QMR

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Cover art provided by Linda Chang Qu

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Letter from the Editors

Dear Readers,

As we finalize this issue, the 45th annual Medical Variety Night is just over a week away. It is fitting that we will be launching this QMR, which is all about the intersection of medicine with the humanities, at MVN - an event where medical students will show that they are much more than just nerdy science lovers, but are also incredibly talented artists! For this issue, Beverley Guan, Jimin Lee (Class of 2017), Jordan Sugarman, and Nathan Terrana, MVN's co-directors, found time amid curtain calls to write an article about the show. And, the creativity goes beyond the stage: this year, members of the class of 2017 transformed their artsy sides into an advocacy project. Read more about that in Sadaf Rahman's (2017) article on the QMed Reads for Paeds initiative.

What would be a discussion of art without some controversy? To get your dose of differing viewpoints, look to our Point/Counterpoint from your very own Editors-in-Chief: we're discussing an important skill set for any medical professional looking to practice more artfully - leadership and followership. Continuing on the theme of controversial current events, Sophie Palmer (2017) takes us through the recent decision on Physician-Assisted Suicide.

Laura Bosco (2017) and Adam Mosa (2018) exhibit their CARL prowess with two excellent additions to this issue: check out Laura's investigation of how the arts and medicine intersect in curriculums across North America, then read Adam's proposal for a study to build students' grasp of the art of medicine by improving communication skills. Mahvash Shere (2018) also explores the research, explaining how best to check that those human skills have translated into patient satisfaction.

Arian Ghassemian and Gerhard Dashi (2017) went out into the field, gathering the quirky tips and philosophical ruminations of some faculty and students who manage to beautifully balance their busy lives. Genevieve Rochon-Terry also brings us some essential secrets from another busy doc: Mindy Lahiri of *The Mindy Project*.

Finally, take some time to admire the two incredible art submissions in this issue, reiterating just how incredibly talented our QMeds are.

As always, thank you to our executive team, our wonderful writers and editors, and our faculty advisor Dr. Jacalyn Duffin for her undying enthusiasm. It's been a fantastic year as your QMR Editors-in-Chief and we look forward to future years of success for the QMR!

Cheers,

Genevieve Rochon-Terry

Louisa Ho

Words from MVN Directors: "Behind-the-Scenes"

JIMIN LEE & BEVERLY GUAN, CLASS OF 2017; JORDAN SUGARMAN & NATHAN TERRANA, CLASS OF 2018
- Co-Directors, MVN 2015

Queen's Medical Variety Night (MVN) is an annual charitable talent show hosted by Queen's medical students, showcasing the talents of medical students at Queen's to the rest of the Queen's and Kingston communities. Drawing an audience of over 500 each year, MVN has consistently been one of the largest events hosted by the Queen's School of Medicine. Our audience includes Queen's medical faculty, physicians and other healthcare workers from local hospitals, as well as undergraduate and graduate students from the university. Over its 44 year history, MVN has become a huge part of the Queen's Medicine experience as an unforgettable show and an incredible feat of teamwork that Queen's medical students can take pride in.

Medical Variety Night is much more than just two nights of entertainment. Even before the start of the academic year, the Directors Team has been working together, applying for grants, meticulously planning each aspect of the show, and coordinating with a large team of performers, administrators and faculty, all in the hope of making the show a success. One of the first steps in our planning was selecting a theme to tie the show together. This year, by popular vote, the theme of "House of CaRMS" was chosen, after an American political drama series, "House of Cards". The television series features scheming, power-hungry characters doing everything it takes to climb the ladder of success; naturally, we saw some potentially humourous parallels with the CaRMS process. We were fortunate to have talented classmates with skills in script writing, acting, photography, videography and editing, who have done a fantastic job bringing the theme together in various formats of promotional materials.

Any performer can relate to the necessity of countless hours of rehearsals to perfect a three minute act. Walking through the new medical building in the evenings leading up to MVN, you will likely find medical students practicing bhangra jumps (for the iconic Bollywood number), rehearsing lines for a skit, or harmonizing for an acapella song. Some performers have years of experience, others have never even been on stage before, but everyone works together, and in the end, the final product is well worth the hard work. It may seem to some that all the hours spent practicing during the academic year are a poor use of time for "busy" medical students; however, it is during these grueling hours of rehearsal that we learn something important about ourselves, something we don't learn sitting in class. We learn how to battle through our own struggles and limitations. We learn how to deal with our frustrations and manage our insecurities. We learn about the joy of striving for perfection but also the beauty of imperfection. And, most importantly, we learn that succeeding together, as a team, is just as fulfilling - if not more so, than succeeding as an individual. These are the memories that are most treasured, and also what makes MVN special for both the performers and those watching. If our audience members can have half as much fun watching MVN as we did preparing for it, we will consider all our hard work worthwhile.

Left to Right: Jordan Sugarman, Beverly Guan, Jimin Lee, Nathan Terrana
- Co-Directors, MVN 2015

Physician Leadership vs. Followership

LOUISA HO & GENÈVIEVE ROCHON-TERRY, CLASS OF 2017

In this issue's Point/Counterpoint, QMR will explore the topic of physician leadership vs. physician followership, and how the dynamic between these may continue to shift in parallel with changes in healthcare structure and challenges.

Physician leadership and followership exist on a continuum. Though the arguments will each privilege one over the other, both are integral to decision making and positive change. Yet it is important to reexamine the role of each in tackling the unique problems with which our healthcare system is faced with today. Current healthcare organizations often have hundreds of doctors, where everyone is a specialist working in small groups. As a result, medicine is increasingly becoming an environment that demands teamwork. In this climate, the word "leadership" has evolved to become about delimiting roles and responsibilities and making functional teams, fostering an environment where the interpersonal relationships and conversations needed to change the cultural norms can happen, with a shift of focus on the needs and safety of patients. On the other hand, many medical students are chosen based on their leadership skills – these students may reflexively avoid having to collaborate or give up the spotlight. Where should we focus our skill development? The arguments that follow should give you some food for thought.

Point: Physicians at the Helm of Medical Leadership

LOUISA HO, CLASS OF 2017

"Physician leadership is critical to shepherd healthcare into the future, creating a delivery system grounded in better health and better healthcare at lower cost."

– American Association for Physician Leadership

Medicine selects for and encourages individuals with demonstrable leadership abilities from the very beginning, as a standard medical school interview evaluation criteria. Throughout the course of medical training, the Manager role under the Royal College CanMEDS framework cultivates continued leadership development, grooming physicians to become leaders in clinics, hospitals, communities, and for some, in health policy as well. In the Point, QMR explores the rationale behind fostering physician leaders and gives some examples of successful physicians leadership. This is followed by a discussion of some of the barriers to success as physician leaders, and how some of these challenges may be overcome in training programs.

RATIONALE FOR PHYSICIAN LEADERS:

"Physicians are increasingly drawn to management positions as a powerful platform for driving [the] reform process..."

Innovation in medical science has transformed medical care; on the other hand, the delivery of medical care calls for change. There is broad recognition that healthcare today faces a number of pressing challenges with regards to access, affordability and quality. Despite continued efforts to improve these parameters through policy, a gap remains between recommendations and implementation in clinics and hospitals. Future success relies on changing how care is delivered; this demands great leadership from the level of administration as well as from within healthcare teams. Physicians are increasingly drawn to management positions as a powerful platform for driving this reform process; after all, it is these system-wide goals of clinical efficacy and quality of care that motivate many physicians in their individual practices.

Having strong physician leadership in healthcare is beneficial for several key reasons:

1) Physicians are expert leaders. Through years spent as medical practitioners, physicians acquire a deep knowledge of healthcare needs and have a unique understanding of clinical issues. The clinical acumen that physician governance offers is unequivocally valuable in directing-making and institutional strategy; that being said, there certainly is also a role for the business acumen of professional managers to ensure operational excellence.

2) Physicians are credible leaders. Physicians tend be highly regarded throughout the community and have well-established credibility on healthcare issues. This places physicians in a strong position for liaising with the government and other stakeholders in instigating changes.

3) Physicians are engaged leaders. Physician leaders who are clinically active are used to coordinating patient care amongst numerous medical staff and support personnel. They are ideally situated for engaging in conversations with the right individuals and creating a culture, in part through leading by example, that supports and adopts improvement initiatives.

EXAMPLES OF PHYSICIAN LEADERSHIP:

Physicians as executives: Physician competencies in strategic planning, critical thinking, advocacy, and stakeholder relations are highly desirable and sought after in leadership. There are a growing number of healthcare organizations appointing physicians to executive positions. Here in Kingston, orthopaedic surgeon Dr. David Pichora is the Chief Executive Officer (CEO) of Hotel Dieu Hospital (the CEO of KGH is Leslee Thompson, who started her career as a

critical care nurse). In the United States, while most current hospital CEOs are non-physician mangers, 5% of hospitals are led by physicians and this number is steadily growing[1]. Notably, some of the most prominent systems in the United States are led by physicians, including cardiac surgeon Dr. Toby Cosgrove at the Cleveland Clinic and neurologist Dr. John H. Noseworthy at the Mayo Clinic. The Mayo Clinic is described as a doctors' organization; there, physician leadership wins out over administrative leadership when there is a tie vote because the Mayo Clinic exists to deliver health care services, not accumulate wealth.

