

**Canadian Federation of Medical Students (CFMS)
2018 Annual General Meeting
Montréal, QC
September 20-23, 2018**

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Friday, September 21, 2018

Introduction & Welcome Address

- Welcome to CFMS AGM 2018!
- Ali Damji, second year family medicine resident and previous CFMS board member, is our meeting Chair
- Nicole (Karonhienhawe), Indigenous Elder, provides the assembly with a thanksgiving address to the attendees
- Meeting logistics overview
- Shared goals - on time, have fun; informative, efficient, actionable
- Start and end on time; get wellness breaks; Resolutions@cfms.org for questions
- Resolutions can be submitted until noon; will be prioritized lower
- Review of agenda, Robert's rules

CFMS Presidential Address

- High level summary and overview of President's work
- Governance - new structure; no red, less yellow, more green
- Approve efficiency of committees - mostly green, one yellow
- Finance, Audit, HR committee; consent agenda to help streamline and expedite resolutions process; more power to schools
- Board ToRs are in progress. Increase school activity on each AFMC committee. Best governance practice too (eg consistent handover)
- Increasing human resources - budgeting appropriate deficits
 - "REMEMBER THIS when we go in-camera"
- Continuing transition of general manager to employer status; Rosemary has a mini-me finally (Stephanie - not President)
- DoA, Governance audit, media training, and creation of formal policies and procedures
 - Lots of media requests over the last year that we had to address
- Education:
 - Unmatched crisis big focus; worked with CAF to create more spots; advocating at all levels for more spots
- Advocacy:
 - Being involved in budget lockup; DoA - indigenous mental wellness; invited to take part in the 2018 federal budget announcement lock up; invited to be in the federal Opioid symposium
- Wellness:
 - Was revamped this year and grown. Really want to grow it more and make it more robust next year. We know Wellness is important.
- Global Health:

- Hosted the IFMSA-GA. >150 students from across the world participated and came to Montreal. Attending gave me a good perspective and hopefully we can foster global health moving forward.
- Thank yous:
 - CFMS Board - the learning curve is steep, but the team hit the ground running. The work done was great. Thank you on behalf of everyone.
 - Rosemary - been with us for 17 years. Continues to work so hard. Every meeting is only possible because of you.
 - Everyone - Imposter Syndrome is real. Reflecting on my journey with the CFMS, since Federal Day of Action 2015 and then AGM 2015
- I hope the CFMS can continue to be a great avenue to use all your skills. To hone them and show them off.
- Let's not just be bold - let's be fierce; the fiercest generation of medical students

Regional Marketplace

Regional Minutes:

- Western Region
 - Building/growing connections is hard in the Western Region - we're broad and it's challenging
 - We are having VP Academics and Wellness reps also attend the Western Medical Schools Conference so that we get more student-faculty engagement
 - CFMS is providing funding to do this
 - The hope is that MedSocs, UMEs, or Deans to provide funding in the future
 - We provide the basis to build more connections - it's on MedSocs to grow those local relations, but we can provide the platform to share local experiences and opportunities as a model to use at your own school
 - Yukon Medical Region - Stephanie will be attending their AGM - we hope to get a student on their board as an observer
 - If a school does send anyone to Yukon for Clerkship, it's an opportunity to grow the CFMS and participate in more areas across the country
 - Is there any potential areas we can all benefit on by talking more about?
 - Career advising - very varying from school to school. Do faculties talk with each other to share their resources?
 - There is definitely variation - the Deans are at Western Deans and do discuss these things, but we're not sure if there's much follow-up after that. Good example of us seeing if there is a lot of variance and then maybe we could send a letter to highlight these differences
 - How about ideas for Western Deans?
 - We should have a specific ASK - very focused so that we can go back in a couple months and say "did you do x?". One potential topic is **Dealing**

with Sexual Harassment and Mistreatment both on a student-faculty level and student-student level

- This spans every school and policies vary between schools - definitely a very viable topic
- What about supporting students on an away Clerkship elective?
 - Joining facebook groups, support from SA - growing to visiting schools would be great
- How were the teleconferences throughout the year? Is there value?
 - I'll turn that to the schools since we serve for them. Do the MedSocs find value in these meetings?
 - Yes - they help to build rapport and it's a method of communication to be up to date to things and helps to build a network across the region.
- Ontario
 - "What's happening at the OMA?"
 - OMA is running an election for the students in the regular OMA elections , which puts OMSA at risk of having a student elected no experience working with the OMA or OMSA
 - Working with VP externals to try to coordinate elections and keep tabs on what is happening at each school
 - Risk that people won't understand what is happening at the OMA with respect to elections, asking for OMSA to communicate why it's important to vote for certain candidates and what these changes mean.
 - OMSA is waiting for OMA legal for a response before officially communicating with students
 - "What is happening with the 52 spots for uCMGs last year. What will happen this year?"
 - OMSA and the CFMS will be lobbying for more long term solutions this year
 - 33/52 spots filled, all have a 2 year ROS
- Québec
 - Discussed no match rates in family medicine in Quebec
 - Quebec should focus on the "valorisation de la médecine familiale"
 - Discuss pass/fail in other Quebec schools
 - Implemented in Sherbrooke last year
 - Implemented in ULaval this year
 - Implemented progressively by UdeM. The 2022 cohort will be pass-fail for preclerkship and clerkship.
 - Discussed electives cap
 - Quebec schools usually have strict electives policies (e.g. must take electives in different entry disciplines)

- Atlantic Region
 - CFMS Assistance with Health and Human Resource Planning:
 - 10 years down the road, what types of physicians will we need? How many do we need?
 - To help with residency planning and future planning
 - Advocating to PMTAs
 - Is this being done elsewhere?
 - USASK is doing this.
 - Project physicians 5-7 years ahead
 - Dax has these documents
 - Lobbying to PTMAS and Provincial Governments
 - Connects to HR as well because it can be beneficial for them to decide on future strategies (i.e., retention and recruiting)
 - Physician recruiter for Health Authorities untapped resource
 - Static residency positions ; can these shift based on need?
 - Culture change
 - Community need vs our desires/passion
 - Needs to be a conversation up front
 - What does your community need
 - In Nova Scotia
 - Doing this modelling themselves
 - What are they willing to share with us?
 - Information is there, how do we get it in an appropriate way
 - Incentives associated with this information
 - Debt forgiveness
 - “knowing information” shift
 - We have the information and we know what we need
 - Relaying message between peers; we all need to think about the need of communities
 - Residents perspective; connect with provincial resident organizations
 - Don’t forget to take into consideration the new R4s/R5s

Resolutions Marketplace

- Discussion tables were held for all resolutions
 - 1) Omnibus By-laws update
 - 2) Motion to establish a policy statement, in support of the Open Letter to Prime Minister Justin Trudeau on the Right to Housing
 - 3) Delegation of Authority Policy
 - 4) Motion to Adopt a Position Paper “Responding to Medical Student Suicide”
 - 5) Motion to Adopt Amendments to CFMS Governance Committee Terms of Reference

- 6) Nemo Contradicente Voting Rules

Strategic Planning Hack-a-thon Topic Selection

- Opportunity to give input on this afternoon's strat planning session
- Similar to hack-a-thon in the past but real time sign up
- Voting on the top 3 topics in each portfolio, so 1 topic will be selected for each portfolio
- Sign up on Facebook page for AGM 2018
- Finance:
 - Student initiative grants - 21%
 - Sponsorships-11%
 - **Funding opportunities - 68%**
- Student Affairs
 - Leadership Awards: 0%
 - National Wellness Program: 26%
 - **Interview database: 74%**
- Global health
 - **International Exchanges: 68%**
 - Global health mentorship: 5%
 - Direction of global health: 2%
- Comms
 - Annual Review: 0%
 - Website: 0%
 - Membership engagement: 100%
- Government Affairs
 - **National Day of action: 59**
 - Position paper process: 18
 - Rapid response team issues: 24
- Education
 - Research: 0%
 - Curriculum: 46%
 - **The Match: 54%**

Finance Report

Motion to move in-camera with Dr. Ali Damji and Rosemary

Moved by: Odell Tan (Saskatchewan)

Seconded by: Cory Lefebvre (Western)

Result: Motion Adopted

financial resolutions listed in the section below

Motion to move out of camera

Moved by: Odell Tan (Saskatchewan)

Seconded by: Cory Lefebvre (Western)

Result: Motion Adopted

Address by Dr. David Eidelman - Dean of McGill

- Introduction by Dr. Ali Damji
- Welcome you to AGM of CFMS, nicest summer in history except for today
- Thank yous to McGill, Henry, Rosemary and to Dr. Osler for coming
- Exciting time to be in medicine, how to preserve universal healthcare in the face of many changes
- CFMS is critical in being able in the way forward
- With the privilege comes responsibility to think about what we will do to help ensure that Canada's healthcare is meeting needs of patients and their families
- This is sometimes a difference than your personal ambition, try and reflect and think about yourselves as leaders in 21st century medicine.
- Medical students now are better than when I was a medical student
- I want to wish you all a great time in montreal, and ensure that you have a lot of fun.
- HAVE A GREAT TIME!!! (also in french)

LUNCH BREAK

Financial Resolutions Session

as from the above Financial Report session

Resolution #1: Motion to approve the audited financial statements for 2017/2018

Moved by: Lauren Griggs (Calgary)

Seconded by: Henry Annan (Dalhousie)

Result: Motion Adopted

Resolution #2: Motion to approve Auditor re-appointment for 2018/2019

Moved by: Lauren Griggs (Calgary)

Seconded by: Henry Annan (Dalhousie)

Result: Motion Adopted

Resolution #3: Motion to accept the 2018-2019 Budget

Moved by: Lauren Griggs (Calgary)

Seconded by: Henry Annan (Dalhousie)

Result: Motion Adopted

from current session

Resolution #4: Motion to Approve a contingency allocation for \$35,000 for wellness survey close out

Moved by: Victor Do (Alberta)

Seconded by: Lauren Griggs (Calgary)

Motion to move in camera with Dr. Ali Damji and Rosemary,

Moved by: Chris (Manitoba)

Seconded by: Odell (Saskatchewan)

Result: Motion Adopted

Motion to table this motion for tomorrow, so we can have it properly written out on what is going on, with Franco to provide documentation for this.

Moved by: Ziyu (McGill)

Seconded by: James Mattina (McGill)

Result: Motion Rejected

Motion to move out of camera and resume further debate during allotted resolution time as a speaker is now here.

Moved by: Henry Annan (Dalhousie)

Seconded by: Cory Lefebvre (Western)

Result: Motion Adopted

Leadership Session

- Title: Learning to navigate Class 5 Rapids - Adaptive leadership skills for a changing healthcare environment
- Presenter: Dr. Sarah Jarmain
- Objectives of the talk
 - Develop and understanding of the factors that contribute to the rate of change and complexity of our current healthcare environment
 - Identity key leadership skills that contribute to optimal performance within this changing context
 - Discuss opportunities for medical students to develop and use these skills
- Personal story on what leadership means to her
- Task for attendees: write down one leadership strength you would like to develop further and why. The importance of the why.
- Referencing CanMeds 2015 leader definition
 - Moved from physician as manager to leader

- Physicians need to increasingly play a leadership role in a rapidly changing healthcare environment
- We need leadership and collaboration
- Blame - blame culture, we need to significantly shift culture of medicine
- Drew Dudley on leadership - Ted Talk video
 - Lollipop moment
- Leadership is about relationships - what you bring into that space and what you do with others; day to day interactions with others, what we give to others
- Leadership is about a way of being, globalization
- Rapids and whitewater and leadership
 - Class 5 whitewater - dangerous conditions and risky outcomes with decision making
 - Nowadays there is so much turmoil, each person needs to be clear in their decision making and have the skills for leadership and change
- Drivers of change - information technology, hospital to community, distributed models; globalization; public's loss of faith, Increased focus on transparency and accountability, health reform and regionalization, changing funding models
- Guide to the future of medicine - professionals and patients and families and technology. The rate of change is significant.
- Adaptive leadership - courage needed to lead, when you lead people through difficult change, you challenge what they hold dear with nothing more than possibility -> talking about vision, why?
- How do we communicate that change? Social change video. "The girl effect" why, how, and what
- If you've got a message to deliver, what are the means that you will do so
- Define vision - individual and shared for the group; focus on productivity and speeding up, instead of slowing down and achieving what is important
- Setting a clear vision allows you to develop those goals
 - What does it look like, feel like, sound like; how will you know when you're there
 - Measurable goals, new behaviors, organizational structures and processes, culture
 - Culture is shifted by behaviours we enact
- Stanford design school: ideal. A new way to develop products and think outside of the box, brainstorming and prototyping.
- David Kelly and his MRI work. He worked with design team on a decal to turn MRI into pirate ship
- Core strategies around leadership -> sense of strategy (vision), how do you take action, results (taking risk to shift gears)
- Adaptive leadership - emotional intelligence (where you're at and the people around you); how you function around others, principled negotiation; how you can maintain relationship, even if you have to work through tough issues
- Sense of character - the role of humility in leadership and the importance of understanding your values and how they come in conflict with the decisions you make.

- Role of development in lifelong learning.
- Whitewater rafting leadership lesson
 - Leaders face forward
 - Politically astute, context you're working in, think far enough ahead
 - Take advantage of strength; how do we mobilize strengths
 - Navigate, have sense of direction and know where you're going, work in teams with that
 - Take big risks, try disruptive novel solutions
 - Reinforce and recognize what is going well
- Framework that CMA, CSPL is LEADS For leadership competency
 - Think about the skills and competencies that we need
 - 5 categories: leading self (self care and emotional intelligence), engage others (communication skills, manage conflict, how to develop others), achieve results (vision, not planning it all out, but having small cycles of change, and where we put our attention), develop coalitions (collaboration and negotiation and co-design), system transformation (system thinking, disruptive thinking)
- Leadership framework overview diagram - leadership and management sides of things
- Important in choosing what you're going to focus on, what's in your control, what you can influence, what you can grow bigger through relationship building; where are you going to spend time and attention
- Opportunities for leadership development:
 - Conferences and workshops (CMA/CSPL annual conference), joule physician leader institute, american association of physician leadership
 - Masters programs
 - Should people do them? Get time and experience under belt as physician, and then go back; helps you to develop expertise and know what you're interested in
 - Books, podcasts, TED talks
 - Mentors and coaches
- Highly recommended reading - white paper on physician leadership - accepting our responsibility
- Reflect on leadership concepts and identify one strength you want to build on and one you want to learn more about
- Questions:
- Adrina from Western: share more about the society for physician leadership? And initiatives on women in leadership roles and gender breakdowns?
 - A: white paper talks about strategies; Gillian Cornohan? Has spent lots of time talking about issues of gender and balance; increasingly it's not about gender, it's about lifestyle choices -> becoming issue for men as well as women, impacting both genders and affecting roles that they can take on
 - Fundamental problem in how we look at physician leadership and how we tackle that
 - Attend conference, lots of discussion happening around this issue

CFMS Hack-a-thon Strategic Planning

1. FINANCE (Funding Sources)

Led by: Lauren Griggs

Minuting: Odell Tan

Session 1:

- How do you get sponsorship?
 - MedSocs are only funded by member fees and admin \$
 - Sponsorships are tough - it's a two way street b/c both groups are looking for something from the other
 - CFMS strategies to appeal to sponsors - they want face time with us
 - SCIP opportunities
- Right now CFMS funds students via 'initiatives' - how can CFMS pivot to ensure we can support students
 - E.g. you want a website, so how can CFMS support you?
- What about the CFMS' surplus? Why can't we just give it away as grants?
 - We have the thought that if we have a profit, we should save it for a rainy day. But the negative of this is that we don't spend that money and it just builds, particularly recently. We have potential to get large sponsorships coming up with lots of money available that we will need to spend.
 - We have initiatives and those are a way to give money away. But we want to find better ways to do this

Session 2:

- We need a sustainable way to provide funding for students. We currently run Student Initiative Grants - \$20k and Strategic Initiative Fund - the latter probably won't exist in the future
- If CFMS is running a surplus, then why not give more money to SIGs?
 - Yes, we increased to \$20k. But we want to make sure we're covering everything - for example, something that doesn't fit under SIGs
 - Maybe award bonus points to someone who has applied multiple times so that we clear the 'backlog'
- What about conference funding?
 - That's a good idea - as long as the travel awards are indicated for things that help the CFMS, like CSPL
 - We should also consider that first-time attendees are disadvantaged when applying for awards. Maybe first time awards?
- uOttawa - Accessibility policy - all events must be accessible; an event must be accessible
 - CFMS could potentially supplement events to make sure they have enough funding to make an event accessible

2. STUDENT AFFAIRS (Interview Database)

Session 1:

- Question: The old interview database had specific questions for specific programs, correct?
 - Yes, correct.
- Question: What were the legality issues of this?
 - Lawyer that spoke with CFMS said that it wasn't a good idea to be disclosing questions that were likely some level of confidential.
 - What I'm worried about is the disparity that exists among schools with respect to the resources that are provided. There may be a role here to equalize and level the playing field. Not right to publish precise questions, but reasonable to publish themes of questions and have a document with "weird" questions to let people know that they are fair game.
 - Would also be useful to have document with "tips and tricks" for different specialities.
 - Could have a document similar to MMI question document where there is just a huge list of potential questions that are floating around.
 - Very few people said that they knew of interview prep resources at their schools.
 - Maybe have one of the VPs from each school send any interview resources from their school into CFMS.
 - Concern regarding this is that people who are creating those documents often have not matched yet, so we don't know how well those strategies work.
 - Could work with RDoC to ameliorate this.
- Question: Does CFMS still have the document. (Yes.) If so, what would be wrong with going through and anonymizing questions in terms of schools/programs.
 - Concern: Programs may still see that their questions are being leaked, especially if they are very specific.
- Question: Have concerns from a school ever come up?
 - Not for the interview database specifically, but the electives database was a similar model, and some schools have been concerned about bad reviews from a single person, etc.
 - Seeing them as questions that are kind of separate.
 - There is a question bank that we have access to and there are concerns about what to do with this. This is less about work and more a decision of what to do with the questions.
 - Set of resources for the interviews (these can be more generic). This would require more manpower.
 - Idea of testimonials from students who went through the interview.
 - General or specific in terms of the program and how the interview went and what you thought, etc.

