Newsletter

Federation of Medical Women of Canada
Fédération des femmes médecins du Canada

Spring 2012 · Vol 25 · No 1

WHAT ARE THE ODDS?

2011 PAP Campaign

Initiated by the Federation of Medical Women of Canada (FMWC) in 2008, the National PAP Test Campaign has become a key initiative during Canada's Cervical Cancer Awareness Week, held in 2011 from October 21 to 27 – with a theme of "What are the odds?"

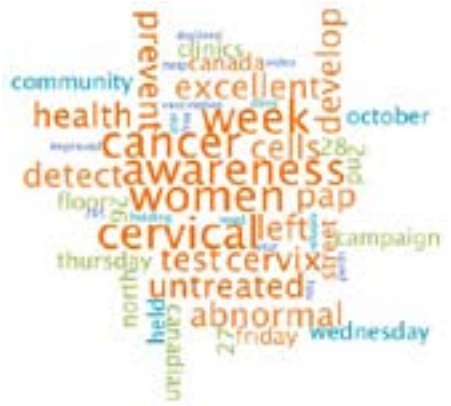
Last year, the FMWC joined forces once again with the Society of Obstetricians and Gynecologists of Canada (SOGC) to plan and implement the 2011 PAP Test Awareness Campaign. Support for this initiative by health organizations included the return of the Society of Canadian Colposcopists. The Society of Gynecologic Onocology of Canada, and the Society of Rural Physicians of Canada.

Campaign support was also significantly expanded last year to include the College of Family Physicians of Canada, The Canadian Cancer Society, Cancer Care Ontario, the New Brunswick Cancer Network, the Saskatchewan Cancer Agency and the Government of Nunavut.

The FMWC and SOGC were also grateful to the following corporate sponsors who supported the campaign through non-restrictive educational grants: Glaxo-SmithKline, Merck Canada and Hologic.

This campaign is important as cervical cancer is a preventable and treatable problem – and that is why we are committed to raising awareness through proper screening and vaccination. HPV vaccination may prevent up to 70% of cases of cervical cancer. Having said that, regular PAP tests are a key part of a healthy woman's life whether or not she has had the HPV vaccination.

According to the Public health Agency of Canada, 15% of women have never been screened and 30% have not been screened in the last 3 years! Every year, in Canada, 1,300 to 1,500 women are diagnosed with



cervical cancer and almost 400 women die of this disease. Cervical cancer deaths have decreased by 60% over the past 30 years, mainly due to PAP screening programs. However, PAP screening programs are different across each province in Canada and vary according to socio-economic status and region.

In 2011 increased media relations activities (with several FMWC members doing interviews and statements for the media) resulted in wide-spread national coverage that resulted in a total of 137 media stories, and reaching a national audience of more than 16 million impressions.

This is the tip of the iceberg.

Statistics also indicate that a large portion of Canadian women who are eligible for the HPV vaccination have not yet received their shots.

With millions of women in Canada who still do not get regular PAP tests and/or their HPV vaccination, this campaign seeks to make it as compelling and as convenient as possible for women to get tested and obtain answers to their questions about vaccination.

In 2011, there were 3,853 PAP tests done this year in Canada at 297 clinics:

Ontario - 128, Saskatchewan - 50, New Brunswick - 28, Québec - 26, British Columbia - 24, Alberta - 22, Newfoundland - 5, Yukon - 5, PEI - 4, Manitoba - 3.

Thank you to all the clinics for their participation. We look forward to working with you and spreading the word about cervical cancer in 2012.

To become involved or learn more about our initiative – please contact us at fmwcmain@fmwc.ca

2012 Cervical Cancer Awareness Week 21 - 27 October, 2012

FMWC Mission Statement

The Federation of Medical Women of Canada (FMWC) is committed to the development of women physicians and to the promotion of the well-being of all women.

La Fédération des femmes médecins du Canada est vouée à l'avancement des femmes médecins ainsi qu'à la promotion du bien-être des femmes en général.

FMWC Executive Committee 2011–2012

FMWC Newsletter

Editor: Dr. Crystal Cannon

The FMWC Newsletter is published three times a year and sent to members as a benefit of membership. Next deadline is May 15, 2012.

Views and reports appearing in the Newsletter are not necessarily endorsed by the FMWC. Contributions of articles, reports, letters, notices, resource information and photographs are encouraged.

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Commercial Publication Agreement No. 1437895; ISSN 1209-1332

Wellness

By Newsletter Editor: Dr. Crystal Cannon

January is always crowded at my gym. It is the same every year but by March only a few of those who started remain. The regulars are relieved and no longer need to wait for their favourite machines. I have been one of those hanging on well past January for the past few years. My health and well-being have improved.

