



CFMS/FEMC Annual Review

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APRIL 2010

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Letter from the editors



Meiqi Guo, CFMS
Annual Review Editor,
Queen's University,
Class of 2011



Ijab Khanafer, CFMS
VP Communications,
University of Ottawa,
Class of 2011

The CFMS is very pleased to present the 2010 edition of the *CFMS Annual Review* — our annual report to members. As this compilation of articles will illustrate, this has been yet another exciting and wonderful year of growth and success for our organization as well as for our members.

The *Annual Review* is divided into numerous sections. The first, titled “CFMS activities” contains the latest updates on projects carried out by the CFMS executive and officers, as tasked by the general membership. Whether it is issues of political advocacy, the environment, student wellness, member services, interorganizational collaboration, website changes, blood drives or medical education, our team has been working hard to represent you and bring you the services you need.

The CFMS is proud to announce that we will be joining the Fédération médicale étudiante du Québec (FMEQ) in hosting the 59th General Assembly (in Montréal) and pre-General Assembly (in Ottawa) of the International Federation of Medical Students’ Associations (IFMSA) in July–August 2010. The great teamwork between these sister organizations guarantees an unforgettable event! You can find out more about this and other global health program updates in the second section.

Our feature interview this year is with Dr. Roberta Bondar, the first Canadian woman in space. Despite her busy schedule, she was kind enough to chat with the *Annual Review* about her struggles and triumphs as a clinician, researcher, astronaut and educator. We would like to thank the Canadian Undergraduate Conference on Healthcare executive, especially Gary Ko of Queen’s Medicine Class of 2013, for facilitating the interview.

Finally, we would like to share with you the initiatives, opinions, experiences, creative works and art of medical students from coast to coast. Join a clerkship student for ICU rounds with Dr. House, learn more about student-driven clinics and journals, travel with students to rural areas and abroad or simply enjoy some poetry and art. We hope these will bring you laughter, inspiration and a few deep thoughts. We were overwhelmed by the number of submissions received this year, but, unfortunately, due to space limitations, it is with deep regret that we were not able to include them all.

Last but not least, the *Annual Review* concludes with a section featuring CFMS alumni: what they have learned and where they are now. Certainly, a few pearls of wisdom that every medical student could use!

The *Annual Review* thanks the Canadian Medical Association publishing staff and our generous advertisers, without whom the *Annual Review* would not be possible.

We hope that you will enjoy reading this year’s *CFMS Annual Review*.

Correction: Shawn Mondoux and Mathew Li’s photographs were featured on *CFMS Annual Review*’s 2009 cover but their names were accidentally omitted from the photo credits. The *CFMS Annual Review* would like to apologize to Shawn and Mathew for the error.

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A letter from your CFMS president



Tyler Johnston,
CFMS President
McMaster University,
Class of 2010

Welcome to the 2009–2010 CFMS Annual Review! The CFMS is Canada's national medical student organization, representing over 7200 medical students from across the country, and the *Annual Review* is our opportunity to report on the efforts of our organization and to showcase the work of Canadian medical students. The work plan for the year is set by our membership at our Annual General Meeting. Guided by our three pillars — representation, communication and services — the 2009–2010 agenda has been filled with important projects.

As has been the trend for the past few years, the CFMS continues to grow both in the number of students participating in our organization and in the diversity of initiatives undertaken. With this increase in size comes the challenge of managing our growth responsibly to ensure that the CFMS is as strong an organization as possible. We've endeavoured to do just that with our institutional memory project, our policy paper review, the creation of an appointments and review committee, a thorough review of our financial policies and other initiatives. With this work, we'll ensure that the CFMS is a strong advocate for students and a strong contributor in the medical education community for years to come.

This has been the inaugural year for the CFMS National Leadership Awards program, which recognizes students, residents and faculty who have made a significant positive contribution to the lives of medical students. Other new initiatives include travel rewards for CFMS meetings, a branding project to expose more students to the work of the CFMS, as well as a review of the various issues surrounding professionalism as requested by our membership.

Probably the most exciting news of this year is that the CFMS Global Health Program in partnership with IFMSA—Québec has been chosen to host the 59th International General Assembly (GA) of medical students in Montréal and the pre-GA in Ottawa in July–August 2010. Preparations have been underway for well over a year and this promises to be an extraordinary event.

In addition to all of these new initiatives, the CFMS continues to advocate a fairer visiting student elective system, to examine distributed medical education from the student perspective and to optimize our website.

I am happy to report that the Student Initiative Grants, which provides start-up money to worthy medical student initiatives; the Political Advocacy Committee; the Global Health Advocates and many of our other programs have also enjoyed a highly successful year.

As you can see from the descriptions above, 2009–2010 has been a very busy year for the CFMS in terms of advocating for medical students, giving them a means to communicate across the country and providing them with services that make their lives a little bit easier.

The articles that follow outline the events of 2009–2010 as seen by our executive, our representatives, our members and our alumni. We hope that you will find them informative and enjoyable. Please contact me, any member of the executive or your local representative if you want to learn more about your organization.

Yours sincerely,

All editorial matter in *CFMS Annual Review* 2009 represents the opinions of the authors and not necessarily those of the Canadian Federation of Medical Students (CFMS). The CFMS assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice herein.



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Education and the CFMS: new milestones for 2009–2010

Shawn Mondoux
VP Education
University of Ottawa, Class of 2011

The VP education role is an incredible one within the CFMS. Not only is this person charged with something that all medical students take to heart, their education, but they also play an important role representing CFMS to outside organizations. As I write this article, I am in Québec City to represent Canadian medical students at the annual meeting of the Canadian Nursing Students' Association.

As a medical student in Ottawa, the opportunities to attend meetings have been many. This year I will have attended upwards of 20 meetings, via phone or in person, and will have represented all of you to organizations such as the Canadian Medical Association, the Canadian Resident Matching Service, the Canadian Medical Forum, the Association of Faculties of Medicine of Canada (AFMC), the Federation of Medical Regulatory Authorities of Canada, all provincial and territorial medical associations, as well as many other student groups. At the CFMS, we take pride in properly and adequately representing our members. I am happy to fulfill part of this important mandate for the CFMS.

Now to the more important, member-mandated issues. Looking back to the AGM in Thunder Bay, members tasked this portfolio with four major issues.

The Distributed Medical Education report and guide

The DME report is the continuation

of the national survey that was conducted last year by then-VP education, Tyler Johnston, and it will largely centre around survey findings. By surveying a significant proportion of our membership, the CFMS has walked away with an important shopping list of issues that are important to medical student as well as a whole ensemble of lessons learned. With this information, we plan to draft the DME guide, a how-to document for getting medical student societies involved in the DME installation and quality assurance process. This guide will include the LCME standards that are necessary for accreditation and it will also make use of lessons learned to suggest areas of increased need and detail to ensure good, healthy DME programs.

The professionalism portfolio

Professionalism, in the context of the medical student, is generally limited to the Hippocratic Oath or some variation thereof, which is taken at the beginning of our days as medical students. Although our obligations to patients remain largely intact since the days of Hippocrates, other issues like social media and personal health tend not to be adequately addressed. If only Hippocrates had Facebook!

That said, the CFMS believes there is a need to draft a national policy for medical students on professionalism, on what it represents, on who it belongs to and into which realms it

extends. The goal is to provide a student-generated document that all medical societies can lean on. The work is moving along quite well and we look forward to seeing the fruits of our labour at the end of the year.

When it comes to work hours, the CFMS is hearing that students are being kept longer and resting less in their clerkship year.

Clerk stipends and work hours

How much do clerks get paid in their fourth year? Are there rules and limits to work hours for clerks?

These are important questions that are being asked by our membership and ones that we are answering. In early February, the basic payment stipends for those in their final year of study were sent out to all members for review. Information is power and we encourage provincial student groups to lobby their schools and governments for additional stipend



recognition if theirs is below the national average.

When it comes to work hours, the CFMS is hearing that students are being kept longer and resting less in their clerkship year. Our request is that clinical clerks should adhere to the same provincial contract standards as negotiated by the provincial resident bodies and that these guidelines be policed by the schools. We will be giving students the chance to discuss the issues surrounding their clerkship hours and then we will

bring our finding to the AFMC. Together, we hope to improve the current situation.

Collaborate with other CFMS members on a variety of projects

Collaboration is the cornerstone of the executive of the CFMS. It's difficult to find a project that doesn't involve many members of the executives. From global health to the environmental working groups, we are working together to make each project a reality.

This is a mandate that our membership gives us every year and one that we are happy to fulfill.

As always, we encourage our membership to get in touch to discuss these issues. Students from across the country are welcome to help us with our mandates.

Whether you have questions, encouragement or criticism, take the opportunity to get in touch.

Please contact me at shawn.mondoux@cfms.org to make your views heard!

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Talk the talk, walk the walk

Ijab Khanafer
VP Communications
University of Ottawa, Class of 2011

As VP Communications, I have had the privilege this year of working with a group of incredibly hard-working and dedicated students. As you read through the pages of this Review, I hope that you are also instilled with a feeling of pride for what individual students and the CFMS have accomplished so far this year.

My role within the CFMS is divided into internal and external communications.

Internal Communication

The website — As directed by the membership at the Annual General Meeting (AGM) in Thunder Bay in September 2009, I have tackled the reformatting of the CFMS website. At the end of Phase I in December 2009, the layout had been changed to make it more intuitive, accessible and user-friendly. Most notably, the “News and Events” tab has been divided into “News”, “Events” and “Documents”. The latter will finally regroup all our important documents in one area. This includes the Annual Review, position papers, the Residency Matchbook, Rep communiqués, the Green charter and meeting minutes. Members can now access CFMS press releases, articles about the CFMS and the Media Rapid Response Team’s letters to the editor under “News”. Information about CFMS General meetings,

Lobby Day and conferences can be found under “Events”.

Phase II will see changes to the Global Health section, the addition of an Advocacy section to promote and accommodate the work of the Political Advocacy Committee (PAC) and finally, a reorganization of the Interviews Database.

Communications with members

In order to better inform our members (from first year through to fourth year) about CFMS services, representation and communication efforts, I have initiated the “Branding project”. Due to be presented at the Spring General Meeting (SGM), this project hopes to increase the visibility of the CFMS amongst members and to foster conversation about what we do as an organization. A series of CFMS-branded products for students in all years will complement the clipboards usually given to first-year medical students.

Bilingualism — During the second half of my mandate, I will be looking at how to increase the bilingual nature of the CFMS. Becoming an organization able to fully function in French and in English is important to better serve our members and to better represent ourselves nationally.

And everything else — I’ve also continued to do what the VP Com-



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munications does best — assisting the Publications Editor with the *Annual Review*, moderating CFMS listservs, sending biweekly communiqués to CFMS Representatives, recording minutes at meetings and facilitating overall communications between reps and exec members.

External Communication

Media Rapid Response Team — This team got off to a start in February 2010 and will continue on past my mandate as the current VP Communications until December 2010 to ensure continuity. The team scours through press clippings to find and respond to issues of importance to the CFMS. Thank you to Alim Nagji (U of A, Class of 2012) and Christine Zadorozny (MUN, Class of 2011) for their hard work!

Press relations — I am very happy



to report that the CFMS has issued two press releases so far this year. In coordination with the David Suzuki Foundation, the Canadian Medical Association and the Canadian Nurses Association, the CFMS contributed to "Prescription for Canada's Prime Minister: Put global health at the centre of UN climate summit". This was released to mark the United Nations Climate Change Conference held in Copenhagen in December 2009.

The second press release was also

preceded by a press alert, and this was to promote our Lobby Day in Ottawa. Media attention was fantastic and greater than expected! Three CBC radio interviews and numerous publications, including Canwest newspapers across the country, *CMAJ* and the *Epoch Times* brought CFMS' Lobby Day to the Canadian public!

Lobby Day — I had the great pleasure of organizing Lobby Day 2010 with Harbir S. Gill (PAC Chair) and

Ashley Miller (University of Ottawa PAC rep). An article follows about our successes this year!

This has been a fantastic year with the CFMS and I am excited to see us continuously grow as an organization.

The CFMS is *your* Federation, *your* Voice. Use it to maximize its potential!

If you have any comments, questions or feedback, please do not hesitate to contact me at vpcommunications@cfms.org.

Canadian Federation of Medical Students

Your federation. Your voice.



- The Canadian Federation of Medical Students (CFMS) is the national representative voice of medical students in Canada.
- Our membership includes over 7000 medical students pursuing their medical careers in 14 member schools from coast to coast.
- Your membership to your Medical Student Society or Association automatically grants you full CFMS membership benefits.

Visit www.cfms.org to learn more about our student resources and your member benefits: from travel and textbook discounts to residency matching advice, and so much more.

A penny saved is a penny earned

CFMS gives you a hand with your student budget

Danielle Rodin
VP Services
University of Toronto, Class of 2012

Many students starting medical school soon realize that their dream of becoming a doctor comes with a hefty price tag. The costs of medical school and all of its trimmings add up quickly, which is why the CFMS has stepped in to help lighten this potential debt load.

Textbook discounts

At the start of each school year, we receive list upon list of “recommended” texts. But how do we know if we will actually use them? How do we know whether they will be helpful or if they will just be a hit to our pocketbook? The CFMS Textbook Review Committee can help with this dilemma. They’ve undertaken textbook reviews, which are posted online and provide tips on which books to keep on your bookshelf.

The CFMS also offers discounts. This year, we offered 10% off on all books published by Elsevier. Look online for Elsevier books that have been peer-reviewed and endorsed. Starting clerkship? Check out the 20% discount on pocketbooks by David Hui. If you want to review medical scenarios for your OSCE, get 15% off the cost of *Case Files: Anatomy* and *Case Files: Physiology* published by McGraw Hill. If you’re entering 4th year, check out our 20% discount on *Essentials for the Canadian Licensing*

Exam, provided to you by Lippincott Williams and Wilkins.

Electronic education software

After a while, carrying all those books on your back may start to hurt. CFMS and Skyscape are offering an amazing deal on electronic educational software for all CFMS members. You can get 25% off educational resources for your PDA and Smartphone.

Vision correction

After all that reading, your eyes might be pretty strained. Throw away those glasses and book an appointment at Lasik MD for vision correction with CFMS member courtesy pricing and discounts.

Insurance

You’ve worked hard to become a physician, so it’s important to protect yourself should illness or disability befall you. We are pleased to offer Canada’s best disability insurance for medical students and residents by Kirkham and Jack. This offer is available exclusively to CFMS members.

CaRMS assistance

Getting nervous about CaRMS? Worried about how you’re going to fund all of your interview travels? Feel like you need a vacation, when it’s all done? The CFMS negotiated 10% off all regularly priced flights on WestJet

To access these services, go to www.cfms.org and click on “Member Benefits.” If you don’t have a CFMS account yet, sign-up at www.cfms.org/signup.asp. The sign-up code for this year is available to you through your CFMS representative. Fill in all the other fields and make up your own username and password.

from 28 Dec. 2009 through 1 April 2010. When you arrive at your destination, check into one of the Choice Hotels partners and receive 20% off. To access and book these discounts, log into the “Member Benefits” section on our website. If the hotel is too much of a splurge, check out our “billetting” database to see what fellow students’ apartment you may be able to crash at.

We are constantly at work to improve our services and to help you on your path to the MD mark. Please feel free to offer suggestions and let us know about other ways that we can be of service. Keep checking our user-friendly website at www.cfms.org for information on all our discounts and on new developments.



The CFMS goes green!

Cait Champion
Ontario Regional Representative
University of Toronto, Class of 2012

**“When the earth is sick and polluted, human health is impossible.
To heal ourselves we must heal our planet, and to heal our planet
we must heal ourselves.”**

— Bobby McLeod, (Koori activist)

In 2009, the CFMS joined the growing environmental sustainability movement happening worldwide by adopting the CFMS *Green Charter* at our biannual general meeting in Edmonton. The *Green Charter* was a major first step both in terms of recognizing the responsibility medical students have in supporting a healthy environment and in realizing this responsibility as an organization by adopting environmentally responsible practices. Since the unanimous show of support in adopting the *Green Charter*, there has been a growing buzz within the CFMS to green our activities and support our member schools in their new and ongoing environmental projects.

In December before the United Nations climate change conference (COP 15) in Copenhagen, the CFMS sent an open letter to

Environment Minister Jim Prentice and Canada's party leaders, urging Canadian participation in aggressive global action on climate change. Through this letter, the CFMS joined many other prominent medical organizations, such as The Royal College of Physicians and Surgeons, in warning about critical emerging environmental health issues.

Organizationally, the Global Health Program's Environmental Working Group, now in its second year, is continuing to make the CFMS as environmentally responsible as possible. The group undertook an audit of our progress in implementing the *Green Charter* and developed a guide for member schools interested in taking on environmental projects. Through the guide, we're hoping member medical societies will learn from successful projects at other

schools and develop them to fit the green needs of their own students.

By continuing to build on the *Green Charter*, the CFMS will increase its commitment to environmental responsibility. With the ongoing efforts of the Environmental Working Group, the CFMS and our members, environmental considerations will become fully integrated into our activities as an organization, as well as a defining part of who we are as medical students and medical professionals. It's an exciting time to "go green," and we look forward to sharing our progress with you at the 2010 spring general meeting in St. John's, Newfoundland!

To get involved with the Environmental Working Group, please contact Cait Champion, Ontario Regional Representative (cait.champion@cfms.org). Also, check out our Green Charter on the CFMS website!