- Possibly beneficial to go to each specialty and ask what they're looking for in their applicants.
- This is onerous, but maybe there is another way to do this.
- Summary of feedback (by Steph):
 - Two-pager of tips and tricks.
 - Videos and other pre-existing resources for preparation.
- If the CMA wanted to create practice videos, that could also be good.
- General themes of questions and how to prepare.

Session 2:

- The driving factors: Had an interview database but we could not continue to maintain and post what was being put out before for a number of reasons including ethical.
- Focus of this discussion is ideas for what you would like in a database:
- R: Can we help connect students together who are applying to similar things and this can help people broaden their thinking around these things.
- Not interview specific things; if you are going to BC for example here are the other things you need to consider...i.e. transit, hotels, etc, department heads and contact info...the problem is that it is hard to upkeep and ensure everything is up to date.
- Will likely need to create a task force.
- Consolidate information based on specialties and what different schools are looking for- you can see some of the things on CaRMS website, maybe we can utilize them and have them help to ensure students know this information.
- CaRMS: CFMS tell them questions that students have and then they can be the ones who answer the carms pages and ensure that there is lots of information
- Schools open to sharing information on learner wellness contact and can talk to someone from each school.
- What happened with the old database?...so the old one was just a bunch of questions....thought it was not appropriate for us to keep a list of questions.
- What can we do for the interview prep that is not providing questions:
- Tips and Tricks overview to help with some general things around interviews. Videos to practice...example CMA makes videos and here are some good examples for people to do. Links to resources for people to prepare, we can help consolidate. Then we can give general themes of questions...so people are thinking about those general themes.
- Should the CFMS just be a platform for people to add whatever and as long as there is disclaimers
- Premed 101 like forum
- Can we have a list of contacts for people to talk to residents etc

3. GOVERNMENT AFFAIRS AND ADVOCACY (National Day of Action)

- Day of Action = ~ 4 students per school come together to discuss
- Shared document from National Officer of Political Action (Linda Lam) on the Shortlisted topics

- Took recommendations from SGM and from the GAAC's, task forces, and other key stakeholders. There are 5 topics were shortlisted and then each committee member ranked from most desired to least desired. This document is now available for discussion to determine our 2019 Day of Action Topic.
- How do we go from big topics to concrete asks?
 - With the assistance and lead of the Day of Action Research Committee
- Voiced support and comments on each Day of Action proposed topic is below
- **Climate Change and Water**
 - Felyene from McMaster, Jessica from Sask, George from Western, Mathieu from Laval/FMEQ
 - Water is a huge determinant, important to not lose indigenous voices in this discourse, a CFMS campaign has started for the purposes of advocating for and developing climate change within medical education curricula, it was also mentioned that CMA sold off MD Financial with 2.6 billion for investment/use and to question if these funds will be divested from fossil fuels. CAPE, the canadian association for physicians for the environment, is expanding chapters in Ontario/Quebec.
 - Criticism for this topic - that there might not be more movement from the current government on this issue as they have already done a lot and are aware of the importance of environment and water
- **Housing**
 - Courtney from Toronto, Privia from UBC, Bernidine from Alberta, Jessica from Ottawa, Jessica from Sask, Mehr from Ottawa, Fatemah from Manitoba, Emily from Toronto, Adrina from Toronto
 - Housing is a fundamental right, major determinant of health, housing is at a crisis moment in BC right now with rural, urban, on and off reserve housing being huge issues and lack of accessibility and affordability, housing is related to other topics, "housing first" perspective, and how this ultimately affects other topics. Placement that student has done in Ottawa and she has first hand experience on the negative impacts of homelessness. Housing is a federal issue. Housing connects to Indigenous mental wellness and has overall health impacts. Toronto held a municipal lobby day on this topic. Taskforce on housing and there is a policy document in development.
- **Poverty Reduction and Economic Inclusion**
 - Ziyu from McGill, Sam from Moncton, Aicheng from Manitoba, Devon from UBC, Mathieu from Laval/FMEQ, Jun from Western, Amanda from Manitoba, Melissa from Manitoba , Pavithra from McMaster,
 - Poverty alleviation and how can it be medical student focused or how can any of these topics be medical student focused/ from a medical student lens, this issue of poverty and proper economic inclusion touches on a lot of people. On economic inclusion, WHO is reaffirming it as a determinant of health, to work on this issue means working upstream and

subsequently affecting other issues on this list. Economic inclusion is important for access to health system and services. Look at income stratification and social services and look at how currently we lean more towards acute care more so and less. Economic inclusion and exclusion has a huge impact on mental health of communities. "Why are there still poor people in a rich country?", this topic could blend well with housing.

- Criticism on this topic - the current government may not do more on this topic as they have already done a lot around the national housing strategy
- **Refugee Health (Interim Federal Health Program)**
 - Naomi from McMaster, Ailish from Queens, Privia from UBC, John from UBC, Zach from NOSM, Jessica from Sask
 - Refugee health is a big topic, what are the asks?, the impacts of refugee health have been seen first hand by students - at UBC (and Ottawa!) there is a program called refugee health initiative that pairs med students with refugee families, it can be understood that not a lot of help is provided to newcomers and they are overlooked in their ability to access health and social services. Has seen more movement on this topic likely with regards to the magnitude of our impact of our efforts. Canada has seen a large influx of families around 2 years ago (Syrian refugees) but 'refugee health' has lagged behind
- **Seniors, Aging, and Accessibility**
 - Ailish from Queens, Adel from McGill, Palki from McMaster
 - Seen in Kingston that there is a lack of care homes for older adults. Aging population has its burden on the hospital system.
- Other topic proposed: Health Human Resource Planning
 - Grace from Toronto
 - The issue of uCMGs, and the Saudi Arabia resident issue highlighting how we are very dependent on visa trainees and relying on foreign resources
- Other topic proposed: pharmacare

Additional meeting notes:

Courtney Hardy from Toronto

- Housing
- Ziyu from McGill
 - Why aren't we doing a topic that is medical student oriented?
 - Explained about the internally facing national day of action
- Ailish, Queens
 - Refugee health
 - Seniors
- Privia, BC
 - Housing climate/ economic inclusion/ seniors and aging
 - There may be ways to integrate this

- John UBC
 - o Refugee health initiative
 - § Help families integrate
 - § He did a qualitative practice on what helped them integrate
 - § This topic speaks to him personally
 - § These people do not get much support other than initially
- Zach Thompson, NOSM
 - o Refugee, narrower scope
- Shanza, Ottawa
 - o Many topics have been worked on by task forces so some work is already done, take this into consideration
- Bernadine from Alberta
 - o Housing stands out to her, can affect multiple populations
- Jessica, Ottawa
 - o Placement at YMCA in Ottawa and some families impacted first hand by homelessness
- Jessica, USask
 - o Loves all 5
 - o Top are 1,2,4
 - o 2 years ago they had student refugees, big deal when they get there right away and then no support right away

ROUND 2:

- George, Western:
 - Climate change and water
 - CFMS is currently engaged to determine curriculum content for environment by 2020
 - Engaged with GH leaders today to evaluate curriculum as it stands
 - CMA has just told off MD to Scotia for ++ \$\$... will they ensure it will be divested? CAPE (physicians in environment is expanding)
 - good time to pounce on this issue with multiple factors coming together
- Sam, CFMNB:
 - Economic inclusion affects SO many people
- Adel, McGill:
 - Seniors/Aging support
- Mehr, Ottawa:
 - Housing and homelessness
 - Federal issue
 - Initial push by U of T has already started

- Manitoba Delegates:
 - Economics is a determinant of health
 - Feeds into housing; housing is downstream from economics
 -

- Devon, UBC
 - Economic inclusion; echoes above
 - Raises concern with environment and climate
 - JT already knows about this etc, whereas housing is another topic that is well discussed at federal level
 - Let's think things that aren't already at the table

- Mathieu, Laval
 - Economic inclusion
 - Fair access to health system and services
 - Agree with climate change as well

- Delegate, U of T:
 - Saudi Arabian Residents; follow along with OMSA lobby day etc etc
 - How much do we rely on other countries when we could support Canadian nationals
 - 3X support for Economic Inclusion

- Jas, UBC:
 - Tangible ask going into election year; take this into consideration.

- Kaylynn, U of A
 - Water specifically; would tie into last years topic well.
 - Balance between students picking new topics vs. building on progress you have made
 - Struggles of this at provincial level

4. COMMUNICATIONS (Member Engagement)

Session 1: Membership Engagement

- Achieng (Manitoba) - you have good reps, responsibility should be placed on reps to have more local focus and keep the message at the school level; allows the reps to personalize like highlighting how Manitoba is great

- Jielin (Western): could we get more information sent out to the reps along with the communique? A lot of members come back to the reps with questions and follow-up and reps feel left out of the know. Would be good to have info to help
- Emily (Toronto): Echo similar sentiments. Often have to bother RRT chair for contacts and follow-ups
- Christina (vp comms) - for those questions, are there insufficient information in the communique?
- Emily (Toronto): research spotlight for example was sparse as to the details about when, where, how long, etc.
- Paul (MUN): chop the communique into the relevant pieces similarly and post on Facebook. Send out the communique and post on facebook. Get it twice
- Pavel (IT): is the e-mail the most efficient method to get the information out?
- Christina (VP Comms): want to balance over exposure while sending out enough information. Reps are valuable way to gauge the amount of info to be sent out. Communique is changing due to anti-spam legislation. Can still use reps insight to pull out pertinent pieces for the med school. The method will likely change in the next few months. On facebook, should we be focusing on internal CFMS things or to expose external opportunities (like CMA)?
- Achieng (Manitoba) - the more the merrier
- James (McGill) -High yield enough to make relevant to medical students
- Christina -
- James - sometimes opportunities have short notices due to communications being out of sync. Is there a way for reps can be informed prior to communques?
- Christina - communique is slow, but our social media will always be out. Highly encourage all medical students to follow on SoMe. Maybe create a reps newsletter?
- Nick (Dal) - having a newsletter/reps update would allow reps to allow answer questions and keep on top of opportunities. Facebook/Social Media often not great with keeping in chronological order
- Christina (Vp Comms) - communications team has been expanded to accommodate for the heavier load of items

Session 2:

- Henry (Manitoba): what are the discussion at the board levels for member engagement? And what has been done and what ideas?
- Wendy (Calgary): specific channels and people to talk to? Broad strategy
- Michael (Dal): with time people learn about the CFMS through word of mouth, btu have hard time engaging students at time of arrival? Is there a way CFMS can get involved at engaging students at the beginning? We have a welcome lunch with the CFMS intro video but a lot of students see it another intro.
- Christina (VP Comms): engaging first years - developed infographic to how to get involved in the CFMS and could be included in the welcome packages for first year medical students. Board level discussion - we prioritized (plus Henry) to engage students. Concrete things - revitalized social media platforms (facebook, insta, twitter, linkedin) - communication of opportunities and celebrating student excellence; for the

communiqué - changing how its distributed due to anti-spam legislation and to make it more just for student → direct emailing method (bypassing reps) similar to CMA method; will hopefully reach students in a timely manner, reps can highlight pertinent and local affairs; reach people more directly; communiqué is sent out via reps; written 15 press releases and 25 media interviews

- Pavel (IT Sr.)- mobile app discussion and trying to figure out where the app would fall under the comms portfolio
- Aran (U of A) - wellness challenge seemed very engaging, but last year it seemed less interesting. What are the numbers?
- Emily (NO Wellness) - fair back of feedback about challenge - very stressful for. This year was different approach to be more accessible and less stress on the reps. This year, we got over 800 participants. It also included clerks and fourth years. It was more individual than team based. Moving forward can be a blend.

5. EDUCATION (The Match)

Strategies for unmatched students

Background: current CFMS efforts

- Unmatched student task force led by a student who has gone unmatched,

Round 1

Wendy, UCalgary: Match process is accelerated in 3 year medical programs, it is difficult to navigate conflicting information that may be more applicable to students in 4 year programs

- Matchbook to highlight differences between 3 year and 4 year timeline
- Kaylynn: challenge is the timeline for decisions and planning is very personalized and it is difficult to make recommendations as CFMS to students for what milestones to meet by which year of studies
 - New electives cap policy may help alleviate the pressure for students to decide early on a specialty
 - It is intended for students to make specialty choices in 4th year
 - Moving electives timeline: we have now moved the time for applying to electives from 28 weeks to 26 weeks prior to starting electives to give students more time to decide which specialties to apply for electives in

Rishi, McMaster: Timeline for supporting unmatched students after Match Day

- Inconsistency across schools in how schools respond to unmatched students
- Kaylynn: currently drafting a letter to submit to AFMC October meeting requesting schools to give at least a half day or full day off on Match Day (definitely before the Match results come out, and ideally after)

Swani, UofA: What are options for financial support available for going unmatched?

- Kaylynn: Differs per school - some schools pay for second round application and stipend for interviews/travels

- This year CFMS gave \$150 per unmatched student if they applied to 2nd iteration
- Schools also differ in the amount they charge for extended clerkship year option (some charge \$5000, some charge full tuition)
- Suggestion for med socs: offer some financial support with their surpluses to students who go unmatched

Aran, UofA: Is CFMS pushing for 5th year option available at all schools?

- Kaylynn: We have a document describing what each school has in place but AFMC is not allowing us to publish it
- Some provinces allow students to re-enter after graduating, some allow you to graduate but you can still do electives, etc. vary on College and Senate policies
- Every school does have 5th year

Round 2

Elisa, McGill: FMEQ students are also addressing the issue

- Elisa: People are afraid of going into family medicine because it is not well promoted (quota for family physicians imposed), suggest one route to advocacy for CFMS is to look into laws regulating physician practice
- Kaylynn: we do not want to step on FMEQ's toes so CFMS generally leaves Quebec on its own in advocacy
 - Quebec is doing a great job encouraging students to match into family medicine but just not in Quebec due to political climate of Health Minister, creating the language gap and ratio issue
 - Encourage FMEQ to lobby their government for policy change
 - In other provinces, have worked with MedSocs to approach their provincial government
 - There is missing input of medical students to fill Quebec resident positions
 - Currently not enough residency seats in Canada, ratio of English students to English-speaking spots is 0.98

Zach, NOSM: My understanding is most spots are funded and allocated provincially - what can the federal government do?

- Kaylynn: Big lobby day ask is better workforce planning tool and funding transfers to provinces to increase spots
 - Education is provincial but the Match is national, and provinces in general have no good planning strategy in planning spots
 - There are also federally funded spots DND

Alex, UofC: Are you aware of any plans to address deficit of Saudi physicians?

- Kaylynn: Programs are still taking in Saudi trainees for this year's match cycle and interviewing them
 - No projected deficit of Saudi residents at present

- We do not have a stance to ask Saudi residents to be replaced because we do not have funding for those spots
- The benefit of the issue is it spotlights the crucial role residents have in our healthcare system

Liane, McGill: Suggestions for CFMS

- Decrease anxiety around unmatched scenario
- Working with RDOCs, PGMEs to make the match process more transparent
- Kaylynn: there is actually a working group called BPAS (Best Practice in Application and Selections) from CaRMS
 - a. If CaRMS builds an application system that is transparent and schools must complete, then it will force schools to increase transparency in selections
 - b. E.g. include a feedback section
 - c. There is a lot of pressure from post-grad, under-grad deans for this as well!