Exercise is likely the most important factor in health and wellness. But there are many other components as physicians well know. In this newsletter Dr. Karen Breeck discusses Compassion Fatigue with suggestions on how to manage it for caregivers. I welcome other articles or personal stories on health and wellness for both yourselves and others.

The FMWC Executive have started developing a Conflict of Interest/ Competing Interest document for the Federation – to help us outline our relationship with industry and continue to follow the guidelines required for accredited CME events. Please read the article by Dr. Pat Mousmanis and feel free to provide feedback or your own articles and opinions on this topic. Followup articles will be welcomed in the next newsletter. We will be actively seeking your thoughts and opinions in advance of our AGM in September.

This newsletter has been delayed for a number of reasons and apologies for our tardiness! There have been a lot of challenges with respect to our National Office location and Kim and Colby are looking forward to when they can "unpack" for good! I originally asked you all to remember to keep moving all winter – I hope this has been the case. If not, spring is here and the outdoors beckons for all to enjoy and be active in.

I would also like to remind those of you who have not renewed their membership to do so as soon as possible - membership has its priviledges!

Keep moving - no matter what your activity. You will feel better for it.

All the best. Crystal.

Share Your Story!

The deadline for the **Summer 2012 newsletter** is **May 15, 2012**

The newsletter will be released in late June. Please forward submissions to the National Office at: **fmwcmain@fmwc.ca**

Please send us submissions/news about:

- ☑ **Achievements**, awards, announcements and congratulations as it pertains to yourself or another FMWC member. Relevant pictures (please include captions) are welcome.
- ☑ **Creative Corner:** We know that doctors have many other talents and we want to showcase them. We invite creative types to submit poems, drawings, cartoons or a humorous column.
- ☑ **"Letter to the Editor":** Please submit your comments to the editor on your experiences/concerns on health care, on women's health, or on your practices.

The newsletter is for your benefit and enjoyment – so please feel free to contribute!

Compassion Fatigue and You

By: Dr. Karen Breeck

I admit that "CF" had always been an abbreviation for "Canadian Forces" for me, but I learned it also stands for "Compassion Fatigue" when I had the chance last June to attend the first annual Compassion Fatigue Symposium in Kingston, ON. The conference was organized by a powerhouse of a lady, Françoise Mathieu who is a mental health professional and compassion fatigue educator. Françoise's opening remarks set the tone of the event... "this is not a BMW conference –no Bitching, Moaning and Whining - It is too easy to fall into the trap of blaming our employers, our patients, the government for our heavy workloads, difficult cases and insufficient funds.

"The risk of falling into that BMW mode is that we can become paralysed: angry and helpless to make any changes. Instead, I want to invite you to come together to form a community of support for helping professionals. By keeping ourselves healthier as front line workers, we can improve patient care. The goal of this conference is therefore to educate helpers, learn, share and advocate for improved working conditions."

Françoise then went on to explain that the #1 factor associated with compassion satisfaction is having social support in our workplaces. The irony of CF is that when people are suffering from it, one of the first things they lose is that very same social support they need so much: "What do we do when we are overloaded at work? We turn on each other - express anger and irritation at our colleagues, we snap at the nurse, we bark at the resident, we don't take the time to really listen to the patient. Over time, this can create a toxic workplace and set the scene for clinical errors and reduced compassion satisfaction."

Research suggests that over 60% of those going into helping professions have themselves pre-existing vulnerabilities for CF – so why is CF not an established occupational risk factor for health care providers ? We all need to know what our occupational health vulnerabilities are and how to protect ourselves from them. Why are we not routinely trained about CF starting in medical school and throughout our practicing lives and CME's ? What would our professional world look like if CF was accepted as a normal consequence of doing what we do as opposed to a shameful thing we whisper about behind people's back "oh, she's on stress leave, couldn't hack the pressure"?

> *"The good news about compassion fatigue is that much can be done to address it once we recognize what is happening to us..."*
>
> - Françoise Mathieu

As we learn more and more about compassion fatigue, it really is a normal consequence of the work that we do as physicians: it is an expected, predictable, preventable, treatable occupational hazard. CF does not have to be misunderstood, misdiagnosed and/or ignored until it results in a severe mental health issue for the provider. If we as a profession, embraced how to identify the warning signs of CF in ourselves and others and all knew what steps to take to get of our personal "red zones"... what impact would that have alone on our present health care capacity and human resources ?

One of the reasons that we as a profession don't know much about CF is that it remains at the early stages of nomenclature: many terms are used to refer to this cost of caring: burnout, compassion fatigue, vicarious trauma, secondary trauma. This makes it hard to research / review studies that still have so many differing definitions or understandings.