Inspiring projects funded by the Student Initiative Grants

Janet Ferguson
Western Regional Representative
University of Saskatchewan, Class of 2011

Back by popular demand, this year's CFMS Student Initiative Grants have been a huge success once again. The CFMS has set aside funding for projects started by medical students at our 14 member schools. The CFMS is looking to fund creative, sustainable initiatives that align with CFMS priorities, increase CFMS visibility and promote inter-school collaboration.

The ideas and enthusiasm generated by the first round of applications has been overwhelming. With a whopping 20 applications, we were happy to be able to fund 10! Below are three examples of projects that the CFMS Student Initiative Grants funded. Read on to be inspired by the work of your peers from coast to coast!

Black Medical Students' Association of Canada

Mariam Deria, McMaster University
When I started medical school orientation back in September 2009, I saw a sea of future physicians filling the lecture hall and noticed that I was one of four students of Black/African descent in the class of 196 students. I am a strong believer that health care professionals must be a microcosm of the community that they represent and, in this respect, there is much room for improvement. To contribute to a change, I decided, along with one of my fellow classmates, to launch the Black Medical Students Association of Canada (BMSAC).

With this organization, we plan to establish resources and specific programs targeted toward increasing recruitment and retention of Black Canadians, an underrepresented minority in medicine. We recognize the role that we as future physicians will play in health care, and we are committed to supporting and enhancing academic, professional and networking opportunities for Black premedical students, medical students, residents and physicians.

We hope that www.bmsacanada.ca will be a one-stop shop for information and resources. The organization is structured to promote interschool collaboration among the 14 CFMS member medical schools in Canada. We plan on having one representative from each school. This will allow us to spread the message of the BMSAC, recruit new members and ensure the sustainability of the program.

"On Exam" — iPod/iPhone application

**Matt Strickland and Geeta Yadav,
Northern Ontario School of Medicine**
Despite the fact that over 30,000 iPod/iPhone applications are available today, none of them provides a system-by-system reference guide for clinical skills that every medical student in Canada must learn. Our project is to create a free app called "On Exam" that will fill this gap by displaying reference information

on how to take a history and conduct a physical examination for various organ systems in a user-friendly format.

The ideas and enthusiasm generated by the first round of applications has been overwhelming.

This application is geared toward junior medical students, but third- and fourth-year clerks can benefit from having, at their fingertips, a reference on how to do a proper exam or obtain a focused history. Having this sort of information available in their pockets would give medical students a tool they can use on the wards to quickly brush up on their skills or even as a study aid for OSCEs.

"First, Do No Harm" — a documentary

Timothy Holland and Alyson Horne-Douma, Dalhousie University

We are second-year medical students with a passion for and background in global health. After participating

in projects in developing countries and talking with other students, medical professionals at universities across Canada and national organizations, we found ourselves questioning how and why we undertake humanitarian and development work in under-resourced countries. Discussions around the ethical dilemmas of this kind of work have been taking place quietly among some experts in the field, but we want to help bring these issues into the mainstream.

Armed with experience in short film-making, we have begun to produce a documentary titled "First, Do No Harm." The film explores the ethical challenges facing health care professionals and students doing electives, work and volunteer placements in developing countries.

The film will highlight the often unexamined ethical pitfalls associated with foreign medical efforts in a developing nation. It will be a resource for students and professionals seeking global health experience and faculties of medicine, hospitals and clinics wanting to strengthen pre-existing programs or develop new collaborative projects with international partners. We hope that by using film, we will be able to capture the passion and energy of those engaged in global health initiatives and increase dialogue among professionals and students in this field.

The deadline for the next round of applications for the CFMS Student Initiative Grants was 28 Feb. 2010. Best of luck to those who applied!

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News from the CFMS Political Advocacy Committee

Harbir S. Gill

**Chair, CFMS National Political Advocacy Committee and Western Canada Regional Representative
University of Alberta, Class of 2011**

In recent years, the CFMS has been commendably increasing its grassroots involvement in all areas, but this is especially true for its Political Advocacy Committee (PAC)! Since its humble beginning just three years ago, the PAC has morphed into a think tank, producing numerous position papers on a variety of topics, and acts as a feedback mechanism to inform the CFMS on future national advocacy directions. This year, it has transformed into a full-fledged lobbying machine! Each school's PAC representative is charged with surveying student interests, then forming a team and lobbying on those issues, whether they pertain to the government, university administration or even the community.

One exciting event during this past year was the 2nd Annual Pan Alberta Political Action Day. PAC representatives from the universities of Alberta and Calgary collaborated to organize an event in which 50 medical students met with 45 MPPs in their legislature offices in Edmonton (53% of all sitting members!) to convince them to increase funding of a rural clerkship program. Before the meet-

ings, students received a full day of training on effective lobbying — an amazing achievement — congratulations!

Aside from Ontario's OMSA Leadership Initiative and Alberta's Political Action Day, no other provincial government lobbying initiatives currently exist. However, CFMS PAC reps in five other provinces are working toward establishing such an event at their school and it will be very exciting to see their achievements.

Other advocacy work coming down the pipeline is in the areas of making schools more environmentally friendly, Aboriginal health, student finances and distributed medical education. At some schools, some PAC reps have even taken the initiative to set up partnerships with the Global Health Advocate program.

A number of schools are pursuing the issue of economic diversity of medical school classes. Many PAC representatives are focusing on alleviating this problem using a multifaceted approach targeting admission standards and outreach programs. These efforts complement the new advocacy direction of the CFMS with

regard to its annual Lobby Day in Ottawa (this year held on 29 March 2010), where economic diversity was the topic of discussion with MPs. PAC representatives are not only participating in this event, but are also taking ownership of its organization by undertaking issue research, providing preliminary training for delegates and issuing MP invitations. Moreover, at the first ever CFMS PAC Conference on 27 March 2010, PAC representatives will be meeting to discuss their schools' initiatives and receive advocacy training.

An indirect effect of these exciting initiatives is that all students involved with the PAC are receiving advocacy training. Despite being one of the key competencies in accreditation criteria, advocacy remains largely untaught in Canadian schools. It is something best taught experientially and this is precisely the kind of thing we are doing in the PAC. In addition, numerous schools are organizing advocacy training workshops for their students.

We're all excited about how far we can go this year — stay tuned! Contact your local PAC rep if you're interested in getting involved!



CFMS Lobby Day 2010

Future physicians call on politicians to help broaden the make-up of Canada's medical schools

Ijab Khanafer

VP Communications, University of Ottawa, Class of 2011

Harbir S. Gill

Chair, CFMS Political Advocacy Committee, University of Alberta, Class of 2011

Lobby day is one of the CFMS' signature annual events during which medical students from across the nation come to Parliament Hill in Ottawa to speak with policy makers on issues of importance. This event is meant to inspire students to become more politically aware and active in their society. Physicians have a tremendous ability to shape decisions around health policy and Lobby Day provides students with an opportunity to experience this process early on.

This year's Lobby Day, held on 29 March 2010, was an incredible success! The event was attended by 58 delegates from all 14 CFMS member schools and attracted almost 100 meetings with Members of Parliament, Senators and bureaucrats. This is the largest number of meetings that the

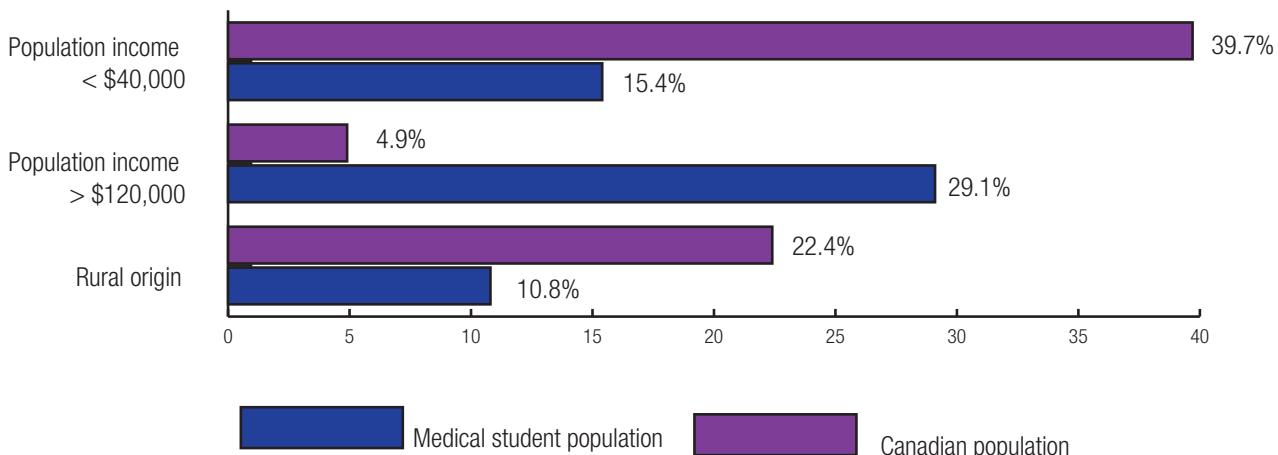
CFMS has had in the event's history!

New this year, the Lobby Day topic advocated for increased economic and geographic diversity in our medical schools. Survey data indicates that medical school is not accessible to rural and low-income students. Our stated position was that inadequate admission of low-income and rural students is reducing physician accessibility in underserved areas. Delegates explained that students with rural backgrounds are 2.5 times more likely to practice in a rural community, while students with low-income backgrounds are more likely to serve low-income patients. Students from either of these backgrounds are also more likely to practice as family physicians, a discipline in which Canada is experiencing significant shortages.

On behalf of the CFMS, student delegates asked MPs and Senators to:

1. Acknowledge that the lack of diversity in medicine is an important health care issue and commit to working toward short-term and long-term solutions.
2. Establish a task force investigating the implementation of methods to increase diversity in our medical schools, such as those that have been initiated in Australia and the United States, including:
 - Offering monetary incentives to interested medical schools proposing strategies for increasing the enrolment of students from low-income and rural backgrounds.
 - Establishing applicant grant programs to assist students in

Comparison of average family income and rural origin in medical student and Canadian populations



Lobby Day in numbers

- # of student delegates: 58
- # of meetings: 96
- # of delegates/meeting: 2
- # of meetings/delegate: 3–4
- # of radio interviews: 4
- # of media articles: 22
- # of MPs who tweeted about meeting: 4

Did you know?

Canadian medical schools are aware of this problem:

- The accreditation standards have recently been revised to require that every Canadian medical school show proof of initiatives to increase diversity, including economic and geographic.
- The Association of Faculties of Medicine of Canada (AFMC) recommended in a report funded by Health Canada that every Canadian medical school enhance admission processes to foster increased diversity and the creation of a representative physician workforce.

financial need with the significant costs of applying to medical school.

The Lobby Day ‘Ask’ was very well received by the majority of MPs, Senators and bureaucrats. Lobby Day organizers will be following up with a number of them regarding recommendations that they have made, including suggestions to work through the Standing Committee on Health.

Before their meetings, student delegates took part in a full day of training. This was marked by a series of speakers, including addresses from Dr. Jeff Turnbull, CMA president-elect; Paul Dewar, MP for Ottawa Centre and Graeme Wilkes, Manager, Government Relations and Advocacy at the CMA.

Also new this year, the CFMS National Political Advocacy Committee (PAC) was heavily involved in the planning of the event. This consisted of the development of the argumentation, the advanced preparation of delegates and the invitation to MPs. We would especially like to thank Ashley Miller, the U of O PAC representative, as she deserves special recognition for her role as the Research Team Leader. Her contributions on the research and development of this issue was key to the success of this initiative.

Of note, Lobby Day weekend was extended to include a first-ever Political Advocacy Committee Conference Day for PAC representatives on Saturday, 27 March. On this day, the leaders in political advocacy at each campus congregated in Ottawa and received special training on becoming better advocates, both at their schools and in the future. High profile speakers included Dr. Robert Conn, Founder of SMARTRISK and PAIRO CEO; Laurel Craib, CMA Associate Director, Government Relations and Federico Carvajal, Canadian Federation of Students (CFS) Ontario field worker.

If you have any comments, questions or feedback about Lobby Day, please contact Ijab Khanafer at vpcommunications@cfms.org or Harbir S. Gill at harbir.gill@cfms.org.



PAC members with Dr. Robert Conn, Founder of SMARTRISK, PAIRO CEO and one of the founding presidents of the CFMS.



Broad differentials — thoughts from an Ontario regional rep

John Snelgrove

Ontario Regional Representative

University of Western Ontario, Class of 2011

I waited about eight minutes in front of the closed (and locked) residents' office door. Now, after several months of experience, I know better than to just stand and wait. "On the first day of your neurology rotation," said the administrative email, "please meet the senior resident at 0800 in the residents' room." That seemed easy enough, but we all know senior residents are busy people and won't necessarily be waiting for you, the fresh, new clinical clerk, to arrive.

A helpful ward nurse solved the dilemma and I quickly found myself absorbed into the productive atmosphere of inpatient medicine. But as a brand new clerk, I felt two tonsils shy of completely useless. That's when I met Jill and Wei. Both final-year medical students from their respective schools, these two immediately became helpful comrades. Jill showed me how to jot down bloodwork 'lytes and the neat trick of folding over the last third of your patient list to provide more room for notes. Wei carefully took me through the task of corroborating PowerChart meds data with what the patient was actually getting.

Later on in a busy emergency room, another clerk, this time from out west, complemented my meticulous (if painstakingly time-consuming) suturing technique and shared fun

facts about cat-scratch disease. A month later, a former CFMS executive member and I found ourselves pigging out on ice cream while drooling over characters from "The Tudors." Kelly Hynes paid me a visit during her ortho elective and explained what sounded like a whirlwind across the nation, rotating through ORs, hospital wards and Tim Horton's line-ups from coast-to-coast.

This experience, although uniquely personal, is commonplace for the medical ingénues of Canada. We live and study in a vast country, but the extent of student reciprocity shows no bounds. This is exactly why I joined the CFMS. This organization is led by representatives from each school, but it functions best with the collective involvement of everyone. Taking a moment to blog about an elective experience on www.cfms.org makes it easier for the next person to make decisions about signing up. Mailing a letter to your member of parliament about medical education accessibility not only raises the issue, it also raises the profile of the CFMS and what we stand for. When you're the clerk admitting a patient with renal failure to your team and he remarks how "everyone with those black clipboards" has taken good care of him, it's encouraging to know he's talking about a CFMS medical student.

This year, I have been lucky to support some impressive projects at the CFMS. Our work on interest deferral put our president and VP education in front of the Federal Standing Committee on Finance, and this year's Lobby Day moved ahead in an important new direction despite parliament hitting the prorogation pause button. With the rapid expansion of campuses and incorporation of distributed education at virtually every Canadian medical school, the Distributed Medical Education (DME) project has kept CFMS busy. We're not there yet, but our organization is well positioned to comment on the policies and effects of the DME pedagogical shift. Last, in keeping tabs on med student needs, the CFMS continues to look at what services would be useful to our members. Coming down the line? Keep your orbits open for deals of stethoscopic proportion.

So the next time you're memorizing carotid branches with dirty mnemonics, screening for mania at 2 am or just trying not to contaminate yourself for the third time during a Whipple's, think of how many other CFMS students were in your shoes. Think of how many more will come to be in a similar situation and consider adding your expertise to the CFMS.

After all, we need people like you.

Medical student parents

Matthew J. Sheppard
Atlantic Representative
Memorial University, Class of 2011

I'm sure it comes as no surprise that many more medical students are choosing to have families during their undergraduate medical training than in the past. While balancing classes, studying, extracurricular activities, social obligations and finances is a daunting task for most of us, some have the added responsibility of being a parent — feeding, clothing, arranging daycare, attending doctor's appointments and I'm sure a plethora of other commitments that I, as a non-parent, cannot even begin to understand.

Before I became a member of the national executive of the CFMS, a medical student who had taken some time off from her education to start a family approached me and inquired about any supports that the CFMS

may have for student parents. I looked into her inquiry and noted that student parenting had not been an issue that had been explored extensively by the CFMS. As the CFMS is a member-driven organization, I decided to take this project on as my primary responsibility during my term as Atlantic representative.

So far this year, I've been active at the local level, exploring the resources, policies and supports that are available for parents at Memorial University and interviewing student parents to see what other options they would like to see put in place. The next phase of the project will involve distributing to other CFMS member schools a functional survey to assess the current national situation and the

needs that are currently being met or not elsewhere.

I have two goals for this project:

1. Develop a catalogue of policies and resources available at each of Canada's medical school so that current inadequacies may be researched and positive changes for student parents can occur.
2. Create a section on the CFMS website devoted to medical student parents to allow them to share resources and experiences and provide links to pertinent and useful online resources.

If anyone has any interest in the student parent project or questions, feel free to email me at matthew.sheppard@cfms.org.





The CFMS Institutional Memory Project

Cait Champion
Ontario Regional Representative
University of Toronto Class of 2012

“The farther backward you can look, the farther forward you are likely to see.”

— Sir Winston Churchill

Institutional memory is a key component of any well-established organization. It provides the framework of common understanding necessary to build the successful, cohesive ongoing projects that help an organization grow. It also provides insight to establish new projects that clearly reflect the vision of a strong organization. This idea is the inspiration for creating a comprehensive CFMS Institutional Memory Project so that we have a clear vision of where we have been as an organization over the past 33 years so we can establish a framework for moving forward.

Being an organization for and by medical students is both our biggest challenge and our greatest strength. Our high turnover, seen in any student organization, is a challenge to developing long-term projects that extend beyond two years. However, a constant stream of new students also means the development of fresh and current ideas; as an organization the CFMS is certainly never obsolete!