6. GLOBAL HEALTH (Exchanges)

Session 1

- a. The purpose is to gather input regarding ideas for optimal strategic plan regarding exchanges. Do you think the current process is working well?
 - i. Sophia (Western) - Unilateral exchanges are problematic. Inequitable to send students for sole purpose of learning
 - ii. Tommy (Toronto) - Voluntourism. Especially clinical exchanges, utilizing resources from areas that do not require unskilled medical trainees. We should look at reframing the clinical exchanges to mandate no clinical work outside of their usual practice.
 - iii. Amy (Manitoba) - Are international rotations ethical at all? Manitoba has limited the number of international opportunities for Manitoba students secondary to perceived voluntourism. Suggestion from faculty members to explore existing partners with University, not just the faculty of medicine.
 - iv. Yung (Western) - CFMS should set up fund to bring students here on bilateral exchange. Set up something to mandate accommodation exchanges.
 - v. Jaymie (Manitoba) - Where does the CFMS exchange fees go? They go to
 - vi. Adriana (Western) - For many other NMOs it is much cheaper to do exchanges than Canada and many more have bilateral. I don't agree that cost is the major barrier to obtaining bilateral exchanges.
 - vii. Michelle - Do we feel exchanges are useful for CFMS Members?
 - viii. Denise (Western) - Hard to pair bilateral exchanges perfectly in terms of 1 in 1 out of each country partner.
 - ix. ?? - IFMSA-CFMS aren't they all bilateral? No

- x. Michelle - Partner choices made at IFMSA is from data post-exchange. We have not explored polling GA prior to AM in order to make these partnerships.
- xi. Ben - SCORA exchanges also exist but hard to disseminate to members? Who facilitates the exchanges from other committees?
- xii. Adriana - We normally select destinations that other students have had positive experiences but also normally are common vacation destinations. This made lend to voluntourism.
- xiii. Michelle - Do we need an exchange task force?
 - 1. General agreement from the crowd

Session 2

- b. Is the process for exchanges working?
 - i. Financial accessibility can be improved. No grants available from CFMS or at home school.
 - 1. Exchanges aren't mandatory
 - ii. Charlotte - If there was money available, do we reduce costs across the board or have a finite number of "scholarships". Financial need or application?
 - 1. Schools with no funding at all should get funding to go on exchanges.
 - 2. U of A has a office of GH that have bursaries for international exchanges and the faculty to go abroad.
 - iii. Michelle - Advocate at each school for increased bursary opportunities.
 - iv. Michelle - Do you feel prepared by your school when going abroad?
 - 1. McGill - not medicine focused, mostly re:safety
 - 2. Is there a CFMS sanctioned pre-departure training? No
 - v. Felicia - A better list of destinations
 - 1. Charlotte - Can't really do that, we only match to country and then the country places in city and specialty.
 - vi. Is there some way for us to support the communities we're going to? Monetary donations and supplies as required.
 - 1. Does this imply a connotation that a monetary value is inherent to the exchanges?
 - vii. Michelle - Are exchanges valuable to CFMS? Even in high/medium-income countries?

Intro to Resolutions

- State your name and school for minuting purposes
- Every institution member gets 2 votes and campus members gets 1 vote, board member gets 1 vote
- Chair reads the motion, mover and seconder speak to the motion (up to 2 minutes between the two)

- General discussion, speakers list of 5 peoples, after those 5 will open another if need be.
- Not strict about the speaking list, but for time constraints we may need to cut down.
Don't repeat ideas
- Important to say whether in favor or opposed for context of chair.
- Please speak for or against
- Point of Information = question
- Amendments, friendly - mover agrees, no vote on amendment, vote on original motion
 - If unfriendly, mover and seconder don't agree that it works in spirit of motion, it triggers a discussion on the motion to amend
 - Amendments can only be made to motions and not position papers
- Question can be called when speakers list exhausted or motion by member
 - Motion to call the question will be debated and voted on, then vote on original motion if passed
 - Requires $\frac{2}{3}$ majority and not simple majority
- Point of Parliamentary Inquiry - asking chair a question about parliamentary processes
- Make sure you vote with placard (high in the air and hold it). You may ask for secret ballot voting.
- Will try to keep to the agenda time. Keep comments concise and focused. Speak to a max of 1 min

Motion to move in camera with Dr. Ali Damji and Rosemary

- **Moved by:** Chris (Manitoba)
- **Seconded by:** Odell (Saskatchewan)

Result: Motion Adopted

Full Motion: "BIRT that the CFMS GA approve a contingency allocation of \$35,000 dollars for wellness survey closeout; BIFRT the CFMS use these funds to terminate the contract. BIFRT CFMS provides a progress update at SGM 2019, and presents the formal report by AGM 2019, including history and timeline of the Wellness survey, why it was not conducted to term, methodological weakness in current CFMS wellness research and initiatives, and recommendations and action plans for future research/projects.

- **Moved by:** Victor Do (Alberta)
- **Seconded by:** Lauren Griggs (Calgary)

Result: Motion Adopted

Leanne (McGill) : Motion to move out of camera

- **Moved by:** Leanne (McGill)
- **Seconded by:** Odell (Saskatchewan)

Result: Motion Adopted

Resolution Session I

Motion #1: Motion to adopt Consent Agenda

Moved by: Rishi (McMaster)

Seconded by: Leanne (McGill)

- Consent agenda will be passed altogether which includes:
 - Executive and Officer reports; and
 - Resolution 6: adoption of nemo contra voting rules; and
 - Resolution 7: adoption of previous minutes.

Result: Motion Adopted

Resolution #1 : Motion to adopt Omnibus Bylaws Update

Moved by: Odell Tan, University of Saskatchewan

Seconded by: Stephanie Smith, University of Calgary

- WHEREAS the Canadian Federation of Medical Students (CFMS) is a registered not-for-profit organization with Corporations Canada; WHEREAS the CFMS adopted the CFMS Human Resources and Operations Strategic Plan 2017-2022 at its 2017 Annual General Meeting (AGM); WHEREAS the CFMS strives to operate utilizing corporate governance best practices where possible, aiming to reduce the frequency of by-law amendments; WHEREAS the CFMS By-laws were amended at the 2017 AGM & 2018 Spring General Meeting; WHEREAS the CFMS By-laws require additional revisions for clarification purposes and to advance the priorities of the CFMS Human Resources and Operations Strategic Plan 2017-2022; WHEREAS the CFMS has a mandate to represent all of its members equally, both publicly and within its By-laws, and the By-laws have previously not been gender-neutral; BIRT that the CFMS General Assembly approve, on the recommendation of its Governance Committee, the omnibus amendments to the CFMS By-laws, effective upon filing with Corporations Canada, as laid out in the attached document. Financial Cost: \$0* *no additional cost as CFMS will file these revisions as part of its 2018-19 Corporations Canada filing *upon approval by Corporations Canada, the CFMS By-laws will be translated into French Level of Effort: 0 hours Line Item: N/A
- Odell: Clean up of the document, making language consistent and gender-neutral. Just making distinctions between vps and directors consistent throughout. We need to make admin section in-line with corporation canada. These changes will be submitted once new board elected and new filling with Corporations Canada.
- Must be voted on, needs $\frac{2}{3}$ majority

Result: Motion Adopted

Resolution #2: Motion to adopt Delegation of Authority Policy

WHEREAS the Canadian Federation of Medical Students (CFMS) is a registered not-for-profit organization with Corporations Canada; WHEREAS the CFMS adopted the CFMS Human Resources and Operations Strategic Plan (HROSP) 2017-2022 at its 2017 Annual General Meeting (AGM); WHEREAS the CFMS strives to operate utilizing corporate governance best practices where possible, including optimal organizational efficiency; WHEREAS the CFMS recognizes the need for formal documentation of organizational procedure; WHEREAS the CFMS General Assembly previously resolved to bring forth the policies referenced in the 2018

Spring General Meeting (SGM) CFMS By-laws to the Assembly by the 2019 SGM; BIRT, in accordance with the CFMS HROSP 2017-2022 Implementation Item 1.1, the CFMS General Assembly approve, on the recommendation of its Governance Committee, the CFMS Delegation of Authority (DoA) Policy and its appendices, as laid out in the attached document. BIFRT the CFMS as an organization operate within the framework of the CFMS DoA Policy for the next year, while the CFMS Governance Committee reviews the DoA Policy, and if necessary, will present recommended changes to the CFMS General Assembly at its 2019 AGM for approval. Financial Cost: \$0 Level of Effort: 5 hours Line Item: N/A

Moved by: Odell Tan, University of Saskatchewan

Seconded by: Dax Bourcier, Université de Sherbrooke - Site de Moncton

- Odell: tried to be as clear as possible in whereas statements and keep us accountable. This stems from strategic plan to distinctively define the delegation of authority and powers throughout CFMS structure. Increases accountability of positions. There was slight changes, the new document has been made available on facebook, drive and website. Changes were made for syntax errors and clarifications
- Dax: policy has been shared between reps RT, president RT, and governance committee with sufficient consultation

Result: Motion Adopted Nemo Contra

Resolution #3: Motion to Adopt Amendments to CFMS Governance Committee Terms of Reference

WHEREAS the Canadian Federation of Medical Students (CFMS) is a registered not-for-profit organization with Corporations Canada; WHEREAS the CFMS adopted the CFMS Human Resources and Operations Strategic Plan 2017- 2022 at its 2017 Annual General Meeting (AGM); WHEREAS the CFMS strives to operate utilizing corporate governance best practices where possible, aiming to reduce the frequency of by-law amendments; WHEREAS the CFMS Governance Committee is compelled by Resolution 2 (Strategic Plan bucket), which was adopted at AGM 2017, to present recommended changes to its Terms of Reference to the CFMS General Assembly at AGM 2018 for adoption; BIRT that the CFMS General Assembly approve, on the recommendation of its Governance Committee, the amendments to the CFMS Governance Committee Terms of Reference. Financial Cost: \$0* Level of Effort: 0 hours Line Item: N/A

Moved by: Henry Annan, Dalhousie University

Seconded by: Stephanie Smith, University of Calgary

- Henry: Governance committee was struck in AGM 2017 and terms of reference were approved. In that, the terms of reference needed to come back to AGM 2018 for reapproval. We added two more positions for general members. Chairship moved from VP Executive to Past-president, and Vice-chair approved by governance committee.
- James (McGill): want to clarify if its $\frac{2}{3}$ majority or if tie broken by chair?
- Odell (Sask): Discussed with Parliamentarian, because that's not a substantive change, this may be removed after being passed, confirming a $\frac{2}{3}$ majority for which the chair would never need to break a tie.

Result: Motion Adopted

Resolution #4: Motion to establish a policy statement, in support of the Open Letter to Prime Minister Justin Trudeau on the Right to Housing

Whereas the letter calls on the Government of Canada to take on points of action for a National Housing Strategy. Whereas the letter calls for accountability mechanisms towards key populations affected by homelessness, that deserve recognition and prioritization Whereas there are significant obstacles to health access, that must be appropriately addressed in a medical curricula and student advocacy; Whereas medical students across Canada have initiated local advocacy efforts to improve healthcare in homeless populations; BIRT the CFMS pass the policy statement "" and in doing so, make public their opinion defend the position if and when the opportunity arises. Financial cost (estimate): \$0 Source of funding/Line item: N/A Level of effort of volunteers/staff: 0h

Moved by: Syeda Shanza Hashmi, University of Ottawa

Seconded by: Yipeng Ge, University of Ottawa

- Shanza: This is a policy statement in response to Justin Trudeau to recognize housing as a fundamental human right. This endorsement will empower taskforce to pursue this on social media.
- Kaylynn (VP Education, NOSM): Point of Information - is there an opportunity to edit the letter after the motion has passed?
- Shanza: The content of the letter would not be able to amended if that then changes the "vibe" of the paper.
 - Kaylynn: Addictions was left out of the paper, while many housing initiatives exclude those living with addiction.
- Trevor Poole (USask) - **proposing a amendment**; seconded by Daniel Lee (USask)
 - BIFRT the CFMS amend the statement to be adopted as a motion of intent instead of a policy statement.
 - BIFRT that the Task Force on Homelessness develop a specific, actionable, and reasonable mandate for presentation and review by the GA at the 2019 SGM
 - Amendment is considered unfriendly
 - Could we change motion of intent to discussion paper?
 - Shanza- still unfriendly because discussion paper has no opinion
 - Removed "BIFRT the CFMS amend the statement to be adopted as a motion of intent instead of a policy statement."
- Devin Mitchell (UBC) - POC: In terms of the normal function of the CFMS. Are task forces normally held to this standard of oversight by the GA?
 - Shanza: We've looked at this recently, how task forces can be accountable to Board and GA. Any document needs to be passed at GA in order to be posted to website and publicly displayed as CFMS opinion.
- Debbie (McMaster) - POI: to clarify with U of S, does 'motion of intent' mean that you want the document to be developed into a discussion paper?
 - Trevor (USask): Yes.
- Alex (UofC) - want to hear from members of task force if objectives are obtainable and it's a doable amount of work, given timeframe

- Shanza: no members of task force here; purpose of task force is to focus on: medical school curricula; advocacy; research and literature review, so other two groups are supported. Large topic for task force, following up with local efforts. Purpose of statement is have national position so when we meet national bodies. Statement is what we will advocate within task force and groups across country. For SGM 2019, we can follow up and bring progress.

Full Motion now reads:

- Whereas the letter calls on the Government of Canada to take on points of action for a National Housing Strategy. Whereas the letter calls for accountability mechanisms towards key populations affected by homelessness, that deserve recognition and prioritization Whereas there are significant obstacles to health access, that must be appropriately addressed in a medical curricula and student advocacy; Whereas medical students across Canada have initiated local advocacy efforts to improve healthcare in homeless populations; **BIRT** the CFMS pass the policy statement “CFMS Response to Supporting the Right to Housing in Canada” and in doing so, make public their opinion defend the position if and when the opportunity arises. **BIFRT** that the Task Force on Homelessness develop a specific, actionable, and reasonable mandate for presentation and review by the GA at the 2019 SGM
 - Financial cost (estimate): \$0
 - Source of funding/Line item: N/A
 - Level of effort of volunteers/staff: 50h
 - Moved by: Syeda Shanza Hashmi, NOHP (University of Ottawa);
 - Seconded by Yipeng Ge, VP Government Affairs (University of Ottawa)

Result: Motion Adopted

Resolution #5: Motion to Adopt a Position Paper “Responding to Medical Student Suicide”

WHEREAS; The CFMS supports the health and well-being of its members. WHEREAS; Burnout, depressive symptoms, and suicidal ideations are prevalent amongst medical students (Dyrbye et al, 2016; Rotenstein et al, 2016) and risk of burnout increases as medical training progresses (McLuckie et al, 2018). WHEREAS; Medical students at risk do not always seek or receive the help they need for fear of stigmatization (Matheson et al, 2016). WHEREAS; Only a proportion of Canadian medical undergraduate programs have an existing response policy in the event of a suicide (Zivanovic et al, 2018). BE IT RESOLVED THAT the CFMS adopt the position paper “Responding to Medical Student Suicide.” BE IT FURTHER RESOLVED THAT the CFMS advocate for efforts in prevention, education, early identification, support, and suicide response protocol among Canadian medical schools. Financial Cost: \$0 Source of funding: N/A Level of Effort: 0h

Moved by: Bianca Sarkis, McGill

Seconded by: Francois Lagace, McGill

- Francois, Bianca, ??: CFMS Health Policy, CFMS Wellness committee, Steph. Integrate mental health into student training. Create student training program to identify peers in distress and refer to appropriate resources at their school. Advocate for all canadian

medical schools to have a plan when communicating with students following a completed suicide of a student.

- Summary: advocate for prevention and postvention? of suicide in Canadian medical schools

Motion to amend and add: **BIFRT** the CFMS VP Student Affairs create a task force to develop a strategy towards a nationwide effort in addressing and responding to medical student suicide, including:

- 1) Researching the current state of such responses
- 2) Developing a operationalizing the advocacy framework within schools
- 3) Advocating to CACMS to require Canadian medical schools to develop response protocol.

Moved by: Leanne Ronciere (McGill)

Seconded by: Emily Yung (McGill)

- Motion considered unfriendly
- Emily McPhail (NO Wellness): speaking against this motion, wellness roundtable already exists with the ability to create a taskforce. It locks us into something that may not be efficient way moving forward
- Frank (U of O): POC - how feasible do you think this is to put into your current portfolio?
 - Steph: With NWI, there are 4 pillars (awareness, resilience, etc..); teams will be requested to work on medical student suicide, work on these efforts. Would be difficult to have a task force on top of all the other work this group is doing
- Odell (USask): speaking against this motion as we have just passed the Delegation of Authority Policy that authorizes the Board or National Officers to create a task force as needed. I further encourage the movers to withdraw this motion if they feel it will fail, as if the GA rejects the amendment, the Board is restricted and will not be able to create such a task force since the GA has specifically voted against it.
- As NWI is already working on it, they look forward to seeing results

Result: Motion to amend is withdrawn.