Françoise Mathieu suggests that we differentiate these terms as follows. Vicarious or Secondary trauma is something that occurs as a result of repeated exposure to traumatic patient/client stories (we hear graphic details about a trauma experienced by a patient but which we did not see or experience firsthand). Therapy is sometimes required for secondary trauma exposures.

Compassion fatigue is something overlapping but separate from secondary trauma. CF is a wider reaching term and can impact anyone who is providing care to another. With CF there is an erosion of energy leading to emotional exhaustion and a shift in our empathy for others. CF can also be responsive to therapy but often the helper just needs a break from the care giving responsibilities and a chance to recharge and rebalance.

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SAVE THE DATE!
FMWC AGM 2012
September 22-23
Westin Nova Scotian
Join us in Halifax!

Compassion Fatigue

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Primary Trauma is what happens to you directly in your line of work: the patient that physically attacks you, or stalks you. Other situations include working in war zones, being physically threatened or at risk (volunteers with NGOs or in the military, for example). Historically, the recommended way to cope with a patient assault was to have a few drinks and take a few days off work and carry on. We are now finding that this does not resolve the trauma exposure, and some helpers are haunted by the primary trauma they experienced and can even develop Post Traumatic Stress Disorder (PTSD) as a consequence.

Burnout is related to unhealthy work conditions such as poor supervision, unrealistic workloads, with a limited sense of control.

These and many other conditions, can lead to a build up of stress and frustration in the physician. Burnout can happen in any job but physicians are known to have particularly high rates. Symptoms usually resolve if people quit or change jobs/careers and seek some mental health support. Moral distress injuries occur when there are inconsistencies between a physician's belief system and her required job actions in practice, when occupational workplace policies or routines conflict with personal beliefs and values. Many physicians experience a combination of some or all of these conditions.

Françoise Mathieu gives us hope though; "The good news about compassion fatigue is that much can be done to address it once we recognise it is happening to us: We may need to seriously reassess our workload, make some changes in our personal life, increase our self care and change our priorities.

The first step I would recommend would be to reach out to other helpers you work with and explore the ways in which you can support one another while doing the challenging work that you do.

Try and see if there is a lot of BMW going on in your workplace and make a pact to stop the gossip and focus on constructive conversations.

Secondly, take a look at your daily routine - do you run your life at breakneck speed all the time? Do you ever have time to breathe, to sit, to exercise? How are you fueling yourself? Thirdly, take a look at your workload: do you have any control over the number of patients you see and when you see them? Could you insert some sanity breaks in your schedule or not see all of your most challenging patients on Friday afternoon?

Explore ways to reduce the volume, or at least consider working four days a week rather than five, if you can afford it. Finally, if you are feeling really worn down and overwhelmed, please consider seeking the professional help from someone who understands what compassion fatigue is. That would be the first question I would ask when calling for professional help. Otherwise, you may end up being diagnosed with depression, or anxiety, when that is only one small portion of the story. There are lots of ways to continue working in this wonderfully rewarding field without sacrificing ourselves completely.

We've all heard of the CMA physician studies indicating a high number of Canadian working physicians meet criteria for moderate to severe burnout. Canadians are not alone, a 2009 Australian Medical Association study showed that 54% medical students met criteria for CF and 69% for burnout - Medical students! A 2011 study showed that US surgeons thought about suicide 1.5-3x more than the general population. Only 26% had ever sought help and the rest self-medicated.

As part of the ongoing Health Care Transformation discussion, we need to stop the blaming of the physicians for everything wrong in the system at present. Working harder and longer isn't going to fix the Canadian health care system. We need to be incorporating self care as a much higher priority for all health care providers as we face the challenges of the future together. We can't make these shifts alone though, we need the full support and understanding of our medical organizations and management/administration. We need a paradigm shift in our society about physicians – we cant keep trying to be the glue that holds everything together and resulting in so many of us working harder and longer. We need solutions for CF/VT organizationally, politically and societally rather than the oversimplification of blaming the provider for "personal weakness".

Actions YOU Can Take Right Now

1. **Read "Overcoming Compassion Fatigue: When practicing medicine feels more like labour than a labor of love, take steps to heal the healer" by John-Henry Pfifferling and Kay GIlley**. Fam Pract Manag. 2000 Apr7(4): 39-44. www.aafp.org/fpm/2000/0400/p39.html

2. **Go to CMA Physician Health and www.compassionfatigue.ca and review their resources.**In particular, consider taking the Proqol self test (available under "Resources" on the Compassion Fatigue Solutions website or direct linked compassionfatigue.ca/category/resources/proqol-self-test/) to see where you stand for compassion satisfaction, compassion fatigue and workplace burnout.