By looking back on the issues we have faced as an organization as well as creating an infrastructure to

ensure good project follow-up in the future, the Institutional Memory Project will help us capitalize on our strengths without letting our challenges overwhelm or undermine our activities. The project consists of two components, one to provide a historical context of the organization, the other to provide a framework for continuity.

A short history of the CFMS — providing historical context

One piece of the institutional memory puzzle is collecting and organizing our past history in a way that it can be used to inform our future plans and decisions. As students in a constantly changing profession, emerging issues that affect students are always coming up, but at the same time, many of the issues we currently face have also been experienced by our predecessors.

One of the major initiatives of the Institutional Memory Project is contacting past CFMS presidents about the major achievements and concerns of the organization over the course of their term. The valuable information we receive from our

alumni will be used to create a CFMS timeline, which will be posted on our website to help orient new members to what the CFMS does as well as provide member school representatives and the executive with background context for approaching current issues.

Tracking past accomplishments and challenges will help us build on our previous efforts as an organization and, as a result, become even stronger leaders and advocates in the field of medicine and medical education.

Infrastructure — support for the future

The second part of the project is not only to collect and organize our history, but also to make sure this history is actually used by the executive, member school representatives and members.

For the executive, this means creating a good transition system that ensures continuity of ongoing projects that are a priority for the organization. This will include web-based storage space for file-sharing and a clear, consistent method of organizing project

files for easy access to project information by future executive members.

For member school representatives and members, this entails using our website to communicate our ideas as an organization and posting summaries of key information, such as motions passed at each Annual General Meeting and Spring General Meeting.

Overall, we want to create a base for building good practices in 2009–10 that will be continued throughout the life of the organization.

Institutional memory – an ongoing commitment to student leadership

Although we have made a good start, the Institutional Memory Project will require an ongoing commitment of the organization and its members to ensure its continued success. We look forward to sharing our work with you at the Spring General Meeting 2010 in St. John's, Newfoundland, and encourage you to get engaged in the strong history of leadership within the CFMS

established through the commitment and contributions of our predecessors.

Although the Institutional Memory Project team is beginning with past presidents to build our historical timeline, we welcome any and all input from other interested CFMS alumni! We would love to hear your perspective on the CFMS during your time as a medical student. To contribute, contact Cait Champion, Ontario Regional Representative, cait.champion@utoronto.ca



UNIVERSITY OF SASKATCHEWAN
College of Medicine

University of Saskatchewan
College of Medicine



The College of Medicine at the University of Saskatchewan is a great place to get your education and start your medical career. This beautiful campus is situated in the heart of the city of Saskatoon on the scenic bank of the South Saskatchewan River and has a wide collection of health sciences. In addition, we are the only campus in Canada with both a Medical College and Veterinary College.

The medical degree and post graduate clinical research programs are excellent. Each year the College of Medicine accepts 60 students into the MD undergraduate program, a number of these are set aside for Indian, Métis, and Inuit people and Canadian students from other provinces. Our students perform very well on the licensing exam required of all Canadian medical graduates and our reputation is that our students are well trained and in demand for residency positions throughout Canada.

Our Post Graduate program allows graduates to specialize in the residency training program of their choice and are not restricted to those offered at the U of S. Those offered at the U of S, College of Medicine, are: Anesthesia, Cardiology, Family Medicine, Rural Family Medicine/Emergency Medicine, Urban Family Medicine, Internal Medicine, Neonatal or Perinatal Medicine, Neurology, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Pediatrics, Pediatric Neurology, General Pathology, Physical Medicine & Rehabilitation, Psychiatry, Medical Imaging, General or Orthopedic Surgery, Rheumatology and Respiratory Medicine.

For students interested in research, the College of Medicine offers a variety of opportunities including MSc/PhD degree programs. With the Canadian Light Source and the Vaccine and Infectious Disease Organization (VIDO) located on our campus, the University of Saskatchewan is able to attract many stellar researchers from around the world.

To learn more about the College of Medicine at the University of Saskatchewan, Contact: College of Medicine, B103 Health Sciences Building, 107 Wiggins Road Saskatoon SK S7N 5E5, Website: www.usask.ca/medicine



CFMS and FMEQ: united for success

Noura Hassan

**Quebec Regional Representative
McGill University, Class of 2012**

First, I'd like to take a moment to express how happy I am to be part of the Canadian Federation of Medical Students. For the past few months, I have been working with a group of highly competent, hard-working and enthusiastic people who want *you*, the CFMS members, to be fully satisfied with what this federation accomplishes and represents. As you read this annual review, you will appreciate why I am so enthusiastic about the CFMS and, hopefully, it will motivate you to become an active member of this fantastic team!

As Quebec regional representative, my major mandate is to be the liaison between the CFMS and the Fédération médicale étudiante du Québec (FMEQ). The FMEQ is, to Quebec medical students, what the CFMS is to medical students in the rest of Canada

and McGill (note that McGill medical students are members of both the CFMS and FMEQ). Thus, the FMEQ provides services to its members, represents its members' interests and facilitates communication among the four medical student societies in Quebec.

FMEQ members make up about a third of all medical students in Canada. Given the significant number of Canadian medical students represented by the FMEQ, dialogue and cooperation between the CFMS and FMEQ is essential to ensure that our national federation accurately represents the interests of all Canadian medical students.

Of note is the significant cooperation that has existed between the FMEQ and CFMS lately, particularly in the context of the upcoming 59th General Assembly of the International Federation of Medical Students'

Associations. This week-long international conference will be held in Montréal in July–August 2010, with a pre-conference meeting in Ottawa. IFMSA-Québec, a branch of the FMEQ and the CFMS-Global Health Program are equal partners in this event's organization and coordination. Successful cooperation between these partners is imperative for this event's smooth functioning.

I know that the CFMS and FMEQ will work as a strong, cohesive team to make this General Assembly a great success. Let the 2010 IFMSA General Assembly in Montréal be concrete proof of the phenomenal combined force of the CFMS and FMEQ. Continuous collaboration, translating into greater positive outcomes for all Canadian medical students is what we are striving for.



Healthier medical students, healthier patients

Ali Okhowat
CFMS Wellness Officer
University of Toronto, Class of 2010



What is the primary factor determining patient wellness in today's health care system? Certainly there are many. Yet, we cannot deny that our system is only as good as the health care professionals who serve in it. Physicians are at the forefront of health care delivery and they play an integral role in determining patient outcomes.

Undoubtedly, the technical resources physicians use in the diagnosis and treatment of their patients are essential; however, we often place far more importance on these resources than those that we use to communicate with our patients. In terms of overall patient wellness, counseling on a healthy lifestyle and providing supportive resources are just as important as the tests and machines we use to improve patients' health.

As key health care information

providers and counselors, physicians need to be able to communicate health and wellness information, as well as serve as models of good practice. Yet, knowledge of wellness and habits of well-being do not become activated when we are licensed. Rather, they must be cultivated far earlier, during medical school years, for example. Individual medical schools have student affairs offices, some have student wellness days and all have some form of crisis resources. However, wellness as a curricular element and proactive lifestyle choice has come to the forefront, only to be washed aside by the stresses of upcoming deadlines and exams. In the absence of a concerted effort to centralize and communicate wellness resources to medical students, should we be surprised that the conditions in our stressed health care system are

compromising the health of our patients?

Embracing Wellness: Healthy Medical Students for a Healthy Healthcare System is an important CFMS initiative that will form the basis of a new, ongoing wellness culture among medical students. We aim to establish a wellness mindset among medical students by providing tools designed and customized to their needs. Themes and topics related to student wellness, such as stress, sleep, exercise and nutrition, financial wellness and mental and emotional fitness will all be addressed.

As leaders in the front line of patient care, we owe it to ourselves and our patients to embrace, practise and promote a healthy lifestyle. We are the Canadian Federation of Medical Students, and this year we aim to put the education and engagement of medical students in wellness front and centre. Working in partnership with provincial and federal medical organizations, we are changing the focus of wellness from a luxury to a necessity — for the well-being of both future physicians and their patients.

The primary factor determining patient health and wellness in a healthy health care system is the human factor — the element of care that links the health and knowledge of providers with that of their patients. Join us as we strive to create a healthier health care system.



CFMS blood drive — 810 units donated in 2009!

Mike Bevilacqua
CFMS Blood Drive Officer
University of Calgary, Class of 2010

The CFMS is Canadian Blood Services' (CBS) longest standing national partner (it's true, look it up!) and, as a result, we decided to move forward with that partnership and become part of the Partners For Life (PFL) program which will really help us maximize the donations we make across the country.

Entering into a PFL partnership gives us access to CBS's vast resources and nationwide team of coordinators who will help organize and promote blood donation opportunities to med students at every CFMS school. Through the PFL program, CBS helps us organize our efforts and makes sure that every student at every school is aware of the donation events in their community. I am confident that, through this program, CBS will help us achieve donation numbers that we would have previously thought impossible.

As a PFL member organization, the biggest challenge is setting up local partnerships between schools and CBS organizers, and I am proud

to say that most CFMS campuses have at least one amazingly dedicated local PFL champion who will work with CBS to schedule and promote our donation events (see table). The local champions are your link to CBS, and they are all enthusiastic about this year's drive; don't be afraid to approach them with any questions or ideas that you may have, as I know they would love to talk to you.

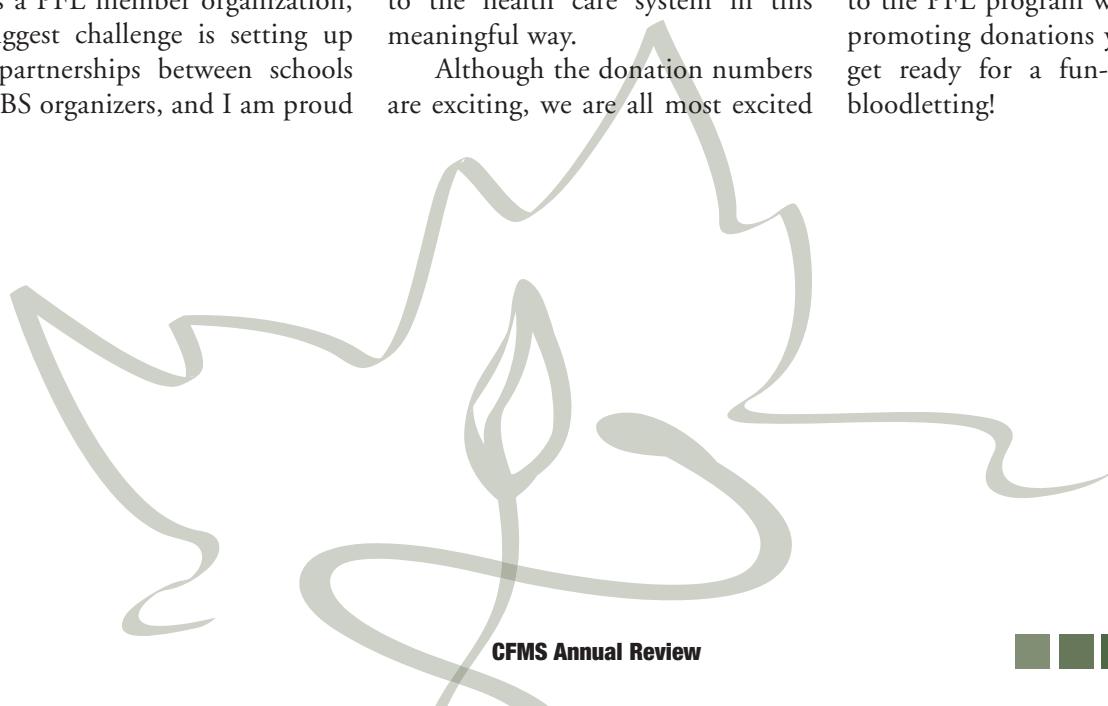
One of the big jobs that the local champions had was to set a donation target for this year, and as the donation numbers come in and we come closer and closer to those goals, it is very exciting! Although the numbers are still coming in, in 2009, the CFMS made 810 donations — a total we can all be proud of! By building on the success of last year's blood drive, we can do even better this year and continue to contribute to the health care system in this meaningful way.

Although the donation numbers are exciting, we are all most excited

about the donation events! To kick off this year, every school held a big, school-wide donation event as a part of CFMS Blood Month in February. The PFL allows for a lot of flexibility, so each school was able to pick the dates that worked best for their Blood Month event; as a result, in February alone, we were able to accumulate approximately 250 donations!

For information on your school's donation activities, talk to your local champion, keep an eye out around the school and check your email for promotional materials. Even if you cannot donate blood, you can still be a big part of your school's donation effort by helping to spread the word and getting your peers excited about our donation efforts. I'm sure your local champion would love some help!

The biggest reason we switched to the PFL program was to get help promoting donations year-round, so get ready for a fun-filled year of bloodletting!



A big challenge is identifying dedicated volunteers at each medical school campus. As students, we tend to have busy schedules and it has been difficult to encourage people to come forward to lead the blood donation efforts at their school. To address this difficulty, we are working to ensure that within the PFL framework, the amount of time and effort spent by our CFMS volunteers is kept to a minimum. CBS has immense organizational capacity, and they are more than willing to make donating as easy as possible.

We are also integrating the blood drive champion position into the election process that takes place at most medical school campuses early in the school year. Some schools have already done this, and I hope to see more campuses take this step. By identifying a dedicated blood drive leader at the beginning of the school year, we can ensure that we maximize our donation potential and help the greatest possible number of people!

Although there will always be more work to be done, between the

success of last year's blood drive, the new programs we have tried this year and the challenges that await us in the future, this is a very exciting time to be a part of the CFMS's blood drive efforts, and all of the energy coming back to me from CFMS schools is absolutely amazing! Keep an eye out for upcoming donation opportunities; for more info, you can always talk to your local champion and, most important, remember to roll up your white coat sleeves and give!

Volunteer blood drive champions

School	Champion(s)
Dalhousie	Kyle Jewer
Queen's	Clarissa Moodie and Philip Harvey
University of Toronto	Jacqueline Zhai and Soumitra Tole
McMaster	Kylie Redekop and Gayathri Raveendran
University of Western Ontario	Charles Ho
Northern Ontario School of Medicine—Thunder Bay Campus	Claudine Lanthier
Northern Ontario School of Medicine—Sudbury Campus	Caelen Rody
University of Manitoba	Rebecca McLean
University of Alberta	Serena Cheung and Rene Lee
University of Calgary	Anjli Pandya and Gwynivere Davies



Building interprofessional partnerships

Daniel Rosenfield
CFMS Interprofessional Education Officer
University of Toronto, Class of 2011

According to the most recent official definition, interprofessional education (IPE) occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. IPE is being recognized worldwide as a way to increase the ability of health care students to practise collaboratively. Given ballooning health care costs, increasing chronic disease and diminished health human resources worldwide, a body of literature has identified the need to teach health care professionals IPE as a means to work together to help address these issues.

The CFMS has been very active in examining the role of medical students in IPE activities across Canada. In 2008, it released a position paper highlighting the importance of IPE in the education of medical students and has continued to build on this initiative. CFMS has been represented at various interprofessional conferences, most recently the National Health Sciences Students' Association national conference at Queen's

University in Kingston, Ontario in March 2009. At this meeting, student representatives from nearly all the recognized health professions across Canada met through the Canadian Interprofessional Student Network and, spearheaded by the CFMS, adopted guiding principles by which each health professional student organization would relate to the others. Some highlights of

this agreement include inviting members to conferences (and, if possible, waiving their registration fees) as well as sharing common resources.

The CFMS recognizes the importance of collaboration with all allied health professions and in effective interprofessional education. We look forward to building more interprofessional relationships in 2010!



Behind the scenes @ cfms.org

Michael Li
CFMS Information Technology Officer
University of Toronto, Class of 2012

As information technology officer, my role is to make sure everything is running smoothly on the CFMS website and listservs. What I do on a day-to-day basis can vary greatly, from managing the events database to phone calls with online advertisers to make sure what they want is compatible with what we can provide. In addition, occasionally some new function or service is required and it is my job to make sure it gets provided in some feasible way. The most recent example is the online survey system I implemented so that we could do the CFMS-Elsevier Raffle.

Here are some of the highlights over the last year.

New mailing list server

Any large organization is only as good as its slowest component, and this is especially true when that component is communication among its staff. About six months ago, the CFMS listservs were transitioned onto a new platform, which not only provided faster mailings but was much more customizable, at both the administrative and user ends. This was necessary to launch the CFMS-Global listserv, which is now very popular.

More website editors

We have encouraged executives and officers to become involved with the website. This has resulted in much more frequently updated content and more accurate information. It can be confusing to have inconsistent or misinformation on the site, and we aim to minimize that by continuing to encourage more officers to get involved.

Website reorganization

This process is being spearheaded by Ijab Khanafar (VP communications)

and is relying on feedback from other executives. We are making the website more intuitive and access to information easier. By the time this annual review is published, you should be seeing some of these exciting changes.

In 2010, there will be more for members (and me) to look forward to at www.cfms.org, such as the promotion of many more useful benefits (courtesy of Danielle Rodin, VP Services) and the launching of the CFMS Wellness website (courtesy of Ali Okhowat, Wellness Officer).

I'll see you there!