- Emily (UofC): POI - Not sure if this is truly a 0 level of effort
 - Bianca: I don't know.
 - Emily: yes, as based on that last point, if the CFMS is advocating then that takes hours.
 - Considered a friendly motion.
- Full motion: WHEREAS; The CFMS supports the health and well-being of its members. WHEREAS; Burnout, depressive symptoms, and suicidal ideations are prevalent amongst medical students (Dyrbye et al, 2016; Rotenstein et al, 2016) and risk of burnout increases as medical training progresses (McLuckie et al, 2018). WHEREAS; Medical students at risk do not always seek or receive the help they need for fear of stigmatization (Matheson et al, 2016). WHEREAS; Only a proportion of Canadian medical undergraduate programs have an existing response policy in the event of a suicide (Zivanovic et al, 2018). BE IT RESOLVED THAT the CFMS adopt the position paper "Responding to Medical Student Suicide." BE IT FURTHER RESOLVED THAT

the CFMS advocate for efforts in prevention, education, early identification, support, and suicide response protocol among Canadian medical schools. Financial Cost: \$0 Source of funding: N/A Level of Effort: 50h

- Naomi (McMaster): motion focuses on helping students 'survive' the result rather than addressing the root cause, and it only puts on onus on programs to help afterwards rather than addressing the actual issues.
- Rishi (McMaster): Against. Framed at clerkship students and doesn't mention early year students which seems neglectful.
- Devin (UBC): in favour and will talk to the comments before me. If you look at the data in the paper, it talks about how 3rd and 4th years disproportionately face suicide and depression. I also think talking about this doesn't negate upstream work and I don't think this motion prevents us from actually advocating for upstream changes.
- Adam (Ottawa): I echo the previous speaker. We should also recognize our authors who are willing to write a paper and bring it forth to the GC, which takes a lot. I think things often get heated during these sessions and it is worthwhile to remember that.
- Chair: Call to question with a minute to discuss.

Motion to table the motion.

Moved by: Theo (Western)

Seconded by: Mira (Western)

- PPI - did we not call the question?
- Chair - this is a grey area. Unfortunate events have occurred in the past. I am allowing this motion.

Motion to challenge the Chair's ability to table motion after question called.

Moved by: Ziyu (McGill)

Seconded by: Frank (Ottawa)

- Shanza (Ottawa): on the COHP, we recommend things come to us in advance. We did review it and sent it to a few people in the CFMS. I now recognize that we should have distributed this to the VP Externals so that all schools had a chance to review such a broad document.
- Odell (USask): Point of order - Parliamentarian to take over chair, as there is a conflict with the GA considering to overturn the Chair's decision
- Parliamentarian (Franco) is now temporary Chair.
- Franco: Clarify we are challenging the decision of the chair to consider the motion to table the paper. If we overturn his decision we move directly to a vote on the original motion. If we don't overturn then we consider the motion to table.

Result: Motion Adopted

- Franco cedes Chairship to designated Chair (Ali)
- We are now considering the motion as written.

Result: Motion Adopted

Motion to rescind the previous decision of this body to approve the previous minutes, as the minutes were not available at the time of adoption.

Moved by: Ziyu (McGill)

Seconded by: James (McGill)

- Chair: To be clear, this motion must have a 2/3rds majority to pass.

Result: Motion fails to reach required 2/3rds majority. Motion Fails.

Sponsor Message from Insurance and Wealth Management Alliance

Saturday, September 22, 2018

Welcome by Chair

Small Working Groups: The Medical Roundtable

CFPC: Increasing exposure to family medicine in undergraduate medical education

Dr. Kristen Kukula and Emma Leon with Victoria Januszkiewicz

Session A:

What exposure do you have to Family Medicine in your program?

NOSM – big emphasis on FM from get go, 50%+ match to family. 1-month placement on reserve in northern Ontario in first year, focus on minority and community health. 2 nd year, 2 one-month placements in rural remote community, paired with a doc, town less than 6000 pop. Must do LIC – 8 months in rural northern Ontario community. 60-70% of grads return to those northern rural settings. Program puts a big emphasis on FM. Some students frustrated about not being able to explore other specialties and areas of interest, but match rate still good to specialties other than FM. UofT – historically lower proportion match to FM than other ON universities. Now all second yr students must do a Family Med Longitudinal Experience, have to shadow once every 2-3 weeks for 4 months in GTA. Great for mentorship opportunity. Large class, 261 students, but large catchment in GTA for matching to preceptors so available preceptors not a limiting factor. Have a FM observership elective week in the summer, it is a one week exposure program, matched with 3 different doctors for shadowing, and then rural day in Alliston, ON. Gives lots of exposure to the +1 options in FM with this elective. This is a Pre clerkship in summer of first or second year. Mentors ++ impt, but many tutorial sessions run by specialists, interest in increasing exposure to teaching with docs that are FPs.

What have sparked your interest in pursuing FM?

-Dal – “shadow a physician day” on 1 st day of med school. Many shadow FMs, and some find this inspiring. Some students have clinical skills preceptors who are family docs. It’s great to have early exposure to family physicians who are teachers and can share their expertise with students. Shows students that FPs are specialists in their field.

-Manitoba – emphasis on rural family med. High demand in that region. Students prefer to work in rural rather than urban electives experiences, state they are having better experiences in rural electives. In med 1 have a 1 week rural week, great because the FMs in those areas had specialized practices (anesthesia, obs/gyne, etc) and it showed students that FM has more opportunities to expand practice and include your interests than you would think. In the rural setting, students thought they were being exposed to a greater variety of cases (vs. in urban, more routine clinic appointments, sore throat etc). Also when you are a student in a rural

community you have more learning opportunities (fewer learners present). Students state “I would not do FM if it was not in a rural setting”

Memorial – Many students there also prefer to do rural. High match to FM, 40-60%. People like the variety options to include in their FM practice (hospitalists, obstetrics, etc).

U of C – Funding from the gov to help do 2-3 day electives in rural communities (\$200/student for travel), but the preceptors are not great (“wont let me do anything,” some would not allow patient interaction only simulations etc) so they had a bad experience and it turned them off FM. The university is now paying preceptors for their services, so maybe more interested in pay than teaching? Very imp't to have GOOD teachers providing good experiences.

Any final thoughts on ways to increase exposure to FM?

-term “family doctor” doesn’t really explain the breadth of what the specialty entails, doesn’t sound as exciting and interesting as the way other specialties are presented

-Dal – in elective student states she saw that there were a lot of extra learning programs in family med and additional training you can access (allergist specialty, etc). Students generally are not aware of the versatility of FM and do not know how you can alter your practice to suit your interests and passions

-MUN - “what can one Family doc do?” – exposure nights to show FPs who have unique practices, highlights the versatility of FM to students early. Idea of rebranding the +1 and additional training as more like fellowships

-positive shadowing experiences are critical. Also seeing variety in the doctor your shadowing practice. This highlights the breadth of FM practice (ie students do not feel very interested and engaged if they are just doing BPs all day)

-Increasing exposure to pre-med undergrads? They would get the positive impression early, when extremely keen and most impressionable. Many first-year students already have an idea of what they see themselves doing. **The window between acceptance to med school and starting classes would be a great time to have shadowing opportunities! FMIGs and department of FM can help create opportunities.

Suggestions for CFPC?

-facelift for FM, exposing people (general public and HCPs) to the breadth of the specialty. All the things they do, etc. FM profile would be helpful for this.

Session B:

Do you believe you have adequate exposure to FM in your program?

-MUN – Mostly rural experience, lots of breadth, but do not get to see what FMs do in urban settings. Would like to see more about FMs doing hospitalist work, etc. Two 2-week FM placements in first year, and then a 8-wk rural setting for clerkship.

-MUN Family Med electives- you rotate to different communities and work with dif FMs, so it is great exposure. Many opportunities to form mentorship opportunities.

-Dal – one rural week in 1 st year, many matched with specialists – this is a missed opportunity for FM exposure. Not many FPs teaching/facilitating clinical skills sessions, tutorials, or lectures. Students are not seeing FPs in position of teaching authority. As FPs are not filling tutors roles, student are getting the opportunity to talk to them and learn about their lifestyle/practice, it make

is more difficult to form early mentor relationships early. Experience early in med school are formative for students, helps them visualise what they see themselves doing for their career. A potential barrier to increasing FPs in classroom setting is that it is challenging for them to get away from practice to do teaching vs. easier for specialists.

-Calgary – lots of exposure early to rural and urban FM in elective. Hardly any exposure to FM in the lecture hall. Many students state “I want to be a specialist, but maybe I will just do family instead.” Culture of FM as a back up

-Quebec -Laval – only specialist model is taught in lectures. It would be helpful to have more family docs giving lectures, to show how FMs are specialist in their practice. This would provide more opportunity for students to look up to FPs (you look up to lecturers as experts in field). FPs currently teaching, but more ethical classes and soft skills (communication, etc). This model is not showing the breadth of family med practice. This program has little to no pre clerkship clinical exposure, they offer the opportunity to do observerships in FM though, and there was a tremendous response for student requesting these opportunities. Students had good experience with FPs

-Moncton – many FPs facilitate tutorial sessions. New program – students are matched up with a FP in first year to shadow the FP on a regular basis. Always told to put FM as a “backup” for carms by the program. The program has high match rates, but many end up matching to FM in carms as it was selected as a back up. Culture shift needed to promote family medicine in school. Student initiatives (FMIG) impt for exposure in med school at that site.

-McGill – they have the exposure early, they have a mandatory longitudinal FM program. You are with the same person for the whole program. Thus if you had a preceptor you did not work well with, you are stuck with them and it makes it a bad experience. Having to match up preceptors for this longitudinal program makes it difficult to find preceptors for other transition programs later in med school, not enough docs to go around in the 1hr driving radius of school.

-It is important to have elective experiences where you actually get to do things, but that you are well supervised and supported so that you have a good immersive experience.

-Calgary-reporting practice on observership/elective/clerkship experiences, for student feedback are not streamlined, each feedback system is siloed, thus if there is a bad preceptor the school may not be aware and they keep matching students with them.

-MUN – Student spoke of the impact of hearing a physician (specialist) say “the smartest ppl in your class should be entering FM” because you need to have such a large knowledge base and know when to refer patients. This helps address the stigma of FM being “just family”, or a back up.

-Clinical tutorial cases – some have the narrative that the FP did not manage the illness properly or missed something, and then the pt went to hospital and into specialist care. Shows specialists as “the heroes”

-should be more of a focus that FM is a Specialty

-there is the idea that specialist make more money, and thus they are more prestigious doctors and more knowledgeable. It would be good to show students that there are pay structures that pay FMs a great salary, comparable to or greater than some specialists. There should also be a focus on the lifestyle opportunities FM provides.

-when you see the graphs presented of physician salaries, they always just have one bar representing FM, but there is such a variety of different practices and payment plans. Perhaps they could break it up to show the variety of FM practices (rural vs urban?, FFS vs APP? etc).

-Stigma also comes from outside medicine. Pts may have a bad experience with their family doc prior to seeing a specialist. Once they see the specialist, they are correctly diagnosed and treated. These are the types of stories people share with their friends and family, you are more likely to talk about the negative experience you had with a doctor than the positive ones.

What can the CFPC do to promote the speciality?

-communication to public - should promote that FPs are gatekeepers, and you need them to recognise your health needs and then refer to specialists and that this is an important clinical skill. They should also focus on promoting the doc/pt longitudinal relationship, and that the family doc is important in managing care throughout life.

-would like to see college promote the fact that there are many salary options now, not just fee for service.

A Focus on Physician Health and Wellness & Gender Equity in Medicine
Canadian Medical Association (CMA)
Chris Simon with Victor Do

Session A

Session Attendees: 12

Discussion:

- Overview of the CMA work in the field of health and wellness. Wellness ambassadors, physician health conference work, survey, policy on physician health. Give funding for the STRIVE program, help RDoC with resilience curriculum
- Gender equity area: new in that more people are now making this a major topic for discussion. Beginning to work with FWIC on position statement, CMA is newer in terms of getting into the discussion areas.
- Start some of the discussion
- This discussion is much more than the “programming aspect of things”....its about the learning and working environment.

Questions:

Prominent challenges in the individual and organization/systems levels:

- Lack of sleep?....is it actual number of sleep hours or is it more so fatigue....maybe a bit of both, it is amount of work hours, generalized fatigue, related to call hours etc.
- Institutional problem: schools preach wellness, give some “programming” solutions, are we looking at the parts of curriculum that are causing stress and burnout, scheduling etc. Sometimes the programs even cause additional issues for us.
- Example from school: week before exam, have a bunch of meetings with different faculty advisors etc to find out how are you doing and so they are often directed towards exams

and the end goal instead of being strategic. Often we see administrators implement their supports in an ineffective manner.

- This is where advocacy training can come in and discuss about how to do this in an effective manner (Implementation)
- Short term wellness vs long term wellness. Strategies and skills for the long run vs the skill development and things.
- New studies consider resilience interventions along with the organizational interventions, and considering the “buy-in” aspect of things...if you see organization trying to make things better than you can also feel more willing to want to make the efforts
- Transition points between undergrad and medical school and then the different stages of medical training.
- Those who come from diverse backgrounds, people are not being accommodated to.
- Imposter syndrome
- Big sister, big brother and the mentorship between the years can help with stress levels and the transitioning point
- Transition block is really good in helping the transition, in terms of how to write notes, normalizing the different struggles that people have.
- How about a pre-residency prep

Gender Equity: most prominent issues in medical training

- Parenting in medical school, affects females more, do we have accommodations for the challenges around parenthood.
- Sometimes some subtle mistreatment/ignoring female students vs male colleagues, don't feel comfortable and feel that you have to act differently than the male students.
- Happens even between classmates; men expected to do more surgery/internal medicine and whenever a female said that they want to do surgery, they are treated differently in saying that “oh that's so great” that you are doing that.
- societal/organizational expectations that reward certain poor behaviours
- What needs to change: a lot of it comes from mirroring behaviour, an ingrained culture, maybe you actually need to start with students and a different level of things
- Top down, bottom up and meet in the middle
- Even public treat medical trainees differently based on their demographics, also need to create safe spaces in the clinical environment, might need to “call out” patients and really make things a safe space.
- Culture of knowing its not o.k. But we didn't expressly call it out...next challenge is the bystander intervention as well...if you see something happening, what role can you play in trying to call things out and make it better.

Session B

Discussion:

- Introduction

- Challenges that students face from a H&W perspective. Wellness is a really touchy “buzz” word, often applied to meet exercise, vegetables, doesn’t leave people the opportunity to explore and do things that mean wellness to them.
- There is also the difference between cultural and interprofessional barriers, individual vs organizational challenges as well
- Senior leadership understanding of student mistreatment, saying things are not so bad.
- Cultural barriers to accessing some of the supports for mental health
- Burnout, sometimes the perspective can be that if you take personal leave you are just putting a burden on other people, major challenge is that you are seen as “not tough enough”...”exaggerated sense of responsibility”, fear of letting others down, very common fear. One of the things is
- Culture of self-induced anxiety and things, people are pushing themselves to attend class even when they are very sick, culture is starting very early. See this in a lot of high performance issues, you don’t want to see yourself as being the first one to blink
- Often we don’t talk about our struggles because it is often taboo, it makes things even worse and people get the things bottled in
- Solutions: would be great to build skills, resilience etc, but people often don’t use these until there are issues, so how do we bring about a proactive culture
- The idea of hidden curriculum, people changing behaviours to comply with thought process in medicine again happens early, this needs to be called out and exposed very early.

Gender Equity piece:

- Q: what is the CMA doing with respect to equality in terms of leadership positions etc. Dr. Gigi Osler, new CMA president really prioritizing this.
- Just in last month collaborating with FWIC, to create a broad position statement etc
- Mat leave and the discussion around gender equity in medicine. Next generation needs to be willing to buck the trend and be willing to change culture and we have to take a stand.
- Along those lines what role do we have in supporting those who make those changes. People need to be aware of the different challenges that everyone has.
- Normalizing the idea that if there is poor behaviour, we do have to call it out as wrong.
- Power imbalance is a major factor for this as well with respect to student imbalance as well.
- Sensitivity training: there is a lot of ignorance around different stereotypes and these things extend beyond just gender.
- Create learning opportunities from different events.
- Professional hazing and other instances of mistreatment there are often challenges for people to report these instances and we really need to protect them when they do it....there needs to be the psychological safety. Myth busting around what happens if you report someone.
- Wellness and gender equity
- During the transition period are there things around hidden curriculum, how to prepare to be a clerk.

