine is the patient interactions and education. I'm very clear with patients that it's not just my job to help you, it's 'our' job, a collaboration. What I'm doing on air is the same thing I do in the office — it doesn't feel any different. It struck me that this was a great opportunity to educate on a much more global level.

In 1993, our third child passed from sudden infant death syndrome (SIDS). I didn't speak about it publicly for many years because it was very personal. By 2000 I had already done Cityline for some time and was approached by members of Health Canada and the Pediatric Society about a national campaign called 'Back to Sleep'. At this time there was a clear association that children sleeping on their back had decreased risk of SIDS, however this was not common knowledge. It struck me after that campaign that so many families blamed themselves because they lacked the knowledge. Television gave me this incredible platform for population education and I was asked to continue medical segments on CTV. It was really at that point that I had the desire to continue taking complicated research and translating this knowledge into simple language that was easy to understand and that had a clear action

plan. I continue to do that to this day and I love it as much as practicing clinical medicine.

AR: When you first started appearing on TV you were one of the first in Canada. Did you get help from other medical professionals?

MS: Certainly having the training in epidemiology gave me the ability to critically evaluate medical articles and interpret them. With more complicated topics that fall outside my area of training, I will always call another medical expert to ask for their opinions. I watched what others were doing on air and was guided by the same basic principles — use language that is easy to understand, never speak down to people, but directly to them and make people feel as if I was in their home speaking with them about important information they need to know. So the more I did it, the better I got at it. I made mistakes along the way, but got an incredible journalism education on the job.

AR: As you create these stories and reports you want them to be relevant and useful. How do you pick your stories?

MS: I have access to all the journals pre embargo. For example, I've seen the *JAMAs* and *NEJM* for next week. As a medical journalist, I get everything in advance and do a significant amount of reading. As time goes forward, you get a sense for picking out which stories will be useful and successful, and this is done collaboratively with the program team.

AR: With all the information available on TV and the Internet these days, do you feel that doctors have a greater responsibility to speak up in the media?

MS: We have a great responsibility because we recognize that a lot of what's out there on Dr. Google is not scientific

cally valid. Social media has also changed how we communicate and has influenced the transfer of anecdotal knowledge. As a part of our training we now focus on evidence-based medicine, a compilation of all the new information being generated — clinical trials often contravene observational data that previously guided medical practice. Patients are becoming increasingly consumer oriented, they do their homework and so it's very important to ensure that we are speaking up in terms of what is science, what is evidence, what the data tells us, as opposed to what's popular and anecdotal.

AR: After being diagnosed with breast cancer, you shared your experience with Canada and the world by writing a book, doing interviews and creating a documentary. What made you decide to do this?

MS: I wanted to be the one who shared that news. I did not want people to talk about me or to lose my voice. Initially, it was just about making a very simple statement — we said that I had breast cancer like many woman in Canada — and that was where it was going to end. But there was such an incredible response from Canadians, I was literally overwhelmed by emails. As I began to go through this journey I was stunned that there was so much that I didn't know, even as a physician. Being the patient now as opposed to the doctor navigating through this was an incredible opportunity to share my story. It was important that we decided to do it as a family, given my husband and children were in new roles as well. The cancer journey was my family's cancer journey. I thought we had a story to tell — it wasn't so much about science, medicine and the decision making around breast cancer, but what happens to families when they go through

this. The network was quite protective and wanted to be sure that this was something I wanted to do. We decided to tell the story and I never regretted the fact that we did.

AR: After sharing your story, do you find it more difficult to separate your personal life from your professional life?

MS: No, 99% of my personal life doesn't make it to air and this is intentional. My cancer journey made it to air because I chose to tell the story. There's no way I could go through breast cancer without it being disclosed nor would I hide it because the message of hiding cancer and not being able to talk about it is not the message I would share with anyone. I wanted to be in charge of the messaging.

AR: Has your experience in television and writing changed the way patients see you in clinic?

MS: I've been doing this for so long that my patients are my patients. They recognize that what they see on TV is one role, and when I'm in the office with them, I'm in there 150% paying attention to them in a separate role. My relationships with my patients are very firm and established so that what happens in my office is patient focused, individual focused. It's very different from what happens on air.

AR: How do you find time to maintain a practice?

MS: I'm a very high energy person and a pretty well organized person. When I look at all the things I do — it's crazy. I write for several publications; I'm editor of Parents Canada; I write a blog column; I have a new national talk show and still do Canada AM; I do lots of public speaking; It's a really busy life, but I love everything that I do! Luckily I don't need a lot of sleep!

