

## ***Interprofessional Education: Roles and Partnerships***

*The Pulse is starting a new section called the Interdisciplinary Page. Students from other health related professional faculties can submit their articles to be published. Our first article is from our friends in physical therapy.*

During our physical therapy clinical internships, students were provided with the opportunity to reflect on the interprofessional aspects of practice related to their clinical placement experience. Part of the learning experience was to appreciate interprofessional issues as they apply to clinical practice in attempt to promote an increased awareness on the interprofessional aspects of physical therapy (PT) practice within the curriculum. To motivate the PT students, a light essay competition was created. Students were asked to describe and critique a process used to facilitate interprofessional communication during their placement. Alana Crowley, a second year physiotherapy student, wrote the most

outstanding assignment and was recognized with the presentation of an award: \$50 U of T gift certificate. Congratulations Alana! Below is an edited version of her interprofessional experience. By: Blythe Owen, PT2, Interdisciplinary Page Section Editor

### ***Rounds: A Perspective on Interprofessional Collaboration***

By: Alana Crowley

During my clinical internship, I had the opportunity to work in a multidisciplinary health care centre. The centre had a team of professionals that consisted of doctors, dentists, nurses, physiotherapists, and acupuncturists. In an attempt to collaborate on patient care, the team would meet once a week for 'rounds'. During these rounds, which were usually held over a lunch hour, individual patients from the centre would be reviewed and discussed among the different health care professionals on the team. The main goal of rounds was to collaborate as professionals to discuss patient progress and

decided on the future direction of the patient's treatment program.

Rounds would begin with one of the doctors (usually a neurologist) who would review the patient history and describe the current treatments that the patient was undergoing. The patient chart was usually passed around among the different specialists, who would each give their professional opinion on the patient's progress, and then identify any problems that may have arisen. In a one-hour period, usually three of four patients were discussed, although this would vary depending on the complexity of the patients.

This was the first time that I was exposed to such an extensive multidisciplinary team and although I knew that rounds were a common practise in most hospitals teams, I had never fully appreciated the number of different professional opinions involved in the clinical decision-making about a patient. Even though I found rounds to be an invaluable learning experience, I would like to comment on some of the ways that I believe could facilitate greater interprofessional communication.

Being a future health care professional, I realize that time is scarce and that appointments do not always run on time.

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### Medic Unplugged: A Colleague's Perspective on the "Blackout" of August 14, 2003

By Andrew Lee

The following is a never-before transcribed, gripping excerpt of a conversation that took place minutes into the blackout:

Andrew (Medic #1 a.k.a. "Andrewman", "Rhino"): Uh.... what's up with the traffic lights? Partner (Medic #2 a.k.a. "Squirrelz"): Hmm.....looks like they're out.

Andrew: [After brief reflection] Uh.....sweet.

[Cue dramatic music]

And for me, that is how I remember the beginning of the blackout. Aside from the blank traffic lights and dimmed store interiors, things on the surface appeared to be "Kool & the Gang" in Milton. It's safe to say that we've all experienced power outages at one time or another, so it was natural to believe the one evolving on August 14 was nothing exceptional. However, as events unfolded over the next hours and days, this turned out to be anything *but* a typical blackout.

In fact, this past summer was anything but typical. I had to deal with a few personal issues during this time (details in *Dear Abbey*), and decided a break from working at a busy station (Burlington) was in order. So, I took a rotation in the tranquil town of Milton. Don't let the medium-security prison or close proximity to Mohawk Raceway fool you. Milton is, for all intents and purposes, a quiet hamlet off the 401. On this day, business picked up in Milton. Emergency Services business, that is.

We had just arrived back at base from doing a call. It was

around 4:00 pm and time to relax and reflect on the day's work. Reflexively, I reached for the TV remote and began tapping buttons. No matter which button was pressed, the set remained lifeless. After 10 presses, it clued in (and the perseveration ceased). NO JUICE!

It was then (and there) that I had a rare epiphany. Yes, you read right, an epiphany. As I came to grips with missing *Jerry's* final thought, the blatantly obvious struck me. What's the chance of the base pager working without electricity? Or how about the direct line to dispatch? Double negative on both counts.

