

CFMS FEMC

Canadian Federation of Medical Students

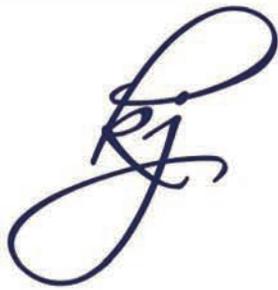


Fédération des étudiants et des étudiantes en médecine du Canada

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PART OF OUR PROFESSION" –
AN INTERVIEW WITH
DR. DANIELLE MARTIN





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Our Mission

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

Our Vision

Tomorrow's physicians leading for health today.

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

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

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

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

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

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

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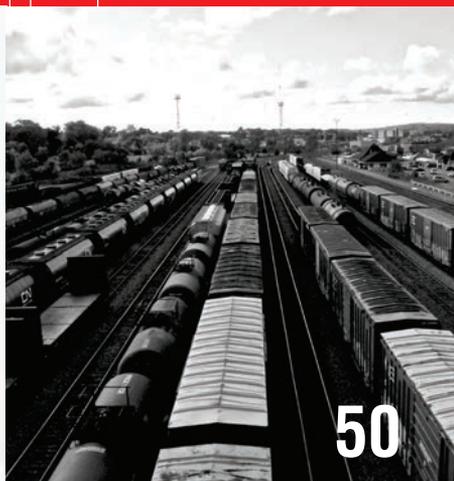
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Josie Xu
Medical student
CMA member

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Letter from the editors



Yin Hui
Annual Review Editor
 Western University,
 Class of 2015



Anthea Girdwood
 VP Communications
 University of Ottawa
 Class 2016

Dear readers,

If, at some point in your career, you think that there is no possible way you can make a difference, we urge you to flip through this issue of the *Annual Review*. Medical students across Canada are accomplishing incredible things every day! We have learned about three student-driven clinics whose success has centred upon a renewed focus on the social determinants of health. The *Annual Review* also has many examples of the ways that students have incorporated global health, the environment, the humanities, and more into their development as medical professionals.

At the same time, medical school can be a time of uncertainty, when our confidence can waver and we can feel unsure of our path forward. If you've felt that way, you are not alone! This *Annual Review* features raw and honest explorations of feeling like an impostor, of the harshness and the necessity of the operating room, and of the experience of loss and letting go.

In our featured interview, Dr. Danielle Martin, most well-known for defending the Canadian Health Care System in front of the US Senate, also has some advice for speaking up even when you are not the most experienced person in a room. A former CFMS President, Dr. Martin shows us that, when we speak from our values, our experiences, and when we know the evidence, any medical student can create change. Needless to say, this issue of the *Annual Review* hopes to empower and inspire all of our members to explore the many ways we can serve as advocates and leaders during our time in medical school.

We would also like to draw your attention to some new additions to the Review. To improve transparency and accountability of the CFMS, we have included our mission and vision with this issue, as well as our Strategic Plan. Created over the course of 2014 with feedback from broad elements of its membership and key stakeholders, the Strategic Plan charts a course for the CFMS for the next three years.

Every year we are awed and humbled by the high quality of the submissions we receive. Unfortunately, we are charged with the difficult task of selecting only a portion of them for publication. We'd like to extend our sincere appreciation to those who submitted their work to the *Annual Review*, and would like to encourage all of our members to share their experiences, initiatives, opinions, and creative works in the future!

The *Annual Review* 2015 editors,

Yin Hui

Anthea Girdwood

All editorial matter in *CFMS Annual Review 2015* represents the opinions of the authors and not necessarily those of the Canadian Federation of Medical Students (CFMS). The CFMS assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice herein.



Lifestyle Checklist

- › short commutes
- › diverse practices
- › lots of room to play
- › great schools for my kids
- › great work environments
- › financial security
- › diverse communities

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Letter from the president



Bryce Durafourt
President
McGill University
Class of 2015

What an honour it has been to represent 8,000 of my fellow medical students as CFMS President! My journey with the CFMS began in my first year of medical school at Lobby Day. From there, I went on to be elected as Québec Regional Representative, during which time I worked to build our relationship with our colleagues at the Fédération médicale étudiante du Québec (FMEQ). Another priority as Québec Rep was to improve our bilingualism strategy. I was thrilled to announce the launch of our French language website at our Spring General Meeting (SGM) in April 2014. At that same meeting, I was elected CFMS President. Since then, it certainly has been an adventure between attending meetings as a medical student representative, to improving my ability to chair meetings, to fulfilling my clinical duties. While I can't deny it may have been stressful at times, I've enjoyed every minute of it!

At our Annual General Meeting (AGM) in Kingston this past September, I officially took over as CFMS President. At that same meeting, the CFMS general membership adopted a new three-year strategic plan for 2014-2017. CFMS Past President Dr. Robin Clouston led the development of this project, involving significant efforts from the entire executive as well as consultations with our membership and key stakeholder groups. In addition to highlighting our new mission, vision, and value statements, the document proposes an expansion of the current capacity of the organization and looks to strengthen its current governance structures, decision making processes, professional image and involvements, and aims to make the organization more relevant to Canadian medical students. Indeed, this document has served to energize the new executive and provides a framework for us as we make decisions that shape the future of our organization.

As CFMS President, one of my main focuses has been the residency matching process. The CFMS continues to advocate for a fair and transparent matching process and we are concerned about the increasing number of unmatched Canadian medical graduates in recent years. We also recognize our obligation to serve the needs of society in an ever-changing landscape of healthcare delivery. The CFMS sends representatives to groups working under the umbrella of the Future of Medical Education in Canada (FMEC) project, whose flagship report in 2012 issued a number of recommendations regarding post-graduate medical education. The first and perhaps most important recommendation was to ensure the right mix, distribution, and number of physicians to meet societal needs. In working towards this goal, I sit on the Association of Faculties of Medicine of Canada (AFMC) Residency Matching Task Force, as well as the Physician Resource Planning Task Force, a joint venture of Health Canada and the AFMC. Through conversations at these and other meetings, I continue to advocate for our members, in the context of a system that best serves the needs of the Canadian population.

In the remainder of my term, we'll be heading to Vancouver in April for SGM, and to Windsor in September for AGM as our very first meeting at a distributed medical education (DME) site. I couldn't have asked for a more exciting way to wrap up medical school. Certainly, looking back to my very first Lobby Day in first year, I never would have imagined that I was about to embark on such a thrilling ride.

Sincerely,

Bryce Durafourt

The CFMS 2014-2017 strategic plan

Irfan Kherani

Vice-President Education
University of Alberta, Class of 2015

Anthea Girdwood

Vice-President Communications
University of Ottawa, Class of 2016

Bryce Durafourt

President
McGill University, Class of 2015

Robin Clouston

President 2012-2013
Dalhousie Family Medicine Integrated Emergency Medicine, PGY2

THE CANADIAN FEDERATION of Medical Students created the first organizational Strategic Plan in 2011, with support from the General Assembly. An external consultant was hired to produce the Strategic Plan, and an Implementation Plan was created by the then-CFMS President, Noura Hassan. That Strategic Plan served the organization for three years and has now been completed.

For this iteration, we have taken a different approach. Drawing on skills that senior Executive members have learned from that first strategic planning process, the CFMS has created its new Strategic Plan internally, led by CFMS Past President (Robin Clouston), with support and education from external consultant, Dr. Jane Cook-Lauder. The CFMS Executive has served as the Steering Committee, with contributions from members of the General Assembly including Medical Student Society Presidents, CFMS Representatives, the Global Health Program (GHP), National Officers, the Government Affairs and Advocacy Committee (GAAC), the Education Committee (EdCom), External Representatives and more.

In April 2014 at the CFMS Spring General Meeting (SGM) in Ottawa, key groups within the CFMS (Medical Student Society Presidents, CFMS

Representatives and Global Health Program members) created a SWOT analysis for the organization in order to determine our Strengths, Weaknesses, Opportunities and Threats. Additional input was gathered from a small group session of General Assembly members at SGM. This was followed by a plenary discussion of the full General Assembly and all feedback was documented.

One week later, the CFMS Executive/Steering Committee met in Toronto with external consultant, Dr. Jane Cooke-Lauder of Bataleur Enterprises, to discuss member feedback. Through a two-day workshop, a draft Strategic Plan was created, comprised of Strategic Directions and underlying objectives. An updated Mission & Vision of the CFMS was created to guide the direction and activities of the organization.

This first-draft Strategic Plan was distributed to our CFMS key groups for feedback (MedSoc Presidents, CFMS Reps, National Officers, GAAC, EdCom, GHP and External Reps). In addition, general CFMS members were given opportunity to comment via email. We also gained feedback from sister medical organizations and medical student organizations via 12 external stakeholder interviews.

The Steering Committee met again in July, accompanied by Dr. Cooke-Lauder. The Strategic Plan was edited based on feedback received. In particular, the draft was edited to convey our sense of social accountability. In addition, Values and Guiding Principles were created.

Over the following summer months, the plan was edited based on additional key group feedback, as well as feedback from several CFMS Past Presidents. Metrics were determined by the Steering Committee and the Year 1 Implementation Plan was created. This full document was presented at the CFMS Annual General Meeting in Kingston in September 2014. It will serve as a guide for the organization for the next three years, from 2014 to 2017.

Who we are

The Canadian Federation of Medical Students is the organization representing over 8,000 medical students from 14 Canadian medical student societies coast to coast. We represent medical students to the public, to the federal government, and to national and international medical organizations.

Mission

The Canadian Federation of Medical Students is the national voice of Canadian Medical Students. We connect, support and represent our membership as they learn to serve patients and society.

Vision

Tomorrow’s physicians leading for health today.

Values

- Energy: We are a forward-looking organization that takes a proactive and innovative approach to problem solving.

- Equity: We aim for equal opportunities for all Canadian medical students and advance health equity for all members of society.
- Excellence: We strive to deliver the highest quality in all that we undertake.
- Empowerment: We motivate our members to take ownership of their medical education and transform ideas into actions.

Guiding principles

- The CFMS is a member-driven organization that is relevant to all medical students from admission

- through to transition to residency.
- The CFMS prioritizes institutional transparency through ongoing and active engagement of medical student societies and their constituent students.
- The CFMS celebrates diversity of all forms including race, national or ethnic origin, mental or physical disability, age, religion, sexual orientation and gender identity, and in turn, promotes the establishment of safe spaces for all.
- The CFMS recognizes the varied cultural, social and economic context within which medical students live. ■

Strategic Direction #1	Strategic Direction #2
<p>Increase member engagement</p> <ol style="list-style-type: none"> 1. Expose student members to CFMS early in medical school to establish relevance 2. Maintain relevance throughout medical school 3. Support local CFMS teams and encourage involvement in local CFMS activities 4. Promote diverse representation of student membership in CFMS roles 5. Welcome additional student members from Québec 	<p>Support student members</p> <ol style="list-style-type: none"> 1. Expand, promote and facilitate access to relevant member benefits and services 2. Champion student health and wellness 3. Facilitate the exchange of ideas and experiences among medical students 4. Expand ethical local, national and international opportunities for members 5. Utilize public profile to support members in local advocacy issues and initiatives
Strategic Direction #3	Strategic Direction #4
<p>Promote excellence in medical education</p> <ol style="list-style-type: none"> 1. Advance student values in medical education decision-making 2. Empower Canadian medical students to lead local change in medical education, supported by best practices 3. Promote measured reform of admissions to medical school and transition to residency 4. Advocate for a Canadian medical education system which best supports the health needs of Canadians 5. Enhance global health education 	<p>Mobilize the medical student voice</p> <ol style="list-style-type: none"> 1. Expand partnerships and affiliations with strategic organizations at the local, national and international level 2. Increase the external visibility of the organization 3. Create a streamlined process for evidence-informed CFMS external policy development 4. Represent the medical student perspective in the evolution of the Canadian health care system
Enabling Direction	
<p>Enhance CFMS organizational effectiveness</p> <ol style="list-style-type: none"> 1. Promote best practices in governance and accountability 2. Refine and formalize internal decision making processes 3. Meet CFMS human resource needs 4. Strengthen institutional memory 5. Formulate a framework for financial stewardship 6. Focus on continual quality improvement 	

Québec update for CFMS annual review

Carl White Ulysse
 Québec Regional Representative
 McGill University, Class of 2016

AFTER TWO YEARS OF handling the Québec Regional Representative portfolio, Bryce Durafourt has moved on to become the president of the CFMS. It was therefore an enormous privilege for me to step into his shoes to fill that position at the last AGM in Kingston. I had been very keen to get more involved with the CFMS since my first Spring General Meeting (SGM), which was coincidentally held in Québec city, and thought that this portfolio would be a great way for me to help our organization progress. Since then, I have been working on several projects for the CFMS. The first responsibility of the Québec Rep is to take care of all bilingualism matters for the Federation. Therefore, I have revived the Bilingualism Taskforce and expanded its mandate in order to make our Facebook and Twitter feeds 100% bilingual, which was accomplished in December 2014. Thanks to the very dedicated Bilingualism Taskforce members, our website is also slowly but surely becoming available in both official languages. Finally, our bylaws and some key policies have been translated by a professional translator in order to ensure the legality of both the French and English versions of these essential documents.

2014-2015 was also a very important year in terms of individual membership

promotion, as the CFMS now represents students in every single Canadian faculty of medicine! After increased promotion of individual membership among the students within non-member schools, including a presentation at a General Assembly at Université Laval, we now have individual members in all 3 french faculties of Québec. The increased interest from Québec students has also lead Université Laval Medical Society (MedSoc) delegates to attend our Annual General Meeting in Kingston. A letter was also distributed to all MedSoc Presidents in Québec outlining the benefits of our membership in order to get francophone students even more interested in our organization. Finally, the CFMS increased its presence at the MedGames hosted this past January by McGill University by making a speech at the opening ceremony. I am also currently working in collaboration with our VP Finance on streamlining the process of joining the CFMS with an online payment form in order to make it as easy as possible for interested students to join our organization.

Another role of the Québec Regional Rep is to maintain the relationship with the Fédération Médicale Étudiante du Québec (FMEQ). I have had the pleasure of attending their General Council Meetings this year and have collaborated with the FMEQ exec on

“[W]e now have individual members in all 3 french faculties of Québec.”

several projects including the pan-Canadian Wellness Survey. I will also be attending the very first edition of Québec Lobby Day in April, an initiative inspired by our own Federal Lobby Day. As has been the case for the past few years, representatives from the FMEQ have also been attending our Lobby Day in order to gather firsthand experience for this project. Speaking of Lobby Day, I was asked to attend as the “French language spokesperson” and have given an interview *dans la langue de Molière* for CBC Radio in Québec City in order to promote our views on a universal Pharmacare strategy.