My family is also critically important to me. When my kids were very small I didn't have this level of public involvement. You need to be guided by the things you love, and because I love everything that I do it's not really a job to do it. It is an honour and privilege to have this bond and trust with viewers who watch us.

AR: What advice do you have for medical students, and for those interested in TV and journalism?

MS: Medical students these days are wiser than medical students of my era. You consider life balance where we never thought to plan for this, never thought about how we would make it all work. It's quite a juggle, particularly for women in medicine who would like to have families. I think that you've got to continue to recognize the fact that you need balance and a career that you love to do. There will always be times when you lose that balance, when your career will become increasingly demanding, when you have to give up family time. In these situations it is important to have a very collaborative partner in life and to be clear in your communication so that neither party becomes resentful.

For those interested in medical journalism, you will be well served by some formal training in journalism, which I've gotten along the way as opposed from entering it from an academically trained area. Volunteer. If you're interested in writing, get involved with your school publication or write for a local community newspaper. Give television a try at a local network. Find a mentor, someone who can help you work through your interests to figure out whether or not this is something you want to pursue. Get your feet wet — and don't be afraid to jump in! ■

What's new with alumni affairs?

Dr. Cait Champion
 CFMS/FEMC Alumni Officer
 PGY1 General Surgery, University of Ottawa
 University of Toronto, Class of 2012

THE CFMS' ALUMNI AFFAIRS program has continued to grow in 2012–13. Over the past three years we have been working to engage our alumni in a supportive mentorship role for Canadian medical students through Alumni Lunches at our General Meetings, the Alumni Q & A and other contributions to our Annual Review, and our CFMS-RBC Medical Student Leadership Awards. Through these avenues our alumni have been generous in their time and energy to help provide students with a perspective beyond the walls of medical school into life as a physician and what it means to be a physician leader within the medical community.

This year has also been an exciting year for me as I have made the transition from medical school to residency and joined the ranks of CFMS alumni. As a resident I've continued my involvement in peer-advocacy and leadership projects and have been delighted to encounter many friendly faces and CFMS connections. The CFMS has a strong tradition of supporting leadership development among medical students, evidenced by the number of alumni sitting on boards of universities, hospitals and medical organizations across the country who believe in creating positive change.

It is with this in mind, that I believe one of the greatest strengths of the CFMS is in supporting medical student leadership and in celebrating and sharing the successes of our members across the country and around the globe. This is

why I'm so excited to see growing alumni participation in the CFMS-RBC Student Leadership Awards, which highlight the leadership contributions of medical students at each member school. 2011–12 saw a record number of award applicants, all of whom deserve congratulations for their roles as leaders and mentors among their peers. I have no doubt that these students will continue to be strong advocates within their communities throughout their careers as residents and staff physicians.

As always, I want to finish up by saying thanks to all of our alumni who take the time to share their experiences, wisdom and expertise. It is from your hard work, successes and challenges, that Canadian medical students have such a strong foundation from which to grow as future physicians and leaders. ■

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

Congratulations to the 2012 recipients of the CFMS–RBC Medical Student Leadership Awards

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Memorial University	Patrick Fleming, Class of 2013

Alumni Q & A

How do you maintain your work–life balance?

Dr. Cait Champion
CFMS/FEMC Alumni Officer
PGY1 General Surgery, University of Ottawa
University of Toronto, Class of 2012

Dr. Alison Meiwald **Emergency Medicine, PGY-5**

Maintaining a work–life balance is integral to being happy. The biggest problem occurs when people make work their life and forget there are other things out there. The hardest (and easiest) thing to do is to make yourself a priority. This means setting aside some time every day for yourself and those people you enjoy spending time with. This may mean getting up 15 minutes earlier so you can enjoy a quiet cup of coffee while reading the paper or deciding that supper time is for eating and conversing with others, not for sitting in front of the TV or playing video games. There are, of course, going to be days where this won't work — being on call, in the OR or working a shift in the ED. That just means that on the days when you can do it, it's so much more important to make the effort. Don't become complacent. Work is important — but it shouldn't rule your life. You should rule your life. Take charge of things, make time for what's important, give everything you have at work, and then give everything you can to your life.

Dr. Brad Dibble **Cardiology**

This is one of the most important aspects of developing and maintaining a healthy practice. You need to maintain time for you and time for your family. And those two don't always go hand in hand.

