QMR

QUEEN'S MEDICAL REVIEW

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Cover photography by Ali Tafti

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From the Editors

Dear colleagues, faculty, and friends,

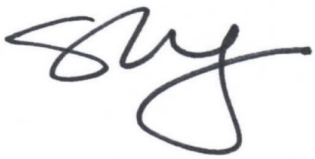
Welcome to a new year, a new term, and a fresh opportunity to try out the protective properties of your winter gear in the sub-zero temperatures of the Nameless New Medical Building.

This new year sees the 2012s anticipating the upcoming CaRMS match, the 2013s entering clerkship, the 2014s doing more of the same (alright, not that exciting), and the 2015s finally leaving behind the tedium of the foundational curriculum to embark on the next stage of their clinical education. All the while, prospective 2016s are frantically practising their multiple mini interview skills and spending far too much time on premed101.com.

Of course, with each new year there are new year's resolutions: some laudable (let's spend less time at Stages), some questionable (let's prioritize partying over studying), and some just plain pathetic (let's try to spend less time in a sling). Will your new year's resolutions this year be in keeping with the Ontario Medical Association and Canadian Medical Association's official stances on smoking, drinking, and tanning? Check out page 8 to see the results of our behavioural survey that asked the burning question: When it comes to things the OMA and CMA tell us are bad (or good) for us, do we jump on board or jump ship? In our "Point/Counterpoint" article on page 18, Katie Pizzuto and Jennifer Kwan face off to argue both sides of that exact question. What's your stance? Along a similar vein, how empathic ought physicians to be? Heather Johnson explores this question on page 22. Join the conversation at our website at qmr.qmed.ca—now with commenting enabled!

Also in this issue: Everything you wanted to know but were afraid to ask about Dr. Henry Averns, Rheumatologist Extraordinaire. Our very own Jalal Moolji asks the right questions in the interview on page 10. The full, uncut interview can be found at qmr.qmed.ca.

And that's the way it is.



Seth Climans Sarah Luckett-Gatopoulos

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Internal News

COMPILED BY AMY GLICKSMAN & EMILY SWINKIN

MEDICAL SCHOOL BUILDING GRAND OPENING

Although the new Queen's Medical School Building has been in use since the start of the semester, the official grand opening took place on September 22nd. In honour of Queen's University's Scottish heritage, a bagpiper led a processional to begin the event. Among those who provided speeches were the mayor of Kingston; Dr. Richard Reznick, dean of the Faculty of Health Sciences; and Thurarshen Jeyalingam, president of the the Aesculapian Society, the Queen's Medical School student council.

Members of the Aesculapian Society and volunteers from the classes of 2012–2015 provided tours to those attending the event, including many alumni. Fourth-year class co-president Elizabeth Miller felt it was "a really special community event because it brought alumni, Kingston residents, Queen's students and medical students together to celebrate."

The $77 million building was funded by grants from the federal and provincial governments, and with generous donations from alumni, faculty, and other supporters. A 2010 referendum initiated by the Aesculapian Society saw current and future students committing to eventually raising $500,000 towards the cost of the building.

The state-of-the-art building includes rooms specially designed to support small group learning. The facility is also designed to support hands-on learning through simulation. Although the building showcases new technology, it also represents a joining of the old with the new; traditional classrooms exist alongside rooms designed to support small group learning, and Starbucks coffee is sold around the corner from a mounted door from the original historic house that previously existed at the site of the new building.

ACCREDITATION

During the month of October, Queen's University's post-graduate programs underwent an extensive accreditation process by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Canadian Family Physicians of Canada (CFPC).

Residents and faculty could be seen throughout the hospital giving tours to members of the accreditation team. According to the Postgraduate Medical Education (PGME) Office website, 27 of 29 residency programs received recommendation for full approval.

SOCIAL EVENTS

Queen's medical students were once again involved in the annual Boys and Girls Night celebration this past October. Each class held separate activities for male and female students before students from all years joined together at Ale House in downtown Kingston. The event raised $800 for the Boys and Girls Club of Kingston.

The social events continued with the fall Formal, which took place on November 18th at Portsmouth Olympic Harbor Restaurant. This year's theme was Winter Wonderland and was an exciting event for all in attendance.

QUEEN'S WELCOMES CLASS OF 2015

The Queen's community is happy to welcome a new class of medical students into the fold. The 2015 class made their presence known on campus during orientation week. As a whole, the class is relatively young, with an average age of 22. However with 22 graduate students and 5 PhDs among them, the class certainly has a wealth of academic experience. With students hailing from Kamloops to Danville, in addition to a sizable contingent from Toronto, the 2015s bring diverse perspectives and educational backgrounds to Queen's. From their strong showing at OMSW to their collective 101 Dalmatians class costume featuring Dr. Conrad Reifel, it looks like the 2015s are off to a great start.

LHEARN-ING WITH QUEEN'S

In a continuing effort to improve and expand clinical learning at Queen's, the University contributed $1 million to the development of the Lakeridge Health Education and Research Network (LHEARN), a state of the art teaching facility in Oshawa. Students have benefited from clinical learning opportunities ranging from surgery to critical care to rehabilitation therapy at Lakeridge over the past several years. Further, Queen's Family Medicine will launch a residency based in Lakeridge beginning in 2012. Queen's University's close ties with Lakeridge and other community hospitals serve to increase distributed medical education, which gives students access to a broader range of clinical exposures and teachers.

External News

COMPILED BY JANETTE SPEARE

INSITE EXEMPTION UPHELD

In a landmark ruling on September 30th, the Supreme Court ruled on Vancouver's safe injection program, and upheld Insite's exemption from prosecution under drug possession laws. Canada's Minister of Health recently attempted to revoke the exemption, which would have resulted in the closure of the clinic, but the Supreme Court ruled that to do so would violate drug users' charter right to "life, liberty and security of the person." Insite is a safe and medically-supervised injection site for intravenous drug users and this decision may pave the way for similar supervised injection clinics in other areas of the country.

MEDICAL SCHOOL FEES UP 6.4% THIS YEAR

Statistics Canada reports that medical school tuition rose an average of 6.4% this year, to an average of $16 024 nationally. Queen's University exceeded the average, costing students $19,786 annually. However, Queen's students may take comfort in the fact that they do not attend McMaster where yearly tuition fees this year were over $23,000 (though the total cost of and education at McMaster is still much lower due to the three-year nature of their program). The Canadian Federation of Medical Students has stated its concern that rising medical school costs will pose a barrier to students from low socioeconomic backgrounds.

BOTOX GREEN-LIGHTED AS MIGRAINE TREATMENT

The celebrity-caliber wrinkle reducer Botox, trade name for botulinum toxin, has recently been approved by Health Canada for migraine prevention. Chronic migraine sufferers who experience four-hour headaches every other day will be eligible to have the toxic protein produced by the bacterium *Clostridium botulinum* injected directly into their faces. In a recent clinical trial, side effects of Botox treatment included migraine headaches, the very problem this treatment is meant to prevent.