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Canada to host International Medical Students' General Assembly for the first time

Sarah Fung
CFMS Representative, Montréal AM 2010
University of Alberta, Class of 2011

At the end of July, approximately 800 medical students from across the globe will descend on Montréal for an intensive week of discussion, debate and collaboration. This event, the General Assembly of the International Federation of Medical Students' Associations (IFMSA), known as Montréal AM 2010, marks the first time that an IFMSA General Assembly will be held in Canada.

Montréal AM 2010 is a joint initiative of the CFMS's Global Health Program and its Quebec equivalent, IFMSA-Québec. Throughout the meeting, students will develop multi-national projects and build partnerships in the areas of medical education, advocacy, public health, human rights, reproductive health and global health. At night, students will discover Montréal's famous nightlife and cultural offerings.

Why Montréal for this August? "Montréal combines an inspirational setting, world-class facilities, professional organization, unforgettable nightlife and a stimulating academic program," explained Alexandre Sigouin-Duquette, president of the Organizing Committee and a third-year student at Université de Montréal.

Canadian medical students have begun to make a splash on the international stage through IFMSA. CFMS representatives wowed other

delegates at the last General Assembly in Macedonia with their work, including a policy statement on indigenous health, a working group on ethical guidelines for international electives and a survey on reproductive health education. With the upcoming General Assembly in Montréal, this represents a prime opportunity for more Canadian students to bring their ideas to international attention.

The General Assembly will be preceded by the pre-GA in Ottawa, a 3-day series of engaging workshops and interactive sessions on topics like global health, peer education, medical education and more. Participants will select one area of concentration.

"Hosting the pre-GA in Ottawa gives both Canadian and international attendees the opportunity to discover these two wonderful, distinct cities," said Austin Gagné, vice-president of the Organizing Committee and a second-year student at University of Ottawa.

All Canadian medical students are part of the IFMSA through their membership in CFMS or IFMSA-Québec. IFMSA represents over a million medical students from over 100 countries worldwide, and is the official student body of the World Health Organization and the United Nations.

The 59th General Assembly of



Canada's got the goods: At the IFMSA 2009 August Meeting in Macedonia, Beverly Wudel (CFMS VP Global Health) shows fellow delegates why Montréal is a natural choice for the August 2010.



Mixing business and pleasure: CFMS delegates kick back and relax after another productive day of standing committee sessions.

the International Federation of Medical Students' Associations will be held in Montréal, Quebec, from 31 July to 6 August. The pre-GA will be held in Ottawa, Ontario, 27–31 July.

For more information and registration details, please visit www.montrealam2010.com. If you are interested in volunteering at the meeting, please email Sarah Fung at cfms@montrealam2010.com.



Global Health



Bringing global health learning opportunities to CFMS students

Beverly Wudel
VP Global Health
University of Saskatchewan, Class of 2012

The CFMS's Global Health Program (CMFS-GHP) continues to provide Canadian medical students with support to grow as global citizens and opportunities to educate themselves and others on health.

The CFMS-GHP is the largest branch of the CFMS, consisting of over 80 students from all 14 CFMS schools. Our team includes global health liaison people (GHLs), global health advocates (GHAs), local exchange officers (LEOs) and national officers (NOs). Each of these groups makes a valuable contribution to increasing the profile of global health and providing opportunities for medical students to develop skills that will be imperative in providing competent medical care in an increasingly globalized world. This update provides only a snapshot of the achievements of this group.

CFMS and IFMSA-Quebec to co-host August 2010 meeting of IFMSA

The International Federation of Medical Students' Associations (IFMSA) is an independent, non-governmental, non-political organization. In 2009, the IFMSA represented 1.2 million medical students from 89 different countries. Delegates to the IFMSA meet biannually to share ideas, collaborate on projects and discuss and vote on policies that affect medical students world-wide.

At the August 2009 meeting of the IFMSA in Macedonia, delegates from

the CFMS and our sister organization, IFMSA-Quebec, put together an impressive and successful bid to host the July–August 2010 General Assembly in Montréal, with a pre-General Assembly to be held in Ottawa. Special thanks to Sarah Fung (U of A), Austin Gagné (U of O), Leslie Martin (U of O), Sana Ghaznavi (U of A) and many, many others for their hard work and dedication to this project. For more information on the 2010 General Assembly or to find out how you can become involved, check out the article in the *CFMS Annual Review*, or go to www.montreal2010.com.

**In 2010,
93 Canadian
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will participate in
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around the world.**

Improving communication

In fall 2009, the CFMS-GHP launched the global health listserv, a distribution list designed to provide

interested students with current information on opportunities in global health, ranging from international conferences to medical electives. The launch was a huge success and the listserv has grown to a membership of over 500 students. A huge thank you to Michael Slatnik (UWO) and Laura Chng (UBC) for their work on maintaining the listserv and keeping Canadian medical students updated on current opportunities in global health.

To improve communications with students, the CFMS-GHP said goodbye to our website www.healthforall.ca and opted to centralize communication by expanding the Global Health section of the CFMS website instead. Here, you can find information on who we are, what we do, current reports on global health activities at the CFMS schools and information on the CFMS exchange program. In 2010, we hope to expand the services provided by the website to include a database where students can share information on global health electives in which they have participated.

Pre-departure training

In 2008, the CFMS-GHP recognized the need for Canadian medical students participating in international electives to receive pre-departure training. This led a small group of very motivated students to develop resources and support for GHLs and LEOs, so that they could provide such training to students at their universities. The program has been very suc-



cessful, with 14 CFMS schools participating. This year, GHLs will be providing feedback, which will be used to refine the program to better serve students' needs. One notable success was the inclusion of pre-departure training in the Association of Faculties of Medicine of Canada's guidelines for medical education. Thanks to Michael Slatnik (UWO), Kelly Anderson (UWO) and Eileen Cheung (UWO) for their ongoing work in this area!

Advancing sexual and reproductive health in Canada and beyond

Queen's obstetrics and gynecology residents led an engaging reproductive clinical skills workshop at the Ontario Medical Student Weekend, hosted by Queen's University in October. Approximately 90 preclinical students learned delivery skills, practised perineal suturing and studied IUD insertion.

One participant commented, "The facilitators were amazing. I loved learning about assisting in vaginal birth and IUDs." Another reproductive clinical skills workshop will take place at the Dalhousie-Memorial University medical student conference in the spring.

The CFMS-GHP recognized World AIDS Day across the country by supporting Give A Day for the second year in a row. Give A Day is a Canadian organization that raises funds for the Stephen Lewis Foundation and Dignitas International. GHLs' creativity and campaigns reached both students and staff, raising over \$5000 for community-based HIV/AIDS programs in Africa. Schools also ran an incredible variety of local events to broaden students' HIV/AIDS knowledge and awareness, including a photo and art auction, collaborations with

like-minded groups, panel discussions, patient presentations, red ribbons, parties and more. Many schools also fundraised for local organizations.

Lobbying for Aboriginal health

In 2008, the CFMS-GHP developed the Global Health Advocacy Program to bring students from across Canada together to develop local and national advocacy projects centred around a theme chosen by the CFMS-GHP. In 2009, the program decided to continue with the previous year's theme of Aboriginal health. Notable successes of the group include adoption of the *Policy Statement on Indigenous Health* by the IFMSA and adoption of the *Policy Statement on Aboriginal Health* by the CFMS, in addition to achievements seen at individual CFMS schools.

In 2010, GHAs will attend the Montreal World Health Organization simulation (MonWHO), where this year's theme will be Pandemic Planning. As pandemics often affect the health of Aboriginal people disproportionately, GHAs will take on the role of representing various Aboriginal groups at MonWHO, presenting issues ranging from the effects of urbanization on the health of Aboriginal people to the prevalence of infectious diseases such as HIV and tuberculosis.

CFMS exchange program

One of the most tangible services that the CFMS-GHP provides to students is the CFMS exchange program. As a member of the IFMSA, the CFMS-GHP negotiates clinical and research exchanges with other member organizations. At the IFMSA meeting in Macedonia this year, we signed contracts with 24 countries, including Greece, Jordan

and Lithuania, to name just a few. In 2010, 93 Canadian medical students will participate in clinical and research exchanges around the world.

The CFMS and IFMSA are working to improve the experience of students participating in the exchange program by developing standardized guidelines for the academic quality of the exchanges. Michael Slatnik (UWO), the outgoing national officer of global health education, is developing guidelines for IFMSA clinical exchanges to help provide students with a framework for participating in international clinical exchanges in a manner that is ethically responsible.

Coordinating these exchanges is an enormous amount of work. We owe national exchange officers, Ken Mendoza (U of M) and Rachelle Findley (U of A), as well as their capable team of LEOs our sincerest thanks for all the hard work they have put in to ensuring the success of this program.

Without doubt, 2009 was a successful and exciting year for the CFMS-GHP and 2010 promises to be even better! It has been a privilege to work with such a passionate and dedicated group of people. Special thanks to Brianne Hudson, past VP-Global Health, for showing me the ropes and helping to mentor me in my new role. I also want to thank the NOs, GHLs, GHAs, LEOs and everyone else who has contributed to the success of these and the many other projects. Your work helps to ensure that Canada's next generation of physicians will have the skills and training necessary to practice confidently and competently in the field of global health.



Healing ourselves through cultural awareness — a sweat lodge experience

Marie Claire Bourque
Global Health Advocate 2008–2009,
University of Calgary, Class of 2011

Medical students recognize that, to provide the best patient-centred care, an understanding and appreciation of the patient's beliefs, background and culture is essential. The curriculum at the University of Calgary provides students with an opportunity to hear about relevant topics in communication and culture as they relate to the care of Alberta's aboriginal populations, but a group of students wanted to take their education beyond what the curriculum offered. Rather than hear about the culture, traditional health practices and best communication techniques, they wanted to experience the richness and depth of the culture firsthand by attending a ceremonial sweat lodge. The following is a personal recount of that unforgettable experience.

On 10 May 2009, 12 medical students from the University of Calgary were warmly welcomed to the Peigan Reserve, 200 km south of Calgary, by Blackfoot ceremonialist and RCMP officer, Morris Little Wolf. Before the ceremony, we sat in a group with Morris and his family and simply enjoyed the cool, fresh, clean air that so many of us forget to taste during our medical school training. The sun was warming our faces while we sat and listened to Morris and his relatives converse and laugh together. Beyond their house, we could see horses grazing in the fields.

While Morris and his family were cordially laughing and sharing stories

to make us feel welcome, we were becoming visibly nervous and apprehensive about the upcoming ceremony. We noticed the pile of smouldering rocks just five metres away and wondered if we would be able to tolerate the heat.

**We went in as
12 pale, anxious,
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overanalyzing
medical students.**

**We came out as one
group of friends and
colleagues ...**

When it came time to enter the sweat lodge, mixed feelings of excitement and fear arose. We hunched anxiously into the small dome-shaped structure one by one, shuffling around the pit that lay in the centre of the room and ducking to avoid the low ceiling. A few community elders were already sitting at the back enjoying the heat. We had been instructed that men and women would sit on opposite sides of the sweat lodge. Eighteen of us

crammed into that little structure, with Morris taking his place at the very back of the lodge. The men removed their shirts while the women remained clothed from neck to ankles. More women were in attendance, which meant the women sat shoulder to shoulder with their knees around their chins, while the men sat up comfortably with leg room to spare.

The air temperature at this point was hot. A peace pipe was passed around the group. We were encouraged to hold it, smoke it and say a prayer with it. The community members each took the pipe, held it, gracefully smoked it and spoke words that resembled something peaceful and sound. Each medical student held the pipe and, unsure of what to do, tried a variety of things: smoking it, pretending to smoke it, keeping their head down while holding the pipe or swiftly passing it on to the next person.

The youngest man from the community was instructed to prepare for the beginning of the ceremony. With the help of a few male medical students, he loaded the centre pit with the smouldering rocks. As more rocks were added, the temperature rose. Students started fidgeting, while the community members remained completely relaxed. The rocks were in place and the ceremony was about to begin. The door was tightly shut and it was then that we realized the depth of darkness we were going to explore. Never before had I witnessed such darkness — a hand waving 5 mm in



front of your face would go unperceived if it were not for the air movement it created.

With the darkness came intense heat, and beads of sweat started accumulating on foreheads, necks, backs and abdomens. A strong and familiar voice, Morris's voice, commanded us to sing with him, even though the language, the song and the words were unfamiliar. So we sang. We sang nonsense words trying to imitate what Morris and the community members were singing. While the words of the songs bounced off the tightly sealed walls, we heard and felt steam. The beads of sweat that had previously formed on our foreheads turned into puddles on our bodies as we experienced volcanic heat.

Suffocation felt near. I couldn't stand it, I was going to die and nobody would notice in the heat and darkness and singing. I would make a run for it. I knew approximately where the door was. But what if I fell into the pit of smouldering rocks? There were only about 12 inches between the pit and people's feet. By the time I thought my escape plan through, I didn't have any energy to lift my body from the ground. I was slouching further and

further, trying to curl into a ball so that the heat could no longer penetrate my limbs. I started crying. Nobody noticed my tears. Everyone was alone in the lodge, alone with the darkness, the incomprehensible singing and the unforgiving heat. For what seemed like an hour, I remained curled up in a ball, sporadically crying and wishing that I had never participated in this activity. Eventually, the singing stopped and the light came pouring into the lodge through the opened door.

The heat lessened. We were allowed to leave the sweat lodge to get a drink of water. We looked at each other. We wondered if anyone else had had the same experience, the same thoughts? Within the first 30 seconds it became evident that everyone had had a similar experience. Were we ready for more? We couldn't back down after only one round. I certainly would not back down if my colleagues were heading back in. So back we went — all of us. For some strange reason, we all wanted more of the punishing sensation that we had just felt.

We endured three more rounds of total darkness, unrivaled heat and foreign singing, each round a little different than the previous. During

the first round, I was alone in the dome, afraid and crying. During the second, the pain and solitude that the heat and darkness brought were not as daunting, for I had become aware that my friends' and colleagues' minds and bodies were experiencing the same thing. The heat, although hotter, seemed friendlier with the knowledge that we were all supporting one another. The third round, the longest, was when I felt the presence, wisdom and warmth of the elders and the ceremonialist through every pore of my body. Their powerful singing, their chants and their prayers drew us in. We sang the mysterious words alongside our First Nations host and we sang against the heat with conviction. At some point in the fourth round, the hottest yet, we started to float, a feeling that we were floating on the healing words sung by the unanimous voice of the group.

We went in as 12 pale, anxious, overstressed and overanalyzing medical students. We came out as one group of friends and colleagues, joined by an experience that left us with a feeling of euphoria and enveloped us with a profound sense of peace and happiness for weeks to come.



One day for neglected tropical diseases

**Rosie Ashton, Dalhousie Global Health Liaison Sr., Class of 2012
Achelle LeBlanc, Dalhousie Global Health Liaison Jr., Class of 2013**

One of my favourite things to do on an airplane is read the complimentary magazine. Cramped in the middle seat at 32,000 feet, I look forward to escaping into the glossy pages and trying to decide what to do in my destination city. Coming back from Edmonton after last May's meeting of the CFMS, at which I represented Dalhousie as the senior global health liaison and co-president of the Global Health Initiative, I picked up the magazine and began to leaf through it. I came across a very cute half-page advert for the Canadian Federation of Podiatric Medicine, explaining that foot care is a life-long commitment and reporting that 80% of Canadians will develop a foot ailment at some point in their lives. The ad caught my eye because underneath a photo of a child's healthy pink toes, it read, "May is Foot Health Month in Canada."

I didn't know this and turned to point it out to another student sitting beside me. "Foot care gets the whole month of May! A whole month! Can you think of any other diseases that get a whole month? I mean, there's Mental Health Week." "World AIDS Day," he said. We paused.

Now, I don't have anything against the discipline of podiatry or chiropody and acknowledge that foot health care is very important, but as a representative of the Global Health Initiative at Dal, this simple advert really got me thinking. As a medical student, especially one who

fundraises for various causes, I'm all over "days." They are exceptionally useful when choosing when to fundraise and I think they're great: World TB Day (24 March), World Cancer Day (4 Feb.), World Hepatitis Day (19 May), Sexual and Reproductive Health Awareness Day (12 Feb.) and, of course, World AIDS Day (1 Dec.).

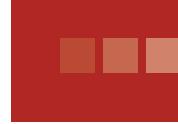
"Parasitic, bacterial and some vector-borne diseases, known to be neglected, are among the most common infections affecting an estimated 2.7 billion people who live on less than \$2 a day."

If you go to the Canadian Cancer Society's website, they have an entire list of 16 days, weeks and months for specific types of cancer.

But if you start looking for other "days," you might run into some trouble. Many of the abovementioned diseases are prevalent around the world, and many of these days could be celebrated almost anywhere. But what is interesting and, I hope, appalling is that some diseases that affect billions of people worldwide are nowhere to be seen and awareness opportunities are limited.

The neglected tropical diseases are a group of identified infections that affect the poorest populations living mostly in developing countries rife with political unrest, slums and uncontrolled epidemics. Parasitic, bacterial and some vector-borne diseases, known to be neglected, are among the most common infections affecting an estimated 2.7 billion people who live on less than \$2 a day. These diseases include dengue fever, Chagas disease, leishmaniasis, trachoma, yaws and schistosomiasis. Many of these have a treatment, although its cost is out of reach for those who most need it. You would be hard-pressed to find a "day" with glossy advertising and rubber bracelets dedicated to these diseases.

I recognize that many readers have experienced the devastation that comes with losing someone to cancer or heart disease and may have little or no experience with tropical parasites. In Canada, we are not likely to contract malaria or sleeping sickness, but I believe that we have a social responsibility to keep them in mind, for the sake of those who suffer from them and do not have a voice. These diseases



are also not so distant: as illustrated by the H1N1 outbreak, most of them are only a plane ride away and Canadians are great travelers.

