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

ANNUAL REVIEW 2017



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Our Mission

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

Our Vision

Tomorrow's physicians leading for health today.

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

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

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

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

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

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

Not a CMA member?

YOU SHOULD BE.

Justin Hall
Medical student
CMA member

Some of the our most popular member benefits include:

- **Advocacy and Representation:** The MD-MP Program connects you with your local representative to enable grassroots advocacy in your own community.
- **Medical e-resources:** Access leading clinical tools and apps including ClinicalKey, DynaMed, RxTx Mobile App and online textbooks
- **MD Financial Management:** Owned by the CMA, MD can help you with debt and credit management, budgeting, insurance advice and much more
- **Member Discounts:** travel, hotels, car rentals, cellphone plans, mobile software, fitness and leisure

For more information, visit:

cma.ca/students



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Cover art

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-William Osler

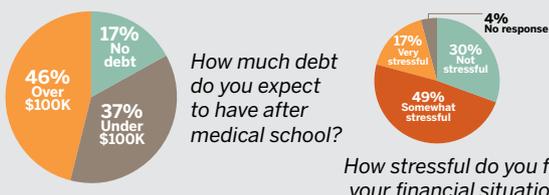
Artist
Usman Khan,
University of Ottawa,
Class of 2019 and
CFMS Official
Photographer 2016-17

4 FINANCIAL CHALLENGES OF MEDICAL SCHOOL

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

1. CRUSHING DEBT

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



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

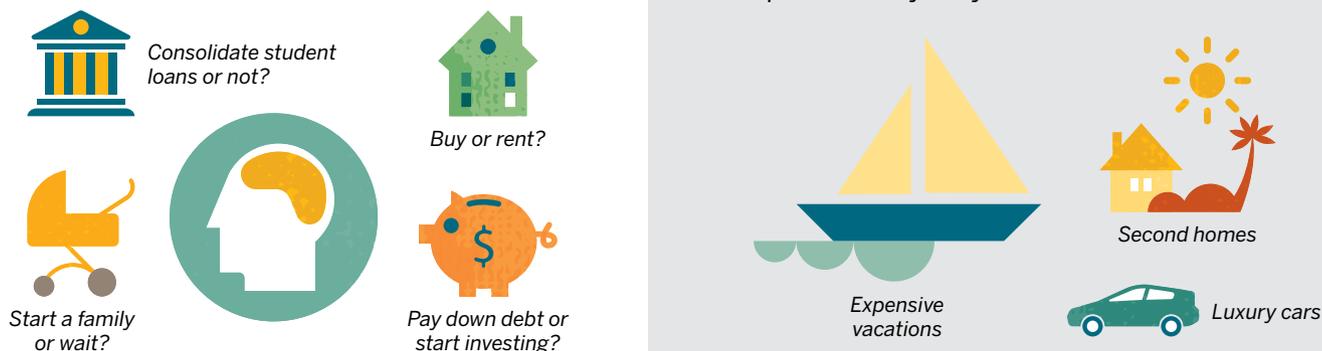
2. EXTRA EXPENSES BEFORE RESIDENCY

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



3. CRITICAL DECISIONS DURING RESIDENCY

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



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As a member of the Canadian Medical Association, you'll benefit from having access to MD Financial Management. MD is the only financial management company dedicated to physicians and is the exclusive financial services partner of the Canadian Federation of Medical Students.

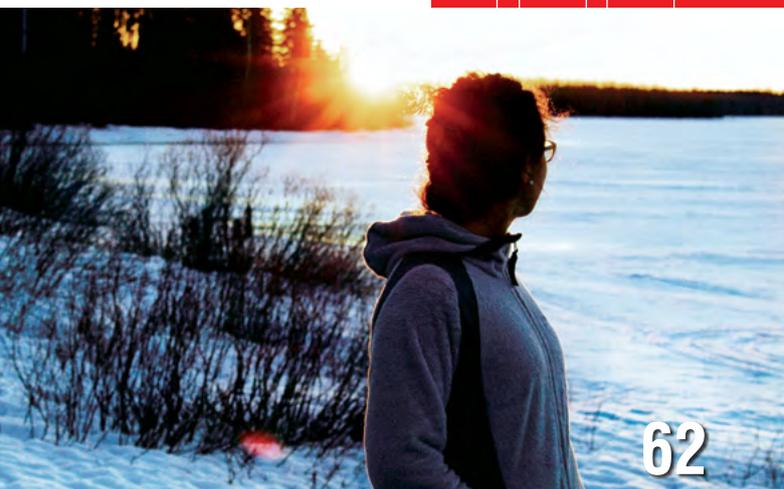
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Letter from the editors

Dear friends and colleagues,



Darwin Chan
Annual Review Editor
McMaster University,
Class of 2018

In 2017, the Canadian Federation of Medical Students celebrates its 40th anniversary of *representing*, *connecting* and *supporting* medical students in Canada. We've decided to highlight this milestone with a special edition of the *Annual Review*, which reflects on 40 years of medical student advocacy through the eyes of the CFMS alumni. This includes contributions from notable physicians such as Drs. Danielle Martin, Andre Bernard, Jesse Kancir and many more.

The Canadian Federation of Medical Student Societies (CFMSS) was first formed in 1977, after student representatives to a meeting of Canada's medical faculties noticed the student's perspective was underrepresented and not adequately unified at the national level. Two years later, the Federation held its third annual meeting, during which its name was formally changed to the Canadian Federation of Medical Students (CFMS). In these early years, the organization's priorities included surveying the financial burden of medical studies across the country, reducing the cost of textbooks and supplies to the membership, organizing summer exchange programs for pre-clinical students, and centralizing the information related to elective programs.

Many of these same priorities are reflected in the CFMS' work 40 years later. Through the Student Affairs portfolio, members are working to evaluate the financial burden of modern medical education across this country, including the extensive hidden fees and expenses. The Student Affairs portfolio also maintains and negotiates the many member services and discounts, with special deals for educational tools, textbooks, flights, hotels, train tickets and many more! The CFMS Global Health portfolio continues to organize exchange opportunities for our students, among its many health equity projects. Last year, there were 186 medical students representing Canada on international exchanges around the world.

In those early years, the CFMS worked to centralize information for away electives. Through its current advocacy work in this area with the Association of Faculties of Medicine of Canada (AFMC), the Federation has helped promote and develop a unified process for elective applications in Canada. In February 2017, it was announced that the final three medical schools would be imminently joining the AFMC's Electives Portal, thus creating a single centralized system for all elective applications in Canada.

Despite the incredible growth of the CFMS through the years, the organization's core activities remain rooted in the priorities of the membership: the medical student in Canada. The specific context of these activities may have evolved, but the underlying principles have remained largely unchanged.

This special edition of the *Annual Review* allows all involved with the CFMS to reflect upon decades of incredible work past, and to align ourselves for years of good work to come. Our cover (designed by Usman Khan) for this issue is a tribute the faces of our future; that of the Federation, of the medical profession and of healthcare in Canada.

On behalf of the thousands of medical learners, physicians and Canadians who have benefitted from the work of the CFMS, we thank you.

Celebrating 40 great years and the many more to come,

Emily Hodgson
CFMS Executive VP and VP Communications
McGill University, Class of 2018

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

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Letter from the president

Dear CFMS members, alumni, organizational partners, colleagues and friends,

2017 marks the 40th anniversary of the Canadian Federation of Medical Students (CFMS). Inside the pages of the 2017 CFMS *Annual Review*, you will experience highlights and reflections of the remarkable history of this organization and witness a glimpse of the incredible transformative work and impact made by Canada's medical students.

It has been an honor and privilege to serve the CFMS and its members this year as CFMS President. I have endeavored over the past year to further our mission to connect, support, and represent our membership at the national level. I am proud of the current Executive Board, the 39 who have come before us, and the organization who strive to do the same.

Key priority areas this year center around 3 themes:

1. **The transition to residency.** Deciding which specialty to apply to, selecting electives, and participating in the 'match' are some of the most stressful aspects of being a medical student. This inherent stress has been confounded by Health Human Resources (HHR) challenges and unmatched Canadian Medical Graduates (CMGs). Over the past three years, the CFMS has been strongly represented on the Physician Resource Planning Advisory Committee (PRPAC), a national steering committee funded by Health Canada composed of representatives from federal/provincial territorial governments and from national medical organizations whose aim is to provide pan-Canadian understanding of population physician needs. In addition to developing a national physician supply and public need based model, which will be released in 2018, this group has championed the unmatched CMG and is undergoing a consultative process to better understand this critical topic. Secondly, this year the CFMS and our partner organizations, the Resident Doctors of Canada (RDoC), Fédération médicale étudiante du Québec (FMEQ), and Fédération des médecins résidents du Québec (FMRQ), are meeting, for the first time, regularly with CaRMS to discuss learner concerns pertaining to the match to develop a revised applicant contract. Thirdly, I am working closely with the Association of Faculties of Medicine of Canada (AFMC)'s Residency Matching Committee (ARMC) to investigate and act on interview and match process breaches. These are a few examples of how the CFMS is supporting and advocating for our members.
2. **Learner wellness.** The CFMS has made great strides this year in its efforts to support its members. After two years of development, the CFMS-FMEQ Wellness Survey was administered in winter 2016. After a year of robust data analysis and writing, the first of many peer-reviewed academic articles was published this winter (2017). This project provided insight into the challenges learners may experience while pursuing undergraduate medical education. The CFMS is continuing with national partner organizations to better understand these stressors and to work to ameliorate them. Over the course of 2017, opportunities will be available for members to participate in further academic inquiry. Stay tuned for opportunities.
3. **Organization structure & capacity.** The CFMS is in the final year of our 3-year 2014-2017 strategic plan. This highly consultative plan identified core project themes for the organization. While as an organization, we have achieved and surpassed many aspects of this plan, we were often faced with capacity and operational barriers. Reflecting upon our 40-year history and our humble roots, the CFMS significantly outperforms its capacity. However, this is unsustainable. Aligning with our 40th anniversary, the executive has a dedicated focus to ensure organizational sustainability. This will take form through an operational focused 2017-2020 strategic plan. Led by our Past-President, Dr. Anthea Lafreniere, and by Human Resource consultants, the CFMS is in the process of writing this plan. Our goal is that with increased capacity, the CFMS will continue to grow and support member-developed initiatives.

In meeting medical students from coast to coast, I have been inspired by the incredible things they accomplish each and every day. Medical students advocate for patient health, perform world-class research, teach and create curricula, and practice wellness - all while vigorously tackling their medical studies with the goal of providing the best patient care for Canadians. I want to thank all of Canada's medical students who volunteer their time in so many different ways - I am humbled to be counted among you.

Sincerely,



Franco A. Rizzuti, BSc



Franco A. Rizzuti
President
Cummings School of
Medicine
University of Calgary,
Class of 2017

CFMS' 40th Anniversary: a retrospective look at the past 40 years of presidents

THE CANADIAN FEDERATION OF MEDICAL STUDENTS HAS A RICH HISTORY. AS AN ORGANIZATION, we have been graced by the leadership of stellar individuals, each with unique accomplishments during their terms. Here, we look back and reflect on their experiences and learn about what they are doing now.



CFMS President 1977

Leo Plouffe, Jr. MD, CM

Vice President, Global Head of Risk Management Pharmacovigilance

It is so great to hear from the CFMS! It is equally great and exciting to see the dynamic spirit that animates CFMS. Congratulations on 40 years.



CFMS President 1989

Bradley J. Dibble, MD, FRCPC, FACC

Medical Director, Cardiovascular and Renal Program and Physician Lead, Division of Cardiology, Royal Victoria Regional Health Centre, Barrie, ON

Congratulations on the 40th anniversary! I feel privileged and honoured to have been involved in this very important organization during my medical education, initially as the junior representative from the University of Western Ontario (now known as Western University), then as the Vice President of Communications, and ultimately serving as its president in 1989. And it started me on a journey that I am still taking to this day.

So what do I mean when I refer to my journey exactly? Well, when I started medical school a little more than 30 years ago, there was a lot of political turmoil with the Ministry of Health within the province of Ontario. So once I joined the medical profession, even in my earliest stages as a first-year medical student, I wanted to help fight and make a difference. We dealt with the banning of extra billing for physicians and the dissolution of the so called “third stream” to licensure, forcing all physicians to complete training within either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, two battles we ultimately lost to the powers that be. But during my tenure, the CFMS also helped to create

an interest-free loan available to medical students that didn't have to be paid back until the completion of all medical education, initially through the Toronto Dominion bank.

If there was any message I would impart to the future physicians of Canada through the CFMS, it's this: be active, be involved. It doesn't have to be in medical politics. But there are other things outside of politics you can do that also make a difference. It might be as simple as coaching your kids' soccer team. Or developing a new program in health care in your clinic or hospital. But it can be also be much bigger. Like fighting a pipeline. Or ensuring that vaccinations are available for children in developing nations. Or supplying medical equipment to an African nation like my friend (and current medical student) Kelly Hadfield is doing. Canadian physicians have done and continue to do wonders that make this world a better place. Please use your own unique gifts and talents to contribute in any way you can.



CFMS President 1994-5

David Keegan, MD, CCFP(EM), FCFP

Associate Dean, Faculty Development, Cummings School of Medicine, University of Calgary

When we think of the CFMS/FEMC, we immediately think of how our predecessors - Drs. Simon Kirby and Natasha Leighl and others - handed over a strong organization to our cohort of the early to mid-1990s. We were grateful to have inherited a CFMS that was well respected by all the other national medical organizations and a CFMS that was in the right committees and forums to have an impact.

And then the party began! Those were lean times for the CFMS, leading us to have executive meetings at people's houses, where we slept on floors, made pancakes in the morning, and then got down to work in representing medical students. It was a time when we considered replacing the Swoosh as a logo and ended up embracing it. It was a time when the IFMSA was a neat opportunity to expand the training options for Canadian medical students.

Those were also difficult days when there were more students graduating than there were positions available in the CaRMS match, when provinces brought in numerous plans to restrict the ability of new graduates to practice, and when we even had to develop subtle understanding of the U.S. Visa system to preserve the ability of medical students trained in Canada to be able to train in the United States.

Looking back, the CFMS provided us personally with an incredible understanding of the Canadian medical training system and provided loads of opportunities to learn how to interact with formal institutions to get real change implemented that increased the fairness in the system. Just as important: through the CFMS we made and strengthened friendships. And if it were not for the CFMS, we would likely have never met, and would never have shared our lives together over these last sixteen years.



CFMS President 1995-6

Nick Withers, CD, MD, CCFP(EM), FCFP

Emergency Medicine Physician, Cowichan District Hospital, Duncan, BC

As the president in 1995-6, there was always some concern about the future of the organization. At that time, we existed on a shoe-string budget and were concerned with raising membership fees by a meagre \$2.50 per year! It was commonplace to host executive meetings at someone's home or have six or eight people crashing in an apartment to minimize costs. No Skype, no iPhones, not even much of an internet! I recall typing my first e-mail on an old Mac when I was Atlantic Regional Representative in 1993 - how times have changed. The amazing friendships made during my tenure with the CFMS have endured and they remain one of my most cherished.

I now see a vibrant, dynamic organization representing the needs and concerns of medical students

and patients both in Canada and abroad. I salute the current leadership and all the amazing people that have contributed to the success of the CFMS. I must also recognize the Canadian Medical Association, the Association of Faculties of Medicine of Canada, Federation of Medical Regulatory Authorities of Canada, and others who provided support and a place at the national table when the CFMS was just in its infancy.

I challenge current students and future generations of medical trainees to stay true to principle, hold us "old-timers" to account and never lose your enthusiasm toward enhancing healthcare delivery both at home and abroad. Congratulations and good luck in the next 40 years!



CFMS President 1996-7

Kevin Busche, MD, BSc, FRCPC

Assistant Professor, Department of Clinical Neurosciences and Assistant Dean, Undergraduate Medical Education, Cummings School of Medicine, University of Calgary

I think the biggest thing that happened during the time when I was directly involved was the collaboration between the CFMS and the IFMSA. I can fondly remember that first IFMSA meeting that the CFMS attended. We had a group of about 12 CFMS representatives who made their way to Prague for a series of interesting meetings and had the chance to interact with medical student leaders from around the world. It was also our first introduction to the world of negotiating elective slots with other countries. Canada was very, very popular and some of the discussions got rather heated!

After my time with the CFMS was through, upon reflection, it was clear to me that I had gotten more out of the experience than I would have ever thought possible. Spending time interacting with the leaders of medicine in Canada allowed me to learn about healthcare as well as practice the skill of thinking on my feet and expressing myself in situations where I might not have felt 100% comfortable.

I think it is important for the CFMS to continue to bring the voices of medical students to the table. Medical students have a unique and important perspective on both medical education and healthcare delivery.



CFMS President 1997-8

Joshua Tepper, MD, MPH, MBA

President and CEO, Health Quality Ontario and Associates Professor, University of Toronto

Accomplishments:

The most significant accomplishments during my presidency year were having the CFMS join the IFMSA, having students join the CMA board, and publishing the first position paper on the mental wellbeing of our medical students. I am particularly proud of the last one even though it was “just a paper.”

Highlights:

Notably, being able to work with a phenomenal group of people with tremendous passion, intellect, and vision for what the future of medical students could be. Some of my closest friends and people I admire the most are

from my time with the CFMS. I don't think it still exists but I was almost reduced to tears when they created the CFMS J.D. Tepper Bursary for Rural and Underserved Initiatives.

Moving Forward:

We need students willing and able to lead at the local and systemic level, to give their voices and passion to the betterment of the system for patients - particularly those who are marginalized. We need future doctors to embrace quality as part of the job, involve patients as partners in care, and see how the broader social determinants of health influence each interaction.



CFMS President 1999-2000

Tara M. Mastracci, MD, MSc, FRCSC, FACS, FRCS

Clinical Lead, Complex Aortic Surgery, The Royal Free London NHS Foundation Trust, The Royal Free Hospital, London, U.K.

Although my time as president of the CFMS gets further from recent memory with each passing year (and each strand of grey hair), the opportunity I was given to work with and serve medical students across Canada had an unquantifiable impact on the physician and surgeon I have become. Participating in public advocacy puts anyone's experiences into context. However, when it coincides with early medical education, the opportunity to be part of a national organization provides an immeasurable perspective

of a physician's responsibility for our society's health. Working with the CFMS taught me that the concept of health went beyond what was recorded on the vital-signs charts at the end of the hospital bed: if doctors did their job correctly, both the health of our patients, and our society would benefit. This was a humbling realization as a medical student.

During my time at the CFMS, we worked for access to rural health, expanded international collaborations, and debated professionalism in practice. We learned

about the richness of diversity throughout our society by interacting with each other, our senior colleagues, and community leaders. Without the CFMS, I may have been much slower to realize my responsibility for the health of society, and my duty as a physician to hold political leaders to account for the principles that embody Canadian healthcare, and even slower to appreciate the negative impact when we, as a profession, neglect that duty.

Many Canadian medical graduates may choose, as I did, to expand their practice beyond the Canadian borders. Although I miss living in Canada, as I have

matured as a surgeon, I have carried the lessons I learned in the CFMS forward with me, and the principles of Canadian Health continue to drive my practice. Providing excellent and evidence based care is essential – thus what defines me as Canadian also defines me as a surgeon, and much of that identity was because of the exposure I gained from the CFMS. I am so grateful and proud to have been a small thread in the fabric of the CFMS's wonderful history. I wish the organization, its current and future members, congratulations on the strides you have made, and the very best for the years to come.



CFMS President 2000-1

Jason Kur, MD, FRCP, ABIM

Rheumatologist, Vancouver, BC and President, BC Society of Rheumatologists

In 2017, it would appear obvious to all healthcare professionals that an articulate and well organized medical student voice would be present at the medical education table in Canada. Yet, surprisingly, this voice has not always been present. One of the biggest accomplishments of the CFMS in the late 1990s was advocating for student representation at all levels of the medical education process, and, moreover, that medical student representation should be vocal in other organizations which make decisions that critically impact the practice of medicine and the delivery of health care in Canada. In the 1990s, however, the idea that medical students be represented was not always shared by our more senior physician peers.