I have three pieces of advice based on what I've learned over the years:

1. Carve out time slots that you dedicate to you alone and other time slots you dedicate to those around you. I'm a creature of habit and that works well for me. I'm not so rigid and inflexible that this "schedule" is adhered to perfectly, but it works well enough that I manage to stay grounded. As examples, I tend to get up earlier than everyone else in my family and give myself about a half hour every morning to clear the cobwebs and get ready for my workday. For my weekends, mornings are generally mine to read, exercise, listen to music and catch up on anything that was put on the back burner during the week. From lunchtime on during the weekend my family has as much access to me as they want. During the week I guarantee that I'm home a minimum two nights a week. So I'll say no to the CME event if I already have call, committee work and a dinner meeting taking three of my weeknights.

2. Learn how to say no. People around you will quickly figure out that you're a good person to invite to participate in various activities, whether it's this committee, that fundraiser or the party down in the city. You can't do everything and it's okay to say no, that you already have too much on your plate "but thanks for asking." Even purely fun non work-related events need to be subjected to this kind of discipline.

3. If you do feel compelled to say yes to a request, but your "dance card" is already full, immediately look at your schedule and figure out what things

you'll have to give up in order to make the time for the new activities. And if you want a happy and healthy life, family and friends should never be on that list. You may have to give up this committee, that service group or your golf membership depending on how important the new task is for you to take on. Perhaps your piano lessons need to be postponed for a year while you're President of the Medical Staff. But that's better than taking on both and not doing a good job at either because you don't have the time to dedicate to both properly.

No one should ever have more control over your life than you, so if things start to seem overwhelming, step back and review everything. Even major aspects of your life may need to take a back seat to new activities. Good luck, because it really is a wonderful life when it's all balanced.

Dr. Irfan Dhalla **General Internal Medicine**

I am not sure I am the right person to be asked a question about work–life balance! Personally, I am considering taking a life cycle approach to the issue. In all seriousness though, we are lucky to be able to pursue a career where we do meaningful, enjoyable work and to be paid well enough to enjoy most of what life has to offer. If you enjoy your work (and can spend most of your free time with your friends and family) then the work–life balance question becomes considerably less important.

Dr. Jason Kur Rheumatology

The best advice I received during my medical training which has helped me to maintain a reasonable work–life balance related to setting up my office practice. As an office-based specialist one can very quickly fall into the trap of scheduling patients five days a week. This occurs commonly in the early years of practice when student loans and debt weigh heavily on new graduates and there is a strong desire to start using the skills one has spent so long learning.

The advice I received from a mentor was simple and somewhat contrary to this approach of working five days a week. From the day you start booking patients in your practice, keep one day a week free from obligations. Physicians find it nearly impossible to scale back work once they are committed to certain schedules. If you block time off from the start, you will not be aware of the perceived diminished financial returns and you will have a day preserved in your schedule as your practice grows. That simple scheduling intervention has allowed me to take on other projects both professionally and personally that have been very life enriching.

Dr. Mary McHenry Pediatrics, PGY-3

A typical day for me is busy — getting up early with my two-year-old daughter and then rushing off to work! I am a third-year pediatric resident as well as co-chief resident for our program. I believe the key to work–life balance is making sure you are doing things you love and are passionate about. I love pediatrics and feel privileged to work at such a great hospital with an amazing group of residents. When I'm not at work, I'm usually spending time with my daughter, playing with dollies and reading books. My days are fun and busy! That is the key :)

Dr. Kevin Busche Neurology

I'd like to preface this by saying that I love my work. I enjoy meeting patients and the people that support them. I relish both my clinical and academic work and I think what I do is important and valued. It's a rare day that I don't look forward to going to work when I get up in the morning. All of that being said, there is one time of the day that I like even better than going to work: going home at the end of the day. This may sound a bit selfish, but I don't think it is.

One of the many wonderful things about being a physician (and there are many) is that, by and large, you are in control of your own time. I know full well that this isn't true while you are a med student, a clerk or a resident, but the time will come where you get to decide how you spend your time. Sure, there are going to be clinical emergencies, extra patients that need to be seen at the end of clinic and reports your department head asks you to write, but these are the exceptions. You get to decide when you take your vacation time and how you schedule your days. Take advantage of this! One of the most empowering things you can do is maintain control over your own life.

Schedule your vacations weeks or months ahead, mark them on the calendar and look forward to them. Don't work during your vacations — devote that time selfishly and unashamedly to yourself and your family.

It's ok to consider working less than full time so that you have more of that free time to spend.