OTTAWA ENDOSCOPY CLINIC CRITIICIZED FOR POOR STERILIZATION

The College of Physicians and Surgeons of Ontario has determined that a private Ottawa endoscopy clinic put more than 6 800 patients at risk of infection by HIV and hepatitis C and B viruses by not properly sterilizing its instruments. Gastroenterologist Dr. Christiane Farazli is now the subject of a class action lawsuit. Clinics such as Dr. Farazli's only became subject to regular CPSO inspections last year in 2010, so similar tales of substandard practice may emerge before the province-wide inspection is concluded in 2012.

GLAUCOMA MEDICATION HAS BEAUTY BENEFIT

The glaucoma drug bimatoprost has been found to confer the added benefit of longer, more luxurious lashes on those who take it. Now the drug is being prescribed purely for its cosmetic benefits and California-based company Allergan, which produces the job has experienced a 35% sales increase. The primarily-female treatment-recipients must contend with a number of side effects including eyelid swelling, discharge, blood seeping into the eye chamber and eye itching, in exchange for their new-found eye beauty.

DIABETES TO AFFECT ONE IN TEN ADULTS BY 2030

According to a recent report by the International Diabetes Federation (IDF), 552 million adults could have diabetes in 2030. This works out to one in ten adults. Currently, about one adult in thirteen develops diabetes. The predicted increase takes into account the aging world population and not the obesity epidemic. The World Health Organization acknowledged that the IDF's predictions were reasonable.

QMR

The Face of Internet Fame

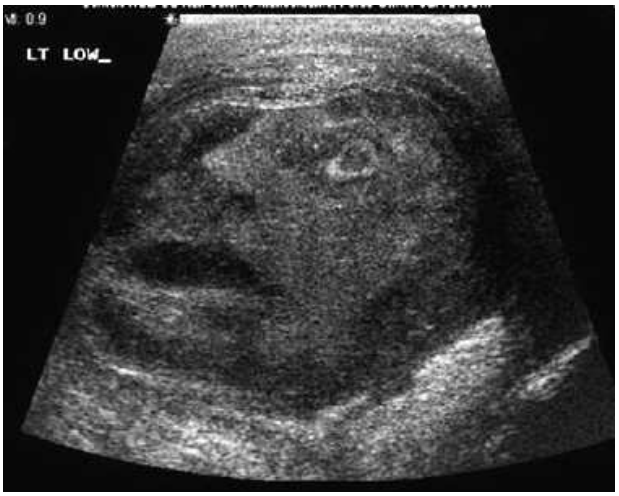
BY JANETTE SPEARE

Queen's University became Internet famous this November for an ultrasound image of a testicle snapped by the urology department. The testicle in question belonged to a 45-year-old man with severe testicular pain. Among dozens of ultrasound images showing a benign testicular tumour, one slice in particular resembled a human face: eyes widened in shock, brow furrowed, mouth agape as if to say "I am your testicular pain." The researchers from the department of urology who discovered the image, doctors Naji Touma and Gregory Roberts, likened the image to the face of a man screaming in pain, although this reporter thinks it looks more like the face of a medical student who breaks wind during dinner with the Dean. The precise nature of the facial expression aside, some larger questions remain: Why do we all see a face? Why doesn't this happen more often? And why on earth is this news?

"People have a documented tendency to want to see faces in things"

Ultrasound images are generated by bombarding some body part with ultra-high frequency sound waves and using patterns of sound reflection to visualize what's inside. The apparent face in the testicular tumour is probably not the face of the Egyptian god of virility (as the researchers considered) but rather just a fortuitous combination of light and shadow resulting from tiny waves of sound shot into a man's testicle. But people have a documented tendency to want to see faces in things. This phenomenon is known as pareidolia, and is responsible for the appearance of the Virgin Mary's face in potato chips, and Jesus' face in grilled cheese sandwiches everywhere. A 2009 brain imaging study showed that, while images of actual faces activate a region of the temporal cortex called the fusiform face area within 130 milliseconds, images that are somewhat face-ish (like sadly surprised electrical outlets) activate the same area a mere 30 milliseconds later, indicating that relatively little re-interpretation needs to happen for your brain to tag something as "face." Astrophysicist and badass Carl Sagan postulated that a hyperactive face detection area would confer an evolutionary advantage on our ancestors, allowing them to determine friend from enemy; the trade-off is that anything that seems to have two eyes and a mouth seems, well, face-y to us.

Given all that, it is a bit shocking that mysterious ultrasound faces don't pop up more often. A reasonably-involved Google image search for freak faces in ultrasound images failed to yield any results, except for a bunch of fetuses, which do actually have faces. My interpretation is that scientists are usually such a humourless lot that they wouldn't dream of sending their silly face images to peer-reviewed journals for publishing, much less under the headline "The face of testicular pain: A surprising ultrasound finding." The incongruity of the sombre topic of testicular tumours with the outright hilarity of the face in the image, coupled with the Internet's taste for the bizarre, goes a long way toward explaining why this story became as popular as it did. If nothing else, when the fifteen minutes of fame die down, maybe it will serve as a chilling reminder for imaging specialists that sometimes when you stare into a testicle, the testicle also stares back into you.



Pot calling the kettle black?

Behaviours of Queen's medical students

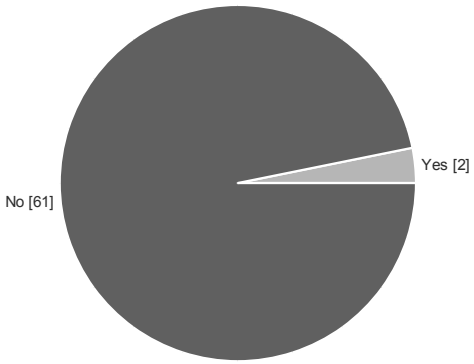
BY SETH CLIMANS

This issue's Point//Counterpoint article [Page 18] asks whether or not medical students should model their behaviour after the advice they will be giving future patients. To assess the degree to which current Queen's medical students abide by the behaviours they prescribe, an anonymous survey was sent to current medical students. The questions were based on the Ontario Medical Association's 'Health Promotion' website [https://www.oma.org/HealthPromotion/Pages/default.aspx] and the Canadian Medical Association's PolicyBase [http://www.cma.ca/policybase] .

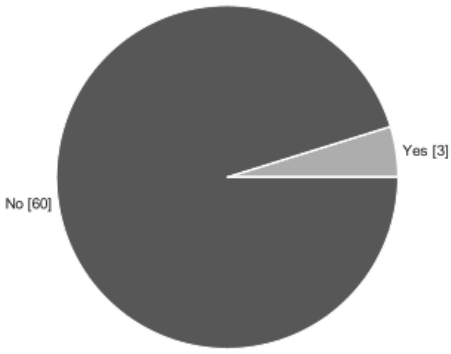
Sixty-three students responded—two fourth-year students, sixteen third-years, thirty second-years, and fifteen first-years.

Alcohol

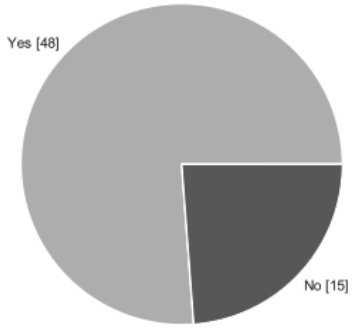
Since starting medical school, have you driven an automobile while your blood alcohol level was likely above 0.08% by volume?