It is worthwhile to note that in a recent report[2], hospital scores assessing quality, service, and cost are 25% higher in physician-run hospitals compared to those run by non-physicians. Hospitals positioned higher in World Report's "Best Hospitals" rankings[3] are likewise led disproportionately by physicians. This suggests that having physician managers confers clinical and organizational benefit to the organizations they lead, although the mechanisms behind this are not fully understood.

"...having physician managers confers clinical and organizational benefit to the organizations they lead..."

Physicians as innovators: Physician leadership is important at the apex of the organization, but leadership occurs at all levels of the system. Physicians are also at the forefront of health policy and healthy delivery innovation on a larger scale. For example, during his time as the Director of the Centre for Medicare and Medicaid Innovation (CMI) at the Centers for Medicare & Medicaid Services (CMS), Dr. Richard Gilfillan developed the Medicare Shared Savings Program (MSSP), which has been widely regarded as an important catalyst in transforming health care systems across the United States. Another prominent figure is Dr. Bob Wachter, who is considered the academic leader of the hospitalist movement: the fastest growing specialty in the history of modern medicine.

Moreover, physicians in both formal and informal leadership roles have led important advancements in healthcare. Several examples of physicians who have made a meaningful impact in informal leadership roles include Dr. Mike Evans, pioneer in the use of social media in patient education for preventative medicine through videos such as the YouTube sensation "*23 and 1/2 hours*"; and Dr. Atul Gawande, a highly regarded health-policy scholar and influential thought leader on contemporary and contentious medical ethical issues, with published work including the books *The Checklist Manifesto* and *Complications* in addition to being staff writer for *The New Yorker*.

Physicians as non-medical leaders: For the sake of completeness, several notable examples of physician leadership outside of the health industry include internist Dr. David Naylor, past president (2013) of the University of Toronto; oncologist Dr. Susan Desmond-Hellmann, CEO of the Bill and Melinda Gates Foundation as of 2014; and Dr. Jim Yong Kim who became president of the World Bank in 2012.

DEVELOPMENT OF PHYSICIAN LEADERS:

Continued success in achieving improvements in medical care depends on identifying, engaging, and developing the skills of physicians to lead the change.

Barriers to success:

"Traditional criteria for physician advancement to leadership regard academic and/or clinical accomplishments..."

1) Essential character traits that make an effective clinician are not necessarily the essential character traits that make an effective leader. Traditional criteria for physician advancement to leadership regard academic and/or clinical accomplishments, and pursuit of academic clinical proficiency competes for physicians' attention towards developing the leadership competencies required to lead.

Suggestions for improving medical leadership[5]:

1) Selecting more medical students who have the ability to become great leaders
2) Integrating medical leadership training in all steps of medical education
3) Offering increased recognition to physicians undertaking leadership positions
4) Privileging managers with a solid clinical background when filling medical leadership positions
5) Offering higher wages and greater incentives to motivate future physicians to orient themselves towards health-related management careers

2) Healthcare organizations are challenging environments to lead[4]. Healthcare delivery goals are multiple and often competing, with constant tension between clinical care, patient experience, and expenses. The duality between aiming for corporate profit and time efficiency, versus patient-centered quality of care and empathy, represents a major dilemma for leaders. The scope of regulation is also very complex and dynamic, with policies and technologies continuously evolving, and evidence about their effectiveness often incomplete.

3) There are limited job opportunities for physicians on hospital management teams. In Canada, there are currently very few CEO or chief medical officer (CMO) positions available that allow fully trained doctors to both make use of their medical skills and act in a managerial capacity. Moreover, in these positions, a complex bureaucracy often persists around the management team, with an underlying disconnect between physicians and directors.

Programs for development:

"In Canada, there are currently very few CEO or chief medical officer (CMO) positions available that allow fully trained doctors to both make use of their medical s kills and act in a managerial capacity..."

Given the increased demand for physician leaders, there is an emerging trend in which healthcare institutions offer physician-leadership programs. The Canadian Medical Association (CMA) offers leadership programs and workshops through its Physician Manager Institute. Even though these workshops are easily accessible and offered across Canada, they are very costly, and few incentives are provide to physicians who consider pursuing this leadership training. For individuals who intend from the start to be doctors serving in leadership roles, McGill offers a joint MD-MBA five-year program. Although it is the only one in Canada, in the United States there are currently 65 MD-MBA programs.

A number of research groups have identified core competencies that are critical for physician-leader training programs. Three main qualities which form the basis of medical leadership are[5]: 1) the capacity to work in teams 2) the ability to personify essential leadership skills and 3) possession of a strong emotional capacity. These abilities are critical for integrating active physicians into existing management structure and bringing realistic contributions to their work team under a positive group dynamic.

CONCLUSION:

In conclusion, the Canadian medical system continues to face challenges that require ambitious healthcare reforms. Many other countries have begun to realize the importance of good medical leadership in leading this change. The leadership responsibilities of physicians are a frequently neglected aspect of practice, and Canada should place increased emphasis on developing a new generation of competent and efficient medical leaders. There are currently a number of promising initiatives related to the integration of leadership training into medical curricula. However, there remain a number of barriers on the path towards sustainable leadership that will have to be addressed as healthcare provision continues to evolve.

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Counterpoint: Followership - Not to be Forgotten

GENEVIÈVE ROCHON-TERRY, CLASS OF 2017

As a medical school applicant, I often got this advice: "Stay involved with one thing for a while, and keep moving up through the ranks! Then, by the time you apply you will be able to talk about how you *led* that activity".

In other words, leadership is the final goal; the ultimate, shining cherry-on-top of that perfect med school application. And followership? That's just the means by which you'll become a leader.

"But there is no leader without a follower..."

But there is no leader without a follower. Moreover, too many leaders vying for control can mean a lack of clear team vision. Having multiple perspectives on how to act, with no one willing to compromise or try the alternative, may hinder decision-making and action. And when the approach is unsuccessful, blame and "I told you so" can ensue. While leadership is important, it is by no means the only, or most critical, part of the equation. It's time to give ol' followership some credit. Often overlooked amidst leadership-focused interview questions and workshops, followership is actually a powerful role which, used correctly, is key in cultivating change. We need physicians who are just as effective as followers as they are as leaders.

Followership is the act of following a leader. Though often associated with passivity and docile obedience, it is not these things – rather, followers actively influence the decisions of a leader through critical analysis, interaction, and support.

There are four recognized styles of followership[1], each employing different levels of critical thinking and engagement. First: passive followers, who do what they are told, but need constant motivation and direction. They do not apply independent critical thinking, and can be a drain on the team energy. Conformist followers, on the other hand, are motivated but still do not think critically on their own. As a result, the team's decision-making process may miss alternative options and lack creativity. The angry rebels of the group are alienist followers. They do lots of critical thinking, but are disengaged from the organization and cynical about the task. They tend to find the reasons why something shouldn't happen rather than looking for productive solutions.

"...followers actively influence the decisions of a leader through critical analysis, interaction, and support..."

The best are exemplary followers. These individuals are engaged and will use critical thinking constructively so that decisions are sound and optimized. One consideration in being an exemplary follower is avoiding group-think, in which group members think about and analyze issues the same way. This can lead to a decision that overlooks potential problems and alternative ideas because the group agrees too quickly. Avoiding this may require bringing people with quite different expertise into the group to shed light on different perspectives.

Finally, pragmatic followers will move between the various styles during a task according to their whim. Like a five-year-old, they are helpful at times, when they suddenly decide to be on their best behaviour and make you a well-meaning breakfast in bed. But ask them to do the same when, just the night before, you didn't let them have ice cream for dessert? They may not be as willing.

"Being an examplary follower... requires the courage to express concerns, and the thought[fulness to do so without undermining the group's respect for the leader."

Being an exemplary follower requires the humility to adapt to decisions about which you were initially concerned, once they have been examined and explained adequately. It demands that the follower support the leader as they go forth with a decision. But it also requires the cour-

age to express concerns, and the thoughtfulness to do so without undermining the group's respect for the leader. This responsibility to think critically about actions means that exemplary followers are well placed to influence decisions and create change. In fact, it can be argued that as a great follower, you can have as much or even more influence than your leader. Leaders are subject to external pressures that can hinder their ability to speak their mind; being the visible face of a project puts you under scrutiny from which your team is often more protected. As a follower, your thinking can be less restrained and more creative because of your less public position.

Here are three areas in which physicians need to adopt a follower mindset:

1) In health policy: let's be advocates for our patients by working with other experts – economists, urban planners, social justice scholars – rather than trying to lead the charge ourselves. We have the training and drive to be brilliant members of a team, but we have many deficits in our knowledge outside of the medical sphere. Our few hours of public health training won't prepare us for the intricacies of creating health policy; but luckily, there are others who have trained for years to have this expertise. When these others are more knowledgeable, it is only by letting them take the lead that we can create well-rounded and viable solutions. When in that position, let's use our intelligence to question decisions with thoughtful insight – not because we want to undermine our leaders or are seeking to take over, but because we genuinely care about a better outcome for population health.

"...let's use followership skills to sit back and let our patient's tell us their story, to really listen as they tell us about their health, their body and their life..."

2) In our clinics: let's use followership skills to sit back and let our patient's tell us their story, to really listen as they tell us about their health, their body and their life. Let's be the follower to their medical narrative. As with working on a team, in narrative medicine we have to sit back and absorb the story, engage with it, learn from it, and act on it.