Arrange your days so that they work for you. If it's important to you to hit the gym or run a few times a week, make sure that you make time for that in your schedule. Set up your clinic days so that you finish with time to do the things that you like to do.

These things are all about looking after yourself and a healthy you is going to be a better physician and a better

person. You are going to provide better care to your patients and do a better job as a spouse, parent and friend if you are physically and psychologically well. Your career as a doctor is a marathon and your personal time is the refueling station that will let you cross the finish line as a winner.

Dr. Nick Withers LCol, Pacific Regional Surgeon

Maintaining work–life balance is a struggle for most physicians and the situation is no different for a Canadian Forces Medical Officer. Unlike many who say turn off your BlackBerry when on vacation, this position causes me more stress than checking it for 15 or 20 minutes a day. I attempted to leave it at home or off during family vacations, but found that I could not enjoy the last days of my holiday knowing I was heading back to 500 emails. Dedicating a short time to email daily allowed me to stay abreast of developments and kept my inbox cleared without significantly disrupting my day. That said, I would highly recommend you only check when it does not disrupt family time. As well, ensure that you turn off any email alerts so that you are not getting anxiety-provoking reminders of work piling up!

Dr. Danielle Martin Family Medicine

Work–life balance? I try not to think about balance as something that is achieved over the course of a single day or even a week. To me, balance is achieved over longer stretches. I might work very hard for a few weeks, but then take a three-day weekend with my family. I might have a busy social week with lots of evening plans with friends and then buckle down and work all weekend. I make an effort to get balance over the course of a few weeks so that all the roles I play get my concentrated attention — but it may not be all in the same short span of time.

In terms of family time, I always schedule a long holiday in the summer so that we can really relax and hang out together. I book a locum to cover my practice and take a good chunk of time to wind down. I also try to schedule time with my partner (and for myself) once a week — a few hours for a date night or an evening out with friends. I schedule time for exercise during the week and I never, ever cancel. If it isn't in my schedule, it won't happen — so I really make an effort to plan ahead.

Balance isn't easy ... it's a moving target and I never seem to get it quite right. The most important thing is avoiding feelings of guilt (I should be home more, I should work harder, I should be a better doctor/friend/spouse/mother/etc). If you can let that go and accept that you are doing the best you can in each area, sometimes doing a little too much of one thing or the other, you find that it all evens out over time. ■

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Beautiful Wonder

Alysha Sears

Memorial University, Class of 2014

I saw a butterfly in November,
And this brought about great wonder:
How would the fragile soul
Reach a warm place 'ere it got cold?

Did the creature know
We were expecting snow?
Who informed her of imminent harm?
How would she keep warm?

Who should protect wildlife
As a husband would a wife?
Should a passerby protect that life?
Should they cause themselves such strife?

No weather forecast reached her.
Her friends did not warn her.
Yet she is alone in November
Fluttering at a flower.

An unexpected and wondrous look I took.
So eloquent and awe-inspiring did she look.
Yet now I sit and wonder.
Yes I really do ponder
Whether I, a mere passerby
Could have warned her that things would go awry?
Could I have made her feel less alone?
Or was it best for her fate to remain unknown?

Perhaps this butterfly represents the lonely souls we choose to ignore.
The ones we choose to forget when we should adore.
How we hesitate to help others meet their needs and desires
To get on with our selfish lives more quickly
Instead of showing our sympathy?
We often choose what is easier
And do not lift up those who are weaker.

An Old Rusty Cart

Brandon Maser

Queen's University, Class of 2016

Tell me more about this emptiness
That permeates your crevasses,
Echoes thoughts of loneliness.
The whispers that doubt, insecurities that sprout
Where nothing else grows.

Scared to show
Those silent tears that nourish fears,
Souvenirs of a man apart.
How long ago did they start?
Have they filled you up, your half-empty cup,
Flooding your fenestrated heart?

Every day is a fight
Against dark dreams of flight,
Against autonomic pleas
For any escape that might appease
Your daily plight,
And offer rest, make life easier to digest.

It's these thoughts that arrest
Your heart, imprison your mind,
As it begs for mercy, or something of the kind,
Pleads non-maleficence,
Fights to end the reticence.

On a scale of life to death,
You're somewhere in the middle.
With every labored breath,
You wither just a little.
Your behavior, robotic,
Your will, osteoporotic, brittle.

Fading and weak, an old rusty cart
Traversing a mountain peak,
Your cold dusty heart
Limps through another week.