Most important, keeping them in mind can change the world! The HIV/AIDS epidemic is remembered each 1 Dec. (often the finale of an AIDS week dedicated to raising awareness) and millions of dollars have been generously donated to causes such as Mothers2Mothers, the Stephen Lewis Foundation and Dignitas International. Through fundraising and awareness, people have been given the drugs they need and educated on how to prevent the spread of infection. The stigma they had faced has been reduced. We can also do this with other diseases, which are sorely lacking attention and are causing the suffering of millions.

How? We can start with a day. One day dedicated to the neglected tropical diseases of the world, one that is circled on calendars and thought about across the country, one that inspires people to look into the missions started by Médecins Sans Frontières, the Drugs for Neglected Disease Initiative and the Institute for OneWorld Health. Students garner a lot of attention, and the CFMS is known for standing up and initiating change. Global health is something we all have a responsibility to promote and talk about, so let's get it into the public eye.



A collage made up of the many faces of medical students from the class of 2012 and 2011 for World AIDS Day 2008. It was displayed at the fundraiser held last December for Mothers2Mothers.





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Dr. Roberta Bondar, neurologist, astronaut, researcher, educator, photographer — “We live only once”

Meiqi Guo
CFMS Annual Review Editor
Queen's University, Class of 2011

Dr. Roberta Bondar grew up in Sault Ste. Marie playing with her chemistry set, toy stethoscope and space models — very fitting preparation for her outstanding career as a neuroscience researcher, neurologist and astronaut. Despite having to go through spinal fusion surgery just one year before her space mission to treat a cervical disc herniation suffered during training, in 1992, Dr. Bondar became the first Canadian woman in space. Dr. Bondar talks to the *CFMS Annual Review* about her space missions, photography, finding the balance between professional and personal life and her best advice to medical students.

Annual Review: When you entered medical school, you were 32 years old, already an accomplished researcher with a PhD in neuroscience from the University of Toronto. Why did you choose to pursue medicine?

RB: My research was in an area that was very much related to human health and disease, and I wanted to do something to actually help patients directly. Research was great, but I also wanted to have a clinical component. As a PhD without an MD, that would not have been possible.

Annual Review: In your biography



sketches, there is often mention of how you loved science fiction as a kid and how you dreamed of being an astronaut as a child. How did it feel when you realized your childhood dream and found yourself in space?

supposed to be asleep to look at the earth and think about the future of humankind. Being philosophical was really what made it very important for me and made me realize I had accomplished my goal.

RB: I must say that space flight itself is exceptionally busy. In my space flight, I had to deliberately take time to float back, look at the earth and think about how this was something that I had always wanted to do. We can get caught up in the busyness of what we are trying to do and forget the reasons why we are doing it. In essence we have to enjoy the journey. While in space, I stole time from when I was

Annual Review: Besides the NASA mission, you were also offered the chance to be a member of the Russian Mir space station team. Is that correct?

RB: Yes, at one point, the Russians had said to me, “We do not have enough data on women in space flights.” I felt at that moment it was not exactly what women should be considered as — just data points. We should be an inte-



gral part of the space crew. I felt that to be up there just to be considered a data point was not in the best interests of women going forward.

Annual Review: After your space mission, you went on to lead a research team at NASA, you became a sought-after speaker and you served as Trent University's chancellor. What made you choose these endeavours over clinical practice?

RB: It's amazing, after my space flight I felt within me a capability, capacity and responsibility to be more international than I could be in clinical practice. That does not mean that in clinical practice we do not interact with the international environment. We do, as researchers, in meetings, with colleagues and through partnerships. I felt that there was a broader mandate for me that was really self-generated — to somehow induce a cultural shift toward liking science and understanding that science is all around us. I felt that being a clinician or a researcher in just one place, in one small field would not generate that for me. My mission was an international mission and when I went around and saw the whole world 129 times from space, I really wanted to continue being international in my focus.

Annual Review: You studied at the Brooks Institute of Photography, had your own gallery shows and published several photography books. What sparked your interest in photography?

RB: My father and uncle were photographers, so when I was growing up in the early 1950s, I was given a camera. Although my family did not have very much money, I was encouraged to take pictures. I loved the technical component very much and I liked working with the lenses. I liked the kinds of activities that



Dr. Roberta Bondar speaks at the Canadian Undergraduate Conference on Healthcare 2009 (www.cucoh.ca) held at Queen's University.

surrounded photography because they always seemed to be very positive things. They seemed to be things that capture our interest and capture our history and I was able to share a lot of emotional moments with my support group (my parents, grandparents and sisters) through the medium of photography.

Photography has always been very important to me and for my PhD at the University of Toronto, I was looking at an experimental model of some components of Alzheimer's disease. I found that when I looked through the microscope, I would try to orient the specimen to the grid so that it would be visually appealing. Maybe I was a little off the wall here, but I wanted the presentation of the specimen to be creative so people would spend longer looking at it and would find it as curious as I did. Then when I was doing my residency in neurology, we used microscopy all the time to develop specimens. This led to my subspecialty of neuro-ophthalmology, which is how we view and see the world around us.

My interest carried through to NASA and I used every opportunity to

study the 13 different camera types on my mission. For example, we had the IMAX camera and part of the research I was doing was documented into the IMAX movie *Destiny in Space*. I learned a lot about camera types and wanted to take photos of earth from space and explore other parts of the planet. Let's face it, there's nothing like going around a planet 129 times to spark an interest in it! I was encouraged to get more formal training, which led me to the Brooks Institute of Photography in Santa Barbara, California.

Photography has always been a way to encourage people to learn and to share in an adventure.

Annual Review: Photography, education, public speaking — you do so much. How have you found the balance between your professional and personal life?

RB: That is an interesting question. I've obviously not had time to have a family. When I was being interviewed to be a member of the astronaut program in Canada, they did a pregnancy test on me. They didn't

know which one was the woman out of the 19 finalists because they didn't have my name on the [urine] bag. I didn't write my name, but had my social insurance number on the bag instead. It's almost as if people were trying to find a reason to exclude women.

My mission was an international mission and when I went around and saw the whole world 129 times from space, I really wanted to continue being international in my focus.

I was in my 30s at that point and I realized that it was not going to be the end of challenges that I would face. So, I stopped drinking caffeine because

I didn't want to have any extra heart beats, and I was really serious about my diet and exercise. I just didn't want to give anybody any reason to not pick me because I was a woman, so in terms of my personal life, it became really important to focus on physical fitness and healthy eating.

Right now, it's a lot easier for me to balance things. I had a mother who was ill and I was able to be back here in Canada to take care of her. That was a wonderful time and I appreciated it. I took up golf three years ago. I wanted to learn to play golf because I wanted something that as I get older, I can keep on doing physically. I wanted to be able to meet people, to be outside, to understand the environmental implications of golf courses and I really liked the neurophysiology of it.

When I balance my life, I balance it with my friends. I've come to enjoy cooking because I don't like going out to eat — people recognize me, which makes me eat in a hurry and leads to indigestion. I like entertaining my friends. I like my house plants. I love my reading. I'm writing three books right now and I'm starting a new foundation in my name that's going to be dealing with the fusion of arts and science and promotes the broad education of science across all age groups.

Annual Review: Wow, you've got a lot on your plate.

RB: Well, we live only once!

Annual Review: Based on all your life experiences, what advice would you give to Canadian medical students?

RB: First of all, congratulations are really important. We do not have enough recognition of the difficulties of medicine as a profession. It's expensive to go through, there are lots of government regulations. But it is, singularly, the most important thing I've done in my life. I have a bond now with all medical students because I do understand we have certain goals in common. We are trusted with the health and life of other people, and there is nothing greater than that.

So my advice is to learn and enjoy as much as you can during formal training because that is when you get the basis of everything that goes forward. It is also important to have a good grounding to develop yourselves as thinkers, to develop skill sets to allow you to problem-solve, to develop interpersonal skills, to understand what research is all about and to cement learning either from informal discussions with people or asking people you meet from different specialties about different patients.

To keep a broad focus on the art and science of medicine in our lives and to enjoy medicine is probably the best advice I can give.



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Student-based community outreach initiatives at the University of Toronto

Peter Szasz,¹ Sagar Dugani,² Christine Law³ and Diana Alli⁴

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The University of Toronto Medical Society's Community Affairs portfolio facilitates community-based learning experiences that prepare medical students to become responsible and socially accountable physicians. Structured sessions that span all four years of the undergraduate medical education program complement curriculum requirements and give medical students opportunities to enhance their community-based education.

In collaboration with the Office of Health Professions Student Affairs, medical students have developed, implemented and directed over 22 community-based initiatives. These programs are aimed at children, single mothers, isolated seniors and the homeless, as well as other marginalized groups, largely reflecting the diverse populations that medical students will, as physicians, serve, protect and advocate for. Our programs include tutoring/mentoring, reducing social isolation of seniors, blood drives and preventative health screening.

Encouraged by the success of these long-standing programs and the need to further contribute to the community, in 2007, the IMAGINE medical clinic was established, in collaboration with the Office of Health Professions Student Affairs. IMAGINE (Interdisciplinary Medical and Allied Groups for Improving Neighbourhood Environments) is an interprofes-

sional clinic run by medical students and our community partner St. Christopher House. In response to gaps in service and care identified by St. Christopher House's Meeting Place — a community centre for the homeless — the concept of this student-run health clinic emerged. The underlying rationale for IMAGINE encompasses community service, interprofessional education, community-based education, breaking barriers and promoting models of excellence.

guage pathology), dentistry, nursing and pharmacy.

IMAGINE helps to increase students' understanding of the socioeconomic determinants of health. The setting exposes them to a primary practice model that includes the health education strategies and health promotion principles needed when working with communities to achieve beneficial health outcomes. In addition, the clinic undertakes research studies to improve services, responds to changing community needs and assists with advocacy.

The IMAGINE clinic was established to increase access to comprehensive health services for our target community. In partnership with St. Christopher House, we are building an environment of collaboration, participation, respect, dialogue and shared learning to form a trusting relationship between health care providers and an underserviced community.

Universities in British Columbia, Saskatchewan and Alberta have undertaken similar initiatives and, through publications and personal contact, these clinics have shared their experiences, learning pearls and expertise acquired during the establishment and operation of their clinics. We hope to do the same for other start-up, student-run clinics as our experience and expertise grows.

IMAGINE has shown us the significant impact that student-driven activities can have on social accountability and responsibility.

IMAGINE has shown us the significant impact that student-driven activities can have on social accountability and responsibility.

IMAGINE provides hassle-free, basic health care services and educational workshops to the community. Delivering these programs requires collaboration among students from the faculties of medicine (medical radiation sciences, occupational therapy, physical therapy, and speech and lan-



Gearing up for and kicking off another year at SHINE

Christine Pask and Sarah Wozney

SHINE VPs of Communication

University of Alberta, Class of 2012 and 2013

The Student Health Initiative for the Needs of Edmonton (SHINE) Youth Clinic, run entirely by students from various health faculties at the University of Alberta, has had another great start to the clinic year. Founded in 2004 by a group of U of A medical students, the clinic has continued to grow and expand to meet the needs of the inner-city youth community it has served ever since its conception. We have experienced a lot of development in the past few months and are excited that SHINE is being recognized not only among other inner-city service agencies, but in the greater Edmonton community as well.

The clinic, which runs every Saturday afternoon from 2 to 6 pm, allows its student volunteers the opportunity to work within an interdisciplinary health care team with a specific patient population. Besides offering medical and dental services, the clinic strives to provide a safe place for youth to come and get a warm meal, a hot shower and some basic supplies to help get them through the week. Each faculty involved provides preceptors to supervise and guide student learning. In addition to the dentistry, medicine, nursing, nutrition and pharmacy, the clinic was excited to welcome counseling psychology, social work and physiotherapy to the team this year. These additions are especially appropriate given the recent decrease in mental health funding in the province of Alberta.

This year the clinic kicked things off with its annual Welcome Back BBQ. Well over 800 people, including patients, community members, volunteers and preceptors, came out to enjoy the great food on a warm September afternoon. The BBQ allows the clinic to connect with its patients and for them to connect with one another. It also helps raise awareness of SHINE and the services it provides both in the community and within Edmonton. The BBQ is also used as a tool to help recruit new volunteers and preceptors for the upcoming year.

cies throughout the city to connect with inner city youth in the downtown core. Presentations are given about many of the issues that youth on the street struggle with daily, including pregnancy, drugs and alcohol. This interaction allows volunteers to raise awareness of the clinic directly among the marginalized population the clinic aims to serve. Relationships are built with these youth, who have had more than their fair share of struggles. Such relations can help establish a positive foundation to encourage youth to access health care and learn about the services that are out there to help them — especially during the cold winter months.

In September 2009, SHINE introduced its development program. The goal is to implement prevention strategies rather than just treating medical problems when they present themselves. Over the past few months, several presentations have been made to educate youth on topics such as prevention of sexually transmitted infections. Youth living on the street do not always have people in their lives who can give them the heads up about what's out there and how to protect themselves, and SHINE is hoping to help bridge this gap in knowledge. The program has also helped to provide patients with those little extras that people living on the street seldom experience (pedicure anyone?). The SHINE Youth Clinic was recently recognized as a community leader from among a

Youth living on the street do not always have people in their lives who can give them the heads up about what's out there and how to protect themselves.

In addition to the weekly clinic, SHINE's outreach program has been in full force this year. Volunteers go into various youth shelters and agen-



Dr. Philip Baker, Dean of the Faculty of Medicine & Dentistry at the U of A, joins students and preceptors on a typical Saturday at SHINE.

number of dedicated humanitarian organizations. “There is no question that recognition like this award is highly appreciated,” says Alex McFarlane, co-director of the clinic. “The other nominees in the category were all spectacular causes and it was an honour to be considered with them.” The Heart and Soul Award, conceptualized by the Foundation for Philanthropy Canada, is a nomination and selection process that celebrates continued individual or group work for the benefit of others. The

clinic is relatively new, still in its first five years of operation, and it was exciting to even be considered in the nomination process, let alone win the award!

At the end of the day, although all of these new developments have been big steps for the clinic, it comes down to patients’ perceptions of how the clinic is doing. A recent needs assessment, carried out by physiotherapy as a research tool to guide their decision to join the clinic, found that SHINE patients have a very positive outlook

toward the clinic and its work. “They treat you like people” and “Needs are met here” were comments from patients. It is input like this that helps push us to continue to improve. We could not do it without the support of our faculties, the Boyle McCauley Health Centre, the Edmonton North PCN, TELUS and our other financial supporters. The continued guidance of SWITCH, the University of Saskatchewan’s student clinic, also continues to inspire us to reach further and aim higher.



Partnership in curriculum renewal — a student's role in the education of future physicians

David Carver, VP of Medical Education, Dalhousie Medical Students' Society, Class of 2012

Adam Harris, CFMS Junior Representative, Dalhousie Medical Students' Society, Class of 2012

Dalhousie University's Faculty of Medicine has witnessed many changes in the past year. The arrival of a new associate dean of undergraduate medical education in January 2009 was quickly followed by installation of a new dean for the entire faculty of medicine in September. As we approached a crucial point in the development of a distributed campus in Saint John, New Brunswick, an accreditation visit proved to be a challenge for our institution. However, Dalhousie has emerged from these challenges and changes, a stronger and healthier medical school — more aware of its many parts and the role that students play in developing the education of future physicians.

Dalhousie is now in the midst of renewing its undergraduate medical curriculum — reengineering its case-oriented, problem-stimulated curriculum into one that truly puts students first. In the early stages of the process, a group of students and recent graduates formed a committee to investigate how we are responsible for the curriculum and how we can increase our involvement in a sustainable way. The findings of this committee have already resulted in a number of positive changes that have been overwhelmingly supported by faculty and administrators alike.

The message here is not to wait until the point of no return. Student



Aris Lavranos (Dalhousie Medical Student Society President), Dave Carver (VP Medical Education) and Adam Harris (VP External Jr.) delivered a presentation titled "Partnership in Curriculum Renewal" at Dalhousie's 2020 Vision: Renewal of the Undergraduate Curriculum conference, 28 November 2009.

involvement is absolutely essential in the development and maintenance of a strong and dynamic undergraduate medical curriculum. No group better understands the intricacies or is better equipped to comment on the strengths and weaknesses of a program than its students. As physicians, we will be expected to reflect on our practices and those of our colleagues and bring about positive changes. This active and reflective process needs to begin now, while we are students, and it is our responsibility to make our voices heard at medical schools across the country.

Just as important, today's students will be tomorrow's teachers and leaders. Canadian medical schools have a responsibility to provide their students with opportunities to become more involved in curriculum development and management. There is no better way to ensure the continuity and continued strength of these schools than to have their future administrators involved first as students, long before they are responsible for making decisions affecting the education of future physicians.

Enhancing HIV medical education: a sustainable student-run initiative at the University of Toronto

Meghan Ho,¹ Derek Chew,² Denise Jaworsky,² Julie Thorne,² Carly Morin,² Nikki Hoffman,¹ Christe Henshaw,¹ Nisha Andany,² Sean Rourke,³ Mark Fisher,³ Anita Rachlis⁴

¹University of Toronto Faculty of Medicine, Class of 2012

²University of Toronto Faculty of Medicine, Class of 2011

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In 2008, a preclerkship HIV elective (PHE) was initiated by five second-year students at the University of Toronto in response to the need for better medical education about HIV. Three first-year medical students were selected to join the committee to assume leadership the following year and help ensure sustainability of the initiative. This student-run elective aims to introduce students to the multidisciplinary aspects of HIV care and the spectrum of determinants of health affecting people living with HIV. It is supported by the Ontario HIV Treatment Network and U of T's Faculty of Medicine and Medical Society. Through collaboration with these partners, as well as researchers, health care professionals and community agencies in the HIV/AIDS field in Toronto, the second year of the PHE continues in 2009–2010.