In the next few months, my efforts will be aimed at organizing the ever so popular travel awards. With the new streamlined process introduced by my predecessor last year, things are expected to go as smoothly as ever. It will be my pleasure to help non-elected CFMS members to attend our Spring General Meeting (SGM) in Vancouver as it will certainly be a memorable weekend! ■

Ontario regional representative update

Kendra Komsa
Ontario Regional Representative
Northern Ontario School of Medicine, Class of 2015

*We cannot live for ourselves, a
thousand fibres connect us with our
fellow men*

– Herman Melville

AS GLOBAL CITIZENS, I believe that every person has a certain responsibility for the well-being of their peers. Living to help enrich the lives of other people is an interesting concept, which I see as the main goal of the medical profession. Without altruistic acts, humanity would cease to exist as it does today.

In the fall of 2014, I was honoured to be elected into one of two Ontario Regional Representative positions on the Canadian Federation of Medical Students. I knew I was being given the unique opportunity to work with a group of talented, hard-working leaders in medical student advocacy and advancement. I quickly realized that the capabilities and dispositions of the executive team I became a part of far surpassed my preceding high expectations. This group of medical students has embodied the principles I have idealized physicians should exemplify. They truly do give of themselves for the betterment of medical students across the country and the improvement of all aspects of health care for our future patients.

As CFMS Executive members, we take on certain responsibilities, tasks and subcommittees throughout the year, aligned with our mission and our new ongoing Strategic Plan. One

of the tasks I have undertaken is to co-chair the Nominations Committee, alongside one of our Western Regional Representatives, John Schulte. This committee was created after a resolution was approved at the fall 2013 CFMS Annual General Meeting. In her role as one of the Ontario Regional Representatives in 2013-2014, Anthea Girdwood has done a fantastic job bringing this committee into fruition.

The Nominations Committee serves to select medical students to act as External Representatives of the CFMS to our partner medical organizations, as well as to fill some positions internally within the CFMS. The Nominations Committee is composed of the Regional Representatives on the CFMS executive and one non-executive undergraduate medical student from each of the medical schools represented at the CFMS. Additionally, pertinent CFMS Executive members are included when positions directly related to their portfolio are being filled.

The CFMS annually has two official calls for external committee representatives, one in the fall and one in the winter. Internal calls occur throughout the year as the need arises. Once the call for applicants is out, medical students from across the country complete applications for the various positions. The applications are made anonymous and graded using a universal marking system by members of the Nomination Committee. Some benefits of this system include that it

“Without altruistic acts, humanity would cease to exist as it does today.”

allows opportunity for the CFMS to increase medical student engagement and involvement, as well as ensuring the process of selecting students to represent the CFMS is fair and transparent.

The Nominations Committee is one small example of the undertakings of the CFMS to ensure student opportunities for getting involved at the national level. Furthermore, the organization can stand to serve as a framework for other organizations, such as medical school student societies. As the past president of the Northern Ontario School of Medicine Student Society, I believe student societies can utilize this process at their home institutions, which would allow for further engagement of members and help to overcome student apathy, perhaps acting as a supplement to the traditional elective process. Finally, I see the Nominations Committee as being an important aspect in the long term infrastructure of the CFMS in order to ensure altruism, leadership and student advancement continue well into the future of this organization, of which I am privileged to be a member. ■

Evolving role of medical student societies: future-proofing

Franco A. Rizzuti
Vice-President Finance
University of Calgary, Class of 2016

THE ROLE OF MEDICAL student societies has evolved over the last 5 years. Today a medical student society can be expected to participate in accreditation every 8 years, participate actively in Faculty of Medicine governance through committees, coordinate Interest Groups and student initiatives, all while being active medical students. Then, in addition to these fulfilling these tasks, tasks that medical students have a vested interest in, student societies are required to run themselves as organizations.

Organizations across Canada today struggle with keeping pace with stakeholder or member needs, adapting to changing market places, and sustainable growth. Student-led organizations face these same struggles, but with the additional challenges of rapid executive turnover, minimal institutional knowledge, and busy student executives. Medical student societies are no exception to this. In addition, within Canada, most have faced the need to stay relevant, without having budgetary or human resources growth in proportion to the enhanced responsibility.

Medical student societies and, more generally, any medical student-led group can plan for the future by developing a strategic plan, establishing institutional memory, and proportionally growing human and budgetary resources.

So what does this future-proofing and growth planning look like?

Strategic planning

While most student groups have Bylaws and Constitutions, not all have strategic plans. These groups can plan for the future by developing multi-year, ideally three-year, strategic plans with specific and measurable goals or objectives set out for each year. Strategic plans should be rooted in the organization's Mission, what they strive to do, and Vision, what the future impact of the organization will be. Often these two aspects can be formed into a single sentence.

The development of this strategic plan often takes one to six months, depending on the extent of the environmental scan and stakeholder consultation. The environmental scan includes understanding what organizations, resources, initiatives, partnerships exist that could affect the organization's Mission and Vision. Consultation may include engagement of the entire student body as well as consultation with the Faculty of Medicine, and other stakeholder groups. It is important to understand what members want and need from the organization, and have transparency in the process.

For an example of what a student-led organization's strategic plan can look like, check out the CFMS' plan on page 10 and online.

Institutional memory

Rapid executive turnover and busy student schedules are the largest barrier to developing institutional memory. Best practices in developing this

memory include:

- Minute-taking
- Executive reports
- Utilizing position-tied emails instead of personal emails
- Robust transition documents from one year to the next
- Overlapping executive terms, allowing the opportunity for shadowing
- Online or cloud repository of core organizational documents
- Annual financial statements, with records of all transactions
- If budget allows, staff which continue year to year

Proportional and sustainable growth

As responsibilities increase, it is crucial that supporting resources, budget, and human resources grow proportionally. Developing a multi-year growth plan aligned with the strategic plan is a great way to do this. Diversifying revenue to include sponsorship dollars, partnerships with other organizations, in addition to student fees and Faculty support, is one way to grow financial stability. Similarly, identifying the need for more human resources or support starts with understanding how many hours are being utilized. Finally, it is important to identify projected needs, such as additional volunteers or positions, or possible staff.

These are amongst some of the many strategies utilized by organizations such as the CFMS. Best of luck growing your medical student societies for the future! ■

Why pharmacare? A prescription to improve health care for Canadian patients

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

LIKE MANY CANADIANS, I grew up believing that our nation has the best health care system in the world. Our universal system often serves as a source of pride. For many, the notion that all patients deserve access to necessary medical services is as Canadian as hockey and apologizing. Our multicultural nation has loosely defined ourselves as warm-hearted folks weathering a cold climate together. However, entering the medical field quickly teaches us the realities that challenge this romantic view. When compared with other high-income OECD nations, Canadian health care ranks poorly in terms of quality care, timeliness of care, efficiency, equity, and cost-effective care. There are a myriad of reasons for our poor performance. This year, the CFMS tackled what we believe to be an important piece of the puzzle: Pharmacare.

Canada has the dubious distinction of being the only developed nation with universal health care and no corresponding Pharmacare program. We are an international anomaly that funds the diagnosis and investigation of illness while omitting outpatient pharmacologic treatment. This fragmented system results in significant financial problems. Canada's annual increase in prescription drug expenditures is rising faster than other OECD countries. Canada spends over 700 USD per capita on prescription medications, the second highest amongst OECD nations. Canada's medication prices are amongst the highest in the world - approximately 30% above the OECD average. Due to the relatively low proportion of public funding for pharmaceutical expenses, these costs come

largely from the pockets of patients.

Financial burdens become health burdens for Canadian patients. Approximately 10% of Canadians cannot afford their prescribed medications, resulting in rationing or non-adherence. In contrast, only 2% of patients within the United Kingdom report cost-related non-adherence.

The pharmaceutical system is complex, but a wealth of research from policy experts suggests Pharmacare can provide significant financial and health benefits for Canadians. For example, provinces often negotiate drug prices on an individual basis. A universal Pharmacare system that supports bulk purchasing on behalf of all Canadians can lower medication prices - a tactic that has already produced promising results. The Pan-Canadian Pricing Alliance, a cooperative effort between provinces to jointly negotiate drug prices, has saved \$260 million in medication costs annually. Through various changes including reduced tax deductions and decreased administrative costs, health policy researcher Dr. Marc-Andre Gagnon estimates universal Pharmacare could save Canadians over \$11 billion per year.

This past November, 68 medical students from across Canada converged in Ottawa to meet with approximately 50 Members of Parliament and Senators with the purpose of discussing Pharmacare. We asked for the creation of a Special Committee of Task Force to investigate the implementation of universal Pharmacare in Canada. Of the Parliamentarians with whom we met, 87% were interested in working with

“Canada... [is] the only developed nation with universal health care and no corresponding Pharmacare program.”

the CFMS to continue to learn about Pharmacare. We have since provided these Parliamentarians with an extended information document connecting them to current policy research, garnered media attention through a Toronto Star Op-Ed article, and submitted a question for the Senate. Government Affairs and Advocacy Representatives and Global Health Advocates will offer Pharmacare presentations to our colleagues across Canada to ensure all medical students have the opportunity to learn about a system model that can truly benefit the patients whom we will serve throughout our careers.

While entering the medical field has eliminated my naïveté, the passion of my colleagues constantly reminds me that it has not altered our idealism. The creation of universal Pharmacare in Canada would be a challenging undertaking, yet there is ample research to suggest that it is a cost-effective and feasible step towards creating that perfect health care system we heard about in our youth. ■

Updates from the CFMS wellness portfolio

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

THIS PAST YEAR HAS SEEN great strides taken in the progress of the CFMS-FMEQ National Health and Wellbeing Survey. Since SGM 2014, we have been fortunate enough to partner with a faculty sponsor, Dr. Erica Frank, out of the University of British Columbia. Dr. Frank is a Tier I Canada Research Chair and physician in Preventive Medicine and Population Health at UBC; lead author of the Canadian Physician Health Study and the Healthy Doc – Healthy Patient project in the US; and an expert in the field of medical student and physician health. Under her tremendous guidance and support, we have drafted a very strong survey instrument that has received positive feedback from multiple external partners.

With a completed questionnaire, we have been working hard the past few months to secure ethics approval and develop strategies for the promotion and distribution of the survey to medical students across the country. Despite our hard work and our initial goal of having results ready for presentation at the Canadian Conference on Medical Education (CCME) 2015, we have unfortunately hit some delays along the way, as is expected in any research project of this size. The source of these delays were manifold, from time constraints of the survey leadership team during the always busy fall months, to the discovery that this project requires ethics approval from multiple centers, as opposed to a single research ethics board, which is the premise we were initially operating under

based on input from multiple sources.

Regardless of these delays, the project continues to move forward and make considerable progress towards a high-quality final project. We remain partnered with Dr. Frank and are also working with Dr. Sue Mills, another faculty from UBC's School of Population and Public Health, who is helping to facilitate remaining tasks regarding ethics, strategy, and logistics. Although our initial goal of having results for CCME 2015 does not seem a feasible goal at this point, we are on track to have all the pieces in place by CCME, such as communication and administration strategies, ethics approval, etc., to allow for distribution later this year. I remain proud of all the work that has been put into this project so far from all members of our survey team, and I am optimistic for an amazing end product.

Apart from the survey, this year has seen substantial growth from the CFMS Wellness Committee. Under the leadership of our new National Wellness Officer, Marie-Pier Bastrash, our committee has gained tremendous traction, with regular communications and collaboration on a couple different projects. Ongoing projects include: work to expand upon the 2014 update on the CFMS' Medical Student Mental Health Position Paper to create a more broad paper on medical student health and wellbeing; ongoing work to develop an online database of health and wellness resources for schools across the country; and work from all committee members to develop strategies for implementation of the wellness survey

“I remain proud of all the work that has been put into this project so far from all members of our survey team, and I am optimistic for an amazing end product.”

across the country.

With the progress of the Wellness Committee over the past few months, and with the leadership of our National Wellness Officer, I am excited to see what 2015 has in store for CFMS wellness projects. There are many exciting ideas for initiatives on the table, and I am confident in our ability to grow this portfolio to an amazing extent.

If anyone has any questions regarding the CFMS-FMEQ National Health and Wellbeing Survey, or about CFMS wellness activities in general, please don't hesitate to contact myself, Brandon Maser, VP Services, at vpsservices@cfms.org. ■

CFMS & Partners in Health Canada present: Share The Health

Anjali Kulkarni

National Officer, Sexual and Reproductive Health

Claire O'Brien

National Officer, Partnerships

Christopher Charles

Vice-President Global Health

McMaster University, Class of 2016

IN THE FALL OF 2014, AN exciting partnership was consolidated between the CFMS and Partners in Health, Canada (PIH). PIH is a non-profit organization working to address health equity and social justice. PIH provides health care and helps strengthen public health systems with sister organizations across the globe, including in Haiti, Rwanda, Malawi, Mexico, Peru and Russia. They are recognized as a world leader in global health, working to bring the benefits of modern medical science to those in need, with an emphasis on patients living in poverty.

Founded in Haiti in 1987 by Dr. Paul Farmer, Dr. Jim Yong Kim, and their close team of advocates and supporters, PIH has grown to not only provide health care solutions in developing country settings, but also provides training, awareness, and partnership opportunities for global health professionals looking to contribute to the vision of equitable healthcare.

Because of our efforts to prioritize health equity and social justice, the CFMS is proud to have formed a partnership with PIH. The CFMS mission to connect, support and advocate for Canadian medical students finds similarities in PIH's objective to support the education, training and mentorship of doctors, nurses, community health workers and allied health professional in various low-income countries.

Our partnership with PIH first involves the Share the Health initiative – collecting community donations and stories in recognition of important mentors to healthcare professionals. This type of mentorship is critical to the work PIH does to continue training healthcare professionals and community health workers in resource-poor settings around the world.

The campaign asks students to choose a mentor who had an impact on their lives (personally or professionally) and share their story. Tributes may be anywhere from 10 - 500 words long, and will ideally include a good quality picture. Photos may be of the mentee, the mentor, both together, or anything that is of significance to the relationship. The tribute will then be posted on the Share the Health website, and participants will get a unique link to make it easier to share it with their mentor or whomever they like.

This will be our first collaborative effort with PIH, and we look forward to many more, as our partnership grows. In his letter to the CFMS on the occasion of the 2014 Annual General CFMS meeting, Dr. Paul Farmer, who is the co-founder of PIH, and Special Advisor to the UN Secretary-General for Community-based Medicine and Lessons from Haiti, wrote,

I am heartened to know that students in the CFMS Global

“Because of our efforts to prioritize health equity and social justice, the CFMS is proud to have formed a partnership with PIH.”

Health Program are our partners in the fight for health equity and social justice. You promote global health education, sexual and reproductive health, Indigenous health, and global health advocacy in Canada and around the world. Thank you for your commitment and solidarity, and thank you for being my retirement plan.

The CFMS Global Health Program embraces these words of encouragement, and will continue to empower medical students with the tools needed to grow as global health leaders and global health citizens by facilitating ethical global health education, advocacy, action and experiences through coordinated national programming. ■



1:10,000

Ratio of nurses to patients in Haiti

COMPARED TO 1:100
IN CANADA

1:14,300

Ratio of doctors to patients in Rwanda

COMPARED TO 1:480
IN CANADA

Pay tribute to a mentor who made your life better.