Do you, on average, drink more than three standard alcohol beverages per day?

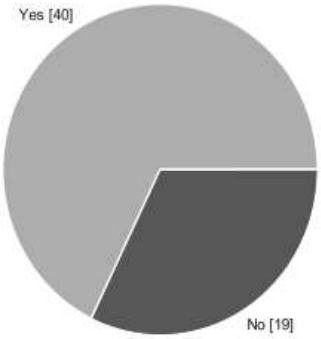


Since starting medical school, have you ever drank more than four standard alcohol beverages in a day?



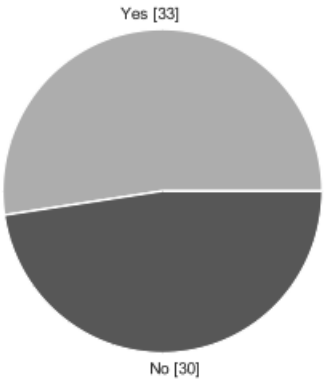
Bicycle safety

Do you, more often than not, wear a helmet when riding a bicycle?



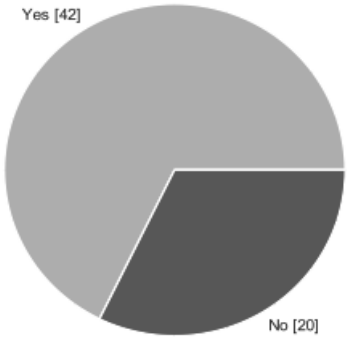
Cell phones and driving

Since starting medical school, have you used (without a hands-free device) a cell phone while driving?



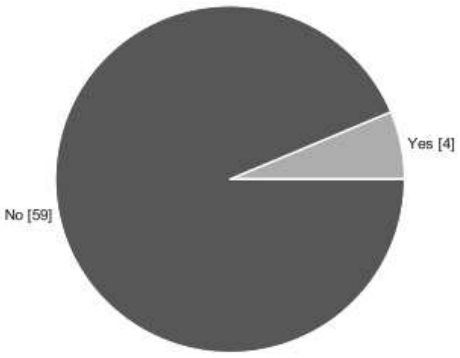
Physical activity

Do you, on average, get at least 2.5 hours of moderate-to vigorous-intensity aerobic physical activity per week, in periods of 10 minutes or more?



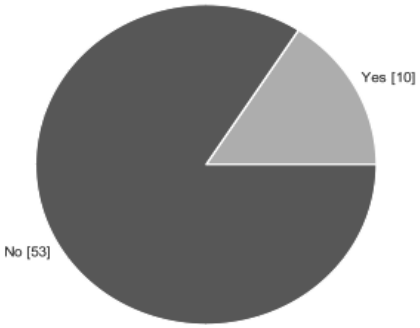
Tanning beds

Since starting medical school, have you been in an ultraviolet-light tanning bed?

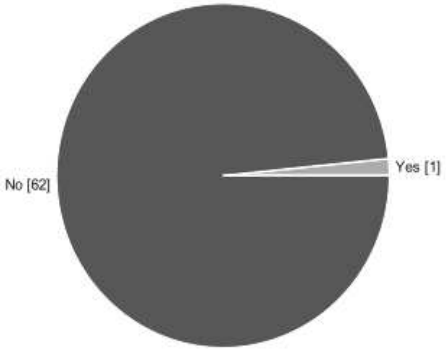


Tobacco

Since starting medical school, have you smoked a cigarette?



Do you, on average, smoke more than one cigarette per day?



With Henry Averns

BY JALAL MOOLJI

To become truly great, one has to stand with people, not above them.
—Montesquieu

On this surprisingly balmy November afternoon, I'm sitting face-to-face with a familiar presence. Despite only knowing him for a very short time, Dr. Averns seems to have that effect on me and most other students. His quick wit, proclivity towards humourous tales and famous sideburns make him a popular professor at Queen's. Behind the Tom Selleck 'stache however, is another story.

JM: Tell us a bit about your school life. How did you get through school?

HA: My career both in school and medical school in England was interrupted relatively frequently by requests to see the Headmaster or Dean, almost invariably because I had said something inappropriate. But I was always academically relatively strong, and so my inability to control my tongue was balanced by achieving well in exams and by being a source of entertainment.

JM: Why did you choose to become a doctor?

HA: At my school, it was expected that all the students would become doctors, engineers or lawyers. I had no respect for the law and I didn't see myself as an engineer. Thus, by default, I chose medicine. When I was 17, I had pondered going and having a career in music. I would have liked to have been a jazz pianist but my father didn't feel that it would offer me the sort of security that I'd get in medicine; so I took his advice. And I don't regret it.

JM: How did you end up in rheumatology?

HA: We have a strong history of rheumatoid arthritis in my family. Both my mum and my aunt had rheumatoid arthritis. So I was well aware of the crippling nature of the disease and the effect it can have on families. When I went to medical school, we were given the choice of which specialities we would like to attend during our clinical medicine attachments. Because I was aware of what rheumatology was about, I chose it and I was one of a very small number of students who did that. The rheumatology hospital was a 5–10 mile drive from the city and was reputed to offer free food, including jam tarts and custard. I was the only student there, and I was attached to one of the most inspiring clinicians I've ever worked with. His manner with his patients was amazing, his clinical skills were extraordinary, and he was a globally wonderful physician. I realized that if you want to define a role model in medicine, this was the man. I think, often, if you see a doctor who has the qualities that you're looking for in yourself, then you might pursue that speciality. And he really confirmed what I'd already suspected, that this was a specialty I was interested in. Role models are absolutely essential. If you're attached to a specialty and you don't feel any sense of rapport with the clinician, or their role modeling is not inspirational, then you're unlikely to choose that specialty.

JM: How did you end up in Canada?

HA: I did my rheumatology training in the UK, and became a consultant in North Devon, which is a very beautiful rural part of the country. I had a fantastic job, a beautiful house by the sea. After 10 years, I realized that this could be my life for the next 20 years and was actually quite anxious that my life seemed planned out too well. I needed to have some new experiences. In addition, over that period, I'd become gradually disenfranchised with the National Health Service, particularly with respect to the barriers to providing the sort of care I would wish to for my patients. The focus in the UK, on government-decreed targets, was often what I consider to be contrary to the best care for patients. So it was a combination of wanting to expand my horizons and a gradual disenfranchisement with the NHS that led me to decide, towards the end of 2005, that I would probably retire completely from clinical medicine and pursue different goals in my life.

JM: How have you adapted to life in Canada?

HA: In the first year or so, I found it a struggle. I was surprised by the different value placed on different specialities. That was not the case in the UK where all specialities are valued and also remunerated exactly the same. I just wasn't familiar with this system. I also struggled a little bit with the fee-for-service model of providing healthcare and I think it's better to salary doctors. Fee for service immediately builds in a conflict of interest and alters the way you practice. I think all doctors really need to ask themselves whether they're in medicine because of their potential earnings or because they have a passion for their patients and the underpinning science. And I think the fact that Canadian medicine is so firmly set on a financial base negatively affects the whole philosophy of clinical practice of this country compared to where I practiced before.

