

Canadian Federation of Medical Students Annual General Meeting

Ottawa, ON

September 21-24, 2017

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Friday, September 22, 2017: 40th Anniversary

Introduction, Welcome Address & History of the CFMS

Robin Clouston introduces past-presidents, guests & board members.

Small Working Groups

Han introduces Career-Focused small working groups.
Designed around career planning rather than exec driven.

Panel Discussion 1: Unmatched Canadian Medical Graduates

Franco R. introducing panelists and First Timers

1. Dr. Geny Moineau - AFMC (@gmoineau)
2. Dr. Ian Bowmer - MCC
3. John Gallagher - CaRMS

Dr. Moineau (AFMC): the unmatched CMG

- AFMC ensures that med students are receiving a high quality education so that you are ready for the residency program of your choice
- No matter which school you come from, you will have certain abilities when you graduate
- Who pays for your training?
 - Mom & dad
 - Loans
 - Provincial government: \$250K-\$500K per year from taxes
- Who decides on training opportunities?
 - Provincial government
- Increasingly complex system and a growing uCMG problem
 - AFMC has prioritized the uCMG
 - Step up work that has already been under way through Residency Matching Committee
 - <http://afmc.ca/blog/2017-06-08>
- Robert Chu - Toronto Star
 - Galvanized the medical community
 - Public is not necessarily aware of this problem
- AFMC Residency Matching Committee (ARMC)
 - Membership: CFMS, RDoCs, FMEQ, FMRQ, UG, PG, SA deans, Managers, CaRMS
 - Asked to bring forward a report, to be presented in October to AFMC board
 - Considerations
 - Ensure sufficient entry (ratios)
 - CMG:Residency spots was 1 : 1.1 previously
 - Today, 1 : 1.03
 - Support for medical students in Canada
 - Access for CMGs
 - For electives and how they are set up
 - Spending your entire fourth year in one discipline is no longer helpful
 - Changes to Match Processes

- What can be adjusted in the algorithm to improve trends?
- Support for uCMGs
 - Faculty support may not be able to support you once you graduate
 - There should be a clear set of opportunities across the country to postpone graduation or have the same access to electives (perhaps even preferential treatment)
 - More years you are unmatched, the less likely you are to match
 - Faculties should take responsibility for their own unmatched students
 - In some provinces, this is a very difficult concept
- Implementation of best practices in resident selection
 - Certain programs don't follow the rules in place
- Improve flexibility for residents to transfer
- Proposed principles:
 - Medical students should be supported on their path to a meaningful career that contributes to improved health of Canadians
 - Faculties should support their graduates on their path to a meaningful career that contributes to the improved health of Canadians → "They are still our responsibility."
 - Pursuant to its commitment to social accountability, the AFMC should support new policy to improve the current matching system to support their graduates on their path to a meaningful career that contributes to improved health of Canadians

Dr. Bowmer (MCC)

- You are investing anywhere from \$100-250K in our education
- Governments invest \$250-500K in our education
- No one who graduates should be without the ability to practice
 - Not in government's, public's or learner's best interest
- What are some of the issues?
- This is not a new problem! It has been a longstanding issue that disappeared when med schools and residency programs expanded during the same year
 - Large buffer of residency spots for these four years
 - Now the buffer is narrowing
- Attitude switch: residency programs should get to choose the individuals they want and students should get to choose the program they want. This is not the definition of social accountability.
 - This has to be addressed
 - Initially, you came in wanting to be a doctor. As you gain clinical experience, you find the place you want to go.
- NFLD: supply problem with physicians in rural areas
 - Introduced a high fee but they would cover your debt if you practiced rural
 - This flopped! Too early for first year med students to know where they wanted to practice
 - If they introduced this in clerkship, it had a 85% retention rate
- The idea of having a residency totally of your choice will not work
- 1994: exactly 1 : 1 ratio (CMG : residency positions)
 - Educated students that they had to go broad with their choices
 - Educated the faculties to list their own students, protect students!
 - Government should ensure there are enough spots for everyone to enter practice
 - **"If you're willing to graduate a student, you should be willing to have them as a resident"**
 - These are the only things that are going to work going forward

- Governments need to feel that that are domestically self sufficient, and manipulate the positions to meet their needs. We have to be prepared for this
- Everybody has a responsibility, everybody has to fulfill that. It is a 3 pronged approach.
- In the 1990's we had an agreement with the government that if we had an unmatched student we would be able to go to the government for that salary for that student.