3) Internationally: if we choose to travel overseas in search of enabling global development, let's use followership to make us more open to learning from those that we travel overseas to help. This attitude is key in global development work, in interventions that will potentially conflict with peoples' culture and ways of life. It's crucial when searching for the best ways to help people with whom, try as we might, we cannot fully relate because we've never been through their experience. In these situations, we need to let others lead – sure, while questioning decisions and reflecting on the interventions, but doing this from the stance of a follower who is more interested in the outcome than his or her own gain.

"There is power in being the follower, the one that makes things happen behind the scenes..."

There is power in being the follower, the one that makes things happen behind the scenes. It requires, however, that you put aside your need for recognition for the sake of the greater good. For many medical students, this implies a major shift in attitude. In a culture that rewards those that stand out – getting into medical school, for example, required careful and deliberate thinking about how to differentiate ourselves – it is easy to feel that followership means settling for less. Yet learning to be better followers may be key to creating change, from our clinics to the overarching health system.

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Leaving FIFE Behind: A Foray into Narrative Medicine

GENEVIÈVE ROCHON-TERRY, CLASS OF 2017

Narrative medicine. For most of my career as a medical student, this term has been lumped in with several other concepts that I always feel a little guilty for not understanding better – things like the precise layout of the myotomes and dermatomes and – according to my clinical skills tutor – the right method for looking at a patient's retina. But it's a topic to which a number of people whose perspectives I respect often refer, and so I set out to try to get a grasp on narrative medicine. This was no easy task; narrative medicine is a young field, and its key thinkers take somewhat differing stances in their approach.

Rita Charon defines narrative medicine as "medicine practiced with [the] skills of recognizing, absorbing, interpreting, and being moved by the stories of illness"[1]. A physician, literary scholar, and the Founder and Executive Director of the Program in Narrative Medicine at Columbia University, Charon is credited with having defined and concretized narrative medicine. She explains that there are two ways of knowing about a patient's illness: the first is via science, through which we analyze a person's health based on signs, lab values and imaging; the second is by attending to and interpreting patients' stories.

In her talk for TEDxAtlanta[1], Charon – looking the part of a spiritual guru of sorts in her flowing, subdued layers – describes how her journey to understanding the role of narrative medicine began once she was out in practice. "What patients paid me to do", says Charon, "was to pay exquisite attention to the narratives that they gave me – in words, in silences, … facial expressions, in their body… in what other people said about them. It was my task to cohere these stories so that they at least provisionally made some sense, to take these multiple contradictory narratives and let them build something that we could act on". Charon, who grew up an avid reader but still felt that she lacked the tools to interpret a patient's story years into her career as a physician, went to Columbia's English department for answers. She explains that "awakening and nourishing [her] own sense of story… transformed [her] practice, [fortifying it] with the knowledge of what to do with stories…".

How does this play out practically? According to Charon, it starts when the physician begins patient encounters with an open-ended invitation for a patient to share his or her story: "I will be your doctor, and so I need to know a great deal about your body, and your health, and your life – please tell me what you think I should know". Then, without writing things down, she sits and listens, deeply absorbing what is being said. People respond to this, Charon tells us, for they are "not only able, but deeply thirsty, to give profound, eloquent accounts of themselves".

> *"…Being there to listen – and listen well – to someone in his or her most human moments is the privilege that we have as medical professionals…"*

The approach that Charon advocates contrasts sharply with the checklists and mnemonics that we've learned to use in our patient encounters. In our current idea of a patient encounter, one where FIFE is used as a verb, the narrative method seems inefficient and insufficient for the purpose of uncovering all those symptoms and past medical histories and doses of medications. Yet Charon and other proponents of narrative medicine argue that the medical profession is not there merely to diagnose and ward off disease, and it is this claim that is at the core of narrative medicine. The primary goal of medicine, says Charon, "is to donate the expertise to an act of fidelity, to give someone company, to form staunch, sturdy affiliation [with patients] within our shabby clinics, so that no one has to be in the glare of sickness, or in the glare of death, alone". Being there to listen – and listen well – to someone in his or her most human moments is the privilege that we will have as medical professionals. It is one of the rare professions in which people from all walks of life will open up to you about their lives, their health and their bodies – if you allow them to do so. To do justice to that privilege, we must know how to listen in a way that honours the patient's story and its meaning. These stories can then give us clues about how to act in our capacity as (future) doctors. Listening to our patients

can provide a glimpse of what the ideal medicine would be, going well beyond numbers-based patient outcomes or statistical analysis of physician wellness, and giving us the practical means to move towards that ideal.

Sayantani DasGupta, another physician faculty member of Columbia's Narrative Medicine program, begins her own TED talk by asking, "When was the last time you felt truly listened to?"[2]. Being listened to, she says, "is one of our truly human needs, and exponentially so in times of crisis, sickness, trauma". The behaviours of listening are numerous and subtle, but we know when we are being listened to – really listened to. DasGupta asserts that listening cannot be replaced with a checklist or the right body language. These things are not listening but acting; faking your humanity when you are tasked with assisting someone in the most humane moments. "Listening", she says, "is tapping into our innermost humanity and making that humanity present such that we might witness the humanity of another". In other words, very much the opposite of the contrived questions required to (cringe) "FIFE" a patient.

"...medical training has the capacity to erode the humanity with which students first enter the profession. Yet, it is our job is to listen to someone in the most humane way possible."

DasGupta adds nuance to the narrative medicine paradigm by highlighting the need to listen to patients with what she terms narrative humility. This requires that the physician take on an attitude of complete openness when listening to a story. Narrative humility also demands an acknowledgement that we cannot master a patient's story the way we master the list of symptoms associated with a particular condition. In an article for The Lancet[3], she writes: "Assuming that our reading of any patient's story is the definitive interpretation of that story is to risk closing ourselves off to its most valuable nuances and particularities." We must open ourselves up to receive stories, to absorb them, listening to them deeply so that we can hear the things that are there rather than the things that we are expecting to hear. Otherwise, we risk missing a key piece of the puzzle: a diagnosis, a psychosocial issue, a barrier to treatment.

DasGupta feels that medical training strips students of the inclination to practice narrative humility through its culture of hierarchy. By informing medical students that they are the best of the best, subjecting them to grueling hospital shifts and enormous pressure that leave little time to care for one's personal wellness, and quietly telling them that medicine is more important than the rest of their life, medical training has the capacity to erode the humanity with which students first enter the profession. Yet, it is our job is to listen to someone in the most humane way possible.

That's where programs like Columbia's Program in Narrative Medicine come in. Such programs (and there aren't many) seek to teach health professionals what they perhaps once knew but have long forgotten: how to bring a narrative medicine mindset into their daily practice. Charon and DasGupta promote a practical approach to learning narrative medicine: students read stories, write their own personal narratives, and practice listening to the stories of real patients. These are simple acts, yet almost instinctual. After all, humans are storytellers by nature – it's been said that it is our storytelling that enhanced our evolution and our discovery. Our brains are made for storytelling – way back when, the act and art of narrative helped us pass on strategies for finding food, navigate the earth, and heal ourselves. And we respond to stories on an emotional level – for example, when we read a sad novel and feel sad though we aren't there.

Learning how to understand narratives results not only in a better understanding of patient experiences, but also of the interactions of physicians with each other and with the medical culture. DasGupta relates how one medical student with multiple sclerosis wrote about her experience and her advice for doctors. Her demand for narrative humility is a powerful one: "Don't stand by the foot of the bed and tower over your patient – she feels small already – take a minute, sit down, listen… Try to understand. Realize that you will never understand. Try anyway". Yet the piece also highlights the risks attendant to such displays of vulnerability within the medical profession: this student published the piece under a pseudonym (C. Sebastian), because of her fear that she may be punished for her openness.

"... The benefits of narrative medicine go beyond patient care: as medical trainees and future physician teachers, narrative medicine may be the key to our emotional survival..."

The benefits of narrative medicine go beyond patient care: as medical trainees and future physician teachers, narrative medicine may be the key to our emotional survival. We need to be able to talk about the struggles we face, the times we have to disappoint our patients, the times we can't help but return home to our partners, children, and friends with a particular case on our mind. Developing a medical culture in which it is okay to share stories – to admit when a patient's trauma is affecting you – is necessary if we are to remain emotionally balanced and capable of navigating the many ups and downs that will undoubtedly characterize the intersection between our personal and professional lives.

My brief foray into narrative medicine leaves me with many questions, in particular around the generalizability and feasibility of a narrative medicine framework. Is wide-scale adoption of the framework possible within the current health care system? Or, should we strive to recreate the system with narrative medicine at its core? Most of all, how does one translate narrative medicine into action? I find myself searching for something concrete within these theories – for some sentence that will instantly instill in me a solid definition of narrative medicine, along with a clear sense of how to know whether I'm doing narrative medicine correctly! Part of me wonders whether my desire to seek practical, actionable steps within the theory is a result of my brain's adaptation to the learning required by medical school. Perhaps the last two years of PowerPoint presentations and lists of symptoms have hindered my ability to rest easy with the theoretical; with that which cannot be mastered and memorized, but rather whose meaning must be revealed with time and experience. And on a different level, does my unease perhaps reflect medical culture's discomfort with that which is messy, complex, unquantifiable?

