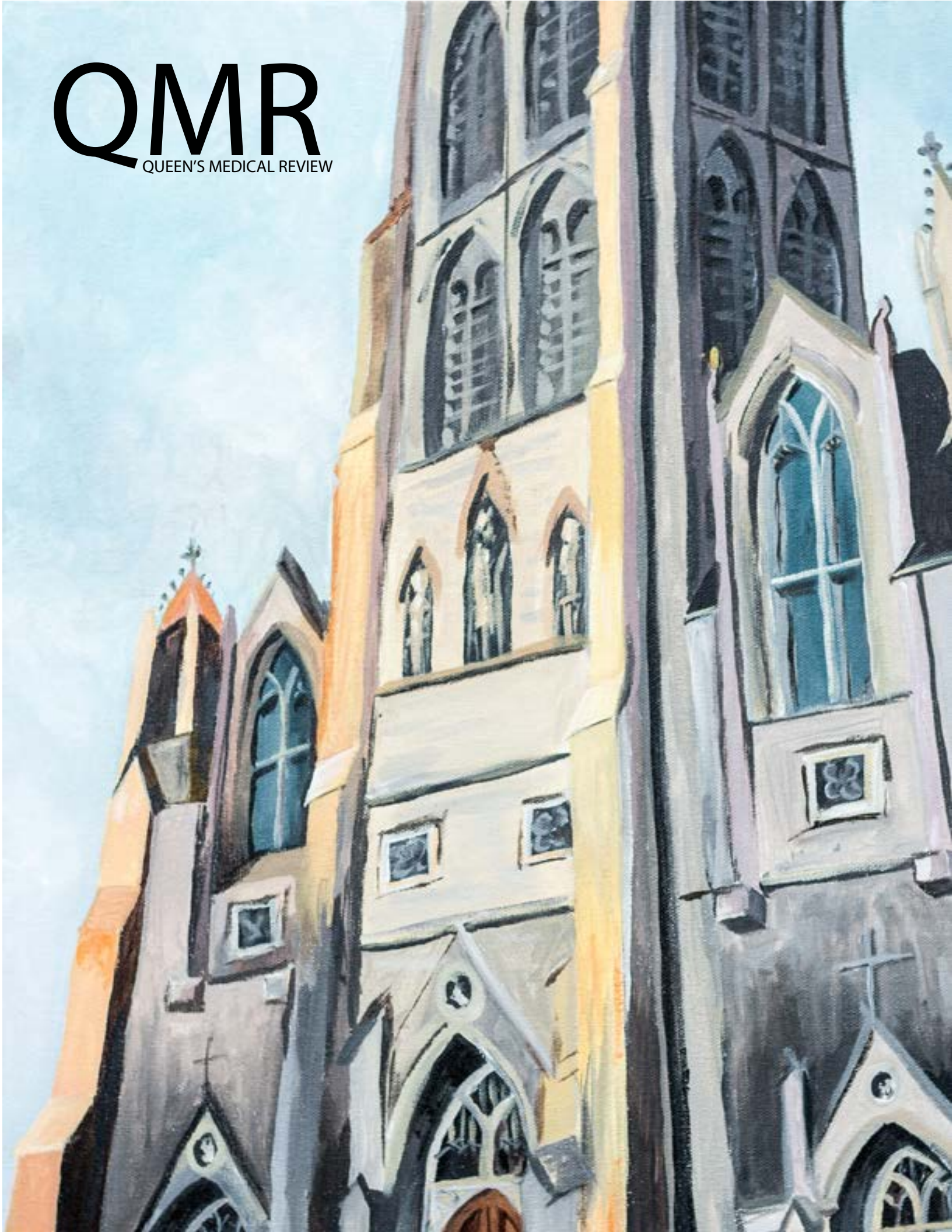
QMR

QUEEN'S MEDICAL REVIEW



Cover art by Madeleine Baetz-Dougan

A note from the artist:

I'm a big fan of taking time to reflect on where we've been and how we got to where we are now. For myself, spending the past five years in Kingston gives me so many opportunities to reflect on this path and consider how I've changed in this city. The city itself has changed too, although there are some iconic places that shape our time here: a sunny day at the pier, a walk through the snow in City Park, or a walk down that old familiar street. This church on Johnson Street is one of those symbols that I'm back in Kingston, ready to start another year and ponder again on the origins of how this adventure at Queen's began.

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Letter from the Editors

Dear Readers,

When was the last time you told your story?

The idea for the current issue, *Origins*, was conceived at the dawn of first year medicine. There comes a time when you've shared enough biography to feel comfortable letting others hear your stories – what brought you here, what makes you who you are, and where you might be headed. Listening to others and reflecting on your own experiences as you go back in time with future friends exposes sameness, difference, and identity; stories bolster the human dimension of our collective new endeavor. But origin stories are not static –we change and they change with us. Like most exercise, constructing narratives deserves reiteration. For this issue of QMR, we asked our colleagues to share their stories and thoughts on this topic.

Kate Trebuss (2018) leads the issue with an elegant and mirthful essay on her foray into tennis and the parallels to her new life in medicine. Transporting us in time, Jordan Sugarman (2018) shares the story of his great-grandfather, a physician who narrowly escaped death during World War II. Learn about QMed's first memories from a set of anecdotes collected by Nadia Gabarin (2017). Is there a place for stories in patient-physician interaction? Trevor Morey (2017) describes the value of including patient narratives in the common terse medical report. In his provocative essay, Thomas Krahn (2017) challenges the notion that stories dictate our identity, while Louisa Ho (2017) shares her analysis of the alluring (and elusive) concept of luck.

In our "Community" section, the editors have brought you a list of med student sourced fiction and non-fiction works to navigate in your free time. Shannon Wilmott (2018) took on the ambitious task of polling the class of 2018 in her article "How well do we know each other?". In the "Opinions" section, McCall and Cottreau discuss "Perspectives on Pharmacare" and give us a glimpse to our next issue on "Politics in Medicine".

As always, we seek creative submission from Queen's Medical Students. In this issue, enjoy the hilarious and possibly too-familiar sensation of medical student syndrome in "The Hypochondriac Chronicles". Calvin Santiago (2018) shares his beautiful photography and some lessons learned during his summer travels to South America. Finally, we would like to congratulate Maddie Baetz-Dougan (2018) for winning the Cover Art Contest for this issue. Please also read about the work Maddie and others took to organize yet another successful Chiaroscuro Charity Art Auction.

Storytelling is not a natural talent but a skill developed with practice. In medicine, where the stories are endless and the meaning is wanting, stories unify and clarify what, and who, we are in this business for. After all, the best conversations often start with "have I told you about that time?"

Cheers,

Adam Mosa

Luba Bryushkova

FEATURE

For the Love of the Game: On Tennis, Medicine, and Mastery

KATE TREBUSS, CLASS OF 2018

"Okay, let's just rally for a bit, so you can show me what you've got."

"I haven't played in, like, a decade…so don't expect much…" I mumble, as I step onto the court clutching a borrowed racket, not even certain I'm holding it right. Vainly, I wonder whether it isn't possible that I'll stun Isaac, the baby faced 19-year old instructor waiting expectantly on the other side of the net, with undiscovered raw natural talent and agility. Who knows, I think to myself, I could be a prodigy. I imagine my long limbs acting seamlessly as a single powerful unit, my eyes narrowed as I calmly return a blur of yellow to my opponent, who misses it by a wide margin, shakes his head and praises me for landing such an elegant, powerful shot. Suddenly, a ball arcs slowly over the net and interrupts my fantasy. Instead of calmly returning the shot as I envisioned in my head moments before, I lope awkwardly in the direction of the ball and stumble over my feet before feebly connecting with it – and launching it straight into the net. On the next shot I don't fare much better; this one hits the roof of the clubhouse and kerplunks its way to the grassy patch behind. My fantasy of natural genius at the game of tennis evaporates after I send about three more shots over the fence and into a lush patch of Black-Eyed Susans growing peaceably in the yard next door.