Share your story and Share The Health.

We learn from people we trust and admire. They're our mentors, and their guidance is invaluable. Whether you're a student, a nurse, a doctor, an athlete or a teacher – in Canada, Haiti, Rwanda or anywhere else – mentorship matters for everyone.

Visit HonourYourMentor.ca to post a public tribute to someone who has inspired you. You may also make a donation in honour of your mentor to help Partners In Health train the next generation of health professionals in developing countries. Share your tribute with the world, and you'll be joining a mentor movement that is transforming global health.

Who will you honour?



Launching March 1, 2015

HonourYourMentor.ca

What's the point of these fluffy advocacy efforts?

Timothy Holland, MD, CCFP
Atlantic Representative 2010-2011

YEAR AFTER YEAR, THE CFMS adopts and endorses a variety of advocacy efforts. A surge of energy will be dedicated to these initiatives for a few years before a new topic comes into vogue. It's hard to say whether the transience of advocacy topics is a good thing or a bad thing. Cynics may say that the rotating nature of CFMS leadership leads to a fickle adopters of trendy advocacy efforts. Optimists say that the CFMS can only carry an advocacy effort so far because of the turnover inherent in its leadership and membership and that we should have faith that it will be carried on to the next level.

Well, I'm here to tell a story that scores one for the optimists.

In 2011, the CFMS Global Health Advocacy (GHA) initiative decided to champion the cause of Refugee and Immigrant Health. In May 2014, three years later, the Halifax Transitional Health Clinic for Refugees opened its doors for newly arrived refugees in Nova Scotia. This clinic was started by myself, along with a couple of dedicated physician colleagues and various employees of the Halifax Refugee (legal) Clinic and the Immigration Settlement Association of Nova Scotia (ISANS).

The cynics might argue that the CFMS GHA initiative and this clinic are unrelated, even coincidental. None of the people involved in setting up this clinic were involved with the GHA back in 2011.

However, I played a little 'connect-the-dots' game that might lead us to a different conclusion. As the Atlantic Rep in 2011, I remember the goings-on of the CFMS at that time. As it turns out, that GHA effort was the first in a series of dominoes that led to the creation of the Halifax clinic. Let me walk you through it:

- a) In 2011, the CFMS National Officer of Rights and Peace encourages the local GHAs to each set up a specific initiative in their local area to promote refugee health.
- b) The local Dalhousie GHA puts together a report highlighting the need for a dedicated clinic for refugees in Halifax. This document included a comprehensive literature review, stakeholder consultations, and an overview of similar clinics across Canada.
- c) This document is presented to the Dalhousie Family Medicine Residency Program in Halifax. The local GHA advocates that the Family Medicine Program would be the ideal home for a refugee-centred health clinic in Halifax.
- d) Faculty at the residency program begin drafting proposals to create this clinic - they also inspire a few fledgling residents to work on the project (one of whom is the author of this article).
- e) These two residents focus their research project on the topic of

“Well, I'm here to tell a story that scores one for the optimists.”

refugee health and advocate to have the residency program spearhead the creation of this new clinic.

- f) Two years pass and the Dalhousie Family Medicine Residency program decide the refugee health clinic initiative is not a priority.
- g) Newly minted family physician, Tim Holland, asks if he can take on the effort independently and picks up where they left off.
- h) Joined by a few other family physicians, together we cut through red tape, forged partnerships, battled bureaucracy, and ironed out logistics. The Transitional Health Clinic for Refugees opened in May 2014.

When I became involved in the refugee health initiative in my residency project, I had no idea that it had been born of the CFMS GHA. In fact, if I hadn't been Atlantic Rep at the time, I might not have ever connected these dots. I imagine there are plenty more scenarios of unconnected dots that have been spawned from CFMS efforts. Score one for the optimists. ■

Student Initiative Grant winners

Leanne Murphy
Atlantic Regional Representative
Memorial University of Newfoundland, Class of 2015

STUDENT INITIATIVE Grants are one of the many ways that the CFMS provides support to its membership. The fund was established in 2007 in response to a growing number of medical student initiatives. This year, we received close to fifty applications from a variety of initiatives from coast to coast. The high quality of the applications we received made selecting the recipients of the funding especially challenging! At the end of the selection process I was left with an overwhelming sense of pride – the ideas and initiatives that medical students across Canada are bringing to fruition are amazing! This is why we need to continue to dream, to innovate and to share. Here is a sampling of the initiatives that received funding this year, as taken from their applications:

What every clerk should know!: keys for successful learning (University of Ottawa)

The transition from lecture-based learning to clerkship can be a challenge with difficulties adjusting to clinical settings and to adopting new roles and responsibilities. Knowing what to expect, how to be helpful, and things to do or avoid is important in alleviating anxiety, enhancing performance and providing the best environment for learning. “What Every Clerk Should Know!” is an anonymous, interactive forum which will help students become comfortable in their clinical environment.

The website will be divided by specialty and location. Within each of these categories students will be able to read key messages written by different

members of the health care team. These messages will be prompted by the question: If you could tell three things to every medical student coming through your rotation, what would they be?

Student wellness initiative towards community health (SWITCH) (University of Saskatchewan)

Please see the article titled Student Wellness Initiative Toward Community Health in this section

Mental health awareness week (MHAW) 2015 (University of Alberta)

Mental Health Awareness Week is intended to raise awareness for mental health on campus through a variety of speakers, a resource fair, and personal anecdotes from students. The safe environment created at MHAW events encourages students to speak out about their experiences, and empowers them to understand how mental illness affects people personally.

In 2014, MHAW featured two evening talks, given by a pre-clerk and a clerk, on their personal experiences with mental illness, and an Open Mike Night. The Open Mike Night promoted understanding, healing and a sense of belonging among attendees, and individuals described the night as inspiring. Speakers indicated that this event helped them realise that they are not alone with their struggles, and provided them newfound support as their peers approached them with encouraging and kind words.

IMPACT student-led clinic Saint John, NB (Dalhousie University)

The Interprofessional students Moving Persons And our Community Towards (I.M.P.A.C.T.) health clinic, hopes to begin in January 2015 in Saint John, NB. Our name resonates with our mission statement: to improve access to health services in a priority neighborhood through the establishment of an interprofessional environment that addresses the biological, psychological, social determinants of health, establish trust and relationships with respect and dignity.

The students working in the clinic will have a unique opportunity to gain first hand exposure to the broad range of health care needs of a vulnerable population. The student led clinic will be composed of students from a variety of health professions that collaboratively plan and deliver healthcare and health promotion services under the supervision and assistance of licensed healthcare professionals. This student led clinic hopes to make primary care accessible by establishing itself in the priority neighborhood, having a safe and open environment, and addressing health issues via primary care services, health promotion, workshops, social services and more on a twice weekly basis.

Partners in time (Memorial University of Newfoundland)

Partners in Time is an intergenerational program which strives to develop meaningful partnerships between people of all ages in the community through activities

based on life-long learning, physical activity, and building communities without ageism. This program will be the first of its kind in the St. John's area.

A pilot of the Partners in Time program will run out of two St. John's community centers for 5 weeks. Medical student volunteers will build stronger ties to their communities and enrich their understanding of community health through service learning. Partners in Time has the potential to unite communities through knowledge, sharing, and physical activity, thereby strengthening social capital in the St. John's area.

Environment: health project (University of Alberta)

Through a series of interactive lessons, the Environment: Health Project (EHP) aims to teach elementary students that our health and the health of the environment are intimately connected, and seeks to foster a sense of environmental stewardship in the leaders and thinkers of tomorrow.

The curriculum consists of inter-related lessons focusing on water, food, and air, with an interactive review at the end. In each lesson we begin with a discussion of the physiologic necessity of the resource in question, and concluding with a discussion of how we can mitigate pollution of that resource. The goal is

to inspire students to think not only of ways that they can help their environment right now, but of the broader, scientific and systems-based approaches that they can lead in the future. The pilot test of the program received excellent reviews from elementary students and their teacher.

HealthstART (University of British Columbia)

HealthstART is a free after-school art program for inner-city students led by UBC medical students with partners from the Vancouver Writer's Exchange. The intention of the program is to address the healthcare issues of inner-city children of Vancouver through art by exposing students to a wide range of health topics using hands-on art projects of various media as well as by delivering successful and well researched lesson plans on the topics of: nutrition, vaccinations, disease prevention, and mental wellbeing.

HealthstART can serve as a unique facet of preventative medicine that inner-city school students receive to supplement pre-existing resources. Parents will benefit from the program by receiving information brochure detailing the purpose of HealthstART and receiving health related information through their interactions with the medical student

administrators and from their children. The students will also be provided with "health promotion packages" that contain health snacks and personal hygiene tools such as toothbrushes and floss.

Stand up for health! (University of Toronto)

Stand Up for Health (SU4H) is a fun, interactive simulation game which aims to develop the participants understanding of the social determinants of health through experiential learning. The game can be played with any number of players. Each participant plays the role of a single parent, is given \$1000, and is challenged to get through two simulated weeks. Players are presented with scenarios which force them into difficult decisions faced on a daily basis by low-income Canadians. Based on their choice, participants pay money when required, read about the consequences of their decision, and also keep track of their stress levels through a stress meter.

By making these choices and feeling the effects of their consequences, participants build empathy with marginalized people and gain an understanding of the difficult choices they often face. At the end of the session, participants are engaged in a discussion where they reflect on their experience in the game. ■

We understand the social determinants of health, now what?

Jon Herriot
University of Saskatchewan, Class of 2016

IN MY MEDICAL TRAINING, I have had the privilege of meeting patients in difficult social circumstances in Northern Saskatchewan and rural Mozambique. But, what I have found personally challenging, is seeing similar inequities at home in Saskatoon. In time spent at the Westside Clinic, a community and health centre serving the needs of Aboriginal and low income populations in Saskatoon, I have gained an appreciation for people’s lives in this community and what medical professionals can do to help.

Physicians know the importance of the social determinants of health as they relate to the wellbeing of their patients. However, without the ability to identify which factors are impacting their health the most – and a way to intervene and change these

circumstances, this knowledge does not serve their patients effectively.

At the University of Saskatchewan, we are developing an electronic clinical tool that will allow clinicians to effectively assess the social needs of their patients, and connect them with the necessary community resources. Just as a patient with a complex heart condition is referred to a cardiologist, if their living conditions are inadequate, they should be referred to a housing specialist. I encountered a patient at the Westside Clinic who came in for a physical exam so that he could return to work. Using an earlier version of our tool, we found that he also had concerns about personal credit and wanted a better home for him and his family. We were able to talk to him about the local credit union across the street where

he could discuss mortgage and credit issues and gave him the phone number of a local affordable housing organization, Quint Development Corporation. Without the tool guiding me to ask these important questions, these issues may have never come up.

This tool can also be used to track the incidence of social health problems in a community, give clinicians the evidence they need to advocate on behalf of their patients to policy makers. By participating in political advocacy work, physicians are looking upstream to change the conditions that lead their patients to get sick in the first place, creating happier and healthier communities. ■

**Society of Rural Physicians
of Canada**



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

For general inquiries please contact:
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www.thunderbayhealth.ca

The UBC Stem Cell Club: strengthening Canada's stem cell donor database

Warren Fingrut

University of British Columbia, Class of 2015

Xiu Qing Wang

University of British Columbia, Class of 2015

PATIENTS WITH A VARIETY of blood cancers and metabolic diseases may require a stem cell transplant as part of their treatment. However, 80% of patients do not have a suitable match in their family and must find an unrelated donor. Canada's stem cell donor-database is used to match potential donors to patients in need. Individuals age 17-35 can register to join this database at stem cell drives, where they provide consent and swab their cheeks to provide a tissue sample. Patients are more likely to match to a donor in their own ethnic group.¹ Additionally, young, male donors are preferred, as they improve recipient outcomes.² However, males under age 35 only represent 12% of the current Canadian donor-database (and only 5% are non-Caucasian males). Overall, it remains challenging to find a match for a transplant; currently, over 1000 Canadians cannot find a match anywhere in the world.

The University of British Columbia Stem Cell Club is a student initiative founded three years ago to strengthen the quantity and quality of membership on the Canadian stem cell donor database. We have established a community partnership with Canadian Blood Services. We are the first student-run group worldwide that has been accredited to independently run stem-cell drives. We have active chapters at all UBC Medicine campuses (in Vancouver, Victoria, Kelowna, and Prince George)

and in September 2014 we founded an undergraduate chapter at UBC. To date, we have coordinated dozens of stem cell drives and recruited 2895 potential stem cell donors (representing 3% of all new stem-cell donors recruited across Canada 2012-2014). We also target recruitment of the most-needed stem cell donors according to the literature: young, ethnically diverse males.^{1,2} Our drives have recruited 35 Aboriginal males under age 35, increasing the representation of this demographic group on Canada's database by 6%. Three months ago, we also began booking appointments at our drives for students to donate blood; so far, we have signed up 75 students for blood donation appointments.

Our initiative equips medical students with leadership opportunities, training, and skills. We empower students to become health advocates for patients in need of stem cell transplants. We hone student communication skills to recruit registrants without compromising informed consent. Our success continues to be a collaborative effort between dozens of students.

Our work could not have been made possible without the generous funding provided by CFMS. CFMS's Student Initiative Grants set our initiative in motion, and supported us as we expanded to university campuses across British Columbia.

This year, we will continue to organize combined blood and stem cell drives, to recruit stem cell donors, and to register individuals for blood donation

appointments. We are also spearheading rural and Aboriginal stem cell drive campaigns to target geographically and demographically underserved communities of Canada. In all, we are confident that we can recruit 1500 new donors in the upcoming year, specifically targeting the most underrepresented demographics on the stem cell registry: young, ethnically-diverse male registrants.

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

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Student wellness initiative toward community health

John Schulte

Western Regional Representative

University of Saskatchewan, Class of 2016

AS A SASKATCHEWAN MEDICAL student, one of the programs I am asked about most frequently is SWITCH, or the Student Wellness Initiative Toward Community Health. It was opened in October 2005 and has seen growth throughout the past decade with the leadership and vision of Ryan Meili, its founder. Today SWITCH is now Canada's gold standard for student-run clinics and continues to offer after-hours services to Saskatoon's core.

SWITCH was established to help address some of the gaps in health outcomes seen in western Saskatoon. Their vision was to make sure that all residents of Saskatoon have equal access to healthcare, nutrition, education, and employability skills to better arm them with tools to create opportunities for themselves, while augmenting the training of Saskatchewan's future healthcare professionals.

With its growth, SWITCH now has the capacity to serve thousands of patients and families each year. In addition, hundreds of healthcare students from varying backgrounds get the opportunity to spend time there. They have students from the University of Saskatchewan, University of Regina, SaskPolytechnic, First Nations University and Saskatchewan Indian Institute of Technologies. All students get to work alongside mentors from all fields of health care, but also with First Nations



and Métis community leaders and elders.