3. **Consider attending:**

2012 International Conference on Physician Health in Montreal
Oct 23-25, 2012
http://www.cma.ca/physicianhealth

and/or the

2nd annual conference on
Compassion Fatigue in Kingston
June 12-13, 2012
www.cfconference.com

Conflict of Interest or Competing Interests?

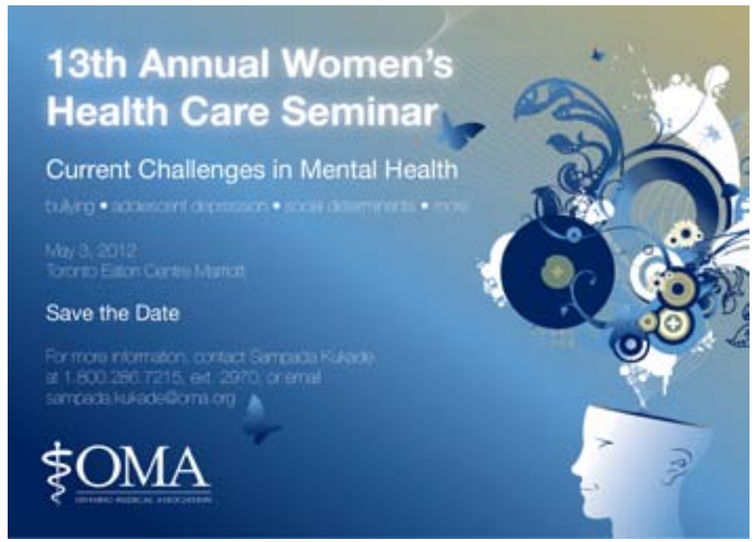
By: Dr. Pat Mousmanis

As members of the Federation of Medical Women of Canada (FMWC), many of you will be in a position to organize educational events for your colleagues either through grand rounds, CME events or FMWC Branch meetings. The College of Family Physicians of Canada, Royal College of Physicians and Surgeons and Academic institutions such as University Medical Schools have developed accreditation criteria and conflict of interest guidelines in order to provide consistency and transparency in the provision of educational activities. These rules are based in part on the Canadian Medical Association Guidelines for Interactions with Industry (2007) and the Pharmaceutical Industry RxD Code of Ethics.

The FMWC CME Committee that organizes the annual conference follows these rules each year in order to qualify for study credits and **would like to have all FMWC members and branch offices across Canada be aware of the accreditation criteria.** The FMWC CME Committee chooses a theme for each annual conference and then tailors the agenda to focus on topics as identified through needs assessment of its members. The needs assessment can be done through a survey, focus groups, from evaluation forms from previous conferences or by discussion with key informants such as planning committee members and members of the target audience. For example, the FMWC recognizes that our membership includes specialists, family physicians and medical students so the CME committee tries to have a variety of topics that are relevant to all three main groups.

Learning objectives for educational meetings will be created based on the identified learning needs of its members to ensure that the curriculum is relevant for all members and consistent with the theme chosen for the annual conference. The FMWC CME committee chooses speakers and topics without influence from industry, government or outside agencies. This ensures that the content of educational presentations and handouts are not biased by commercial interests and does not promote individual products or policies.
New rules around Conflict of Interest require that speakers must be compensated directly by the FMWC rather than by a third party. This includes honorarium, travel and accommodation costs.

Speakers are now required to disclose potential conflict of interest including any personal or family ties to industry relating to their presentation. This can be done through a printed slide at the beginning of the talk that is submitted along with the content of the power point presentation at the time of application for Study Credits.



The disclosure should also be done verbally during the talk directly to the audience. If the speaker has declared a 'conflict of interest', the FMWC CME committee is responsible for ' managing ' the conflict and usually has chosen to review the content of the slides in order to ensure that there is no commercial bias in the presentation. All accreditation bodies also insist that the audience evaluates the speaker to ensure there is no commercial marketing delivered verbally during the presentation. You may have noticed that there is always a question about ' commercial bias ' on our evaluation forms.

Industry, government and other agencies (biotech, medical device, service delivery and not for profit groups) must comply with the CMA rules and should provide funding directly to the FMWC CME committee through educational grants that are unrestricted. The rules stipulate that display booths by sponsors cannot be in the same room as the educational lectures. You will remember that the FMWC has consistently had a separate room where nutrition breaks are held adjacent to the display booths set up during the CME event. As the rules have been modified and tightened, the FMWC has modified its CME workshop planning to remain consistent with the new conflict of interest guidelines and accreditation criteria so that we can always receive accreditation for study credits for our members.