- OSCE around mistreatment... "how would you report etc."

New Opportunities for Medical Student Financial Wellness

MD Financial Management (MDFM)

Alison Forestell & Mike Greb with Lauren Griggs

Session A

Discussion:

- MDFM and promise to students/residents with sale to Scotia
- Affinity agreement (how CMA and MD will continue to work together)
 - No investable assets are needed for students to get advice, provide content/information sessions/financial literacy
 - Students: Managing debt, TFSA, how to pay for medical school, insurance, preparing for residencies
 - Residents: consolidating student debt, paying down debt vs. investments, buying a house, etc.
- LOC - discussions on how to make it best for students
- Products and services committed to students, trying to help limit financial stress, tools that are helpful to students
- OnBoard MD - tool/website that consolidates a lot of the questions medical students have
 - Interviewing medical students to figure out what the big problems are, develop solution, get feedback from the students
 - Aggregates info that is available on many other websites; "one stop shop"
 - Speciality navigator

Questions:

- OnBoard MD - What is in for MD?
 - Intertwined with finances; OnBoard MD can point students toward MD, and hopefully you'll start asking about finances and then they can ask about finances
 - Your financial health affects your overall health; if we can help cover off some of those things, that helps you in the long run
 - Can make a difference in the medical community
- At McGill, faculty invites MD to talk; with moving to Scotia, how will they change
 - OnBoard MD - talks will be available in bite sized pieces, accessible at students convenience
 - Talking to schools, trying to figure out best way forward -> connection with CMA, can take off logo if they do come into schools
- Timeline of financial decisions, are there resources for that?
 - Working on that currently, hasn't been put on OnBoard MD yet, would be mostly guidelines and help you figure out questions to ask; very personal, hopefully push you towards an MD advisor who can individualize it

- New products that MD should be thinking about for students?
 - Timing of financial vehicles
-

Session B

Discussion:

- MDFM and promise to students/residents with sale to Scotia
- Affinity agreement (how CMA and MD will continue to work together)
 - No investable assets are needed for students to get advice, provide content/information sessions/financial literacy
 - Students: Managing debt, TFSA, how to pay for medical school, insurance, preparing for residencies
 - Residents: consolidating student debt, paying down debt vs. investments, buying a house, etc.
- Commitment to what we already do right now and continuing that
- Changing of offerings because now they're with Scotia
 - LOC - repayment for LOCs especially when students go unmatched
 - Mortgages - don't offer them, on radar and talking with Scotia so they can offer them
- OnBoard MD - tool/website that consolidates a lot of the questions medical students have
 - Interviewing medical students to figure out what the big problems are, develop solution, get feedback from the students and if they like it, gets put on the website
 - Aggregates info that is available on many other websites; "one stop shop"
 - Journey; Speciality navigator

Questions

- Looking at how to pay and manage money once you transition into practice
 - Can link to many different partners if the advisor can't help
 - Transition points -> MD really trying to understand transition points and helping students and residents through that
- OnBoard MD and updating it
 - New tools popping up once a month, adding to existing tools, etc. Trying to keep everything up to date and adding information as they get it
- Students are worried about being pushed to buy Scotia products, now that they're a subsidiary of Scotia
 - Not going to be pushed to buy Scotia products, will try to be unbiased, can still come for advice regardless of if you own Scotia products or not; more options to sell to students
- New products/What can MD add to their portfolio?
 - Would love tool for comparisons of LOCs/insurance (DI/life)
- Why did CMA sell MD

- MD didn't know about sale; CMA wants to focus on advocacy, not a core focus of business
- MD didn't have the options you'd have with a bank; innovative products, while still remaining focused on physicians
- Mostly around refocusing for both CMA and MD

Electives Diversification

Association of Faculties of Medicine of Canada (AFMC)

Dr. Beth-Ann Cummings with Maylynn Ding & Dr. Kaylynn Purdy

No attendance due to such large number of people at this group for both sessions, would use too much time for attendance

Session A

Discussion:

- Dr. Cummings: Here to talk about why the Deans would like to move towards an
 - “Statement: Electives cannot exceed more than 8 weeks in a given entry discipline”
 - Beginning with the class of 21
 - Previously there was a statement that said you had to do 3 different elective disciplines, but that was not enforced, and not equitable between schools that had greater numbers of elective weeks. There was concern from post-grad that they were going to be expected a large number of electives in one discipline.
 - Want to try remove the expectation to do multiple electives in one discipline in order to match
 - We did not want to lump too many things into one discipline, which is why we went with entry routes
 - This part of a bigger process nationally to try address the mismatch between student profiles and interest.
- Ailish, Queens: Can you define an entry route
 - Dr. Cummings: Anything that you can apply to in the R1 match. By doing subspecialty electives it doesn't necessarily broaden your profile
 - Student: But a student that wants to do internal, it could actually hinder your career exploration
- Dax Moncton: How is this going to be enforced
 - Dr. C: Each school has to individual figure out how they are going to track it.
- Rae Queens: How does this apply to Pediatric cardiology or Emergency:
 - Dr. C: Peds cardio would be internal medicine, as is emergency
 - Research at McGill is counted as part of the discipline you are doing research in. No clear point on this yet
- ?Grace UofT: Some schools do prefer students to have done electives at their school. Do you think schools will change their ways?

- Dr. C: Post-grad is going to have to change the way they do things, it will be a loss for the way they do things.... (incomplete minutes for 1 minute)
- ?Adam Ottawa: The actual number our students took issue with actual number as we only have 10 weeks of electives. There is going to be change in how they evaluate files, but how will I ensure that they prepare for the change in how they evaluate files:
 - Dr. C: Although the AFMC board has not weighed into this proposal officially yet, they have a large influence over their post-grad deans. Only having done a lot of electives in 1 discipline, it doesn't make for a strong resident, Big deans will need to discourage their program directors from selecting this way. Trying to give post-grad a way to assess this, BPAS is one such document, and post-grad is having to report back to what they are doing with moving BPAS criteria forward.
- Ray Queens: Will there be an exception for uCMGs on the electives cap?
 - Dr. C: The intent was for the elective cap to still apply, so if they have done 8 weeks in internal in 4th year, they won't be able to do anymore in their 5th year.
- Dr. C: We are bringing this back at our meeting in October, and we want to give post-grad the time to respond and communicate what they plan to do.

Session B

Discussion:

Dr. Cummings: Intro by Dr. Cummings, and opening statement as per session A

Ume programs recognise their dual responsibility.....while recognizing their ability to engage in an increasingly competitive match....cannot exceed 8 weeks in any single entry discipline.

Already a national agreement that students should do a minimum of 3 different disciplines, but each school defines disciplines differently. Currently 30 different entry disciplines at carms, seemed like the most fair way to every possible entry route. Wanted to try to reduce the economic burden, and reduce the number of equities between different total number weeks of electives. This is one of the things as UME deans we have control over for BPAS, and we can push the post-grad programs to react and longer do what they would be doing.

- ? Aran Uofa: Peds is one entry level, but all the subspecialties are very different
- Dr. C: Everything counts under 1 entry route for Peds, you also have subspecialties for Gen Surg such as trauma or colorectal, if you start bending the rules for one, it becomes messy. It doesn't mean that entry routes is the right answer
- Avri Lynn Queens: Current discussions at AFMC on how to hold schools accountable to ensure that they are following the rules
- Dr. C: Its up to each curriculum committee to approve it, and how the monitoring is done will depend on each schools indFull Motion: "BIRT that the CFMS GA approve a contingency allocation of \$35,000 dollars for wellness survey closeout; BIFRT the CFMS use these funds to terminate the contract. BIFRT CFMS provides a progress update at SGM 2019, and presents the formal report by AGM 2019, including history and timeline of the Wellness survey, why it was not conducted to term, methodological weakness in

current CFMS wellness research and initiatives, and recommendations and action plans for future research/projects.

Moved by Victor Do (Western Rep); Seconded by Lauren Griggs (VP Finance); Motion unanimously Passed

Individual monitoring. It has to be 17 schools or 0, so we needed buy in from all the schools. It becomes up to the curriculum committees to approve it after, post-grad has a responsibility to explain to their program directors what it applications will start to look like.

- Katie Nosm: Many thoughts at NOSM, we do a longitudinal clerkship, and we only get 4 week cores, and limited exposure through core curriculum. Concern that differences in curriculums, and that we have less exposures.
- Dr. C: Exposures are a little bit different exposure from school to schools. Post-grad doesn't look at difference in curriculums, they do look at electives. All the curricula are fairly generalist focused. Most schools don't report what subspecialities students have done, the core-curricula are generalist focused across the country. Curriculum committees should have ways to add in needs
- Andy UofT: For competitive specialities they bar might be lowered, maybe more people would be drawn to toss in their application. The competitiveness of "problem disciplines" went up and back up rates when up, and unmatched rate was really high. Questions the efficacy of elective diversification policy in the match.
- Dr. C: Students are felt not to be competitive for their back up because they didn't have a profile that speaks to any parallel plan. All changes have unintended consequences. If you are doing more disciplines, if won't ruin your profile for one discipline, but will give you a better back up plan. Not everyone will have an aptitude even if they have the will, students feel boxed in because they feel they have to put their eggs all in one basket. Programs can't expect more than 8 weeks
- Kevin U of S: Will schools be changing their requirements to get an interview.
- Dr. C: We will be giving post-grad a sample of what student profiles will now look like. Many students can't afford to get across the country for electives or interviews, so you are most likely going to do your electives in your first choice discipline in a place you are considering.
- Ashley McMaster: There is a huge pressure to put all your eggs in one basket, how are you going support students in the class of 2019/20
- Dr. C: Lots of discussions at national tables about uCMG supports, more career guidance and helping unmatched students. BPAS that aims to help programs be more transparent in selection, which makes it hard for students but also for a career advising. This is one piece in a massive jigsaw puzzle,

- Nabir McMaster: Decision around 8 weeks of electives before carms, why 8 weeks? Why not lower or higher, and is an individual school considered in this?
- Dr. C: I don't think that this proposal will solve everything, and it's better than what we have now, didn't want to go lower than 8 weeks, a schools with 20 or 24 weeks will not have sufficient electives to offer to students, the more you reduce the number of elective weeks, the more you reduce the number of electives that can be offered.

Addressing CaRMS Applicant Uncertainty
Canadian Residency Matching Service (CaRMS)
John Gallinger & Ryan Kelly with Cory Lefebvre & Dr. Franco Rizzuti

Session A

Discussion:

- John: opportunity for CaRMS to share some new things and receive feedback. Strategy is to make things easier for everyone in the Match process (students and faculty). Try to remove uncertainty of the match process. Give an update, get some feedback and guidance.
- Ryan: shifting organizationally to look through the students' perspectives and less from the CaRMS perspective. First pass to collect data from the clients about uncertainty in the process. Did you have enough information to tackle issues. Survey went out this year - first year. Incoming students into the match and outgoing residents (those who recently completed the match). Distributed student affairs leadership across the country. (Parallel initiative) Survey results: (Over 1000 respondents)
 - Top 5 areas aligned across groups. Same gaps felt by most people
 - Higher level of uncertainty among french medical students (37/39 questions were flagged for French vs 19 questions for English medical students)
 - Some uncertainty around whether or not the match process is completed
 - Developed help center (place to seek information) where the website more for broad overview. Social media channels are more about timelines and deadlines than to answer questions
 - Top 5 areas of uncertainty:
 - Lack unmatched student feedback
 - Evaluation of application elements
 - Deferral of match year
 - Provincial differences in employment contracts
 - Presentation of information to programs during file review
- Zach (NOSM): student affairs department had a lot of uncertainty and they advise students. How will CaRMS address?
 - Ryan: they provided answers in how they perceive medical students feeling regarding uncertainty.
- Ben (NOSM): student affairs answered how students felt?

- Ryan: Yes. Added the student affairs branch because we can feel that we can address the gap along with how student felt. It's about
- Amir (Mac): Data is still out there. Are resources not distributed efficiently or actual gaps?
 - Ryan: I'm not sure that the information isn't distributed. Think there's a disconnect between what students seek out and what we passively provide. CaRMS can send information ad nauseum but it's easy to look over the emails in the inbox. Students are busy individuals. Develop a spot where to go. CaRMS developed help center for one-stop place for students to go for if they have a question. Makes it easier for students to find information rather than sift through multiple emails
 - John: part of the challenge and feedback needed. What's the best way to provide the information? Some are time-sensitive while more may be curiosity-driven. What are the best channels? What are the best timing? What's the best place to find the information? Want to make more transparent for the process
- Avri Lynn (Queens): Did you get representation from every school?
 - Ryan: distributed broadly and respondents from every school. Kept it aggregated to maintain validity. Rates were different compared to english cohort (more respondents but bigger pool of student). Small exercise to provide some direction for CaRMs. Focus on the top priorities than focus on everything
- Ryan: How do you best consume information? Would we be more effective at filling this application? This isn't happening to confirm. An idea is that a large time window may contribute to information overload and confusion around. What's the best way to communicate?
 - Theo (Western): Email fatigue. Having a place where students can access would be better. Emails should be sent in a way to redirect students to the necessary forum. Maybe work with the student affairs deans so that they can talk with their final year students about the CaRMS process.
 - Ryan: We do a school presentation every year. Usually takes place in spring. They've been recorded. Do students forget that this resource exist. It's different between listening to a lecture and watching a 1.5 hour video online
 - Silvio (Western): Like the instructional videos. Mandatory half-sessions in clerks. Clerks are stressed about CaRMS and will attend. Working closely with Student Affairs and Clerkship coordinators. Unsure how many people will watch videos online.
 - Anastasia (ottawa): just heard the talk. Very helpful and broke down the process very well. But the information is as detailed and explained as well on the website. There's a way to collaborate with schools and get program descriptions out earlier?
 - Ryan: program descriptions does not change all that much from year-to-year. As to the number of positions, they don't get finalized until mid-october due to funding being sent to the schools. If a program is

registered in the match, then that program will be in the match.

Supporting program items rarely change from year-to-year

- John: knowing the timeline helps with understanding setting the quota

Session B

Discussion:

- Franco: Discussion of application experience and seeking feedback. Survey results presentation
- Andrew (UoA): As to unmatched applicants, can we have third or four iterations
 - Ryan: post-match process - not a match - programs can keep spots open and for applicants to seek out programs. Just not a lot uptake. Programs concerns that after two rounds, applicants may not be interested or they've been considered multiple times. This is hosted in the help centre and will be developed int
- Nathan (Calgary) - protecting cmgs in second round?
 - John: CaRMS isn't involved in policy, they provide data and numbers, but no opinions. This is up to schools, governments and policy makers
- Naomi (McMaster): Is the full list of questions on the website
 - Ryan: Can distribute to the leadership.
 - Naomi: how were questions chosen?
 - Ryan: worked with client service teams and looked through the questions that were coming in. Used that to inform questions asked (based on FAQ data)
- John: we regularly meet with learner organisations
- Ryan: how do we push support to students? Or how students can receive students?
3-month window and is a long process in applying to CaRMS
 - Julie (Alberta): Statement where is says URGENT or IMPORTANT in emails subject lines may flag emails to students.
 - John: It's less about deadlines, but more about addressing process questions and uncertainty. The channel, method, timing, etc
 - Wendy (calgary): Communicating with schools and admins to deliver the message of CaRMS to students. Sometimes students are redirected to website while others will show students the exact tab/page to seek out the information. Having a clear message upfront in career offices
 - Ryan: old practices for communications were to over communicate. But if you send so much information, its difficult to parse the important bits of information from the less important. Focused on tightening up the succinct of the message.
 - Eleanor (Alberta): Does CaRMS visit each school?
 - Ryan: every year we provide a spring presentation for the final year students and a presentation for pre-clerks on the same day. About 1.5 hour talk. Talks are recorded for future consumption which has impacted attendance. But it's not likely that students will watch over hour long videos
 - Eleanor (Alberta): When is the first time typical students will open an account?

- Ryan: match process opens first wednesday in September and students have access to make accounts
- Eleanor: interacting with the CarMS earlier may allow students to have a better understanding, but with the potential of CarMS being overfocused.
- Ryan: It's been thought about opening the process earlier. There's a push from some school student affairs to disconnect from CaRMS and education. There's a balance to opening up the accounts to learn
- Jas (UBC): are there FAQ or docs for students?
 - Ryan: Survey had a spot where respondents can ask more questions. Our hope is to have a doc/place where questions and answers are outlined.