At a usual evening at SWITCH, you can expect to see medical care, counseling, physical therapy, immunizations, sexual health education, exercise advice, nutritional education, and needle exchange. In addition to interprofessional clinical services, SWITCH has expanded to offer programming, childcare, homework help, and a hot meal on each shift. This has allowed undergraduate students outside of the healthcare fields and junior healthcare students to join the team.

As SWITCH celebrates its first decade of service this year, its focus and goals

remain the same, serving both patients and students. It doesn't look like this will be changing anytime soon, as nine of twelve members of the Board of Directors are currently students in the healthcare fields. In addition, a culture of volunteering has been established. People who have not worked with SWITCH are becoming harder and harder to find.

If you have more questions about SWITCH or are interested in getting involved, please visit their website (<http://switchclinic.ca>) or contact their executive director (switchdirector@gmail.com). ■

The floppy chicken theory: the development of a student-led clinic in Thunder Bay

Jaya Bastedo

Northern Ontario School of Medicine, Class of 2017

“So basically they said that we are a floppy little chick stuck in its egg”.

I AM MEETING WITH THE MEMBERS of the steering committee of Compass North Clinic and a fellow student is re-telling his encounter with a faculty member. We are a group of social work, nursing, and medical students working together to create something that has never existed in Northern Ontario: a student-led clinic. Over the past 15 years, student-led clinics (SLCs) have popped up across Canada.¹ In these clinics, students from various disciplines assume the primary responsibility for operating the clinic. Supervised by licensed preceptors, they plan and deliver health-care and health promotion, typically to marginalized populations. SLCs provide an opportunity for students to learn to work in an interprofessional team and engage in community service learning - learning through service and reflection. For the community, SLCs can become another entry point to the healthcare system, working to reduce the barriers that marginalized populations face when accessing care.

Our SLC, Compass North Clinic, has not yet opened its doors to patients. While it can be discouraging to be compared to a baby chicken, that faculty member was right. We're not strong

enough yet to burst out of our shell. However, the process of building our strength has been an important experience for our committee.

In trying to establish ourselves as an organization, gain approval from our academic institutions, and find a place for ourselves in the community, we have learned about interprofessional collaboration, the inner workings of academic institutions, and how to navigate and present ourselves within these. We are learning how to work with our peers to develop a formal, sustainability committee and about the healthcare players and needs of our city.

Our major challenge has been seeking institutional approval. While being passionate about the SLC model ourselves, it has been difficult to navigate the administrative requirements by our academic institutions. We are being exposed to administrative complexities and institutional politics while being forced to learn how to pitch an idea, prove its worth, and gain support. While the process has been frustrating, having to prove ourselves has made us stronger and given us a better chance of stretching our majestic chicken wings and creating a viable, sustainable clinic in the future.

The most rewarding aspect of being part of the committee has been the

opportunity to work with my peers to create something completely new, and trying innovative ways to make our committee work at its best. There are few times in medical school when we get to be creative and ask the question: “How do we want to do this?” It has been energizing to try and come up with our answer as a team.

Many of our current committee members will have moved on to other projects by the time Compass North Clinic breaks out of its shell, however, I believe that we will be better chickens in our own right because of our experiences on this committee. For aren't we all, as students, floppy little chicks, trying to gain the knowledge and experience we need to break out of our school shell and be the best health care workers we can be? And isn't the best way to do this to learn and work with other chicks on a new project we believe in? So for now, I am happy to be called a floppy chick, and look forward to the day that someone will call me, and Compass North Clinic, a full-fledged chicken. ■

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A letter to the past me

Jimmy Yan

Western University, Class of 2015

HEY “HOT SHOT”,
It’s me. You - in roughly 4 years from now. I, you, we...ahem... are about to graduate medical school, and I thought it would be a good idea now, at this point, to write back to you, me, us as you are just getting into medical school in the spring of 2011. What I bring to you is a one-time offering of advice and insights. No questions, just listen.

Before we talk about medical school stuff, I just have to say one thing - take photos of yourself seriously. Shaving your head before grad where you are the Valedictorian, the faux-hawk before your passport, and don’t get me started on the pic you chose for your Western student ID. Pictures can be your impression on others and they follow you for life. Make it count.

Yes, you are telling yourself that you’re excited to move out of BC. I know it’s because you’re caught up in the notion of change and that living in a new place where you don’t know anyone will challenge your personal growth. I also know that, deep down, you’re a little anxious by the reality of it. It’s okay to admit that to yourself. You don’t need to “fake it until you make it” 100% of the time. Be as comfortable as you need to be. It’ll work out.

When you end up moving, don’t bother shipping your old books across the country. You won’t end up using the

“If uncertain, just try for it anyway”

majority of them. Same goes with all the kitchen equipment and house supplies. And go easy on buying textbooks that you won’t use. Save your money.

Cut down on the Vancouver talk when you get to London. Nobody east of the Rockies cares. Just be content to know that your hometown is awesome and keep that bond with the other West Coasters you meet.

Look for and apply to opportunities early and often. If uncertain, just try for it anyway. Worst case scenario, you don’t get it and you’re back at where you started. Nothing ventured is nothing gained.

Yah, yah, yah, you keep saying to yourself that you’re all tired, cynical, and jaded with student leadership and

“A neglected relationship is like a mirage, seemingly solid, but without substance”

politics. You keep saying you want to get away from it all. “Moving away will be a chance for a fresh start, a new identity,” you’re telling yourself right now. False. Embrace what you like and what has been a major part of your personal development. While you’ve got some time on your hands right now, look up the OMSA and the CFMS; if I know you, and I think I do, you’ll be very interested in them.

It’s not that you don’t, but this is still important to say: make the effort to keep in touch with the friends out back. School and studying are important and it’s easy to use the “too busy” excuse to throw your relationships to the side, because relationships never seem urgent. But a neglected relationship is like a mirage, seemingly solid, but without substance.

You’re in for a bit of a shock with your exam results. Don’t let it discourage you from working hard. I think it’s something we can still learn to deal with better. I won’t say exactly which exams you should study for, which questions to watch out for, or how your rotations went, for better or worse. That’s for you to explore and discover - remember, it’s still a story that you have to go out and write for yourself.

And hey, in four years, it’s time for a new chapter.

Work hard, but have fun. ■

A crescent in the eye: a personal experience with incidental findings

Allyson Shorkey
Queen's University, Class of 2017

Mike Baxter
Queen's University, Class of 2017

PICTURE THIS: IT'S THE night before your OSCE, and you want to get in some last minute practice using the ophthalmoscope. You ask your classmate if you can look into his eyes, like you've done many times before. This time though, you notice a black crescent around his optic disc – something you're certain was not there the last time you looked. What do you do? This is what happened to Mike and I last December.

These experiences are quite commonplace for medical students. As second years, we are in a unique position of having enough clinical skills competence to find an abnormality, but sometimes not quite enough medical knowledge to differentiate a normal variant from something more serious. Despite almost a year and a half of medical education, we could not resist the temptation of 'Dr. Google'. It was simple to search 'darkening of the optic disc' and to worry over images of melanocytomas and optic nerve atrophy. We felt scared, worried, and helpless.

The possibility of finding abnormalities while practicing on one another is a common concern cited in the medical education literature.¹ On one hand, we are lucky to be able to practice clinical skills on one another. It is incredibly valuable to practice in a safe and low-stress environment, and to receive feedback from a non-intimidating source. In addition, if the darkening around Mike's optic disc were something serious, we would have found it early, leaving lots of time for intervention. In fact, there was a case last year of an American medical student who diagnosed an AAA as part of his school's

Standardized Patient program.² On the other hand, practicing on one another also provides ample opportunity to uncover incidental or harmless findings, which can be overwhelming for students involved. And, in our case, healthcare dollars were spent unnecessarily working up an incidental finding that would have never presented symptomatically.

This encounter brought up a number of ethical dilemmas for us. For instance, is it appropriate to ask our Clinical Skills physician tutors, who we see on a weekly basis and who sometimes demonstrate clinical skills on us as subjects, for medical advice? We also considered emailing an ophthalmologist who Mike knew through some observerships, but thought that this might have been an unethical jump of the healthcare queue. On a similar note, what if we found something in a classmate during a more formal clinical skills session? Our Associate Dean of Medicine, Dr. Tony Sanfilippo, has an interesting blog entry relating to this very question.³

So, what should medical schools do to prepare students for the possibility of finding medical abnormalities in one another? Should we delay physical exam teaching until the relevant block of medical knowledge has been taught? Or, should students be discouraged to perform physical exam maneuvers on anyone besides Standardized Patients? Much of the literature recommends the use of peer physical exam practice, with a formal policy to guide the investigation of abnormalities in medical students when found during clinical skills courses.^{1,4} We don't know what the exact solution is, but, fortunately for us, we are part of a medical school that fosters a

“Despite almost a year and a half of medical education, we could not resist the temptation of ‘Dr. Google’.”

supportive atmosphere where we feel comfortable bringing issues like these to one another and to administration. We hope that all medical schools can foster the same environment, where all students are there for one another through this challenging experience of bridging the gap between the development of clinical skills and the interpretation of positive clinical findings. ■

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Back to the basics

Kristin Chow

Western University, Class of 2015

SINCE STARTING MEDICAL school, I've wanted to be an emergency physician, an obstetrician/gynecologist, a rheumatologist, an orthopedist, a general surgeon, and finally a family doctor.

What a list!

Now that I'm at the end of my journey, I'm sure those close to me are amused that I've decided – very happily – on family medicine. My mother has listened to my raving about why the new specialty I found was the best one, to tears when a specialty I thought I'd enjoy didn't live up to my expectations, and to endless strategy conversations about CaRMS.

I think one of the hardest things to work out for me was distinguishing the people and the experience on a rotation, and actually liking a specialty. I had a great experience on general surgery – I had great residents, lots of teaching, and lots of opportunity to participate in the OR. I liked my team, and was praised and often told that I should seriously consider a career in surgery. I mistook the interest other people had in my being a surgeon, and my enjoyable experience, for a genuine interest in being a surgeon. Don't get me wrong, I love the hands-on aspect of

“Family medicine meant I wouldn't have to give up things I enjoyed”

surgery, but I hadn't seriously considered what a surgical career entailed. For a while, I vehemently defended surgery, brushing off doubts put in my mind by others.

When I was at the end of clerkship doing my core family medicine rotation, I considered for the first time that I might be a family doctor. My friends, who had heard me touting the advantages of surgery for months, were surprised. I felt like I was disappointing people who had expected me to be a surgeon, or people would think I was intimidated. I had a hard time explaining my decision, even to myself.

Retrospectively, it made a lot of sense – you can see from my list of potential specialties that I really enjoyed all of clerkship. Family medicine meant I wouldn't have to give up things I enjoyed, like the emergency department, well baby visits and ambulatory care. I could have long-standing relationships with my patients, and wouldn't have to give up the procedural work I enjoyed. Furthermore family medicine offered the flexibility, portability, and job security I was looking for.

I figured out why I wanted to be a family doctor when I thought back to what had prompted me to go into medicine in the first place. My younger brother has autism, and was diagnosed when not many people – even doctors – had heard of it. No one had any help to offer or even suggestions, and my parents worked tirelessly to help my brother.

I came in to medicine wanting to prevent the experience my family had. I wanted to help people through difficult diagnoses and during times of uncertainty;

“I came in to medicine wanting to... help people through difficult diagnoses and during times of uncertainty”

if I didn't have the answers, at least I could be a support. When I went back to the basics of what I wanted in a career, family medicine makes perfect sense.

Medical students these days have so much to consider when picking a career, and while you're in medical school it can seem like you have to decide right away, to set up observerships and research, pick your clerkship order, and set up electives. For those struggling with a decision, trust me that there is time, and there is time to change your mind – even in August before CaRMS. Through the excitement of observership, clerkship, and the enthusiasm of others for their specialty, don't lose sight of your values and what brought you into medicine in the first place. ■

Learning from the Boyle Street Community

Colin Siu

University of Alberta, Class of 2017

REMEMBER BEING TERRIFIED the first time that I walked into the Boyle Street Community Centre, a non-profit inner-city Edmonton agency that assists people challenged by homelessness, poverty, addiction or marginalization. I avoided eye contact, refrained from engaging in conversation, and somehow made it to our volunteer rendezvous point without interacting with anyone.

Approximately a year later, I took on a summer research position at the Royal Alexandra Hospital that required me to work for one week at Boyle Street as an orientation to inner city health issues. Over the course of one week, the community at Boyle Street welcomed me into their family, and even invited me to a birthday celebration for a staff member. I made friends with a guy that would swing by every day to chat with the staff there – we bonded over our common frustration over constantly breaking phone screens in our clumsiness. I had the honour to listen to the stories of a portion of the Boyle Street community

Pain

A lot of the stories that I heard were that of pain: personal physical and mental pain, pain from being absent from families and friends, pain passed down from generation to generation. I don't dare say that I completely understood this pain

nor could I truly empathize, but I can say that each and every story was full of pain.

Choice

"They had a choice," you say. Well, no, not really. We don't make a choice to have an addiction, mental health issue, or low socioeconomic status. Yes, there may have been precipitating factors that led to these endpoints but to say that a choice was made to have an addiction is ignorant, as we often cannot even begin to fathom the build-up of duress that lead to the tipping point. No one, absolutely no one that I talked to, wished anything remotely similar for their children.

Strength

Perhaps one of the greatest lessons that I had at Boyle Street was about perseverance despite numerous obstacles. Many of the people I met were able to find positivity in challenging scenarios and energy to support other community members going through difficult times. Furthermore, they had well-outlined plans for what they wanted to do in the future and were actively working to further their education or seek employment.

At the end of my summer term, I looked back to the first-year medical student that was afraid to enter Boyle Street. If I was a patient from the Boyle Street community presenting at the Royal

"We don't make a choice to have an addiction, mental health issue, or low socioeconomic status"

Alexandra Hospital, how would I feel walking in? What would I think if no one was willing to make eye contact with me or interact with me in any way? What if I added to this, my past experiences with the medical system – past discriminatory remarks from a doctor or being mistaken as one of "those alcoholics?"

Our goal as doctors is to help patients improve their health and quality of life. It's not about forcing our opinions on others or debating moot points on the assumption that we know best. It's about meeting patients where they are at and providing options for treatment when they are ready. If they are not, caring for their health in the best way we can. Healing can start before we start scribbling on our prescription pads – healing is about understanding and accepting where your patients are coming from, to do this, we need to first listen and experience. ■

The importance of representing the ineffable

Elena-Bianca Barbir
Queen's University, Class of 2017

I COULD BEGIN BY DESCRIBING her – her strength of character, her beauty, and those carefully concealed black-purple marks, which she bore with diffidence.

Or I could begin by depicting the effect of her arrival to the ER – shattering the monotony that accompanies the completion of routine paperwork.

I might also be inclined to provide a description of our initial encounter – but here, I stumble. Describing the observable facts of her admission is fairly straightforward, the exact details remain imprinted in my memory – what the resident and I were doing the moment she walked in, how she looked, which examination room she was led into, the words that were exchanged, her vitals, her presenting symptoms, and the events which prompted those symptoms. These descriptors don't encompass an experience, however; they omit much of what needs to be communicated to properly represent the situation to you, my reader.