With the growth in representation and the

concomitant responsibility placed on the CFMS, the CFMS required a more professional presence in Ottawa. Our presence in Ottawa allowed for our voice to be heard, and it brought with it the possibility of sustained long-term outreach with our sister organizations. All these elements led to one of the best decisions we made in 2000, recruiting Rosemary Conliffe as our office administrator. She became our vital linchpin in Ottawa. Her continued presence and expansive knowledge has been invaluable for countless medical students and CFMS leaders since. In closing, I would like to take this opportunity to extend my deepest gratitude to Rosemary for all the wonderful work she has done for the CFMS.



CFMS President 2002-3

Danielle Martin MD, CCFP, FCFP, MPP

*Family Physician and Vice President, Medical Affairs and Health System Solutions, Women's College Hospital
Assistant Professor, University of Toronto*

Please see page 17.



CFMS President 2003-4

Sayeh Zielke, MD, MBA, FRCPC

Cardiologist, Medical Director, Chinook Cardiology, Lethbridge, AB

The CFMS continues to be one of my favorite organizations that I have been involved with. The three words that best describe my thoughts on CFMS are: idealism, energy, and productivity. I always felt that as a group of students, we accomplished so much with so little. Though there are many highlights and accomplishments that I reminisce about from my year as CFMS president, there are a few that stand out to me, including: the organization of the first CFMS Lobby Day on Parliament Hill and the production of

the first *Annual Review* (only a few pages). However, what has surpassed any accomplishment and survived the test of time are the remarkable relationships formed through the CFMS. I continue to cherish the friendships formed during my time at the CFMS with other students, colleagues, and especially our very own wonderful Mrs. Rosemary Conliffe. I am also particularly grateful to have met my now husband of ten years through my travels during the year I was president.



CFMS President 2004-5

Ashley Waddington, MD, MPA, FRCSC

Assistant Professor, Department of Obstetrics and Gynecology, Queen's University

I have continued to follow the work of the CFMS by reading the annual reports and I am so thrilled by the continuing development of the organization to meet the needs of medical students across Canada. I remember my involvement in the CFMS as a very empowering time. It felt like our voices were heard when we spoke on behalf of medical students and patients. That sense of having a voice has stayed with me as I have continued to advocate on behalf of patients and the medical profession through involvement in the Society

of Obstetricians and Gynecologists of Canada (SOGC), in my residency program, and in my current position as an academic clinician. Never doubt that your experience and knowledge matter. Often, you are the only person who knows and cares about an issue as much as you do! Make the effort to engage with others and share your experiences while learning from theirs. I think that is how effective change can happen, but it is always incremental so don't give up if you don't solve an issue on your first try!



CFMS President 2005-6

André Bernard, MD, MSc, FRCPC (Anesthesiology)

Assistant Professor, Anesthesiology, Dalhousie University

Medical Director, Pre-Op Clinics, QEII Health Sciences Centre, NSHA

Board Chair, Doctors NS

I've said it many times over the years: among all the organizations with whom I have had the pleasure of working, the CFMS stands out as the most agile, productive, and dynamic. Since entering practice in 2012, I served the CMA as its representative to the World Medical Association and presently chair the Board of Directors of Doctors Nova Scotia. My leadership outlook today was largely shaped by my time with the CFMS. As we (and I still say 'we') celebrate 40 years, I raise up the CFMS as a catalyst for both

leadership development and for nurturing medical students to be agents for transformative action. I am struck by the legacy of the individuals who commenced their medical leadership through the executive of the CFMS. Issues and burning platforms come and go (and indeed sometimes stay the same!), but how the CFMS transforms medical students into dynamic change agents is what impresses me the most about we have accomplished over our history.



CFMS President 2006-7

Philip HJ Brost, BSc, MD, FRCPC

Staff Psychiatrist, MDABC and Staff Psychiatrist, Vancouver Coastal Health at Ravensong Mental Health Team

Highlights:

When I think of my time with the CFMS, the highlights remain the personal and the collegial. Working with the CFMS allowed me the opportunity to challenge my understanding of medical education and health care to incorporate both national and international perspectives, all while developing lifelong friendships with amazing people with whom I remain in touch to this day.

Moving Forward:

I think involvement with the CFMS allows medical students an important seat at the table where the ever-evolving conversation regarding both medical education and healthcare in general is occurring. As the future physicians of Canada and the World, it is important that their voice continue to be heard.



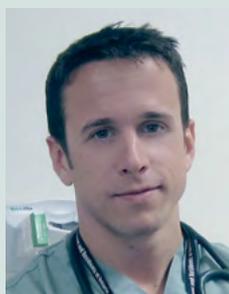
CFMS President 2007-8

Shaheed Merani, MD, PhD, FRCSC

Fellow in Transplant and Hepatobiliary Surgery, University of Nebraska Medical Center

The Canadian Federation of Medical Students has always been uniquely situated to have a fresh view of the opportunities to advance the health of Canadians and the world. Therefore, I am thrilled to see the organization celebrate its 40th anniversary. While I expect many of the issues faced by the CFMS have evolved somewhat in the years since I was president, I trust that the organization will continue to engage and empower Canadian medical students in health

advocacy. During my time with the CFMS, we found that collecting, housing, critically analyzing, sharing, and ultimately advocating with primary and secondary data was recognized by stakeholders as a valuable way to advance our shared goals at the national level. I encourage the CFMS executive to continue to work with member societies to help them reach their goals. Congratulations and best wishes for the years ahead!



CFMS President 2008-9

Jonathan DellaVedova, MD, FRCPC

Consulting Pediatrician

Assistant Professor, Clinical Sciences Division, Northern Ontario School of Medicine

Accomplishments:

- We successfully bid for the IFMSA General Assembly in Montreal.
- We published the first edition of the Matchbook.
- IMGs joined the CaRMS match first round, but we successfully prevented the “open” match many were advocating for.
- We made the initial presentation to the AFMC for what would eventually become the common electives portal.
- We started the CaRMS “sweep” - so many specialties would host their interviews centrally or logically from west-to-east or east-to-west.
- We adopted the green charter for the CFMS and medical student societies.

Highlights:

I still remember very fondly my time at the CFMS. Ultimately the highest highlight was the friendships I

developed, many of which have carried forward nearly a decade. And not just electronic stalking through social media - we actually get together whenever possible, travel to see each other, and even spend some vacations together. The CFMS really brings together people of a certain service-minded “above-and-beyond” character that is sometimes difficult to find elsewhere.

Moving Forward:

As for major opportunities for medical students and residents these days, I am already blown away by the resumes I read during residency applications. The degree of community engagement and commitment to disadvantaged groups should be broadcast for all the world to see: this is what our youngest generation of doctors has been up to! What I would like to see is a generational takeover and a return to social justice principles amongst older physicians. It may take our students to drag us there!



CFMS President 2009-10

Tyler Johnston, MD, MPA, MPH

Emergency Physician, Muskoka Algonquin Healthcare, Huntsville, ON

Accomplishments:

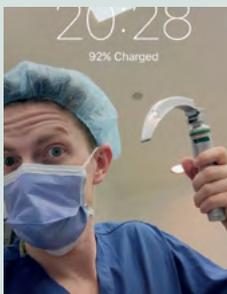
1. The CFMS's 1st Strategic Plan - meant to ensure we provide value to our members and do the things they want us to do.
2. Non-Profit Banking Legislation / RBC Banking Deal - helped secure the financial viability of the organization going forward.
3. Advocacy regarding medical student debt and deferral of student loans during residency - testified before Federal Finance Committee in Ottawa.
4. Advocacy regarding underrepresented groups in medical schools (low-income and rural individuals).

Highlights:

1. Working with all the wonderful people on the executive committee and in the other national medical organizations.
2. Testifying before the Federal Finance Committee.
3. Working closely with Rosemary Conliffe.

Moving Forward:

1. Ensuring student input in competency based medical education.
2. Engaging the public to mobilize them and enlist their assistance with major issues in healthcare (e.g. system financing, system design, health human resources).



CFMS President 2010-11

Matthew J. Sheppard, MD, FRCPC

Anesthesia Chronic Pain Fellow, University of Toronto

I will always remember my time with the CFMS. As president, working on issues specifically relevant for medical students and helping the CFMS grow as an effective organization were two goals of mine. During my time as president, from an issues perspective, I was most happy with the work we did on paving the way for the electives portal, helping enhance distributed medical education, and increasing our role in advocacy. The executive team that worked with me were some of the most talented, dedicated, and brilliant people I've ever met in my life.

I believe the most important issue for medical students should continue to be the learning environment of medical students in Canada and ensuring that appropriate resources and opportunities continue to be made available for trainees. The CFMS is uniquely positioned to take leadership in this role and it is an opportunity that will continue to present itself and must not be wasted.



CFMS President 2011-12

Noura Hassan, MD, CM, MPH

PGY-5 Obstetrics & Gynecology, McGill University

My term was very eventful and rewarding on many levels. One of the CFMS' most significant accomplishments that year was the development of a National Electives Portal; the AFMC Board passed a resolution to fund and develop this electronic portal which was proposed and lobbied for by the CFMS over many years. The federal government also agreed to defer loan reimbursement for medical professionals practicing in rural and remote areas until the end of their training in response to Lobby Day 2012. Finally, we highlighted the growing concerns with health human resource (HHR) distribution and impending physician oversupply on national platforms hence

instigating the development of a national task force on HHR planning; we accomplished this through lobbying directed at deans of medical schools and Ministers of Health.

My involvement within the CFMS Executive was among the most formative and defining experiences for me on personal and professional level. First and foremost, I forged strong, meaningful relationships with inspiring individuals. The CFMS' most valuable asset is its membership which constantly challenges the status quo and proposes disruptive solutions to issues spanning from public policy and social justice to educational reform and duty hours.

The healthcare system is changing at a very rapid pace. This is indeed a very exciting time to be entering the medical field. As professionals in training, I highly recommend that you learn about health system structures and different payment models. Doing so will help you understand healthcare delivery on a different level and will make you think about ways

we can provide more comprehensive, affordable, and higher quality care to the population. The more you understand, the more you can help make a difference! The system is changing no matter what, and it's happening now. Make sure they are the right changes that yield better health for us all.



CFMS President 2012-13

Robin Clouston, MD, CCFP, CCFP (EM)

Family & Emergency Physician, Saint John Regional Hospital

Assistant Professor, Department of Family Medicine, Dalhousie University

The Canadian Federation of Medical Students will always hold a special place in my heart, and as a past president I experienced first-hand the powerful voice that Canadian medical students have that can shape the Canadian medical education landscape.

The year 2013 saw renewed collaboration between CFMS and FMEQ, including the launch of a national survey on medical student wellness. Canada sent a team of 12 delegates to the International Federation of Medical Students Association in Baltimore, Maryland, and CFMS Lobby Day and advocacy efforts focused on Canadian Health Human Resources. My greatest achievement for CFMS came in my Past-President year in 2014 when I led the creation of the CFMS Strategic Plan for 2014 - 2017.

My year as CFMS President was personally transformative. I started out feeling heavy with the duty before me, a medical student among the physician leaders of Canada, needing to speak for all Canadian

medical students. I learned I had to project confidence even when I felt unsure; I had to speak articulately with tact and respect in order to best be heard. As the year wore on the confidence grew from within. Truly, the CFMS and its medical student members are the experts on the needs of Canadian medical students, and when we speak from this expert voice the medical community listens.

My time with the CFMS showed me that medical students and indeed physicians have a powerful voice in the Canadian healthcare landscape. In our cities and towns, we learn the needs of our patients, including poverty reduction, better elderly care, the needs of refugee and indigenous communities, addiction services, and mental health. I would challenge all medical students to connect to your local community and use this powerful voice to advocate for those who need it the most; it is as transformative for us as it is for our communities.

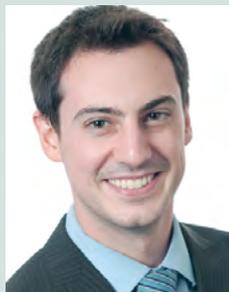


CFMS President 2013-14

Jesse Kancir, MD, MSc, MPhil (MPP)

PGY-2 Public Health and Preventive Medicine, University of British Columbia

Please see page 17.



CFMS President 2014-15

Bryce Durafourt, MDCM, MSc
PGY-2 Neurology, Queen's University

It has been less than 6 months since my time with the CFMS came to an end, but I already miss it immensely! Thanks to a team of incredibly dedicated full-time medical students and support from the amazingly devoted Rosemary, we were able to accomplish so much for an organization of our size. One highlight from my year as president was the development of our partnership with MD Financial Management. Through this partnership, we were able to increase support to bring non-elected members to general meetings, and also increase awareness about availability of financial advice to students earlier in their training. My fondest memory on the advocacy front was the opportunity I had to address the House of Commons Standing Committee on Health on behalf of the CFMS, and to deliver

a brief prepared – with 48 hours' notice – by a handful of the executive. Two of the committee's recommendations, one on the need for better health human resource planning and the other on the Canada Student Loan Program, took into account comments that I presented on behalf of the CFMS. By far, though, the greatest memories of my time with the CFMS were the friendships I forged with fellow student leaders from across the country. While we did not always agree on policies, we all shared a love for advancing the profession, representing our colleagues to the best of our abilities, and ultimately leading towards improving the health of all Canadians. It was an honour to serve as CFMS President and I am excited to watch the organization continue to grow and thrive in the years to come.



CFMS President 2015-16

Anthea Lafreniere, MD
PGY-1 Anatomical Pathology, University of Ottawa

While I've recently taken a step outside of the CFMS and into residency leadership, I maintain an intimate connection with the organization as Past-President. Projects are on-going, conversations and dialogues continue, and many of the issues I faced as president are unresolved. My presidency still feels like a work-in-progress, with my own objectives for the CFMS not yet realized.

During this 40th Anniversary year, I cannot yet see what of the work we did during my four years with the CFMS will shape the organization in a lasting way. Of the issues we advocated for and the sometimes seemingly unwinnable battles we have taken on, I'm not sure what will make a meaningful difference in the lives of medical students present and to come.

I can say that I feel a shift in momentum within the organization and I feel its drive to assert itself on the national stage. I see the way in which medical students are coming into their own within the sphere of medical education and politics. The "first fifteen" are establishing themselves as strategic, innovative, and indispensable to organized

medicine. Do we continue to encounter those who question the experience and the validity of the "younger" voice? Without question. But medical students, residents, and new-in-practice physicians are unified in a new way and are ensuring that our voices and our values – social accountability, equity, and sustainability - are receiving more than just token acknowledgement.

Not only do I have many fond memories of working and advocating alongside the best and the brightest in medicine, but I also have memories of celebrating marriages, new babies, and of being present during personal hardships. I know that in every major city in Canada, I have friends who will welcome me into their home. While I may not have travelled far enough down my own path to appreciate what I learned and what I did and how I was shaped by it, I can see how the CFMS has connected me to people and how those connections will last the entirety of my life in medicine.

Reflections by Dr. Kancir and Dr. Martin

On Tension, Social Accountability, and a New Professionalism in Medicine

Dr. Danielle Martin
CFMS President 2002-2003

Dr. Jesse Kancir
CFMS President 2013-2014

Some of the sections of this piece were reprinted with permission, originally published on Longwoods.com, at www.longwoods.com/content/24974.

BEFORE MEDICAL school, we both had heroes who were authors and thinkers known for their writing, not their medical acumen. For Jesse, it was Chekhov and Keats. For Danielle, it was Toni Morrison and Paolo Freire. It was through their work – mostly unrelated to medicine – that we came to understand that healing happens in many ways and requires many skills. Throughout our time in medical school, we both held fast to the hope that a physician could be a hybrid, a blend of the clinical with whatever other identities you had and could cultivate. The

“Throughout our time in medical school, we both held fast to the hope that a physician could be a hybrid, a blend of the clinical with whatever other identities you had and could cultivate.”

hope was to avoid losing ourselves through medical training, and instead find ways to maintain personal integrity while gaining a professional identity.

During medical school, and in particular our involvement with the CFMS a full decade apart, our heroes began to be not only the giants of literature or political theory, but also contemporary physicians actively engaged in transforming healthcare systems. It was amazing to gain inspiration from watching physicians navigate complex political, medical, and economic systems. For Danielle, James Orbinski stood out as a hero in the field of humanitarianism and medicine; and in later years Don Berwick in the United States became a personal hero for his amazing mix of skills and impact. Jesse says that Danielle herself was one of his early heroes (which makes Danielle blush but also makes her very happy). He admired her for her leadership with Canadian Doctors for Medicare and her voice as one of Canada’s leading health policy activists.

Danielle has recently embarked on a new leadership journey with the release of her new book, “Better Now: 6 Big Ideas to Improve Health Care for All Canadians.”

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The book has gotten widespread coverage and stimulated fresh discussions. She says that she pictured the members of the CFMS as she wrote it, asking herself what they would want to know and need to know about how our system is structured and how we can help make it better. She was thrilled when the Dean of Medicine at the University of Toronto Faculty of Medicine committed to buying copies for all first and second year students – it is her dream for the book that eventually it will be read by all medical trainees across Canada.

After publishing the book, Danielle kept thinking about medical students, so much so that she thought, “what do I wish today’s medical students could know, or reflect on, as they learn about healthcare system issues?”

This led to the publication of a recent op-ed in the Longwoods Open Letters Series entitled ‘Dear Class of 2020.’ In the letter, Dr. Martin highlights the tensions that characterize our healthcare environment:

“The future of healthcare is defined not by a linear trajectory of ‘progress,’ but by a series of competing tensions that our decision-makers will need to navigate. These tensions can only be resolved at the system level, and with your participation. Among these tensions, three stand out for me: 1) the tension between population health and personalized medicine; 2) the conflict between high technology and the rise of ‘slow medicine’; and 3) the friction between standardization and individualization of care.”

These tensions have been going through Jesse’s mind lately given the ongoing tension both within the medical profession and between it and society. In conversations with students at the most recent CFMS Lobby Day, it was clear that they, too, were aware of shifts in the profession. What was most telling was the number of students who were interested in learning how to think about and engage more deeply with government as a routine part of their professional experience. In this sense, they realized through the emerging tensions of medicine that engagement – what we would call social accountability – was not an annual activity or only needed in response to contract negotiations.

Again, from Longwoods:

The future of Canadian healthcare will be determined by the ways in which we – and ultimately our systems – navigate tensions such as these. How we navigate them will be determined – in part – by how physicians navigate the balance between social accountability and self-interest...

“[...] our heroes began to be not only the giants of literature or political theory, but also contemporary physicians actively engaged in transforming healthcare systems.”

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It's time for a new professionalism in medicine, one that is emerging in Canada and needs us to nurture it. It will be built not just on doctors' devotion to patients nor on the advancement of our own interests, but on our willingness to be partners in a bigger system that is constantly responding to conflicting paradigms. In that future, physicians will be an integral part of the complex system, rather than simply working alongside it.

For Jesse – having worked as a Policy Advisor to the federal Minister of Health, Dr. Jane Philpott – this need for physicians to evolve their thinking was seen consistently. Being able to step away and see medicine as an outsider let him see both its beauty and its isolation: medicine can be a deep but narrow thing. Serving a Minister of Health who was also a physician, Jesse returned to medicine convinced that physicians with their extensive training, consistent exposure to communities, and varied backgrounds bring an especially rich perspective to public discourse. Health policy and politics is ripe for more physician engagement, just as are other areas of the public, private, and social sectors that are critical to building healthy communities.

“The CFMS was an important part of our medical school journeys and it will continue to be for a new generation of physicians.”

As former CFMS Presidents, we both care deeply about the experience of medical students and residents and, specifically, how they can marshal their non-medical skills – whatever they may be – to make the world a better place (perhaps that background has something to do with our time at the CFMS). For both of us, having been medical students not that long ago (!), we remember well the many core questions about identity that students share as the forces of medical education shape our thinking and perspective.

We are so happy to have the opportunity to look back on 40 successful years and to consider the next 40, too. The CFMS was an important part of our medical school journeys and it will continue to be for a new generation of physicians. It was at the CFMS that we both learned how to be part of a community of medical people who share our dreams and ambitions, for ourselves and our profession. Medicine needs the CFMS and for medical students to actively participate and ensure that you and the organizations that represent you are part of building a better healthcare system and, through it, a better society.