JM: How has the definition of physician changed over your

career?

HA: I don't think it has really. I think that a generation ago, physicians were universally respected and no one would dare question them. I think that nowadays, patients and colleagues in allied health professions are prepared to question us as and hold us to account. But I still think that the medical profession is the best profession. I still regard it as a huge privilege for patients to share their problems with me, to rely on me to examine them, and to trust my opinion on how their problems should be managed. To me, it's a privilege and an honour. And I genuinely have a love for the skills of clinical practice, both in terms of communication and physical examination skills. I still think that these are the cornerstone of medical practice. Despite all the new technologies that are emerging in almost every speciality, the ability to actually form a relationship, a therapeutic relationship, with the patient is what defines a physician.

JM: Do you think more should be done to encourage medical students to become generalists –

HA: Yes.

JM: Like family doctors?

HA: I think that family medicine still has a ways to go in Canada. I would like to see the training a little bit longer to bring it in line with many other specialties. I would like to see a lot of the patients who are referred to secondary care seen in primary care. I think that would be better both for the doctors and the healthcare system. But in order to achieve it, there would have to be some fundamental changes, not only in training but in models of care. In the UK, chronic care of diseases like diabetes, arthritis, and dermatological problems would stay in primary care and would only infrequently be referred to secondary care. I think that's better for everybody because it allows the secondary doctors to focus on patients whose outcomes you can actually positively change.

JM: How are allied healthcare professionals, like occupational therapists and dieticians changing medical practice?

HA: I don't think they are changing medical practice. Certainly in rheumatology, for as long as I can remember, the roles of different members of the team have been relatively well defined. I personally feel uncomfortable with models which try and move work normally done by doctors onto other healthcare professionals just because doctors feel it is "below them." I think it's not always the wisest thing to do. But I've always worked in a team where nurses, physios, OTs, have defined roles in the overall management of the patient, and I embrace that.

JM: Why do you feel uncomfortable about transferring more medical responsibilities [onto allied healthcare professionals]?

HA: Sometimes I think that what doctors are doing is cherry-picking and identifying things that they find more routine and more boring and I'm not necessarily confident that moving that onto others is a good idea. On the other hand, a well trained specialist nurse can provide a superb service – we just need to be careful how we do it. Remember that nurses and pharmacists, for example, have not been trained as diagnosticians and trained to globally manage patients. I think that they have their own role in the overall health of the patient but I worry that there's a danger that we're going to pass on some of what doctors do to nurses, and some of what nurses used to do really well to less well-trained individuals. I don't think moving a doctor's work onto other healthcare professionals is the only way to tackle the national doctor shortage.

JM: Do you think Canada should be training more doctors?

HA: I think that Canada should fundamentally review the healthcare system. I definitely believe it should be far more focused on primary care. Each specialty should review the currently internationally agreed workforce guidelines on ideal ratios of specialists to population and use those as a benchmark for what we provide. I know for rheumatology, there is undoubtedly a national shortage, but I don't know what the numbers are for others. In addition, we need to train more primary care doctors to take on some of our specialist work.

JM: Can you name one easy way healthcare in Canada can be made more effective?

HA: Yeah, I think that having a single primary care doctor who is the sole individual responsible for decisions, and who acts as a gatekeeper to secondary care would be a major improvement. One of the problems with the current model is you can have a cardiologist, rheumatologist, dermatologist and primary care doctor with occasionally a little bit of confusion about who's actually steering the ship. And in my opinion, there should only be one person steering the ship and that should be the family doctor in consultation with secondary care. The specialist should go back to its traditional role, which is the consultant.

Dr. Averns on Canadians:

HA: I find Canadians incredibly frustrating. They're ridiculously courteous and I think the conflict of this courtesy is their political correctness; many Canadians are so desperate not to offend, that they'll put up with situations and not speak out against them. I find that completely bizarre because culturally, I'm used to speaking out when I don't agree with something. It's a little bit like the Hans Christian Anderson tale about the emperor's new clothes where only one little boy was able to shout out that the emperor didn't have any clothes on. I'm fairly certain that I was put on this planet to act like that little boy and point out every so often when something is self-evidently ridiculous.

JM: Can you give any advice to medical students about how to rectify this?

HA: Yes, speak out when something is ridiculous or wrong. Do it with grace, humility and courtesy. Never be rude but if you tow the line in a situation with which you don't agree, you're actually diminishing yourself. Remember you are always your patient's advocate.

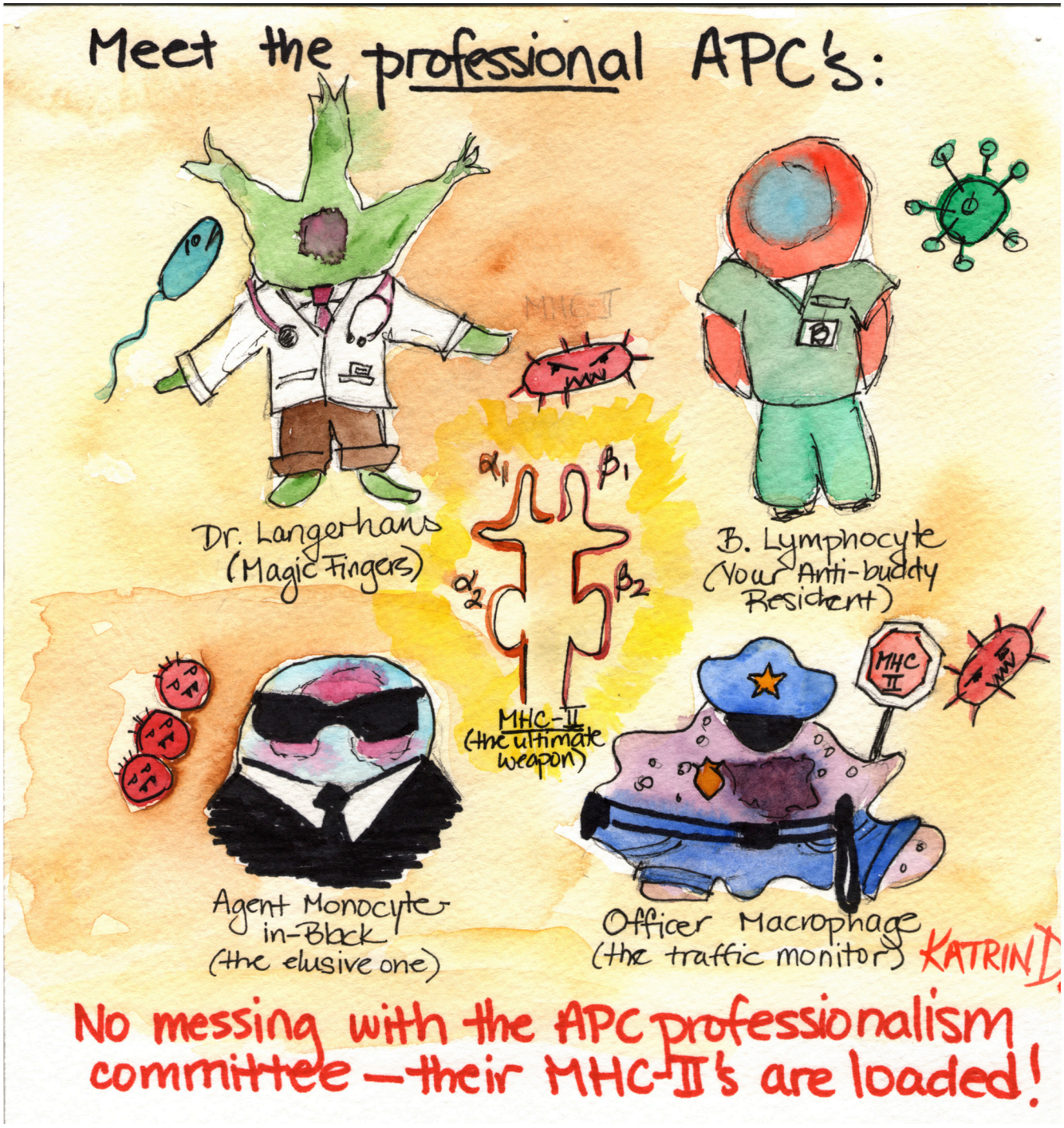
JM: If you had one piece of advice for future doctors, what would it be?