The assessment period ends, and I see that Isaac knows as well as I do that he has his work cut out for him this summer. Kindly, he calls me to the other side of the net, reorients my grip on the racket and details his plans for me for the hour. Humbled and more than a little embarrassed, I try to focus on what Isaac is telling me about the steps involved in a forehand ground shot, but my attention keeps drifting to the 8-year old hitting fluid, effortlessly powerful drives down the court next to mine, and I can't help but wonder whether joining the Kingston Tennis Club for the summer might have been a terrible, rather pricy mistake.

What does tennis have to do with medicine? One of my favourite essays by physician-writer and tennis enthusiast Atul Gawande was also inspired by the game. Gawande, a very good but by no means professional-level player, became frustrated when he noticed that his game had plateau-d and didn't seem to be improving no matter how often he practiced. A friend suggested he hire his club's pro for lessons and lo, with some critical and attentive coaching, Gawande found himself playing a better game almost immediately. This got Gawande thinking: professional athletes are supposed to be among the best players of a particular sport, yet how many professional athletes don't have a coach who helps them to support and refine their performance? But in medicine, once a physician or surgeon completes their residency and becomes an attending, few will ever receive direct feedback on their clinical skills ever again. Gawande decides to apply the coaching model to his surgical practice, and the rest of the essay describes the experience of being "coached" in the operating room and the various ways in which it did or didn't serve to improve his surgical technique.

For me, tennis prompted a different insight. I began medical school a little later in life than many of my colleagues. Already well into my 20's and about 2 years into a Ph.D. in literature before I realized that I wanted to be a doctor, I was 29 when I finally donned a white coat and stethoscope for the first time. Before the start of classes last Fall, I fretted about what it would feel like to join a class where the average age was 24: would others be quicker to take to the material and the technical skills we used in clinical practice and leave me and my, by comparison, aged brain struggling to catch up? Would I feel relatively handicapped by my limited knowledge of the sciences? Would my peers judge me if I struggled to grasp concepts that to them seemed straightforward?

Even as I worried I might not be able to keep up with my peers, I secretly indulged in a mildly conceited fantasy that I might well be a natural at all aspects of medicine in spite of my different disciplinary background, or perhaps even because of it. This notion was shattered not long into my first week of classes, during which time I quickly realized that many of my bright, focused, and ambitious colleagues were at least as skilled as I in all of the areas of achievement I had prided myself on – some even more so.

Humble pie usually isn't truly bitter, but it isn't exactly sweet or savoury either.

Interestingly, this optimistic (some might say deluded) little fantasy of natural aptitude never entirely went away. It's something I think the vast majority of medical students – most of whom are pathological over-achievers – indulge in from time to time when approaching a new technical skill or clinical problem. Maybe I'll be so good at suturing this pig's foot that the surgeon teaching the workshop will offer me a summer studentship…maybe I'll rock the respiratory exam so hard the SP will up and quit because they're convinced they'll never see anyone do it half so well ever again…maybe I'll deliver this oral report so skillfully my preceptor will applaud and tell all her residents to take note of my masterful delivery…maybe I'll reach the correct diagnosis before it comes to anyone else caring for this patient…etc. etc. etc. The less inflated and narcissistic version of this, of course, is the niggling hope most of us carry from situation to situation: that whomever is supervising us won't have any feedback to offer because we performed so flawlessly whatever was asked of us.

And yet the reality is that most of us will spend a long time whacking balls at the net and sending them soaring into neighbours' backyards before we are skilled enough to maintain a rally. It'll be even longer before we'll play with the proficiency and consistency of those instructing us. Some of our shots will always be stronger than others. We need the feedback of coaches and supportive teammates in order to adapt and improve our technique. But it takes practice not to be disappointed when we don't nail the shot on the first try, and to refrain from comparing ourselves to the pros and prodigies we meet along the way.

I gained a lot from playing tennis this summer. I've become truly active again for the first time in over a year and found a sport I'm growing to love. I make about as many shots as I miss now, maybe a few more. I've been invited to join a group of women for doubles on Saturday mornings, and they let me serve as many times as I need to without any apparent annoyance. I'm no prodigy, but with some consistent practice and a whole bunch more lessons I think I could probably be half decent some day; I might even get good enough to play Gawande, if I keep pouring my line of credit into lessons.

Most importantly, however, I began through tennis to recognize the extent to which even low-grade embarrassment and pride can impede our development as physicians. My first tennis lessons were painfully embarrassing, as I botched shot after shot fed to me by the infinitely cheerful and patient Isaac, who could somehow see and point to improvement in my game even on days when it looked to me as though I was becoming still more hapless. Rallies with more experienced players (many of whom were much younger than I) were even more excruciating, because I felt constantly self-aware of how little I was challenging them, how much they had to lower their expectations to play with me. I found myself constantly apologizing for being at the level I was at, even though it would have been absurd to imagine I could have been any less terrible any faster. I felt guilty asking people to play with me, even though I knew rationally I wasn't going to improve unless I kept returning to the court.

In medicine, when we haven't mastered an exam maneuver or a technical skill, too often it's easier to let someone else take over than to muddle through on our own. Certainly this doesn't apply to scenarios when a patient might be endangered by a medical student's attempt to practice something he or she is not yet adept at; however, such situations are far less common than those in which we have the foundational knowledge to undertake a task safely, and yet are reticent to move forward because we lack confidence in our ability to perform the task perfectly, or at least reasonably skillfully.

For many medical students, it is almost physically painful not to be perfect (or at least good) at something on the first, second, or even third go around. We're a pretty high achieving bunch, and probably for a majority of us many things came more easily to us than to our peers in many areas of life. We have a near congenital aversion to feelings of incompetence. I for one have breathed many a sigh of relief on occasions when someone else in my clinical skills group stepped up to perform an exam I haven't totally mastered and allowed me to slink back into the corner to observe.

On many occasions this summer, it was tempting to decline opportunities to work on my tennis skills because in doing so I had to expose all the gaps in my knowledge and ability and recognize the fact that it may take years for me to close them. It's all too easy to forget that that there is, or should be, pleasure even during the phase that precedes competence and expertise. The difference between the desire to be good at something and the desire to learn something is surprisingly subtle and yet vital to grasp, both if we hope to become medical experts and to find happiness in our professional lives. It is impossible to be happy, I think, if we expect to be fully formed practitioners before we've even started.

The kind of humility and self-acceptance that comes from endeavouring to learn a skill that is both new and challenging is also a crucial ingredient for successful collaboration, as it incites patience for those still developing their own skills and knowledge. It translates well, too, to our relationships with patients, whom we often expect to "get it right" on the first go around with a new drug regimen, diet, or lifestyle change. By starting out as a beginner at something –whether that something is tennis, another sport, writing, a musical instrument, photography, painting, cooking or debating – medical students have an opportunity to develop their capacity to empathize with others who are struggling to overcome the embarrassment and disappointment that too often accompanies any effort that isn't immediately successful.

I'm still working on being kind to myself when faced with skills and problems that don't come easily to me. But after this summer I'm far less likely to permit myself to evade scenarios that might require me to use skills that I still consider underdeveloped, and I hope I'm becoming more empathetic towards others who are working on their own skills, whatever those may be.

So, whether or not you've played tennis before let me know if you'd like to hit a ball around sometime. I'm game.

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.

What is your first vivid memory?

NADIA GABARIN, CLASS OF 2017

For this issue of QMR, exploring origin stories, we asked Queen's Medicine students to share with us "What is your first vivid childhood memory?"