Without these systems in place, how were we to be notified of incoming calls? The phones were dead, the pager was dead, the computer was dead, and yes, even Elvis was dead! Not to fear, an OT6 is here! Luckily, we checked the main radio in the vehicle and discovered it (and the associated network) was still functional. We left base and remained mobile in our vehicle, with dispatch giving out calls over the airwaves.

One call promptly came in. Then another followed. One after the other, calls throughout the region were being generated at an alarming rate. My partner and I must have done four calls in a span of two hours immediately after the blackout began (well above the average for Milton).

Several patients were found trapped in elevators and had become short of breath (SOB) as a result of their confinement. Home oxygen units ceased to function,

again leading to acute SOB cases. There were MVCs (motor vehicle collisions) resulting from blank traffic lights and confused drivers. Even crews themselves were getting trapped in malfunctioning elevators, sometimes with patients already on their stretchers!

And working on VSA patients (vital signs absent) became a nightmare. Care usually involves some degree of CPR (cardiopulmonary resuscitation), monitor/defibrillator use, airway management, IV (intravenous) access, and meds administration.

With the loss of power, you now had to perform all the above *as* you carried the patient down multiple flights of stairs (I think the most was 12 floors!) and struggled with darkness, balance issues, and fatigue. When I recall these instances, the word "awkward" comes immediately to mind. All of this was taking place as thick, black smoke billowed ominously from the Petro-Canada plant in the distance.

And yet we, as a community, pulled through it all. There were no mass looting sprees or (many) instances of people taking advantage of others. Various members of the local community – civilians, Emergency Services workers, hospital staff, business owners – banded together. Bravo, Milton! Good show, Ontario! The time flew right by.

8:00 pm rolled around--two hours past the end of my scheduled shift. The back and arms were aching. Bed was looking awfully good right then. But I stayed.....

### Rural Medicine – In Need of Intensive Care?

Sarah Munroe

“When I think of ‘the rural doc,’ some of those classical paintings by Norman Rockwell enter my mind....I can imagine the plight and pleasures of Dr. Joel Fleishman’s experience from the show ‘Northern Exposure.’” – James Chang, MD

As a member of a small town, with a stint as a medical secretary in a small town clinic under my belt, I have to laugh at that thought. Granted there is a distinction between truly rural, in the ‘watch out for bears’ sense, and small town southern Ontario. However, in terms of ‘underserved areas’ the difference diminishes.

It used to be that only remote northern communities had difficulties recruiting doctors. Today, however, small and medium sized communities in addition to rural areas across southern, central, and eastern Ontario are suffering from the same problem. In absolute terms, there are more under-served communities, and the need for more physicians, in southern Ontario rather than northern.

The problem comes down to 22.2% of Canada’s population, about 7 million people, living in rural areas. Approximately 36% of rural Ontarians have trouble finding a family doctor, up from 26% just a few years ago (Stats Canada 1996).

According to the Society of Rural Physicians of Canada, Ontario has one of the worst patient to general practitioner ratios. The obvious question is why is there so much of a problem? It seems understandable that newly trained physicians often would not want to practice in remote northern areas for any number of reasons, including

climate, lack of job opportunities for spouse, and problems arranging vacation coverage.

However, this does not adequately explain the shortage in southern Ontario. It may come down to the relatively small percentage of Canada’s medical students coming from rural areas, only 10.8%. Possible reasons to account for this low percentage range from the added expense of living far from home to weakness in the education system in small centers, making competition with urban students more difficult.

Studies have shown that the most significant factor in choosing rural medical practice is where you are raised. Around half of students of rural origin choose rural medicine opposed to 20% of urban students. Due to this, incentives have been created to encourage rural students to attend medical school, as well as general benefits for any new physician who works in an under-served area.

These incentives range from changes in medical school admissions criteria to the “Free Tuition program”, which reimburses final year medical students, residents, and newly graduated physicians up to \$40,000 in tuition fees in exchange for three or four years of work in a area designated as under-served.

Other initiatives, such as the opening of a new medical school in 2004 at [Laurentian University](#), Sudbury, should help.

Specifically at the University of Toronto, rural electives are available, and are helpful in promoting awareness of rural medicine. Also, the *Rural Health*

*Initiative* is a student-run organization that promotes rural medicine through speaker series, elective placements and community outreach projects.