HA: I think the answer is, never cut corners. It's very easy, when you've got too much to do or when you're tired, to provide care that is not of a standard that you would like to see. I think if you know you're cutting corners, that's a huge alarm bell that you need to re-evaluate what you're doing. My other piece of advice is to try and remember what it must be like to be a patient. Imagine that the patient is your wife, daughter, or grandmother. Even the most annoying patients when imagined in this way, begin to become easier to understand.

JM: Do you have any final messages?

HA: If you listen to the last line on The Beatles' Abbey Road, I think the same applies in medicine; that you will get out of it what you put in to it.

And in the end
The love you take
Is equal to the love you make.


Meet the professional APC's:
MHC-I
Dr. Langerhans (Magic Fingers)
B. Lymphocyte (Your Anti-buddy Resident)
MHC-II (the ultimate weapon)
Agent Monocyte-in-Black (the elusive one)
Officer Macrophage (the traffic monitor)
KATRIN
No messing with the APC professionalism committee—their MHC-II's are loaded!

A Work of Art: Chiaroscuro 2011

BY LUCY HORVAT & DANIEL TING

Every so often, the Queen's Medicine family unites for a greater cause. The 4th Annual Chiaroscuro Art Show took place this year on October 5. The show and silent auction, which was held in the David C. Walker atrium of the New Medical building, raised over $2,000 for the Juvenile Diabetes Research Foundation (JDRF).

Chiaroscuro was founded by Queen's Medicine Alumnus Jonathan Lee (2010) to raise funds for the JDRF, an organization focused on Type I Diabetes research. The cause is close to Jonathan's heart, as he has lived with the condition since he was a child.

Chiaroscuro is an Italian art term that describes the use of light and dark tonal contrasts to add dimensional depth to a painter's subjects. Renaissance and Baroque artists, including Rubens, Michelangelo, and Caravaggio, employed this technique. The title is fitting for such an event, as the dramatic highs and lows of dealing with juvenile diabetes forms a similar, striking contrast.

Chiaroscuro is also an outlet for medical students to display their artistic abilities. The night showcased Danya Trabousi's (2014) contemplative, atmospheric violin, and Joe Gabriel's (2015) captivating spoken word. The art ranged from exotic scenic photography to hand-woven quilts and detailed, Netter-esque medical illustrations, including a work by Shannon Zhang (2015) entitled, "Origins and Insertions of Muscles Moving the Humerus".

The Chiaroscuro team would like to thank all the students, faculty, and community members who contributed to making this evening a success. We look forward to seeing a strong participation again next year, and encourage all students to contribute their artistic talents to the cause. Until then, happy painting, photo-taking, quilting, sculpting, and dreaming.

The new medical building's atrium, filled with art and art lovers

Organizers of this year's Chiaroscuro, from left to right, Ron Spiller (JDRF representative), Angela Li (2013), Sarah Patterson (2014), Daniel Ting (2014), Micaela Coombs (2013), Lucy Horvat (2013), John Xu (2014) and Shanda White (JDRF representative).

Joe Gabriel delivers a spoken word performance.

Observership

BY SARAH LUCKETT-GATOPOULOS

I must be the stupidest medical student she's ever had observe. I'm pretty much the stupidest medical student I've ever known.

I sigh heavily and twist in the seat she's put me in, off to the side of where she is sitting with her patient, pushed into the corner where I certainly can't get into any trouble, but also can't see the patient's face or hear the patient's murmured answers. Doctor and patient turn toward me, two female faces infinitely more mature than mine. I must have sighed more loudly than I'd realized, and I feel a dark red flush start to creep over my face. I try to fight it down, but I know from experience that fighting it only makes it worse, and it crawls its way up from my stupid chin to my inexperienced nose and onward over my unprepared forehead until I'm a big, red, embarrassed ball of Worst Medical Student Ever. And now I'm sweating, too.

I furtively try to wipe the sweat from my brow with the sleeve of my white clerk coat. What a surprise that clerk coat was. When I arrived at medical school in September, the only white coat I'd seen anyone in medicine wearing was the long, flowing sort. The kind that's appropriately dignified, and – if television medical dramas are any indication – perfectly fitted. The kind that commands respect. Instead, I discovered that I would be wearing a short coat, cut to the hip in the most unflattering way, which – like riding the short bus – is neither dignified nor commanding of respect. We were told that this short coat, which not all schools use, is an identifier. It is. So far it has identified me to attending physicians as someone to be patronized and, on one occasion, lamented as a waste of resources. It has identified me to residents as someone upon whom examsmanship tips and pearls of wisdom should be bestowed, and to clinical clerks as someone laughably inferior. It has identified me to fellow medical students as someone as hapless and ignorant as themselves. It has identified me to nurses as someone who should never be allowed to do anything of even moderate importance lest my extraordinarily limited skill set kill someone.

Ostensibly, the coat is supposed to identify me to patients as a learner, but I'm pretty sure that's the one place the message hasn't gotten across. Patients see the white coat and, incredibly, actually trust me. Every time I speak to a patient, I carefully, patiently introduce myself the way we were taught on our first day ('Hello, my name is Hapless Medical Student, and I'm a First Year Ignoramus'), so that there can be no shadow of a doubt about my lowly status. Yet, the white coat – no matter the length – somehow has made me a doctor in their eyes. It means instant respect for someone they'd otherwise dismiss as too young, too baby-faced, too utterly, completely, and inexcusably stupid to spill their pains, expectations, and frighteningly embarrassing inner lives to.