Despite my lingering questions, I am left feeling encouraged – cautiously hopeful about the promise of a framework that acknowledges the privilege of being privy to patient stories, a privilege that makes the doctor's role all the more relevant in a world of Dr. Google and his broad and utterly faceless differential diagnoses.

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Reads for Paeds: Advocacy from the Class of 2017

SADAF RAHMAN, CLASS OF 2017
Co-Chair, QMed Reads for Paeds

The tradition of giving back to the community is a strong one at the Queen's School of Medicine. At the end of their Global Health unit, the first year class is encouraged to generate and manage a project that positively contributes to the lives of a Kingston patient population. It is from this admirable tradition that the QMed Reads for Paeds Project was initiated by the Class of 2017. The idea for a children's book project was proposed by Geneviève Rochon-Terry and received more than half the votes among the ideas proposed.

The QMed Reads for Paeds project seeks to develop illustrative, engaging and age-appropriate books for children with illness. Currently, 45 students are working in teams on eight different projects, with tremendous support from numerous faculty members. The book topics were chosen based on input from these faculty members, and focus on high-need paediatric conditions that are most in need of this initiative. Topics traverse many different domains and include: diabetes, cystic fibrosis, Wilm's tumour, haemophilia, juvenile idiopathic arthritis, functional abdominal pain, eating disorders and fractures.

We are pleased by and immensely grateful for the support that the Reads for Paeds project has received. Aside from contributions by almost half the Class of 2017 in creating the books and from faculty members in providing their enthusiastic input, the Aesculapian Society, the Alma Mater Society and Medical Variety Night are key sponsors. Their contributions will help in covering the printing costs for the first round of copies. The books will then be distributed free of charge to paediatric patients dealing with those diseases, with the hope that the child-centric writing and illustrations will help to de-mystify their illness.

It is exciting to think of the potential reach for this project. While this initiative will first be piloted in Kingston to assess its uptake and impact, the books can easily be distributed more widely. There are plans to offer the books in electronic format, which will facilitate this large-scale distribution. The prospects for generating books on new topics are also numerous and we hope that the project can be sustained with interest from each successive incoming class. It is humbling to think of the impact that the Reads for Paeds project might have and we hope to report back with good news within the year.

Assisted Suicide as a Philosophical Question

SOPHIE PALMER, CLASS OF 2017

In the recent Supreme Court of Canada decision on Carter vs. Canada (AG), the provisions in the criminal code prohibiting physician-assisted suicide were unanimously struck down. This legal decision is only the beginning of a wider discussion about death and dying that Canadians and Canadian physicians will need to have in the coming months and years – particularly as the 12-month suspension on the ruling ends and assisted dying comes into the open.

"…Medical students and physicians carry a double burden in this regard: we can expect to have this service requested of us in the future, and we also may wonder about whether we as patients would one day request the hastening of our own deaths. "

With a life and death issue as weighty as this one, it is difficult to know where to begin in categorizing one's own beliefs and preferences about the issue. Medical students and physicians carry a double burden in this regard: we can expect to have this service requested of us in the future, and we also may wonder about whether we as patients would one day request the hastening of our own deaths. Philosophy as a humanitarian discipline can aid in the exploration of what, for some, may be a very difficult question. For those who are confident in where they stand on this issue, a basic knowledge of philosophy can aid when considering difficult questions, or in analyzing the roots of one's beliefs on this issue or any other.

Philosophy is traditionally split into three branches: epistemology, metaphysics, and axiology (which is similar to what in medicine we might call ethics). Each of these branches addresses and questions the meaning and reality of our world in a unique way.

Epistemology

Epistemology is the study of knowledge, and questions the nature of knowledge and how one comes to know. A clear example of the importance of epistemology comes into play when considering arguments over the term physician-assisted suicide vs. physician-assisted death, vs. physician-hastened death, or any other rendition of the above. How do we define suicide? How do we define killing? In order to answer these questions one must absorb an abundance of information from one's surroundings, in addition to working through the internal thought processes that must occur to come to an answer. It is also important to question the way these definitions come to be. Is it ever possible to know the suffering of another person? In a world of evidence-based medicine, are quantitative measures of suffering more valuable than its qualitative aspects? If we attempt to quantify suffering, will this be valid? What information do we use to determine whether or not a patient is "committing suicide" or "hastening death," and what is the difference between these two terms? Medicine is meant to be evidence-based, but there are questions of knowledge that randomized-controlled trials can never answer, and this is why medicine is also humanitarian. But in physician-assisted suicide, one must be confident in the epistemology of suffering, flawed and humanitarian as it may be, in order to make decisions about when this practice has the potential to be a kindness, and when it can only be a harm.

"…Medicine is meant to be evidence-based, but there are questions of knowledge that randomized-controlled trials can never answer, and this is why medicine is also humanitarian."

Metaphysics

Metaphysics is the study of existence, seeking to explain the nature of being and reality, including what is beyond experience. While religion offers a metaphysical explanation for existence, it differs from the philosophical

discipline of metaphysics in that metaphysics is generally more flexible and is based on logical deductions. The metaphysical beliefs (be they informed by religion or not) that one holds about life, death, and life-after-death or its lack thereof may strongly influences one's beliefs surrounding physician-assisted suicide. Similarly, one's metaphysical beliefs on issues such as consciousness, free-will, and self-determination come into play as one assesses the "capacity" of an individual to request physician-assisted suicide. When does despair about illness and one's death become medicalized in the form of a major depression? When does a clinical depression become a subverting feature of one's own free will, a defining cause of incapacity? The answers to these questions are only tenuously answered by psychiatry and much of the answering may be left up to the individual physician.

"…When does a clinical depression become a subverting feature of one's own free will, a defining cause of incapacity? "

Axiology

The last main branch of philosophy is one that physicians and medical students may be the most familiar with: axiology, the study of value and value judgements. While axiology is in a sense broader than ethics, in that it encompasses the study of aesthetics and religion, its sub-branch of ethics is the one most relevant to clinicians. Ethics, also known as moral philosophy, is the study of principles of ethics and morality—how do we determine what is right and wrong? What does it mean for something to be right and wrong? Are these valid constructs? The application of ethics to physician-assisted suicide is excruciatingly clear, and the majority of what has been written and said about physician-assisted suicide has been done so in order to make a statement about whether it is "right" or "wrong." Different individuals follow different lines of thought, and draw on forms of epistemology and metaphysics in order to determine the ethics of physician-assisted suicide. Various sets of values come into play—the value of mercy, of not killing (and one's own definitions of killing and mercy), the value of a longer life, the value of pain, the value of avoiding pain, etc. These values can form a complex economy and physicians and patients may need to balance many competing and sometimes contradictory values when considering physician-assisted suicide.

A discussion of philosophy and its application to physician-assisted suicide is not an exercise in clarification. Rather, it is an opportunity for consideration, to methodologically question the axes upon which beliefs and knowledge lie, meaning is generated, and right and wrong are ultimately determined. The British philosopher Bertrand Russell describes this gift of philosophy well: "To teach how to live with uncertainty, yet without being paralyzed by hesitation, is perhaps the chief thing that philosophy can do." An awareness of these basic philosophical questions can allow us to accept and acknowledge what we do not know – and perhaps cannot know – while continuing to act in the patient's best interest and in line with their wishes.

The Art of Medicine, or Art for Medicine?

LAURA BOSCO, CLASS OF 2017

INTRODUCTION

The budding intersection of arts and medicine represents the gradual shift in prioritized competencies within medical education. Following the technical and scientific revolution, medical education curriculums were primarily focused on shaping students into medical experts. There was a growing reliance on imaging and basic-science investigations, an increase in professional burnout, and a public that appreciated the value of scientific advances but distrusted their clinician's devotion to their best interests[1]. In 2012, Darrell G. Kirch, President of the American Association of Medical Colleges, stated, "In surveys, the public had great confidence in doctors' knowledge but much less in their bedside manner"[2]. Albeit the medical curriculum consistently emphasizes the importance of moral standards, professionalism, and communication skills, the didactic educational style used to convey these principles have not adequately produced the desired effects in students[1]. Studies at the University of California, Irvine, have discouragingly shown that the standard of communication skills in medical students readily decreases throughout their training[3].

"... a connection was established between common ethical lapses amoungst physicians and their disengagement with the humanities..."

Back in 1979, a connection was established between common ethical lapses amoungst physicians and their disengagement with the humanities[1,4]. It only fits that humanities and arts were sought out as a potential means to address these concerns. "Medical humanities" is the integration of literature, narrative, poetry, theater, and visual arts into medical training[5]. When compared with the traditional didactic education style, the medical humanities curriculum permits students to become exposed to new methods of learning, different approaches to viewing the patient experience, and the ability to "access competences in tangential ways that are not possible through the traditional medical school curricula"[1].

This article will review the structure and outcomes of three medical humanities programs: three examples of visual arts training at Harvard Medical School; the "Program of Medical Humanities and Arts" at the University of California, Irvine, School of Medicine; and the use of theater arts in the Overlook Medical Centre in New Jersey.

"... "Medical humanities" is the integration of literature, narrative, poetry, theater, and visual arts into medical training."