John Gallagher

- CFMS is a member of CaRMS, (we are JG's boss)
- 50 years old, created to be a fair, objective, unbiased body to facilitate a high stakes decision making process
 - Deliver a stable, optimized match
- CaRMS does not have stakes in the individual outcomes of the match
- HOWEVER, we want it to be stable & optimized and we want the system to work effectively
- We don't make decisions on: Eligibility, number of positions, who is interviewed, selection, ranking
 - HOWEVER, we provide information & data to all decision makers to help people make informed decision with as much transparent information WHILE still protecting privacy & confidentiality
- System improvement: Ensure the processes & system work as intended and are reliable/fit for purpose
- Jump in unmatched in 2011 and then again in 2016 and higher in 2017 at 2.4%
 - 2013-2016: 99.4-99.6% - students matched to date (match in a subsequent year)
 - 2017: 96.5% - students matched to date
- Our perspective -> everybody works very hard to ensure this system works as intended. The system produces strong results on many fronts, however:
 - uCMG
 - The 68 unmatched graduates is evidence of a system that is not delivering intended outcomes
 - "We are all in on making sure that everything that can be done to improve it is done."
 - Varied reasons why people are unmatched
 - "The applicant who ranke one program in one discipline is very different than the applicant who ranked 12 programs in 3 disciplines."
 - Inputs
 - Factor in previous years' participants
 - Argue that there are enough positions for every CMG, but the concentration of the unfilled positions (geographically, language)
 - Supply & Demand
 - There is an increasing pressure on disciplines that are already under pressure, the number of applicants choosing a discipline is higher than the number of places → Oversubscribed.
 - Apply broadly, if you target yourself in one of those disciplines, understand the consequences of those choices.
 - "You will live with the consequences."
 - Changes & Implications
 - Building additional tools - interactive tools demonstrating no. of positions and no. of applicants ranking that specialty as their first choice
 - Policy choice changes

Questions

- Alyse (Mac): After a tough year at Mac, I've had the opportunity to speak with Dr. Chu's family. What do people have the right to know about if they don't match? What access can students have to feedback, especially those who are repetitively unmatched?