She turns to me and asks me to take the patient's blood pressure. This, I know how to do. Still, as I fumble to release the death grip my stethoscope has wound around my sweaty neck (it is tangled in my hair), I feel a twinge of regret. Purple. What a stupid colour. No self-respecting physician in training would make such a frivolous choice. Why didn't I pick black? Grey? Even navy blue would have been a better choice. How can I expect to be taken seriously with a purple stethoscope? Not even purple – plum. With another heavy sigh, I fumble to find the brachial pulse, thanking whatever deity med students are supposed to subscribe to that this patient is skin and bones and has the biceps tendon of my dreams – thick, sinewy, and immediately obvious to my fumbling fingers. From here, it's a short hop to her – thank you, God of Medical Students – pounding brachial pulse. I pull the BP cuff from the wall, put it on, with trembling fingers,

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Don't worry doc, I got the sodium-free, zero-cholesterol cigarettes.

in less than 3.5 minutes flat, fumble at her wrist, and enthusiastically inflate the cuff until her radial pulse disappears. I deflate the cuff, put my stethoscope to the brachial pulse, and re-inflate. I deflate the cuff in increments, listening for Korotkoff sounds. By the time I have the earpieces of my stethoscope halfway out of my ears and am feeling a bit like a rock star – I totally owned that BP on the first shot – she, that shining beacon of unachievable physicianship, is asking me how I ever got it into my head to take a blood pressure that way. Yes, that's what they teach us in the textbooks, and even in clinical skills education, but it's time-consuming and not at all important to do it so "academically," she says. I start to feel a red, burning flush creep over my ears again and can't believe how stupid I was to believe for a second that I could ever do something right, praise-worthy even.

She asks me to listen to the heart, and my own sinks. I fumble again with my plum stethoscope, placing it in each of the four prescribed locations – All Patients Take Meds: Aortic, Pulmonic, Tricuspid, Mitral – straining, with eyes closed, to hear both the "lub" and the "dub" of S1 and S2, trying to distinguish them from the "lub" and "dub" of my own pulse pounding in my ears, but also trying to imagine how anyone, anyone at all, could possibly divine the presence or absence of murmurs and additional heart sounds. I tell her the patient's heart sounds "normal," though I'm not at all sure, and I'm appalled when she doesn't immediately listen to the patient's heart herself, just to be sure. She thanks me, a phrase of dismissal.

I sigh again, this time in relief, as I sit heavily in my dunce's chair in the corner. My job is done, at least for this appointment. And, I hope, there is nowhere to go but up.

"As you know, we have many cells applying for this position.
How would you differentiate yourself?"

Point

"Be it resolved that medical students should model the lifestyle and behaviours that they will recommend to their patients."

BY KATIE PIZZUTO

Picture this: John walks into your office for his periodic health exam. John, like close to 25% of the Canadian population, is obese [1]. You have frequently suggested to him – some might call it nagging – that he change his eating habits, start going to the gym, and quit smoking. Today, John is tired of being told what to do and retorts: "Well, look at you, doc. If this is so important for my health, why do you look just like me?"

So should we, as future medical professionals, be held to the old "practice what you preach" adage? The research certainly suggests so. The results of the Women Physicians' Health Study indicate that American physicians who consume less fatty food, don't smoke, and exercise were more likely to prescribe these preventative measures to their patients [2]. These physicians seemed to use their personal interests and beliefs to catalyze behavioral change in their patients. Furthermore, the ability to draw from personal experience about how to successfully make lifestyle changes may strengthen the doctor–patient relationship.

Let us play devil's advocate for a minute. One could argue that a doctors who struggle to follow their own advice can sympathize with their patients about the difficulty of lifestyle changes. While this response from a physician is important in supporting the patient, this response may not be enough to convince the patient to believe your advice [3,4,5]. Would you prefer to be taught how to play soccer from someone who has only ever watched it on TV?

This brings us to the issue of credibility: do patients believe physicians who do not heed their own advice? A study conducted by Drs. Frank, Breyan, and Elon found that when physicians disclosed information about their personal health behaviors, patients found their encounter more believable [6]. Further, confidence scores from patients receiving lifestyle counselling from obese physicians are consistently lower than those for their trim counterparts [7]. Seventy-four percent of Canadian doctors agree or strongly agree that they are perceived as being more professional if they subscribe to a balanced and healthy lifestyle [8].

As a Canadian medical community, we are doing pretty well in terms of practising what we preach. In a study of the Health Practices of Canadian Physicians, 90% of those surveyed reported themselves to be in good to excellent health, with only an 8% obesity rate, 3% smoking, and 1% excess alcohol use. Despite their busy lives, they managed to exercise an average of 4.7 hours per week, as well as undergo routine screening tests [5].

Will the next generation of Canadian physicians fare as well? It is up to us to decide.

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QMR

Counterpoint

BY JENNIFER KWAN

In recent years, we have learned that many health professionals do not follow their own medical advice. For example, a 2010 American study reported that fewer than 8% of medical trainees and 26% of attending physicians engage in the recommended amount of weekly exercise. This may be an unsettling statistic, but the question that needs to be addressed is whether physicians' poor habits will negatively affect patient care. After surveying current literature, it seems that mandating doctors to follow their own lifestyle recommendations has limited benefits and may not be the best method to ensure good patient care.

One may argue that doctors who exercise frequently or eat healthier are more likely to counsel their patients to act similarly. Studies have shown, however, that it may not be the physician's personal behaviors that are the deciding factor. In fact, the authors of a 2010 study in Preventive Cardiology found that the strongest predictor of whether doctors counsel their patients on exercise and diet was their perceived adequacy of training in these areas [1]. Unfortunately, more than three-quarters of physicians and trainees felt that they had received insufficient preparation in counselling on topics like dietary choices [1]. These findings suggest that we should focus on further educating medical trainees in preventive health counselling. This may be an effective approach to increase the proportion of doctors who offer healthy lifestyle advice to their patients on a regular basis.

Another issue that has been brought up is the lack of credibility of doctors who ignore their own advice. It seems intuitive that a doctor who practises what he preaches is more convincing. However, a recent 2010 Dutch study suggests that the health status of a physician may not be a primary determinant in ensuring patient adherence. In this study, two thirds of patients heeded the advice of their doctors despite the fact that they did not consider their doctors to be good role models of health [2]. From this statistic, it can be argued that a patient's failure to adhere to lifestyle recommendations made by physicians cannot be addressed solely by changing the doctor's personal lifestyle. Instead, the solution is more likely to involve focusing directly on the patient's health by having physicians demonstrate their competency and willingness to find an appropriate management plan for their patients [3].

The 2006 IMPALA (Improving Patient Adherence to Lifestyle Advice) study tested patient adherence to lifestyle recommendations when health care professionals followed a focused preventive medicine approach involving risk assessment, risk communication, application of a decision aid, and motivational interviewing [4]. Improvements were noted in patient risk awareness, anxiety, and satisfaction with the communication [4]. It seems that the key to greater patient attentiveness and adherence to lifestyle advice may be the doctor's approach to preventive medicine and not his or her personal health status.

Some doctors have pointed out that the expectation for them to be ideal models of healthy living is based on an outmoded paternalistic view of health care delivery [5]. With the expansion of public access to knowledge and resources on healthy living, patients have similar access to health information as do their doctors. As a result, doctors should not be expected to live up to a higher standard of healthy living than the general public. Doctors and medical students are regular people and requiring them to universally follow their own lifestyle recommendations is unrealistic. Dr. Elizabeth Murray, a general practitioner and researcher at the Department of Primary Care and Population Sciences at University College London, UK, supports this view [5]: "We need to get away from the idea that doctors are perfect and it's a mistake to think only the perfect can give advice," she says. "Self-help groups like Alcoholics Anonymous show that support comes very well from people who are facing similar problems" [5]. A corollary may be that doctors who are perfect role models can be a detriment to patient care as they are not able to empathize and relate to patients as well as their less-perfect peers.