International Exchanges and Ethical Learning
International Federation of Medical Student Associations (IFMSA)
Hilary Pearson & Michelle Quaye & Charlie Coleman with Sarah Zahabi

Session A

Discussion:

- Pre-departure training
 - Differences in robustness of training across the schools
 - UofA
 - 2 exchanges - IFMSA and UofA Field stations
 - 12 hour elective to go on exchange in GH - cultural safety, pitfalls, advocacy sessions, faculty experiences in the field
 - Can be filled by shadowing
 - Some interactive sessions
 - Some reflective work
 - UofC
 - Does not accept IFMSA exchanges
 - Western
 - Links to online resources + internal resource with ethics courses
 - Recommendations
 - No international selectives
 - 1 hour lecture that is student run
 - McGill
 - All health programs have to do pre-departure online course (4-hour module)
 - Security, cultural safety, ethics of travelling to low and middle income countries
 - IFMSA-Qc
 - 3.5 hour in person training
 - 1-2 hours of lecture

- 1 hour video
- Mandatory to go on exchange
- McMaster
 - 4-6 hours of pre-departure training run by the GH office
 - Feedback: general and not context specific
 - Not useful suggestions for specific cultural context
- UOttawa
 - Similar to McMaster
 - Mandatory GH sessions but only 3-4x per year, very general
 - Faculty run
 - Optional student-run
- UBC
 - Other GH programs in parallel with IFMSA exchanges
 - Robust programs specific to location
 - Optional courses
 - 1 single evening of general pre-departure training
- Queen's
 - Faculty run
 - All healthcare professionals
 - Preparing for volunteering and not so much shadowing
- UofC
 - Calgary accepts students but does not send people of IFMSA exchanges
 - Members do not know about them, lack of knowledge in general
 - Long-standing partnerships with other sites and preceptors go as well
 - Many incentives to do it through UofC
 - Contracts are organized in the summer and timing of breaks in 3 year programs can also be a deterrent
 - Especially since it is used as a mandatory component for the program
- McMaster
 - Students do go on IFMSA exchanges
 - Do not have as much support at our actual school in terms of sending students
 - Ireland and Australia are the bulk of exchanges offered by Faculty
 - Students go to IFMSA to seek out other opportunities
- Action items:
 - Mentorship buddy system with someone who went to a similar location the year before
 - Feedback currently is not robust but is available
 - Feedback while on exchange could be explored
 - Timing of the email is a factor for feedback

- Pre-departure training passport
 - Language course
 - Reading about the culture
- Syllabus for what topics should be covered and then each school makes their own course that addresses
- Either or option
- List of what needs to be covered and then create training for schools that do not have any support
- Checklist
- LEOs could be spearheading a Toolkit
 - Buddy system
 - Better quality feedback that is context specific
 - Useful and interesting for participants
- Ethics of unilateral exchanges
 - Problems with certain schools sending a lot of students to one country and that country not being able to send students back due to our lack of accommodation
 - Problematic that we are using up educational opportunities better used by locals and then not accommodating students here

Session B

Discussion:

- Pre-departure training model
 - Currently school-specific
 - Many have faculty run program that is mandatory and or optional student run training
 - Checklist of what recommended pre-departure training would include is an idea that was presented
 - UofT
 - No pre-departure training
 - We have non specific safety abroad training
 - Country-specific training is what the literature encourages
 - UofT will never offer this
 - The exchanges are not sanctioned
 - They worry about liability if offered
 - Exchanges generate a lot of revenue
 - We could use these funds to make sure that students are not going to have a party but rather to learn from highly skilled physicians
 - Gap in our system about GH ethics
 - Students think they can contribute and they are not thinking about the direct use of resources

- CFMS could create a module
 - Fix this
 - Clinical exchanges
 - Research exchanges need to be at least 10 weeks
 - Proposal
 - Partnered with organization that does this work
 - Country-specific pre-departure training
 - For all countries
 - UofT
 - Putting together their own GH exchanges at the expense of the university
 - Research focused
 - Both student and physician have put in a proposal
 - Goal: make it less self-serving
 - UofA
 - GHs partner with direct of GH and develop a curriculum in partnership with them and provide the pre-departure training
 - Country-specific aspect is important to include
 - Student-led country-specific
 - With checklist
 - Buddy system
 - Better than what we have now
 - There is literature out there and it already exists
 - We don't need to reinvent the wheel
 - We can just go out and provide it for student and it is more legitimate
 - The student might inadvertently hurt the host country if they are not well prepared
 - There is also upon arrival training that is offered by some countries
- Passport model
 - Use whatever resources are available in your school
 - Fulfilling those criteria
 - Leaving space for personal student driven
 - Language, history
 - Suggestions of what could be done to fill those hours
 - How to track that
- Ethics of unilateral exchanges
 - Bilateral = people switching places in a country (not necessarily at the same time)
 - Unilateral = Canada going to another country
 - Those are offered to us by other countries
 - We use the fee from that to provide opportunities for the exchange student going to that country

- In the clinical exchanges we have 40 bilaterals and just under 70 unilaterals
 - Countries coming to us offering
 - You pay as a unilateral to that host country
- In Canada
 - In-coming students are considered 4th year elective students
 - That is where they fit into our system
 - In other countries it is a very different student
 - I found this preceptor and they are willing to take a student therefore we send a student there
 - Each country has their own way of regulating their system
 - Not necessarily competing with other students as it is in our system
 - Very different for each country
 - We take student feedback and ranking and those are the ones we are going to offer more of, quality of education, English-speaking, negotiating with the NEOs
 - Giant fair at the IFMSA and work through contracts with them
 - There are organizational boundaries to consider
 - Australia is like us and they only take 4th year students
 - Is it possible to take on a shadowing position?
 - Exchanges going out, they are almost all completely shadowing
 - Longer programs in other countries
 - We cannot pursue independent preceptors
 - It undermines each university's system for recruiting preceptors
 - We can't betray those relationships
 - It is just part of the way that whole system runs
- Should we limit our unilateral?
 - We would not be able to replace them
 - If it is not done ethically, then it should not be done at all
 - We are not willing to accept students from another country and yet we are pushing students on these other countries
 - We are not necessarily pushing, these are opportunities that are available and they have said that they have space for these students to come
 - We have decided to provide these opportunities
 - They have these spots open for all countries not just Canada
 - If you want to host Canadian students we have lots of people who would love to come but we have limited bilateral spots

- It is a transparent process to the other countries
- They offer these contracts and want students to come
- How are these contracts negotiated?
 - How do we hold parties in that agreement accountable and responsible
 - There are codes of conduct in terms of the student, local group, national group, in terms of how its all run
 - We are attempting to harmonize the world using students, we have our structure in how it should be and then people in operate in however their system works
 - Contracts are negotiated differently for each country
 - There are suspensions of contracts as an accountability measure
 - Is there transparency around that?
 - It is on the IFMSA website
 - Each country has their own page
- Being accepted on exchange
 - Not enough follow up throughout the whole process
 - How can this system be streamlined and standardized
 - Lag period between the acceptance and the approval
 - Update on the website
 - 2 weeks before exchange that it is confirmed
 - Variation between when pre-departure trainings are
 - Once you are accepted, here are the next steps you can expect
 - These are the months you can expect it
 - For this step there is variation
 - This is your contact person
- Action item:
 - Committee for unilateral ethics
 - Consider the pros and cons
 - Formal rigorous evaluation

Impact of the uCMG Crisis on the Transition to Residency

Resident Doctors of Canada (RDoC)

Dr. Emily Stewart with Dr. Henry Annan

Session A

Discussion:

- Henry Annan introduced Dr. Emily Stewart as the Vice-President of RDoC.

- Dr. Stewart: Resident Doctors of Canada is national representative body of Canadian residents. When it comes to uCMGs in particular, although they are not technically RDoC members, RDoC does sit at many of the tables where these discussions are had and advocates on these issues in that way. Specifically, we advocate for career planning, learner privacy and financial planning. With regards to learner privacy, one of the things RDoC pushed for was for an opt-in consent process for data sharing between CaRMS and the AFMC. We are also very active in the resiliency space, which is very pertinent to uCMGs. We adapted the Road to Mental Readiness curriculum towards one for medical residents. We have also prototyped an app which will be coming out shortly. We recognize that mental health is not a solo endeavor and that it can be the result of stressful environments. We are also doing a lot of work to change the culture of intimidation.
- Devon Mitchell, UBC: Do you collect residency wellness information for incoming residents?
 - Dr. Stewart: No. Our National Resident Survey is conducted every 2 years. We try to avoid doing too many surveys for fear of survey fatigue amongst our members. Some of our provincial housestaff organizations do conduct such surveys. Interestingly, however, from our data, 75% of residents have reported being victims of intimidation and harassment. Ninety percent of this intimidation is verbal and 71% is from patients. This is the leading source of intimidation with the second most common being from allied health professionals.
- Liang Chen, McGill: Can you comment on RDoC's response to the Saudi Trade Action announcement and whether you see this as an opportunity to advocate for more residency positions?
 - Dr. Stewart: RDoC did put out a statement, however, as you can imagine there are a lot of different ways to approach advocacy in this regard. This was a huge deal. From CFMS perspective, certainly residency positions for uCMGs would be one way to look at it. However, Canadians studying abroad also felt that the open seats should go to them. And obviously, the Saudi residents also wanted advocacy to focus on them staying. RDoC was especially concerned about how this would affect call requirements for current residents. At the end of the day, the truth is we should have never got to this point as a country. RDoC was trying to push organizations to ask themselves the question, "How did we get here?" We know Ontario and Quebec were hit especially hard by the announcement. Our current process as it pertains to Saudi residents is a unique solution to a problem we have in Canada. We need to fill the call roster but we do not have enough physician jobs. This is not sustainable. Our HHR should not be at the whim of a political crisis. We are currently discussing future direction as a board and am happy to chat with you more on this topic.
- Frank Battaglia, Ottawa: How do you think advocacy for more residency positions will impact physician jobs in Canada?

- Dr. Stewart: I think a lot of organizations are asking themselves the same question. RDoC really wants to be an expert at what residents want. We know as a country, we don't do good HHR planning.
- Dr. Damji: I lead the RDoC practice committee. We created the Physician Resource Planning Task Force and had representation from all the main organizations, looking at scopes of practice. We are hoping to be able to project HHR planning in Canada. The problem is provincial planning does not always translate to national planning. I think CFMS should be aware that this group exists. RDoC also has HHR principles and has an emphasis on generalism. We know that the current system does not optimize for this.
- Dr. Stewart: We are also looking at Entry Routes and having conversations about why entry routes are chosen the way that they are. Additionally, we are looking at national portable licensure. We know this will take a lot of time, but physicians are not able to move between provinces. Thankfully there has been some pick-up in this endeavour.

Session B

Discussion:

- Henry Annan introduced Dr. Emily Stewart as the Vice-President of RDoC.
- Dr. Stewart: Resident Doctors of Canada is national representative body of Canadian residents. When it comes to uCMGs in particular, although they are not technically RDoC members, RDoC does sit at many of the tables where these discussions are had and advocates on these issues in that way. Specifically, we advocate for career planning, learner privacy and financial planning.
- Ben Cassidy, NOSM: Can you speak to the financial transition to residency?
 - Dr. Stewart: I can certainly speak to this personally. Resident Doctors of BC just put out a podcast on this issue actually. One thing we recommend is don't be afraid to put things on your Line of Credit. Many residents don't get paid for the first 3 months. We also encourage residents to "live like a resident" and to pick one splurge item. You don't have to live in poverty but also do not live like a staff. RDoC has financial literacy webinars on its website. We do not endorse one bank.
 - Dr. Damji: I also found resident guides from the Colleges of family medicine very helpful, even if you are not in family medicine.
- Dr. Stewart: RDoC is also doing a lot of work on resiliency and has a resiliency curriculum that we are excited to deliver to all residencies. We also developed an app. We also know that mental health is not only the responsibility of the resident, but actually mostly on the environment. Ninety-one percent of residents who report harassment, have been harassed by patients, followed by allied health professionals. We are also doing a lot of work on learner privacy. Taken the wrong way, personal information can go to the colleges. We are making sure consent processes are opt-in instead of opt-out.

Finally, I just wanted to add that although uCMGs are not RDoC members per se, we really put our support behind the CFMS.

- Ben Cassidy, NOSM: Can you comment on RDoC's response to the Saudi Trade Action announcement?
 - Dr. Stewart: Yes. RDoC did put out a statement and used it as an opportunity to highlight the work we do. We tried to make sure there was increase in call requirements for residents as a result. Moving forward, we are trying to push medical organizations that have benefited from the current Saudi arrangement to re-examine how we got here in the first place. It is unfortunate that we do not have a more robust system. We know that there is a mismatch between the call requirements and number of jobs and this is not sustainable. We must also recognize that there are different advocacy avenues on this topic.
- Ailish Valeriano, Queen's University: Is RDoC advocating for more residency positions?
 - Dr. Stewart: We looking especially hard at entry routes and whether the current number and system makes sense.
 - Dr. Damji: I lead the RDoC practice committee, which formed the Physician Resource Planning Task Force. There is lots of representation from major medical organization bodies. We are working on models to predict the oversupply of doctors. It is important for people to be aware that such a group exists. RDoC also has HHR principles.
 - Ailish Valeriano, Queen's University: Is this data available to us?
 - Dr. Damji: Not yet, but probably soon.
 - Dr. Stewart: We are also looking at innovative solutions such as a National Portable Locum Licensure. We know that many new-in-practice physicians would like to locum and the current system is a barrier for people to practice in rural communities for example. FMRAC has created a working group to look into this.

CFMS Board of Directors: Three-minute Thesis

- VP Student Affairs - Stephanie Smith
 - Restructuring funding to ensure as many students get awards
 - Wellness committee is turning into Wellness roundtable led by Dyad partner
 - Wellness committee will manage wellness program
 - New national officer of services and services committee - discounts, interview database, etc.
 - Restructured the program to ensure function
 - Thanks to Emily McPhail and Victor Do
- VP Education - Dr. Kaylynn Purdy
 - 1. Access to MedSKL.com for all CFMS Members (logon via CFMS website)
 - Jordan Ho and Anish Naidu = Medskl question bank

- 2. Addition of uCMG guide to the Matchbook:Linda Fei, Casey Wang, Illustrator: Nancy Duan
- 3. Establishment of uCMG Task Force and uCMG Mentorship Network led by Peter Farag from UofT
- 4. Medical student voting seats on the Royal College Fellowship Affairs and Regional Advisory Committees
- 6. CBME Medical Student Summit with sponsorship for 2 students from each Canadian Medical School to attend in Halifax – with plans to continue this in future years at CCME led by Silvio from western
- 7. Passing of Learner Information Sharing in Canadian Medical Schools guiding principles document at SGM 2018 – Nathan Rider
- 8. Establishment of a Research Committee lead by our NORs
- 9. Decreasing the opening of the elective window from 28 to 26 weeks starting Jan.9/2019, working towards a refund models, and working with the AFMC to ensure we can create elective policies that make sense. – Spearheaded by Maylynn
- 10. Additional Spots for uCMGs via the Canadian Armed Forces post-match
- 11. uCMG Federal MP Meetings at Parliament Hill to advocate for an increased ratio and better HHR planning led by Yipeng and Victoria
- VP Global Health - Chris Briggs
 - I would like to acknowledge the National Officers and dyad partner who stepped up when I took a temporary absence and did a great job.
 - This year with GHs has earmarked funding to create a pan-Canadian initiative
 - Sent 16 people to IFMSA in Montreal and hosted the post-GA - sent some people to Mont Tremblant, Quebec City, and Niagara/Toronto ← great thanks to Sarah and Lucy
- VP Government Affairs - Yipeng Ge
 - We held national day of action on indigenous mental wellness and health in Ottawa. Two LoIH Josh Nash and McQuellan? Speak to CBC
 - Assembly of First Nations
 - Physician resources planning and uCMG - all this can be found in the government affairs exec report. Including the federal budget
 - Highlight a few provincial/local lobby days:
 - Western Municipal Lobby Day successfully added naloxone
 - MUN - funding for mifygysemo
 - Sask - increased spending for youth and child mental health care
 - McMaster recently had lobby day to advocate for consumption sites
 - Revamping position paper process
 - Shoutout to Shanza Hashmi (NOHP), Linda Lam (NOPA) and Charles Yin, Amanda Sauve, past past NOIH, and Willow (NOIH)
- VP Communications - Christina Schweitzer
 - Not present.