“I cannot form a simple, straightforward narrative that would convey the unique discomfort I felt when I learned that she was a victim of intimate partner violence”

When I try to verbalize my emotional reaction to her story, and to the vulnerable state she – uneasily – slipped into, as the clothes slipped off, to show the resident and I the physical manifestations of her story, the language I have at my disposal begins to feel somewhat inadequate. I cannot form a simple, straightforward narrative that would convey the unique discomfort I felt when I learned that she was a victim of intimate partner violence. Or rather, a victim of heinous abuse: blows to the head; steel-toe boots to the small of her back; disdainful terms hurled in conjunction with limbs at her defeated form. Her traumatic HPI, something she understandably struggled to articulate, was punctuated by many silences filled with the soft sound of Kleenex filing out of their box.

It would be so much simpler to stop at the facts of the story – the results of her physical exam, her labs and imaging, and the plan that was made for her. This covers the basics of patient care – was the patient well looked after, does she feel safe, does she have a suitable plan? Rafael Campo, a poet and essayist who teaches and practices internal medicine at Harvard Medical School, comments on this tendency in medicine: “in biomedicine, we're so good at appropriating the narrative – the biopsy report, the CT count, the potassium level. Writing (or any other art form, for that matter) gives patients an opportunity to say, this is my cancer, this is my HIV. It's not generic, what you see on the mammogram or how many lymph nodes are positive—I'm an individual.” Campo frames the issue from the perspective of the patient, believing that the art of medicine encompasses the duty to encourage patients to

“The therapeutic potential of artistic expression, I'd like to believe, extends to physicians and medical trainees as well”

express themselves artistically, as they work through the nuances of their disease processes.

The therapeutic potential of artistic expression, I'd like to believe, extends to physicians and medical trainees as well. In order to retain the capacity to accompany our future patients through the emotional burden of their disease processes, we must maintain our wellness, and avoid burn-out. “Medical humanities” has become something of a buzzword recently – often flung around as something nebulously positive. Campo, in very definite terms, pinpoints the power the arts have had for his patients, as well as for himself, seeing poetry as a “necessary tool for both healing and empathy.” His perspective further reaffirms that medical practice is in a privileged position. It can draw on both the sciences and humanities, two realms so often pitted against each other, to improve the patient experience – so why not take advantage? ■

Becoming a “grown up”

Elaine Tang

Western University, Class of 2015

THE MEDICAL FIELD IS A strange place. It is one of the few places where as a 20-something pushing 30, people still ask you, “So, what do you want to be when you grow up?” I thought I had made my big life decision when I decided to pursue medicine. Then, within the first few weeks of medical school, it was very quickly impressed upon me the importance of picking a specialty. I required this one crucial piece of information to decide which research projects I should find, which preceptors I network with, how I should to structure my clerkship year, and a thousand other decisions. I was learning that my life would vary drastically whether I am a surgeon, an internist, or a family physician. As a first, second, and even third year student, this choice was bewildering. I felt a need to decide and decide quickly.

If you are one of the statistical 30% who knew exactly what you wanted going into medical school and are sticking to those ideas, kudos to you! For the rest of us meandering in this nebulous sea of specialties, committing to a decision is a daunting task.

Looking back on the last four years of my life, I can honestly say best way of figuring it out was going through the process of your clinical year. That being

said, there are three tips I have for picking a specialty:

Be open to new ideas and take your time

For most people, medical school is a great time to explore different options for a future career. Even for those who are set on a specialty, take an interest in all areas of medicine and you might be pleasantly surprised. If you change your ideas a few times throughout the four years, no biggie. This is not a test, and you are not expected to have all the answers right way. A lot of medicine is self-discovery and reflection, so take the time to think about your life, what you want from it, and how other aspects of life measure in comparison to medicine. Not all specialties are created equal and not all workdays have to end at 7pm. These are big decisions that you’re making. Be honest with yourself and consider carefully.

Talk to everyone: your peers, residents, staff members

Everyone has different reasons for why they picked a field. Talk to people within and outside of your fields of interest. Other people may bring up concerns that you had not taken into consideration before. Residents are a wealth of experience in terms of knowing what the next 2-5 years of your life will be like and the staff

“For the rest of us meandering in this nebulous sea of specialties, committing to a decision is a daunting task.”

will be able to offer advice/insight into what life is like after residency, no matter how far away that may seem right now.

It’s never too late to beef up your resume

If you decide that you want a surgical specialty in third year, how are you going to get those 10 research publications you need to match? Even though third year is busy, there is still time to do other things beyond going to work. You will be able to find new research projects, do extracurriculars, and get a publication or two in there if you really make it work. If you decide you really want a specialty, you will find a way.

At the end of the day, pick something that you will enjoy doing for the next 30 years. You will be doing this for the rest of your life. Welcome to “adulthood”! ■

The operating room: in three parts

David Sheps

University of Toronto, Class of 2016

THE PEARL (PART 1)

I was in awe.
 this spherical orb of flesh
 like a beautiful ripe grapefruit
 arose from the hollowed cavity of
 some old fat woman.
 Her skin fell aside like a banana peel
 as they removed the shining pearl.
 She was like all the rest
 but this tumour was special.

THE DISSECTION (PART 2)

An hour ago
 he had a relatively normal day at work
 a wife and kids waiting at home
 and a vague sense of being unwell
 Now
 there was more blood on the floor than
 in his body
 and his open chest was a silken crimson
 pool.
 The vacuum couldn't inhale enough
 blood

to refill the limp veins and arteries
 where it belonged.
 Blood dripped down the sides of the
 operating table
 soaking the surgeons' pants and form
 ing placid lakes on the floor.
 We voyeurs stood at the entrance to
 the theatre
 watching the drama unfold from
 behind the sterile curtain.
 Blood geysers gurgled
 as the surgeons desperately tried to
 clamp the bleeding vessel.
 A single spurt of blood spat from his
 screaming aorta
 flew six feet in the air
 and landed on my colleague's chest.
 "Fuck. Now I need to change shirts."
 We watched the futile efforts for several
 minutes more
 then left the mess behind.
 Sometimes people die
 but for the rest of the day, all we could
 speak of was the drop of blood on his
 shirt.

"Sometimes people die
 but for the rest of the
 day, all we could speak
 of was the drop of
 blood on his shirt."

IN KIND (PART 3)

She was a kind old soul
 so we pierced her skin and drugged her
 so she couldn't breathe.
 We jammed a tube down her throat
 and taped her eyes shut.
 We stripped her and sliced her in half.
 We dug through her bowels with our
 hands
 and we stole a piece.
 We stapled her skin and woke her up
 and it was the kindest thing we could
 do for her. ■

White coat impostor syndrome

Eve Purdy

Queen's University, Class of 2015

YEAR 1. I BUY THE SHORT
 white coat and don it with pride,
 but it is too crisp, it is too clean. I
 feel like an impostor.

Year 2. I dislike the short white coat
 and try to shed it when I can. I am mor-
 tified when I realize its length outs me
 as an impostor. All I need is my stetho-
 scope and my penlight for clinical skills.
 Though I might pretend, I actually feel
 no more legitimate when I go short white
 coatless.

Year 3. I sometimes regress to the
 short white coat while on call. Sheepishly,
 I am glad for the pocket space and
 warmth it provides. Hospital workers rec-
 ognize the significance of its length, and
 I find myself relieved when it reminds
 them that I am the earliest of learners, an
 impostor.

Year 4. As I continue to work, my
 white coat gets dirty and it becomes
 wrinkled. As that unglamorous transfor-
 mation takes place, I start to feel, not like

an impostor, but as though I have finally
 found my home in its fabric. I also dis-
 cover that I do not need the shelter of the
 short white, no longer clean, no longer
 crisp coat. I can speak with patients and
 do my job without its shell. I trade the
 short white coat for a gown and cap. On
 that day, for the first time in a long time,
 I feel pride.

PGY 1: I buy the long white coat and
 don it with pride, but it is too crisp, it is
 too clean. I feel like an impostor. ■

Split selves

Vivian (Jiaji) Xia
McMaster University, Class of 2017

“Alright, the last four, come with me.”

IT IS CLINICAL SKILLS AT THE General and we mechanically split ourselves into neat packages of twos, tasked to take a history and physical and report back with a working diagnosis. We are led around corners and through doors, moving past workstation hubs bustling with activity despite it being dinnertime. My mind is quiet. We enter a room, our preceptor facilitating quick introductions and just as quickly whisking away to deposit the last pair with their patient. I see him, a large middle-aged man dressed in a thin blue gown with electrical lead wires disappearing underneath the dark blue neckline.

The interview begins and Rational Me leaps forward unrestrained, feeding off of the energy of my colleague and this task that I have been given. She fills my brain, already reflexively flipping through filing cabinets of risk factors, clinical prediction scores, triads/quadrads/pentads of signs

and symptoms, nudging items on my list of differentials up or down with each spoken response like a real-time scoreboard. She interprets, she anticipates, she deducts, she questions. Always thinking ahead, using answers to inform her meticulous selection of subsequent questions to eliminate the possibility of one disease and engage the possibility of another. The Past Medical History stream of questioning slowly dwindles to an end, and we approach the Family History.

Deep breath in. “Are your parents still with us?” Tone slightly softer, eyebrows slightly knitted - body language poised at a low 2 out of 10 on the scale of inquisitive concern.

He speaks briefly about his parents and traces out a history of colon cancer in his family, like he’s been through this before. He lingers on his favourite aunt. “I was beside myself when she passed away from cancer before she hit 50.”

Emotional Me peeps out; this is her trigger. She notices how he willingly elaborated, she hears and sees his affect, she’s

aware of my colleague standing silent beside me. I wait for her to express empathy but she’s dazed and blinking, feeling his emotions and recognizing the opening but not knowing how to say or what words to choose. Rational Me presents a rational response, and I grab at it desperately as a last resort: “I’m so sorry to hear that.” Robotic. Unfeeling. I start to cringe even before my mouth forms the sounds; I continue cringing as the words grate out of me like clumsy gears in antique clockwork. My expression of concern overcompensates for the squeaky superficial phrase as my cheeks inadvertently flush at the failed attempt at empathy.

“Oh it’s not your fault,” he says, as if confused at my apology, and the awkwardness and the miscommunication and the misunderstanding make me squirm but thankfully my colleague jumps in and the questions resume.

The rest of the interview continues without a glitch and I walk away with my two selves retreating back into the hollows of my mind, still disunited. ■

Let go

Beatrice Preti

Niagara Regional Campus

McMaster University, Class of 2017

SHE WALKS OVER TO ME, EYES WARM
AND BRIGHT
Doc, what happened to that patient from last Friday night?
Jess and I were wondering, he was so sweet and kind!
We hope it wasn't serious, what did the lab techs find?
I look at her, eyes full of life
In this line of work, an unusual sight
I swallow hard, not sure what to say
Though it's my job, and there are rules to obey
The parts of my heart which haven't yet scarred
Make answering questions like these ones hard
I guess I'm still human, or, at least, half so
And part of me falters when I have to let go
My eyes meet hers, but they're not nearly as wide
As I tell her the patient from last Friday died
This life-and-death cycle happens all of the time
So why do I feel as though I've committed some crime?
The hope in her eyes goes up in smoke
And she covers her mouth as a sob makes her choke
He was such a nice man, she says, oh, God bless,

I'll just be a moment, Sir, I ought to tell Jess
I watch her leave, and something strange stirs
In the middle of my chest, and my vision blurs
The tears of the present and the past are mixed
Because I know that some people can't be fixed
I don't know what will happen next
After my student has gone to tell Jess
There will be a scar on her heart, the same as on mine
But, as she stands in the lounge, she writes a few lines
I notice the paper, but I don't say a word
What could I say to an act so absurd?
There are no words to describe all the things that we feel
When the words on a chart on a desk become real
But the student thinks she knows, her smile's now a frown
And when she gets home, she'll write this all down
And I'll let her try, without saying a word
She's still very young, and the things that she's heard
Are nothing compared to the things she will know
And one day she, too, will learn to let go. ■



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I remember you

Emily Jayne Milko
McMaster University, Class of 2016

SO MANY YEARS SINCE I LAST saw you. So many months since I last thought of you.

But today I passed a man who reminded me of you, not in how he looked, but in his body language, his intent and focus on the project in front of him, and suddenly it hit me. You were dying.

It's been years since I've heard any solid stories of your life now. In fragmented pieces, a story strung together of a stubborn drunk determined to drink himself into the ground. Why is it, when faced with unpleasant situations, we turn to clichés? Do we have so little respect for the human experience, that we must whittle it down to simple expressions?

It's just part of the culture for [men, women] of that [ethnicity, era, class].

A man of weak character.

Just another alcoholic.

And how ashamed am I that at some point, I don't remember when, I started understanding you, understanding your life, through these clichés and not through the reality in which you lived.

Perhaps I'm being too hard on myself. I was young when I last saw you, maybe twelve or thirteen, though I really couldn't say. There wasn't a defining moment that marked the last time I saw you. There were circumstances out of my

control, which don't matter now, but which very clearly shaped the way things turned out. Closure was not in the cards for us.

Two months of clerkship training is enough to see patients with alcohol-related complications. To hear the judgment on the part of residents, nurses, physicians and other medical students.

He did it to himself.

He deserves this.

Just another alcoholic.

Once again, months had passed since I last thought of you. Day 8 on my neurosurgical rotation I got a call from my mom telling me you were just admitted to ICU for respiratory failure secondary to aspiration pneumonia and a subdural hemorrhage.

I was afraid to see you, but as soon as I entered the ICU, the medical student inside of me took over as I tried to piece together your story and determine your prognosis, just as I would any other patient. I knew I needed to tell my attending my relation to you, since my team was consulted, but I was embarrassed – you were just another alcoholic – and, I am ashamed to say, for a moment I didn't want to be associated with you and your alcoholism, worried I would be judged for sharing your DNA.

Having actively campaigned to decrease stigma and improve mental illness resources for students in my undergraduate career, how could I now be so hypocritical as to be ashamed of your mental illness? How could I expect to show empathy to other patients suffering from alcoholism, when I couldn't even show it to you? Chastened, I resolved to remember you as the dynamic, whole person that you were, and not as the mental illness that you suffered from.

You were kind.

You were smart.

You were not just another alcoholic.

I am five years old. You are in the basement working on a project (you always had multiple projects on the go), and you come upstairs to the living room, where I'm playing with my brother. You call me by the nickname you always use for me, your "little mouse", and ruffle my hair with your calloused hand. You play chess. You read and write English (your second language) despite no English education. You are a terrific mechanic and exceptionally knowledgeable about world events. You are loving and fair.