The FMWC is currently involved in planning the next annual conference which will

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The Silent Sufferers

By Dr. William Easton

Imagine you have a condition that causes you to lose urine involuntarily every time you cough, sneeze or laugh. To make matters worse, you had a vaginal procedure to correct "a dropped bladder" almost 20 years ago and were told at the time that you could expect recurrent problems of a similar nature in the future. This current problem has been getting worse over at least the past five years. You can't even pick up your grandchildren for fear of losing urine involuntarily.

Your friends tell you this is just a "minor nuisance", part of getting older, but now you have to wear heavy protective pads every day.

You have had to stop all forms of vigorous exercise and are even afraid to go dancing for fear of an embarrassing accident. In the past few months, you have been losing urine during intercourse, and although your partner is very understanding, it is off-putting to say the least. The last straw was when you were at a restaurant having lunch with friends when someone told a hilarious joke. Mortified, you had to leave before lunch was over, with your sweater wrapped around your waist to hide your soaking wet pants. The next day, you make an appointment with your family doctor. She asks a few pointed questions, does a pelvic examination and determines that you have a mild degree of recurrent pelvic floor prolapse creating a condition of stress urinary incontinence. (SUI)

She instructs you in the technique of pelvic floor strengthening exercises and puts you in touch with a dietician for advice with regard to a weight loss program. Most importantly, she reassures you that effective management for this condition is available, and that there is no need for you to permanently restrict your lifestyle because of fear of incontinence.

You take your homework seriously, do at least 50 Kegel's squeezes a day, and lose at least 6 pounds per month. Three months later, as planned, you return to your doctor for a follow-up assessment. You now have a BMI of 27, and are still doing your exercises diligently. Despite this, your bladder control is only marginally better, and you are now developing a chronic vulvar irritation from daily pad use. You also feel that the bladder has "dropped" even further, and you now have a sensation of pressure at the opening of the vagina. The volume of urine loss during intercourse has become even worse.

Your doctor agrees that conservative management has been unsuccessful, and suggests that a surgical approach may now be indicated. She refers you to a urogynecologist for further investigation and management.

Later that week, the doctor calls you and says it will be at least six months before you can see the specialist. When she says this is still the correct course of action which will most likely lead to permanent cure of your incontinence, you swallow your disappointment and wait.

Finally, the day of your appointment with the specialist arrives. She takes a detailed history, carries out a pelvic floor evaluation, and, because you are now experiencing urinary urgency and frequency, orders cystourethroscopy and urodynamic studies to clarify the nature of your voiding dysfunction.

When all investigations are completed, she tells you that you have Type III urinary incontinence, or intrinsic sphincter deficiency, partly secondary to the previous surgery and the associated scar tissue formation. She explains that your own pelvic floor support structures are damaged to the point that no amount of exercise will restore them to normal function, and recommends a laparoscopic pubovaginal sling procedure using synthetic mesh as a definitive correction of your incontinence.

Fine, you say, this bladder problem has been ruining my life for far too long, so let's go ahead with the surgery as soon as possible.

Then the hammer drops. The specialist says that, due to "problems at the hospital" it will be approximately two years before the surgery can be done. After finding the courage to tell your family doctor that you lose urine with any kind of exertion, and worse yet, lose urine months to see the specialist, and then being told you will have to wait another two years for the surgery, the frustration and disappointment is unbearable. The tears start to come, and they just won't stop.

This is the kind of situation I face in my office several times a week – trying to gently "break the news" that although effective surgical treatments are avail-

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Team Canada Healing Hand *a.k.a* Hockey Mom in Haiti

By Colleen O'Connell

FMWC Honourary Member 2012

Colleen O'Connell

Serendipitously in 1986, instead of attending my high school graduation I was helping shuck peas with a family in Kenya. While not quite a "I once had a farm in Africa" moment, (although I did get to see the car used in the movie while I was there), that spring and summer were pivotal in my decision to pursue a medical career.

As a volunteer with the International Red Cross, I worked at a clinic in Mathare Valley, one of the most densely populated urban slums in Kenya. I experienced the power and the art of medicine in an area of the world, both exotic and tragic, and was hooked. With the support and encouragement of the Faculty of Medicine at Memorial University, I was allowed to both defer medical school for year spent in Thailand as a research assistant at Mahidol University Faculty of Public Health, and to later return to complete research and electives. Similarly I was indulged during my Physical Medicine and Rehabilitation residency, completing research elective in Mozambique, where three months was spent examining and interviewing amputation survivors to determine access and outcomes of prosthetic rehabilitation.

Recognizing the paucity of resources in developing countries, coupled with the impact of a physical disability on survival in such environments, the need to work towards improving capacities in rehabilitation was apparent. In 2002 after leading a team in Haiti, Team Canada Healing Hands (TCHH) was founded.