◀ LIFELINE EXPRESS

HORACE CHENG, University of Ottawa, Class of 2014

Mother holding her daughter while waiting for her cleft lip repair surgery aboard the Lifeline Express train hospital. Hope and laughter permeated the waiting area as children with cleft lip received free surgical repair, a procedure that was beyond the financial reach for many families in rural India.

LIFELINE EXPRESS ▶

HORACE CHENG, University of Ottawa, Class of 2014

Operating rooms specifically fitted within the train cars, with visiting volunteer surgeons and professional OR staff on-board. The train hospital serves as a mobile platform where medical expertise can be delivered to under-served areas across India.

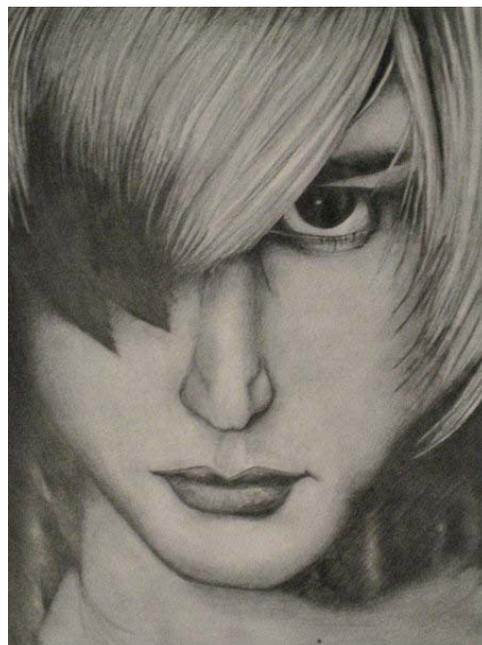


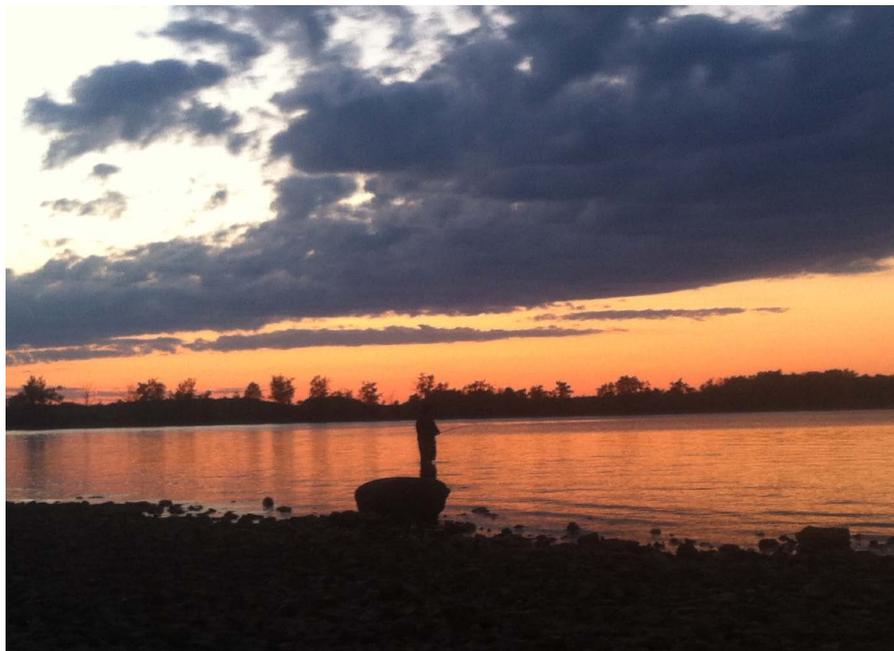
◀ LIVING IN COLOUR

DIANA SONG, University of British Columbia, Class of 2014

SERENDIPITOUS SELF ▶

DANIEL PALUZZI, Queen's University, Class of 2016





◀ **LONELY FISHERMAN**

ANTHONY VO, University of Ottawa,
Class of 2015

ROAD CLOSED ▶

ANIL KESHVARA, University of
Saskatchewan, Class of 2016



SERENITY ▶

BAHAR BAHRANI, University of
Saskatchewan, Class of 2016



Red. Blood Red.

Eve Purdy

Queen's University, Class of 2015

A chaotic emergency room
filled with infinite patients focused on nothing but their illnesses,
hurried doctors focused on nothing but the same,
and a medical student who stands still
transfixed by the colour red.
Blood red.