Grandpa, I remember you... ■

The choice

Annie Wang
University of Toronto, Class of 2018

AS I WALKED THROUGH THE double sliding doors, I tried to inconspicuously smooth out my scrubs for the last time. The nurse at the front desk eyed my bright-orange “Observer” badge and smiled at me, the cool, professional smile of a veteran. “You need a mask,” she pointed to a box in the corner, “You must wear it at all times while you’re in the OR.” I nodded, and quickly grabbed one from the pile.

She led me down the hallway, her steps quick and silent as her black clogs grazed the floor. We arrived at OR 11, where the surgeon I was shadowing for the afternoon, Dr. X, was operating. The surgery started three hours ago, she told me, it’s a major surgery and will probably go well into the night. My stomach did a little flip at my luck – a major surgery! I thanked her and tried not to look too ecstatic as I donned on my mask.

I walked into the OR and introduced myself as a first year medical student. The patient was lying at the centre of the room, his body draped in sterile blue. In the harsh surgical light, I could see his chest slowly rising and falling. Dr. X,

“His voice was barely audible behind his surgical mask, yet his words sliced through the room like a hot knife”

his fellow Dr. G, and his resident Paul were all huddled around the patient, their eyes focused and alert. The scrub nurse stood close by, her hands hovering over the instrument table like hawks ready to swoop down onto a prey. The anesthesiologist, surrounded by beeping machines, and circulating nurse, situated by the supply cabinets, both nodded at me from across the room. I took a position by the foot of the patient, and tried to stand still.

This was not my first time in the OR, yet I could not contain my marvel as I watched the surgery proceed. An hour went by; Dr. X passed the scalpel over to his fellow Dr. G and told him to continue. At first, everything went on as before. While Dr. X watched, Dr. G delicately moved some tissue out of the way to gain access underneath. The resident Paul held a protractor steadily in each hand, his body perfectly still. Light tapping rang from the instrument table as the scrub nurse switched one clamp for another. Overhead, faint music played from the radio.

“*What the hell do you think you’re doing?*” Dr. X demanded suddenly. His voice was barely audible behind his surgical mask, yet his words sliced through the room like a hot knife.

“*I’m isolating the tissue sir.*” Replied Dr. G, his hands were frozen in space.

“*No, you’re destroying it!*” Said Dr. X sharply. I heard him swore. I could feel the entire OR tense up – I tensed up.

“*I’m sorr--*”

“If I were faced with this choice again, would I choose different?
Do I dare to choose differently?”

“I don’t care if you’re sorry. I want you to stop destroying my tissue!”

The surgery continued, but Dr. X’s reprimands didn’t stop. For the next four hours, he not only berated Dr. G’s surgical competence, but also questioned whether Dr. G was deserving of his spot in the fellowship program. I stood there, my feet rooted to the ground and my jaw clenched. I didn’t dare to move. Dr. G either quietly apologized or was silent entirely. I was silent too. Paul, the scrub nurse, the circulating nurse, and the anaesthesiologist—we were all silent. At one point, Paul the resident caught my eye, and raised his eyebrows at me. I raised my eyebrows back at him. Still, I did nothing.

That night, with my scrubs stowed away in my backpack, I walked home in the dark. I thought of how, just a week earlier, we were asked in class to reflect on our biggest fears for clerkship. I wrote down that I was afraid of feeling powerless within the hierarchical nature of the hospital. I was afraid that I will see a superior’s actions cause lapses in

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patient care and not be able to speak up. I was afraid that under an environment of learned helplessness, I will become a cynic and forget the reasons that led me to choose to become a doctor in the first place.

I don't know if Dr. X's actions resulted in sub-optimal patient care; maybe you can even argue his actions led to better outcomes for this patient. But I do know that I saw one human being treat another malignantly, and I froze. There I was, choosing to succumb to the hospital hierarchy, and I was not even yet a member. As a first year medical student, I undoubtedly had many shadowing and observership experiences

before me. If I were faced with this choice again, would I choose different? Do I dare to choose differently?

I hear from my classmates and my teachers that things are changing. Conflict resolution and teamwork courses are now part of our curriculum. Medical schools are choosing applicants that demonstrate willingness to listen to others. The speeches we hear during orientation week are infused with words like cooperation and humility. Still, I wonder, because I believe actions of individuals build the shift in culture. Because in that OR, when faced with such a choice, I chose to do nothing.

One day, I will be a resident, and

then a fellow. One day, I will be Paul. I will be Dr. G. Should I just trust that by then, things will be different? Should I just trust that in this future, doctors will treat their healthcare colleagues with respect?

And in the meantime, will I keep holding onto my silence? ■

Editor's note: the names in this article have been modified to protect the anonymity of the persons involved

Social media: slacktivism or something more?

Anthea Girdwood
Vice-President Communications
University of Ottawa, Class of 2016

IN EARLY JANUARY, I FOUND myself in a Facebook thread with a number of strangers. A blogger and mutual friend had a question for his compilation of “doctor friends”. As we were all getting acquainted, one such unknown medical student remarked to me “I think we pseudo-met... and by met, I mean you hounded us all to tweet about CFMS.”

It would seem that this reputation as a hounder-of-tweets has stuck and, my fervor, never wavering in the face of criticism, often leads others to air their complaints about social media to me.

“Why would anyone care about what I have to say on Twitter?”

“At best, people are going to be apathetic. At worst, annoyed.”

“It’s not like it makes a difference anyways”.

“It has been said that social media allows people a sense of anonymity to express that which cannot be said and, in so doing, depersonalizes the interaction”

Why do I encourage students to become a part of the conversation? Why do I think that social media matters?

Because there are people behind every post. And people make change.

It has been said that social media allows people a sense of anonymity to express that which cannot be said and, in so doing, depersonalizes the interaction. That statement is not without merit. But, depersonalized and artificial as it may be, it is people who make these posts, people unique and thinking and engaged in some wider, interactive entity. It is being exposed to ideas, the learning, the education, the connectivity, which allows people to take action offline. Consider the oft-cited mobilization of Arab Spring protests – it was Twitter that allowed them to connect and to organize, but it was taking to the streets that left the impression.

Social media alone cannot in and of itself create change, but the people that it reaches can. As evidenced in the new CFMS Advocacy Toolkit - available to all CFMS Members - social media is but one element of communication to successfully making change. Previous CFMS Lobby Days demonstrates the many avenues for delivering your messages. While social media – the sharing of photos, research articles, resources, and more – is perhaps the most apparent media element, the Lobby Day Team advocated by writing letters to MPs and important stakeholders, by holding television and radio interviews, and by meeting in person with their MPs to have a conversation.

This year, the Communications Portfolio has and will continue to work to inform and engage Canada’s medical

“Social media alone cannot in and of itself create change, but the people that it reaches can”

students. Alongside the Government Affairs Team in advance of the 2015 Federal Election, we plan to promote medical student voter turnout. We will summarize and share health-related party platform information and also hope to elicit responses to our healthcare questions from candidates across the country. We also are working to create a Media Education Tool that will build on the existing CFMS Guide to Medical Professionalism: Recommendations for Social Media, providing concrete strategies for students to use and monitor media for any purpose.

Like most things in life, when it comes to social media and advocacy, you get from it what you put in. If the extent of your involvement in any issue is a change to your display picture, the impact you make is minimal. But, if you engage with leaders, if you educate yourself, if you share in the conversation, you can be a part of something more. ■

The case for antimicrobial stewardship: a student call to action

Ali Damji

Ontario Regional Representative
University of Toronto, Class of 2017

Vanessa Zannella

University of Toronto, Class of 2017

Antonio Lee

University of Toronto, Class of 2017

HAVING BEEN INSPIRED throughout my term by the incredible grassroots advocacy undertaken by Canadian medical students, both myself and two fellow University of Toronto students have decided to embark on a challenge to raise awareness of a growing concern in Canada and across the globe: antimicrobial resistance.

Let's start with the basics.

Antimicrobials are drugs that destroy or incapacitate infectious microorganisms. Over time, microorganisms that have been targeted by antimicrobial therapy have developed strains that are resistant to the therapy including methicillin-resistant *staphylococcus aureus*, Vancomycin-resistant *enterococci*, and *clostridium difficile*.

So why should we care? Antimicrobial resistance poses a significant danger to all patients. In 2013, one in twelve patients was infected with at least one resistant microorganism in hospitals across Canada every day leading to approximately 2,000 deaths per year.^{1,2} Furthermore, deaths due to *C. difficile* and its resistant strains have increased four-fold in the past twenty years and show little signs of relenting according to the Public Health Agency of Canada.³ This will only worsen with Canada's aging population, as patients are more likely to have multiple comorbidities, weaker immune systems, prostheses, and medications, which all increase their susceptibility to infection by resistant microorganisms. In fact, some experts predict that drug-resistant microorganisms will kill an extra 10 million people per year worldwide by 2050 – more than

who currently die from cancer.⁴ As future doctors, resistant organisms are a potentially catastrophic reality that we must act on.

While we cannot change the natural selection processes that cause resistance, there are many other modifiable factors that exacerbate resistance. Stagnation in research and development has led to the creation of only four new classes of antimicrobials since the 1970s. This pales in comparison to HIV drugs for example, where 30 new drugs have been brought to market since the 1980s.⁵ The reasons behind this phenomenon include: patents expire too quickly to be profitable; the loss of smaller companies that typically create antimicrobials due to mergers and acquisitions by large pharmaceutical companies; and the reality that antimicrobials are used for short-term, discrete periods of time, making them less profitable to invest in.

A second important consideration is prescriber and patient culture. Think of when you were sick last. Many of us may have said to someone "Oh, I was so sick I needed antibiotics!" As a society, we are emotionally attached to antibiotics and use them to validate our medical illnesses and this has an effect on prescriber and patient behaviour. A 2004 study by Altiner *et al.* found that physicians prefer to avoid confrontation and assume that their patients want antimicrobials and report satisfaction in having their patients leave with specific treatment plans.⁶ What we fail to realize, however, is that when we send that patient with a cold home with a prescription for antibiotics because "it can't hurt" and "he seemed like he really

wanted them", we are bolstering an unnecessary and dangerous threat.

Fortunately, the world is realizing we cannot go on like this. The UK has declared that, alongside terrorism and climate change, antimicrobial resistance is a threat to the entire nation's economy and security. In September 2014, United States President Obama signed an Executive Order directing key federal departments to overcome the rise in resistant bacteria. Finally, in November 2014, the Government of Canada published a document entitled *Antimicrobial Use in Canada: A Federal Framework for Action*.

Eyes are now on the Canadian medical community and its students to join the fight against antimicrobial resistance, which will affect each and every one of us in our careers. The question is, will we rise to the challenge? ■

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“Non-Compliance”: why terminology matters

Emily Macphail

University of Calgary, Class of 2017

A WORD THAT I DON'T believe patients hear frequently (if ever, ideally), is “compliance”. Yet since beginning medical school this past July, I can't even begin to count the number of times that I've heard “non-compliance” cited as the most likely reason to consider for a patient's lack of positive treatment response.

Recent years have seen a healthy swing towards patient- and family-centred care, a concept which sees a patient not as a problem to be solved or a person to minister to, but rather as a fundamental member of the health care team. This is fitting, for without the patient, there would be no team, nor a need for one's existence. Even more importantly, the patient is the ultimate expert on their symptoms, their life, and the goals of treatment. This shift in attitudes is not one that has come intuitively for many health care providers, and it isn't one that fits easily with the traditionally hierarchical culture of medicine (which, thankfully, is similarly moving towards a more equal, team-based approach).

The Oxford dictionary defines “non-compliance” as “failure to act in accordance with a wish or command”. If you apply this definition to patients, it takes on an inherently judgmental and paternalistic tone, automatically placing the physician as an authority figure with the right to “command” and the patient as a subject to be judged, and if they do

“...without the patient, there would be no team, nor a need for one's existence...”

not present the desired results or follow orders, is deemed to have “failed”. The term acts to divide the team, rather than uniting them in the fight against illness. Interestingly, if there must be power imbalance, it might be more correct to place the patient in the position of power, having granted the physician the privilege of being intimately involved in their most personal and vulnerable moments. We exist to serve and heal, not to demand and condemn.

What is even more concerning about the term is the predominance of its usage with particular patient populations, often

“The term [non-compliance] acts to divide the team, rather than uniting them in the fight against illness”

the ones who are more vulnerable and have more obstacles: those who have psychiatric conditions, are elderly, or live in poverty. This is worrisome because in any case where a patient is not improving in response to a prescribed treatment, our next step should be to fully explore the reasons for this. Stopping at the fact that they are not following instructions is negligent. We need to determine the reason why. The majority of the time, this why is not willful disobedience as “non-compliance” implies, but rather the result of barriers which need to be actively addressed

“Stopping at the fact that they are not following instructions is negligent. We need to determine the reason why”

(e.g. unbearable side effects, insufficient information, prohibitive medication costs, etc.).

The conventional use of a simple term may not seem like a major issue, but the emphasis on clear communication which runs as a thread through every step of medical education and practice suggests that it should be. Research has shown that patients labeled as “non-compliant” receive poorer care in future interactions with the health care system. Therefore in order to follow our oath of “first, do[ing] no harm”, we must be clear about the barriers that have prevented a patient from following a prescription, rather draping them with a blanket term that simultaneously brands the patient and obscures the full situation.

As future medical professionals, if we want to truly work with our patients to improve their health, we need to stop using the term “non-compliance” as a catch-all and instead listen to their context to determine why they may not be following treatments precisely as prescribed and what else to try. And that is one request that there is no reason to not comply with. ■

About the CFMS Travel Award

EVERY YEAR, THE CFMS SETS aside funds to provide financial assistance for CFMS members who wish to attend our General Meetings. This grant supports non-elected members to attend CFMS meetings with the goals of fostering greater member awareness of CFMS structure and function, promoting increased interest in the CFMS, and

facilitating increased participation in CFMS activities. The application process is competitive and the CFMS routinely receives a far greater number of applications than the number of funded spots available. Applicants are selected based solely on the merits of their written application as judged by a selection committee. There are two opportunities

to apply for a travel award each year: in August for the Annual General Meeting in September, and in February for the Spring General Meeting in April. Interested in applying? Keep an eye out for the calls for application in the CFMS Communiqué! ■

Reflections on the 2014 CFMS AGM

Adrienne Duimering
Island Medical Program
University of British Columbia, Class of 2017

THE CFMS AGM PROVIDED the unique opportunity to meet medical students from across Canada. As a student at the Island Medical Program, a distributed site of the UBC MD Program, I was particularly interested in discussing strategies employed by other schools to maintain connectivity between sites. The small group sessions facilitated a valuable discussion with regards to distributed learning programs. A relevant topic of discussion was with regards to weighing the value of students completing their first semester at the main medical school site before relocating to their distributed site for the remainder of the program. This is a topic that has been a point of

discussion at UBC, and it was useful to hear students' perspectives from other schools.

From the small group session centred on medical student mental health, the topic of mindfulness in the curriculum at several schools was discussed. Mindfulness sessions and counselling sessions have been successful strategies that have been implemented at other schools. Since the CFMS meeting I have been working with faculty and students at my program to introduce mindfulness sessions into the curriculum. I have shared with the organizers of our "Doctor, Patient, and Society" course the idea of having a counsellor outside of the faculty available to students.