What does all this mean for the average citizen who decides not to live in a large centre? The answer is a long wait. A wait to find a doctor who is actually taking new patients. A wait to have an appointment with the doctor you already have, since time is at a premium with each doctor being over-capacity. A wait to see your doctor when you have an appointment, since people will simply walk-in when no appointments are left for booking. This is not even mentioning the wait to see any type of specialist, where four to six months is considered reasonable for medium-sized centres.

What it comes down to is the choice of medical students, residents, and new physicians. Between incentives provided by the government and the rural communities themselves, becoming a rural physician has its perks.

Aside from monetary concerns, there are other advantages to working away from cities. According to Herman Lee, a family physician from Camrose, Alberta, “You have a closer connection to everyone....I see patients on the street and we call each other by first names.” As one medical student says, “this style of medicine is definitely easy on the mind and very gentle,” and after the pressures of medical school, is that not what everyone needs?

**Glaucoma and Cataract – More Issues Than What Meets The Eye**

**By Anonymous**

In 1996, I started to get blurry vision in my right eye. I thought that I needed new glasses, so I went to see my optometrist. I am already very myopic, so my optometrist just said that I had “floaters” in my eye. I was not satisfied with this answer, so I sought out the help of my family doctor. I was referred to a general ophthalmologist who referred me to a retina specialist. My retina was normal, but she decided to follow me up every 6 months.

In 1997, I got new prescription glasses and I started to have double vision. I went to another optometrist because I was not happy with my first one. My new optometrist put some prisms into my lens, which improved my vision. I told my new optometrist about my past vision problems and he decided to do a visual field test. The visual field test showed that I had already lost some vision, so I was referred to another ophthalmologist, this time one who specialized in the cornea.

I was sent to the eye clinic at a Toronto hospital to do an orthoptic assessment of my eyes, and then I was sent to an eye muscle specialist in 1998. The eye muscle specialist did two more orthoptic assessments and I got a new pair of glasses. Unfortunately, I still had blurry vision and diplopia. The eye muscle specialist thought that the new glasses should have helped, so she referred me back to the cornea specialist.

I was getting frustrated with being passed back and forth between doctors and not getting

any improvement in my vision. I asked the corneal ophthalmologist what was wrong with my eyes. He said that I was myopic, I have floaters, and I have cataracts. That was the first time someone had used the word “cataract” to describe my condition. I followed up with this ophthalmologist for 2 years, but no action was taken regarding my cataract and the lack of action was never explained.

My vision was progressively worsening. There were haloes around traffic lights at night, I was still seeing double, and my vision was getting dimmer and blurrier. I had to get closer to objects to read and I had trouble recognizing faces in a crowd. I complained to my ophthalmologist again and he offered to refer me back to the eye muscle specialist. The eye muscle specialist was on maternity leave and I was told to phone back in half a year.

I was getting increasingly impatient. My vision started to affect my ability to work. I am a nurse at a downtown tertiary care hospital and I was starting to get concerned about the safety of continuing to work.

In 1999, I went back to my first general ophthalmologist. He was aware of my many visits to the other ophthalmologists. I expressed my concerns and frustrations and I finally found a sympathetic ear.

She told me that I was a very complicated case and she did not feel comfortable operating on me. She referred me to another ophthalmologist who specialized

in complicated diseases of the cornea and external tissues. The new ophthalmologist was also an associate professor at U of T and he would have the expertise with which to help me.

In October of 1999, I went to my first appointment with this new ophthalmologist. He answered all of my questions about cataracts. He also diagnosed me with open angle glaucoma and referred me to the glaucoma service at a Toronto hospital. I had been seeing several ophthalmologists for 3 years before I was finally diagnosed with glaucoma!

Both of these specialists decided to operate on my right eye for glaucoma and cataract at the same time. Due to long waiting lists, my right eye was operated on almost 2 years later in Feb 14, 2001. My left eye was operated on 4 months later in June of 2001.