Resolutions Session II

- No remaining resolutions

Q&A with Outgoing CFMS Board

- Ali Damji: You can send an email with your question to resolutions@cfms.org if you do not want to ask a question at the microphone
- Q: U of A: Commend work for uCMGs, ask for more information about future directions and information about the process of how it came about?
 - A: Yipeng: Second lobby day on inward facing issue was decided on by the previous VP GA, there was enough funding for 6 individuals to rep CFMS at those sessions. Students asked to look at ratio of medical students to residency spots and bring that issue up. Second was to look at evidence based tool when doing national planning and human resource planning. Third to discuss the uCMG issue and a federal/provincial-territorial meeting to bring up issues that are present across borders. Presidents roundtable contributed to that letter writing campaign. Sarah Zahabi, Sarah Silverberg, Henry, Maylynn were present. Document that was brought forward to federal government is available in the government affairs report.
 - What came of it: Health Canada, minister of health have received ask document, prominent members of cabinet have sent letters to the minister of health on this topic. They are aware of this issue, the complexity of the issue, and that they have a role to play. Haven't yet seen commitment to the asks so continued pressure is needed and continued relationship with those offices.
 - Follow-up Q: What's the plan to include other schools in the consultation process?
 - A: Yipeng: most recent consultation in June, another one is planned in a few months. Not sure what is on the agenda. Will send information on that to med socs so that it is representative of the country
 - Follow-up Q: Is there more effort to publicize the efforts? It is not well known by general members
 - A: Yipeng: There was a press release that is available and can be shared.
- Debbie from McMaster: Wellness program has changed and is now emphasizing inclusion. To you explain how that is going?
 - Stephanie U of C: At AGM last year it was questioned what are you doing for engagement beyond the wellness challenge? Worked with Victor Do to add in additional elements other than social media, increase access to other resources. Spread out over two month themes to allow a longer timeframe for more inclusion and different methods of interaction.

- Victor: Importantly the theme was about moving to a continuing campaign throughout the year because wellness is not a month. Wellness month still works well but not reaching all of our members.
- James from McGill: Reading Global health report was a compilation of the national officers report, what did the VP global health do in the leave of absence, conclusions and summary section was missing, would be good to know what occurred within the portfolio
 - A: Chris Briggs: Left out a few things from the report. Representation on committees as well as the IFMSA. Largely the role is coordination. Willing to review the document for format and add in the subjective conclusion that is proposed.
- Liang from McGill: Congratulations to executive board for this meeting. This meeting has been the most interactive meeting thus far.
- Chair: Last call for questions: no response, closed.
- Henry: VP Comms had a bit of a issue this morning, Henry wanted to thank the IT officers Pavel and Adel, on behalf of Christina. These guys do not sleep, they update the website, send emails. We are so so appreciative of everything that you do

Chair: Members of the board return to the seats, will do the MD financial award presentation now.

MD Financial Travel Awards

- Victoria: Introduction. Congratulations. Welcome to your first CFMS meeting. We'll do pictures too.
- Western Regional Winners
 - Julia Sawatzky Alberta
 - Gayathri Wewala, Alberta
- Ontario/Quebec Regional Winners
 - Adrina Zhong, Western University
 - Avri Lynn Ding, Queens University
 - Tina Binesh Marvasti, University of Toronto
- Atlantic Winner
 - Ryan Kelly, Memorial
- Wildcard Winners
 - Denisa Rusu, Western University
 - Aden Mah, Saskatchewan
- Let's acknowledge our winners and MDFM.

The Canadian Residency Matching Service

- Intro for John Gallinger, CaRMS CEO
- Will keep it to 10 minutes, this is not a full blown data presentation,

- Lots of places to get deep dive into how the applications work, processes work and match outcomes work. This is not what this talk is about. I want you to know how CaRMS works.
- Organizing construct of CARMS:
 - We have 10 members
 - Member-based organization
 - 4 members are learner organizations
 - FMEQ, CFMS, RDoC, FMRQ
 - They nominate 6 board of directors
 - When a member is nominated, they become a representative of CaRMS, not of your learner organization but you bring that perspective
 - Helps us make decisions and provide direction which is consistent with what matters to our learner clients
- We have 4 pillars that we draw on
 - Service - consistent service to rely on us
 - Client experience - when people come into the Match, it's their first time. We try to remove anxiety, uncertainty, and we try to make sure people have the info they need
 - Stewardship - things are fair, equitable, and safe for applicants AND programs. We run to respect those principles. Also financially, we provide value for money. We want to be around for the long time.
 - Relationships with clients and partners - we partner
 - Strategy: Strategy really is all about improvement, deciding what we need to focus on to get better.
- #1 Service excellence and continuous improvement
 - Never satisfied
 - From a match outcome perspective, we are focused on uCMG
 - Our role in that is that decision makers have the data that they need
 - We run various scenarios and provide them some feedback
- #2 Superior CARMS experience
 - Find the balance between giving you information when you need and how you need it
 - Not too soon, not too much
 - Balanced and relevant to what you need to do the important work you are doing
 - Lifelong career for many of you
- #3 Financial stewardship
 - Reducing fees
 - Not compromising the service
 - Value for money
 - Investing where it matters for clients
- #4 Supportive stakeholder relationships
- Closing

- What matters to you, matters to us
- Make contact as an applicant with our helpdesk
- Advocates and representatives and communicating what matters
- What I'd like to wish you all is good health, good learning and good fun in the years to come
- Q&A
 - System online struggles in the last few days prior to the deadline
 - Can we increase that capacity?
 - Avri Lynn Queens: Project on addressing applicant uncertainty, and will CaRMS be conducting a follow survey from the Q and A Session at Queens
 - JG: We are feeling comfortable about what is on that list, but you can send questions into us or to steph
 - Yipeng Ge uOttawa: Strategic theme 4, stakeholder relationships, and relationships with ministries of health provincially and federally. ? Agenda alignment and relationships
 - JG: Relationships with ministries mostly around making decisions to around Data, policy and eligibility. We can run a simulation. They are in the policy world as are the faculties, and we are data providers, they are not clients but stakeholders. Agenda alignment happens everytime we come together, and everytime I meet with people from other organizations, and decisions that are being made around the education continuum and what impact that may have on the match. CBME is now in the post grad world, there are questions in around what that means for timing and subspecialty matches.
 - Yipeng: What kind of relationship is fostered between provincial and territorial ministries.
 - JG: By in large adhoc, we get most of our info by a faculty, when there are multiple faculties in a province we need to be more coordinated, COFM in ontario. We look to both faculties and COFM to ensure the messages are synonymous, very little in the way of federal relationships, provinces are main, from an HHR respective we are becoming more active and interested in being a tables and we add value to these. We want to make data available
 - Kimberly McGill: Feedback after uCMG, feedback can help them be better prepared and provide closure. Is there space for CaRMS to work on this?
 - JG: How and in what form and how much are ongoing questions, no agreement to as what this would look like. Our role is if there is an appetite or a way to envision how to do it, we are happy to be a source of anonymized data. If there is way we would be happy to do that.
 - Andy UofT: BPAS. Is it within your role to have programs to have better accountability with selection policies?
 - JG: There is a working group right now. Kaylynn is on BPAS. We have identified 5 of the recommendations from BPAS that can be enabled from

the CARMS online application system. A lot of it is consistency with information. Certain information is required to be in a program description. WHAT IS THE criteria for do not rank. This could be enabled through the CARMS application. We only enforce what others want us to enforce. The PGME deans want a platform for things that they all agree are good e.g. whether a program requires you to do an elective on site. For you to be considered you have to do an elective on site is a requirement for some programs. We can and will do this if the PGME deans says that this is something that they want enforced. We have a lot of input. I am hoping that this year next time we will have some tangible changes in the CARMS online changes that will reflect the BPAS work.

- Maylynn McMaster: CCME there was talk of interview interface in CaRMS system and this could be a tool to see if interviews are only offered for on site electives
 - This is actively underway with FMEQ and RDoC are on this.
 - We have developed a portal that would do
 - Program has a place to indicate if people will be invited to an interview
 - That info is conveyed to applicants
 - Every applicant will be accounted for in some fashion
 - Invited or not invited
 - The idea is that this is a gate
 - If you don't have all your applicants identified on that portal then you cannot move forward to the next part of the process
 - We will have full dataset for all the applicants
 - Safe way for interviews other than emails
 - Applicants did not receive interview invitations a few years ago which created uncertainty and upset and this program should help this
 - They may well communicate via email but the system that we will offer will be an absolute location where people can find their information
 - There can be scheduling information via email
 - You will see the interview invite on the CARMS website but the timing and the response can be email communication - fail safe where you can always find exactly the status and can provide your response

CFMS Board Elections and Results

no minuting of election speeches or questions

announced at dinner

- VP Finance: Odell Tan (Saskatchewan)
- VP Communications: Victoria Januszkiewicz (MUN)
- Director Education: Maylynn Ding (McMaster)
- Director Government Affairs: Yipeng Ge (uOttawa)
- Director Student Affairs: Victor Do (Alberta)
- Director Global Health: Michelle Quaye (Western)
- Western Regional Directors (2):
 - Wendy Wang (Calgary)
 - Fatemeh Bakhtiari (Manitoba)
- Ontario Regional Directors (2):
 - Rishi Sharma (McMaster)
 - Debbie Grace (McMaster)
- Quebec Regional Director: Adel Arezki (McGill)
- Atlantic Regional Director: Dax Bourcier (Moncton)

Sunday, September 23, 2018

Welcome

- Roll Call:
 - All schools present except Queens and UBC
 - All Board of Directors members present
- Quorum is valid

Motion to destroy the electoral ballots and accept the election results as presented at dinner last evening (listed directly above).

Moved by: Odell Tan (Saskatchewan)

Seconded by: Cory Lefebvre (Western University)

Result: Motion PASSED.

Choosing Wisely Presentation

- Testing of app and codes
- Unnecessary care can be dangerous to patients and waste healthcare resources
- Unnecessary care Report - lot of data used by Choosing Wisely
- "More is not always better"
- Involving medical students is that we can start teaching these principles earlier -> makes intervention most effective
- Making list of therapies that are dangerous to the patient, based on speciality
- Quality assurance study showed 30% of tests are not helpful - uses healthcare dollars and exposes patient to unnecessary harm
- We also want to emphasize that Choosing Wisely is non-partisan campaign funded by neutral bodies - like Health Canada, CMA, PTMAs, etc.
- Medical Student Leadership
 - Don't suggest ordering the most invasive test or treatment before considering other less invasive options
 - Don't suggest a test, treatment, or procedure that will not change the patient's clinical course
- STARS (Student & Trainees Advocating for Resource Stewardship)
 - Implement more choosing wisely theory and best practices in curriculum changes
 - Student-led efforts
 - CWC interest groups (6 schools)
 - Curriculum changes (10 schools)
- Ottawa - survey for preclerkship: can students make cost conscious decision making -> many feel they aren't ready; many think it's important for their future career to be able to do this, should be mandatory teaching
- National Collaboration

- National Campaign week
- Case competitions between schools
- Self-learning module online to be completed by students nationwide
- Pocket guide/pocket cards/clipboard
- Distribute lanyards, badges to medical students
- George (Western): Choosing Wisely do they do any research in disparity in testing? Identifying populations at more risk?
 - At this point, not much has been done. New initiative and applies to broad population. Excellent move forward.
- Thank you for the presentation. Inspiring work.

Joule: A Panel on Innovation in Healthcare

- Franco: What does digital transformation mean?
 - Dr. Kora - many in medical industry have difficulties with digitalization of medicine. Need to create innovation ecosystem. Joule hopes to bring information for the anticipated digitized changes to practice. About 150 cmgs go unmatched last year.
 - Joule in order to help prepare medical students, will be launching innovation internship for unmatched students, for 8 months. Takes students and they can apply for it and they can learn about innovation in healthcare. Creating devices and software technologies is one piece but implementing policy is another. Spend some time at the Hague. Some can work at Dubai Health Innovator space. We know there will be a lot of interest. Exploring opportunities for those to be involved after residency or when in practice.
 - Priority to unmatched students for this program through Queens
 - Reasonable definition of innovation - imagination is fundamental part of human conscience, creativity is expression of your imagination, innovation is applying creativity to solve a problem
 - Dr. Yannick - in 2012 with trying to establish remote teaching of ultrasound, the platforms weren't there so we made them. People often don't know what they need. Reacts evolved from a tele-teaching platform into a teleconsultation platform for expert consultation.
- Franco: What keeps you at night when you think about Canadian health care?
 - Linda: are we preparing our healthcare system for improving technology? No one person is responsible for technological innovation. There are a number of things we really want to do in terms of assisting. Embedding innovation at the institutional level. If we are not using the digital tools within the hospital that creates a problem for access for you as future physicians. We want to embed these Joule innovation beds in centers across the country. In Vancouver we are working at BGH at the ER. We will bring the digital tools and embedding in the workflow. Where does it go in the workflow. Does it save time or add time.

Another one we are looking at is in a long term care facility. Another one is having a virtual bed at home and working with a pediatric hospital in the east so that the child can be discharged with the family and monitored from home. These are some of the things we are looking at doing. Accredited digital literacy program. I am accredited and I know what to do. We are preparing you to do that. This is currently not in the curricula across the country. We want you to start to see the utility in what we are doing. We have to disrupt the system and embed those tools to better help you in your practice. One of the other things I wanted to share with you is that I met Dr. Beaulieu 2 yrs ago and part of what Joule does is look at physician innovators of Canada. This is just one of the many talented ones we have. Joule promotes them. Dr. Beaulieu is with the Sask government to change the system and change the payment structure. We are working with the Yukon to help change the system. We help them scale. We provide them opportunity through the medical network. This what Joule will be doing as we go forward.

- Gigi:
 - I will go back to answer the first question: what keeps me up at night? I thought of that question high level and drilled it down. The opioid crisis and sustainability of our HCS. In terms of tech and innovation, I'm gonna ask you guys. Just by a show of hands. I'm a boots on the ground doctor. I see patients I go to the OR. I am all of your attendings. By a show of hands, is your medical school curriculum is it adequately preparing you for the advancements in technology and digital innovation. NO HANDS MIC DROP
 - What keeps me up is this huge gap between where WE are, we as the front line doctor and educator, I would say you are probably being taught the same way that I was taught in medical school and the rest of the panel. What we are teaching you is not what is coming. I see that from talking to front line doctors, healthcare summit it was up there. The questions I was getting was like this is great but I still use a fax machine and I still have a pager. When it comes to technology and innovation. We know the WHO WHAT WHERE WHEN AND WHY it's the HOW that keeps me up at night. These are the HOWS that keep me up at night:
 - How are we going to inspire the political will to change the way HC is delivered administered remunerated
 - How will we deal with the regulatory barriers and licensing requirements.
 - In Kenora I can't provide virtual care unless I have an Ontario license. There are licensing requirements. We know an internist who teaches POCUS in Africa. If we are operating on patients or seeing patients, we apply for and pay for medical licenses in the country in which we are working. Recently UGANDA medical authority has stipulated that if you are a foreign team you must have a medical license. That speaks to fairness and equity. It speaks to providing the same standard of care. Internationally as well, when you cross borders there are ethical concerns

that you have to consider. Privacy: how do we keep health information private. In Manitoba. Our health authority restricts the way we can communicate. There is also our health authority. Costs - comes down to political will. Who is going to pay for some of the infrastructure for virtual care for rural communities. How do we ensure equitable access to all populations.

- Franco: touch vexing questions and challenges for us medical students as tomorrow's future physicians
 - Joules strategic plan - will be focusing on the intersection the new digital technology centre, education, healthsystem players and wrapping it up in an innovation platform. 4 health institutions to turn on its head. Privilege of seeing ideas come to life are those who have the money to create the ideas or the people who can write the grants. Joule innovation care spaces - major barrier to implementing ideas in health care - 1) idea generation/difficult to do so on the front line 2) finding a place to build ideas (eg. rapid prototyping) 3) place to safely test the idea (first space in Emergency Department Vancouver General Hospital, second in Saskatchewan, third in patients' home) and 4) building a company off ideas after safely testing them in healthcare innovation spaces. Joule wants to support these companies to thrive.
- Dr .Osler - CMA2020 is the vision statement and plan for the future. Things to remember 1) our vision is a vibrant profession and a healthy population. Are we training the right people for the right jobs. Transition from medical school to residency and into practice. That would be an interesting panel to have next year. RC is looking for tech and transformation. I am on residency training committee for our program. WE are training residents the exact same way that we trained them when I was a resident. Numbers of training and what is being taught. There are still these gaps. What are they doing to prepare or are they working in Silos as well?
- OPENS UP FLOOR
- Ben (NOSM) - a lot of us have grown up in the digital age, we're adapting. What we don't often do, think about consequences. What is joule doing to think about the medical-ethical situations about technological innovations?
 - Healthcare is fraught with medical ethics issues. Ethics is part of the technological implementation. There isn't a blanket statement. Biggest ethical questions. What does machine learning and artificial intelligence do to medical ethics.
 - Joule is collaborating with key decision makers. Do many one-offs with thought leaders. Have the dialogue with the key players. Work with the CMA to write out policy. Deliver a policy/white paper
 - Gigi: such an important questions. Question of ethics has to be built into every time we think of this
- Silvio (Western) - healthcare innovation - often resistant to change. A lot of practicing physicians are too busy to work with these changes. How can we foster innovation and embrace it?