Watching my grandfather come toward me in the hallway of our house. It was the only time I met him – I was 3 years old.

-Anonymous

My first memory is going to go meet my oldest brother for the first time; I must have been 3 or 4 years old. I thought it was really weird to have a brother that didn't live with me. We picked him up at his apartment in Toronto and his door was painted like space with stars and galaxies. He took me to the ROM to see the dinosaur exhibit, and I decided he was pretty great.

-Danielle Nelson, Class of 2017

Stealing a toy away from my best friend (I was two and she was one; we are still best friends to this day).

-Gina Eom, Class of 2017

I was playing hide and seek in the dark with my brother and some family friends and my brother was 'it'. I ran into the bedroom and saw his trumpet case sitting on the floor. I 'hid' by simply crouching down behind the case, feeling super clever. I heard my brother come into the room, look around, and then leave. He actually had not seen me. To this day I am still shocked at my amazing hiding abilities and my brother's less than amazing seeking abilities.

-Alex Peloso, Class of 2018

I remember getting lost in a huge mall because I had wandered off to play some video game. I ended up sitting with the security guards and they bought me a large soda to keep me happy (i.e. to stop me from crying). Overall, I was pretty happy with my soda.

-Anonymous

My first childhood memory is a trip to Florida that my family took at age 5. The only thing that I remember about the trip is losing my Barbie in one of the lakes. I was so upset that one of the workers at the lake had to put on full scuba gear to fetch my Barbie so that I would stop crying!

-Allyson Shorkey, Class of 2017

Riding in the ambulance after a rock got caught in the blades of a lawn mower, flew through the air, and tore open my cheek. The scar has been a pretty good conversation starter over the years.

-Genevieve Rochon-Terry, Class of 2017

My first memory is riding on the back of my dad's bicycle in a baby seat. I now ride that same bicycle to school every morning.

-Eliott Cohen, Class of 2017

I was walking with my mom and grandmother in the Meatpacking district of Manhattan. It was maybe 1991, the butcher shops were still there and the chic bars and hotels wouldn't arrive for another fifteen years. I know I couldn't have been more than three years old because my mom was pregnant with my little brother. The sidewalk curbs in Meatpacking are at least 1 ft high and if you're not paying attention it can be dangerous. My grandmother was trying to step up onto the sidewalk as we crossed the street and didn't quite make the ledge. She bashed her shin into the concrete edge of the curb and let out a painful cry. I remember the chaos as we rolled up her pant leg and saw crimson red running towards her socks. I think it was the first time I ever saw blood and is my first memory to the best of my recollection.

-Adam Mosa, Class of 2018

My first memory is that of a Duracell AA battery. I recall pondering what a magnificent object; so simple, yet so powerful. It had magical abilities to animate all my favourite toys. I recall wondering, 'why isn't everyone also fascinated with these things?'

-Anonymous

My first memory is that of a Duracell AA battery. I recall pondering what a magnificent object; so simple, yet so powerful. It had magical abilities to animate all my favourite toys. I recall wondering, 'why isn't everyone also fascinated with these things?'

-Anonymous

Playing "Power Rangers" with my brother ie. starting a brawl when it was on TV, to the point that the show was banned in our house.

-Alana Fleet, Class of 2017

My kindergarten teacher invited all of us to come over to his house for a Halloween party. He lived down the street from the school and all of my friends were going to the party. For some reason (and I can't exactly remember why) the last thing I wanted to do was go to this party. The morning before school my mom pulled out this pirate costume that I was going to wear to the party and as soon as I saw it I started crying more than I had ever cried before. My mom kept asking what was wrong and was pretty confused as to why I wouldn't want to go to this party when everyone else was going and there was going to be a sweet jumping castle. But after getting nowhere for about 10 minutes we came to a compromise: if I put on the pirate costume and take a picture I wouldn't have to go to the party. I quickly stopped crying, took the picture and stayed home. I still have the picture.

PS. I have also seen pictures from this Halloween party and it looked so sick, I totally missed out.

-Trevor Morey, Class of 2017

Spilling an enormous glass jar of mustard onto the floor.

-Anonymous

Pushing a mechanical butterfly on a stick that flapped its wings with every wheel turn in a park in South Korea with my parents and paternal grandfather (who had bought me the butterfly)

-Rufina Kim, Class of 2018

My sister told me she was 9 which would make me 4 at the time. I was in my dad's arms on one end of the hallway, crying my lungs out, not fully aware of the significance of this moment. My sister was hugging my mom's left leg, pleading, probably for the yelling to stop. My dad was threatening to take me and move out of house. Not surprising, given that they never really liked each other anyway. Who'd have thought that I'd develop steadfast family values after growing up with virtually none?

-Anonymous

Waking up on my birthday and receiving a red toy tractor... just riveting.

-Mark Woodcroft, Class of 2017

I was having the time of my life rocking back and forth on a wooden chair near my father's desk. Unbridled ambition was my undoing as I rocked too far forward, fell out of the chair and cut my face on the corner of his desk. And that is the story of how I got these scars.

-Doran Drew, Class of 2017

It Never Hurts to Ask

TREVOR MOREY, CLASS OF 2017

I was walking through the halls of a hospital on my way to see a patient a few months ago. Part of my mind was wondering if I was adequately caffeinated to take histories from patients and another part was thinking about what my differential diagnosis for the chief complaint of `chest pain with shortness of breath` should be. Could it be a Myocardial Infarction? Pneumothorax? Pulmonary Embolism?

"...why was I was not asked a question about who the patient was? I was only asked about the disease that had been dwelling inside of them."

As I entered the room, I took out my notebook and jotted down the answers to all of the questions I had been taught to ask and at the end of the visit, I had a pretty good picture of what disease was present. I had checked all of the appropriate boxes; I felt great; I felt useful. I felt as though I had actually learned something and was then able to apply it.

I presented the case to the attending physician I had been observing and they told me I could use some work on my oral report but that I had the right idea. I saw the attending check off a box saying `meets expectations` on a lined yellow sheet of paper in their head. I then thought to myself, why was I was not asked a question about who the patient was? I was only asked about the disease that had been dwelling inside of them.

"...were no check boxes for asking about the patient's family, their experience, their origin, what their life was like outside of the hospital, what they had done for the 60 years prior to having this disease knock on the door like an unwanted party guest and interrupt their life..."

There were no check boxes for asking about the patient's family, their experience, their origin, what their life was like outside of the hospital, what they had done for the 60 years prior to having this disease knock on the door like an unwanted party guest and interrupt their life. It turned out I was having a conversation with the disease and not the patient; asking the disease what I could do to most effectively send it away, rather than asking the patient about how the disease was affecting them or how I could make them more comfortable. Maybe that's why they call it the history of the presenting illness and not the history of the presenting patient.

So why are there no checkboxes for asking the human questions? Why must a medical student be programmed to ask about the red and yellow flags raised by disease, yet not be adequately encouraged to have a discussion with a patient who might be raising a white one? Why can we not have both? Is it a lack of teacher experience? A lack of evidence suggesting that this may create better physicians? A lack of enthusiasm from medical students themselves? A lack of time during the patient visit? I don't have the answer, nor will I pretend to.

"...Maybe that's why they call it the history of the presenting illness and not the history of the presenting patient...."

I constantly hear patients telling me `so and so` is a great doctor because they spend time listening to my story. So why are the new generation of `so and so's` not encouraged to listen to, learn from and retell their patient's stories? Every medical student possesses the skills to ask a patient about their life -- to learn about the illness experience and listen to their stories. But just like all of the other skills a medical student has, these skills continually need to be refined. One of the best parts about being a medical student is that we are afforded the opportunity to spend more time with patients and to ask the questions that may or may not be on checklists.