The cataract surgery went well; however, the glaucoma surgery on my right eye did not. The pressure in my right eye was still high. The glaucoma specialist decided to operate again on the right eye. The pressure was normal in both eyes now; however, I was told that irreversible damage had already been done to my optic nerve. The present surgeries could only prevent further damage, but there was no chance that my vision could improve. I was very upset. If one of the ophthalmologists had diagnosed me earlier and taken action, more of my vision could have been saved. Now I realize

that since I was a complicated case, I was passed around among doctors who were hesitant to act.

I realize that specialization allows doctors to become experts in their field; however, I felt that there was a lack of communication between the different ophthalmologists. Waiting for appointments also cost valuable time because my eyes got worse as I waited.

For example, I was told that there are only four eye muscle specialists in Toronto and when my eye muscle specialist went on maternity leave, there was no one who could see me. I would recommend that more doctors get trained in this area. As the population ages, the incidences of cataract and glaucoma will increase.

Now I have to adapt my life to my severe visual impairment. I had my driver's license taken away. I used to be a very independent person and now I find it difficult to depend on other people for transportation. I really feel that I have lost my freedom.

I recently found out that the minimum requirements to

drive for personal use is not less than 20/50 with both eyes open and examined together. For visual fields, one must have 120 continuous degrees along the horizontal meridian and 15 continuous degrees above the below. I was surprised that I did not even meet these minimum requirements.

I also retired from nursing because I did not feel that it was safe for me to work. I am now on disability retirement pension. With two children in university and no income coming in, retiring from my job has been hard for the family's finances. Also, I had to give up a lot of my hobbies, like knitting, sewing, and crafts. I find reading in the evening very difficult. With my eye problems now, I am clumsy and slow. For example, I have trouble making phone calls because I can not read the phone numbers. I missed my home bus stop twice because I could not see it in the evening despite living in the same area for 23 years. I am constantly looking for things. I read with a magnifying glass and my acuity depends on the lighting, background, and contrast.

My family has urged me to contact the Canadian National Institute of the Blind (CNIB) to get some group support and counseling. I have been feeling very depressed because I am not as active as I use to be. I feel ashamed to attend social functions with my friends because I do not want them to see how clumsy and slow I am with my eye problem.

My family and friends do not seem empathetic of my condition. My eye problem is not a visible disability, so I have a hard time explaining to others my problems. Also, since my eye problem will not improve, I would like to get some training on how to adapt my everyday life skills to my disability.

My doctors had only tried to cure my physical condition, but none of them thought to help me socially and emotionally through this time. My one message to future doctors would be to help your patient physically, socially, and emotionally through their illness because all three aspects are critical for successful treatment.

### *Interprofessional Collaboration: Con't from pg 1*

However, as a result of the inevitable time shortage, I observed that many of the team members would miss rounds. There were some weeks where only a handful of health professionals would attend and often many of the disciplines were not represented. The downfall of this was that instead of collaborating with 15 professionals, there would only be five professionals to provide suggestions for the patient.

I would recommend to organize rounds so that each type of health care professional is asked to comment on the patient being discussed so that a wider representation of disciplines are considered in the patient's overall treatment. I occasionally noticed that the discussion in rounds were monopolized by a few doctors, and that the treatment plan was focus solely on pharmacotherapy rather than other treatment alternatives that could have been proposed by

other health care professionals in the team.

Overall, I felt that a multidisciplinary rounds approach was an excellent way to facilitate interprofessional communication. A greater number of professionals in attendance and extension of the discussion to include all disciplines in the health care team would ameliorate interprofessional communication and thus improve patient care.

## Interview with MSB Staff

### Turning the Tables

By Sarah Ingber

This article is in honour of the new occupants of room 3153 and all the years that have come before them. What is more anxiety provoking than medical school interviews – aside from the rigors of the DOCH 2 matching process?

For those of us prone to bouts of nervousness - not much can top that tension. That is why I decided to turn the tables on the staff at MSB and see how they would fare with some of the most non-medical interview questions submitted by you.

Now, I most certainly did not ease them into the process with the simple yet vague question of “Tell me something about yourself”. I got straight to the point with an effortless comparison to a kitchen appliance. No one was quite sure how to answer that one and definitely unable to provide any semblance of a reason for their choice. Most people responded with something along the lines of “Are you kidding?” There were

some creative answers. One person wanted to be a microwave because it is a symbol of how adaptable the kitchen is to modern society and the respondent is adaptable to new situations. Someone else wanted to be a blender because he is a good “mix” of everything.