The room is prepared for an endoscopy,
the machines recruited in anticipation of a gastric bleed,
the lights are dimmed to better see the screen.
But one remains on, shining brightly,
a spotlight accidentally directed at the hanging transfusion bag.
The medical student cannot force her gaze away from the beautiful red.
Blood red.

The procedure is over,
the scope removed and the patient recovers.
The team retreats but the medical student stays.
She is transfixed by the beautiful,
hemoglobin-elevating, life-saving flow of red.
Blood red.

The long shift is over,
a new team takes to the floor,
the night shift leaves, relieved to be walking out the doors
but the medical student lingers,
she worries about the red.

The medical student worries that when she leaves
the beauty of the red will go unnoticed.
Transfixed by its power,
she steals one more glimpse
and out of respect chooses a new favourite colour.

Thunder

David Sheps

University of Toronto, Class of 2016

Your wrinkled skin,
is soft and awkward
in my fumbling hands.

Gripping your arm like a paper crane,
pushing through your corduroy skin
I fear
the slightest squeeze might break you.

Like my first dance in grade seven
I hold you, clumsily
keeping distant in this close contact
as I search for your quiet pulse.

My sheepish grin meets
your crinkled smile,
reassuring, like an older lover.
It's alright to be nervous your first time.

Braids of sweat gather as
I fail
this simplest skill.

A pause.
Then

Seconds thunder

Your every beat a defiant laugh
Blasting through your weary wrist

It patters on my fingers
But hammers heavy on my heart.



A transition to clerkship: planting the seeds

Vidhi Thakkar

University of Ottawa, Class of 2014

Medicine is a calling, a true test of one's heart and head
 So many concepts, approaches, and ACLS algorithms I've read
 And yet the goal is to heal people's health state
 While at the same time keeping myself up to date
 Remember there is a fine circular balance in life
 That social support and colleagues are my way to fight strife
 It will be tough at times, but internal resilience is key
 Athletes don't always worry, may be anxious and stress free
 They anticipate and plan, expecting the worse hope for the best
 And when I'm given the time, I will go see my family and rest

Compassion, empathy and caring are the way to finding a healing power
 Connecting with others, I want my medical and people skills to flower
 Coping skills in tough times and talking to friends will be my reality check
 To ensure that I put together the pieces of this medical deck
 Come what may, I know I can think
 Reason, logic and science are always on my mind's brink
 But can I really do, can my hands and technical skills allow me to do
 The art of surgery and medicine, to help patients and be true
 Of an honest, genuine nature, this thought I grew.
 And so here I go, off to class to learn best methods of prescription writing
 This next year will indeed be very exciting.
 I hope I can continue to dream real and strive
 These 21 months are certainly my time to thrive

Balance

Andrea Gauster
Queen's University, Class of 2013

BALANCING A MUSIC CAREER as a singer with medical school is challenging. I realized this in my first two years at Queen's when my music was gaining momentum and I had a hard time giving up any opportunities. I continued to tour and play bi-monthly gigs, recorded my second album and rarely refused an interview opportunity. As an independent artist, this was a struggle because I was doing all of my own booking while attempting to maintain an adequate online presence (something crucial in the music industry these days).

And then there was the studying, the interest groups, research, making new friends and getting to know a new city, finding time for family, working

out, sleeping! Most of the gigs I played entailed late nights and were often out of town and this did not always jive with the early mornings demanded by medicine. Very quickly, my life became overbooked. I was tired, had gained 15 pounds, was catching every cold being passed around and was on an easy path to burning out. Something had to give. I had to learn how to say "no".

In a fit of stressed-out fury I remember writing a blog entry right before our December exams that described my need and desire to take a step back from all of my commitments. I wrote "I made the conscious decision to CHILL this holiday season. No gigs. No plans. No studying. Just taking it day by day."

I started to feel better in the months that followed. I still played shows, but they became more interspersed. I turned down interviews that overwhelmed my schedule. I studied at better hours of the day. I even started watching TV! I continued to write songs, but as the demands of medical school and clerkship increased, the amount of actual music I produced became less and less.

But I felt balanced.

When people ask me how my music career is going now, my answer is torn.

On a personal level, I really can't complain.

Music and songwriting have become such a big part of who I am and how I make sense of my own emotions and reactions to the world I live in. This has been huge for me as I've entered the world of medicine and witnessed the range of stories, happy and sad, that we as health care workers observe on a daily basis. Staying in tune with my artistic side has also allowed me to keep the human condition at the forefront of my interaction with patients. Personally, I think this will only benefit my future career as a clinician.