Sincere congratulations on your milestone. ■

History of Canadian healthcare and policy

Sarah Silverberg
CFMS VP Government Affairs
University of Toronto, Class of 2018

AS MEDICAL STUDENTS, WE are primed to think about the future of health care. In government affairs, this often means looking at how current and future policies will shape the way we practice in years to come. In celebration of our 40th anniversary, I wanted to bring forward some interesting tidbits about the history of healthcare and health policy in the country.

Very little in the way of organized healthcare was available prior to Confederation. Remember, our country is older than germ theory! While some local communities set up health boards to control outbreaks of cholera, typhoid, and smallpox, the 1834 legislation from the Parliament of Upper Canada was the first to authorize such boards. In 1882, Ontario was the first province to establish a full time Provincial Board of Health. And in 1885, Ontario sent some doctors to Quebec to arrest those unwilling to be vaccinated against smallpox.

Most medical students know about Tommy Douglas, who “fathered” Medicare in Saskatchewan in 1962. But fewer students may know about the

“What might come of a surprise to some is how recent the establishment is of some of our public health infrastructure.”

ensuing strike. At the time, the Canadian Medical Association, the local College of Physicians and Surgeons, and other groups strongly opposed this “socialized medicine.” This culminated in a 1962 physician strike in the province to oppose medicare. The strike ended in a failure after 23 days, and the legacy of medicare was able to expand across the country. The national program was developed in a few stages. The Hospital Insurance and Diagnostic Act of 1957 led to the federal government and provinces to cover acute hospital care, as well as laboratory and radiology services. The *1966 Medical Care act* extended that insurance to cover doctors’ services.

One piece of health care history with unintended consequences was the reformation of the mental health system. In the 1950s and 1960s, Canada made large reforms to treatment of those with mental illness. We started to move away from asylums towards “de-institutionalization,” a policy of integrating these patients into the community rather than segregating them, hidden away from the public. Almost 80% of all psychiatric hospital beds were closed. The goal was to improve the lives of patients, but many faced a lot of difficulties managing in the community. It took another 20 years before the need for community support to be fully recognized and acted on. While de-institutionalization was an important step, care was lacking without community mental health reform.

What might come of a surprise to some is how recent the establishment is of some of our public health infrastructure. The Public Health Agency of Canada (PHAC) was founded in 2004, in part as a recommendation following the SARS crisis in 2003. Dr. David Naylor, Dean

“As our generation moves forward to improve on our health care model for changing needs in the country, it is important to remember that the road to where we are today has been full of twists and turns.”

of the University of Toronto’s medical school, developed a report after broad consultation that recommended the development of a federal public health agency, the creation of a chief public health officer, and the building of a pan-Canadian public health network. PHAC’s creation has improved national accountability and coordination in national crisis.

Our history of health care is rich with problems, disagreements, and reforms. As our generation moves forward to improve on our health care model for changing needs in the country, it is important to remember that the road to where we are today has been full of twists and turns. I, for one, am confident that we will continue to innovate, to make mistakes, and to get messy. As we forge ahead, we will carve a bright new path. ■

An approach to your line of credit, one student's perspective

Daniel Peretz
CFMS VP Finance
McGill University, Class of 2018

SO YOU JUST STARTED medical school (or are several years in) and are getting nervous about your finances. You took out a line of credit because, well, four (more) years without any income is a long time. You cringe every time you dip into your line of credit because you worry. Are you using your line of credit more than you should? Will you be able to pay it all off? The purpose of this article is to lay some of your fears to rest by providing useful information regarding your line of credit. We'll make some simplifying assumptions in an effort to answer two commonly asked questions: 1. 'How much debt will I have when I graduate?' and 2. 'How long will it take me to pay it all off?'

How much debt will I have when I graduate?

Let me start by setting your expectations. The intent here isn't to give you an exact figure, but rather a range of possibilities along with the assumptions on which they are based. With this, you can decide how applicable these results are to your particular situation and adjust accordingly.

That said, a student beginning medical school with no savings and no debt can expect to graduate with total debt somewhere between \$90,000 and \$130,000. This range is based on the assumption of a 3.0% interest line of credit and total annual expenses ranging from \$20,000 to \$30,000. Naturally, the most important variable here are your annual expenses. These include tuition, books, rent, food, clothing, entertainment, and anything else you spend your money on. These differ from province to province, school to school, and most importantly, person to person. I would encourage you to make a budget of your

monthly and annual expenses to figure out where on this range (or beyond it) you may stand. I would also encourage you to incorporate an amount for unexpected expenses. For example, your fourth year of medical school will likely be more expensive than you foresee given the costs of residency applications and travel required for electives and interviews.

How long will it take me to pay it all off?

This question introduces several additional factors and variables which make the answer quite person and situation specific. How much debt will you graduate medical school with? How long will your residency/fellowship be? Will you increase your debt during residency/fellowship or begin to pay it down? What will your annual income be? Which province will you work in and what will your tax rate be? How will your expenses change? Will you be starting a family? Do you plan on buying a house? Making investments? As you can imagine, there is no simple answer with so many variables.

To simplify the question, we will make some assumptions on which to base the answer. Most individuals are able to live off their salaries during residency and thereby keep a stable amount of debt throughout. So we will start by conservatively assuming that your debt upon graduation of residency (whether two or five or any other number of years in length) will be \$150,000. This allows us to eliminate the variability relating to length of residency programs. We will also assume that the interest rate on your line of credit stays at 3.0%, that your income is taxed at current Ontario tax rates, and that you decide to make a down payment for a home in your second year following graduation from residency.

Now, rather than making assumptions for what your annual expenditures or annual income will be, we will show results based on a range of possibilities. Based on these assumptions, Table 1 below shows the number of years after graduation from residency it could take to pay off your debt. As you can see, by keeping your expenses within a reasonable range, you should be able to pay off your debt within the first 5 years of working, all while becoming a homeowner along the way.

Table 1. Years after residency to pay off debt

Annual Expenses	Gross Annual Income	
	\$200,000	\$300,000
\$25,000	2 years	1 year
\$50,000	3 years	2 years
\$75,000	4 years	2 years
\$100,000	7 years	3 years

Lessons Learned

From what we've seen above, the only true certainty is that no single answer applies to everyone. Situations and circumstances guide results. The main conclusion here is to breathe a sigh of relief knowing that you should be able to comfortably pay down your debt no matter the anxiety it may be causing you. A \$50,000 increase in your debt would only push back your ability to pay it down by about a year or so!

Nonetheless, remember that your expenses are the single most important factor in determining how much debt you will have upon graduation and how quickly you will be able to pay it down. Keep track of your expenses, budget appropriately, and most importantly, worry not. ■

Towards Reconciliation: engaging indigenous communities for medical education

Amanda Sauvé

CFMS National Officer of Indigenous Health
University of Western Ontario, Class of 2018

Adriana Cappelletti

University of Western Ontario, Class of 2018

The Truth and Reconciliation Commission of Canada

THE TRUTH AND Reconciliation Commission of Canada (TRC) published its final report in 2015. The Commission was involved with over 900 events across Canada between 2008-2014 and collected over 6750 statements of residential school survivors and their families. The Commission's mandate was to reveal the complex truth about the history and ongoing legacy of residential schools, highlighting the individual and collective harms against Aboriginal peoples. It also aimed to guide and inspire a process of truth and healing within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities.¹ Included in the TRC final report were 94 'Calls to Action,' of which five focused specifically on Indigenous Health.

Calling ourselves to action

It is well known that Indigenous people in Canada are faced with significant disparities related to health. The commission's five 'Calls to Action' specific to Indigenous health intend to guide our nation towards equality in health and wellbeing for the population. With the hope of contributing to reconciliation, the two of us as medical students have committed ourselves to advocating for the provision of cultural competency training for healthcare professionals. Specifically, we are focusing on Indigenous community engagement to develop an experiential teaching tool called "Stand Up for Indigenous Health."

Truth and Reconciliation: Call to Action # 23

"We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the health-care field.*
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.*
- iii. Provide cultural competency training for all healthcare professionals".*

– Truth and Reconciliation Commission of Canada: Calls to Action, 2015.²

Practicing cultural competency requires not only a tolerance for cultural diversity, but an understanding and appreciation for historical experiences, ongoing colonial legacy, and the unique strengths and barriers among Indigenous communities. Ideally, this education should be standardized across medical schools with adjustments to account for regional differences in Indigenous experiences.

In an effort to achieve this goal, we are adapting Dr. Latif Murji's educational tool called 'Stand Up for Health' (SU4H); a two-hour simulation in which students experientially learn about social determinants of health by stepping into the role of a low-income Canadian. The scenarios being developed for our Indigenous version of SU4H will address social determinants of health in urban, rural, and remote Indigenous communities. Furthermore, the scenarios that students will face are based on real life experiences of Canada's Indigenous people. Community partnership is

"The Commission's mandate was to reveal the complex truth about the history and ongoing legacy of residential schools, highlighting the individual and collective harms against Aboriginal peoples."

essential to developing culturally appropriate and representative scenarios. We are collaborating with Indigenous communities to co-facilitate gatherings both on and off-reserve in which we engage community-based focus groups to elicit the community's experiences with health and healthcare. The stories shared with us have not only been invaluable in developing an understanding of the community's needs, but also in enriching our understanding of the value of Indigenous knowledge systems and ways of learning.

In keeping with traditional Indigenous practice, we call on Elders to open and

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close the focus-group gatherings. We offer culturally appropriate gifts of gratitude to Elders for sharing their wisdom and knowledge, including tobacco ties (a traditional offering to First Nations and Métis Elders when making a request)³, gifts of pure cotton fabric in traditional Indigenous prints, and honorariums. To promote a safe space, we conduct these focus groups in sharing circles in a community setting, which is generally considered a comforting and healing practice among Indigenous Peoples in Canada.^{4,5}

We are still in the process of furthering community engagement, and we are very keen to partner with other Indigenous communities to incorporate their voices into 'Stand Up for Indigenous Health.' If you know any individuals or groups who would be interested in voicing their experience, please contact Adriana Cappelletti at acappel3@uwo.ca.

Final thoughts from your National Officer of Indigenous Health

In November 2016, I had the rare opportunity of attending the Atlohsa 94 event in London, Ontario, where I listened to a speech by the honourable Justice Murray Sinclair (TRC commissioner). He discussed his experiences with the commission and the vision for what is required as we move forward. He urged everyone to learn the truth about the history and legacy of the residential school system by taking the time to read the TRC final report. He also left the audience with a challenge. As the future leaders of healthcare in Canada, I am calling on each of you to accept the following challenge presented by the Honorable Murray Sinclair: "Make a commitment, read the 'Calls to Action,' choose one, and do what you can in your current position to help make it a reality." I made the commitment to contributing to reconciliation, will you? ■

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The case for Social Medicine Certificate Programs

Marguerite Heyns & Dylan Ginter
CFMS National Officers of Global Health Education

Jessica Bryce
CFMS VP Global Health

THE CFMS GLOBAL HEALTH program focuses on national and international advocacy work through the ratification of position papers, curricular advocacy, and foreign medical exchange. These efforts would be enhanced through the implementation of a standardized undergraduate global health medical education program.

Over the last decade, several studies have identified the positive impact an undergraduate medical student global health training would have.^{1,2} Longitudinal exposure to global health as a theme that informs all aspects of healthcare has been suggested as the ideal model for global health education. Specifically, learning models with a combination of local community

“Historically, medical education in Canada over-emphasizes biomedical components of medicine while under-emphasizing health inequity issues and social determinants of health.”

engagement, peer and community feedback, coursework, global health electives, and adequate pre-departure training and post-return debriefing provide the most comprehensive global health education.

Upon review of current GH programs among medical schools, “Learning needs to take place within the context in which it will be applied. Topics such as professionalism, health advocacy, social determinants, and ethics must be taught in ways that help learners move from knowledge to practice, acquiring the necessary skills throughout their medical education. Just as in clinical learning, educators will have to provide students with opportunities to experience what this knowledge looks like in their hands. If medical students believe that what they are learning will have little or no impact, they will quickly become disengaged.”⁶

Historically, medical education in Canada over-emphasizes biomedical components of medicine while under-emphasizing health inequity issues and social determinants of health. This does not provide physicians with the capacity to fully understand their patient’s health context and the barriers that ultimately determine the success of their interventions.³ Numerous studies have shown that a comprehensive global health medical education extends the role of the physician to include that of a health advocate.^{2,3}

Key gaps in practices exist in the delivery and measureable impact of current GH programs. Fragmentation

and the lack of national standardization has created barriers to the formation of uniform and comprehensive GH training.⁴ Ultimately, in order to meet student demand and the societal expectation for socially competent physicians, GH education must be integrated into the primary curriculum.⁵ Integration enables access for all students and a wider perspective of health practices at local and global levels.⁵

We took a step forward toward greater standardization with the ratification of the Global Health Core competencies (GHCCs) during the 2015 CFMS annual general meeting. The document provides a framework for the standardization of global health-based medical education that is informed by physician leaders in global health across Canada. The goal of the document is to facilitate the eventual integration of all the competencies into formal undergraduate medical curricula. Unfortunately, formal curricular change is slow. Medical students want access to such training now and do not want to wait until accreditation standards and university curricular subcommittees meet this demand.

Students at medical schools across Canada have been working diligently to meet this need and demand through the implementation of extra-curricular student-led global health-based certificate programs. These certificate programs aim to fill the gap in current global health medical education and give medical students the tools and experience to become competent physicians in the field of global health. The heterogeneity of Canadian culture, geography, and people is also reflected in the types of global health programs offered at Canadian

medical schools. Each medical school needs to be socially accountable and mandated to meet the needs of their surrounding communities. Variability between provinces can make a single, nation wide global health certificate program difficult to implement and maintain. A set of nationally validated guidelines has therefore been developed to aid students in creating their University specific global health certificate programs.

The Global Health Portfolio at the CFMS is in the process of creating an adaptable, online social medicine certificate program in which medical students across Canada can participate in and receive the global health training that is lacking in current medical education. This program will follow the nationally validated guidelines for global health

programs, will incorporate the Global Health Core Competencies, and will therefore be a step towards standardized undergraduate global health medical education. Each medical school will also be able to adapt this program to their province/community specific needs.

Until Canadian medical schools create a comprehensive global health medical education curriculum integrated into the regular medical curricula, the CFMS Social Medicine program will offer students the education they want in a standardized and uniform way while maintaining local social accountability.

For more information about this project and to learn how to get involved, please contact the National Officer of Global Health Education at noghe@cfms.org. ■

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What's the plan?

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I'M SITTING ON AN AIRPLANE, flying somewhere over Calgary and Vancouver and my heart is heavy. This isn't a leisure trip, a hurrah for finishing exams, or a typical visit back home. I'm going home to say my final goodbye to someone who meant the absolute world to me. I'm saying my final goodbye to someone who taught me so much about strength and kindness and perseverance. I'm saying my final goodbye to someone who I've been losing slowly for the last seven years. I'm saying my final goodbye to a body whose mind left us a while ago. I'm saying my final goodbye because it finally feels okay to do so. I'm saying my final goodbye to my grandmother.

Looking back at these last few years, I can't help but think of the small victories and the bigger losses. She remembered my name – victory. She thinks we're in a

different time period – loss. She spoke a coherent half sentence – victory. She can't speak at all – loss. She ate a whole cup of pudding – victory. She's lost her ability to swallow – the ultimate loss. And with these victories and losses, I think of how her journey may be over, but it continues for so many other families. How many families are going through their own victories and losses, counting the tiniest of blessings?

My personal reflection led me to think of the system we're in – a system that is not ready. A system with a culture of reactivity instead of proactivity. A system focused at solving problems and less so at preventing them. When we approach a medical problem, our thought pattern has been conditioned. What is the presenting problem? What is the history of the problem? Is the problem urgent or

“My personal reflection led me to think of the system we're in – a system that is not ready. [...] A system focused at solving problems and less so at preventing them.”

“People say geriatrics isn’t exciting enough. There’s no “saving of lives” or any validation from helping the old – they’re going to die anyways.”

can it wait? And the cornerstone – given this information, what is the plan? What investigations do we need to do to confirm exactly what the problem is? What can we do to solve the problem?

Where am I going with this? We have a problem in Canada that needs solving.

Our population is aging. Our population is getting older and with this, our population is getting sicker. The problem is we don’t have the resources in place to address this problem. Not from a medical standpoint, not from a societal standpoint, and not from an economic standpoint.

What is the history of the problem?

Over the last couple of decades, life expectancy has increased given our successes in medicine and technology. We no longer die in our teens of infections. We live until our 80s and 90s and we die not from a single condition but likely from a myriad of chronic health problems. There are currently 261 geriatricians in the country. The average number of geriatricians per 100,000 population sits at 0.7 – that’s not even one whole geriatrician for 100,000 people.¹

Is the problem urgent or can it wait?

Over the next 25 years, the number of people 65 years and older is projected to double.² You decide if it’s urgent.

And our favourite question, what is the plan?

There is none.

The Canadian Medical Association started a DemandAPlan campaign before the 2015 federal election. Over 30,000 people signed the petition. I’d be curious to know the demographics of the people that signed the petition. How many were physicians? How many were allied health care providers? How many were seniors? How many from the general population? And what really piques my curiosity, how many were medical students? The Canadian Geriatrics Society estimates that during medical school, students receive approximately 80 hours of geriatric exposure compared to over 300 in, for example, pediatrics.

We are told from our first day in medical school how special we are for being here. We are told how we are the future of medicine. We are told of the extreme responsibility we will have to our patients. We are told of the expectations that society has of us. We are told about the power and privilege our career in medicine will bestow on us.

Do we not have a responsibility to use that voice?

But you’ll say, oh you’re passionate about geriatrics so of course you’d want to use your voice for that. There are so many important issues we need to be advocates for. We can’t do everything.

I am not asking for everyone to become geriatricians. I’m not asking people to write letters to their Members of Parliament requesting increased resources

“Is it not our responsibility to ensure those latter years of life are at least not void of the supports that allow for some dignity?”

for the elderly. Recognizing that there is a problem is a start. Changing the culture of medicine is a start. Not referring to the elderly patient with Alzheimer’s disease as the “old demented guy” is a start. Trying to discharge an elderly person to their home for better quality of life and not just to free up a bed is a start. And we can work from there. Crowding of personal care homes, the lack of effective and minimal home care, polypharmacy – these are just skimming the surface of the medical side of the problem we’re facing. We need to address these issues as part of a national, provincial, and municipal plan. But in order for there to be enough interest and enough commitment to demand that these issues be addressed, we need to form a culture where we recognize the problem. We need to form a culture where we respect and dignify the population enough to show that we’re interested in making a plan. That population will be our parents one day; that population will be us one day.

Many of us who have any interest in geriatrics do so because we had an older person in our life who inspired us to want to do better. Someone who may not have been treated as well as they should have by the system because of their age. Someone who drove us to make sure no one has to go through what they had to.

People say geriatrics isn’t exciting enough. There’s no “saving of lives” or any validation from helping the old – they’re going to die anyways. Is it not our responsibility to ensure those latter years of life are at least not void of the supports that allow for some dignity? We need to come together and ask, what is the plan? ■

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The CFMS then and now

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WE'RE ABOUT TO CELEBRATE a special anniversary. The CFMS has its 40th birthday in 2017, and the Annual General Meeting in Ottawa will demonstrate our excitement about such a significant milestone. But before we get to celebrating, I want to look back at where the CFMS came from.

Before the CFMS, medical student government in Canada belonged to the Canadian Association of Medical Students and Interns (CAMSI). CAMSI approached many of the same issues we do today: medical student payment and tuition; engagement of the membership with the executive;¹ and advocacy to governments and the Association of Faculties of Medicine of Canada.² The interests of CAMSI also included the championing of public health care,^{3,4} warning of the dangers of overspecialization; and organizing electives in general practice across the country.⁵ In these ways, the CFMS and CAMSI are two sister organizations separated only by time. Today, the CFMS advocates to the federal government at our annual lobby day, we work with the Association of Faculties of Medicine of Canada to improve medical education, and we organize electives all over the world for Canada's medical students.

But CAMSI and the CFMS differ in two key ways. CAMSI ran the match of medical students to first year residency positions (then called internships) from 1949 to 1969.⁶ And CAMSI's own journal gave medical students voice in scientific and educational matters from 1942 to 1968.⁷

CAMSI shut down operations in early 1970s, almost 40 years after it was created in late 1930s.⁸ Soon before that, in 1969, the provincial healthcare authorities, the AFMC, the regulatory colleges, and the organization that would become Resident Doctors of Canada came together to create the matching service ultimately named the Canadian

Residency Matching Service (CaRMS).⁹ Today, CaRMS fills an important role by conducting the matching of students with residency programs in a way that protects medical students' rights to privacy and fairness as job applicants. That solution remains as viable in 2017 as it was in 1969.