If you could be any fruit, which would you be and why? One person wanted to be an orange because an orange is well-rounded and everyone likes oranges! Someone else wanted to be a kiwi because a kiwi is unique and exotic. Someone mentioned that he was already a “couch potato”, but a potato is not really a fruit!

Next we move on to people’s favourite books. I include this question as a great short list of reading aside from Grant’s and Harrison’s. Some of the top books mentioned included: The Thornbirds, Lord of the Rings, The Great Gatsby, A Fine Balance, A Prayer for Owen Meany and Sophie’s World. A

bilingual respondent suggested Le Petit Prince and he insisted on the French version. For those looking for something a little deeper we have: the Bible, War and Peace and the Oxford Short Dictionary.

There was one question to which the answer was fairly predictable, and one has to wonder whether people were being completely honest. I did tell all participants they would remain anonymous, however no one was willing to take a risk. When asked what their favourite reality TV show was no one would admit to watching anything resembling reality TV aside from the news and Hockey Night in Canada

I hope this article has not dredged up too many terrible memories of sweating in your one and only powersuit. Just think of all the fun we have to look forward to... CARMS!

*I would like to thank all the staff at MSB that opened the door when I knocked and answered a few questions for me.*

## Elifer’s Advice Column: Pump Up That Iron

Dear Elifer,

I really want to donate blood at the MSB blood drive on November 11<sup>th</sup> and 12<sup>th</sup> but I am not sure I am eligible. Last year it looked like everyone was having so much fun. I tried to donate but to my shagrin my iron was too low. This year I am even more worried because I just had the flu shot last week. Help!

Sincerely,  
Wanda Donate

Dear Ms. Donate

There is no need to feel concern, with these tips you will have your iron levels up ASAP! Firstly make sure you eat foods high in iron including: lean red meat, oily fish like tuna and sardines, eggs, nuts, dried fruit, beans, lentils and green veggies.

Secondly, don’t forget your orange juice – remember vitamin C helps us absorb iron. If the above tips do not work then you can visit

your doctor and he/she might recommend some iron supplements.

Other things to consider before donating blood is to stay hydrated, get a good nights’ sleep and eat a meal prior to donating. With regards to your recent flu shot you only need to wait two days after being vaccinated before you are eligible to donate. Good luck and see you at the **BLOOD DRIVE!** Sincerely, Elifer

## Interviews On Campus

### Say What?

By Shazeen Suleman

It was high time to find out what the rest of the world was thinking. The Pulse stopped random people on campus, including graduate, humanities and social science students, professors, researchers and staff. We asked them to answer a few questions.

After they had answered everything, we explained that these were some of the worst interview questions that we could find. Here are a few of the questions and some creative answers.

**Q:** *Explain the Theory of Relativity in three words or less, two if you're feeling ambitious.*

“As birds fly.”  
“Only light's constant.”  
“Things moving fast.”  
“Perspective is everything.”  
“Too overused!”

**Q:** *What's the most challenging thing you've dealt with?*

“Cancer.”  
“My girlfriend  
(insert evil look from girlfriend).”  
“My mother.”  
“This question.”  
”Moving away from home.”

**Q:** *How are people on the East and West coast different?*

“They live by different oceans..?”  
“Different kinds of hip hop.”  
“They have different postal codes.”  
“Their clocks read different times.”

**Q:** *What book are you currently reading?*

“The Polished Hoe – Austin Clark”  
“East of Eden – John Steinbeck. Yeah, it's from Oprah's book club...”  
“Why I hate Canadians – Will Ferguson. Yes, I'm Canadian.”

“Harry Potter!”  
“Icy Sparks. Not “I see Sparks.”

**Q:** *Tell me something you're good at.*

“I'm good at the microscope.”  
“Everything.”  
“Rock singing.”  
“Threading needles.”  
“Last minute scrambling. That's different from procrastination.”

**Q:** *What would your dad say are your three best and worst qualities?*

**Best**  
“I'm smart, a dancing queen, and responsible.”  
“I'm a good mom, with a good sense of humour, and helpful.”  
“I'm persistent. I guess he'd say I have good interpersonal skills, and I'm organized.”  
“I think he'd say I'm intelligent, ambitious and philosophical.”