On a career level, things have slowed down. My iTunes revenue has dropped, CD sales are at a minimum, I play less live shows now than I have since I started pursuing music professionally and my Facebook page is probably the least active it's ever been.

But I feel balanced.

Looking back on my time in medical school thus far, I have to say that I have no regrets. Pursuing a music career alongside a medical one has taught me about my limits. I can look back on these four years and be proud that I didn't abandon my artistic side even if it's not as publicly present as it has been in the past. I can also look back and say that I made amazing friends, maintained old relationships and am on my way to accomplishing my long-term goal of becoming a doctor. Besides, every time I listen to Dylan or Cohen, Sarah Harmer or Justin Bieber, I'm reminded of one beautiful thing — music knows no age. So I'm in no rush.

To learn more about Andrea and her music, visit www.andreagauster.com and <https://itunes.apple.com/us/artist/andrea-gauster/id322015943#> ■



8 Friends, 12 Instruments and Q Weekly Music: Getting to Know UBC's Honourary MD

Danielle D'Aleo, University of British Columbia, Class of 2014
Bronwyn Malloy

ON THE LAST DAY OF EXAMS in December 2010, James Harris (MD 2014) used all of his many wiles to gather everyone he knew in UBC Medicine that played any sort of musical instrument into his parents' living room. Some were friends; others were barely acquaintances that he had overheard talking about music. He also used his sister's friendship with a UBC English student studying and writing song lyrics to lure Bronwyn Malloy over on the same day. The idea was that maybe Bronwyn could help write a song for the group to perform at the Spring Gala. Little did they know, Bronwyn would make them do many more things than that — already involved in the local small venue music scene, Bronwyn encouraged the group to play several shows around town in the months prior to the Gala. When the first of these venues asked what our band's name was, "Honourary MD" was officially born.

From the first day, the music worked, but much more importantly, the group worked. When we played at the historic Railway Club in the fall of 2011, our music was described by an enthusiastic Ubysey reviewer as "big, positive and danceable freak folk." The reviewer may have been describing our sound, since we collectively play the guitar, piano, bass, violin, flute, trumpet, drums, mandolin, accordion, ukulele, banjo, sitar, glockenspiel, and tablas, and we all sing sometimes, but the phrase could equally describe our group dynamic.

We're big! Our members include, Ben

Trepanier, Danielle D'Aleo, James Harris, Jaspreet Singh, Kevin Fairbairn (all MD 2014), Theo Jankowski, Glen Manders (MD 2013), Bronwyn Malloy and Paul Healy, the Honourary MDs themselves.

We're positive (and danceable) and we like to perform upbeat, playful music, often incorporating snippets of popular songs into our own compositions (most infamously, using Rebecca Black's "Friday" as an intro to our song "Veins"). Band practice has always consisted of 40% music, 60% laughter.

Meeting every Sunday night for band practice was a stretch for all of us — trying to get through Brain and Behaviour and learn five new songs at once was probably crazy. Then again, there's nothing like convincing Jas to teach you how to play rudimentary tablas, singing at the top of your lungs to relieve study stress or agonizing about writing a melody instead of an exam, and suddenly realizing that we'd written a song we all liked. It was

amazing watching some kids sing along when we learned how to play Justin Bieber for a brief show at BC Children's Hospital.

As for the "freak folk" description, we sort of play indie folk (Edward Sharpe's "Home" is our favourite song to cover), but we also like to turn folk on its head by dancing goofily onstage, jumping off amplifiers and pretending we're playing miniature stadiums. Sometimes, these stadiums are as miniature at the MSAC, where we played both our first and last live gigs at Arts in Medicine nights. The support of the UBC Medicine community at these events and all of our shows has been so incredibly special to us. Without their enthusiasm, generosity and eternal willingness to dance along, we would never have left James' living room.

To listen to Honourary MD, go to <http://www.youtube.com/user/honourarymd> ■



TLGLTP (topless) — The Glitter Brick Road

Kevin Fairbairn

University of British Columbia, Class of 2014

ONE OF MY TURNING POINTS in medical school was during our first set of lab exams in first year. I was looking down at a blank anatomy answer sheet and some glitter fell out of my hair. It was then that I knew that things were going to be ok, not because I knew the answers, but rather because I was happy.

My band had decided to set up a show during the exam period and as luck would have it our lab exams would fall the day after (1 vs 6 doesn't go a long way in a vote). I decided to play the show and try out this 'balance' thing people kept talking about instead of cramming. I didn't sleep that much, but I figured that's good practice for clerkship.