The publication of a medical student journal, however, remains both a nearly-forgotten memory and a distant dream. Henry Sigerist, an early champion of socialized medicine, published in the CAMSI Journal in 1943.⁴ Saskatchewan Premier Tommy Douglas wrote in the CAMSI Journal soon after he was elected in 1944.¹⁰ Other authors in the CAMSI Journal wrote on practice structure, educational policy, and social issues. Like CAMSI, the CFMS has also made important contributions to published academic literature. Irfan Dhalla studied medical student demographics, tuition, and income inequality in 2002 as CFMS Vice President of Education.¹¹ The findings of the 2015 CFMS Wellness Survey are approaching publication and will make a significant impression on Canadian medical education. But the CFMS has not yet recovered a tool for creating new knowledge or advocating for change like the one medical students had in the mid-20th century.

In 1977-1978, Leo Plouffe and Robert Conn led the creation of the CFMS.² They created a strong foundation upon which the new generation of physicians can look ahead to the future and shape the profession.¹² This year, the CFMS took significant steps to restore medical students' capacity to contribute to medical education research. Dr. Glenn Regher of the University of British Columbia was named the inaugural CFMS National Research Chair in Undergraduate Medical Education. And Branavan Manorjaran was awarded the role of CFMS National Officer of Research, the CFMS's first.

Together, we are attempting to build capacity in the CFMS to take research projects from idea to publication. Who but medical students are forced to look 50 years into the future of the profession? We have foresight not thanks to genius but out of necessity.

I hope the next 40 years of the CFMS will look much like last 40. I hope the CFMS will advocate for diversity in the profession, for the right of learners, and for systems that care especially well for the patients who can no longer care for themselves. But I also challenge us to think big. Medical students have a social responsibility to shape the system in which we will work. Building the capacity to create research-based knowledge should be one of our first steps on the road to our next 40 years. ■

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Global health vs. social medicine: what's the difference?

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“What is global health?”

OUR FELLOW STUDENTS ARE often left wondering how to define this broad discipline. The truth is that there is no universally accepted definition of “global health.” A common misconception is that global health is synonymous with international health, defined as the opposite of local health. This is not true. The buzzword these days is social medicine, another rather ambiguous word to add to the confusion. The terms global health and social medicine are often conflated and some distinctions should be made.

The Association of Faculties of Medicine in Canada (AFMC) as well as the CFMS global health core competencies use the following definition of global health: “an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide.”¹ Geopolitics

“Social medicine challenges physicians and medical learners to engage and understand patients’ realities beyond the walls of the clinic or hospital”

are inextricably linked to global health and this requires an understanding of how social forces shape patterns of disease and the access and reform of healthcare. The emphasis in global health is the scope. It is important to not limit our perspectives to only local or international health issues but to understand how both are influenced by and dependent on each other. Global health places healthcare in a worldwide context.

Social medicine informs the perspective of this context. As defined by the social medicine consortium,² “Social Medicine is the practice of medicine that integrates:

1. Understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care;
2. An advocacy and equity agenda that treats health as a human right;
3. An approach that is both interdisciplinary and multi-sectoral across the health system;
4. A deep understanding of local and global contexts ensuring that the local context informs and leads the global movement, and vice versa;
5. Voice and vote of patient, families, and communities.”

Social medicine challenges physicians and medical learners to engage and understand patients’ realities beyond the walls of the clinic or hospital. Social medicine offers physicians an opportunity to bridge the gap between public health and patient-centered medicine. It can provide physicians with tools for treatment and prevention on local and global scales.

Social medicine serves as a framework to deliver care in the setting of political, geographical, and social realities. Global

“[...] we can all agree on the principle – as future physicians we must strive for equity in health for all people.”

health serves as a context in which we can provide this care; it informs the practice of medicine everywhere. In an article exploring the fundamental role social medicine and global health play in the curriculum at Harvard Medical School, Kasper et al wrote, “As bankers cannot disregard the economies of other nations as having no impact on their domestic fortunes, physicians – and medical schools – cannot focus only on the patients in front of them.”³ As the authors explained, all health is global health, all medicine is social medicine. Regardless of the term used, we can all agree on the principle – as future physicians we must strive for equity in health for all people. ■

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On fainting in the OR on Rwandan Liberation Day and a refreshed perspective

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Jessica is a third-year medical student at Schulich School of Medicine and Dentistry at Western University. She participated in a clinical observership in orthopedic surgery at Centre Hospitalier Universitaire de Kigali in Kigali, Rwanda this past summer.

On July 4th, 2016, I fainted in the OR

IT WAS THE BEGINNING OF MY clinical placement at Centre Hospitalier Universitaire de Kigali in Kigali, Rwanda. I had crawled into to bed at 8 p.m. the night prior feeling ill. It seems I had finally caught the same bug as the other Canadian medical students.

But, a multi-hour forearm tendon/nerve repair was planned for the next day and I didn't want to miss it. So in the morning, I donned the thick cotton scrubs, scrubbed in, and entered the impossibly hot OR. Side note: as an inexperienced pre-clerk, I had essentially nothing to contribute, barring my exceptional retractor-holding-and-gauze-dabbing skills (one could train a monkey to hold retractors). For my benefit only, the attending surgeon was speaking English, the "academic language," rather than the native language of everyone else in the room, Kinyarwanda. Did I mention that surgical supplies were limited? If I was going to be using gloves, a mask, and a gown, I'd better make damn sure I learned something.

“Back home, they say that everyone faints in the OR at least once.”

But go figure, 30 minutes in my stomach started churning and I could feel my body temperature rising. My thick scrubs became drenched with sweat. The internal dialect began: “I totally have malaria” (I was taking malaria prophylaxis and so far the mosquitos had kept their distance - I hadn't received a single bite); “am I sweating through my gown - can they see the sweat?” (the gowns were plastic, you don't sweat through plastic); and then it became melodramatic - “maybe I just can't stand forearm surgery. Is it possible to get through an orthopedics residency without ever operating on the forearm? No that's dumb, the malaria must be getting to you.”

Back home, they say that everyone faints in the OR at least once. That it is no big deal, the nurses expect it, just ask to sit down, and don't (figuratively) sweat it. But even at home I thought that they just say this for the benefit of the non-surgeons in the room; for those that can't wait to get through their surgery clerkship rotations and never enter the OR again. It turns out I was wrong.

I like to think that back in the familiar environment at Western, I would have handled the situation better. I would have found a way to make fun of myself or crack a joke about yet another medical student who passed out in the OR. But this wasn't home. This was Rwanda, where English is the second language. Where I don't know the medical culture norms. Where the doctors work in hot ORs with no air conditioning despite the Equatorial heat, where every orthopedic case is an emergent one, and no one is near compensated enough. Yet there they are, cheerfully listening to rap while working to repair the patient's deep forearm lacerations with no scrub nurse on a national holiday in a steaming

hot OR. Who was I to pass out in the OR?

July 4th, 2016 was Liberation Day in Rwanda, marking 22 years since the end of the genocide. Liberation Day is a day of remembrance of a dark past and celebration of the huge humanitarian strides that have been made over the last two decades. Today, the outsider would see very little of the conflict that once existed between the Rwandan people. There is an acceptance of one another, people of different religions and races live side by side, and women have greater rights than they do in comparison to most countries in Africa. The people are very friendly and the capital city is safe and clean, making Rwanda an excellent place to live.

On my very slow and embarrassed walk back from the hospital, I was caught up in a whirlwind of thought: “what are the doctors going to think of me when I go into the hospital tomorrow?” “will they even let me back in the OR?” “what if they never accept visiting Canadian medical students because of me?”

Of course, in true Rwandan and orthopedic style, the next day one of the residents made some joke about cold Canadian ORs and then it was back to “help me cast this patient, we won't be able to get them to the OR for a few more days.” In this one simple exchange, this Rwanda resident exemplified the mentality of Rwandans. He honoured my dignity and got back to business. Did I learn how to do an intricate forearm repair in Rwanda and secure my destiny as a hand surgeon? No. But if I can one day have even half of the respect and resiliency of the average Rwandan resident, I will be proud.

I guess those gloves, mask, and gown were put to good use after all. ■

A Summer in Tanzania

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I WAS OVERWHELMED WITH the beauty of the vast landscape that surrounded me. The diversity of wildlife in Tanzania's Ngorongoro Conservation Area was unique. As we drove away from the elephants, zebras, and gorillas by the road, we began to see the Maasai villages that consisted of groups of four or five homes scattered throughout the land. The three days and two nights I spent in Olbalbal, one of the largest Maasai villages, was one of the most memorable times during my eight-week medical observership in Tanzania in the summer of 2016. It was during this stay that I began to understand the complexity of Tanzania's healthcare system.

While the physical environment was unlike anything I had seen before, it was Tanzania's social and cultural differences that were most astonishing. In Olbalbal, people lived in harmony with the wild animals and a family's wealth is measured in cattle, not money. The Maasai people live a traditional pastoralist and highly patriarchal lifestyle. Most Maasai women do not have access to education, speak only their tribal language, and have no means of earning money. Women rely on their husbands to give them animals for meat and milk, and do not otherwise have control over their own food. As a result, Maasai women rarely have a sense of autonomy or control in society.

The Maasai also have very limited access to modern healthcare services.

“The Maasai people live a traditional pastoralist and highly patriarchal lifestyle.”

Traditional birth attendants play a critical role in the birth of new members of the community and provide most of the medical care during pregnancy. I felt very fortunate to be able to observe a Canadian expert in health education for marginalized people. As a medical team, we worked with the traditional birth attendants, discussing the importance of proper sanitation techniques during delivery, and proper nutrition for pregnant women. From generation to generation, the traditional birth attendants have gained wisdom and knowledge that have been passed down through stories – a very different form of learning from the education we receive as medical students in Canada.

Prior to the visit, our team felt that we had the potential to teach, inspire, and motivate the birth attendants to strengthen their engagement with their communities as health leaders. However, we also understood our limitations. The book “Emusoi: Maasai Girls Tell Their Stories” by Kasia Parham describes how the Maasai are often resistant to change by external forces acting in the name of progress because these changes may challenge their culture. Like many traditional peoples, the Maasai are more open to changes that come gradually and from within, rather than changes suggested by outsiders. One of the most surprising and memorable incidents threw this learning into doubt: during an intimate conversation about the importance of economic empowerment of Maasai women, we were suddenly interrupted by a loud blast of music. One of the birth attendants, dressed in spectacularly beautiful traditional clothing, began to push aside layers of clothing to find her belt, unzip a side pocket and, finally, pull out a cell phone. The Maasai we met did not skip a beat with this technology, all the while

“The incongruity between the community's access to technology and its lack of access to education seemed absurd to me.”

staying loyal to their otherwise traditional lifestyle.

The incongruity between the community's access to technology and its lack of access to education seemed absurd to me. I sometimes felt that working with Maasai women was taking a downstream approach to addressing the challenges facing them. It was difficult to imagine a course correction that would enable a traditional pastoralist Maasai culture to thrive in a developing world. As we left Olbalbal, where we woke up to giraffes grazing the acacia trees ten feet away from the house, I had a lot of questions. By sharing new ideas with the birth attendants, were we simply outsiders challenging the norms of the Maasai? Were we encouraging them to abandon a part of their identity, or were we providing them with tools to strengthen their community? Could I contribute?

As a first-year medical student abroad, it was naïve to think that I could contribute significantly to a foreign health care system. Before deciding to go to Tanzania for a medical observership, I thought long and hard about travelling abroad. I did not want to do more harm than good. I

feared that I would be taking too many resources such as gloves and masks from the hospital when resources were clearly lacking. I feared I would take student learning opportunities from other aspiring doctors and nurses, particularly from Tanzanians. I feared that my skin colour would reinforce the idea of the wise “white intellect” and undermine local physicians who were much more competent than me.

However, I am very grateful for the opportunity to learn so many lessons first hand. I saw how inequities in the social determinants of health shape lives, learned how the role of the physician is perceived in Tanzania, and questioned my contribution as a medical student in a very foreign environment. While it is impossible to reduce my experience to a few paragraphs, there are some insights from the trip that stand out as ones that changed my perspective. The insights

boil down to: 1) the value of travelling for educational experiences, 2) the need for self-reflection as a medical student, and 3) the importance of cultural sensitivity as a central component of effective health-care.

After two months in Tanzania, I felt like I needed more time. It was impossible for me to understand the intricacies of the health care system in a country that is so different from home. Healthcare is about more than the physicians and the care they can provide; it is about history, politics, sustainability, social determinants of health, and so much more. I found solace in the idea that I was merely an observer and that my role was not to create change. However, sharing these stories is important to me because I believe we need to think about the contributions we want to make as medical students and future physicians, both at home and abroad. ■

“Healthcare is about more than the physicians and the care they can provide; it is about history, politics, sustainability, social determinants of health, and so much more.”



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Spiti Valley

Shandel Riedlinger
University of British Columbia, Class of 2019

IT WAS ONLY AFTER A 16-HOUR drive from Delhi to Manali, and half-way through another 12-hour drive from Manali into the Spiti Valley, that I realized I was truly spending the next month in the middle of nowhere. The roads had become worse, turning from rough pavement to gravel and dirt. It made our progress very slow as the drivers navigated around potholes, large rocks, and herds of cows and horses.

As I looked out the front window of the Jeep, I saw goats speckling the mountains in the distance and realized it had been hours since we'd seen any sort of building... or people for that matter. Within minutes, however, a temple covered in ceremonial prayer flags came into our view. There was nothing around it for miles and it was located at an elevation of 4,500 metres above sea level. It was absolutely fascinating. The breeze was so strong, all we could hear was the sound of prayer flags flapping in the wind. My fingers and toes tingled from the medication we were taking to prevent altitude sickness. Whichever way you looked, you saw beautiful mountain views.

After a few hours, we passed through an archway that welcomed us to the Spiti Valley. We had finally entered one of the most remote and unpopulated regions of India.

For the next month, myself and four other UBC medical students worked at the Munsel-ling Boarding School; the heart of a small village nestled within the Himalayan mountains. With the help of a Canadian physician and two local nurses who worked at the school, we performed health screens on over 500 children. We screened for a number of health concerns, including anemia, scabies, worms and lice, as well as for vision, dental, cardiac, respiratory and gastrointestinal problems. What we

didn't expect was the magnitude of the prevalence of these health problems.

Our first day of screening was a sobering experience. Student after student was examined, each with visible nits glued to their hair. More than 90% of the girls at the school had lice. Clearly, the original plan to treat a small number of students would be futile and we needed to treat at the population level. The entire school would require lice shampoo.

Additionally, almost all of the children had cavities, and many had rotting teeth. The cause was multifactorial, including a lack of access to dental care, a diet filled with sugary treats, and a lack of education on tooth brushing. We worked with the nurses to enhance the curriculum on dental hygiene and ensure they were given adequate class time to present this material. After meeting with a healthcare team at a nearby village, we found out that for the first time in years,

“With the help of a Canadian physician and two local nurses who worked at the school, we performed health screens on over 500 children.”

a dentist was willing to take on the challenge of treating the students.

Through blood testing, we were also able to identify children who were severely anemic. They were prescribed iron supplements provided free of charge from the government and would have





“One of my favourite moments was pointing to the vision chart expecting the five-year-old in front of me to not quite understand, until a tiny voice piped up and said ‘E is for Elephant!’”

follow up visits with one of the doctors on the healthcare team we’d met. To ensure the sustainability of these interventions after we had left, it was important to help the students access local resources.

During our time at Munsel-ling, we worked with students anywhere from 4 to 19 years old, but it was the kindergarten class that was the most challenging and entertaining. Although the older students could speak English and Hindi, the younger ones barely spoke anything but their traditional Spitian language. We relied heavily on the nurses to help us translate. One of my favourite moments was pointing to the vision chart expecting the five-year-old in front of me to not quite understand, until a tiny voice piped up and said “E is for Elephant!” She managed to make it through the full row of letters perfectly

listing off the corresponding animals.

In the evenings, we entered the data we’d collected for the day, ate traditional meals with the teachers, and revelled in the slow pace of the village. On our first few nights the stars would come out, giving us a perfect view of the Milky Way and the time to reflect on the incredible journey we were on. Later in the month, the moon was so bright it perfectly lit our path as we headed to bed after dinner.

In an odd way, the days passed by slowly as the month flew by. It was a month I will never forget. Whether it was the people I travelled with who turned into family, the kind words we received from the teachers and staff, or the absolute trust that filled the students’ eyes, I will always remember how these experiences have shaped me. I grew as a traveller, as a medical student, and as a person. ■

Non-profit platform to improve CPR training rate and bystander CPR administration rate in communities

Han Joo Lee

Canadian Red Cross Training Partner
Canadian Red Cross First Aid + CPR Instructor
Dalhousie University, Class of 2018

CARDIAC ARREST CAN CAUSE ischemic brain damage in as fast as four minutes and brain death in ten. Halifax EMS aims to respond within nine minutes to avoid brain death but many still suffer severe brain damage. The response time is even longer in rural regions. This is why bystander CPR is the most important aspect of post-cardiac arrest care. Without it, patients often suffer irreversible brain damage by the time they reach emergency department. Most die or experience severe lifelong disability because they arrive too late to benefit from in-hospital acute care.

The bystander CPR rate is very low in Canada.^{1,2} As a result, survival rate in cardiac arrest occurring out-of-hospital is less than 5 percent.^{1,2} This is more than three times lower compared to 16.3 percent in King County, Seattle.³ This discrepancy can be attributed to ineffective training designs which pose too many barriers, and lack of political interest. Along with

“We truly believe that our efforts will train and enable the public to provide bystander CPR and thereby reduce adverse outcomes.”

other students in various healthcare fields, I have created a non-profit platform to reduce these barriers by taking actions described below. We truly believe that our efforts will train and enable the public to provide bystander CPR and thereby reduce adverse outcomes.

1. Full Canadian Red Cross Certification courses at a drastically reduced cost

Extremely expensive certification cost is one of the biggest barriers Canadians are facing today. This has resulted in a culture where one certifies only when it is required for work or school. We are challenging and trying to change this culture by drastically reducing the certification cost (for example, from \$120 to \$65 for Standard First Aid + CPR, and from \$80 to \$40 for CPR). This will relieve the financial pressure for those who would not have gotten training otherwise.

2. Free continuous chest compression CPR training to the public and the non-profit groups serving the public interests

Another problem with the current CPR training model is that it covers too much material (management of diabetic emergency, hyper/hypothermia, stroke, seizure, poisoning, etc.). This results in 16 hours of constant teaching, less than 30 minutes of hands-on CPR practice time, and participants not retaining the necessary knowledge following the course. We have created a concise and focused 90-minute continuous chest compression

“[...] bystander CPR is the most important aspect of post-cardiac arrest care.”

CPR training program for the public based on the Medic II program which is successfully delivered by the Seattle Fire Department. This program will focus on enabling participants through simplified instructions and hands-on experience rather than lecturing large sum of information for corporate/political reasons.

3. Free continuous chest compression CPR training to high school and junior high school students

Many Canadian provinces such as Ontario and BC provide CPR training to their young students during secondary education. However, there are no such programs in Nova Scotia. We have contacted various agencies regarding this matter, but have been told that it is an unattainable goal due to lack of large funding this initiative will require. We are aiming to challenge this claim by proving that it can be done by a small group of medical students with minimal personal funding. Ultimately, we plan on beginning an advocacy initiative once we have proven the program's feasibility to urge the Department of Education to take action.

4. Free continuous chest compression CPR training to the rural and marginalized population

In the Canadian healthcare system, healthcare resources are often out of reach for rural communities or marginalized populations. Ambulance response times are much longer, thereby relying more on bystander CPR. Our goal is to bridge this increased need by training people in rural communities. To achieve this goal, we have contacted rural community centers, low-income support organizations, and student organizations to coordinate our efforts.