There is plenty of reason to believe that, though doctors can choose to follow their own advice, it may not be necessary and can actually be disadvantageous to do so. Instead, a focus on improving education in preventive medicine for medical trainees may be a more sound approach when aiming to provide appropriate lifestyle counselling, enhance adherence, and improve the general health of patients.

NGIG

BY KATRIN DOLGANOVA

Geriatrics as a specialty suffers doubly from the fact that the elderly patient population is reaching all-time high numbers and because medical student interest in pursuing geriatric medicine remains extremely low. More than 13% of Canadians are over the age of 65 [1], and that number is projected to reach 25% by 2031 [2]. One and one-quarter geriatricians per ten thousand individuals aged 65 and older are needed to provide adequate medical care, but Canada lags behind many other developed countries with a ratio of only 0.57 [3]. To achieve the target ratio, at least 30 new fellows must be trained each year [4]. Yet, in the 2010 CaRMS match, only 8 fellowship spots were filled, out of 24 available in Canada [5].

Geriatrics is an unattractive specialty to many students. Several themes emerge from interviews with students, including futility of care, a lack of curative medicine, difficult and frustrating patients, and the financial burden of extensive training [6,7]. These types of negative attitudes from health professionals date back to the very beginning of geriatrics as a specialty in the early-to-mid-1900s, when physicians, including William Osler, openly described the elderly with disdain as "useless" and a burden [8].

In an attempt to reverse these attitudes and improve recruitment, Canadian and American medical schools are including in their curricula geriatrics-specific lectures, modules, and patient cases. This does not necessarily equate, however, with positive attitudes toward the elderly.

Research suggests that, while more content in the medical curriculum does increase knowledge, skills, and awareness of issues related to the health of older adults [9], it does not improve medical students' attitudes toward seniors nor does it encourage students to choose geriatrics as a specialty [3]. In fact, many students – even those who finished a geriatrics-specific clerkship – feel frustrated by geriatric care and harbour negative attitudes toward elderly patients [6]. The difficult, complex, and often uncertain nature of disease management frustrates students and makes them pessimistic. According to Diachun "the lack of student interest in geriatrics is not surprising given that students are often exposed to negative attitudes toward older people in clinical skills courses" [3].

Ageism is prevalent in our society [10]. To appreciate the extent to which our culture reveres youth, vitality, and cure, one need only turn on the television or skim through advertisements for skin products, plastic surgery, and "anti-aging" therapies. Ageism is not confined to media and general public opinion, but has strong roots in medicine as well. In the United States, for example, physicians are able to complete a Fellowship in Anti-Aging and Regenerative Medicine, which focuses on "detection, prevention, treatment and reversal of age-related decline" (see http://www.faafm.com for more information). Their stance that aging is a pathologic process that must be prevented and aggressively treated is in contrast to that of the Canadian Geriatrics Society (CGS). The CGS frames aging as a normal part of life and makes the promotion of "excellence in the medical care of older Canadians" its primary goal.

Unfortunately, efforts by CGS and Canadian Academy of Geriatric Psychiatry (CAGS) to recruit medical students and residents into geriatric internal medicine and geriatric psychiatry have been unsuccessful [4]. In a 2006 Canadian Journal of Geriatrics supplement, recommendations were made to develop new strategies for increasing physician human resources in geriatrics. Among them was a recommendation for "education committees and/or interest groups" to "allow members of the organization to share information, advocate for improvements, and plan group initiatives" [4].

Four years after these recommendations were published, the National Geriatrics Interest Group (NGIG) was established by a group of Canadian medical students who had an interest in geriatrics but were cognizant of the lack of collegiate support and exposure to role models in geriatrics. The NGIG seeks to improve the medical care of elderly Canadians through the promotion of geriatric education in Canadian medical schools, and the provision of financial and mentorship resources to interested medical students.

Members of NGIG have access to an online portal of practical information for local geriatrics interest groups (GIGs), including ideas for workshops and lecture series topics. NGIG is now also an official student branch of the CGS, which means that each member school has access to funding from the CGS and opportunities to attend conferences and geriatrics events. Even more importantly, the group provides an open and friendly forum for discussions about all things related to geriatrics and care of older adults – from undergraduate curriculum, clerkship rotations, and residency training to addressing negative stereotypes about elderly patients.

NGIG is actively recruiting medical students from all schools to become involved, either as general members or as leaders

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Women in Medicine

BY KLAUDIA JUMAA

On October 19 of this year, the Queen's chapter of the Federation of Medical Women of Canada (FMWC) continued its newly-founded tradition with its second annual Women in Medicine Evening. The monumental success of the 2010 interactive panel prompted this year's FMWC co-directors, Erin Rogers, Renée Farrell, and Klaudia Jumaa, to continue the tradition with a whole new panel of speakers from various specialties.

The purpose of the Women in Medicine Evening was to facilitate communication between successful women in medicine and female trainees. It was designed to promote open discussion of pertinent issues, provide a platform for providing advice and guidance, and to inspire female students to consider diverse specialties.

The 2011 panel consisted of seven female physicians who graciously volunteered their time to speak about their experiences in medical training and practice, their work-life balance, and perceived inequalities between male and female physicians. The session was designed as an opportunity for students and physicians to ask important questions that may not otherwise be openly addressed: When is the best time to have children? What obstacles are unique to female physicians? What supports are available for female trainees and clinicians? The floor was also opened up to questions from the audience, and medical students, clerks, residents and practicing physicians – male and female – participated in a discussion of these important issues.

The Queen's chapter of the FMWC is currently planning casual small-group meetings with a female physician in the winter term to encourage ongoing discourse.

If you'd like any information, please contact your local Queen's FMWC representative Klaudia Jumaa at kjumaa@qmed.ca.

If you are interested in joining the FMWC, please visit http://www.fmwc.ca. They offer reduced membership fees for medical students.

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within the new group. If you would like to meet like-minded people who share an interest in working with older adults, or want to become a student advocate for geriatric patients, you can visit http://canadiangeriatrics.ca/students.

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Empathy

BY HEATHER JOHNSON

Empathy, according to the late Dr. Robert Buckman, "is the ability to understand another's experience, to communicate and confirm that understanding with the other person and to then act in a helpful manner" [1]. As any first year medical student is quick to realize, empathy has become the watchword for modern medical education. It has been known for many years that empathy, and communication skills in general, are factors in determining whether a patient decides to sue for malpractice following a bad outcome [2,3]. Recent research also suggests that empathy not only increases patients' satisfaction with their care, but also increases the likelihood of a positive outcome. In a 2011 study of family physicians and their diabetic patients, patients of physicians with a high "empathy score", as determined by the Jefferson Scale of Empathy, were more likely to have well-controlled levels of glycosylated hemoglobin, a measure of blood glucose control, compared to patients of physicians with lower scores [4]. It is intuitive that a patient who feels heard by his or her physician would be more willing to trust that physician and be more likely to share information that might be relevant to their condition or care. These factors could increase the chance of a positive outcome.