During the 2008–2009 PHE, 18 second-year medical students were selected as core participants. The PHE consisted of six components: lectures, small-group sessions, independent reading assignments, clinical observerships, community agency placements and a point-of-care HIV counseling and testing workshop. In total, seven 1-hour lunchtime lectures were held

on topics such as "HIV and complementary and alternative care," "Fighting AIDS in Lesotho" and "Challenges in pediatric HIV infection." The lecture component was open to medical students and students in other health care professional programs at U of T and other postsecondary institutions. Some PHE activities were organized in conjunction with other student groups such as the Aboriginal Health Elective and U of T's International Health Program to maximize participation and minimize organizational overlap. Average attendance at the lectures was 70 students, and average student satisfaction was 96.3%.

Seven small-group sessions were held for core participants. A case-based session and a session on the principles of medical management of HIV were particularly well received. Each participant was required to read one peer-reviewed journal article and present the findings informally at the beginning of a session.

Participants were given the opportunity to complete two half-days shadowing a physician in HIV primary care or an infectious disease outpatient clinic. Each participant was also matched with a community agency

where they spent one or two half-days gaining a broader perspective on the psychosocial aspects of HIV care and available community supports for people with HIV. Finally, a 3.5-hour point of care HIV testing and counseling workshop was presented to core participants by representatives of the AIDS Bureau of the Ministry of Health and Long-Term Care and the Hassle Free Clinic. Workshop participants found the session to be very informative, practical and interactive.

The PHE elective was a much-needed opportunity to fill the gap in HIV knowledge that is not taught within our curriculum.

The PHE was well received by core participants, other students who



attended the lunchtime lectures, members of the Faculty of Medicine and partner community organizations. During and after the elective, participants submitted evaluations of each component.

One student wrote, "The PHE elective was a much-needed opportunity to fill the gap in HIV knowledge that is not taught within our curriculum. It greatly highlighted the challenges in HIV care, but also the advances and promise in treating HIV as a chronic disease. It is really

essential knowledge, especially for those who will be working out in the community or with special populations in Toronto and around the globe." Another commented, "I had the opportunity to learn more about and reflect on issues faced by people living with HIV and their health care providers. It was interesting to learn about interactions with law, psychosocial issues and meeting HIV physicians and patients first hand. I will feel more comfortable serving this population in the future."

To improve the PHE program, modifications were made for 2009–2010 that take into account feedback and comments from past participants. This session has 17 core participants and includes five main components: lectures, small-group sessions, clinical and community placements and the point of care testing and counseling workshop. Thus far, a small group session on "HIV and discrimination" and a lecture on "Innovations in HIV care" have been held. In addition, the elective will provide an open opportunity for 10 students (including those not in the elective) to take part in two mentorship events, where each student will be paired with a person living with HIV to learn first hand about their experiences. The development of partnerships with additional community agencies and the creation of further educational opportunities in HIV care are being explored.

We have presented our findings at conferences across Canada and hope that the U of T PHE will serve as a model for other student-run initiatives that aim to enhance HIV curricula. From our experiences, we have learned that the success of an HIV elective and its impact on HIV education is greatly enhanced by partnering with both faculty members and the HIV community (community-based agencies, organizational networks, researchers and health care professionals), as well as other student-run elective and interest groups. To ensure continued success of the PHE, we are continuing to gather feedback to further improve the PHE for medical students at U of T.



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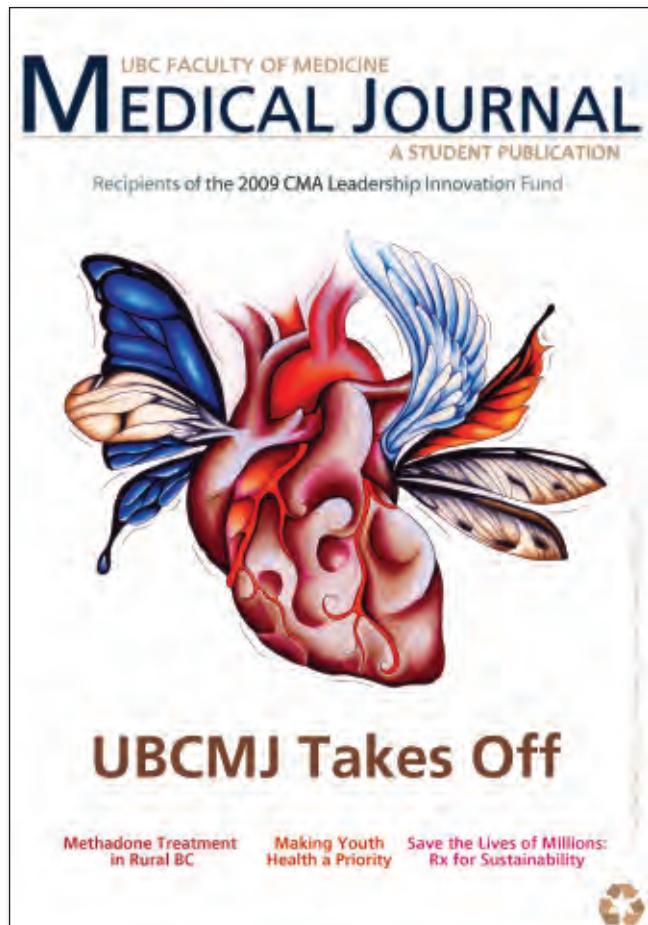
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New kid on the block: UBC medical journal takes off

Ciara Chamberlain, Tanya Griffiths and Pamela Verma
University of British Columbia, Class of 2012



On 8 Sept. 2009, UBC celebrated the publication of its first issue of the *UBCMJ*, the official student-run, peer-reviewed publication of UBC's Faculty of Medicine. More than 100 medical students from all levels of training and three distributed sites are involved as writers, artists, reviewers, editors, layout designers and executive directors.

This student-driven journal was founded based on the need for health science students to have an interdisciplinary forum for academic dialogue. The journal gives young trainees the opportunity to develop skills, such as writing, medical editing, peer review, critical appraisal, graphic design, management and team-building. All submissions are peer reviewed by students and faculty members with content expertise. The *UBCMJ* accepts articles in all areas of medicine and health science, and features original student artwork and graphics.

The journal has received critical acclaim and was recipient of the Canadian Medical Association Leadership Innovation Award. Media coverage has spanned both national and local levels. The journal is published twice annually. Recruitment of articles and reviewers for the third edition is already underway (submission deadline: 26 Feb. 2010). To download the first issue or to find further information about how to get involved in reviewing and submitting, visit www.ubcmj.com.



Queen's Medical Review: five issues and counting!

Dan Finnigan
Queen's University, Class of 2011

Medical schools with student-run journals are nothing new. A number of Canadian medical schools such as the universities of Toronto, Dalhousie, McMaster, McGill, Alberta and British Columbia have their own versions and now Queen's can be included in this group.

The new *Queen's Medical Review* (*QMR*) was started by members of the 2011 class. Its goal is to create synergy within our community by providing a forum for sharing insight gleaned from various experiences and for student discussion and debate on health care issues. For instance, the *QMR* publishes articles probing the economic sustainability of our health care system, our organ donation system, as well as stories about student electives in Kenya. The support and interest of the Queen's community has demonstrated that such a publication is welcome.

The most recent issue focuses on the artistic interests and talents of Queen's medical students. Copies of the *QMR* can be downloaded at www.queensmedicalreview.com. We hope that this journal will continue to be carried forward as a forum for students to share their varied and fascinating experiences.



Tracking radiation exposure from radiology and related exams, using “Radiation Passport” for the iPhone

Mark Otto Baerlocher, MD

PGY-5 Radiology

University of Toronto

Over the last few decades, medical imaging has made impressive and rapid advancements in the availability, quality, resolution and accuracy of radiology examinations. This has allowed for huge improvements in patient care, both in the diagnosis and, with the rapid rise of interventional radiology, in the treatment of diseases. Other specialties have also based treatments on radiology developments; for example, coronary angiography and angioplasty, originally developed by Dr. Charles Dotter (an interventional radiology pioneer), are now widely performed by cardiologists.

The increased use of radiology exams does not come without risks. In particular, ionizing radiation is associated with radiography, computed tomography (CT), nuclear medicine scans and fluoroscopy (used with angiography and angioplasty). Ionizing radiation presents two levels of potential risk to patients: deterministic effects (non-probabilistic) and stochastic risks (probabilistic).

The primary stochastic risk is the risk of developing cancer. In a controversial paper in a November 2009 issue of the *New England Journal of Medicine*, Drs. Brenner and Hall estimated that if current CT usage rates in the United States continue, up to 1.5–2% of all cancers may become attrib-

utable to radiation from CT scans alone. Other researchers report that a substantial minority of requested exams in the US may not be “clinically indicated,” but are performed for other reasons, such as medico-legal considerations or because of poor communication among health care workers.

One of the problems associated with discussing the risks from medically related radiation is the difficulty in creating accurate risk-estimate models. Several models exist, with many underlying assumptions and related hypotheses. Arguably the most thorough is that created by the Biological Effects of Ionizing Radiation (BEIR VII) Committee, a large US government committee tasked with reviewing the best evidence on the topic every few years.

The BEIR VII uses the linear, non-threshold model, which assumes that the risk from radiation is linear (double the dose is associated with approximately double the risk) and has no lower threshold (any exposure, regardless of how small, increases risk). The BEIR VII model also assumes that the risks are additive, in that each successive exposure throughout a lifetime increases the risk of developing cancer incrementally. Although much of the data used to create such models originate from atomic bomb data, there are

now published, direct, epidemiologic data regarding radiation risks.

One of the problems associated with discussing the risks from medically related radiation is the difficulty in creating accurate risk-estimate models.

The risk of developing cancer secondary to radiation exposure is generally greater for females and younger patients (the younger the patient, the greater the risk for a given exposure). For example, the estimated risk of developing cancer secondary to radiation from a CT scan to rule out pulmonary embolism, at an average dose of 15 mSv (the published average), in a young woman 25 years of age is approximately 1 in 422, and her risk of developing fatal cancer from the scan



is 1 in 1022. The same exam, at the same dose, for a female patient who is 55, is associated with risks of approximately 1 in 1005, and 1 in 1518 of developing non-fatal + fatal cancer and fatal cancer only, respectively.

Radiation Passport for the iPhone

For this reason, I teamed up with my brother Adrian Baerlocher, who runs Tidal Pool Software (www.tidalpool.ca), a company that develops applications for the Macintosh and iPhone/iPod Touch platforms, to create Radiation Passport (see www.tidalpool.ca/radiationpassport/ for further information).

The purpose of this software is to track or “log” patients’ radiation exposures and calculate the estimated risk of developing cancer due to exposure to medical radiation (or separately, from background radiation). The application is intended to be useful for both patients and health care workers. Health care professionals may use it to

look up the estimated effective radiation dose associated with a specific medical imaging exam or related procedure and the estimated risk of developing cancer (non-fatal and fatal) due to that exposure, specific to the gender and age of the patient. Patients may use it to track their personal radiation exposure over their lifetime.

Radiation risk awareness

There are many other resources available for both medical trainees and patients, and I encourage everyone to make an effort to gain a better understanding of the underlying issues. For example, one excellent resource that I’ve used is Image Gently™ (www.imagegently.org).

There is little doubt that this issue will continue to increase in importance; in fact, it has already made and continues to make international headlines in the lay media. Many of these stories may lead to misinformation, and it will be your job to answer your patients’ questions.

Learning about this issue may also impress your future residency supervisors. A number of studies have revealed the marked lack of radiation risk awareness among both medical trainees and medical staff. Develop a firm understanding of this issue, and you’ll prove to be a tremendous resource for your medical team, not to mention your patients!

Although there should be no question that the rapid increase in use of such exams has allowed for greatly improved patient care both in the diagnosis and treatment of patients, it is also important to remember that exams using radiography, CT, fluoroscopy and nuclear imaging are not entirely benign.

If you have questions on this topic or suggestions and comments, please do not hesitate to contact me at mark.baerlocher@utoronto.ca.

Note: Dr. Mark Baerlocher does not receive any revenue from the sale of the Radiation Passport iPhone application.

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Bill C-384 —

euthanasia and physician-assisted suicide in Canada

Ugo Dodd

University of Ottawa, Class of 2011

On 13 May 2009, Bloc MP Francine Lalonde introduced Bill C-384 in parliament. This was Madame Lalonde's third attempt to legalize euthanasia and physician-assisted suicide in Canada. The bill received its first hour of debate on 2 Oct. 2009. Three trade-backs and a prorogued parliament means that the bill will receive its second reading in May 2010 at the earliest.

In introducing this bill, MP Lalonde is proposing amendments to sections 14, 222 and 241 of the Criminal Code to provide that "a medical practitioner does not commit homicide [if] he or she aids a person to die with dignity, if the person... either continues, after trying or expressly refusing the appropriate treatments available, to experience severe physical or mental pain without any prospect of relief, or suffers from a terminal illness."¹

In a letter to Madame Lalonde in October 2009, the CMA reiterated its policy,² "Canadian physicians should not participate in euthanasia or assisted suicide."³ Furthermore, "euthanasia and assisted suicide must be distinguished from the withholding and withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life."

This bill presents an excellent opportunity for Canadian physicians, residents and medical students to think about what might motivate

patients to request euthanasia or assisted suicide. A narrow focus on the ethical issues in this discussion may miss the more important undercurrent of this bill. Are there gaps in patient care and in the health care system that could provoke a perceived need for euthanasia and assisted suicide? If so, what can medical students do to address these gaps? Four broad concerns were raised in the CMA letter; the first two have immediate applications for medical students.

1. *Adequate palliative-care services⁴ must be made available to all Canadians.*

Many medical students have little to no training in the area of palliative care, yet all of us will encounter patients with life-limiting illnesses and patients at the end of life.

- If you feel that your curriculum lacks adequate training in the areas of palliative care, pain and symptom management, grief, bereavement and interprofessionalism, speak to the appropriate faculty and staff about effective and creative ways to include this information in your medical education.
- Start a special interest group in palliative care; if one exists, participate.
- Complete at least one elective in palliative care during your medical school training.

A recent study⁵ from Oregon, where physician-assisted suicide is legal, showed that the top three reasons

Euthanasia —

deliberate killing of an individual by action or omission in a painless manner, with or without that person's consent, for allegedly compassionate reasons.

Assisted suicide —

counseling, abetting or an act of aiding an individual to kill himself or herself.

for requesting physician-assisted suicide were wanting to control the circumstances of death, future poor quality of life and future pain. Properly summarized, fear was the top motivator for patients requesting physician assisted suicide. One of the many advantages of the palliative care approach is that it emphasizes taking the time to listen to patients. Although excellent palliative care cannot immediately quiet all the patient's fears, through its practice we can address many myths and misunderstandings about a patient's disease, treatment or personal experience that may be contributing to that fear. We can, in the words of the renowned bioethicist, Dr. Margaret Somerville, help patients make dying their last great act of living.

2. *Suicide prevention programs should be maintained and strengthened where necessary.*



Suicide screening and prevention is an area of medicine that relies strongly on good history taking, something we as medical students can perfect early on.

- Ensure that you screen patients with terminal or life-limiting illness thoroughly for depression and suicide.
- Attend a workshop on suicide prevention.⁶
- If your curriculum lacks information on suicide prevention, particularly among elderly and chronically ill populations, speak to the appropriate staff or faculty at your school.

In conclusion, as stated by the CMA, "Because of the controversial nature of these practices, their undeniable importance to physicians and their unpredictable effects on the prac-

tice of medicine, these issues must be approached cautiously and deliberately by the profession and society."² Regardless of whether the laws concerning euthanasia and assisted suicide change, it would be abhorrent for a patient to ask for euthanasia or assisted suicide because something wasn't done to bring them the necessary comfort and support. Unequivocally, it is the personal responsibility of each medical student, whether in agreement or disagreement with the CMA policy, to learn how to provide the best possible care, particularly for patients with life-limiting illnesses or those approaching the end of life.

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The Aberdeen Hospital in New Glasgow and Sutherland Harris Memorial Hospital in Pictou are just 90 minutes from Halifax and the Robert Stanfield International Airport. Moncton and Charlottetown are not much further and we're minutes away from the warmest waters north of the Carolinas and some of the most beautiful beaches in Nova Scotia.

The Aberdeen Hospital is a 112-bed regional facility providing a broad range of primary and secondary services through inpatient, outpatient and community-based services. Services provided include: anesthesia, cardiology, diagnostic imaging, emergency, general surgery, internal medicine, obstetrics and gynecology, ophthalmology, orthopedics, pathology, pediatrics, psychiatry and urology.

Sutherland Harris Memorial Hospital plays an important role in the lives and communities it serves. It has a 12-bed restorative care unit, a 20-bed veterans unit and various outpatient and community programs and services.