A registered Canadian charity, TCHH is dedicated to the development of sustainable physical medicine and rehabilitation education, training, and care in areas of need. TCHH has been working primarily in Haiti with international partner Healing Hands for Haiti, (HHH) as well as other local-based organizations, and has conducted over 50 trips with nearing 300 volunteers.

Our focus is on teaching and training of health professionals and community workers to increase their capacity to deliver care to adults and children with disabilities.

The 2010 earthquake was devastating, and with already active programs in Haiti, we were able to assist with the emergency response, joining Handicap International's team. Tasked with providing rapid assessments of catastrophic injuries to determine emergent needs, we had insight into the critical needs for persons with spinal cord injuries. TCHH dedicated significant resources to provide continuous volunteers to both provide care for the complex injured, while providing rapid training and mentoring throughout 2010.

We assist in evaluation of therapy and equipment needs for adults and children with disabilities in orphanages, clinics and therapy centres, always in partnership with the local care providers and families.

Now two years post earthquake, much of the focus of TCHH volunteers has shifted back to providing education and training through mentoring, workshops, lectures, and collaboration in clinical environments. In addition, I have been able to contribute to international initiatives for disaster preparedness and response through committees of the International Spinal Cord Society and International Society of Physical and Rehabilitation Medicine.

Although work and personal life have some clear separation, the lines are blurred when it comes to Haiti. Our family has 'gone global' on many levels, with husband Jeff Campbell managing logistics as well as team leadership, and Haiti-born sons Samuel (9) and Vénel (8) ensuring we keep cultural perspectives vibrant and current. True spare time is rare, but many hours are spent at hockey rinks (or driving to hockey rinks within a 800km radius) to cheer on our own Haitian sensations. Being able to share and live as a family, the philosophy of being a global citizen remains my proudest achievement.

MWIA Calendar of Upcoming Events 2012

June 29-30, 2012
Central European Region in Batumi, Georgia
Further information at:
www.gmwa.org.ge

October 7-9, 2012
Central Asia Regional Meeting in Chiang Mai
Further information at:
www.tmwa-6carc.com

October 17-20, 2012
Latin American Regional Meeting in Guadalajara
Further information at:
www.pamwa2012.org

21-23 November 2012
Near East and Africa Regional Meeting in Cairo, Egypt
Further information at:
communitymed@yahoo.com

July 31-August 3, 2013
The 29th International Congress will be in Seoul, Korea.

www.mwia.net

The Silent Sufferers

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able for most patients with anatomically based urinary incontinence, the hospital resources required to apply those treatments are not. This can be because these resources have been diverted to preferred wait time procedures such as joint replacements and cataract surgery, or the health care authorities in the region believe that the surgical management of urinary incontinence and pelvic organ prolapse in women is, as I have been told on more than occasion, "not a priority."

Multiple North American and European studies have demonstrated that 25% of women will experience symptomatic pelvic floor dysfunction at some point in their lifetime. Symptoms may include urinary incontinence, pelvic organ prolapse, recurrent bladder infections due to incomplete bladder emptying related to distortion of the pelvic floor architecture, painful intercourse, fecal incontinence, chronic vulvitis, and urinary retention among others.

Between 10 to 15% of women will have symptoms of sufficient severity to cause some degree of physical and/or social disability. In addition to the problems noted above, fear of embarrassment by involuntary urine loss or unpleasant odor causes some women to enter a kind of self-imposed social isolation. Not surprisingly, the incidence of clinical depression is significantly higher in women who suffer from urinary incontinence. Employment disruption and marital stress are also frequent concomitants of this condition.

To make matters worse, loss of bladder control is expensive. The cost of absorbent pads and underwear can easily amount to $2000.00 per year. Add to this the additional laundry and clothing costs required and you make a significant dent in a fixed income. One U.S. study has estimated that total dollars spent by patients with urinary incontinence is greater than the national expenditure on cancer care.

Why, then, is the investigation and management of pelvic floor dysfunction and urinary incontinence in women "not a priority?" What is the basis for federal and provincial Ministry of Health policies that provide preferential funding (and thereby access) for surgical treatment of cataracts and arthritic joints, but not for a woman who may be housebound in diapers, unemployed, socially isolated and clinically depressed?

Much political hay is made based on the "major progress" achieved in shortening wait times for specialized treatment in "the big five" priority areas – cardiac, cataract and cancer surgery, joint replacements and advanced diagnostic imaging.

These same politicos would have us believe access to surgical treatment in all other areas has not been negatively affected by "cannibalization" of OR time and hospital resources in order for cash strapped hospitals to meet wait time priority targets on which preferential funding formulas depend.