HARVARD MEDICAL SCHOOL

The Harvard Medical School uses "visual thinking strategies" (VTS), an evidence-based method of museum art education that aims to foster more comprehensive thinking skills through a series of questions, such as "What is going on in this image? What do you see that makes you say that? What else can you find?"[1]. The goal behind VTS is to have the student use visual cues and cognitive skills to acknowledge what they do not know, and to train students to explore more intricate, and uncertain material[1]. The first course is a nine-week session entitled "Training the eye: improving the art of physical diagnosis". Nine museum exercises are introduced to teach students about artistic concepts such as line, symmetry, form, and texture; to practice observation, description, and identification of meaning in the pieces as a group; and to link them to clinical findings in physical exams, such as the neurological exam, dermatological exam, and respiratory exam. The course also has a series of clinical lectures, which aim to further highlight the relationship of artistic concept with visual diagnosis and physical examinations[1].

The second course is dedicated to internal medicine residents at Brigham and Women's Hospital, and incorporates retreats, discussion sessions, and a night at the museum of fine arts led by a museum educator[1]. The night at the museum has five stations. The first introduces VTS questions to help create multiple interpretations of a piece, and the second provokes discussion relating the work of art

to an aspect of their professional life[1]. In the third station, interns choose a piece from the impressionist gallery, then share their reasons for their selection with a colleague[1]. The fourth station focuses on difficult conversations, where interns view a sarcophagus and reflect upon their experience caring for dying patients. The final station involves meditating in a replica Buddhist temple in the gallery[1]. This course is currently a mandatory aspect of internal medicine training, aiming to promote well-being, humanistic qualities, and prevent trainee burnout.

The third course revolves around teambuilding workshops for multidisciplinary teams in general medicine[1]. The purpose of the course is to foster awareness of team dynamics and differences in communication styles, and allow the group to overcome hierarchical barriers through respectful discussion[1]. The museum educator briefly joins each team and observes their overall dynamic, and challenges them to art-related exercises. For instance, one exercise involves each team member studying an abstract structure in silence, and then creating a gesture they feel reflects some aspect of the object[1]. Then, they combine their gesture with those of their team members to create a fluid movement that collectively represents their interpretation of the piece. This is followed by a discussion outlining their definitions of teamwork, and reflecting upon interactions from clinical rounds[1].

"...This course is currently a mandatory aspect of internal medicine training, aiming to promote well-being, humanistic qualities, and prevent trainee burnout."

Although specific data assessing improvements in communication, intragroup dynamics and overall patient care is currently lacking, the overall feedback from these three courses is reported to be overwhelmingly positive, and enrollment requests for the non-mandatory courses exceed the number of positions available[1].

SCHOOL OF MEDICINE,
UNIVERSITY OF CALIFORNIA, IRVINE

The Program in Medical Humanities and Arts at the School of Medicine in University of California, Irvine was initially implemented in 1998 to enhance empathy, compassion and altruism towards patients, and to hone clinical communication and observational skills[6]. It is based on three structural principles, the first of which is horizontal coherence[6]. This links humanities material by theme and content to existing courses within a given year, such as reflecting upon the subjective experience of a gross anatomy course, or reading prose and poetry to reflect upon issues surrounding patient care. The second principle is the organization of medical humanities material from year one to residency, as it progressively introduces concepts of increasing depth and complexity[6]. The final structural principle is the program's application to clinical care. As students progress through their medical training, the humanities curriculum increases its emphasis on patient care, teaching, and communication[6].

"...FSEE supposedly differs from using standardized patients because standardized patients are asked to relay the same information in an identical manner to each learner."

The teaching within the program is based in small group discussion, typically triggered by the student's creative projects, as well as by readings, artwork, and creative writing. In the first year, students are presented with a mini-lecture on humanities and medical practice, a panel of physicians and patients outlining the value of creative writing and painting, as well as small group writing exercises that explore the patient experience[6]. In second year, small group discussion is focused on the student-physician/patient relationship, the student's training, and the patient experience[6]. In clerkship, the internal medicine and pediatrics rotations continue to assign creative projects and faculty-led group discussions, whereas the Family Medicine rotation takes a new approach to humanities integration[6]. It requires students to read literary selections linked to clinical cases, and write a SOAP note that outlines the impact of the readings on their treatment plans. In addition, there is an optional fourth year humanities research elective[6]. Thus far, the Family Medicine residency program and the Physical Medicine and Rehabilitation residency program have integrated humanities sessions into their curricula, with a focus on communication skills in difficult situations, and on chronic medical conditions and disabilities[6].

Again, objective data studying changes in communication, group dynamics and patient care is limited, however some studies assessing aspects of the medical humanities curriculum demonstrated improvements in self-reported empathy and attitudes regarding the applicability of humanities to professional development. Moreover, the program seems to be well-received: standard anonymous evaluations

used with medical students, residents, and faculty, have indicated a "moderate to high level of satisfaction" with the program.

"...The integration of humanities into medical education aspires to provide a creative means of addressing challenging medical competencies. ."

OVERLOOK MEDICAL CENTRE

In the Overlook Medical Centre in New Jersey, Eisenberg et al. take a different approach to incorporating humanities into the medical school curriculum. In keeping with the majority of clinical education, the Overlook Medical Centre utilizes "Facilitated Simulation Education and Evaluation" (FSEE), which uses theatre arts to apply a hands-on approach to developing communication techniques in medical students, residents, and practicing physicians[7-12.] FSEE supposedly differs from using standardized patients because standardized patients are asked to relay the same information in an identical manner to each learner, whereas FSEE actors are not standardized, leading to unpredictable and genuine interactions. FSEE aims to train and test the "nonstandard, nonuniform, patient-centered, highly nuanced interpersonal communication skills" necessary in medical practice to help achieve an accurate diagnosis, and manage emotionally challenging and sensitive patient interactions[13].

After two years of training with the FSEE program, participating residents have reported feeling more confident communicating clearly and empathetically[13]. Specific excerpts from their course evaluations stated they felt the program provided immediate feedback during real-life scenarios, gave them an opportunity to practice difficult conversations with patients and family members, and emphasized the patient as the center of communication[13].

"...Being comfortable with this ambiguity is important for successful patient-physician encounter. ."

CONCLUSION

The integration of humanities into medical education aspires to provide a creative means of addressing challenging medical competencies. The wonderful thing about art lies in its ambiguity; there is no right or wrong answer to its interpretation. The artist's intentions are unknown, leaving us without a set of guidelines, instructions, or predictable responses when we navigate their work. Being comfortable with this ambiguity is important for successful patient-physician encounters[14], and can encourage students to see patients as unique individuals with a medical concern, instead of an embodiment of their chief complaint. Furthermore, the separation of art and literature from clinical responsibility is thought to establish a more relaxing, stress-free study environment, giving students freedom to be more imaginative and playful in an aspect of their education[6].

As with any new idea or initiative, we are left with the inevitable, pragmatic question: does it actually work? Can medical humanities ultimately improve physician performance or, more importantly, patient care? And as any discussion section of a paper will emphasize, answering this question requires further exploration through well-designed, randomized controlled trials. For the time being, we can continue enjoying our favourite branches of the humanities, and entertain the notion that maybe, just maybe, we will be better physicians because of it.

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Proposal to Use Patient-Derived Feedback to Develop Student Communication Skills

ADAM MOSA, CLASS OF 2018

As future clinicians, we should aim to understand the people we need to help not just as patients, but also as individuals enmeshed in an array of unfamiliar relationships. Navigating new relationships with doctors, allied health professionals, and administrative healthcare systems can be challenging and stressful for patients and families. Humanistic medicine provides a way for physicians to transcend the incomplete explanatory models of science to sustain and affirm the humanity of their patients in the face of illness.

Consciously resisting attempts to characterize illness in technical terms is a central goal in providing compassionate healthcare. For new medical students, this goal is complicated by the dual obligation to learn the language of medicine while developing the skills needed to effectively communicate with patients. This skill is the cornerstone of humanistic medicine and the vehicle that physicians use to understand their patient's illness and sources of suffering.

In undergraduate medical education, the assessment of non-medical expert physician competencies, such as communication, is challenging. For practicing physicians, one approach that has gained increased attention in recent years is Multisource Feedback (MSF). MSF in health systems is based on the central principle that facilitating new dialogues with the input of multiple voices, such as patients and colleagues, provides more comprehensive insight into the strengths and weaknesses of health practitioners.

At Queen's, the undergraduate medical curriculum promotes student self-reflection and feedback from peers, faculty, and standardized patients. To further develop student communication skills and guide performance, I would like to initiate a pilot study to adapt multisource feedback for undergraduate medical education with direct patient feedback. By creating a structured feedback assessment tool for patients to evaluate clinical clerks in the 3rd and 4th year of medical school, we will collect empirical data on communication skills. This study will be the first in Canada to systematically assess the value of patient-derived feedback for the development of communication skills in medical students. By promoting patient voice while also providing students with useful feedback, we aim to encourage the skills that will lead to future positive therapeutic relationships.

If you are interested in participating in a pilot program or have thoughts on the development of communication assessment tools for students, please reach out. I am eager to hear your thoughts and appreciate any insights you can offer.