5. Advocacy work to raise awareness

We believe that the lack of public awareness and political interest played a big role in creating the currently poor outcomes in Canada. Denmark was in

a similar situation in 2001 with post-cardiac arrest survival of 3% when they began their national political campaign to increase CPR awareness.⁴ They have since nearly tripled their survival rate to 10.8% in 2010.⁴ Our goal is to take the first step to achieve similar success by advocating for better CPR coverage in Canada by hosting various awareness events throughout the year.

We truly believe that our efforts will train and enable the public to provide bystander CPR and prevent adverse outcomes. We aim to achieve this overarching goal by 1) drastically reducing the cost barrier, 2) designing more effective teaching plan, 3) paying special attention to demographics who may lack resources, and 4) by urging political action. Once fully implemented in Halifax, we aim to expand across Canada. Please visit our website at <http://leecpr.simplesite.com> for further details or updates on our progress. ■

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Now there's an app for that! Medical students help design the first radiology undergraduate mobile app

Alexandra Roston
University of Alberta, Class of 2019

What is it?

WITH EVERY PASSING YEAR, technology seems to play an increasingly important role in medical education. More schools are moving towards paperless learning environments, online modules, and even smartphone apps. One such app, released by the University of British Columbia Undergraduate Radiology Team, is the Radiology Teaching App. This free, not-for-profit app is designed specifically to complement medical learners in their training. It also incorporates some of the hottest topics in medical education: high tech learning, self-directed studying, and finally, collaboration between learners, residents, and staff to improve medical education.

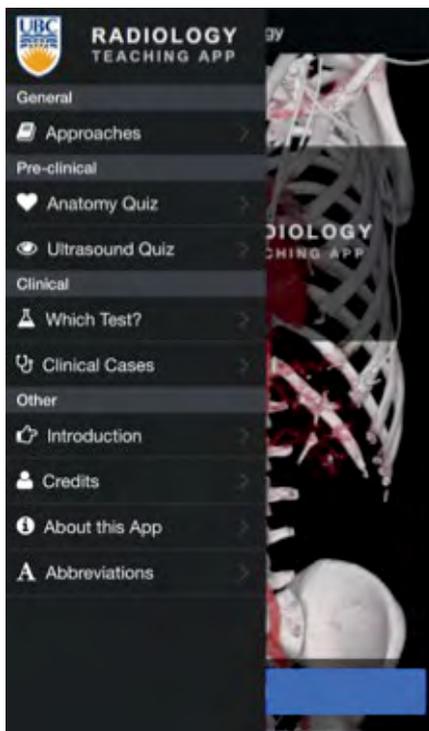


Figure 1. The content is divided into a Pre-Clinical and Clinical curriculum to make it easy for students to navigate.

Why is it unique?

This app is designed as a standalone undergraduate radiology curriculum. In fact, it is one of the first medical student apps of its kind. Learning objectives are based on standardized undergraduate radiology objectives from the American University of Radiologists, with content guiding students from the first day of medical school to the first day of residency and beyond. The app is arranged into two main sections: (1) pre-clinical, focusing on anatomy and ultrasound; and (2) clinical, focusing on ordering imaging and clinical cases (Figure 1).

The app includes over 500 anatomy questions featuring X-ray, CT, MRI, and ultrasound images. It also has more than 60 fully-worked clinical cases and a quiz designed to teach imaging appropriateness.

Quizzes are highly customizable according to content, imaging modality, and question number, with scores provided upon quiz completion. Because of their highly customizable nature, these quizzes can be tailored to the student's current focus, regardless of their medical school. Whether learning through a spiral curriculum at the University of British Columbia or within a System Block curriculum at the University of Alberta, students can customize quiz content to complement their current classroom (or clerkship) learning.

Clinical cases include scrollable datasets and detailed case descriptions, as well as differential diagnoses, diagnoses, and findings. The clinical details of the cases are vivid, with each case containing "Clinical Pearls" section to relate the imaging to real patient cases. In addition, each case feels very similar to the

"Built for medical students, the app was developed by a team that included faculty, residents and, of course, students."

small group "Case Based Learning" sessions that now form an integral part of most Canadian medical curricula, which keeps the learning process exciting and highly patient-oriented.

Were medical students involved?

Built for medical students, the app was developed by a team that included faculty, residents and, of course, students. As a preclinical student at the University of Alberta, I was honoured to contribute as the project's medical illustrator. In this role, I created original schematics which can be found in the "Approach to Chest X-ray" and anatomy quiz sections (Figure 2). Through these illustrations, I helped the present complex visual material in a relatable way. Being a preclinical student, I also learned a tremendous amount about the cases and anatomy while trying to distill complex diagrams and concepts down to a 2D, accessible image. As a novice learner, I also gained insight into the multidisciplinary process of developing e-learning tools. Built for

“Because of their highly customizable nature, these quizzes can be tailored to the student’s current focus, regardless of their medical school.”

medical students, the app also included the participation of another of students, including Csilla Egri (UBC, 2017), Vivien Hu (UBC, 2019), Dan Metcalfe (UBC, 2017), Philip Edgcumbe (UBC, Year 6 MD/PhD) (Figure 3).

The project was led by Dr. Kathryn Darras, a UBC PGY-5 Diagnostic Radiology Resident (@teachradiology) and the software was developed by Dr. Matthew Toom, a UBC PGY-1 Family Medicine Resident. The faculty supervisor for this project was Dr. Savvas Nicolaou, Professor and Vice-Chair of Undergraduate Education at the UBC Department of Radiology and the faculty sponsor was Dr. Bruce Forster, Professor and Head of the UBC Department of Radiology.

What’s the take home message?

We would like to make all Canadian medical students aware of this app. Just as radiology itself combines cutting edge technology with expert anatomy knowledge, this app combines accessible technology with radiology learning. Designed with input from medical students, it’s both understandable and entertaining. The quizzes provide a sense of accomplishment, while the cases keep learning patient-centred and clinically relevant. Anyone, from Year 1 to residency and beyond, can enjoy this app—whether to brush up on old skills, or learn new ones altogether. It covers the “must know” aspect of medical imaging suitable for all medical careers!

How can I get it?

The Radiology Teaching App is available for free in both the Apple and Google Play app stores (<http://www.ubcradiologyapp.ca/>).

This app was funded through an educational grant and is not-for-profit. ■

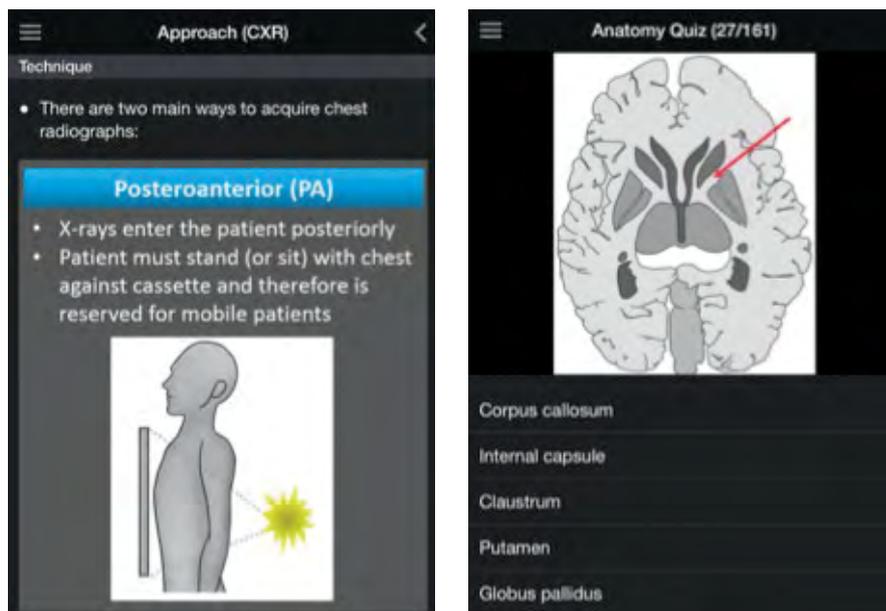


Figure 2. Screenshots from the app demonstrating the original illustrations. (A) Approach to Chest X-ray Section (B) Neuroanatomy Quiz Section.

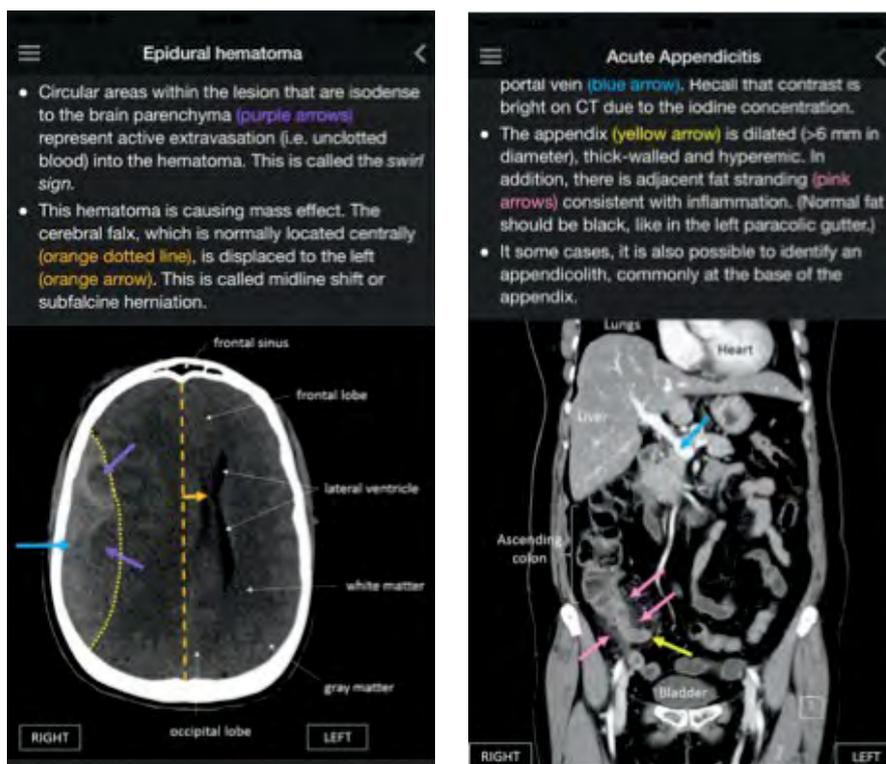


Figure 3. Screenshots from the app of showing examples of two clinical cases. (A) Epidural hematoma (B) Acute appendicitis.

The Stem Cell Club – spearheading stem cell donor recruitment at medical schools across Canada

Simran Parmar

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Kiran Rikhranj

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Dr. Warren Fingrut

PGY-2 Internal Medicine, University of Toronto

THE STEM CELL CLUB IS STUDENT-run non-profit organization that works to recruit Canadians as stem cell/bone marrow donors. We are a community partner of Canadian Blood Services, and we are accredited through them to run our own stem cell donor-recruitment drives. At these drives, we guide potential donors to provide informed consent and a tissue sample (cheek swab) – this information is then inputted onto Canada’s stem cell donor database, the OneMatch Stem Cell and Marrow Registry. These donors can then find out if they are a match to a patient in need of a stem cell transplant who cannot find a genetic match in their family.

We have reported on our initiative in

the past two issues of the CFMS *Annual Review*. In 2015, we outlined our initiative’s successful launch at the University of British Columbia’s medical school, and our subsequent expansion to all of its distributed sites.¹ In 2016, we reported our successful expansion to five medical campuses across Ontario.² In this issue, we are pleased to report that we have successfully launched Stem Cell Club chapters at four additional medical campuses: McMaster University (Waterloo campus); University of Manitoba; University of Saskatchewan (Regina campus); and Queen’s University. To date, we have recruited over 6027 potential stem cell donors (representing 1.5% of all donors on Canada’s current

donor database). Our recruitment strategy focuses on the most-needed donors according to the literature: young and ethnically diverse males.^{3,4} From November 2012 to December 2016, 60% of 4450 recruited registrants were male. From October 2013 to December 2016, of the 1886 males recruited, 59% self-reported as non-Caucasian and 77% were of age 17-25. We have recruited 78 young Aboriginal males, increasing this demographic group’s representation on Canada’s registry by ~7%. Altogether, we have developed a capacity to recruit over 2250 donors annually, of which the majority are ethnically diverse males.

Our initiative enables medical students to realize the CanMEDS roles. We

“Through targeted recruitment of the most-needed donors, we guide students to be stewards of limited healthcare resources.”

empower students to become leaders in Canadian healthcare and health advocates for patients in need of stem cell transplants. We hone student communication skills to recruit registrants without compromising informed consent, and to sensitively and professionally redirect ineligible donors

to help in other ways. Through targeted recruitment of the most-needed donors, we guide students to be stewards of limited healthcare resources. We develop students' quality control skillsets by instructing them to use our checklists and to maintain good documentation practices. At our drives, students act as scholars, teaching other students about stem cell science and the principles of stem cell donation. Medical students at each chapter of our club work collaboratively with each other and with students from other disciplines across their university to recruit donors. Through tracking outcomes at every drive we run, we emphasize continuous quality improvement.

We invite other medical students across Canada to partner with us and establish stem cell clubs at their respective schools. We offer our support, guidance, and mentorship to any individuals or groups of students interested in starting up their own stem cell clubs. We will share our evidence-based training modules, experience running drives, and other useful resources. We will

connect you directly with Canadian Blood Services and Héma-Québec, and work to accredit your group to run stem cell drives independently. We can, together, dramatically increase the number of individuals we recruit to become stem cell donors, and save lives of patients who cannot find a match today. Interested students can email Dr. Warren Fingrut at wfingrut@gmail.com to discuss the next steps. ■

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Perspectives of a medical student completing an elective in the pediatric emergency department

Yaesh Sardiwalla
Dalhousie University, Class of 2019

A New Year

TRANSITIONING INTO THE second year of medical school is a pivotal moment in medical school. Expectations are raised, responsibility for clinical work increases, and it suddenly hits you that you're a quarter of the way to becoming a physician. There is a new sense of trust imparted by patients to students, unfounded or not. Perhaps the comfort in beginning to find your value as a health-care provider explains the added trust from patients. In this reflective piece, I will explore my perspectives on working in a pediatric emergency department.

The Scene is Set

The IWK Emergency Department (ED) in Halifax has a certain charm with its colorful walls and overall cheery appearance, typical of a children's hospital. The cohesiveness of the staff is unique. A part of me thinks there must be an inherent pleasantness to individuals who choose to spend their careers working with sick children. An overwhelming sense of calmness, patience, and reassurance was a refreshing change, especially for someone early on in their career. The warm environment was conducive to personal exploration.

My first day in the ED was a whirlwind experience. In retrospect, it felt as though I was on a Hollywood-inspired scene. There was a motor vehicle accident resulting in two children requiring urgent attention. Seeing meticulous non-verbal coordination of the trauma team was akin to watching a choreographed dance. When the patients arrived, an algorithmic assessment of the initial injuries was completed. Care was taken to appreciate

that there was a very scared, young person on that stretcher. The time prioritized in humanizing the patient was not simply to develop rapport, but rather done continually to show something simple – that we cared.

Veneration for the Therapeutic Figure

A stranger with a stethoscope versus a parent – who does a patient trust more? For children, their solace remains in the clutches of their parents, and it is the parents who hand their scared children over to be healed. This provokes an interesting question on the foundation of the physician-patient relationship. Being a physician is a powerful role but one that is humbling with great responsibility. The accountability serves as a perpetual reminder to improve my clinical acumen and become more deserving of the trust afforded.

The Art of Pediatric Medicine

Pain brings with it significant patient suffering with both acute and long-term consequences. Healthcare providers working with children incorporate various pain mitigation strategies to make their visit more bearable. Certain techniques may not be stipulated in guidelines, but they epitomize an overarching empathic attitude demonstrated in pediatrics. I questioned why such strategies are not routinely practiced in adult care.

Most children that I have examined present with treatable, acute conditions. The converse to this presentation is the child who you know is seriously ill right away. There have been a handful of such cases that I recall vividly, and pondered over long after a shift has ended.

The Emotional Toll of Sick Kids

The resilience and bravery of even the sickest children to me is what the human spirit ought to be: an enduring, resistant, and relentless desire to survive. I remember a courageous, severely anemic girl in pre-school suffering from a days-long epistaxis. Her skin was blanched and dry, her lips a smoky leaden colour. She gracefully allowed us to examine her and although exhausted and in extreme pain, she did her best to cooperate with our interventions. When I feel overwhelmed by the gravity of certain situations, I think of her perseverance.

There is something to say about naivety. When I am unable to share good news or see an immediately gratifying response to treatment, my concern for the patient grows. Medicine for me is still almost a relentless pursuit to find hope at times when there seems to be none. I realize that this attitude is unsustainable, however as pragmatism develops with my growing clinical understanding, I will ensure that the great responsibility owed to my patients does not diminish. For this sake, I hope that the spirit of being 'naïve' is something that will never wane.

The comparisons between pediatric and other departments have been striking to me. There is a notable improvement in understanding, patience and empathy between healthcare providers and patients in the pediatric setting. The hidden curriculum is often discussed with negative connotations attached, but this experience shows how the warm art of medicine can be practiced with empathy and understanding. ■

Start with compassion, and the rest will follow

Rachel Loebach

University of Western Ontario, Class of 2018

"You have no idea how it feels to be me."

I AM INTERVIEWING A DESPERATE, suicidal man. I am doing my best to express empathy, to take on his perspective, to connect. I am trying to step outside of myself and into his world.

But, in all fairness, he isn't wrong. I have no idea how it feels to be him. And it would be a harsh injustice to pretend that I did.

Medicine is stock full of confusing concepts. Most wouldn't think to place *empathy* into that category. However, while emphasized, praised, and preached as a vital tool for connection and understanding between physician and patient, empathy is inadequately defined for practical application. So I did a little research and inadvertently discovered some interesting pitfalls to 'putting yourself in someone else's shoes.'

1. Accurately 'seeing the world through another's eyes' is virtually impossible.

My idea of what a person's perspective looks like is just that – *my idea*. It will be shaped and coloured by *my* view of the world, *my* past experiences, *my* thoughts and values. *My* neurocircuitry will use its hardwired presets to form a picture of another's experience.

Ultimately, I'm still using my eyes to see through someone else's lens.

2. Guesswork and bias are inevitable and precarious.

I have to make broad inferences about the complicated processes that determine how another person feels, thinks, and experiences the world. In all likelihood, the margin of error in my assumptions will be tremendous. Consequently, I will relate much more realistically to people who are similar to me in terms of worldview,

upbringing, and values. As a result, unconscious bias is born.

3. The spectrum is hard to navigate.

There are different types of empathy. *Cognitive empathy* focuses on the mental act of taking on the perspective of another. *Emotional empathy* involves experiencing and feeling another's emotions. Being too far on the cognitive end of the spectrum can appear dissociated and void of concern. Being too far to the emotional side impairs objective clinical judgement and negatively impacts your own well-being.

Therefore, empathy involves seeing inside someone else's brain, becoming conscious of unconscious inclinations, and finding a balance between cold detachment and emotional burnout.

Is there a 'How To' book on this somewhere? While empathy can play a role in forming connection, maybe there is an alternative tool that can sidestep some of these shortcomings.

For this, I turn to empathy's cousin: compassion.

Contrary to popular belief, compassion is *not the same as* empathy. Compassion is a deep awareness of another's suffering with motivation and desire to help alleviate it. Compassion means being moved into action by acknowledging the misfortune of others and honouring our shared humanity.

More to the point, compassion can be developed, strengthened, and practiced. One method of doing this is actually quite simple. Some call it 'loving-kindness meditation.' Some cringe at the word 'meditate' and would prefer 'mental exercise.' In any case, the purpose is to bring to mind a positive emotion and ruminate on the feeling it creates.

I beseech you to try it. Focus on each step for 1 minute.

1. Bring to mind someone you love and focus on them. Think of how profoundly you care for them and wish for them the very best.
2. Notice the feelings of happiness and positivity that arise when you think about how you feel for this person. This is what it feels like to love someone.
3. Now focus on other family members or friends who you also care about. Try to retain this emotion and project it onto them.
4. Go one step further and think of someone you don't know, maybe a patient, while focusing on that feeling.

This idea of wishing the best for someone, of deeply caring about their well-being and happiness? This is compassion. Practicing this little exercise often reinforces these emotions.

And research shows that feeling compassion improves your own well-being too. It's good for the soul.