"... Stories may not improve our ability to understand the science of medicine, however, they help to improve our understanding of medicine as an art."

Every patient story provides a medical student with a unique learning opportunity to discover new things about the practice of medicine. Just as an uncommon medical presentation would be published in a case report to promote exposure, we as medical students should be encouraged to share unique patient stories, with permission, to improve ourselves as future physicians. Stories such as how one assisted the single parent who could not afford the medications for her sick child or how one helped the elderly person who after suffering a stroke had no one to help them at home. Stories can also help us to understand where our patients are coming from -- their origins. There may not be any p-values or confidence intervals on these stories, there is certainly a lack of certainty, but they encourage us to start thinking about how we would care for these unique patients. Stories may not improve our ability to understand the science of medicine, however, they help to improve our understanding of medicine as an art. We should create a 'journal of interesting patients' and use this resource to help improve our practice. Medical students could tell stories anonymously to protect their patients' privacy then compile and broadcast them to other learners to provide valuable exposure to situations that one had never considered. There is no CanMEDS role for 'storyteller' or 'journalist' but that does not mean they are not important parts of medical practice.

So my challenge to you as medical students and medical professionals is to start writing and sharing 'patient reports' about the unique stories that your patients share --- we all possess the skills required. I encourage you to add, "tell me your story" to your sacred seven when taking a history. It never hurts to ask.

Origins

THOMAS KRAHN, CLASS OF 2017

Human beings are, at their core, collections of stories. Oral histories anchored human memory, while books, news, biographies, and the internet tell us how to live based on others' past experiences. Modern advances in science have made ideas the next step in evolutionary advances, allowing certain individuals and societies to succeed over others independent of biology.

"...Truth, in large part, depends on the mouth from which it is spoken. ..."

Yet there is a critical flaw in this gigantic chain of information –veracity depends on the source. And the source is in all cases, human. Truth, hampered by language and the subjectivity of individual experience, is often difficult to transfer accurately.

Humans are emotional creatures. The emotional tug of certain narratives make us more or less likely to believe them. Past experiences, language, culture, and even aesthetic factors all play into the believability of information. And some stories are so compelling they make us believe in the possibilities of the universe.

"...Narratives are powerful tools. They can be used to bid for forgiveness or justify anger. A powerful narrative can draw an audience on board and make us root for the protagonist..."

While successes are often framed in terms of destiny –"I have always wanted to be a doctor"; "I am a good person, therefore my actions are good". This profession becomes a calling from within, a path to righteousness. How do we explain failures: it wasn't meant to be. It was e else's fault. We often make exceptions for ourselves, expecting others not to make such compromises. Or discount information because of the source. Truth, in large part, depends on the mouth from which it is spoken.

Yet these selves we create, these narratives, form our primary motivations for pursuing aims, and help explain the chaos of the universe to ourselves. The facsimiles of reality that exist in our minds seem certain, yet cannot be verified. Emotions serve to solidify our certainty.

How can we delude ourselves into thinking the universe is so concrete? So knowable?

"...Leaving the who-are-you box unchecked obviates a lot of opportunities for more defined candidates..."

Narratives are powerful tools. They can be used to bid for forgiveness or justify anger. A powerful narrative can draw an audience on board and make us root for the protagonist, even though who is considered good or evil can largely be a matter of framing. Fiction can speak to political issues in ways that evidence cannot. 'Uncle Tom's Cabin' spoke more loudly in it's time against the evils of institutional racism than any biological evidence of non-inferiority.

Politicians frequently use a good narrative to great effect. The American mythos of manifest destiny motivated and justified Western expansion, while vague vignettes of conversations with voters support the character of the politicians and the strength of their arguments.

"...And so I aimed for medicine. What attracted me was the certainty of it all...."

What's in a narrative? A protagonist, an aim, a set of circumstances connected together in a coherent fashion, framed as a struggle and triumph.

But what if we are just animals, existing in an eternal present? Not every set of actions needs an overarching explanation, though instincts don't make for very good stories. We get hungry, need shelter or company.

In crafting this argument, I realize I have told you somewhat of a story about myself, about my struggle to define a narrative, for validation and recognition. And often the words that people want to hear seem to explain the circumstances much better. I learned that in 4th grade, during my interview for the gifted program.

"So, what do you want to be when you grow up?"
"I don't know"

My gifted program aspirations were dashed by this honest display of uncertainty. Trying to frame the seemingly random events that have populated my life with some kind of overarching reason is difficult, if not impossible. It all has to make sense you see? Every detail. Falling into some perfect grand narrative. I mean, that's how it is on TV.

"...Our attempts to shoehorn life experience into one narrative limits the complexity and the multidimensionality of our existence, reducing individuals to stereotypes or caricatures. ...."

I expected that there was some sort of certainty that you reached at a certain point in your life, when the narrative aligned and everything became clear.

This certainty of uncertainty worked well for me throughout adolescence, justifying a curious but unfocused renaissance education, but it surprisingly limited me in university, as I entered the real world. In the real world you must fit someone's pre-existing expectations if you want to fill a role or succeed. Friendships demand certain values or interests, while employers and educators prefer protégés of a certain malleable temperament. Leaving the who-are-you box unchecked obviates a lot of opportunities for more defined candidates.

And so I aimed for medicine. What attracted me was the certainty of it all.

By becoming a doctor, I knew I would be doing something good for individuals and society. I knew that it was a challenge worth achieving and that it provided for a good job and role in society. And it was clear what kind of person you had to be to be accepted.

"...Part of being an effective doctor means being able to sift through various historical accounts looking for where the truth ends and where narrative begins...."

I took the right courses, adopted the correct interests and extracurricular roles, knowing that this is what good people do when they want to achieve and help society. It was a sort of quest for certainty. If I could achieve this goal and become this role, then maybe I would become something recognizable.

All of this culminating up into my acceptance in medicine. It had to happen, or my narrative would break, and all the uncertainty of life would come flooding back in.

My narrative had passed the test.

Part of what drew me to medicine was the narrative element. Information is presented in a narrative format, as histories are taken from patients, and presented in case format. Illness is truly a subjective experience, with temporality being of the Cardinal 7 characteristics of a medical complaint. The biopsychoscoial model of disease looks at all the intersecting factors in a patients life that contribute to complicate a patient's disease. And as physician you are able to share these patient's experiences and learn from them.

Yet now that I am in medicine, I can't imagine what it would be like to have my history taken. Looking around me, at superiors and peers, I realize that no one can explain their life in a consistent manner. Our attempts to shoehorn life experience into one narrative limits the complexity and the multidimensionality of our existence, reducing individuals to stereotypes or caricatures. We would do well to remember that the same applies to all the people we encounter every day, including our patients.

Adapt or die. We are just animals, with morals, hoping that our day-to-day survival activities align with a larger purpose. Life is continually changed. We have to adjust our expectations, our models, and our understanding of the world as new information becomes apparent or the world changes.

At its essence medicine is about reality not possibility. A good story is only medically useful so far as it is consistent with an understanding of human disease. Elaborations or exaggerations must be parsed out, or taken with a degree of doubt, as justifications for the pathologic situation are weighed. We must be aware that there is a reality behind the situation. Part of being an effective doctor means being able to sift through various historical accounts looking for where the truth ends and where narrative begins.

"…Origins provide a useful frame of reference to understanding people, and can help us make sense of our surrounding, but they do not replace the ever-present uncertainty and wonder that comes with living in an unexplained universe."

For scientists and clinicians, truth is our grail; judgment suffers when we mistake stories for truth. Read any scientific article and you will notice the disparity between the results and the discussion. Facts are reported in the results, while their interpretation (that provided by the authors) is supplied in the discussion. It is important to draw this distinction.