Despite the importance of empathy in clinical interaction, research suggests that physicians are not taking advantage of opportunities to empathize with their patients. In a recent CMAJ article, Dr. Buckman and his colleagues highlight two studies that quantitatively show an empathy deficit [1]. In both studies, taped doctor–patient interviews were evaluated for "empathetic opportunities" – moments when it would have been appropriate for the physician to show concern, understanding, or simple acknowledgement of a patient's emotions. The first study – which examined interviews with oncologists and their patients with advanced cancers – determined that the physicians took advantage of these opportunities only 22% of the time [5]; a similar study involving lung cancer patients and their oncologists recorded an empathetic response rate of a mere 10% [6]. Buckman et al. attribute this paucity of clinical empathy to insufficient training resulting from a lack of focus in the curriculum, poor teaching methods, and a general failure to recognize empathy as something that can, in fact, be taught [1].

Medical schools are now doing all they can to ensure that new graduates are better equipped to empathize than those who have gone before them. However, there is surprising variation in their approaches. In the United States, an increasing number of schools are requiring their students to complete courses in the "medical humanities". Research suggests that such courses are effective at teaching empathy, but this approach has yet to be fully implemented in Canada [7]. Here in Canada, first-year students at Queen's Medicine are familiar with the First Patient Program in which pairs of students are matched with a patient to be followed during their pre-clerkship years. Among other skills, the program is designed to help students contextualize the patient experience and better understand what the patients' illnesses means to them. Empathy also features prominently in the Queen's Clinical Skills course, particularly in the first few weeks.

Still, empathy may have its disadvantages. In a 2009 study by Zantinge et al., researchers sought to determine whether a physician's "emotional burnout" or dissatisfaction with the time available to address the patient's mental health actually correlated with decreased awareness of the patient's mental state [8]. To their surprise, they found that the "burned-out" and dissatisfied doctors were actually more aware of the mental-health state of their patients. These results have been interpreted by some to mean that "physicians who are more sensitive to and willing to engage with patients' emotional concerns (by training or by temperament) might be more vulnerable to burnout, perhaps because they try to achieve more for their patients" [9]. Though this could be used to argue against becoming overly empathetic with patients, many feel that this simply indicates a need for physicians to receive better training on how to handle the emotional aspects of medical practice[8,9].

Recently in the New York Times, cardiologist Lisa Rosenbaum equated the empathetic doctor to other medical fads such as Hormone Replacement Therapy and bloodletting [10]. It may be that this obsession with "nice" doctors is just a fleeting trend, but present evidence and intuition currently find in favour of empathy to improve health care delivery. Nevertheless, given the emphasis on empathy in its medical curriculum, Queen's Medicine seems to feel that empathy is here to stay.

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Photography

BY ANDREI VAGOAN

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Ontario Elections

BY HEATHER JOHNSON

On October 6th, the Ontario electorate gave the Liberal party its third straight victory under leader Dalton McGuinty. Both the NDP and Progressive Conservatives parties made gains, while the Liberals lost twenty seats, finishing just one seat shy of a majority government. Although much of the debate leading up to the election surrounded the economy, an Ontario Medical Association (OMA) poll suggested that as many as 9 out of 10 Ontarians considered health care to be the most important issue in this election [1]. In the wake of the election, we are left wondering to what extent each party's health care platform swayed voters, whether election promises were in touch with Ontario's health care needs, and how greatly the upcoming Health Care Transfer renegotiation featured in voters' minds.

In their election platforms, each party emphasized their commitment to improving health care in Ontario [2–5]. Both the NDP and Conservatives took aim at reducing administrative budgets and freeing health care dollars to be redirected towards "frontline" care. Each sought to reduce bureaucracy by eliminating Local Health Integration Networks. In both their platform and their advertisements, the Liberals focused strongly on their previous health care successes, in particular their reduction of surgical and emergency room wait times. The Green Party of Ontario differed slightly from the rest in that their platform contained an abundance of systemic changes, many of which predictably related to environmental sustainability. Despite these unique focuses, the parties' approaches to health care reform were similar in many respects. Reduced wait times, increased home care services, and improved access to primary health care services were recurring themes, and none of the proposed changes could be called particularly controversial.

The creation of a party platform is an arduous process; there are countless numbers of people to be consulted, and in the end only certain recommendations will make the cut. It seems logical, however, that the advice of Ontario Medical Association would carry sway, given their expertise and perspective on the health care system. In January 2011, the OMA released a set of recommendations intended to alert the provincial parties as to what it considered key health care issues for the upcoming election. The document, entitled "Better Care. Healthier Patients. A Stronger Ontario", outlined general principles and specific recommendations for policy makers [6], some of which were incorporated into party platforms. In accordance with OMA suggestions, multiple platforms included pledges to increase funding for home-care, the number of hospital beds and the use of electronic medical records. Liberal, NDP, and Green Party platforms included pledges to reduce adult and child obesity. The Liberals' platform was the only one to mention mental health, which was also identified as an OMA priority. Interestingly, none of the specific recommendations regarding the support of medical learners appeared in any of the platforms. The NDP promised to bring 200 new doctors over four years to underserviced communities by forgiving student debt, while the Conservatives vowed to increase the number of residency placements for Ontarians who had obtained their medical education elsewhere. The Liberal platforms contained promises to train physicians, but made no specific statements regarding changes to training or medical school enrollment. The similarities seen between party platforms are in line with OMA recommendations, suggesting that Ontario's political parties are on the right track in dictating future health care reforms.

Perhaps more important than campaign promises was the looming specter of the Health Care Transfer (HCT) renegotiation. In the 2013–2014 fiscal year, the existing transfer agreement will expire, and the amount of funding Ottawa contributes to the provincial health care budget may be subject to change. Many worry that if the federal government plans to reduce their relative contribution, the provinces will not be able to maintain their current level of service, let alone improve it [7]. The three major parties had all pledged to fight for the current model [8], in which federal funding increases by 6% each year. However, the Liberal party used the question "Who will stand up to Stephen Harper on health care?" as a major talking point. The party argued that the Liberals will be better suited than their NDP or Green counterparts to stand up to a conservative Federal Government should Ottawa push to lower the transfer amount, making reference to the funding cuts made by provincial Conservative leader Tim Hudak as Junior Health Minister under Mike Harris.

One cannot say to what degree the HCT, or any particular campaign promise, influenced the election outcome without proper polling. Now that the votes have been cast, it remains to be seen what McGuinty's minority government can achieve. While the economy is his major concern, Premier McGuinty has claimed that HCT negotiation is a "top priority" [9]. It will be interesting to see in the coming years whether Ontario chose the right man to "stand up to Stephen Harper," and whether this minority government is able to make campaign promises a reality.

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Photography

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Creative Writing Contest

Queen's Medical Review is holding a creative writing contest! Submit your original short stories, poems, and essays for a chance to win one of three great prizes ($50.00 for first place, $10.00 each for second and third place). Winning submissions will be published in the upcoming issue.

Please send entries of 1500 words or less, typed and double-spaced, to queensmedreview@gmail.com with "Creative Writing Contest" in the subject heading. Please submit no later than February 15th, 2012.

There are three rules for writing a novel.
Unfortunately, no one knows what they are.
W. Somerset Maugham