- Gigi: I have been guilty of this. It's clunky. I'm too busy to deal with password changes. How do we at the CMA deal with waves of technology? Some of it comes from advocating change in the system to make it less onerous and less time-consuming to do things. Grassroots up. Public involvement too. Must look at potential cost savings. Lots of upfront costs and this is scary - might scare off regional and provincial health authorities. But if you look at the cost of an acute care bed, it costs 20x more than a LTC bed. An acute care bed costs 7x more than a LTC bed. So talking about this matters. It will alleviate costs. It will reduce cancelled surgeries that happen b/c there's not enough beds to do the surgery. That is my way of transforming the healthcare system to be more willing to set the change and start the inertia. It's going to take a collaborative effort, especially from the public. When you poll the people, healthcare is at the top, partnering with the public, about cost savings and sustainability.
- Deepak: in addition, there is one thing of having advantage having all these medical students in the room because you can be that change. We lack flexibility because physicians are resistant to change. Remember this discussion when you start practice and be that change when it comes up in your practice. It's critical that you become comfortable. Only 20% were comfortable. If that were 100%, we could facilitate so much more change. Physicians have the power to drive change. Don't be afraid. It happens across the world. You can be the change and it is possible to do this.
- Emily (Alberta): Personally amazed by technologies presented. We find a lot of these innovations concentrated in urban centres while rural, and indigenous communities are left behind. What do we do about it?
 - Lynn: Virtual care is important. Some technologies are being scaled into remote communities (e.g. SK). We need to work with specific communities to understand their healthcare gaps and identify tools they need. We have multiple virtual care projects going on, particularly to spread to Indigenous communities. One Joule Innovation Grant focused on Indigenous homeless in Hamilton. That's the goal of those grants - spread these ideas across the country.
 - Gigi: I agree, I think virtual care is important and can close some of those gaps, and that some of that tech is given or donated. Need to have full collaborative partnerships with the communities that you are working with.
- Frank (Ottawa): Leaders have great ideas, we want to go back to our schools, but met with resistance with faculties. We don't have time to do this, how do we ask our faculties to implement change that is important for the future of healthcare.
- Pavel (Manitoba): I drool at all of this. Dr. Osler, you talked about privacy. What keeps me up at night is our electronic patient records. In Winnipeg, where the Health Science Centre runs on paper patient charts, these things seem like far-fetched ideas. But what about going a step further for the personal health record. Who has seen their own chart? We're developing open standards and cross-system exchange, but how do we do these things?

- Victoria (MUN): Does the CMA and Joule have any plans to help with education advocacy - like with the attendings who don't have time? Are there any top-down approach and strategy to help students with facilitating these discussions?
 - Deepak: discussing plans for education. Challenging and simple to do. The voice of medical students is very powerful. Whenever you want to make a change, you just need to find a few people who come along with it and they need to be in the room. You want people on the curriculum committee who sympathize and listen to you. E.g. this is a perfect opportunity. You have an amazing catalyst here. Tell them: there's only 20% of med students comfortable with digital tech, so we need education around this to ensure the longevity of our profession. Docs are competitive! If they see it in one place they'll compete to be innovative next. Informatics - I think industry will solve this problem. Interoperability issue will HAVE to be resolved by industry b/c there is just so much demand for it. On the personal health record, most of you will face this where patients are requesting for their own health records. CMA will now have a member of the public on the board you can see the change happening.
 - Lynn: when you try to implement something in a province. Joule goes to the government to share what could happen and how we can act as a partner. We have early adopters -select few doctors who implement from get go - and it's a halo effect where then the fence sitters will start trying it. Bring the innovator to present the tool and technology to the government
 - Gigi: Grass roots and top down you have heard, going to your medical schools and speaking to the people who make the curriculum is your best bet. The CFMS invited the RC, AFMC, CFPC, and you have the whole spectrum of education, ask them, say we are concerned about this coming wave of technology and how we are being taught. EMRs: they don't talk, they don't communicate. What about the patient being the owner of the medical record, beyond patient portals, that is interest of doctors, we are responsible for keeping the patient record. Give them the info so when they see a specialist, they can show off their own data. I have x and x. I think it's of interest to patients and doctors.
- Christina (Calgary): Clerkship elective students have complained that they need to learn a new EMR every two weeks. Think this untapped source of information for EMR innovation as to the advantages and disadvantages of each system as they travel. Is there room for students to discuss EMR innovation and interoperability? If you have a student who wants to innovate, how do you find the 'thing' you want to innovate for?
- AvriLynn (Queens): Does CMA and Joule have plans to support student advocacy for curricular change - not just the 10-20 who get into an internship
- See Previous question by victoria, Dr. Osler touched on the top down approach, does the CMA and joule have plans to support our advocacy for curricular change?
- Alex (Calgary): In a world where we can 3D print stents in a surgical suite, is there anything being done to encourage physicians to use these modern technologies. In a world where we can print 3D stents, is there anything being done to encourage docs to use the innovative technologies? There's no way fax is the most effective way to fax

referrals. Is there any program through the CMA that encourages docs to move on from using stagnant technologies.

- Andy (Toronto): We talked a lot about curriculum change and this is a strong suit for U of T. We talk about it in the curriculum but there is no way to enter that space of innovation technology and entrepreneurship and there is no avenue to channel their energy to. What are ways for us to really enter and push forward for innovation and technology.
 - Yannick - remember that there's things that sometimes just work - the iPad that people didn't think would work. Now look at it. You don't need to search for innovation, go with what you see around you. Let the problem/issue find you rather than you seek out the issue.
 - Gigi: Similarly on that there is venn diagram that I use. IWDK. The intersecting circles find that one section in the middle that is your passion that will excite you everyday. You love it, the world needs it, you get paid for it, and you're good at it. When you find the center of the circle you will be passionate engaged and inspired you will love what you do. CMA yes at a high level there are plans. Henry is your rep on the board. The board has talked about this at a high level. The CMA answer is yes. We break down some of these silos facilitating leadership adoption and integration from the physician point of view.
 - Deepak: - How do you find that thing? Henry Ford "Sometimes people don't know what they want." If he asked, people would have said faster horses. Encourage oyo to look around you. Front line innovation and getting ideas from the front lines at the various locations, The platform we are going to roll out actually builds creativity intelligence quotient. If you share with people and bring them along with you for the journey, incremental journeys and find out what they really love, and build a collective creativity quotient is where it gets really powerful. We will watch where it goes in the next few years.
 - The Joule has resources to support curricular development. Were connected with the medical schools. Digital literacy program to be rolled out soon. Resource centres will be established in the four areas shortly.
 - E-consults and faxes are such an archaic tech. Sask says by the end of 2019 they no longer want to use faxes. It requires more players. I think it's about setting audacious goals to motivate these changes.
 - Lindy: Digital literacy course will be offered to all students free from Joule, working through that to see how we can team the funding to see how you can do that.
 - Franco: There are surprises but not that many on the word cloud.
 - Super happy to see Equity up there. Speaks to where we want to go with CFMS. This is some of our mandate to think about these big tough questions. Lots coming down the pipeline. CFMS and Joule working closely. Partnership growing closer day by day. How do we grow the partnership and how do we make sure that you are engaged and the members are engaged.

- Lindy: Thank you, we are here to listen and learn, send us a note, or text or email. Let us know your ideas, we are seriously listening to what we heard today.
- Ali - Thank you for coming, the engagement shows how much this on the minds of medicals students. As a gift we have upstream medicine books - “quote from book” Thank you for being a part of today’s session.
- GROUP PHOTO!

Scavenger Hunt Winners Announced

- Sarah: It’s been great. We made a photo montage that will now play.
- Winner: Calgary
- Second Place: Western
- Honourable mentions to McMaster and Toronto

Inspire Democracy

- Federal election that will be happening in the fall. Encourage others to vote! And have conversations with those running around healthcare.
- There’s booklets and pens around from elections canada.
- Campaign called inspire democracy, engage with with individuals with disabilities and with indigenous voters and new voters, which include immigrants, migrants and youth.
- We all have a role to play in engaging those around us like physicians and patients, etc. Online modules and brochures and other resources available to help with encouraging and engage these voters.
- Debunk myths around Canada’s democracy, thing such as riding history, and how to engage others in the conversation
- Let Yipeng know if you want to be involved in this, it will be in October 2019, and be engaged in federal leadership around healthcare change. We all have the power to engage in that process, and that is one of these opportunities
- Yipeng has business cards with contact info, and you can get kits mailed to you, or they can come and do a talk
- If you are possibly thinking of becoming a candidate 5-10 years down the road, there are resources they are happy to provide for.

Ali: Planning committee from McGill to come to the front, they have worked hard to ensure that is a fun and engaging meeting for all of you. I know they have put in so many hours, and so welcoming. I have never been so excited about montreal. Let’s give them a round of applause.

Ali: It’s been inspiring to be here, you are able to do things even staff physicians aren’t able to talk about, you are amazing.

CFMS 2018-2019: The Year Ahead

Presidential Address by 2018-2019 CFMS President, Stephanie Smith

- Thank you to Dr. Damji, we all know how busy it can be to do residency, and taking time for this event to go as it did, I've heard really positive things about engagement. So thank you so much for taking the time to do this.
- Thank you to all of the outgoing Board Members: Christina (Communications), Sarah (Quebec), Kaylynn (Education), Lauren (Finance), Cory (Ontario), Chris (Global Health), Franco (Past-President)
 - We are doing so well as a organization to make change, thank you to all of you that have come up to let us know that you have appreciated what we are doing
 - Thank you to everyone who said thank you the other day, it really means alot to know that you appreciate the things we are doing.
 - Sarah has done a great job of improving collaboration with FMEQ and we want to continue to grow this relationship throughout the years
 - Christina, I learned a ton about communication from you, it is not an easy portfolio but we are very thankful for all that you do.
 - Chris, you are always positive and energetic and the first to let us know that we need to focus on ourselves and our wellness. Thank you so much for managing the biggest portfolio in the organization and for mentoring Michelle in the process.
 - Kaylynn, you manage the portfolio I know the least about but you do an amazing job and represent us toso many different organizations. You were the returning member who coached us and helped us to make the progress and efforts that we have. This will continue on with your legacy!!!
 - Cory, AKA NOMCOM KING. It is not a fun process but just one of the MANY things he has done. It will not be an easy thing to live up to. Look forward to your opportunities with OMSA as OMSA Co-Chair.
 - Lauren, i know nothing about finance, but Lauren has been taking so much time with me and has gone above and beyond so that I can know and understand this portfolio. She is passionate and engaged. Sad to see you go.
 - Franco, We can't let you leave! We need you. You are staying. End of story. Franco wants this organization to be the best it can be. He is an active player and has pushed forward with many initiatives. You make sure we are organized and that the information is coming to us always and that we understand it. You support our envision and make us stay on track. You always have the BEST shirts.
 - Rosemary: been working with CFMS for 18 years. If anyone knows organization better than Franco, it is Rosemary who has the experience and institutional knowledge, gives her heart and soul to the CFMS. So fortunate to have you.
 - Henry: he was a very difficult place last year where was I, had to brought up every new person up to speed on the board. He knows EVERYTHING, each position paper and governance paper, etc. He was so focused on our wellness. He cares about wellness. Sent us daily videos for music and I can't do that. Members of the Board knew they could go to you if there were ever any concerns or needed to take a step out. I'm looking forward to your continued mentorship as you Chair the Board this next year.

- I will plan on working on my French. Thanks for this opportunity. I want to take the chance to get to know each one of you. I was a nursing officer in the military before starting medical school.
- One thing impacts me. I remember when I was in Afghanistan and I was really tired at the end of a day. Had a patient report to the front door. We imagined what he would look like. He carried in his 9 y/o son. He needed us to save his son's arm. It was nephrotic and gangrenous. We can't save the arm, but we will work to save the son's life. He had travelled 6 hours carrying his son. The son was playing soccer and got caught in crossfire.
- They tried to bandage him at home. Best chance was ped hospital. Started 6 hour trek. Son wasn't looking well. Father said "Can you please amputate my arm and give it to him?". Most profound moment that impacted me. This is the reason for pursuing medicine. To meet people at their most vulnerable. To be impacted by these profound moment
- It is absolutely paramount that we continue working to fix the cultural barriers that allow us to survive the way that we deserve, and on the other side, giving our patients the care that they deserve.
- We deserve this and our generation and make a difference. We are passionate and driven and energetic. We are all busy, our plates are full. You are here because you have a strong voice, you are here and want to advocate for your peers.
- Wellness is such a big piece of this puzzle. I felt burnout in June, 21 day stretch,
- I lost my first patient in a rural town , a patient whose family I had gotten to know, and who made me feel grounded to the community. I was driving to my placement, I was tired, I didn't feel welcomed by the staff and team on anesthesia. I almost hit the car ahead of me. I recall thinking I was less than a foot away from a collision and I thought, well it I wouldn't have wanted to get hurt, but if I had had a small collision, I would have work off to today....I didn't enjoy reflecting on this thought, but it really bothered it, so I told my preceptor (Who I adore) what I felt and she said something to the effect of well I don't know how you would have coped with the hours we worked back when I was in medical school". I felt defeated, alone and weak.and this from an off the cuff/no malintended comment from a preceptor I respect and really like. I truly worry about those that are experiencing similar situations, but that don't have the social support network I have to reach out to friends and family, support at school or the ability to speak up.
- I can't even begin to faterm the additional stress of making it through medical school and finding yourself without a residency position...I think it is reasonable to expect the system to support us and ensure we match to a residency program. We have all been impacted in one way or another by the 222 students that were unmatched after the first iteration, and the 169 still unmatched after the second. I am proud of how CFMS lobbied the government and advocated for support for all unmatched medical students....and look forward to see where this goes. There must be change and traction in the positive direction, or this problem with only compact further and numbers will continue to rise.

- The lessons I have learned while deployed and working for the army over the last 17 years and over the last couple of years with medical school and student leadership, have provided me with a unique perspective- one that allows me to be “comfortable with being uncomfortable” and to recognize how much we can accomplish in a 24 hour period. Yet I still have a breaking point. We all do. We need to listen to it and ensure we are the healthiest version of ourselves so that we can fully give our passion, drive and empathy.
- I have also learned the importance of staying well, so that you can look after your team. My experiences have fundamentally taught me to:
 - Get to know the members of your team and develop an understanding of their strengths and weaknesses
 - Advocate for opportunities to promote their skills
 - Adapting your leadership style to enhance your connections.
 - These are my commitments to you and the board.
- In closing, I’d like to bring this all back to the ABC’s of my presidency platform presented as SGM. I spoke of my commitment to:
 - A. **ADVOCATE FOR AND SUPPORT STUDENT ENGAGEMENT**
 - That’s why I wanted to do the Strategic planning hackathon. We now know some of the key areas you want the board to focus on the coming year:
 - FINANCE: FUNDING OPPORTUNITIES
 - GA: NATIONAL DAY OF ACTION
 - SA: INTERVIEW DATABASE
 - GH: INTERNATIONAL ELECTIVES
 - COMMS: IMPROVING MEMBER ENGAGEMENT
 - EDUCATION:
 - B. **BUILD COLLABORATION AMONG MEMBERS AND EXTERNAL ORGANIZATIONS**
 - Take the input from student engagement to the organizations that can support our vision.
 - C. **CHANGE the CULTURAL**
 - NWP to develop more understanding around student mistreatment, long work hours, unrealistic expectations.
- Lastly, through my experience as Executive VP, I’ve learnt that what makes a great president is someone who LISTENS to their membership, and who passionately COMMUNICATES their thoughts and concerns to stakeholders... As president, I promise to promote and represent your collective agenda, not my own. I will work with you to develop strategies and bring about change that focuses on the issues **YOU** believe are the most important as we advocate, build and collaborate. “The secret to change is to focus all of your energy.... not fighting the old, but on building the new”.
- I will leave you with this: IF WE ARE WILLING TO DO THE WORK THAT OTHERS ARE NOT, WE WILL LEARN MORE, WE WILL ACHIEVE MORE, AND MOST IMPORTANTLY WE WILL INSPIRE MORE. Thank you.

Ali: Last order of minutes. Please in your journeys home keep using social media to connect

Motion to adjourn the Annual General Meeting.

Moved by: Stephanie Smith (Calgary)

Seconded by: Kaylynn Purdy (NOSM)

Result: Motion PASSED.

Meeting Adjourned