Epic moments in medicine — airways

Steven Green
University of British Columbia, Class of 2011

With the usual audience assembled around him at rounds in the ICU, the ever-intimidating internist we'll call Dr. House began another speech. Not content simply to give his opinion on H1N1 vaccinations ("If you don't get vaccinated and then you pass it to your grandma, who then dies. Can you live with the fact that you just killed her?") or to wring the med student through several different impossible clinical scenarios ("Wrong answer. Patient's dead."), he decided that now was the time to explain his thoughts on how an ICU should be run.

"Any idiot can run an ICU," he said, "You just come here and keep doing the same thing that was being done yesterday, and you'll keep most of the people here alive, you'll keep all of them on ventilators, and none of them will leave."

"But giving an order to extubate someone — that takes guts. Most docs are scared of extubation. They'll intubate all the time, but when it comes to pulling the tube out, they hold back. But if you just keep holding back, nothing happens. No one goes home. No one gets better."

He then turned to the nurse in charge of the current patient, a man who had in fact been extubated several times and each time had had upper airway obstruction and been intubat-

ed again, and he said, "We're doing it." While he proceeded to write "EXTUBATE" in large letters across the patient's chart, the respiratory therapist in the corner muttered, "I feel like there should be some kind of epic music for this moment. Maybe an organ."

They proceeded to extubate him, in a fashion deserving of a John Williams score, and Dr. House continued his rounds with a smug grin on his face.

The respiratory therapist in the corner muttered, "I feel like there should be some kind of epic music for this moment. Maybe an organ."

Of course, about three extubations later (all of which referenced his previ-

ous speech), the first guy's nurse came running back saying that he was having significant stridor, aka his airway was obstructed and he needed to be reintubated again.

Cue another speech by Dr. House: "I am, of course, very good at intubating. But I'm not the best. And this guy has had several intubations and likely has significant swelling and trauma to the airways, so he'll be hard." I could probably do it, but if I screw up, I make it harder for the next guy. "Like I said, it's not that I'm not good at intubating — I'm VERY good at intubating. But I'm not the best."

Turning to the nurse, he demanded, "Page anesthesia, STAT."

Within a few minutes, the doors to the ICU parted to reveal the Airway Master. Armed with a British accent and the kind of silver mustache that commands respect, he proceeded straight to the so-called "difficult airway," took a look and said, "Easy."

Laryngoscope in one hand, endotracheal tube in the other (and gloves on neither), he proceeded to intubate with the same nonchalance that I might use while buttering my toast on a Sunday morning.

Dr. House's impression? "See how he doesn't wear gloves? That's a real man."



It was all Greek to me

Jennifer Muir

University of Toronto, Class of 2010

I learned an important lesson in Greece two summers ago. It was something that, as medical students, we're always told, but is hard to appreciate in the absence of personal experience. Whenever a clinical skills tutor back home in Toronto told me that effective communication is the most important skill I'll need to care for patients, my student brain always shouted, "Wait! What about diagnosis? What about knowing which labs to order, what to look for on physical exam, what kind of IV to start? Surely those things are more important!" Now, after immersion in a situation where I faced real communication barriers, my outlook has changed.

I arrived in Larissa, Greece, in the middle of the night. I was a subway, two planes and a long train ride away from home and, although my trip had gone smoothly so far, I was still a little overwhelmed. Not only was this my first time traveling abroad alone, but it was also the first time I'd been surrounded by signs written in a language I couldn't decipher and voices spitting harsh syllables I couldn't recognize. Eyes wandered my way and settled on the out-of-place, white-blonde hair I'd had all my life, but had never been so self-conscious of before.

I was reveling in all this newfound attention when I was greeted by my host, George, who kissed me on both cheeks as he shook my hand. In my other hand was the gift I'd bought for him in the Canadiana store at Pearson Airport — maple-leaf-shaped chocolates filled with Niagara ice wine.

As we drove to the hospital where I would be working during my exchange, George explained, "Most students in Greece know some English because it is a required subject in school." Many also go on to take private lessons to improve their English, especially in the medical field, where a shortage of residency positions in Greece makes studying abroad a near must.

heat, birds flying through the hallways because of open windows with no screens, the absence of computers, everyone — doctors included — smoking and the fact that most of the time I couldn't understand a single word anyone was saying! While George had been right, many of the medical students did speak some English, most discussions were carried out in Greek and any English conversations I had were extremely effortful. After only one week, I was already missing the luxury of fluid, easy communication.

Through a series of laboured and sometimes frustrating conversations, my appreciation of the importance of communication grew enormously.

My tour of the hospital that night was a blur, as was much of my first week in Greece. I spent the time getting to know the Greek medical students, attending their lessons and rounds on the pediatric wards. There was so much to get used to: the intense

I began to spend my free evenings in Larissa's abundant outdoor cafés, and it was not long before the friendliness of the local people became apparent. Often, I was joined at my table by people who were interested in where I'd come from and what I was doing in Larissa. We chatted in broken phrases, waved our hands and played a kind of charades game as we tried to piece together what the other was saying. Through a series of laboured and sometimes frustrating conversations, my appreciation of the importance of communication grew enormously. Just look at what lengths people go to understand and be understood; look at how distressing it is, how helpless one feels when communication proves impossible.

Back at the hospital, I had begun another new learning experience: I was shadowing residents and staff in general surgery. Fresh out of first-year medicine, I had never seen the inside of an operating room, so it was with slight

trepidation that I walked down the long, tiled hallway to OR 1. Pushing aside the swinging door, I stepped into another world. As I gazed down at my first view inside a living human being, my mouth dropped open in amazement behind my white paper mask. The surgeons spoke in hushed tones as they worked on the wide-open abdomen, elbow-deep in small intestine. Surely this was the coolest thing I'd ever seen in my entire life!

I returned to the OR every day for the next three weeks, learning mostly by watching the surgeons, anesthesiologists and nurses. I found surgery to be very visual, but also amazingly auditory and even somewhat olfactory. Here, it didn't matter that I couldn't understand the language, I was taking in laparoscopic images of gall bladders and hernias, the dull squishing sound of hands exploring the open abdomen, the buzzing and beeping of the harmonic knife, the silence during the opening incision and the smell of cautery. I began to marvel at how similar we can be anatomically and yet how different and divided we can be in our thoughts, actions and emotions.

Then again, were we really so different after all? Since arriving in Greece, I had felt a natural divide between myself and those around me, which I had attributed to differences in culture and language. However, when I watched patients being wheeled into the OR, when I studied their body language and their eyes, I recognized a kind of universal language that had nothing to do with words. We are similar in our ability to



read and respond to nonverbal cues and this ability can break down barriers and draw us together. Even glances can be comforting and therapeutic.

After four weeks in Larissa, my exchange was over, but I took an extra month to explore the rest of the country. Camping in my little pup tent from the base of Mount Olympus to the seaside cliffs of the tiny island of Folegandros, I created many more fond memories, met dozens more interesting people and spent a lot of time reflecting on my experiences to date.

What had I learned in Greece? Surely I had come to realize first hand what dozens of Toronto physicians had already emphasized to me — communication is key. The helplessness and frustration I felt when communication broke down, when despite my insistence and hand-wav-

ing I remained disconnected and misunderstood — and the opposite feeling I enjoyed when I finally was understood — was enough to convince and remind me that medicine is as much about the art of communication as it is about the science of diagnosis and treatment.

Yes, it is important to learn differentials, lab indications, fluid balance, etc., but it is equally important to allow your patients to feel heard and understood, to pay attention to what they're saying and what they're not saying and to ensure they comprehend the message you're conveying. To many people, medical terminology might as well be Greek, and visiting the hospital might as well be stepping into another country. In such cases, a kind ear, well-chosen words and a reassuring smile will speak volumes.



Guardian

Medium: Woodcut on rice paper
Allison Chow
Queen's Class of 2010



Sleeper

Medium: Woodcut on rice paper
Allison Chow
Queen's Class of 2010



Anatomy Notes

Medium: anatomy notes (pencil, paper), acrylic paint and glue on canvas board
Kathleen Callanan
Memorial Class of 2013



Sfumato

Medium: Pencil
Jon Lee
Queen's Class of 2010

Edmonton to Oxford — from the wild west to Hogwarts

Peter J. Gill

DPhil Student, Department of Primary Health Care, University of Oxford
MD/PhD Program, University of Alberta

On 22 Nov. 2008, I received a phone call that would change my life forever. I had been awarded a Rhodes Scholarship to complete a DPhil (PhD) in Primary Health Care at the University of Oxford. From this point onward, my life was transformed from CaRMS, reference letters and elective planning, to preparing to move to England to study at one of the oldest and most prestigious universities in the world.

How to describe Oxford?

In trying to describe Oxford to others, I embarrassingly ask people if they've seen any Harry Potter movies. Most people laugh, some stare blankly, others blush and say yes. Hogwarts is very much like Oxford. The dining hall at Hogwarts is filmed in one of the formal halls in Oxford, students at Oxford are members of a college similar to Gryffindor or Slytherin; and students wear a black gown to dinner, special occasions and to write exams. However, there are a few notable exceptions: magic wands are replaced with MacBooks, brooms are replaced with bicycles and owls are replaced with "mobiles."

Life at Oxford

Although medical school is challenging, the pace is fast and decisions are made thoughtfully, but quickly, Oxford teaches you how to think. I've spent the first three months of my DPhil thinking, asking questions and searching for answers. Much of your learning is

accomplished informally. Often I'll meet professors for tea and a biscuit (certain stereotypes are true) or chat to colleagues in the pub over a nice pint of local ale.

Through the Rhodes community, I've had the chance to meet people from all over the world, including Pakistan, South Africa, Australia and Zimbabwe. The Rhodes Scholars are a humbling group of individuals with incredible personalities and wide-ranging interests. Our discussions cover medicine, religion, development, economics and politics.

Oxford is famous for athletics, particularly rowing — a sport deeply entrenched in centuries of tradition. As a member of Magdalen College, a 552-year-old college with nine Nobel Laureates and other notables, including C.S. Lewis, Oscar Wilde, T.E. Lawrence of Arabia and former Prime Minister John Turner among its alumni, I naively joined the novice rowing team. Before long, I was waking up at 6 am for the morning session and biking 10 km to the boathouse each direction. Besides rowing, the abundance of sports is truly remarkable — football (soccer), rugby, squash, cricket, etc. There is no shortage of athletics and no reason to be unfit.

Summary

The move to Oxford has been intellectually and academically challenging, while personally and professionally rewarding. I am privileged to be able to attend such a prestigious



Peter Gill and the Rhodes Scholar from Pakistan, Mohammad Ali Rai, wear their subfusc at University of Oxford's Matriculation Ceremony.

institution, study alongside leaders in the field, partake in world-class research, meet current and future leaders, participate in athletics, travel with ease and become integrated in a fulfilling life. Oxford is an institution rich in tradition, filled with both frustrations and bliss. But Oxford, if you allow it, will leave its mark and transform you in ways that few institutions can.



Oxford: sunny outlook

Raed Joundi

DPhil Student, Neurophysiology, University of Oxford

Queen's Class of 2014 (originally Class of 2011)

I have been in Oxford for only three months, but it feels like a lifetime. When I am asked to describe this place to friends or family, I often hit a mental block and then out bursts a flurry of cheesy words. Magical, enriching, inspiring — these all come to mind in my vague attempts to capture what my experience here has been like so far.

Magical: My heart skips a beat every time I see the great Magdalen Tower jutting out from the landscape, listen to the boy's choir sing in our Harry Potter-esque dining hall or walk through one of Oxford's many spectacular gardens. I still haven't become accustomed to donning a tuxedo and gown for formal events, punting down the river Cherwell on a sunny day (rare) or brushing past the rows upon rows of centuries-old books in the historic Bodleian Library, and I don't think I ever will.

Enriching: Oxford, more than any other place I have been, allows you to be the person you want to be. You are given the tools and raw materials to pursue your passions. When it comes to grad studies, independence is the name of the game at Oxford. What this means in my own case is an open mandate to study the pathophysiology of Parkinson's disease. This lack of direction is scary in the beginning, but the freedom to ask a question and chase it down is exhilarating. Outside the lab or classroom, one has an opportunity to learn about anything and everything. Fascinating speakers, a diverse international student commu-



Raed Joundi, Rhodes Scholar, at Oxford University.

nity, an environment that fosters learning and debating and more coffee shops and pubs than you could shake a wand at, together create the perfect conditions to become, well, smarter. And when your brain starts hurting, there are enough sports, clubs and social activities to complete the experience.

Inspiring: Walking through the streets of Oxford, gazing at the majestic towers with hand-carved gargoyles and knowing that this place has been around for more than 800 years is uplifting. Remembering that these halls nurtured literary giants like J.R.R. Tolkien and medical heroes like Charles Sherrington, William Osler and Wilder Penfield is humbling. But perhaps the most inspirational part is the people. In particular, I am lucky to be a part of the Rhodes Scholarship community which brings together students from all corners of the globe, with the goal of somehow making the

world a better place. And, very quickly, after meeting many of these idealistic and passionate individuals, you see how this could be possible.

Admittedly, there are some rough edges. The grey skies and endless rainfall day after day make you yearn for the slightest crack in the clouds. The dull diet of fish n' chips, steak and potatoes might not be one of Britain's finest points. But through this you come to appreciate the sunnier days and tastier cuisine that much more. And waking up before the crack of dawn to glide down the water in a rowing eight boat reminds you of the endearing, lasting bits of culture that make this place truly special.

In a few years, I am sure I will look forward to returning to medical training at Queen's and putting to use what I have learned here. Until then, I plan to listen to others' ideas, generate a few of my own and, rain or shine, "soak up" the adventure.

Shine a light

Daniel Abramowitz
Queen's University, Class of 2011

By the time the 2010 Olympics began, the flame had traveled for 106 days, over 45,000 km and through 12,000 hands. However, the most special 300 metres — for me, at least — took place in the small town of Napanee. I was lucky enough to be selected to carry the Olympic torch through an essay writing contest sponsored by Coca-Cola. While winning any contest in itself is a thrill, being selected to participate in the Olympic celebration is also an honour.

On the morning of my run, the Olympic torch staff told me two things: everyday is Canada Day when you're on tour with the torch and, for 15 minutes, I would feel like I am Brad Pitt. At the time, the advice seemed like hyperbole, but by the end of the morning I realized it was an understatement.

Riding on the bus to my drop-off location, I was overwhelmed by the tremendous support from Napanee. The torch relay brought the town together and ignited a sense of pride and patriotism in all of the residents. When I arrived at my starting point, I exited the bus with the torch in my hand and a smile from ear to ear. I was immediately mobbed by a swarm of people and camera flashes. Some were family holding signs, some were classmates who came to watch, but most were strangers coming to share the moment.

In the distance, we could see the



Daniel Abramowitz's parents and medical school classmates cheers Daniel on his Olympic Torch run.

torch drawing near. My heart started to beat faster and faster, the crowd started to cheer louder and louder. Then my torch was lit and I was off. I wanted to run at a medium pace and really soak it in, but that went out the window once the torch was ignited. I ran what felt like the fastest 300 metres of my life and just as quickly as it started, it finished. I passed the flame to the next torch bearer, smiled for one last picture as they turned off my torch and I climbed back on the bus for the short drive back to reality. Running with the torch was amazing! I am glad I was able to be a part of the Olympic celebration.



Daniel Abramowitz's Olympic Torch gets lit.



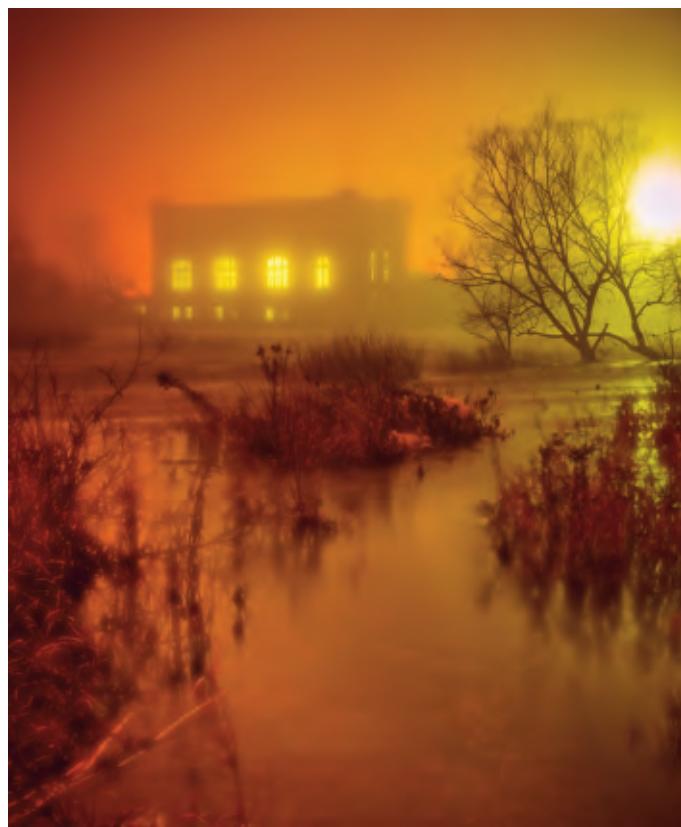
Peace

Medium: Photography
Jacques Balayla
McGill Class of 2012



Quaker Factory in Dead Winter

Medium: Photography
Alex Atfield
Queen's Class of 2012



Midnight Fog at Peterborough Hydroelectric Dam

Medium: Photography
Alex Atfield
Queen's Class of 2012

Palliative case in four sentences

Julie Kvann
McGill University, Class of 2011

“62-year-old male. Known hypertension. Admitted for work up of lungs and liver nodules not yet diagnosed.” My first in-patient: three sentences on a patients’ list. A few weeks later: “Level of care 3, disseminated cancer. Consult palliative care unit.” My first palliative care patient: two sentences. “I want to go back home.” One sentence. “I want to go back home.”