So looking across the room at this man in a hospital gown with markings on his neck from the rope he had tied there, I do not know how it feels to be him. I cannot know *his* desperation, *his* depression, *his* defeat. But I do know that he is suffering. And I know that I don't want that for him. I want him to be healthy and well, and I would feel the same if a loved one were sitting across from me instead.

"You're completely right. I don't know how it feels to be you. But I can see you're hurting badly and I'm here to listen."

I can see you're hurting badly - an empathic statement. By focussing on compassion, empathy is effortlessly able to play its role.

Maybe there is an important lesson here. Start with compassion, and the rest will follow. ■

Grieving while in medical school

Emma Herrington

McMaster University, Class of 2018

MY FATHER TOOK HIS OWN life five months into my training as a medical student. His death was public; photos of the scene were shared on twitter before I even knew. On the morning of his death, I was working at my family medicine placement in Burlington. At the time, my main concerns were trying to remember the order of palpation and percussion as part of the abdominal exam and learning how to complete SOAP notes. My brother called me as I was walking into the room to take a history. During trauma, heightened senses result in transposing those negative emotions to environments that are visually similar. I now strongly associate the uniform design of family clinic examination rooms with loss.

My father's work colleague gathered me from the clinic; I carried nothing but my white coat, stethoscope, and McMaster clipboard into my hometown. The last note I had scrawled into my clipboard before I found out that my father killed himself was, "adrenal insufficiency." A part of me, the young woman who was just starting to learn about Addison's disease, died with my father that day. Only five months after his death, I'm unable to specify which part – I just know that I am no longer the same person.

Society's response to suicide is one of self-fulfilling curiosity, awkwardness, and fear. I initially thought that these visceral reactions would not translate to the medical student world. In this world, I told myself, we are learning about mental health and self-care; in this world, I told myself, we are learning how to comfort patients and break bad news.

Yet, when I returned to school after missing only ten days of classes, I entered a dismal maze of ostracism. It is a maze I have still not managed to exit. The walls of this maze were built not only by the same curiosity, awkwardness, and fear that I

experienced outside of McMaster, but also by myself.

If you are a medical student and you know someone who is grieving, I offer some insight on how to create a safe space:

1. Acknowledge how hospitals can be triggers

Following my father's death, I spent a great deal of time around hospitals supporting family members as their bodies responded to the shock. For those who are grieving, hospitals may not be associated with just classes.

2. Acknowledge how a simple history taking can be a trigger

Whether it's breaking bad news or asking about self-harm, these discussions are difficult and exhausting when grieving following a suicide. Keep in mind that these histories can include those taken from standardized patients or with clinical skills preceptors – this means that grieving students are routinely placed in environments directly related to their own negative life experiences.

3. Consider how their life at home has changed

As we know, outside of medical school we all have our own personal relationships. For a grieving medical student, the transition from home to school is exceedingly difficult. I would compare it to entering different dimensions that require completely unique versions of my personality. Simply inviting another student to share the challenges they face when transitioning between dimensions is a true demonstration of thoughtfulness.

4. Do not take a history of the dead individual

We, as medical students, are trained to dig deeper and explore health issues.

Curiosity is of paramount importance in medicine. However, remember that the person sharing their grief with you is not a patient seeking formal assessment and treatment. Provide them with the space to share details when they are ready. When it comes to suicide specifically, asking about potentially missed signs instills a sense of guilt in the loved ones who are left behind.

5. Be sensitive when it comes to their social anxiety

Because of the public nature of my father's suicide and how people responded, I developed extreme social anxiety. I could no longer attend large groups sessions/lectures. I was fearful of what people would say to me, how people would look at me, and what topics would be mentioned during lecture. Recognize that the grieving individual's comfort with social interaction may or may not have changed. Ask them how to offer support in social settings. Check in with them weekly to gauge if their level of comfort is changing. Socializing outside of class when grieving is uncomfortable and awkward. The emotions that are synonymous with grief do not always allow someone to socialize in large groups with alcohol. Acknowledge that this may limit their ability to share their story and ask how you can accommodate. Furthermore, there are periods throughout the grieving process when social interaction is not possible. If someone who is grieving appears to have lost all interest in your usual activities, be patient and accepting.

6. Do not attach any timeline to their grief

While the stages of grief do exist, I would argue that they do not happen sequentially and are not required to exist separate from one another. Grieving is an individual process. Do not get

frustrated with where they are in the process of grieving.

7. Encourage them to engage in self-care activities

Ask them what activities make them feel more balanced, rather than happy. It could be as simple as hitting the weights together, making a healthy meal, or going for a hike.

8. Create a safe space to discuss feelings of self-harm

These are difficult conversations to have. But the truth is that self-harm is a real concern after the death of a loved one. If you are not comfortable having those discussions, then ensure that they are aware of services they could utilize in times of need.

9. When you don't know what to say, say exactly that!

Rather than anxiously uttering some sort of platitude that could be interpreted as insensitive, offensive, or both, simply admit when you do not know what to say. This honesty is appreciated. If words fail completely, offering a hug is not unreasonable. Before you speak, consider your motivations. If you are simply trying to get information, understand that your interaction with the grieving individual should be centered around their needs, not yours.

10. Be willing to learn

There may be times when you do or say something that is interpreted as insensitive, even when you had the best intentions. Take this as an opportunity to ask why it was insensitive and explain what

you meant by your action or comment – communication is key.

Ultimately, grief is a deeply personal journey that becomes even more difficult to traverse while in medical school. Keeping these ten things in mind may provide you with the opportunity to form a rewarding connection with a grieving medical learner. By applying a trauma-informed approach to your interactions, you may rescue a colleague from a maze they feel unable and too fatigued to navigate.

For those reading who are grieving while in medical school, I comfort you with psychologist Carl Jung's concept of a wounded healer: one day, your own hurt will allow you to better serve a patient; in fact, the depth of your pain may be a measure of your power to heal and connect. ■

Undertow

Ronald Leung

McMaster University, Class of 2018

HER BODY WRITHES UNDER the yellow fluorescence light. She gazes around the room with glazed eyes. Her hair is matted with blood, streaks of red that run down her clothes.

I grasp her arm. My introduction passes over her head. Do you know where you are, I ask. A beat passes. The emergency room, she says. Her hands move loosely with no pattern. I turn to her son, a teenager. He smiles. She drank, he says. I snap on gloves, putting up a barrier.

Streams of fresh red drip past her neck. I investigate its source, attempting to wield the balance between clinical provocation and a necessary infliction of pain that medicine so often demands. I sift through clumps of hair caked with blood, pulling gently to expose any lurking lacerations. Her scalp is made bare. An open fissure races across her occiput. Raw, dripping, red. I step back, my hands held away from my chest and in the air, gloves glistening.

As I turn to leave, her son puts his hand on her wandering arms, which seem determined to investigate the source of her pain. Liquor coats her mind, just as it coats her tongue, and she is unable to resist probing her head with curious fingers. Again and again, the son pulls her back. Each time, with a gentleness that speaks of a caring wariness echoing a familiar routine. She begins to cry. I want to go home, she says. He puts his chest close to hers. It's okay, he says. It's okay, it's okay, he whispers. His words soothe her. She still struggles, but with diminishing resistance begins to accept his embrace.

For a second, silence sweeps the room, all the more emphasizing a mutual understanding that has passed between them. And once again, I wonder about what I was witness to. In the slipstream of medicine, I find myself privy to moments of private struggle that the facade of societal purity usually masks.

This woman and her son, what else have they weathered? What paths led them to this night? And perhaps most pressing—what roads lead them away? I will likely never see them again. That ephemeral contact lingers in medicine. I think of all the future lives I will exist momentarily in, a blip in their river of existence. Perhaps that contains a great sorrow, of being privileged with the most private of details, but only seeing patients through this prism, to never touch the possibility of truly knowing them.

Later, after cleaning the wound and sending neat staples into the skin that pull the bleeding gap close, her son turns to me and apologizes. Sorry for wasting your time, he says. I feel my words leave me. For how could he know that in that moment, I felt the service we provided was immensely necessary, but only an incomplete relief? I had stemmed the tide of blood from her scalp, but another river of grief flowed around them, unabated and relentless. ■

A day in the life of my shoes

Kaylynn Purdy

CFMS Ontario Regional Representative

Northern Ontario School of Medicine, Class of 2018

IT'S 7:45 AM, AND I AM PULLED out of the locker. I was cramped all night under the weight of some neuro-anatomy textbook and a package of juice boxes. Once I am securely attached to my feet, I am running up three flights of stairs and I carefully dodge a suspicious yellow spill. Soon we are on the third floor and I feel the familiar scuffs of the ICU linoleum under my soles. After successfully navigating around the chairs of the nursing station, we find an empty computer to check the latest lab results and imaging reports.

I overhear that the MRI of Bed 2 “doesn’t look good.”

“Multiple areas of infarction. The cerebellum is shot. The basal ganglia are completely infarcted and he likely has complete cortical blindness. Large temporal lobe infarctions bilaterally, and some in the frontal lobe. But his brainstem is intact, he might be able to breathe on his own again. He will never live a purposeful life though, he will be confined to a bed and nursing home forever. Another victim of fentanyl. He is only 25.” It’s only 8:05 am, and I already know it’s going to be hard day.

During rounds, I can hear the wails of the mother and sister of Bed 2 crying as I try to pay attention to discussions about nutrition and ventilator settings. The owner of my feet gets asked a question, I feel their weight shifting on my insoles under the pressure. I was caught off guard by the question, and stepped on a dirty piece of gauze left over from last night’s new admission.

I can feel my feet tensing, straining at my laces. There is a family meeting after rounds to discuss “goals of care” for Bed 2. Nobody likes these discussions and I silently bear witness to them all.

The mom and sister of Bed 2 are

crying before I even step into the conference room. The father is standing stoic in his work boots.

“You have two options. We can actively try to keep your son alive and do everything in our power to do that. He might make some recovery, but he will never be the same, he will never compose music again. He will never walk and probably never talk again. He will depend on around-the-clock care, and maybe a ventilator for the rest of his life. The second option is to stop all life-sustaining interventions and allow nature to take its course, and we will do everything we can to keep him comfortable. If you choose the second option, he could be with us for days to weeks. It is impossible to say. The decision of how you would like to proceed is up to you.”

The mother’s cry made my lace eyelets cringe. She cried out: “Why God? Take him if it is his time, don’t make us choose!”

With that, I followed polished shoes

“I overhear that the MRI of Bed 2 ‘doesn’t look good.’ ‘[...] He is only 25.’ It’s only 8:05 am, and I already know it’s going to be hard day.”

out through the door and into the hallway. A tear fell on my laces from above. After a short pause, I walked into say hello to cheerful man in Bed 1 eating lunch. Tonight, I look forward to the comforting weight of a textbook. ■



Wellness

Laura Kim

CFMS Western Regional Representative
University of British Columbia, Class of 2019

ONCE A YEAR, THE JOURNAL of the American Medical Association publishes a Medical Education themed issue, discussing topics that affect medical learners. On December 6, 2016, JAMA's annual MedEd publication boasted two major systematic reviews focused on medical student wellness. This gained traction with numerous high profile media outlets, including CBC, CNN, and TIME Magazine, adding fuel to the already fiery conversation surrounding learner wellness and resiliency.

The article that garnered the most media attention was a rigorous systematic review and meta-analysis conducted by Rotenstein et al, aiming to estimate the prevalence of depression and suicidal ideation in medical students.¹ In this review of 195 studies, involving 129,123 participants in 47 countries, the authors demonstrated that 27.2% of medical students screened positive for depression, of whom only 15.7% sought treatment. Furthermore, 11.1% reported suicidal ideation during medical school. The authors emphasized the necessity for preventive efforts and supportive infrastructure for medical students as they advance in their education.

“27.2% of medical students screened positive for depression, [...] 11.1% reported suicidal ideation during medical school.”

This article prompted me to reflect on the strains that medical students face during their training, and the dire sequelae that result if mental health concerns are not managed appropriately. Throughout our education, the importance of primordial, primary, secondary, and tertiary prevention of disease are underscored day after day. Why, then, is student wellness not managed the same way? Often, we rely on our student affairs offices to react to the effects of a stressful learning environment, while neglecting to address the upstream determinants of student wellbeing proactively. If the data demonstrates that medical students have high rates of depression and suicidal ideation, why not apply the philosophies of preventive medicine to promote wellness in the medical education system?

Conveniently, published on the next page of the JAMA issue, Wasson and colleagues performed a systematic review to answer my question: it examined the curricular and extra-curricular infrastructure associated with improved learner wellness.² In their study of the 87 articles, certain programs were correlated with medical student wellbeing, including pass/fail grading schemes, formal mental health and wellness programming, and balanced clinical vs. didactic curricula. However, the authors admitted that the overall quality of the studies was low, identifying a gap in the literature that necessitates more, high-quality medical education research.

Since the term “evidence-based medicine” was coined in 1990 by Dr. David Eddy,³ it has been touted as the holy grail, guiding our clinical decisions. And yet there are no evidence-based guidelines outlining an ideal structure of undergraduate medical education that promotes student wellbeing and resiliency. Learner

“[...] applying evidence-based and preventive medicine practices not only on how we care for our patients, but how we care for ourselves.”

wellness is not a new problem: studies published decades ago prove that the medical community has been concerned for a long time, yet the body of literature to guide our MedEd and wellness practices is still missing. At this point, we can shift our efforts away from looking at the problem (it's very clear that there is one), and redirect our academic efforts to identifying what we can do to solve it. Instead of viewing medical student stress and ill-health as inevitable components of the training process, I urge the medical community to practice what it preaches: applying evidence-based and preventive medicine practices not only on how we care for our patients, but how we care for ourselves. ■

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The Present

Lucy Smith

Memorial University, Class of 2019

"Yesterday is history, tomorrow is a mystery, today is a gift, which is why we call it the present." – Bil Keane

History Taking

THE MOST COMMON QUESTION people ask me to start a conversation is, "where are you from?" – a question that I probably answered more than one hundred times during my one month exchange in Germany, and asked a lot more often than "what is your name?" This seemingly simple question is actually quite complex for me to answer when traveling. Where I was born, where I spent my childhood, where I spent my teenage years, where I matured into adulthood, and where I live now are all in different places. The longest time I've ever lived in one place was five years in Markham, Ontario and that started only as a temporary home while I was completing an internship for school. All the traveling and moving around means I'm

"It is so easy to become overwhelmed by the uncertainties of tomorrow that it is almost comforting to live in denial [...]"

used to saying goodbyes but that doesn't mean it has gotten any easier. In fact, it actually got harder the older I became. It hurts to think that some of the most amazing people I've met during my travels, I may never see them again. The reality is, none of us had much control over where we came from and most of us will probably end up somewhere we were not expecting.

FIFE

We live in a world where it is hard not to worry about tomorrow. On the professional front, we worry about CaRMS, we worry about clerkship, and we worry about surviving the next phase. On the personal front, we worry about relationships, we worry about finance, and some of us even worry about our health, whether it's physical, mental, or both. It is so easy to become overwhelmed by the uncertainties of tomorrow that it is almost comforting to live in denial - procrastination and subsequent cramming are classic coping mechanisms among students. The equation for happiness simply equals to reality minus expectation. Some of us live with the expectation that any suffering today is only temporary because tomorrow, the future is promising. You have to ask yourself, what exactly do you expect to make you happier tomorrow? If it's money, the reality is that as our incomes increase so do the bills. Student loan gets replaced by mortgages, and tuition gets replaced by childcare expenses.

If medical school feels too busy and you are hoping for a relaxing future, the

"[...] procrastination and subsequent cramming are classic coping mechanisms among students."

reality is that working professionals often have even less free time because they lose that flexibility students have. If it's simply the uncertainties about the future that scares you, know that the only certainty in life is change.

Dx/Rx

Carpe diem is a generic prescription for life – a cliché that most of us find difficult to stay compliant with. It can be extremely hard to focus on the present if we question our past decisions and worry about our future uncertainties.

On the flip side, some of us enjoy the present so much that we choose to put off everything till tomorrow. Value today, but put it to good use. Call that family or friend you've been meaning to reach out but never got around to doing it. Take care of your mind and body because that extra hour of cramming today probably won't do you that much good tomorrow.

Travel when you can because while the youth does not have the money, the established professional will not have the time, and the retired soul may no longer have the health. Our time is now, and the journey matters more than the destination. ■

Social Media and the medical profession

Sahil Sharma

University of Western Ontario, Class of 2020

SOCIAL MEDIA IS A POWERFUL tool in developing networks, learning about current information, and disseminating newly acquired knowledge. It is a dynamic representation of one's interests and beliefs. It can quickly reach hundreds to thousands of people if used properly. This fact is both exciting and shocking for incoming medical students.

The aspect most often stressed by faculty members is the one that appeals to the potential downsides of social media, leading to an initial aversion to becoming an active member or abandonment of currently active social media accounts.

The abstinence from social media is a guaranteed way to avoid posting anything that might reflect poorly on one's character, something so strictly surveilled in the medical profession. However, in frightening new students from becoming active social media users, medical schools miss an opportunity to nurture this potential tool that medical students can use to progress in their medical career and to become better physicians.

There are several benefits to using social media but I have categorized them into 3 principal categories: Continual Learning, Influencing Public Discourse, and Networking.

Continued Learning: Stay Current with Medical/Scientific Literature

By allowing you to quickly gauge the popularity or quality of an article based on the level of engagement, students who may not have an abundance of free time to read about a certain topic can hone in on those that may be revolutionary in the field or present a controversial view. These articles will most likely become the most discussed in their classrooms or social circles. Therefore, the ability to identify them early on and read the ones that are most pertinent in the field rations time effectively.

Often, a post on social media regarding healthcare is accompanied by a short excerpt from the article that summarizes its main points. This is done to help draw in viewers who may find the content to be interesting but may not have been initially interested upon first viewing. By having a short summary of the main findings or what the article is trying to argue before the initial reading of the article, medical students may be able to better understand the contents and its relevancy to their education. Furthermore, certain social media users can post PDF versions of the article with pre-highlighted sections to help a novice reader hone in on the most relevant parts. These tools allow a medical student to save time in reading an article and also teaches them valuable skills about how to scavenge high-yield information from a body of text.

Influencing Public Discourse: Use Platforms to Address Controversies, Prevent the Dissemination of Misinformation

A unique advantage to reading posts that have a high level of engagement is that it allows an informed individual such as a medical student to identify potentially misleading articles. There are several examples in recent history where a shocking headline has circulated heavily throughout social media platforms but has not been a true reflection of the study that is referenced in the article. A medical student may be able to apply their knowledge to question these controversial claims and may be able to inform their social media followers about its downsides. Therefore, the level of engagement can help informed individuals identify articles which may be falsely swaying public opinion and help curb these within their local social media circles.

“For learning and engagement, there is no better tool than social media [...]”

Networking: Interact via Brainstorming, Questions, or Critiquing

User engagement is one of the most important and underutilized tools of social media. Often the author(s) of a certain paper have social media accounts themselves through which they initially post about their publications. These posts are then spread first from those that follow these individuals (most likely professionals with interest in the related area) and slowly into surrounding circles where the demographic is less and less specific. A savvy student can trace posts back to the original post by the authors and engage in meaningful discussion about parts of the article. If they are unclear about a certain part of the article or would like to comment on it, they can simply quote that section and then “tag” the authors. If the original authors don't respond, many individuals in that original circle of dissemination will most likely read the comment and provide feedback. If engaging in discussion is a bit daunting then students can engage in discussion with their medical class by commenting on posts or tagging friends who may be interested.

When it comes to using social media, the benefits outweigh the risks when used with curiosity and caution. For learning and engagement, there is no better tool than social media to parse through the high volume of information in today's new digital age. ■

“Personalized” vs. “Personal”: an entreaty for preserving identity within Medicine

Emily Macphail

University of Calgary, Class of 2019

MEDICINE HAS A WAY OF stripping away identity – or of subsuming it. While illness is often the culprit in the case of patients, the profession of medicine itself can do the same for its trainees.

In the hospital, everyone is reduced at times to the garb required of their position, however temporally allocated it may be. Patients huddle under one-size-fits-no-one gowns, while medical students and residents live alternately in interchangeable scrubs or white coats, skill level differentiated only by length. As a resident, if you're lucky, your name might be embroidered over your pocket, moving you vaguely closer to being an individual under the jacket that identifies you first as a member of the medical profession.