ReFIFEing the Art of Medicine: Evaluation of Patient Satisfaction Through a CARL Lens

MAHVASH SHERE, CLASS OF 2018

The science of medicine depends on clinical proficiency in diagnosis and treatment. The *art* of medicine, however, is a fascinating enigma. Amidst the endless facts and diagrams, it makes its way into our curriculum as the non-medical expert competencies, the FIFE amidst the Sacred Seven of a presenting complaint, and patients' stories of their illness and care experience. We're sometimes comforted by being told that it is a *learned skill*. Yet the art of medicine's elusive quality remains a cause for some uncomfortable pauses and existential anxiety between mandatory reflections.

Will I be a good doctor? What is a good doctor? How do patients determine who is a good doctor?

"Patient satisfaction" measures are increasingly utilized as a way to evaluate the quality of healthcare delivery. But their similarity to the business model and "customer satisfaction assessments" causes many clinicians to question their effectiveness and relevance (1,2). Beyond their role in health administration and hospital ratings, the usefulness of these measures to a physician in terms of applicability to providing care is what concerns many skeptics of this model (1).

"...patient satisfaction" is typically defined as any measure that seeks patients' evaluations or affective responses to distinct dimensions of the healthcare experience..."

It is well understood that "satisfied" patients are more likely to comply with and continue treatment in contrast to "unsatisfied" patients (3). Thus, "patient satisfaction" is certainly an important measure; however, there is much debate within the literature with regards to the definition of "satisfaction" and its relation to other measures. Is satisfaction limited to the clinical care provided by a physician, or do factors such as access to healthcare services, hospital infrastructure including parking, food, and guest services, as well as relationships with the multidisciplinary care team influence this complex measure? (2,4) While the answer is largely a combination of measures, and often dependent upon the assessment scale used, "patient satisfaction" is typically defined as any measure that seeks patients' evaluations or affective responses to distinct dimensions of the healthcare experience (1,5).

Patient satisfaction measures can vary in terms of Content or Methods (Figure 1).

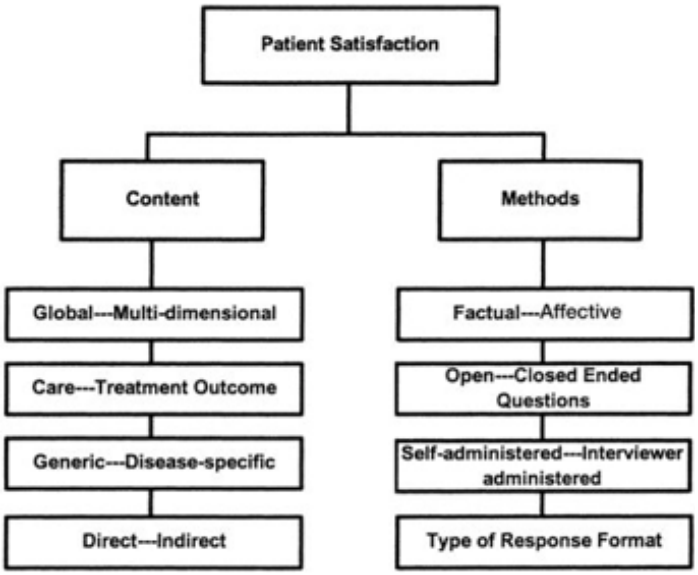

Fig 1. Characteristics of Patient Satisfaction measures (2).

Content can evaluate global or multidimensional aspects of patient satisfaction, care-dependent outcomes for treatment, or can be limited in terms of patient population or disease-specificity. These measures can also combine patient's personal experiences with healthcare and their general attitudes towards healthcare (2).

In contrast, differences in *Methods* determine how a survey is administered. The types of methods used to assess patient satisfaction can vary based on the assessment of factual/affective responses. Typically, the methods use a patient's account of what actually occurred. Surveys may be comprised of open and closed ended questions, they can be self-administered or interviewer-administered, and they can vary in terms of response formats – for example, the agree-disagree scale format (2,5). While response format

surveys currently predominate patient satisfaction assessment, they have limitations due to potential ambiguity and the way that slightly different question framing can inadvertently alter the nature of the response.

In our current culture dominated by reviews and ratings, research provides lessons for choosing the assessment framework by which patients will review medical professionals. For example, feedback and response surveys are typically complicated by an intrinsic *selection bias* because individuals who are dissatisfied are more likely to articulate their concerns than individuals who are satisfied with their care (2,4). However, studies indicate that this is a complex issue and we may actually be under-estimating patient *dissatisfaction* with the use of standardized scale-response surveys. Common examples of scale-response surveys include the 5-point evaluation rating scale (excellent, very good, good, fair, poor) and the 6-point satisfaction scale (extremely satisfied, very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, very dissatisfied). A study conducted by Williams et al. to compare unstructured interviews and standardized satisfaction surveys amongst patients revealed that their use of the standardized response survey underestimated their negative experiences, and that overall positive or negative experiences reported during interviews didn't correlate well with their standardized response survey score (6). Similarly, when Dougall et al. compared patients' verbal feedback and standardized response surveys, they found that both these measures indicated high levels of satisfaction, but in-depth interviews revealed many negative perceptions and expressions (7).

Amidst this controversy, a recent review by Ishikawa et al. describes that patient-centeredness is a multifaceted construct and that there is no single theory or method of evaluation that captures it in its entirety (8). Patient-centered communication is the key to patient satisfaction, and this model demands adjustment to the needs of the patient and the demands of the situation (9,10).

Yet is healthcare delivery entirely based on the demands of the patient? Does our current understanding of patient satisfaction through response surveys echo the business model of "customer satisfaction" so deeply that our patients are consumers of healthcare?

While there is significant debate in the literature with regards to the consumer-satisfaction model of patient satisfaction, current studies in healthcare delivery research advocate for multifaceted tools to assess different aspects of care (3,8,9). Given that the goals of care may be variable, and are achieved through a dynamic negotiation between the patient and physician, Ishikawa et al. emphasize the patient-physician communication model – requiring a joint consideration of the physician's viewpoints and the patient's competencies – to mutually assess the provision of and the response to care (2,8,10).

Current patient satisfaction assessments in Ontario are primarily hospital-based (Canadian Hospital Reporting Project) and facilitated by the Canadian Institute for Health Information (11). Beyond its existing assessment features, a section on the "*Patient Experience*" was recently added as a primary measure of the effectiveness of healthcare delivery.

Overall, an assessment of patient satisfaction represents an important tool necessary for reporting, development, research and evaluation of healthcare delivery. An understanding of the complexity of assessment tools and the underlying outcomes being evaluated will help future healthcare administrators, clinicians and physicians in optimizing methods for healthcare assessment and delivery. Finally, while the literature lacks consensus, moving towards a combination approach with broad-spectrum assessment of global indicators of healthcare delivery, while offering combination-surveys for feedback regarding more specific aspects of care will help better capture the multifaceted enigma that is *patient satisfaction*.

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Perspectives: The Art of Balance

ARIAN GHASSEMIAN, CLASS OF 2017 & GERHARD DASHI, CLASS OF 2017

Practicing medicine is as much an art as it is a science, but so is living a fulfilling life as a medical professional. In keeping with the theme of the current issue, we set out to explore the art of balancing a demanding career with an enjoyable life outside of medicine. In doing so, we have compiled a number of personal narratives from our peers and mentors to share with our QMR readers. Enjoy!

Dr. Robert (Bob) Connelly

Associate Professor of Pediatrics

Q: What were you afraid of giving up as a junior student/ staff? What did you give up?

A: Nothing really. I've always been obsessed with whatever I enjoy at the time. As a student, that was being a good doctor. As a resident, I started marathon running (because of a medical student) and became obsessed with that until I woke up at 40 and realized my body could no longer handle it. And that was actually very liberating. But I still have an obsessive enthusiasm about everything, which makes managing my own expectations extremely important – especially when I get obsessed with work that I like or want to do. I envy people who are able to manage everything perfectly. I basically do the things I like until something with a deadline takes precedence.

Q: How do you work efficiently?

A: I really believe in tools or frameworks for being more productive. One methodology I like and try to use is GTD ("Getting Things Done" by David Allen) which offloads stuff from your brain so you can have an "Inbox 0" and be critical of new things as they appear. The trouble I have is keeping just one inbox. Very simply, if it takes less than two minutes, do it now! Next, is there a due date? Great, do it before then. Finally, do a daily and weekly review of things you want to accomplish in the short-term and throw out tasks you that never get done. I also try to not check email during working or productive hours, leaving it for coffee breaks instead.

Some software I use are Omnifocus (Mac program that uses a system like GTD), Sanebox (scans emails and learns to filter what's important), and Evernote.

Q: Are there any books, art pieces, or quotes that you find motivational or that reflect your personality?

A: "It is amazing what you can accomplish if you do not care who gets the credit". I find this quote by Harry Truman very true and helpful in managing my work.

I also like what my wife says to me: "You just worry about doing a good job at the things you're doing, and not what others are doing." Don't try to do everything, especially just because others are doing it, because you will be overwhelmed. Remember what they say, "If you want something done, give it to someone busy", because that person never says no and is worried about disappointing others.

"...Very simply, if it takes less than 2 minutes, do it now!" - Dr. Connelly

Dr. Anthony (Tony) Sanfilippo
Associate Dean of Undergraduate Medical Education

On living life as a medical professional and finding time for things outside of medicine:
According to Dr. Sanfilippo, the consuming aspect of medicine is not just the hours, but the fact that it is often on his mind. While it's enjoyable to reflect and think about the profession, it can be like "water dripping into every crevice" with the thoughts permeating through your mind at various events and stages of your daily life.