We in the front lines who have to deal with frustration, disappointment and tears on a daily basis know otherwise. The very fact that a wait-time priority scheme exists underscores the fact that health care resources in many areas are woefully inadequate.

The argument is not that women with pelvic floor problems and incontinence are more or less of a treatment priority than someone with cataracts, a sore knee or even cancer. All of these conditions are deserving of prompt, specialized treatment. All of these conditions cause pain, anxiety and suffering. But it is just plain wrong to consider a treatment delay of up to two years as acceptable for any treatable condition, particularly one with so many associated physical and social disabilities.

There is a saying in urogynecology that sums up the unfortunate truth: "Incontinence doesn't kill you, it just robs you of your life."

We can and must do better, but this will not happen until governments understand and act on the massive burden of morbidity caused by pelvic floor dysfunction and incontinence, either urinary or fecal. Patients affected by these problems are understandably reluctant to publicly trumpet their concerns in order to attract political attention. We must find a way to do it for them, and with them.

Dr. William A. Easton MD, FRCSC is an Assistant Professor, Department of Obstetrics and Gynecology, Division of Urogynecology and Reconstructive Pelvic Surgery at the University of Toronto.

ARE YOU

FMWC memberships run from January 1 to December 31 each year.

All 2011 memberships have ***expired*** and members need to renew to remain in good standing and to continue to receive access to our newsletter, services and meetings.

If you have not already done so, please visit **www.fmwc.ca** to check your renewal status, or respond to one of our upcoming email reminders. Please direct any questions to Kim or Colby at:

fmwcmain@fmwc.ca

FMWC's Interim Business Meeting

By Kimberley Hogan, FMWC Executive Coordinator

While the weather outside was mild, on Saturday January 28th the FMWC Board held the 2012 Interim Board Meeting at the Sheraton Hotel, in Ottawa, ON.

The IBM provides the opportunity for Board Members to meet in person and deal with important matters for the Federation. In addition, it provides an opportunity for Board Development.

The agenda covered a great deal of reporting for the Federation - which gave a picture of where the Federation stands with its business - what will become priority in the following year and who will be participating. Needless to say our Branches had been busy since last September and the morning went quickly.

After lunch - two important topics were presented: creating a Conflict of Interest (COI) /Competing Interest policy for the Federation and a discussion regarding the Federation's By-law committee and it's upcoming activities.

The day concluded with a presentation on Effective Governance Practices by Mr. Tim Plumbtre.

Highlights Included:

- the nomination of Dr. Charmaine Roye as the chair of the Bylaw committee
- a successful PAP campaign that included 3853 PAP tests in over 300 offices across Canada
- welcoming of a new Executive Coordinator to the Federation
- Recognition that the FMWC needs to concentrate on the acquisition of new members and encourage present members to renew on time
- The restructuring of the MALF and MARF funds into a separate non-profit organization entitled "Maude Abbott Charitable Funds" is well underway
- Creation of a joint PMI session for our 2012 AGM focusing on Women and Leadership for the AGM 2012
- 2011 Financial Audit will be occurring in March 2012

Overall, the IBM was a great success - and will be followed up by a Board teleconference in April 2012.

Maude Abbott Research Fund (MARF) – Submission Deadline is June 30, 2012.

The Maude Abbott Research Fund is generously sustained by our members for our members to support new and exciting research across Canada. Research grants of up to **$2,000** will be given for research in the areas of Women's Health, Education and Promotion.

For more information about applying for a MARF Research grant, and an application form, please visit **www.fmwc.ca or contact** contact Dr. Shajia Khan, Chair, MARF committee, 613- 234- 2594, shajia.khan@sympatico.ca

Please donate generously to the MARF Fund:
- ✓ Donating when you renew your membership online
- ✓ Sending a cheque now to MARF
- ✓ Fundraising through your local branch.

Successful applicants will be announced at the Annual Board Meeting in Halifax, NS in September 2012 and notified by mail.

Annual General Meeting 2012

Halifax, Nova Scotia
September 21 to 22, 2012

Program / Speaker Highlights

Dr. Sue Swiggam
Lost in Translation: Communication Challenges in Clinical Practice

Dr. Karen Breeck
Where are the Women in the Board Rooms?

PLUS:

Dr. Mamta Gautam
Dr. Jean Gray
Monica Olsen

Please reserve your hotel rooms ASAP as our AGM overlaps with the Atlantic Film Festival.

Pre-conference PMI Course Offering:

Strengthen YOUR Leadership Capacity

Thursday September 20 to Friday September 21, 2012

www.fmwc.ca

In Passing... Dr. Marguerite (Peggy) Hill

It is with great sadness that we announce the passing of Dr. F. Marguerite (Peggy) Hill on the morning of January 15, 2012. Dr. Hill died peacefully in the comfort of the Toronto home built by her father, and where she lived her life.