Still though, the importance of identity is worth pondering in this era of “personalized medicine,” where promises to the public currently consist of the idea that soon we will routinely within appointments take a drop of blood, perform genotyping right there in the office, and prescribe the precise medication that a patient will respond optimally to. Or the theory that we will be able to sequence full microbiomes then tell patients exactly what to eat to nourish their specific beneficial gut bacteria in order to maintain a healthy weight – an idea somewhat akin to a modern day “eat-for-your-type” diet.

Pharmacogenomics, metabolomics, and “toxgnostics” aside, the best medicine has always been personalized. Optimizing type 1 diabetes management for a recently-diagnosed seventeen-year-old girl who is living on the street looks very different from doing the same in an eight-year-old boy who was diagnosed five years prior, has heavily involved parents, and

can access additional health benefits via his family. Modifying one's approach in order to meet our patients where they're at is where the art and science of medicine collide.

In our striving for enhanced personalization and precision in our medicine though, we need to remember this: personalized medicine will solve nothing if we lose the person in the process. The medical world necessitates the clarification that loss, here, is not a reference to death, but instead to the gradual erosion of identity that often occurs along one's medical journey – be it patient's or physician's.

Despite a desire for tailored treatments, a management plan designed around a string of letters representing strands of DNA is not sufficient. This allele versus that allele is less important than the fact that one patient is an artist, and anything that would jeopardize her ability to use her hands is unacceptable; whereas another just wants to be comfortable enough to enjoy her remaining time with her grandchildren. The transience of state is similarly relevant – illness doesn't erase who a person is, despite its potential to unrecognizably obscure one's humanity. The elderly patient with dementia may be angry, uncooperative, and fully uncertain of where he presently is in time and space, but he is still the veteran who served in World War II and the entrepreneur who started his own company, and he deserves the respect and acknowledgment of his identity that he would have been shown as the same person under different circumstances.

Closer to home, as a physician, if you breathe, sleep, and live entirely within the medical world, you risk losing that which enables you able to not just take care of

“[...] keep the medicine that you practice as person-centred as it is personalized.”

your patients, but which allows you to care for your patients. Connection breeds empathy, and to connect, it is necessary to also inhabit a world outside the medical “bubble”: a world in which you are someone other than “Dr. X,” where you are reminded that “basic” knowledge might not be so straightforward for everyone, and where the context of world events does not first filter through a medical news site. Equally importantly, maintaining a non-medical identity provides you with protection. If your entire existence is interwoven with being a physician, your emotional survival becomes precariously balanced on the same. And if one day you must trade your white coat for vulnerability and a hospital gown of your own, it's essential that you have a remaining identity as a person to bring along.

So in the busy clinical hours, and the often equally hectic days and nights of studying and striving to become the physician that you will be, consider this appeal to also continue striving to be the person that you are, and to keep the medicine that you practice as person-centred as it is personalized. See your patients as the people they are, existing with an illness, but not eclipsed by it, and remind yourself that identity as a person should always come ahead of the identity derived from a role alone, regardless of overwhelmingly present or hard-fought it may be. ■

A vision: healthcare system improvement in British Columbia

Perneet Sekhon

University of British Columbia, Class of 2020

COMMUNICATION IS A VITAL part of providing good medical care. Communication needs to be clear, comprehensive, and translatable for all healthcare professionals involved in patient care. Part of communication is accessing information. Having quick and easy access to information is essential to continuity of patient care. By discussing current obstacles surrounding electronic medical health records (EMHRs), I hope to spark interest in this area and contribute to improving healthcare in British Columbia.

In Canada, until recently, recording patient information has been for the most part on paper. Hospitals, clinics, and other healthcare providers were responsible for recording and safeguarding these records. This gave them ownership. As you could imagine, this situation created a problem of transferability between healthcare providers.

Patients now had to submit requests for their medical records to be transferred

“Having quick and easy access to information is essential to continuity of patient care.”

to any new healthcare providers. This was a barrier to communication that negatively affected healthcare delivery in British Columbia.

As we moved out of the paper recording phase to a computerized system, the era of EMHRs was born. This would seem to be the solution to information transferability. And it currently is – however, only to an extent. The problem that now arises is due in part to the set-up of British Columbia’s healthcare delivery system. In British Columbia, there are five Regional Health Authorities (RHAs): Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health. Each of these health authorities are responsible for healthcare delivery in their given geographic areas.

Within each RHA, there has been a movement towards a ‘common’ EHMR to be utilized by all hospitals and clinics within the RHA. This has been achieved by the use of a common operating system which acts as a platform for the EHMR. For example, Interior Health currently uses Meditech 6.14, whereas Vancouver Island Health uses Cerner.

Information transferability between users of this system is significantly improved. The problem that still remains unfixed is information transferability between the different RHAs. This problem continues to exist in part because of the different operating systems used by the different RHAs. Patients therefore still need to overcome the hurdle of accessing

“The problem that still remains unfixed is information transferability between the different RHAs.”

their medical records when receiving care in more than one RHA.

The issue around informational transferability with regards to EHMRs is a relatively new problem. More attention and discussion needs to be brought to this problem as it can significantly improve patient care and safety. PharmaNet is good example of a province-wide information network system used in British Columbia. It provides pharmacists in communities throughout British Columbia access to up-to-date information regarding patient prescription history. As a result, pharmacists are able to better monitor and screen for appropriate medical dispensing.

The benefits of a province-wide EMHR in British Columbia are clear: it will improve patient care experiences, allow healthcare professionals to deliver better services, and lower the cost while increasing the efficiency of British Columbia’s healthcare system. ■

Introducing our Travel Award winners

THE CFMS TRAVEL AWARDS selects a limited number of recipients each year to attend the Annual General Meeting (AGM), which was held in Edmonton, Alberta last year. With assistance from MD Financial Management, CFMS provides financial assistance for the costs of the trip.

The opportunity allows non-elected medical students to attend CFMS

meetings with the goals of fostering greater awareness of CFMS's mission, promoting increased interest in CFMS, and facilitating participation in CFMS activities. Applicants submit a written application and are selected by a committee.

In 2016, we selected eight stellar applicants from medical schools across Canada: *Daphne Cheung*, University of Toronto
Angela Han, University of Toronto

Bushra Khan, McMaster University
Blake Lerner, University of Manitoba
Brendan Lew, McMaster University
Aalok Shah, Queen's University
Sarah Silverberg, University of Toronto
Grace Wang, University of Toronto

Included in this section are reflections from some of our travel reward winners. ■

Bushra Khan

McMaster University, Class of 2018

THE BEGINNING OF MEDICAL school signified the introduction to so many wonderful and new opportunities. There were so many firsts: the first time I donned a white coat, the first time I took a patient history, and the first time I had a patient to take care of. First, the firsts happened, then the acronyms started coming; OMSA, CFMS and AGM to name a few. I was inundated but also intrigued that there was so much opportunity for great work, great relationships, and great friends to be made in this new world of Canadian undergraduate medical education.

In July, I received word that the Canadian Federation of Medical Students (CFMS) was looking for applicants for its annual Travel Award to attend the Annual General Meeting (AGM) in

Edmonton. I had become increasingly aware of the amazing work the CFMS was doing to around improving the delivery of medical education, advocating for the student voice in relation to residency cuts, and placing a much-needed emphasis on student wellness. I like to be deliberate in the organizations I choose to work with and the CFMS resonated with me!

Before I knew it, I was flying non-stop to Edmonton where I was greeted by a slew of welcoming CFMS Executive members. The weekend was an enlightening experience being surrounded by the most engaged minds in medical education from across Canada. I had the opportunity to evaluate proposed CFMS position papers for endorsement, vote between candidates running for CFMS Executive

positions, and learn to improve my own advocacy skills through workshops hosted by CFMS alumni. Besides the professional improvements that I made during the Annual General Meeting, the friendships I established during the weekend were by far the most memorable. I can now truly say that I have friends at every medical school in Canada and I am committed, now more than ever, to work with my colleagues across the country to ensure a high-functioning healthcare system for the future. A heartfelt thank you to the wonderful team at the CFMS for providing with the opportunity to attend the AGM. I'm sure that my medical education and my future work will be a reflection of the great people and the great moments I had in Edmonton! ■

Aalok Shah

Queen's University, Class of 2020

CONSIDER MYSELF VERY FORTUNATE to have been selected as a CFMS travel award winner. As a first year medical student and a “first timer” at this conference, I not only learned about the structure of CFMS and how it practices advocacy on a national level, but I also broadened my intellectual horizons by interacting with many inspiring delegates from medical schools across Canada.

Through voting on various motions pertaining to medical education and the medical student experience across Canada, I learned how hardworking and passionate students could inspire change on a national level. Seeing how involved

other delegates were in the discourse during these resolution sessions also demonstrated to me how receptive and open other students were to the implementation of change. This experience was very empowering as a first-year student, as I am now aware of the process that will allow me to make a tangible impact on issues that I am passionate about.

Being introduced to the global health portfolio is another aspect of the conference that helped me immensely. After attending various small group sessions in global health, I became aware of several opportunities the CFMS provided for medical students, such as the IFMS

and CFMS international exchange. This experience was pivotal in helping me campaign for and become elected as the Junior Global Health Liaison at Queen's University. As the GHL Jr., not only will I represent the CFMS' global health portfolio to Queen's students, but also organize talks and conferences for any student interested in becoming engaged in global health.

Overall, I am very grateful to have received such an amazing experience right at the start of my medical education, and I will try my best to build upon this strong foundation over the next four years. ■

Sarah Silverberg

CFMS VP Government Affairs

University of Toronto, Class of 2018

THANKS TO THE GENEROSITY of the travel award, I had the privilege of attending the Annual General Meeting in Edmonton. This was extremely valuable to me as it allowed me to connect in person with many of those who I have worked with on drafting position papers all year, develop a plan going forward for the implementation of such policies, and to run for VP Government Affairs in person. It was valuable for me to hear and participate in the discussion surrounding the Medical Assistance in Dying paper, which two of my colleagues presented on behalf of our small working

group. It gave our team a broader perspective on the perception of medical students on the issue and helped us understand better what students would like the CFMS to advocate for with regards to this topic.

I also had the opportunity to meet with many of the students working with me on drafting a paper on Parental Leave in Medical School, an effort that I hope we are able to bring to the Spring General Meeting. Lastly, it was so helpful for me to hear the ongoing debates and concerns, and to be part of the discussion on the direction of the CFMS, as I take on the

role of VP Government Affairs. Not only did I get to introduce myself in person to many of those that I will be working with in the coming year, but I also got to hear from past executive members, as well as meet with my future executive team and get to know them through the election process.

Thank you so much for allowing me to strengthen my role in the CFMS community, and I hope my work throughout the year builds off of the strong start I got this weekend. ■

Grace Wang
University of Toronto

THE CFMS ANNUAL GENERAL Meeting (AGM) in Edmonton was a phenomenal and humbling opportunity for me. I was able to meet like-minded individuals and further enable myself to take action on important issues.

I talked to several attendees about satellite campus involvement. Through my school's Medical Society, my role is to oversee student clubs and ensure both of our school's campuses are equally represented. I spoke with students from different campuses of other schools to hear approaches that make their student body more cohesive. I learned about the new McGill satellite campus, the inter-campus slumber parties that Western holds, and the collaborative events held between

McMaster's three campuses. I look forward to presenting my newfound knowledge to our Medical Society so as to spark discussion and movement on this issue.

I was pleased to hear the various controversial issues the CFMS discusses and advocates for. I firmly believe that it is through taking a stance on issues like end-of-life care and suicide in indigenous populations we can garner respect and attention from medical students across the country. To witness different perspectives on issues and to hear the passion and integrity with which people spoke was inspiring.

I was delighted to see how much mental health was highlighted. I spoke with Alberta representatives from the

Mental Health Monologues and was impressed by their supportive campus culture. Hearing discussions like this on the national level emphasizes how important it is for us to have open and respectful conversations about mental wellbeing of young healthcare professionals.

The CFMS AGM was also really fun! I met the most extraordinary people, and Edmonton exceeded my expectations. My first CFMS AGM was a fantastic experience, and I am ever grateful to my Travel Award for making this possible. ■

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Dr. Herbert Ho Ping Kong, Leaving a Legacy

Darwin Chan

Annual Review Editor

McMaster University, Class of 2018



DESCRIBED AS BEING “AS BRILLIANT AS DR. HOUSE but nicer” and called a “giant in the world of medicine” by the media, Dr. Herbert Ho Ping Kong, currently a senior consulting physician at the University Health Network (UHN) and Professor of Medicine at University of Toronto, is renowned as an astute general internist who solves the difficult and mysterious cases that other physicians could not. Medical students and residents know him as an influential clinical professor and his excellence in teaching is manifested in the form of a collection of awards amassed over four decades. Perhaps the greatest distinction that separates him from his peers is his passion for using the art of medicine, which utilizes our senses of touch, hearing, and seeing combined with empathy for and curiosity about the patient, to make the right diagnosis.

RETIRED FOR 14 YEARS BUT still practicing part-time, Dr. Ho Ping Kong's longstanding clinic is finally winding down later this year. The *Annual Review* had the chance to catch up with him at the tail end of his journey to share his wisdom. We talked about the state of medical education, the art of medicine, and his experience as a general internist and diagnostician.

This year marks our 40th anniversary. One of our themes this year is passing the baton from an older to a newer generation of health professionals. If you could speak to your younger self, what would you tell him?

I would tell him that it's a great privilege to be a physician and this privilege comes with responsibility. We need to understand and utilize the great explosion of scientific advancements and technical advancements. At the same time, we need to remind ourselves that as physicians we have a human side. This contribution in combination with science and technology makes the complete physician. That's what my message would be.

You spoke during a speech earlier this year about how being a great diagnostician can be achieved by using our attentive eyes, our open ears, and our sense of touch. With the advent of technology in today's age, how do you foresee the dynamic between the subjective and objective and technology changing in how we assess our patients in years to come?

I think that medicine is really an incomplete science even though there are great advances in technology, science, new treatments, and so forth. There's a great part of medicine that remains in a grey area where we sometimes have no diagnosis and yet we have to treat; we have no cure and we have to care about those patients. I think there must be an

integration of the caring side of medicine; the compassionate, empathetic side of medicine that deals with communication, empathy, and advocacy. I really think that we need to remind ourselves and work at it. If you look at what's happening to our major leaders in medicine, the people who have been put into those positions based on their scientific background, at almost every university, hospital, institution, there is this talk about what it means to be a physician and how to make sure that the human elements are taught, learned, and applied to the practice of medicine.

How do you envision an ideal situation in which we are able to integrate the humanistic aspects of medicine with the new advent of technology?

I think that we have to work hard at this. I think that too frequently we spend too much time at the computer, typing our histories without even looking at the patient. We spend too much time looking at our handsets, without realizing that the patients notice this. I think there are advantages in having knowledge and quick guidelines at your fingertips but it's also important to be able to relate to the patient, to develop a bond between patient and physician which especially in difficult cases can help move forward the diagnosis and treatment. I think that we need to find an equilibrium where we don't allow technology to take over the entire doctor-patient relationship. Some of my friends in the United States, some now in Taiwan, now recently put this in great terms where they are trying to integrate the art of medicine into the curriculum: they don't want their students or doctors to be robots. I think that is a very great starting point as you move on to discuss where we are going to go with this humane side of medicine.

How do you go about teaching that?

We need mentors and physicians who actually practice that way and we've got lots of physicians in our system who

actually are the ideal type of physician. Lecturing might help, writing might help, but I think the big push will come from physicians who have that humane approach to medicine and from those who are compassionate and empathetic. At the same time, we need to fully appreciate the great advances with technology.

In your book, you wrote that in the 1980s one of your residents in Montreal almost ordered a biopsy of what they thought was an enlarged liver, which was actually an enlarged kidney after you examined the patient via simple palpation. The art of medicine encompasses our human senses of touch, seeing, and listening as you describe it. What else does it entail?

I think there are fundamental skills in seeing things, listening, feeling but that's not all of the art of medicine. I think that those human faculties allow us to interact with the patient. When we place a stethoscope on a patient's chest, true it is to try to hear the pericardial rub or listen for mitral stenosis, but it is also to make a bond between physician and patient. The very act of putting it there is developing that doctor-patient relationship and earning trust from the patient.

The art of medicine though is not only just those physical things that we would do as doctors, it's also about having compassion and having an understanding of what the patient problem is, whether it's clear or unclear, and then trying to do something about it. It's about advocating for the patient. So I think that the art of medicine also extends into those areas of medicine in which we have no answers, and as physicians we need to follow the wisdom of our predecessors and do no harm when we are unaware of the diagnosis of the treatment. For example, the tincture of time, allowing things to play out, is important.

What is the current state of medical education with respect to teaching the art of medicine?

Here in Toronto, Dr. Lisa Richardson and Dr. Nadine Abdulla have been pioneering a regular curriculum once every two weeks or so having special teaching rounds on the art of medicine which comprise of topics that are not usually taken care of by the usual curriculum; a lot of problems that are moreso humane and philosophical rather than technical. I think it's important that institutions develop those kinds of programs to teach it formally. Of course, I think it has a lot to do with the hidden curriculum and having mentors who actually demonstrate these qualities.

From your experience as a teacher and as a colleague to others, there must have been instances where you observed both a right way and a wrong way to teach medical students. In your opinion, what is the wrong way to teach?

It's historical in the past that at one time for example when you did ward rounds you conducted them in the corridor only. I was fortunate to come from an institution where we always examined patients at the bedside. When I came to Canada initially there were some hospitals where the senior residents and attending staff would do rounds outside the patient's room and not go to the bedside. At that time, we used to think that knowledge was the key to being a good practitioner, but we've come to realize that knowledge is not the only expert principle that we need to have. We also need to know how to communicate with patients, how to examine them, and how to be empathetic. Over the years, we have become better at understanding that to be successful, we need to develop that confidence from patients and their trust in physicians.

Where does your enthusiasm for teaching come from?

I taught high school for about 9 months before I went to medical school. At the time, I wasn't a very good teacher. I remember that I had 30 students and I taught math. I had no training as a teacher, but I was able to work my way through and to get feedback. So I had my feet wet when I was about 19 teaching high school students.

Later, I was influenced by great teachers. Dr. Osler, even though I was never taught by him directly, his name was always there as a teacher, as a diagnostician, as a physician. I had a generation of British trained physicians from Glasgow, London, other parts of the UK, who had the same philosophy as Osler had of being the complete physician and physical diagnostician and having the astute intuition and experience to make the right diagnosis and make the appropriate investigations. So I had great teachers when I was a medical student. They were all different and I took different approaches and put them all together.

I also had great influences from other professions. There was a detective from Montreal who had myeloma who went undiagnosed. He had seen me teach and I was teaching physical exam skills – looking at things, palpating not just feeling, listening not just hearing – to students and he turned to me and said to me, “that's the way I actually teach my students on how to approach a criminal case.” It taught me that even in medicine we tend to think we are completely different from everybody else but in fact there are generalizations and observations that are not only common to medicine but also to police who do their work.

From your vantage point, how has medicine changed over the years in terms of how it is delivered to our patients?

I think that if you go back to the 1960s when I started, it was at the

beginning of the era of subspecialization, especially in internal medicine where you went from being a general consultant to an endocrinologist, respirologist, gastroenterologist and so on. This also applied to surgery where you were a general surgeon and you became a urologist, neurosurgeon, thoracic surgeon and so it also happened elsewhere. And I think what happened is that medicine became compartmentalized. At one time at some medical schools we were streaming medical students from their first year of medical school into one of these subspecialties which I think was wrong because after several years we realized that you must have a general base of fundamental principles to practice what medicine really is before going into subspecialties. I saw that this subspecialization actually produced great advances in the technical aspects of medicine but with that came compartmentalization. The patient presents with not just one problem, but problems in more than one system, especially in the elderly. And with that comes the need to integrate things. I think that is even more true today with the older population with multisystem disease. I think we need physicians who have that broad general base to deal with multiple problems.

It seems like general internists weren't as greatly valued in the past as they are today.