He also emphasizes that it is important to maintain relationships and commitments outside of medicine. For Dr. Sanfilippo, this includes continuing to practice his faith and remaining involved in faith-based community events, scheduled dinners with his family every night, weekend breakfasts with friends, and annual golf trips. He describes discipline as key: it's important to make time for personal activities and actually schedule the events into your day.

On deciding when to say "yes" to requests:
As the Associate Dean of Medicine and a practicing cardiologist, Dr. Sanfilippo wears many hats (both literally and figuratively) and always has his plate full.

So when it comes to deciding when to say "yes" and when to pass on an opportunity, Dr. Sanfilippo prioritizes tasks that suit his interests and skills, and those that he finds important with respect to his roles and responsibilities. In this way, he can decide if he is actually needed and where his involvement would be of most benefit. He also recognizes the importance of finding the appropriate people for different tasks, then stepping back and making sure things are progressing in the right direction, explaining "if I don't have the big picture, then who does?"

On being where he is today:
" [It's important to] have direction but be open."
Believe it or not, Dr. Sanfilippo had no plans of becoming the Associated Dean of Medicine. Rather, he envisioned himself as a general practitioner out in the community. What led him here was a mixture of following his interests and pursuing what "felt right at the moment". Dr. Sanfilippo further comments that while it is important to have a general idea of what to do for the next 3-5 years (as he did), it is also important to be wary of the dangers of having a rigid and specific plan.

Touching on interests outside of medicine:
Dr. Sanfilippo loves reading about history, specifically biographies of outstanding individuals who overcame adversity and were able to succeed despite their circumstance. Some of his favourite figures include Abraham Lincoln, Theodore Roosevelt, Louis Armstrong and Ella Fitzgerald. He goes on to describe the determination that resonates through the lives of these individuals. These historical figures demonstrate that resilience and overcoming adversity are just as important as raw talent in order to succeed.

"... [It's important to] have direction but be open." - Dr. Sanfilippo

Dr. Frances (Fran) Crawford
Assistant Professor and Emergency Physician

Work/life balance is different in each of life's phases:

Phase 1: Before kids
Spend these years working hard on fellowships, developing special skills, and perhaps becoming board certified in a country that you might like to work in one day. Consider moonlighting in an underserviced area. Although it's more work, the gratitude you feel from administration, nurses, and patients will prevent burnout. Do this while keeping a close eye on your diet, exercise, and personal relationships.

Phase 2: With kids
Congratulations on the birth of your first child! You now have 2 full time jobs. You'll be blown away at how much more stress this brings. You can't even tell your friends for fear that they'll think you aren't coping. Hire a NANNY! You'll fight less with your spouse. You'll also be able to work when your kids are sick and your colleagues will respect you for not calling in sick all the time. Pay the nanny very well, then you won't have to train a second or third. You can't afford it, you say? Do you think you will be able to pay off your student loans faster by working part-time?

Consider a work/travel combination. I worked for a cruise line for 16 years. My family came with me for FREE, and I got paid. My children experienced the wonders of all seven continents while I got to tackle some crazy cases and increase my medical skills.

Phase 3: Empty nest/Semi-retired
Consider working hard for three weeks, then taking a week off. Visit family/friends, run a marathon, focus on a hobby, or just strike a beautiful place off your bucket list. When you return, you will be more than ready to do lots of shifts and fulfill other duties. After all, you get to go away again. Don't put off other interests but do them while your health is still good.

Two final pieces of advice:
1. Do the online Myers Briggs Personality test sooner than later. Find out who you really are and work with that. It is life changing.
2. My Dean at University of Western Ontario, Dr. Silcox, recommended an unlikely "medical" book to our class: "Love and Limerence" by Dorothy Tennor. It taught me what really, REALLY motivates people, every person. I use this information in my personal relationships and my job. It has reduced a lot of stress by understanding people."

Matthew Hammond:
Pre-Clerk; Eli, Abby, and Olivia's Dad

"The demands of professional work have a sneaky way of expanding and often squeezing out other important goals or interests. Family time and physical fitness time are two areas that may not be codified in one's weekly calendar and can be quickly overcome by work commitments. During first year, Stauffer library became my second home and my kids began telling people: "Dada isn't home anymore because he's a doctor now". Recognition of how my commitment to school was impacting my kids prompted me to develop some intermediate goals to help me align with my end-game. For example, I enrolled as a leader with my son's Beaver colony so now we have weekly activities that are formalized in my schedule. It has been of value for me to be able to roughly envision where I want to be at the end of my career and life, to develop goals that will move me (usually indirectly) towards that vision, and to make commitments that help me realize those intermediary goals. I think it's important to have a clear sense of who you want to be in life, have a strategy for getting there, and take time to enjoy the journey!"

"... I think it's important to have a clear sense of who you want to be in life, have a strategy for getting there, and take time to enjoy the journey!" - Matt Hammond

Things Matt's kids say to him:
Eli (7y): Why do you want to go to school so much?
Abby (4.5y): You need to read my doctor book at school. It has everything that you need to know in your whole body and it will help you be a doctor faster! OK? I put it in your school bag.
Olivia (15m): Dada!

Dr. Casimiro Cabrera-Abreu
Associate Professor of Psychiatry

"When I reached middle age I thought that one of the perks of arriving "Nel mezzo del cammin di nostra vita" was the automatic emergence of Oslerian gravitas. My two children taught me otherwise: life is too short to take yourself too seriously. I was mystified when asked to write about the experience of balancing my own life! It is easy to parody the CanMEDS Roles and suggest that at the end of your training you'll be a balanced combination of Sir Edmund Hillary, in your physical endurance, Marie Curie, in your breadth of knowledge, Ghandi in your moral rectitude, and finally, Mozart when playing your piano after a hard day of work! No tips are thus needed if one follows the virtuous path of the CanMEDS Roles. Sadly there is no evidence-based manual to guide doctors in reaching that "vital equilibrium." In its absence the maxim "Know thyself," attributed to Thales of Milethus, appears enlightening. Less well known is the maxim by Solon of Athens (engraved on the walls of the temple of Apollo) "Nothing in excess" or "Keep everything with moderation." I think that this dictum would work now as it worked more than 2000 years ago".

"... Sadly there is no Evidence Based manual to guide doctors in reaching that "vital equilibrium." ..." - Dr. Cabrera-Abreu

Dr. David Lee
Associate Professor in the Department of Medicine and Chair of the Division of Hematology

Over the years, Dr. Lee has developed four principles that have helped him manage the competing demands of work, family and the self:

1. Exercise often. Investing the time and energy for exercise pays off tremendously for me, well beyond just the physical benefits. It increases my intellectual and emotional capacity to tackle more. I exercise regularly both in the winter and summer. Running is my meditation; squash is my release. Playing in a squash league and signing up for races gives me something to shoot for, and keeps me accountable. Discipline is key and the flexibility of running allows me to fit it in no matter how crazy things get sometimes.

"... Compartmentalize work. Work creep is like entropy and requires energy to contain. " - Dr. Lee

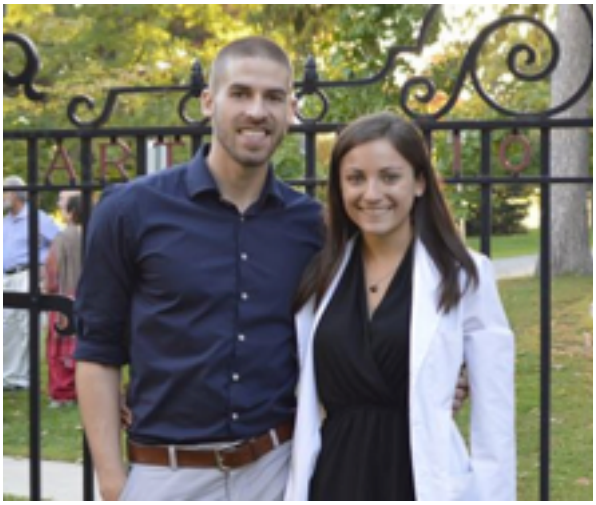
2. Socialize with people outside of work. Commitment to our profession means that it's easy for our world to become narrower and narrower. I like my co-workers, but socializing with my fellow squash players and runners reminds me that I am part of a bigger community.

3. Compartmentalize work. Work creep is like entropy and requires energy to contain. Outside of being on-call, I set limits on what work I do at home and how long I do it. This takes discipline and my family keeps me honest and accountable.

4. Eat dinner with your family. Everyone knows they should not miss award ceremonies, recitals, or graduations, but a good attendance record for routine stuff is just as important. While it is not always possible, dinner together on most nights is actually very achievable. You have to eat anyways, plus I like hearing what happened at their school or work earlier that day.

Oops, gotta go.... I'm gonna be late for my squash match!

Alyssa Louis
First Year Clerk



"In undergrad, I'd sit in the library letting days pass by, leaving every night at 10:50pm - in time to pick up a 6-pack of Pabst Blue Ribbon and a TV dinner. If there is an art to living, this was four years spent with a blank canvas. Now I try to do things that make me happy. Something I've come to realize is that there is always time if you make it. I've never really thought of myself as someone with good balance, just someone who knows what is important to me and what makes me happy. Doing a good job clinically makes me happy, so I spend time studying to enable me to do so. Time with my partner, tasting fine ales, cooking, board sports, and travel also make me happy, so I make time for these activities as well. I encourage anyone who is having difficulties with balance to ask themselves what is important to them and what makes them happy and once they figure it out, to go and then make some time."