We need stories. These are the memorable moments of life and are what make us human. But we as individuals are not the narratives we tell, nor can we be reduced to the sum of our experiences. We are present, multi-faceted, ever-changing beings. that medicine, in its wisdom, may provide guidance but never completely understand. Origins provide a useful frame of reference to understanding people, and can help us make sense of our surrounding, but they do not replace the ever-present uncertainty and wonder that comes with living in an unexplained universe.

Untangling Luck

LOUISA HO, CLASS OF 2017

One of the things that I really enjoy about being a part of the QMR is partaking in the discussions that take place during our brainstorming sessions. At our most recent round table discussion for QMR 8.3 – Origins, it became apparent that the idea of an 'origin story' meant something different to everyone, inspiring a breadth of approaches for putting our unique narratives into words. Personally, I found myself struggling to identify a specific memory that served as a pivotal moment in my life, leading me down my current path. As much as I firmly believe that I am where I am today a result of my own hard work and dedication, it is impossible to deny that along the way, many a time, I simply got lucky. In this piece, I will be exploring the influence of luck in all of our origin stories, and the role that luck will continue to play in future roles as physicians.

I want to start off by acknowledging that exactly what the term "luck" means varies from person to person, belonging in the realm of culture and religion for some; a consequence of karma or retribution to others; and for a few, plain randomness - a creative exploitation of the unforeseen. In this article, I will focus on luck as that which happens beyond a one's control; it may be further classified into three types as follows.

There is the kind of luck in simply being the kind of person one is, a sort of existential luck, sometimes referred to as constitutional luck. It is a complex interplay between genetics and environment and other causal factors that affect our biography, from brain chemistry to physical traits. This in turn influences our personality and intelligence, health and abilities. I was certainly lucky to be born into a middle class family in 21st century Canada, a society that highly values academia and knowledge, and, importantly, a culture that has not denied me of any opportunities on the basis of gender, race, or financial considerations. There are numerous additional philosophical and ethical arguments to be made about the implications of socioeconomic class, global equity, but further discussion is beyond the scope of the current article.

Next, there is the luck of being at the right place at the right time, known as circumstantial luck. These circumstances, brought on haphazardly, tend to be the memories that we conjure up when we try think back to pivotal moments in our lives. For instance, my dragon boat career has a been big part of my personal development; I've had opportunities to develop my leadership skills, I've met people who have mentored through the process of getting in medical school; and in addition I've been able to nurture my personal fitness and healthy lifestyle which is a big part of who I am today. It is unnerving to think that if I had not happened to run into an old acquaintance at the gym, offhandedly mentioned that I was considering joining a dragon boat club, and then subsequently been convinced to try out for out for one particular team (there were a total of 13 teams at University of Toronto), none of this would have happened. Similar arguments can readily be applied to chance meetings, conversations, experiences that lead to interests or opportunities in our personal and professional lives.

Finally, there is luck of ignorance; luck with factors one is not aware of and can only be identified in hindsight. It is the kind of luck that which evades any logical explanation and is impossible to place a handle on, and makes for truly serendipitous or unfortunate series of events. Most of life's activities lie somewhere in the middle of the continuum where on one end skill is the only determinant, and on the other hand this elusive force of luck dominates completely.

The age of evidence-based medicine aimed at waging a war towards nullifying this element of luck in clinical decision-making. Our medical education vehemently tries to uphold the promise of a rational, scientific world that hews only to that which is statistically significant, with guidelines and policies and recommendations aggregated only from the most meticulously conducted scientific research. We prefer to believe we live in a crisp, predictable world where everything that happens has an evident reason. Using evidence-based or consensus recommendations is the accepted approach to decision making at every level of health care, because it is supposed to improve decisions made by individual physicians. Perhaps more poignantly, it gives us some comfort in having an algorithm to follow, rather than being lost in the chaos of randomness, which falls outside the ordered row of science.

After all, especially where health is concerned, luck is far too arbitrary, too senseless of an explanation for us to accept, and for us to tell our patients. But despite the never-ending quest towards evidence suggesting its non-existence, too often things don't add up; the reason for patient's deterioration is no reason at all. And that is when luck is precisely what we what we use to explain whatever it is we really cannot explain. Acknowledging the element of luck is almost an adaptive meme; believing in luck as a self-fulfilling prophecy may produce positive thinking, alter responses for the better, but also as a mechanism as subsequent escape from personal culpability and responsibility, with the awareness that one is not to blame for every single bad outcome.

The science of medicine is complicated by the intangible art of medicine. This art can be messy: a diagnosis that remains elusive because a patient does not present with textbook symptoms, another patient not responding to treatment they way they are expected to. There isn't always an applicable protocol for every situation, and even when an individualized recommendation exists it may be subject to biases and errors in perceptions. This has been acknowledged for centuries, but sometimes we forget.

"...Medicine is a science of uncertainty and an art of probability.
-Sir William Osler...."

QMR

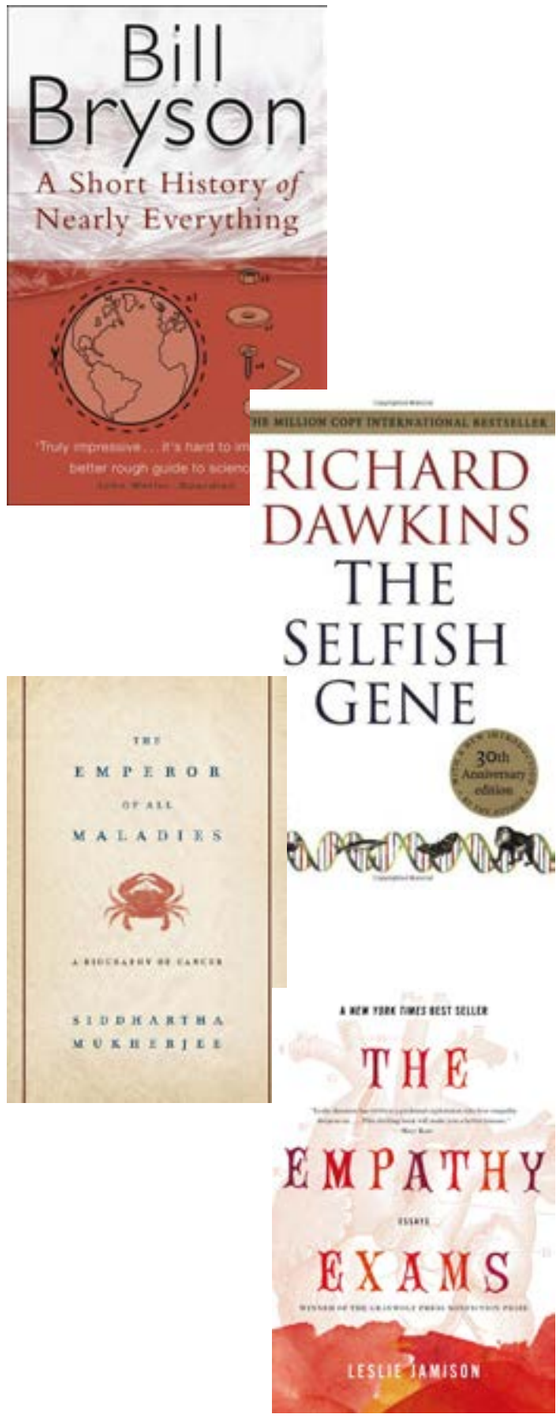
What's on your reading list?

ADAM MOSA AND LUBA BRYUSHKOVA, CLASS OF 2018

Are subzero temperatures and gloomy skies keeping you indoors? Are you looking for a new and improved way to procrastinate? Pour yourself a cup of hot chocolate (or wine, if that's more your thing), and cozy up with a good book. We asked other QMeds to tell us about their favourite books. There is everything from philosophy to fantasy to fiction - behold, the ultimate QMed-approved reading list.