Dr. Hill was born on May 24, 1919 into a family that encouraged independence and self-sufficiency. During her high school years at North Toronto Collegiate, she was a brilliant and well-rounded student who excelled in both her studies and athletics. It was there that she first encountered Dr. Marion Hilliard, an accomplished obstetrician, and first considered a career in medicine.

In 1941 she enlisted in the Canadian Women's Army Corps in WWII, achieving the rank of Captain and serving as one of the few women psychologists. On her discharge in 1946, she decided to pursue studies in the Faculty of Medicine at the University of Toronto. She graduated with a Doctor of Medicine in 1952, and at the top of her class. She subsequently became the first female chief medical resident at the Toronto General Hospital in 1957.

Following her training in internal medicine and nephrology, Peggy Hill joined the Department of Medicine at Women's College Hospital. For 26 years she practiced at Women's as a teacher, clinician and researcher, and for many of these years, Physician-in-Chief of Medicine - only the second woman to achieve such a distinction at a University of Toronto teaching hospital. During that lengthy tenure, she worked tirelessly to establish the culture of compassionate, interdisciplinary, patient-centred care that defines Women's College today. Dr. Hill was a role model; she contributed significantly to the opening of new frontiers for women in medicine. She was a founding member of the Canadian Society for Nephrologists and a member of the Federation of Medical Women of Canada.

In 1968, she was promoted to full professor at the University of Toronto, and became the first woman ever to be appointed to the Board of the Canadian Imperial Bank of Commerce. On July 1st 1994, Dr. Hill was appointed as a Member of the Order of Canada for her efforts in teaching and patient care. In retirement, Dr. Hill's travels took her from the Amazon to the Arctic, from Papua New Guinea, Australia and New Zealand to Europe and the UK, and from one end of North America to the other.

When Dr. Hill retired from Women's in 1984 her friends, colleagues and patients established an endowment in her name. Through the generosity of these individuals, and Dr. Hill herself, this fund has grown, providing funding for a Chair in Academic Women's Medicine and an annual lectureship, which pays tribute to women leaders in academic medicine. Through this endowment, her legacy has lived on.

Typical of her, Dr. Hill requested no funeral or memorial service be held in her name. However, we encourage online condolences, and anecdotes, to be relayed via http://www.trullfuneralsyonge.com/ In lieu of flowers, donations may be made to the F.M. Hill Trust Fund, Women's College Hospital Foundation.

In Passing... Dr. Magdalene Laszlo

Dr. Magadalene Laszlo, a longtime member from BC, passed away on December 6, 2011. She worked as a general practitioner in Burnaby, after coming to Canada from Hungary in the 1950's. She was a loyal supporter of the Federation and attended many meetings nationally and internationally.

Our condolences to both friends and families on the passing of these formidible women.

RBC Canadian Women Entrepreneur Awards

Do you know an extraordinary woman entrepreneur? Recognize her achievements by monimating her for the 2012 RBC Canadian Woman Entrepreneur Awards.

The purpose of the Awards is to provide national recognition to Canada's women entrepreneurs, whose successful businesses and achievements contribute so much to the Canadian and global economies as well as to their communities.

To learn more about these awards and workshops please visit ***http://www.theawards.ca/cwea/index.cfm***

Conflict of Interest

...continued from page 5

be held in Halifax Nova Scotia on Saturday September 22 and Sunday September 23, 2012. At this time, we welcome input from our members on topics they would like to see included so that we can meet your learning needs. The FMWC CME committee is keen to follow the various accreditation criteria and conflict of interest guidelines as set by the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada.

Have you had any experience organizing CME events for your colleagues? How have you handled potential conflict of interest issues? Has your organization had difficulties meeting accreditation criteria or obtaining study credits for your members? Do you have any experience in drafting local medical school or medical organization conflict of interest guidelines? If you do have any comments or questions, please notify the FMWC Board by contacting Kim or Colby at fmwcmain@fmwc.ca.

Calendar of Upcoming Events 2012

Ongoing
PMI: Leadership development for physicians (CMA)
Various cities across Canada
On-line registration now open: www.cma.ca/pmi

May 3, 2012
The 13th Annual Women's Health Care Seminar
Ontario Medical Association
Toronto, Ontario

September 20-23, 2012
FMWC's AGM, Leadership & Advocacy Workshops
Westin Nova Scotian Halifax, NS
Pre-meeting PMI Sept 20 & 21

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West – **Vacancy**

To reach one of the Board members, simply email fmwcmain@fmwc.ca or call the National Office and your message will be forwarded to them: 1-877-771-3777 (toll free) or 613-569-5881 (in Ottawa)

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