Learning about Global Health Initiative (GHI) projects conducted by students has led me to look for opportunities to connect the distributed sites at UBC to the main GHI program at the Vancouver Fraser campus. I enjoyed participating in a video to raise awareness for the important implications of climate change on health.

Being a part of the CFMS General Assembly voting and learning the full responsibilities of CFMS positions was useful knowledge that I have passed on to students at my site. The CFMS is integral to maintaining connectivity between medical students across the country, and I have been eager to share all that I have learned with my colleagues. ■

Connecting Canada through the CFMS

Leanne Murphy

Atlantic Regional Representative

Memorial University of Newfoundland, Class of 2015

THIS YEAR I WAS FORTUNATE enough to win a travel award to CFMS AGM in Kingston and I could not have been happier. I had been involved with the CFMS as a school representative for the previous two years and I was still interested in staying involved. I've met so many wonderful and interesting people through the CFMS. This has never been more evident than this year as I embark upon my 4th year elective tour for CaRMS. Each new city I visit is peppered with familiar faces, most of which end up being CFMS related. Some of these faces I know well, others are simply familiar,

likely from a brief conversation at a Saturday night social or a small working group.

The latter are the more interesting of the encounters. They usually go like this: It's the first day of a new rotation in a strange city, people are everywhere and no one quite knows where to go or what to do. You make eye contact with the person in front of you in the administration office line, they look vaguely familiar. On average it takes 45 seconds to make the connection. "Oh! You were at the CFMS meeting!" Then we end up chatting about the most recent meeting, the mutual

acquaintances, the issues that came to light and our ideas. All of a sudden this new and strange city is somehow more welcoming and homey.

That is the beauty of the CFMS. It makes you feel connected -- to people, to ideas, to the profession. It makes you part of a team -- working for a greater goal, uniting students from across the country. I'm very lucky - as the newly elected Atlantic Representative I get to stay involved with this great organization, to stay connected, and to be a part of this team! ■

Global Health at the CFMS AGM

Shahob Hosseinpour

University of Toronto, Class of 2017

ON SEPTEMBER 18, 2014, I attended the 2014 CFMS Annual General Meeting. As a "First Timer", I had very little idea what to expect and, to my delight, it was truly a wonderful meeting.

I am currently the Senior Local officer for Global Health Education at the University of Toronto and, as an avid advocate for global health. I was proud to see that the AGM had a separate and very strong global health program prepared. One of the biggest highlights of the

conference was meeting fellow student leaders and having an opportunity to discuss and share ideas of how we could further advocate for global health in our respective medical schools. For instance, during our small group session we had an opportunity to learn from other schools on how to improve the effectiveness of our global health teams, and discuss ways that we can develop improved communication between schools to further inter-school collaboration.

Another aspect of the conference that

I found incredibly impressive was the dedication to which we discussed the various position papers put forward. It was clear that each school was eager to fairly represent their student body and each individual's arguments were respectively addressed and considered prior to voting for the position. In all, the meeting provided me an unbelievable opportunity to meet truly inspirational medical students from across the country that I know I will be working with in the years to come. ■

AGM highlights

Sean Hurley
Dalhousie University, Class of 2017

AS THE DALHOUSIE MEDICAL Student's Society (DMSS) Sports and Wellness Representative and Dalhousie's Representative on the CFMS Wellness Committee, I was grateful to receive funding to attend the CFMS Annual General Meeting in Kingston, Ontario.

From the Dalhousie perspective, I believe my attendance at the AGM will benefit Dalhousie Medical Student body. In November 2013, our alumni gave us a \$125K donation to student health and wellness. As a result, we started a

Dalhousie Wellness Committee with our Student Affairs Department. By attending the CFMS AGM, I was able to speak to many students at other universities and ask them about their wellness initiatives. From these conversations, I believe I can help to implement many of these ideas into Dal's wellness program.

In addition to the wealth of knowledge I gained from the meeting, I was able to contribute to many discussions related to wellness. Dalhousie has a lot of unique student initiatives aligned with the CFMS six dimensions of wellness from

interest groups and sporting activities to a very well developed medical humanities program. Through small working groups and informal conversations, I was able to share some of Dal's experiences with students from other universities.

Finally, I thoroughly enjoyed attending the conference. I now have a better understanding of the key issues facing medical students across the country and I definitely embraced the opportunity to network with other students. ■



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“Political activism, an integral part of our profession”— an interview with Dr. Danielle Martin

Yin Hui

Annual Review Editor

Western University, Class of 2015

Anthea Girdwood

Vice-President Communications

University of Ottawa, Class of 2016



WE HAD THE PLEASURE OF SPEAKING WITH Dr. Danielle Martin, who is a family physician in the Family Practice Health Centre at Women’s College Hospital (WCH) and an Assistant Professor in the Departments of Family and Community Medicine and Health Policy, Management and Evaluation at the University of Toronto. She holds a Masters of Public Policy from the School of Public Policy and Governance at the University of Toronto. She is the Vice-President, Medical Affairs and Health System Solutions at Women’s College Hospital.

Dr. Martin’s focus is on improving health at the system level as well as the individual level. Her clinical work has involved remote northern medicine as well as a current focus on maternity care, and she is an active medical educator.

Dr. Martin’s involvement in political activism and advocacy for health care system change began before entering medical school. Most recently, she appeared in front of the United States Senate as part of a panel showcasing various universal health care system models contrasted to the American health care systems. She also served as the CFMS President 2002-2003.

What made you go into medicine, and specifically, what made you become interested in improving the health care system?

I think for many physicians it's common to develop an interest in health care system issues as a result of encountering them in clinical practice. For many people, the experience of taking care of patients and discovering challenges and opportunities in the system through the provision of clinical care was how they developed a passion for system improvement. It just happened to be the case for me that it was the reverse - before I came to medical school, I was working in health care policy and politics. So, my interests and background are in health care policy (although I did do my undergrad studies in biochemistry), and my interest in medicine really began as an interest in systems and policy. After looking at and thinking about broader system issues, I felt like it was important to learn about what life is like delivering care in the frontline in order to be able to participate in improving the health care system in ways that are realistic and work for patients and providers. So I went to do medical school at Western and I fell in love with family medicine. I became very passionate about primary care and about the longitudinal relationships one develops with one's patients in family medicine. I feel very lucky that I've had the opportunities to practice clinical medicine and now I can't imagine giving it up.

What brought you to practice in northern Ontario?

When I was a medical student, very actively involved in CFMS I might add, I went to do a rotation in Sioux Lookout as a part of a rural northern placement opportunity in my final year. I became really interested in aboriginal health issues and in rural and remote medicine in general. I think there is a really particularly important role that

family physicians can play in smaller communities and these are areas where one can really maximize the scope of practice. I was very moved by my experience in Sioux Lookout, and my mentors and their work there also inspired me. I promised myself, as soon as I graduated, I would go back. After graduation, I did a couple of month-long locums in Sioux Lookout and on northern reserves. From there, I just continued to locum around the North. Soon, I helped to start a program at the University of Toronto, where, for the next five years, I would practice 6 weeks in Toronto and 2 weeks in a community called Geraldton in Northern Ontario. I'd take residents with me to try to give the residents at U of T Family Medicine the same kind of exposure to rural medicine that I had been so moved by when I was a medical student. I continued to do that until I had my daughter 5 years ago and, at that point in time, I put down full-time roots in Toronto.

I'm reminded of some physicians who were very moved by their work as primary care physicians to become involved in political activism, and then decided to leave clinical medicine to continue with policy and politics. I wonder, have you ever considered leaving clinical medicine to pursue policy and politics in a full time capacity?

I certainly have had that conversation. It's not something I'm interested in at this point in my career, and I don't really think that that's going to be my path. While I think it's incredibly important that we get good people involved in politics, and I have a huge amount of respect for physicians who have made that transition into political life, I think that there are also a lot of other ways that physicians can help improve the health care system. I think my particular skills and interests are better used in trying to influence

“I actually don't think [being politically active is] separate from our job, I think it is our job.”

public policy from where I sit as a clinician, to communicate with the public to increase public awareness of health care system issues and, to try to really improve the health care system on the ground, where care is delivered.

You talked about small-p politically active. What do you mean by that? How do you think medical students can get involved to become politically active?

What I mean by small-p politically active is nonpartisan activity. As medical students will understand very well from their studies, health is an inherently political issue. What determines people's health and their wellness is not just their pathophysiology and their genetics. What determines their health status is the social determinants of health, much more so than anything we do as physicians. So, as people who care about the health of the population, I think it is critically important that physicians be active on issues like poverty, education, and health system reform, because it's only by being active on those really important issues, issues that are determined in the political space, that we can help improve the health of our communities. I actually don't think that it is separate from our job, I think it is our job.

I learned a lot of the skills that I use as an advocate when I was a trainee, eventually including as the president of CFMS and later, of PAIRO (now PARO). I was very active as a medical student in London. We did a lot of work locally around access to

medical education for students from lower income backgrounds, medical curriculum reform, as well as women's health and reproductive rights. There is no end to the issues that medical student can become active on either from an education perspective or from a clinical care perspective.

I saw you guys put out an Op-Ed in the Toronto Star around Pharmacare.¹ I think it's terrific work, that's the kind of thing medical students should be involved in. You are going to be heading into a health care system that is tremendously valuable but also profoundly imperfect - so it's going to be our job to fix it. We can't leave that work to others, we have to engage physicians in that work, and you might as well start now.

You are someone who has truly engaged herself in advocacy in all levels, speaking before the United States Senate Subcommittee about the Canadian health care system. We wanted to hear a little bit about how you became involved in this and what your goal was in taking part in that debate?

Essentially, the US Senate has a subcommittee that deals with health care issues. The chair of this subcommittee, Vermont Senator Bernie Sanders, organized a panel with representatives from countries with universal health systems. The goal was to discuss what the U.S. might learn from other countries to improve their own system. There were representatives from Denmark, Taiwan, France, and a person from Harvard who's an expert in comparative international health care policy. I was honoured that they approached me to ask me to speak about the Canadian health care system. There was a vetting process that I had to go through, showing my credentials to both the Democrats and Republicans on that committee. Then I was pre-interviewed by both and I was asked to

submit a written brief which should still be up on the Senate website.² I had to prepare a five-minute remark followed by a question and answer period. I was very honoured to talk about what I think Canadians are most proud of with respect to our health care system, and to discuss some of the challenges we face and how we are trying to deal with those challenges. It was important to me not to sugar-coat it and pretend our system is perfect, but I was asked about what I think the US could learn from what we are doing well, so I tried to do that in my five-minute brief. Then there was a pretty spirited Q&A - it certainly felt to me that the majority of the questions were directed at me!

How was the overall atmosphere in that room? It looked very tense on YouTube when they were grilling you about your views of the Canadian health care system and, in many instances, where you had to defend aspects of our health care system.

I didn't feel the atmosphere was particularly tense. This is politics. That is the background that I come from. It's sort of like going to watch Question Period in the House of Commons. There is always an element of political theatre to these things. You know you are not truly there to change anybody's mind in a five-minute presentation. When a Senator is asking you a question, he's not really talking to you, but instead talking over you to his public and trying to make a point against the other side. Especially in their two-party system, where their opinions are very divided about what the future of the American health care system should look like, it becomes a pretty heated debate. I'm a player in that room, but not the main event. The two sides were engaging in a dance with each other - which I happened to be a part of for a brief period. So I didn't feel it was tense - I felt like everybody was doing their job,

“... there are three things that we can all speak to with relative authority no matter what stage of our career we are at... evidence... values... our own experiences.”

and, I must say, I actually enjoyed it. It was spirited, but the questions that were being asked reflect misrepresentations of the Canadian health care system that are portrayed in the American media. I was very grateful to have the opportunity to set the record straight and to try to represent what's best about and what we value about the Canadian system.

We were excited to talk to you because you are considered a younger player in the field of health policy and politics. How do you stand confidently as someone who may be younger than the average person at the table? Do you have any advice for medical students who are trying to get themselves heard from a position of lesser authority?

It's not an easy question to answer. I think there are three things that we can all speak to with relative authority no matter what stage of our career we are at. The first is evidence. It doesn't matter how old you are, if you are going to go out and talk about something, it's important to know your evidence, know the literature. In fact, one of the reasons why I didn't feel particularly fazed by the interaction at the US Senate was because I know the international comparative health systems literature.

There was very little that these guys could ask me that was going to stump me. So having the confidence that you know your stuff is really important, and you can do that at any age, at any stage in your career, at any issue just by reading, going to talks, and listening to what experienced mentors can teach you.

The second is values. I think that's an extremely important component and one that is maybe undervalued in the culture of medicine, but extremely important in the eyes of the public and the general population. We need to be unafraid as physicians to say what our values are. In Canada, one of the underpinning values of our system is that access to health care should be based on need and not on the ability to pay. I think anyone, at

any age, or any stage of their career can articulate that value without sounding judgemental or as if they know it all.

The third thing is our own experience. Even as medical students, you are already having interactions with patients on the wards and you also having interactions with people as citizens, as family members, as patients yourselves. We have all experienced the health care system. You can speak about your own experience not from a position of having seen it all, but just speak with humility about what you have seen and what you have observed, and what makes you concerned, or what makes you proud, or what gives you hope.

You don't have to have been in the game for 30 years to be able to speak

convincingly to those three things and it's always a good idea to come from a place of acknowledging you don't know everything. That's true at the beginning of your career, and that's equally true that the middle and end of your career. Nobody has a stronghold on the truth, so I think there are ways to do advocacy that are principled and courageous, but don't claim more expertise than any of us has. I think you can do that at any stage. ■

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1. http://www.thestar.com/opinion/commentary/2014/12/11/its_time_for_a_universal_pharmicare_system.html
2. <http://www.help.senate.gov/hearings/hearing/?id=8acab996-5056-a032-522e-e39ca45fcfbc>



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Drifting away

Carolyn Reardon

Dalhousie University, Class of 2015

Today is a “good day.” At least right now it is, early in the morning. Sometimes it seems my good days drift into bad days before I can grab on and anchor myself against the tide rushing out, taking with it words from the tip of my tongue, names that had been long adhered to faces. And I’m left grappling, searching, fumbling – as if in the dark.

Some days, I can’t say exactly how long I’ve been here. On my good days, I remember our old restored beach house just fine, but I know that it’s no longer home. On my bad days, I’m homesick, although I can’t quite conjure an image of the home I long for. Perhaps the beach house, sometimes barely a fuzzy outline, dotted with the clouded faces of our children at various ages. Perhaps my rural family practice, since that was where I truly felt at home. That is, of course, until the bad days started creeping in, and it grew hostile and unfamiliar. The whispers of the staff, the bewildered, accusatory looks of the patients, and me, not quite certain of what was real or imagined. Yes, I think that’s how it happened. I most often think of our first apartment, above my father’s store, where we lived during my first years of practice. Where we first noticed him slipping; the misplaced items, then the finances in ruins. Some days, some hours, really, it seems not so far away, that time and place.