Fiction

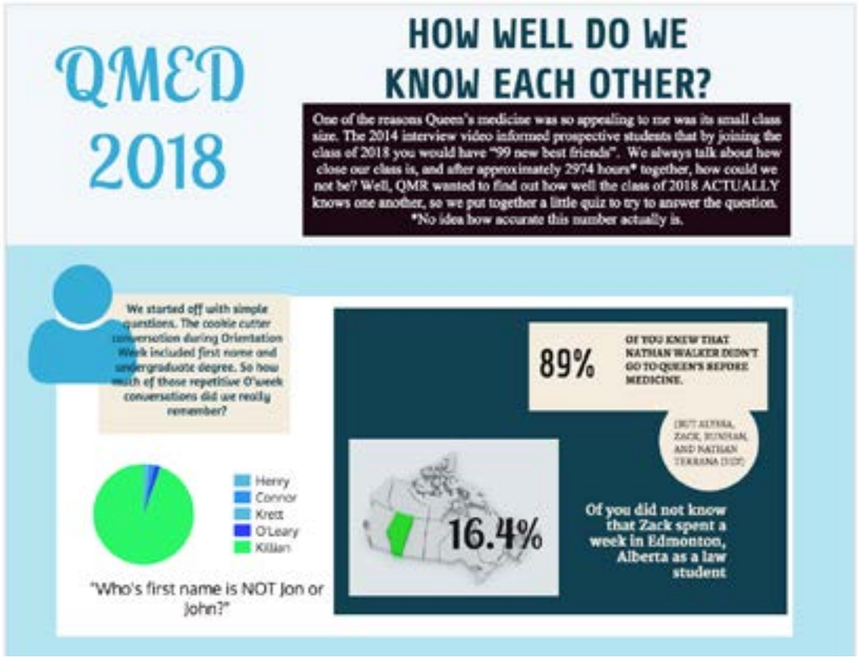
House of God, Samuel Shem
The Lions of Al-Rassan, Guy Kay
Life of Pi, Yann Martel
The Book Thief, Markus Zusak
Ender's Game, Orson Scott Card
Extremely Loud and Incredible Close, Jonathan Safran Foer
The Poisonwood Bible, Barbara Kingsolver
A Song of Ice and Fire, GRRM
The Road, Cormac McCarthy
The Little Prince, Antoine de Saint-Exupéry
Flowers for Algernon, Daniel Keyes
Beloved, Toni Morrison
The Hitchhiker's Guide to the Galaxy, Douglas Adams
Love in the Time of Cholera, Gabriel Garcia Marquez
Zen and the Art of Motorcycle Maintenance, Robert Pirsig
Never Let Me Go, Kazuo Ishiguro
We Need to Talk About Kevin, Lionel Shriver
Middlemarch, George Eliot
Written on the Body, Jeanette Winterson
Stitches, David Small
Persepolis, Marjane Satrapi
Cutting for Stone, Abraham Verghese
The Godfather, Mario Puzo
QB VII, Leon Uris
The Physician, Noah Gordon
Curious George, Hans Augusto Rey and Margret Rey
Eragon (and sequals; series known as Inheritance Cycle), Christopher Paolini
Americanah, Chimimanda Ngozi Adichie
The Prince of Nothing Trilogy, R Scott Bakker
Malazan Tales of The Fallen, Steven Erikson
Tinkers, Paul Harding
Dirk Gently's Holistic Detective Service, Douglas Adams
Perfume: the story of a murderer, Patrick Suskind
The Hungry Ghosts, Shyam Selvadurai
A Sunday at the Pool in Kigali, Gil Courtemanche