- Dr. Moineau: This should never happen again. This has to be ramped up at the level of the faculty (support for uCMG). UOttawa: There are ways to manage either allowing the student not to graduate so they have the same rights & privileges, or provide post-MD opportunities. Every faculty should have this responsibility and demonstrate how they're managing it. Discussing what feedback can be given
- Ahmer (McGill): You spoke about the ratio narrowing to 100 : 103. Has there been discussion restricting number of medical student spots?
 - Dr. Moineau: The deans need to think about this. We can tell the provincial governments to fix this ratio, but economically, they will be unlikely to say they want to increase the number of residency; they will likely suggest to decrease the number of medical students. This would not be a very popular answer to the deans, as they would be receiving less funding. In Quebec, ministry has decided they are doing this already! They don't need as many doctors as they are producing, so they are reducing the number of medical students by 17 per year for three years.(total of 52 spots)
- Ahmad (Mac): What kind of timeline is being considered for implementing changes?
 - John: From a technical perspective, most things are possible with enough time. Difficult to make changes in the middle of a cycle.
 - Genny: What you are hearing and seeing is that we are all working together to find these solutions, it has been declared our most urgent issue. Decisions are being made by different groups, want to be fair to the current people in the system/match year. Suggest that governments make changes. Need to make sure that we have consulted appropriately, there are many elephants in the room, need to balance any changes that we recommend may affect IMGs. "Support of the unmatched in 2018, faculties have agreed to own that problem. In a year from now, they can say that all students were get matched subsequently."
 - Franco: CFMS has been part of all of these conversations. Position paper coming out for debate on Sunday.
- Western (Silvia): The message about applying broadly is mentioned often. 50% of specialties have more applicants than spots. There is a hidden pressure to do more electives in the field. How do we reconcile the advice being given, given that there are fewer spots?
 - John: Evidence of increased "application inflation". Whether one application will help your results is up for debate. 95% rank in first 5 programs, but average number of programs ranked is 18! Don't limit yourself to a discipline, and "eyes wide open" to the consequences of a limited application breadth. Algorithm is designed to be applicant-preferring. No conversations so far have led to a discussion about changing the algorithm. Regarding electives, data is difficult to draw clear cause-effect. Yes, some programs tend to prefer applicants who have focused their electives in their area, while other programs in the same discipline do not. This is a difficulty with the uCMG analysis in 2015 and identifying "red flags", but these electives strategies are also found in applicants who matched. There is no current formula. Good personal letter, reference letters, clear interest in that discipline.
- Dylan Ginter (Sask): CMGs are not being matched. There are spots allocated to IMGs. Can you speak to this?
 - Dr. Bowmer: MCC has been funded to do work with assessing IMGs. There is no question that IMGs will continue to be part of the pressure on residency positions. Half of IMGs enter through residency program. Other half go through alternative pathway with local assessment. Federal government wants to ensure that IMGs are integrated in the country. Provincial government responded with specific IMG spots with return of service. This is a political issue. There is a large lobby group. Almost half of IMGs are Canadians who have gone off shore and are coming back for residency spots. Not sure what the solution is. The governments have tried to manage this with assigned spots. Ontario has 200 IMG spots, but then have reduced the CMG spots. MCC is looking

at setting up entry without going through residency if that is possible - 8 programs across the country. When you look at priorities across the country, we have been told by Committee on Health Resources that the critical areas are Family Med, Internal Med, Geriatrics & Psychiatry. There is the greatest need here, as identified by provinces.

- Genny: Folks on the diversifying question: It's about applying across the country, and make both your electives and application look at alternate system. Don't be all "eggs in one basket." Regarding IMGs: it depends on the provincial minister of health! What can you do? Go to your deans, and remind them how important you are to them. Remind them.
- Vivian (Mac): I didn't get a lot of exposure to non-clinical careers. I suspect that this is similar to other schools. Does the AFMC have a role to systematizing education on this topic?
 - Genny: Having that MD will be fabulous for you in whatever you choose to do. We should help students understand non-clinical career options.
- Victoria (Toronto): Thanks for making this your #1 priority issue. uCMGs are very complicated issue! Are the schools, provincial, federal levels sitting down together and solving this problem? Are students at the table? Everyone should have a residency spot - has internship or family med spots been discussed?
 - Genny: The goal is no CMG unmatched. Realistically, there may be the odd graduate who is not suited for clinical practice. When you look at how applicants processed the application, it looks like they don't want to match. We have to be thoughtful that family medicine shouldn't be a default. We have to get as close to zero uCMGs as possible. We are looking at Physician Resource Planning (CFMS is there, with other learner organizations, assistant deputy ministers of all jurisdictions) and the uCMG is an important topic for them; they are putting money towards it, are analyzing it. This is feeding into pan-Canadian Committee on Health Resources. AFMC is working to inform the government's understanding, explain repercussions. However, it ends up being a decision of each province.
 - Victoria: Can we identify students who are not suited for clinical practice earlier?
 - Genny: Just because you got in doesn't mean that you will graduate. Are you truly suited to the career? We don't do this well.