A few drops of water and salt trickled, an IV solution because he was not able to drink anymore. A few more drops this time. He shouldn’t have seen it. I was wearing a surgical mask. He still told me he was sorry to make me cry. It’s me who should have sought for his forgiveness. My mask wasn’t strong enough to keep my emotions all inside.

“At home, I can throw myself out of bed and nobody will say anything. There won’t be any uproar and nobody will come running to help me out. I will have to get back into my bed by my own means. Do it by myself, you understand?” He finally smiled, as if telling me about it made him half-realize this dream.

Something so simple, and yet so complicated.

It would be so inhumane to let a patient fall from his bed and not help him, and yet, if I had the means, I would have given him every medication possible so that he could do it.

Not everything can be cured. But healing is always possible. No matter what is happening. We have the choice.

However, who are we to decide that cure is not possible anymore and that healing is going to take priority? Who are we to decide to use drugs that are not used in any other circumstances because we were thinking, often based more on gut feeling than real evidence-based science, that this patient’s life is ending? Who is really apt to take that responsibility? No one. But we still have to use our knowledge to carefully weigh what is best for the interests of our patient.

Mister C. died during my night shift. The next morning, I took his name off the patients’ list.

Midnight call

Shreyans Shah
McGill University, Class of 2011

The midnight hallway is dimly lit,
But light shines off the coat.
I could walk this route anyway.
The passage is familiar.
I recite my lines,
Everything that I know,
And the movements we choreographed.
It’s opening night.
While the mind is at work,
It also delights in the act,
I am caught in this dance,
Destined to forever change partners,
Tools of the trade I keep them close.
I think of the children long ago listening through
wooden tubes,
Giggling as they see silly grown men put their ears to
a chest.¹
Or those who in their desperation for more alcohol,
And convinced that there are barrels still full of wine,
Percuss their own abdomens pleased that they are now full.²
Even after a hundred years,
A brisk tap below the knee is still enough to make the most
timid person,
Smile at the absurdity of their jerking limbs,
Amused at their brief impulse,
The edges of their smile are raised and symmetric.
I smile back pleased that there is one less thing to look
out for.

1. Linnaec, who is credited with inventing the stethoscope, was supposedly inspired by children playing near the Louvre. As one child made pin scratches on one side of a wooden tube, the other would listen to the transmitted sounds on the opposite end. After inventing the wooden stethoscope, Linnaec comprehensively studied the respiratory sounds of his patients and correlated his auscultatory findings with the lung pathology he observed at autopsy. From this study, Linnaec developed a classification of respiratory sounds that is still learned by medical students today. Linnaec’s findings were originally disputed by the eminent physicians of the time who disputed the efficacy of the stethoscope, preferring the then standard technique of listening directly to a patient’s chest for respiratory sounds. The physician would place a handkerchief on the chest and rest his ear on it.

2. The use of percussion as a physical exam technique is thought to have been transmitted from wine makers who would use the technique to assess the volume of their wine barrels.



Medicine (and TV bingo) in Baie Verte

Julia Stratton

Memorial University, Class of 2012

For two weeks every spring, Memorial University's Faculty of Medicine sends its first-year medical students off to a rural location in Newfoundland (or New Brunswick for the New Brunswick students). This past spring, I was one of those students.

Together with a classmate, I set off to Baie Verte, Newfoundland, with stethoscope in tow. This area of the province was new to us, so naturally we were very excited to see the Welcome to Baie Verte sign seven hours later and stretch our legs due to our "medical student syndrome" — fear of deep vein thrombosis.

The next two weeks were wonderful. Each day would start off with breakfast with the hospital staff (and yes, they would feed us lunch and supper as well) and continue with a combination of clinic time and various community activities. These activities included visiting the mayor, local RCMP officer, the pharmacy, local miners' registry, the high school to provide reproductive education and admission information to prospective medical students and participating in an evening of TV bingo in the long-term care unit. It was quite an experience! For those unfamiliar with TV bingo, you purchase bingo cards at the gas station and tune into the local community channel at a specific time to watch a live bingo broadcast. If you happen to win, you sprint to the phone to call in and claim your prize. Unfortunately, I didn't win.

Experiencing the diversity of rural family medicine was my favourite part

of the trip. The hospital where I did my placement is small, but it serves the 1500 inhabitants of Baie Verte as well as the entire Baie Verte peninsula for a catchment of 7000 people. It has two wonderful full-time doctors and a great nurse practitioner. Together, they run their own practices and the ER with some help from a doctor in a nearby community.

I learned quickly that, although they are family physicians, they have to be adept in all areas of medicine. For example, on my first day of clinic, we were dermatologists removing a cancerous skin lesion, psychiatrists assessing a troubled teen who threatened to kill others and himself, oncologists learning that a long-time patient was going to lose his battle with lung cancer, orthopedic surgeons putting on and removing casts, endocrinologists trying to stabilize an out-of-control diabetic patient and ob/gyns providing prenatal care and performing Pap tests — and the list goes on. My experience also extended outside the clinic, as I traveled to satellite clinics in the surrounding areas and made house calls.

I learned a lot from the one-on-one teaching I received at the clinic and was embraced by the people of the community. I provided them with health care and they reciprocated with life advice. On one memorable occasion, I was even given advice about how to find a husband. So, if you ever get the chance to experience rural family medicine, take it, as it is an experience like no other.



From CFMS to CFMS — lessons in leadership

Lieutenant-Colonel Nick Withers, MD, CCFP
CFMS President 1995–96

As a first-year medical student in a class of 56 at Memorial University of Newfoundland in 1992, I never imagined the excitement and challenges I would face in my professional life! Encouraged by Dr. David Keegan (CFMS president 1994–95), I was elected as the CFMS Atlantic representative in 1993, which led to another executive position as vice-president education the following year. The highlight of my time with the CFMS was my term as president in 1995–96. Little did I know that my experiences would prepare me for the challenges waiting in another CFMS — the Canadian Forces Medical Services.

With financial considerations as the prime motivator, I enrolled in the Medical Officer Training Plan in the summer of 1993. The adage “it seemed like a good idea at the time” has certainly proved to be accurate, which is a little surprising given I had no prior cadet or military experience except my short stint with Beavers as a 7-year old!

Since enrolling, I have had an amazing career in the Canadian Forces. I have lived literally from coast to coast: from St. John’s to Calgary, Winnipeg to Goose Bay, Ottawa to Comox. My family even had a chance to live in Germany for about two years. Each of these locations has had some unique challenges, but it’s been rewarding.

What is perhaps the most memorable period has been my time with

our Special Forces. I had the privilege of working with our elite from 2000 to 2003, and I participated in training and operations that were truly amazing. Subsequently, I was senior physician with Canadian Special Operations Forces Command from 2007 to 2009.

Take this responsibility seriously and use your intellect and abilities to improve the lot of those around you.

My time in Germany would be a close second to this time with Special Forces. In 2006, the Canadian Forces unexpectedly began to take casualties in Afghanistan at an unprecedented rate. I was tasked to liaise with the US hospital in Landstuhl and assist in the aeromedical evacuation of our injured to Canada. The strength and resolve that these soldiers and their families demonstrated during the most difficult of circumstances was an inspiration to me and has changed my perspective on life forever. “Don’t sweat

the small stuff” has been my mantra ever since!

As a student representative within the CFMS, I recall high-profile presentations to the CMA and numerous other groups, which were far more exciting than much of the “grunt” work like organizing meetings, completing reports and laying the foundations for the organization. However, these skills have proven invaluable as I have progressed into the senior ranks of the Canadian Forces.

I recall being quite anxious about public speaking as the CFMS VP Education, but repeated opportunities have allowed me to hone these skills and become far more comfortable in this realm. Communication skills are critical to a leader and this prepared me for numerous live CBC interviews that I would later conduct in Germany to update Canadians on the recovery of our soldiers at Landstuhl Regional Medical Centre.

Managing clerkship with the responsibilities of CFMS president ensured that I managed time effectively. This skill has become incredibly useful as I currently balance my home life (with children aged 3, 6, and 8 years) with a busy career and a part-time emergency medicine practice. My perfect wife Heather has made this much easier, so choose your partner wisely!

There are a few lessons I have learned from outstanding leaders within the Canadian Forces. “Perfect is the enemy of good and it

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will never be perfect." It is difficult for many of us with obsessive-compulsive disorder — you know who you are — to accept less than perfection. Unfortunately, we sometimes let form obstruct function and, consequently, we delay initiatives until they are perfect, but too late to be relevant. Sometimes we need to provide the 90% solution accepting that the last 10% will require disproportionate time or resources. I did not learn this lesson until recently, so I likely drove the remainder of the CFMS executive crazy during my tenure.

In my emergency medicine career, I sometimes fall back to the position of "Don't just do something, stand there." Particularly in the emergency department, we are very anxious to act and, indeed, this is often required to save lives. However, we must also recognize when it is in the patient's best interest for us to do less, be it invasive procedures or expensive testing and instead practise the art of medicine. This cannot always be appreciated while mastering your skills as a medical student, but it becomes very apparent as a community ER physician.

As physicians (or physicians-to-be), we have been afforded amazing opportunities and privilege. Regardless of your specialty or position, you will be considered a leader in your clinic, hospital or community. Take this responsibility seriously and use your intellect and abilities to improve the lot of those around you. If you eventually find yourself in an administrative position, I strongly urge you to maintain a clinical practice so that you can truly provide clinical leadership to your organization.

Where they are now?

Dr. Chris Pollock, Vice-President Finance 2005–2007

I can't believe how quickly time is passing. I'm already halfway through my 5-year residency here in BC! I'm eagerly counting down the months until my fiancée and I will be able to move back to Ottawa and start practising.

Dr. Paul Gross, CFMS Quebec Regional Rep, 2005–2006, McGill rep 2004–2006

I am originally from Montréal and received my medical degree from McGill University in 2007. I completed a residency in family medicine at St Paul's Hospital in Vancouver. Currently, I am doing a 3rd-year fellowship in international health through the Department of Family Practice at UBC. My professional interests include global health, aboriginal health, tropical medicine, HIV, addictions medicine, palliative care and ecosystem health, particularly how it pertains to climate change. I will be going to Malawi to work with Dignitas International in March–April 2010. My long time love, Carolyn, and I were married in April 2009 in Mexico, just before H1N1 hit. We are happily married and have no plans to leave Vancouver in the near future.

Allison Meiwald, Vice-President Communications 2005–2007

I've finally begun my last countdown! I'm officially closer to the end of my residency than the beginning — more than two and a half years in and I'm pacing myself for the homestretch.

Completing undergrad, medical school and residency is definitely a marathon and not a sprint. As you move through each phase, it seems

there are many markers that are anxiously approached with a countdown: one week until the MCATs, 2 months until acceptance or rejection letters are out, halfway through clerkship, only one more CaRMS interview, one hour to match time, four days until I'm a resident and, now, only two and a half years and I'll be a real doctor!

Although nervousness accompanied all these points, excitement was also just bubbling under the surface. As you move farther along in residency, your level of independence increases. Little by little you realize that you might actually be starting to figure things out. You're finally used to being called "doctor" and having to "give orders." You only have to think a therapy through twice instead of half a dozen times before prescribing it. And this is exhilarating! You are trusted, asked for your opinion, treated as a colleague.

For me, that excitement is starting to grow. When I was a child, I would tape together strips of cardboard and make loops out of them to make them a "chain" as my countdown to Santa. Each day in December, I would tear off one loop. I'm so excited to be on the down slope that I feel like making a chain with just under 900 loops and tearing one every day from now until 30 June 2012! It's my last countdown and I can't wait to get my career started — to not second guess myself, to be an attending, to have lots of medical students asking questions about my specialty.

I know that for an emergency room physician, there will always be day to day excitement, definitely something worth counting down to. Now, if only I knew how many loops I need to start my countdown to retirement.

Dr. André Bernard, President 2005–2006, Vice-President Finance 2004–2005, Vice-President International Programs and Partnerships 2002–2003

Greetings from England! My time with the CFMS still feels like yesterday and it excites me to see the organization growing and evolving as time passes! As many of you know, I was involved from 2002 to 2007, during a time of rapid and vibrant change for the CFMS. As I reflect on it, we "grew up" significantly during that period. From maturing our policy stances to enhancing the sophistication of our communications, representative and advocacy efforts, the CFMS demonstrated confidence and widespread credibility among members, national partners, the government and other stakeholders. The CFMS of today has been built on over 25 years of exceptional work by exceptional people. This collective accomplishment is something of which the medical students of Canada can be proud!

Where have I been since my time with the CFMS? After my year as president, I matched to anesthesiology at Dalhousie University. My formal organizational involvement continued as I took on the roles of treasurer and subsequently vice-president of the Professional Association of Residents in the Maritime Provinces (PARI-MP). I also spent two years on the Board of Directors of CAIR, chairing its Advocacy and Policy Committee in 2008–2009.

As I write this, I'm in my fourth year of residency, but have taken a hiatus to do a master's of science in health policy, planning and financing at the London School of Economics and



Political Science (LSE) and the London School of Hygiene and Tropical Medicine. This has been an incredible experience for me, providing an opportunity to fuse a dedicated interest in health systems, policy and global health with a passion for clinical anesthesiology. I will return to Dalhousie in September 2010 to resume my clinical duties and hope to practise anesthesiology in Halifax when I complete my residency training.

On a personal note, on 18 July 2009, I celebrated my marriage to my partner of seven years, Sean Foreman. Family and friends from around the world joined us to mark the occasion. We were particularly touched by the attendance of our dear friend Rosemary Conliffe, your CFMS general manager, with whom I keep in touch regularly!

I'm always happy to hear from anyone affiliated with the CFMS — past or present (andrebernard@gmail.com)! Best wishes to any alumni readers with whom I had the pleasure of working over the years!

***Phil Doiron, CFMS Ontario
Regional Representative 2007–
2008, CFMS Representative to
CAIR 2007–2009***

After finishing medical school at McMaster University in the spring of 2009 (but not before running off to Cuba for a week with some of my favourite classmates and friends), I moved to Toronto and started a residency in dermatology. I cannot believe the year is almost half over. The Canadian public is that much safer — well at least until next July. I am very happy I managed to sneak in one last CFMS AGM (Thunder Bay September 2009) — so many great memories! Best wishes for the future, I look forward to hearing much more amazing news from the CFMS.

CFMS alumni babies



Dr. Nick Rose, MD, PhD, Dip Sports Med (CASM), Emergency Medicine Chief Resident, University of British Columbia, his wonderful wife Jenn and their two beautiful children



Isa Lucille Barrett Martin, born on 8 Oct. 2009, daughter of Dr. Danielle Martin (CFMS President 2002–2003) and Steve Barrett



Benjamin Firszt, born in June 2008, son of Dr. Ray Firszt (CFMS VP Finance 2002–2004) and Alyssa Firszt



Dr. Herbert Brill (CFMS VP Finance 2000–2001) with his son, Morrison Nethaniel Brill, born 3 Aug. 2009 at 23:59, one minute before his due date!

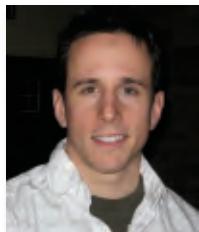


Aden McIsaac, born 27 Nov. 2009, son of Dr. Dan McIsaac (CFMS VP Services and CFMS Representative to the Medical Council of Canada 2006–2008) and Laura McIsaac

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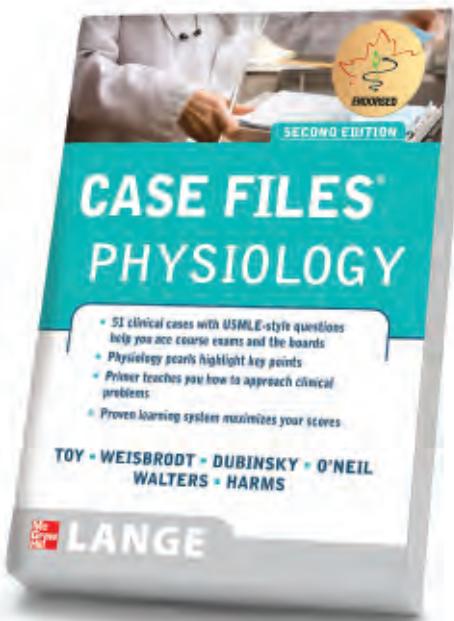
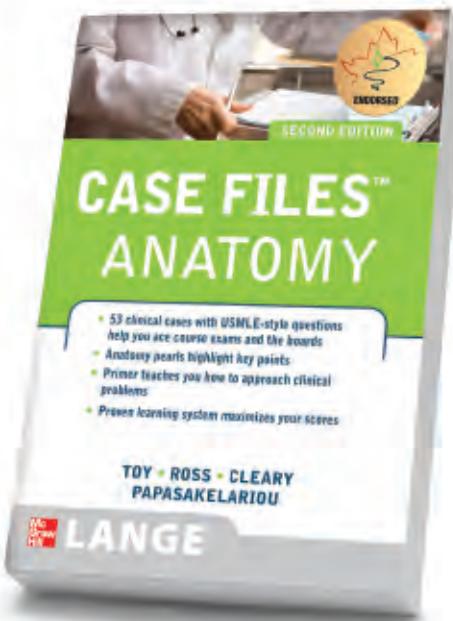
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