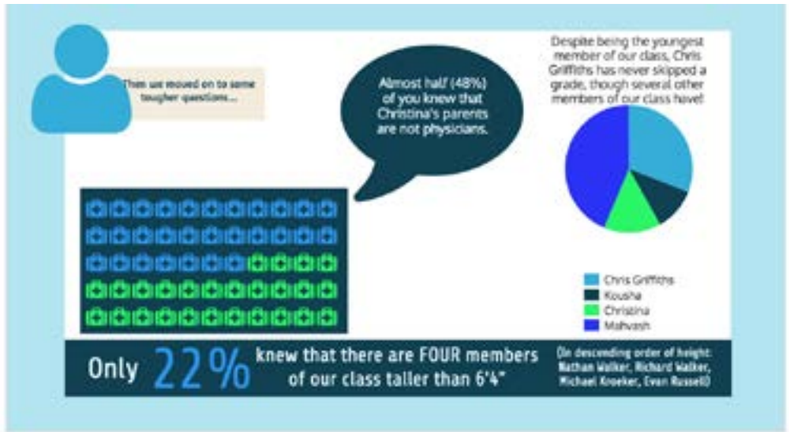


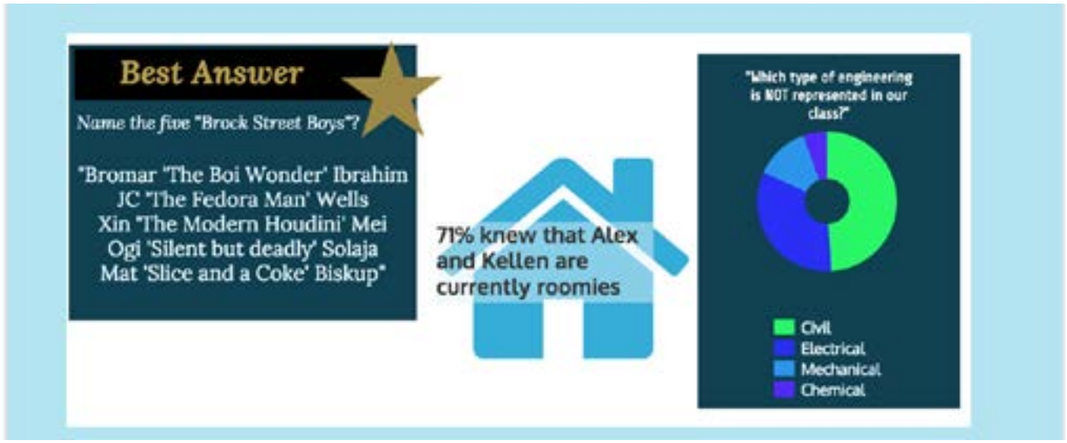
Non-Fiction

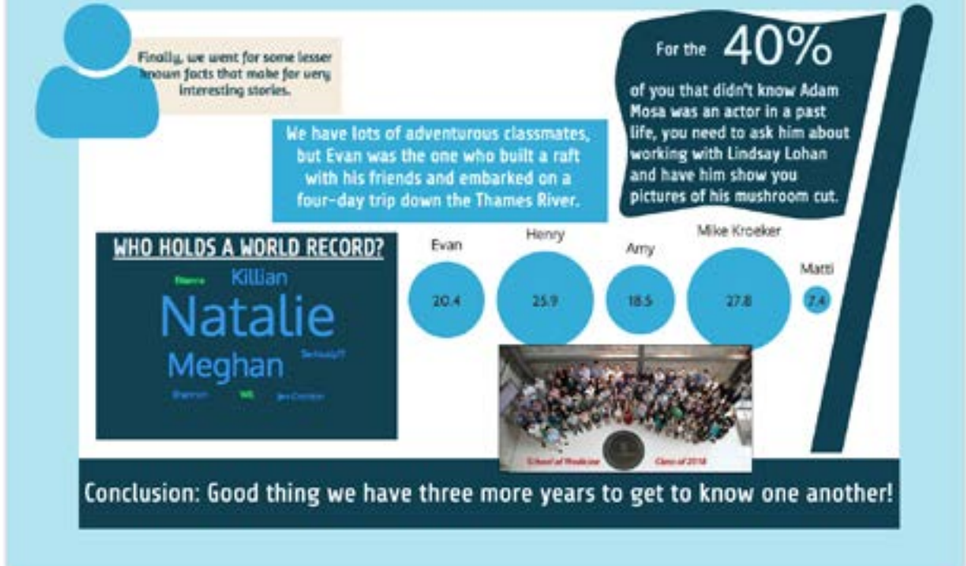
On the move: A life, Oliver Sacks
Make it stick: the science of successful learning, Peter Brown
How Doctors Think, Jerome Groupman
The Lives of a Cell, Lewis Thomas
The Art of Medicine, Herbert Ho & Ping Kong
The Empathy Exams, Leslie Jamison
Better, Atul Gawande
The Immortal Life of Henrietta Lacks, Rebecca Skloot
The Emperor of All Maladies, Siddhartha Mukherjee
The Selfish Gene, Richard Dawkins
Walden, Henry David Thoreau
In the Realm of Hungry Ghosts, Gabor Mate
Think and Grow Rich, Napoleon Hill
A Short History of Nearly Everything, Bill Bryson
Far From the Tree, Andrew Solomon
Autobiography of a Face, Lucy Grealy
Clearing the Plains, James Daschuk
The spirit catches you and you fall down, Anne Fadiman
Cosmos, Carl Sagan
The Making of a Surgeon, William A. Nolen
Hurry Down Sunshine, Michael Greenberg
The Year of Magical Thinking, Joan Didion
A General Theory of Love, Thomas Lewis et. al
Twelve Patients: Life and Death at Bellevue Hospital, Eric Manheimer
Basic Economics, Thomas Sowell
An Imperfect Offering, James Orbinski
They Poured Fire on Us From the Sky, Alephonsian Deng
Bringing Down the House, Ben Mezrech
Devil in the white city, Eric Larson
Monster: the autobiography of an L.A. gang member, Sanyika Shakur
One Summer: America 1927, Bill Bryson
Crash Course World History, John Green
The Sixth Extinction: An Unnatural History, Elizabeth Kolbert

SHANNON WILLMOTT, CLASS OF 2018









Perspectives on Pharmacare

JENNIFER MCCALL, CLASS OF 2018
JILLIAN COTTREAU, CLASS OF 2017

For decades, Canadians have recognized that health care is a human right and that it should not be denied to people because of their income, language, colour, or sexual orientation. I don't need to tell you all about Tommy Douglas and the origins of our public health care system, because Dr. Duffin does a much better job of that.

What we would rather discuss today is the beginnings of a new movement, one that most of you have heard of: the movement for a national Pharmacare plan. We have come to a point in Canada's medical history when hospital coverage is no longer enough. We need it, we appreciate it, but the reality is that healthcare does not end when a patient is discharged or leaves their doctor's office.

Canadians spend millions of dollars every year on medications that are not taken in hospital. For some, this means filing receipts with an insurance company. For others, it means sending the bill to ODSP. For many others, however, it means paying out of pocket for the co-payment or full price of a drug that they simply cannot afford. The working poor, those who make just enough money not to be eligible for ODSP, are most at risk. They will have a hard time paying even a small co-payment as they strive to survive in an ever more-expensive economy. Although these groups are most vulnerable, anyone can feel the financial burden that comes with taking medications at home. Middle-class citizens living with chronic disease, people with pre-existing conditions not covered by private insurance, and so many others. Currently, 1 in 10 Canadians cannot afford the medications their doctors prescribe (Law et al., 2012).

As future physicians, one of the reasons that this issue is particularly important to us is that it can prevent us from doing our jobs properly and providing the best care. As the most conscious physician, you could keep up with the most recent evidence-based medicine, critically appraise the drug literature, and refine your list of the best medications for a given condition. But, if your patient cannot afford the most effective, most appropriate medication, or any medication at all, what will that serve? Your patient may not even tell you that they did not purchase the medication because of stigma and embarassment. You will have an especially hard time convincing your patients to spend money on preventative drugs, when it is only a far off possibility that they will develop disease, or on medications for asymptomatic afflictions like hypertension.

A group of your peers at Queen's believes that Canada needs a national Pharmacare plan. We are called Kingston Students for Medicare, an interprofessional student chapter of Canadian Doctors for Medicare. We are a new group this year and are very excited to hit the ground running with initiatives like getting Kingston City Council to pass a motion to support Pharmacare, hanging out at HHRC to talk about access to care, and reaching out to federal election candidates to make Pharmacare an election issue. While we have chosen to make Pharmacare the focus this year, our primary tenet as a group is support of public health care.

At present, Pharmacare is getting a lot of attention in the media. We chose to focus on Pharmacare this year because we want to capitalize on this momentum. We also believe that Pharmacare, as an initiative of accessible public health care, will strengthen the idea of public health care and therefore encompasses both ideas that are central to our group's existence.

In case you are not yet convinced that Canadians would benefit from Pharmacare, we would like to present you with a bit more information on why this should matter to you, both personally and professionally.

- Pharmacare is good for small business. Employees that can afford their medications are happier, healthier, and more productive. They miss less sick days and are more productive when present. However, small businesses can not afford insurance plans and their employees suffer when medications are too expensive (Martin & Morgan, 2015; Law et al., 2012).

- A Pharmacare plan would save Canada 14 billion dollars per year, according to one conservative estimate (Law et al., 2012). These savings would come due to an increased purchasing power, which will helto drive down drug prices, as well as decreased administrative costs. The increased purchasing power and consistent demand may also help ensure supply and prevent drug shortages.

QMR

- Pharmacare would make access to medications equal across the country, instead of having different drugs covered in different provinces. This might also push Canada to publish an essential medicines list.

We hope you are convinced. The time for action is now with a federal election around the corner and much support in the media, garnered by the likes of Dr. Danielle Martin and Andre Picard. We would encourage you to come out and join us, in our origin, at Kingston Students for Medicare. If you would like more information, please check out the resources below. Here's hoping that by the time we finish our residencies, in 2020 and beyond, that Pharmacare will be implemented in Canada and allow us to better serve our patients.

1. Law, et al. "Estimated cost of universal public coverage of prescription drugs in Canada." Canadian Medical Association Journal. 2015
2. Law, et al. "The effect of cost on adherence to prescription medications in Canada." Canadian Medical Association Journal. 2012.
3. Martin, Danielle and Morgan, Steve. "Pharmacare is good for business." Evidence Network. 2015.
4. Morgan, et al. "The Future of Drug Coverage in Canada." Pharmacare2020. 2015.

The Hypochondriac Chronicles

ANONYMOUS

"I feel a twinge of pain in my left chest… and there is a tight component to it… Hmm… where is it coming from? Is it from my bone? Muscle? Could it be my heart? Heart problems DO run in my family… but I'm 25, eat well and exercise…Nah… it can't be my heart… It's definitely coming from outside my ribcage...I'm definitely not having an acute coronary event… but presentations can be atypical… what if this is atypical? What if I'm doing myself a disservice by ignoring it… if I pass out now, does anyone know CPR?"

"…My heart is beating quickly but like clockwork. I don't feel the slightest need to faint, and no elephants can be found sitting on my chest, but still – that tiny random pain has me worried I'm in imminent danger…."

The above races through my mind, as I'm running on a treadmill. I'm not particularly struggling either (not to brag). My breathing is fine, just faster and deeper. My heart is beating quickly but like clockwork. I don't feel the slightest need to faint, and no elephants can be found sitting on my chest, but still – that tiny random pain has me worried I'm in imminent danger. It passes, and I forget about all those worries, and continue on – at least until it visits me again at some unforeseen time in the future. This has happened before, at least a handful of times. Soon I may also start wondering if it's something else, perhaps an ominous sign of something brewing under the surface.