"... If there is an art to living, this was four years spent with a blank canvas. Now I try to do things that make me happy" - Alyssa Louis

Top Lessons from *The Mindy Project*

GENEVIÈVE ROCHON-TERRY, CLASS OF 2017

Overwhelmed by endless studying? Need some time to veg out in front of the TV? The Mindy Project is a great go-to show if you're looking for a light comedy that almost feels like studying. It follows a New York OB/GYN as she navigates her career, relationships, and a hilarious team of colleagues. For those of you who have never watched it, here are some classic quotes that just might come in handy one day.

On remembering to FIFE…

"No matter how good of a doctor you are,
A good bedside manner will take you far.
Write that down".

-Mindy.
Season 3, Episode 10

On the importance of breastfeeding…

"If with a baby you want to win,
Always go skin to skin".

-Morgan, quoting Mindy.
Season 3, Episode 10

On why you just can't let FOMO win…

"I am not good at saying no.
One time I left I flea market with a samurai sword".

-Mindy.
Season 1, Episode 1

On celebrity baby birthing…

"They barely even needed me.
I mean, Kim's canal is spectacular,
And Kanye's tender birthing rap really just did the rest".

-OB/GYNE to the stars, responding to Mindy's questions about delivering North West. Season 2, Episode 18

Origins:
On the Safer Side of Mischief

JORDAN SUGARMAN, CLASS OF 2018

I knew my great-grandfather very well. I consider myself very lucky to have had such a great relationship with the older generations of the family, the result of my family's seemingly contractual agreement to have children in their early twenties. He and I were, in fact, born on the same day – June 11. There were many opportunities, however, where we may never have known one another.

The week before I was born, he had come to Toronto from his home in Minnesota to visit my mother, both to attend her dental school graduation and to be around for the far reaches of her pregnancy. An obstetrician by trade, he was committed to delivering me once my mom went into labour; an idea immediately shot down by her and her own obstetrician, who noted that my great-grandfather did not have a license to practice medicine in Ontario. Despite his protests, he was eventually convinced to stay out of the room when I was delivered. When I was handed to him, a squealing mass three generations removed from his own, he said it was the best birthday present he had ever received.

He approached everything in life with the same cavalier attitude with which he approached my mom's labour and delivery. Yakov Efimovich Yankelevich, or Shunya, as he was affectionately called, was born on June 11, 1921 in Kiev, USSR to a relatively well-off family. His father, Efim Yankelevich, was "the greatest obstetrician in all of Kiev, Ukraine", as has often been grandly relayed to me in thick Slavic prose. Shunya, as I've equally as often been reminded, was the next best.

Growing up, Shunya was what could only be described as a rapscallion at best, and a terror at worst. He was never very studious, often preferring booze to books. This greatly upset his father, a serious and very studious physician. He was what could best be described as a womanizer, moving from relationship to relationship with the sensitivity and deftness of a Russian man – which is neither very sensitive nor very deft.

His childhood and adolescence was not difficult. His family was able to prosper in Ukraine during the famine-ridden 1930s through his father's great influence and his family's involvement in the black market. And, in 1941, both at his father's urging and in an effort to avoid the draft, he passed his exams and was admitted to the Kiev Medical School. Nevertheless, Shunya was called up that same year, shortly after his admission, to serve.

Like many families worldwide, World War II was a pivotal moment for the course of our history. It was simply a dangerous time for the majority of the world, with many people uprooted and communities destroyed. On a personal note, I cannot stop fixating on two moments during my great-grandfather's involvement in the war upon which my existence hung in the balance. Two moments which would have removed me from history, which would have vacated my seat in medical school, which would have snuffed out my entire family. Two moments where Shunya's precociousness, that same precociousness that resurfaced at my birth, served him and me very well.

The Eastern Front was a difficult place to serve. Equipment and ammunition shortages were common and disease rampant; malnutrition only compounded these issues. This was the environment to which Shunya, undertrained in both medicine and combat, arrived in the winter of 1941, before the invasion of the Nazis. With time, the environment only worsened to become a sheer hellscape.

Before the invasion, as the war effort was ramping up, Shunya got a pass to spend time with his family. Not wanting to leave his family, with winter ending and burgeoning into spring, he forged his pass to extend the dates of his leave. When he returned to the Front he learned that he was to be Court Marshalled for his insubordination, and that his unit had been deployed without him. Then the Nazis invaded, and, amidst the accompanying chaos and disorganization, he was never called to court. Several days later, he got word that his original unit had encountered combat, and that except for Shunya, there were no survivors from the unit. He was reassigned.

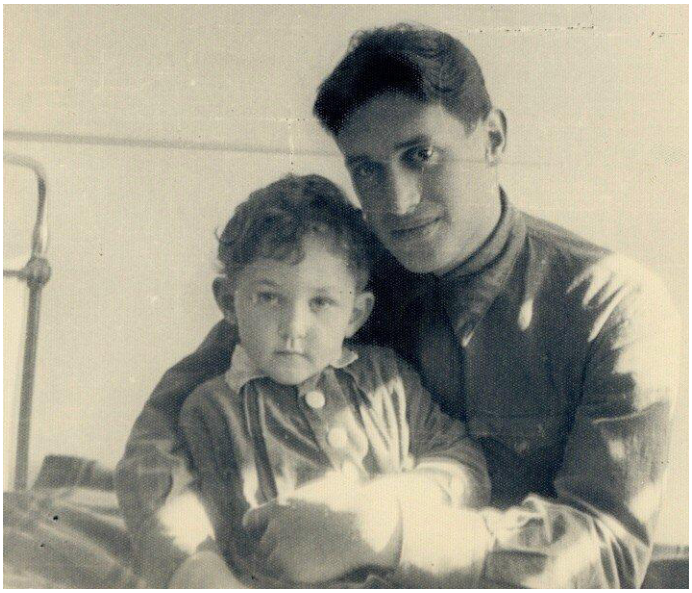
Shunya's job as a medical orderly was to pull wounded Russian soldiers from the front lines and to fire at German soldiers as necessary. He had a penchant for collecting German pistols – all of which were inevitably confiscated by his superior officers, who were wise to Shunya's ill-timed bravado. Many of his war stories involve this boldness of character, despite the fact that his life was at risk on a daily basis.

Shunya never thought he would die, nor did he fear death during the war. He often said that the thought of being killed never entered his mind. He kept a metal-bound journal in his breast pocket to document his experiences, which was also against the rules.

By August of 1941, two months into the invasion, the Germans had taken significant advances on the Eastern Front, and Shunya's unit found themselves backed up against the Dnipro River. Though under constant heavy assault, Shunya put his head down and kept frantically working, still never afraid of the looming possibility of death. That is, until he looked down at his shirt and saw it was soaked – not with sweat, but with blood. He had caught shrapnel, which caused a collapsed lung and other significant damage to his chest. When his shirt was ripped open to assess the damage, a large piece of metal was lodged in his diary, just above his heart.

Shunya was evacuated the very next day to a hospital away from the Front. Shortly after his evacuation, the Germans pigeonholed the Soviet army in Kiev, killing 600,000 men. Shunya would have undoubtedly been among them.

I didn't choose to write this story to eulogize my great-grandfather, or to glorify war. During our orientation, Dr. Sanfillipo mentioned that we, as future doctors, will each affect the lives of 150,000 people throughout the course of our careers. That number stuck with me, and made me think about not only the events in my life that allowed me to be here, but also the events in my ancestors' lives. This reflection gives me cause in every difficult day that I experience in medical school. I urge all of us to think about one person who, if circumstances had even been slightly different, would not have led to our existence. It's a humbling feeling and in the face of daily difficulties, this kind of reflection may save one of our lives as Shunya's journal saved his.



QMR Cover Art Contest

Linda Chang Qu - *"The Art of Medicine"*

My depiction of the physician-as-artist is inspired by the ingenuity of medicine to mend a purely physical medium, and in turn produce a work of art that speaks the human experience.

Medium: Digial (Photoshop CS2)

Maddie Baetz-Dougan - *"Cochlea"*

I find it pretty incredible that all these tiny pieces in our bodies can allow us to see, feel, and listen to the world around us. I chose this image of the cochlea because of just that - step back and remember this little thing is what is physically connecting you to the music you love. There is something inherently artistic and beautiful about the way our bodies work, and in my opinion, focusing on those details can renew anyone's appreciation for its complexities.

Medium: Acrylic on canvas

FUTURE ISSUES:

Enjoyed Jordan Sugarman's article on page 30? Share your own path to medical school in our next issue. Contact the Editors-in-Chief at queensmedreview@gmail.com for more information.

HOUSE *of* CaRMS

Am I really the sort of enemy you want to make?

45th Annual Medical Variety Night (MVN)

April 10 & 11, 2015 @ 7pm Duncan McArthur Hall (511 Union St)

Tickets $12 in advance (online only at mvn.qmed.ca), $15 at the door

Proceeds support *Almost Home* and *Reads for Paeds*