In the 1960s, everybody moved towards some sort of subspecialty program. Starting in the US and soon after in Canada, I think the general movement took us on a different road because in Canada we have a primary healthcare system run by family practitioners whereas in the US the majority of the primary care was done by general internists. In Canada, we had to develop a specialty in general internal medicine. We took some time but eventually it became the norm. In fact, at almost all hospitals in Canada now, the general internists are the ones who deal with different systems with the help of subspecialty colleagues.

In your book, you wrote that there is no greater joy than being your brothers' and your sisters' keepers. I imagine that this intended meaning also entails taking care of each other as colleagues in the medical profession. What do you make of the recent systematic review and meta-analysis regarding the increased prevalence of depression and suicidal ideation among medical students?

I've been through some very sad stories that go back fifty years. I had one colleague in anesthesia in the 1960s who committed suicide after making a mistake. I've been in Jamaica and in Montreal where physicians have committed suicide. I recognize that self-harm is one of the things that we physicians

need to deal with. I think it's important to recognize that as physicians we have a special responsibility to take care of our fellow colleagues, residents, and students. My own approach has been to, at any request, never turn away a physician or a student seeking help from me. As a result, a significant part of my practice for the last 40 years has been taking care of doctors and students. I consider it a privilege to do that.

In your fifty years of practice, how did you combat the daily rigors of medicine to maintain your curiosity, empathy, and enthusiasm?

I've always wanted to be a doctor. I always felt privileged to be in a position where somebody entrusts their life to you. I'm fortunate to have that from the beginning. I don't think we all have the same compassion for people. It shows up

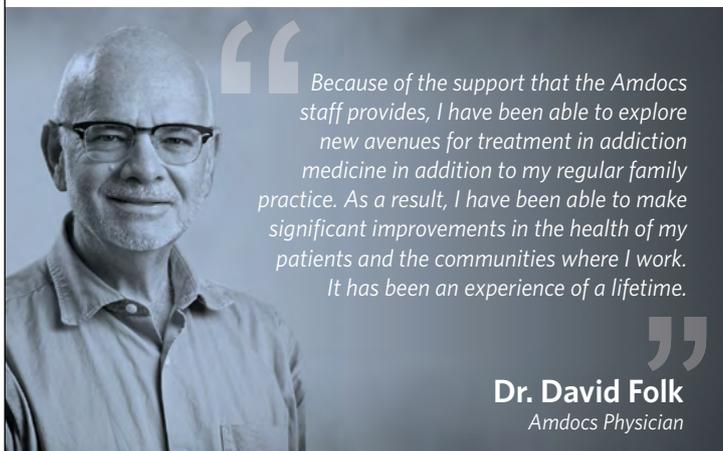
in kindness. I think people have always mentioned that I've been a kind person. I've always had a feeling of joy, of content, of happiness, of satisfaction when I do something for a patient. I've also been fortunate over the years, even though I've always practiced medicine in the wards, in the clinic, I've always had that change of job to speak. Among other things, I did 5 years as director of clerkship, 10 years as director of division, 10 years as director of the residency program. I think it's important to not do the same thing as you go along. I've been very fortunate to be able to change my role in the hospital system in a significant way and not lose that ability to do something creative and make a difference for the institution. I think change is important.

What are you doing now?

I've been retired since I was 65 but I've been moved into the Chang Chair

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for 11 years and last year I did a year as the Osler professor at UHN. I think my practice will probably close at the end of June. We've been winding down. I will become honorary consultant and physician at UHN and probably emeritus professor at U of T. I will probably stay with the UHN foundation in some fundraising capacity. I have this book project that is going better than I thought and I know it has generated interest outside of Canada and in Taiwan. The chairman of the accreditation council for medical schools in Taiwan bought the rights to my 'The Art of Medicine' book to translate it into Chinese. That project will last another two years. I've gone from being a teacher who never lectured for 40 years since I always taught by the bedside, and now I've moved a little bit away from that and I'm doing some keynote addresses. I have three or four lined up for the next year or two.

I read that some patients even after being treated and feeling better, they return to your clinic to see you. Now that your clinic is winding down, what will you miss?

I'll miss the one-to-one relationship that has always sustained me over the 40 years. I'll miss the thrill of making the right diagnosis. Having had it for 40 years you have a feeling that you may want to continue. I'm currently doing two days a week but there comes a time when maybe it's best to move on. I think it's probably time now since it'll be 14 years after officially retiring.

Any last words before the end of the interview?

I've had a really good run for 50 years. I've been in Jamaica, did a PhD, wrote in several journals, trained in London, worked in Montreal. There is

a lot for me to be thankful for. When I look back, I think that we as students, specialists, or generalists, it is important to think about the less fortunate, the sick, and patients from the less developed parts of the world. We really need to practice that we are our brothers' and sisters' keepers. Everything I do comes back to that. ■



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Know yourself, find your passion, and most of all, show up: an interview with CMA Past-President, Dr. Cindy Forbes

Alexandra Taylor
Dalhousie University



DR. CINDY FORBES IS THE PAST-PRESIDENT OF the Canadian Medical Association (CMA) and a practicing family physician in Nova Scotia. She graduated from Dalhousie Medical School in 1985 as President of her graduating class and continued on a leadership path to become President of Doctors Nova Scotia (DNS) from 1996 to 1997. She was more than happy to share her experience in various leadership roles and advice on how current medical students can be future leaders in provincial and national organizations.

How did you get involved in DNS and CMA?

Early in my practice I started going to branch society meetings because I was interested in local issues. From there, I went on to the board of DNS. There were things that were clear to me just starting that I thought needed to be addressed. I found, over the years, that getting involved is much less frustrating when you have a say. That gave me satisfaction and energy to keep going and deal with issues each day. It can be frustrating if you feel powerless, which becomes a set up for physician burnout.

When I became president of DNS, there were several meetings a year at the CMA so that was my first introduction. I was also a delegate for the General Council meetings. I was then nominated to chair the Council on Health Care and Promotion for three years.

How can medical students get involved in their provincial bodies?

Most provincial/territorial medical associations have both a student and a resident representative and this is a wonderful introduction to medical politics and a great way to meet a group of highly engaged physicians. Many PTMAs also have other standing committees or health promotion activities that include student representation - go on their websites and search for these opportunities. One such example is volunteering for the DoctorsNS Youth Run, or getting involved in your community such as volunteering at a refugee health clinic.

Students can also take advantage of directly contacting their representatives if they have issues or ideas because they are listening to their members. I think students might not understand the impact they can have. One of the most important things you can do individually is to show up. In today's age, where communication is at your fingertips, we are certainly using more and more online engagement, but with everyone's lives being busy, when you physically

meet with someone it has a bigger impact. You can't underestimate that.

How do you balance your practice and leadership roles?

There is not one single answer. You are always looking and assessing what your priorities are. I think it is a matter of not sacrificing too much of any one thing all the time. I also find a lot of these roles are invigorating. You are using a certain skill set in your practice and then find yourself at a national level advocating. It fills up the tank and gives you energy instead of many things that you do where you have to spend your energy.

I felt supported in those roles and that I was contributing. If I think about all the different roles I have played, they have allowed me to look at things wearing a different hat and not just one view point of being a physician in an office. I think it has really made me more tolerant and understanding.

How do you balance both professional and family commitments?

There isn't one magic answer. Having a supportive family is huge. The other is having supportive colleagues. If they didn't believe the work I was doing was important or didn't support me, I couldn't have done it. That kind of support doesn't just happen. You have to build and create that culture and collegiality by caring about each other as people. Part of caring for each other is covering each other's patients when they are away or ill or being ready to listen when difficult situations arise.

The other piece is constant surveillance. Know your own red flags that indicate when things are getting to be too much for you. CMA's Physician Management Institute promotes the module on Self Awareness as one of their core courses. Understanding your own strengths and weaknesses can be very empowering.

Why is CMA important after residency?

We have to realize that within the next 10 years, the majority of physicians in Canada will be Generation X/Y. One of the key challenges is how we make sure that the CMA as an organization remains relevant to young physicians.

I believe that having a physician organization that allows the profession to speak with one voice on national issues that are important to doctors and our patients is hugely important. Hopefully that has been demonstrated with some of the recent advocacy on assisted dying and seniors care.

The other important role is by providing products and services that support us in our work caring for patients and in our daily lives. I think that physicians in the early years of their career soon discover the need for a reliable source of up to date information and clinical tools, along with the importance of focusing on staying healthy - mentally, physically and financially.

What advice would you give to medical students?

The best advice I would say is think about what you are passionate about. There might be other things that you think need to be done but if you don't feel that passion then it probably won't be as rewarding. If you are someone that thinks you would like to be more involved or have a leadership position, look for like-minded people and get together with mentors. Create the opportunities, don't just wait for them! ■

Never been born

Beatrice Preti

McMaster University, Class of 2017

HER EYES FILL WITH MEMORIES OF BLOODSHED
and gore
“Hey, doctor,” she says. “I wish I’d never been born.”
Her legs are too short to reach to the ground
So I lend her my arm, and help her jump down
She runs to the window, and looks at the sky
“It’s raining,” she says. “Someone’s made angels cry.”
Her little feet patter like drops on the floor
My hands start to shake. I can’t take any more.
So I make my excuses and run from the room
My crafted façade lies shattered in ruins
My childhood, my life never prepped me for this

Where a child tries to die to find solace and bliss
I stare out the window as rain splashes down
I push out my heart, and I hope that it drowns
And, once I am sure that I’ve lost it (for now)
I take a breath in, and turn back around
I return to the room. She’s still standing there.
Her eyes are like oceans of endless despair
She speaks to me still, but I cannot hear
Though my body is present, my mind is not here
I don’t know what to do; my conscience is torn

What can you say when a child wishes she’d never been born? ■

Bypass

Shreya Jalali

CFMS Ontario Regional Representative
University of Ottawa, Class of 2019

HIS SCENT CUTS THROUGH THE ROOM’S DIM
romance
Cold blade draws the first line
Across dripping thoughts spilling over a dam,
his lips
so chaotic they seem
together
serene.

It’s hard to breathe here, on this precipice
Does he see me as I waver?
Does he feel my doubt as I sink my folded hands
Elbow-deep in red
Flowing slower, fading into fingerprints with less and less and
less hope
After all,
Everyone’s just looking for something to worship
and finding it gone.
The scalpel, the gods, this – your choice.

There are killers here, no different from lovers
Telling their stories amongst the remains:
Scene littered with a hand here, a heart there, drenched
In the shrieking hum of fluorescence
Flickering lights that falter like a pulse

From here, I see the drained remains
Of who we were, hidden away
Like a crime, or a polite white sheet over the body

He swallows my hunger
It keeps him fed, behind that sheet
His eyes half-shut, leak
Formaldehyde tears. ■

The theory of an approximate knowledge of many things

Rahul Walia

University of British Columbia, Class of 2019

STROKE
 there are different types
 ischemic
 a blockage of sorts
 the brain needs blood
 there are billions of neurons to feed
 billions, numbers I can't conceptualize
 there are billions of galaxies
 within them, billions of stars
 amongst them, billions of planets
 including ours

and on this planet, you came about
 to play, to hurt, to love, to laugh, to procrastinate by watching
 that show for the billionth time
 and to learn
 learn a little about the world around you amongst the billions
 maybe you won't get to know everything, maybe not even a
 billion things
 but if you're lucky, just maybe
 you'll gather an approximate knowledge of many things. ■

The afternoon I held forgiveness in my psalms

Yasmin Jajarmi

McMaster University, Class of 2018

ASK FOR ME AND YOU SHALL RECEIVE, FORGIVENESS TOLD ME ONE AFTERNOON,
 But seek me
 in that other holy place: in your patient
 whose body is the temple;
 find me there –
 and after, when you have peered up,
 through the astrologist's telescope,
 witnessed every constellation kiss,
 and still missed his Cancer –
 after, when you have helped her birth a still-born still-heaven child,
 when you notice medicine never birthed you whole either,
 when you notice medicine did not birth you
 in a hospital or a water bath,
 but in an ivory tower –
 jump, choose Camelot
 and ask that I am mixed in the river-rime
 ask for me to stay an afternoon
 to remind you of your pulse,
 and I'll remind you: landmark first, then press,
 count: brach-ial brach-ial
 break-heal break-heal,
 break heal: look,
 look at how your pulse fills its own cracks. ■

Zeno

Shreya Jalali

CFMS Ontario Regional Representative
University of Ottawa, Class of 2019

THE BREEZE GRAZES MY ARM IN THIS MOMENT,
with finely woven fragments of light and dust
that take form for a moment then scatter again.

I breathe them in – each particle, a person
a world unto himself,
unknowable.

Each floating speck
each changing life

following its own downward spiral
onto this glistening hardwood floor,
is quietly bound to every other.

So we tend towards one another across infinity
like these ashes and this dust
visible only under an unfocused gaze, illuminated by warmth
and the smell of smoke in old sheets and
the vague hum of conversation next door. ■

The shoreline, liminality of life

Moira Haggarty

Northern Ontario School of Medicine, Class of 2019

I wrote this poem while on a cultural immersion placement in the
First Nation community of Nibinamik (Summer Beaver) in May
2016.

HERE, I AM.
I find myself at the shoreline,
Below a soft sun,
Amidst a sweet wind,
And enveloped by a warm air.
Yet, just yesterday, pelted by snow,
Amidst a rugged lake,
A frightened sun,
A sharp air.
Here, I am. Or am I somewhere in between?

On the edge of civilization
Yet on the edge of wilderness
On the gateway of water's highways, connecting us all.
Yet off the grid, utterly unconnected.
Or am I somewhere in between?
I am now woven in this circle of people.
I am fully in this moment,
Yet in a flash, it'll be gone, only to be fondly remembered.
Here, I am.

Pressure to know, know, know,
Makes me crave to create, create, create.

Pressure to plan, plan, plan,
When I just want to be, be, be.
Pressure to achieve, achieve, achieve,
When maybe, the sweetness is in the in between.

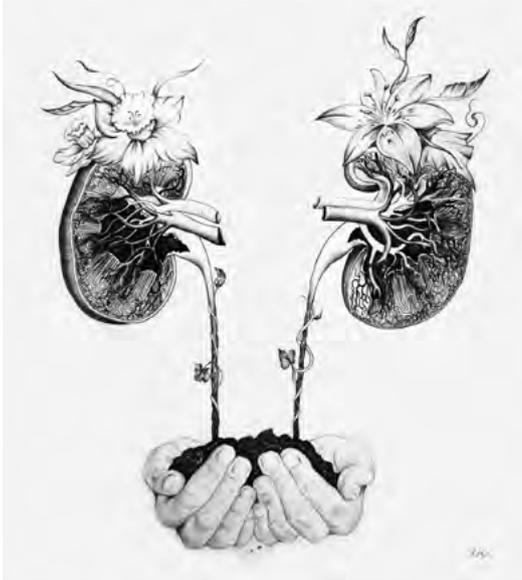
Is there a place where the shoreline ends, but before the waves
begin?
There, where the sun shines crimson bright.
There, where the moon glows crystal white.
In the place, where the shoreline ends?

Here, I am, in the in between. ■



Kidney blossoms ▼

Louisa Ho
Queen's University, Class of 2017



The pieces symbolizes the delicate physiological balance that kidneys sustain. With nurturing, hands-on care, the kidneys are seen to take root give life to beautiful blossoms. Growing from one side are daffodils, representing life, but on the other is a single lily, the flower of death.

Untitled ▼

Daniel Turski
McMaster University, Class of 2019



DR. LYNN PHNOAD GRADUALLY DISCOVERED THE NEED TO SIMPLIFY HER SCIENTIFIC JARGON WHEN SPEAKING WITH SOME OF HER PATIENTS.

The heart of medicine ▼

Louisa Ho
Queen's University, Class of 2017

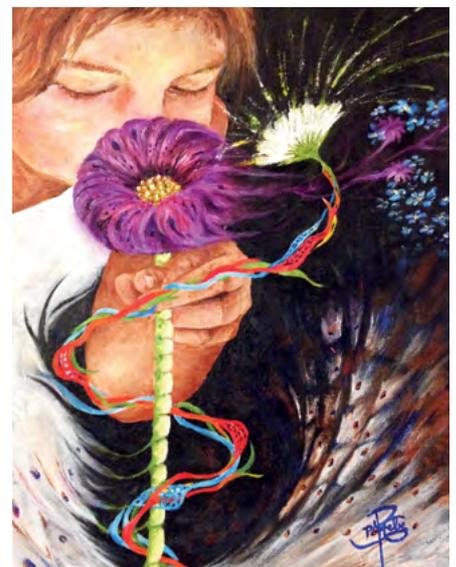
This piece represents what the medical school experience has been to me. Our future vocation in medicine has in many ways become a core part of how we define ourselves and is at the heart of who we are. But what has made these years truly special is being surrounded by a community of dynamic minds, which is symbolized by the network of dendrites, and these connections that will continue to flourish for years to come is what has made this journey so deeply meaningful.



Body garden of the medical mind ▼

Phoebe Cheng
University of British Columbia, Class of 2018

This painting celebrates the beauty of life and the intricate processes that maintain it, using flowers as metaphors for the micro- and macroscopic elements of the human body. Embedded within the mosaic of "cells" and "tissues" are two entwined flowers forming the Rod of Asclepius, a symbol of medicine and healing.



Lois ▶

Anastasia McCarvill
Dalhousie University, Class of 2019

“Lois” is a pencil portrait of a palliative patient in Halifax whom I have come to know very well. The crow perched on her wrist, a symbol of death, is a friend of hers; Lois lives harmoniously, graciously with the reality of her imminent death. Her crown emphasizes her regal grace; to know and to serve this woman is a privilege.



◀ Thrive

Vikhashni (Winnie) Nagesh
University of Calgary, Class of 2018

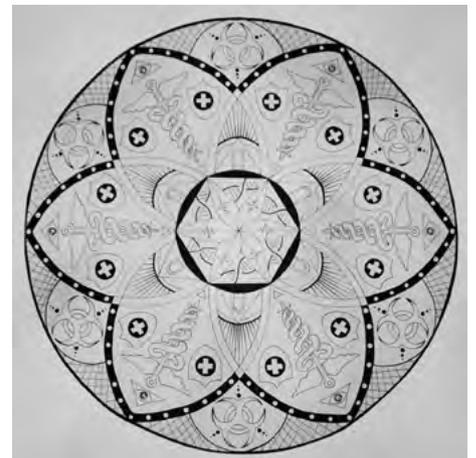
My inspiration was pediatric congenital heart disease patients that I encountered during an elective in Guyana. My goal was to portray the distinctive sternal scar following surgery, the transition from a cyanotic to an oxygenated heart and the extraordinary resiliency of those children with the flowers. This painting is depicting growth, recovery and thriving of life- not only of those kids, but myself.



▼ Medical mandala

Lucy Luo
CFMS Quebec Regional Representative
McGill University, Class of 2019

The Mandala (Sanskrit for “circle” or “completion”) is an ancient and cross-cultural symbol of wholeness, unity, balance and interconnection. It is a representation of both the microcosm and the macrocosm, and can be related to all aspects of life. Having always been attracted to patterns and details, I created this mandala to conceptualize my personal understanding of medicine.



▼ Untitled

Laila Nasser
McMaster University, Class of 2017



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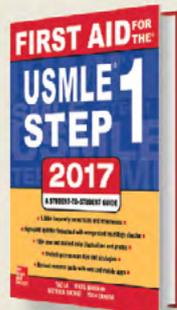
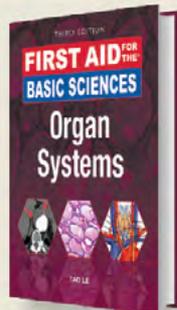
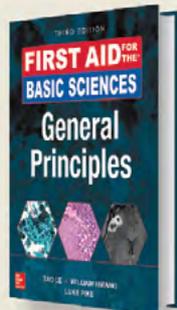
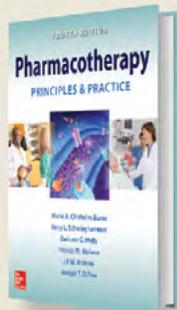
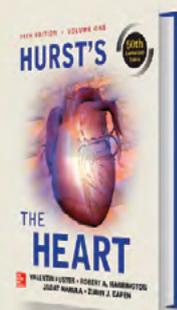
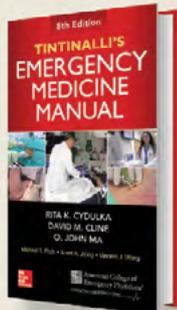
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