How naïve I’d been then, as a young man, checking my own father into a place just like this. To have thought that I would somehow be immune. How embarrassing – a physician, formally trained in the neurosciences, and less formally, but nevertheless experienced, in the intricate layers of human behaviour, from years immersed in the lives of my patients. Friends and neighbours, really. Steeped in the daily fumbblings of human imperfection, I should have known better.

But I know now, on my good days, that deep down I truly believed it; that I could cultivate a life so meaningful it would just stick. That I could acquire enough knowledge, that I could see enough beauty, that I could travel to enough remote corners of the world, that I would build a life so interesting, so important, it could never be forgotten. The memories could never drift away, they would be anchored by the richness of the sunsets watched, the foreign streets navigated, the waters swam in, and the babies delivered. I could spread myself out like the ocean, into the intricate voids in the lives of my patients, into the mysterious holes of scientific knowledge, so that when the tide ebbed, I would pool there, remaining. And when my bad days started, I was shocked by my dismay that my plan hadn’t worked. I hadn’t even realized it was a plan. I had simply believed that I could see clearly enough. That I could love strongly enough.

Looking back, on days when I do look back, I don’t think it was arrogance. Perhaps just youthful optimism, propped up by an underlying fear that it would happen to me, too. That I would be the one staring out the window of the nursing home, day in and day out, with a face as blank as a fog bank when my own kids came to see me. On my good days, I mourn for that ignorant optimism and that panicked energy, pushing me to rush, rush. On my bad days, I’m still mourning something, although I just can’t put my finger on what. My wife? My kids? But the kids come from time to time, I believe.

Why can’t I forget to mourn? Why can’t these innate feelings drift away, like the names of patients I had seen for over thirty years, and the proper places for the instruments used every day in the office? Drifting, at first just within sight, but then fading until that tiny point on the horizon disappeared.

On the days that tread water between good and bad, I think maybe I became saturated, from all the things I rushed to absorb, now seeping out in all directions, forming a puddle on the floor. Maybe I rushed too much, and didn’t absorb them at all. I can’t say, now.

The beginning of 2014 marked the launch of the Canadian Medical Association Journal (CMAJ) Student Humanities blog. The blog, which is run in conjunction with the Canadian Federation of Medical Students (CFMS), was created to provide a venue for high quality student work concerning the medical humanities. Submissions sought have included poetry, essays, critiques, reviews (films, novels, theatre, etc.), interviews (profiles or conversations), reflective pieces, event reports, graphic medicine and visual art pertaining to the medical humanities. Since its launch, a diverse selection of quality student work has been published on the CMAJ Student Humanities blog. Drifting Away is one of the many exemplary pieces published on the blog, and can be found at <http://cmajblogs.com/drifting-away/>

My pull

Taneille Johnson
Western Regional Representative
University of British Columbia, Class of 2017

Noticing my hair on the floor for the first time
Not knowing how it got there or why there's so much
Just sweep away and forget; must continue studying.
Hours pass.
Need to do well on my midterms.
There's more hair on the floor.
But where from?
Reaching back to my scalp and feeling thinning
Is it from me?
Rushing to the mirror, inspecting- "do you see a bald spot?"
Negative. Must continue studying.
But now I can't focus. I'm curious what the hair means.
From my head to the floor- I must have pulled it out.
But I don't remember doing that.
What were my hands doing all that time? Typing? Flipping pages?
Now I'm not studying. I need to study. Focus.
The hair can wait. Ignore the anxiety.
You need the grades: medical school GPA

You only needed to notice the hair once.
To realize that your hands were in your hair, running through
To select one particular hair- the one that was different
And pull. The pull feels good. But you don't know why.
Soothing. It helps the anxiety. But you're scared.
What if it becomes a coping mechanism?
Don't worry: only two more years of undergrad till med
I should still have a full head of hair by then
Besides, it's curly. No one will notice.

Final exams.
There's hair on the floor again
Anxiety a new high but pulling helps.
Pulling when studying. Pulling when with friends.
One hair at a time. Relaxing.
Doctors tell me it's not normal and
I should find different ways to cope
But you didn't go to med school when the entrance average
Was a 4.0
Giving me a medication. Telling me that it will help.
I don't need a medication. I need to study.
Telling me that I have a mental illness.
Shaking my head. I'm intelligent and young.
Pulling while Googling "Trichotillomania"
There's hair on the floor again
Now guilt.
Maybe it's not normal.
I'll deal with this later though: I need to study.
Besides, it's curly. No one will notice.

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Isolation (photo essay) ▶

Jennifer Walker

Northern Ontario School of Medicine, Class of 2016

Northern Canada has a psychosocial culture closely tied to the land and geography. Harsh climate and challenging landscape contribute to the isolation of sparsely populated northern communities. The psychosocial culture of these sparse garrisons is paradoxically embedded into the national culture of unity across broadness. Railroads, the trans-national highway, bridges, lakes and rivers connect pockets of civilization across an expanse of rugged wilderness. A desperation for connection, forged out of an identity in solidarity and posture in psychosocial loneliness, is captured in the undertones of the landscape, the industry, the infrastructure, and the transportation of Northern Canada.

As a medical student placed in isolated recesses of Northern Ontario, my artistic endeavours allow me to express and assess my own psychosocial interpretations of an isolated culture that extend into my practice as an abstract form of compassion, allowing me to understand the psychological and social habitats of my patients.



Triptych (tempera on canvas)

► Drawing on the artist's time dealing with patients suffering from mental health conditions, these pieces seek to capture the experiences of mental illness.

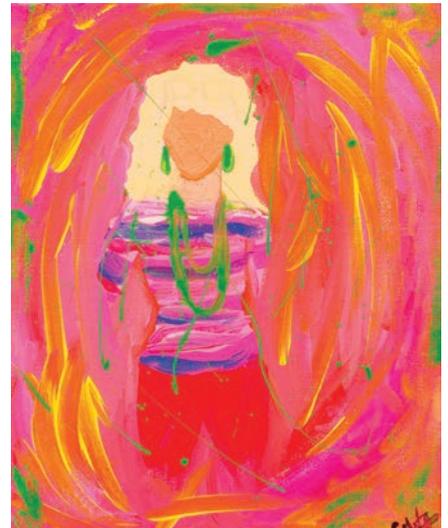
Grace Yi Wang
University of Calgary, Class of 2016



Triptych: Depression



Triptych: Psychosis



Triptych: Mania



◀ Smoking kills (acrylic on canvas)

Laura Schep
Dalhousie University, Class of 2017



◀ Adaptation of Flamingo Waters by AnnMarie Bone

Laila Nasser
McMaster University,
Class of 2017

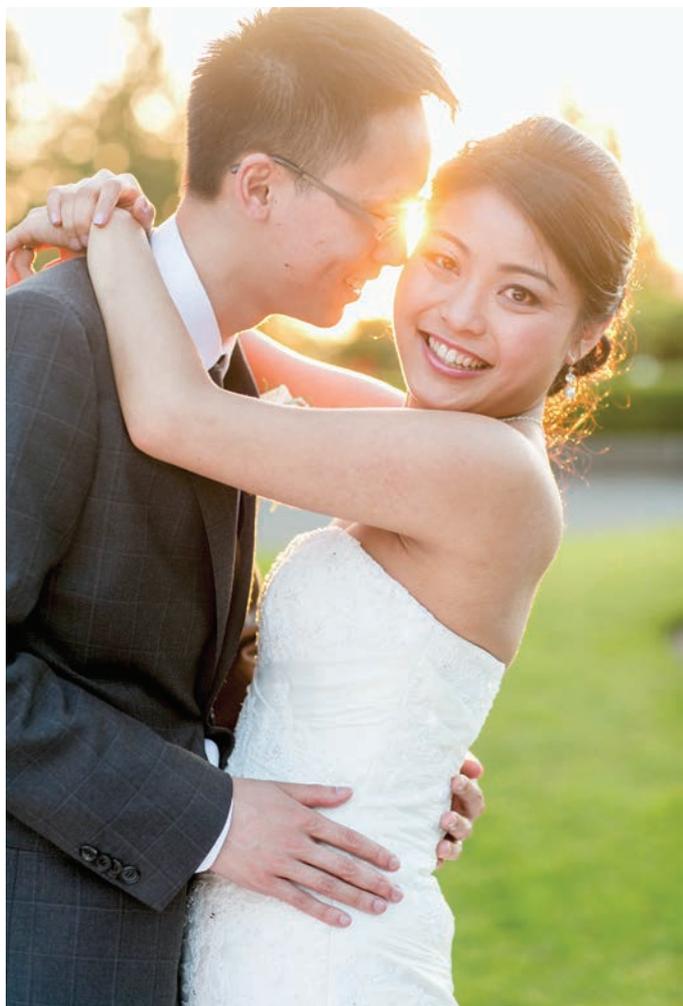
Love amid ▶ the ruins

Dani Cadieux
Western University, Class of 2016

Life depicts the ruins of Saint Anthony's Chapel in Edinburgh, Scotland. My husband and I hiked to this spot after our wedding ceremony in December 2011. Not only does Saint Anthony's Chapel bring back the fond memories of that special day in our lives, but also serves as a reminder that often times the most spontaneous and unplanned moments are the ones that I cherish most.



Weddings



◀ Josephine Chow and Charles Au May 31st, 2014

Dr. Josephine Chow UBC
CFMS NEO/NORE 2012-2014
PGY1 in Family Medicine, Calgary



Babies



◀ Anna Meiwald Davis
Born July 25th, 2014
Parents Allison Meiwald and Rob Davis

Allison Meiwald, BN, MD, FRCPC
VP Communications 2005-2007
Consultant Physician - Division of
Emergency Medicine
Assistant Professor - Schulich School of
Medicine and Dentistry
Western University, London, Ontario

Baruch Alter Juda ▶
Born August 24th, 2014
Parents Ari and Tamar Juda

Ari Juda, Western University, Class of 2015



◀ Violet Mondoux
Born March 29th, 2014
Parents Shawn Mondoux and Bronwyn Hammel

Shawn Mondoux M.D., B.Eng.
PGY2 Emergency Medicine
University of Ottawa / The Ottawa Hospital
CFMS VP Education 2009-10



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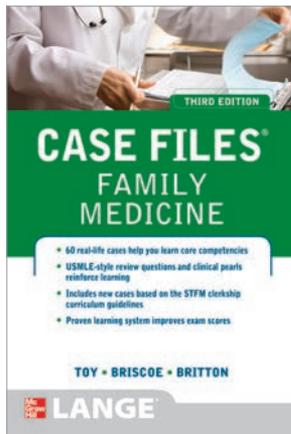


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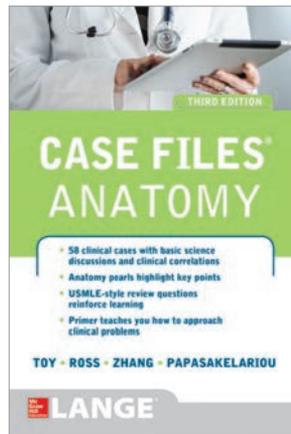
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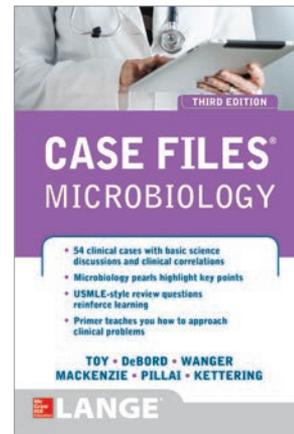
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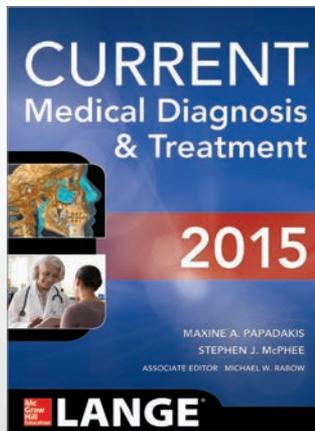
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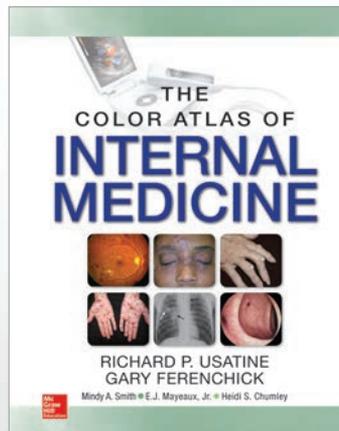
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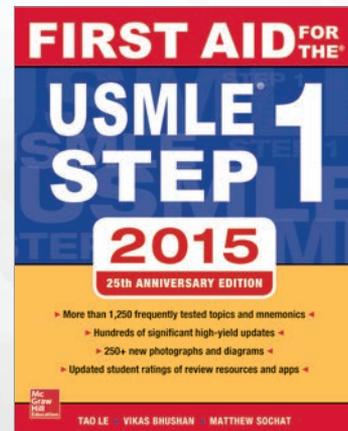
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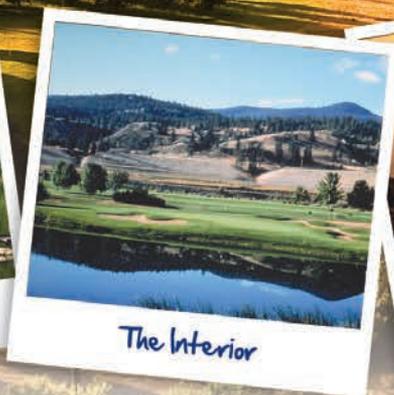
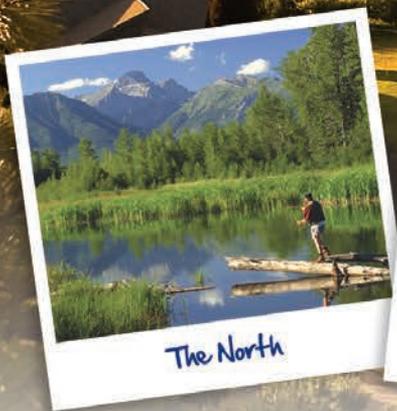
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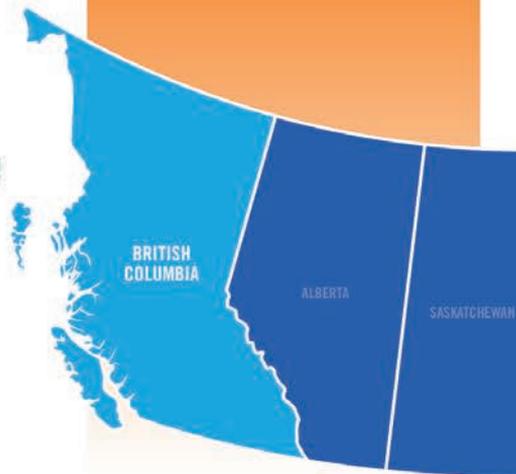
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