**Worst**  
“I have to be told things ten times, I'm kinda messy and I watch too much TV.”  
“I'm impatient, way too social and I'm single.”  
“He wouldn't say.”

**Q:** *What kind of movies do you watch?*

”Documentaries.”  
“Everything except chick flicks.”  
(Editor's note: this was a guy)  
“Chick flicks.”  
(Editor's note: this was a girl)  
“Very few.”  
“No horror!”

**Q:** *What is your favourite saying/quote?*

“It's not the number of times you breathe in your life, but the number of times life takes your breath away”  
-Anon.  
“Mountains are just obstacles that make the view from the top worthwhile.”  
-Anon.  
“Great spirits have always encountered violent opposition from mediocre minds”  
-Albert Einstein  
“Aim for the moon.  
If you miss, at least you'll be among the stars”  
--Anon  
“Whether you think that you can, or that you can't, you are usually right”  
--Henry Ford  
“If you are what you eat, then I'm fast, easy, and cheap!”  
-Anon.

## Upcoming Events

### The Athletic Pulse

This is a new column in "The Pulse" dedicated exclusively to the goings on of the intramural world. Read on and find out more about the exciting events of this intramural season!

### Team Updates – "Bad Breaks"

The girl's soccer team is currently 1-1 on the year. Their first game was a tough 5-0 loss to Scarborough, followed by a gritty 2-1 win against St. Mike's.

The softball team, Quaranteam has played in two close tournaments going undefeated in the first until a playoff loss to dentistry, who went on to win the tournament. They were 2-1 in their second tournament and almost made the playoffs. The MVP of the tournament, Fady (OT5) sacrificed his thumb for the team in the first game of the second tournament. He can be found catching babies at St. Mike's with a broken thumb.

The men's basketball team had a bad break with Chris Peskun (OT5) breaking his hand during the first tryout. So, they're calling up Neil Verma from the minors for some muscle up front. Expect to see them in an exciting game against Mississauga, the returning champs and the team that meds lost to in the finals last semester.

The girl's hockey team is off to an exciting start against Trinity/PT/OT with a hard fought 2-0 defeat against some of the leagues best players.

### OT7's to Watch

This year the meds intramural teams have added the skill and athleticism of Linda Taggart and Joanne Chehade. Both are members of OT7 and we can't wait to watch them help lead our teams to victory! Linda is a member of the meds soccer team who brings almost 2 decades of soccer experience including her time spent on McMaster's Varsity Soccer Team. She has already demonstrated her skill and leadership on the field during this intramural soccer season. Joanne comes to us from the University of Western Ontario Varsity Basketball Team and we are excited to see her stuff on the court!

### Upcoming Events

Come out and support your colleagues as they fire up the courts, water, and ice in these upcoming games

Co-ed inner tube water polo Sunday Nov 16, 3:15pm AC, 50m pool

Men's basketball (DS) Wednesday Nov 12, 9:05pm AC

Men's hockey Thursday Nov 20, 10pm Varsity Arena

Women's basketball Monday Nov 17, 7:10pm AC

Women's hockey Wednesday Nov 19, 9pm Varsity Arena

Many teams have completed their season for this semester, but you can come out and join or support those teams that will be starting up again in January!

To find out more about intramurals, visit the U of T intramural's homepage at:

[http://www.utoronto.ca/physical/Athletics\\_and\\_Recreation/intramurals/index.htm](http://www.utoronto.ca/physical/Athletics_and_Recreation/intramurals/index.htm)

## EARTH TONES

Earth Tones Benefit Concert was founded by medical students and staff in December 2000 to support programs and initiatives for destitute children around the world.

Venue: University of Toronto, Convocation Hall, St George Campus, 31 King's College Circle.

Date: Saturday, November 22nd, 2003.

Time: Doors open at 6:30pm. Concert starts at 7:00pm.

Tickets: \$15 in advance, \$20 at the door.