The cycle continues.

What could it be? It could be nothing. It likely is nothing – after all, we're living breathing beings, and not one of us is perfect. Random pains come and go and mean nothing. No one will ever know what caused them and what made them better, and that's ok, because such is life, and such is the rational me trying to take over.

But the irrational makes sure it's heard, only too clearly.

Shin pain turns into compartment syndrome or osteomyelitis.

Too many trips to the bathroom? That day I had Diabetes.

Jaw pain? Giant cell arteritis? Another atypical cardiac event? Why is this pain not going away?
Maybe this IS something serious. Jaw claudication? Maybe my carotid arteries are stenosed. Am I going to have a stroke?

As part of my ritual du jour, I run the sacred seven through my head.

What anatomy lies beneath? What else could be hurting my jaw? Where exactly is it in my jaw? Is it actually in my jaw? No, more localized. It's not my jaw, more my TMJ. Ah wait… A revelation.

I grind my teeth at night. I have a mouth guard for it (that I don't wear) and it is exam season. Maybe the stress is getting to me. Maybe the pain will go away if I start wearing it for a while (spoiler alert – I did and it did).

My poor adrenals. So much anxiety with so little reason.
I was sick with a GI bug a few weeks ago, a more than likely explanation for the GI issues I'd had as of late. But I couldn't help wondering…

Do I have a biliary obstruction? But I don't have any biliary pain. Can it be pancreatic cancer?

I check to see if I have scleral icterus.

Abdominal pain? Barely. Probably more made up than felt, but still.

"…Too many trips to the bathroom? That day I had Diabetes….."

Can it be cancer? Ovarian? Colorectal? Uterine? What about my bladder – it could be bladder cancer. But I haven't had hematuria? What if it's microscopic? God I wish I had a dipstick. Curse you abdomen, why must you be so difficult to decipher?

"… Should I go to the doctor? Aren't they going to judge me or think I should know better? What would I have to say?…"

Rationally, I think, I search and I consider.

I'm not the right age for this – I won't be the right age for this for at least a few decades. I don't have these risk factors. I don't have most of these symptoms and the ones I have are either made up or so vague they can be virtually anything. Not to mention, this cancer is rare…I don't have it. But what if this once, just this once, despite all evidence, all odds to the contrary, I'm wrong?

Should I go to the doctor? Aren't they going to judge me or think I should know better? What would I have to say?

I silently interview myself and come to the conclusions that what I have to offer in terms of a history isn't much to go by in any direction. I'm the kind of patient that I would be unimpressed by. I feel guilty of my judgement, and vow to remember this feeling next time I'm frustrated in an interview. I can relate. I too yearn for that sense of relief, for validation that there's nothing wrong with me, regardless of my fragmented and rather inconclusive story. Maybe I know better, but when you're in the hot seat that doesn't matter much.
I don't know what to do.

I entertain the idea of seeking medical attention. The thinking shifts – how would this play out? I rarely go to the doctor. I think of what the doctor might do.Would they order imaging or some kind of diagnostic test? Have a definitive 100% answer as to what's wrong with me?

I know the answer already. I look up it up anyways. Unlikely. I'm frustrated. That gold standard invasive test is my ticket to full and complete peace of mind. I want it, and I know I'm not going to get it – so what's the point?

I shouldn't go. I should wait this out. Yet, they have experience. They know better. I still want their opinion.

Tonight, I'll decide that tomorrow I will make that appointment.

Finally, I'll be able to get some peace of mind.

Tomorrow I'll change my mind.

Repeat.

Snapshots of Peru

CALVIN SANTIAGO, CLASS OF 2018

Arequipa:

The city of Arequipa is the second largest in Peru. It was founded in 1540 by Spanish colonialists and have played an important in the country's history. The historic centre of the city of Arequipa is a UNESCO World Heritage Site and the buildings are famous for the use of unique volcanic white stone called 'sillar,' which is only found in this region. Historically, Arequipa has been the home of many Peruvian intellectual, political and religious figures.

Lake Titicaca:

At just above 3800 metres, Lake Titicaca is the highest lake in the world and the largest lake in South America. Set between the borders of Peru and Bolivia, Lake Titicaca is dotted with many picturesque islands including the famous Uros Islands which are sometimes known as the Floating Islands. The inhabitants are descendants of a people dating back to pre-Incan times and speak mostly Aymara. These floating islands are constructed out of dried totora reeds which grow in the lake.

Machu Picchu:

As a UNESCO World Heritage Site and one of the New Seven Wonders of the World, Machu Picchu is arguably the most famous landmark in Peru, if not South America. Little is known for certainty about this Incan site, but it is believed to have been built for the Incan emperor Pachacuti around 1450. The walls of Machu Picchu are built using a technique mastered by the Incas called 'ashlar' in which stone blocks are cut to fit perfectly without using mortar.

Salinas and Aguada Blanca National Reservation:

The Salinas and Aguada Blanca Naitonal Reservation exists to preserve the native flora, fauna and landscapes formations. The protected natural area contains the region's many volcanoes including Misti, Chachani, and Pichupichu. It is also home to many wildlife including herds of vicuñas, alpacas and llamas.

Chiaruscuro 2015:

On the origins of a style, an event, and a personal passion

MADDIE BAETZ-DOUGAN, CLASS OF 2018

If you're like most people I have talked to, you've probably got some questions about Chiaroscuro: how to pronounce it, what it means, and why I got involved. This fall, I had the opportunity to organize the annual Chiaroscuro Art Auction alongside my colleague Rufina Kim, and not without the help of several talented QMed painters, sketchers, origami folders, photographers, and art lovers alike. To begin to answer those questions I know you've got, I'll fill you in on the important details first.

Chiaroscuro is a term borrowed from art history that is used to describe a painting style that relies on harsh contrasts between light and dark in a scene. The style lends drama to a scene, often with candlelight illuminating the faces of important biblical figures. I recall learning about chiaroscuro using Caravaggio's famous painting the Calling of St. Matthew, depicting the moment that Matthew is inspired to follow Christ. An important point that I also know you might be wondering wondering, it is pronounced: key-are-oh-SKEUR-oh.

The next important question, then, is why is the art auction named Chiaroscuro? The auction was first started by Jonathan Lee (Class of 2010), who chose to organize the fundraiser for the Juvenile Diabetes Research Foundation, a disease he was diagnosed with as a child. Jonathan understood how chiaroscuro could describe not only art, but also the challenges and contrasts he has faced in living with this diagnosis in his own life. This year, we managed to raise almost $1000 towards this important cause through the sometimes competitive bidding done by friends, faculty, and students alike.

On a personal note, Chiaroscuro was a special event to have helped organize for reasons that extend beyond the interesting history and ultimate goal of the fundraiser. I have always been passionate about visual art, whether it's the appreciation or creation of something beautiful. As a first year medical student, I recall being told to not forget about your passions and to invest time into things other than medicine that make you happy. Taking this advice pretty seriously, I purchased a new set of acrylic paints and brushes and began painting again after a 3 year hiatus – and I haven't looked back since. In the midst of the auction, I had the pleasure of creating a painting, collaborating with artists and wonderful local businesses (including Camera Kingston and Kingston Frameworks), and then stepping back to see everyone enjoy the works and appreciate the artistic talent. The experience gave me time to reflect on the impact of art on my life, as well as our community at Queen's. It has the power to bring us together and allow us to contribute to something beyond ourselves.

Reflecting back on origins, I remember both the origins of my personal interest in artistic expression, and the origin of Chiaroscuro art auction itself. I feel grateful for having participated in something that has meant so much to me in my life, and is similarly meaningful to others including Jonathan Lee and patients living with juvenile diabetes. I am confident that next year's organizers will keep the tradition alive and add something unique to Chiaroscuro's story.