When playing in a band you are more than an instrument. It is a

complex relationship of love and trust. I play in a group known as 'TLGLTP' or just 'topless' to some. During the past two years we've travelled across the country from Victoria to Toronto, played on top of mountains, in trains, and in both packed and empty clubs. We have been through ups and downs, lost members, gained new ones, and made a record. What brings us together is the opportunity to create an emotional connection. More often than not it includes sweat dripping off your face, makeup, spandex and a whole lot of glitter. Through either live or recorded media we strive to communicate the intimacy that we share as a group and provide an environment where people can open up. Whether or not you are in medical school, having fun is part of

living and this should never be completely compromised.

Music for me is more of a way of living than a lifestyle choice. It is simply something that I have always been involved with. I know that it will be my support through medical school and be there after the sun sets on my medical career. This dedication and compassion is not unique to art. The creative realm extends far beyond traditional artistic boundaries and expressive emotion can be found in nearly any activity. What unites us as medical students and artists is a passion for life and it is this passion that drives us every day.

To find out more about the band and their music, go to <http://toplessgayloveteknoparty.com/> ■



Weddings ...



**David Martin, Queen's University,
Class of 2014**
Date of wedding: June 1, 2012
Location: Brampton, Ontario
Name of spouse: Tiffany Martin (nee Hanlon)



**Jennifer Sibley, University of British
Columbia, Class of 2014**
Date of wedding: August 10, 2012
Location: Kelowna, British Columbia
Name of spouse: Matt Sibley (UBC 2011)



**Robin Clouston, Memorial University,
Class of 2013**
Date of wedding: August 4, 2012
Location: St. John's, Newfoundland
Name of spouse: Warren Coombs



Mimi Lerner, Univerity of British Columbia, Class of 2014

Date of wedding: August 19, 2012
 Location: Vancouver BC
 Name of spouse: Cameron Lam



Nicole Stockley, Memorial University, Class of 2014

Date of wedding: July 21, 2012
 Location: St. John's, Newfoundland
 Name of spouse: Shannon Patrick Sullivan

Babies ...



Suvera Dorais Ram
 Birthday: October 28, 2012
 Birth place: Calgary, AB
 Parents: Rithesh Ram, Univerity of Calgary, Class of 2012 and Veronique Ram (MD/PhD, Class of 2016)



Emilia Gail Arafon
 Birthday: July 13, 2012
 Birth place: Delta, BC
 Parents: Melissa Aragon, Univerity of British Columbia, Class of 2014 and Hector Aragon

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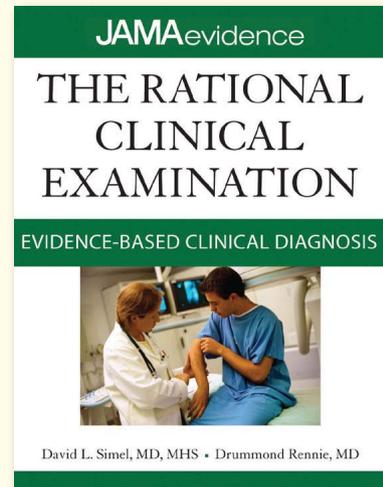
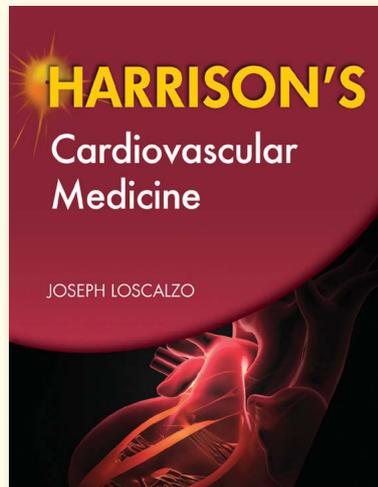
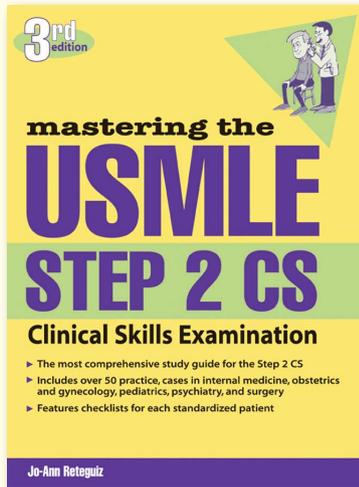
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