To purchase tickets, call 416-978-2764 (Office of Student Affairs)

or e-mail:

[earthtones\\_2003@hotmail.com](mailto:earthtones_2003@hotmail.com)

For more information, see:

<http://icarus.med.utoronto.ca/ihp/earthtones/>

## **Canadian Physiotherapy Association - It'll Move You!**

By Mandy Smart, Professional Development Student Leader, Second Year PT student

The Canadian Physiotherapy Association (CPA) is the professional organization that promotes the practice of physiotherapy and supports physiotherapists at the provincial, national and international levels. For almost 85 years, the CPA has been dedicated to building the profession and fostering excellence not only in practice, but also in the area of education and research for ongoing professional development of its' members. The CPA plays a strong advocacy role, influencing healthcare legislation provincially and federally.

The National Student's Assembly (NSA) is the internal body within the CPA that is made up of student representatives from across all the Canadian Universities. It is a student directed organization that allows students to network with each other, creating a strong, unified voice for all physiotherapy students in addition to providing a platform for idea sharing and involvement in professional decision making processes.

I invite you all to learn more about the physiotherapy profession by visiting the website at [www.physiotherapy.ca](http://www.physiotherapy.ca).

*This information is extracted from the CPA website: [www.physiotherapy.ca](http://www.physiotherapy.ca)*

## **Promoting an Interdisciplinary Student Mind**

By: Jen Silva (OT President, co-president of the OT/PT Student Association)

As a representative of the Occupational Therapy (OT) & Physical Therapy (PT) Student Association, I was pleased to receive an invitation to write for the interdisciplinary page of The Pulse. I feel that this page is an opportunity for the various disciplines in the Faculty of Medicine to introduce themselves to one another, as well as provide information about important issues or events.

The OT & PT Student Association is a joint student council between students in the Departments of OT and PT. One of the purposes of the council is to promote educational, professional and social interaction among members of both programs, which occurs mainly by organizing activities for students. The council also acts to facilitate communication between the students, the departments and the University of Toronto.

This interaction between the students begins with the executive, which is equally comprised of OT and PT student leaders, ensuring that everyone has a voice. All students are welcome to join a committee and assist in organizing and running events.

In keeping with the interdisciplinary nature of the current healthcare environment, the OT & PT Student Association is in the process of communicating with the Speech-Language Pathology (SLP) students and exploring ways we can promote further interaction between our departments.

It is through media, such as The Pulse, that the message of promoting an 'interdisciplinary student mind' may be further developed. This student mind is aware of the role of the other disciplines, including their underlying philosophy and goals of intervention. This student mind is also aware of how a patient's or client's health and well-being may be enhanced by referring him/her to the appropriate profession. The Pulse provides an opportunity to present this message and I'm confident that there are many students who are interested in contributing to its development.

## Clubs

### Calling all Budding Neurologists

By: Mark Boulus

The Faculty of Medicine at the University of Toronto provides an exciting opportunity for students to learn more about neurology through a program called SIGN (Student Interest Group in Neurology).

SIGN, is a group consisting of medical students interested in neurology. It is headed by a respected neurologist, Dr. Liesly Lee, from Sunnybrook and Women's College Health Sciences Centre.

Through monthly meetings, members have the opportunity to:

- Discuss interesting cases and patient presentations
  - Find out about various scholarship opportunities.
- SIGN members are eligible to apply for the Medical Student Summer Research Scholarship

of \$3,000 and the Medical Student Annual Meeting Travel Scholarship of \$500

- Participate in a mentorship program with a neurologist
- Make contacts (this makes setting up electives much easier)
- Ask professionals in this field about neurology. One fifteen minute session during one career night may not answer all those burning questions!



Each SIGN chapter has a faculty advisor who provides guidance, support, and continuity to the group. The University of Toronto chapter is fortunate to have had Dr. Liesly Lee as its faculty advisor for the past three years.

Dr. Lee is an excellent teacher and shares fascinating cases with the group at each meeting.

The SIGN program was inaugurated in 1998 by the American Academy of Neurology (AAN). The mission of this program is to foster medical student interest in neurology by providing opportunities for students to participate in clinical, research, and service activities in neurology and to increase students' neurological knowledge.

If you would like to join SIGN or find out more, please feel free to e-mail Mark at [mark.boulos@utoronto.ca](mailto:mark.boulos@utoronto.ca).

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