Summaries

- Dr. Moineau: Remember, 97% will match. Please talk to school leadership. Talk to the big dean and remind them that this is important.
- Dr. Bowmer: 97% is the takeaway. Continue to lobby for the uCMG.
- John: 68 is not acceptable. We need to improve as a system. Ensure that your colleagues are aware of all the information that is available. Talk to CaRMS about ideas for what would be helpful. We are open to these conversations as part of the improvement.

Panel Discussion 2: Entry Routes

Franco introducing the panel:

1. Irving Gold, Executive Director of RDoCs
2. Dr. Genevieve Moineau, AFMC
3. Dr. Harris, Royal College of Physicians & Surgeons of Canada
4. Dr. Paul Sawchuk, Director-at-Large for CFPC

Irving Gold + Geny

- The Current Situation: 29 entry disciplines
 - FRCPC
 - In 1929: General Medicine & General Surgery

- In 2017: 28 entry disciplines, 37 subspecialties, 3 special program, 23 areas of focused competence
 - CFPC
 - In 1954: Family Medicine
 - In 2017: 19 areas of enhanced skills
- Learners are forced to make critical decisions too early in the process. It is something that is an issue. Inability for learners to adapt quickly and inability for system to respond to needs of Canadians. There is confusion as to whose needs are actually being served. Lack of evidence supporting the status quo.
- Primary role of entry disciplines: To prepare an **appropriate** number with the **requisite** knowledge, skills & attitudes to meet the **needs of Canadian society**
- We believe that the role of med schools is to serve the public.
 - AFMC has been trying to envision what the future of medical education should look like
 - First recommendation: address social accountability of faculties of medicine.
 - FMEC PG: Right number, mix, and distribution of physicians to meet societal needs
 - Led to deputy Ministers of Health creating Fed-Prov Committee on Health Workforce
 - Ensure effective integration & transition along the educational continuum - review & redesign current practices/systems, including conversation about entry disciplines. This needs to be continued.
- RDoCs view: Nov 2015 Position Paper
 - RDoC believes that the mix of PGME entry disciplines and their ability to serve the needs of the Canadian healthcare system, must be continually reevaluated to ensure they are aligned with societal patient needs, generalism, and flexibility
 - Should not be determined by service requirements! Should be about social accountability
 - Coordination of decisions should be made so that curriculum & residency programs are designed with an educational focus
 - Decisions to create, maintain and remove entry disciplines should be made independently of RCPSC designated specialties (uncoupling of specialties & entry disciplines)
 - Opportunities to train in generalist & community settings
 - Status quo is not the answer!
- Proposed definition: "Entry routes, for these purposes, will be defined as any field of medical training that can be entered directly from medical school."
- In our review of the work that has been done, we will be able to come out with a report that will have recommendations. This must be brought to the attention of our government, because they are who makes the final decisions with the faculties of medicine. This will be brought to the PRPAC and other relevant groups. We want to readjust entry routes to enable students to think of careers in a more general sense.

Dr Harris (RCPSC):

- Royal College established by parliament in 1929. Role of the college is to set the standards and determine what the specialities and subspecialities are.
- Specialities are defined by breadth and focus, a subspeciality is something you spend all of your time doing. The evolution came about when FM was established as a speciality. We did not want to create a system that wouldn't allow people to finish a speciality program.
- Moving more towards a competency based model to improve the current system. There is something in place to review speciality review every 6 years -> Future, generalism, etc. The outcome of this review is that is a regular review, that can identify gaps and trigger a full review. (Only 28 specialities, medical biochemistry recently being removed and dermatology currently under review)
- Canada is known for the quality and efficiency of our output, and we do this because we are so focused.
- Were in the process of creating competency based programs.

- We need to link this to HHR, but I need to ask the question: “Do we need to look at an input model, or an output model, need to be careful what we ask for. Current model is output. Need to focus on what is essential, which is serving the needs of the public.”
- “Be careful of what we are wishing for. We may consider reducing the number of entry positions.” But he implied that we should think about it more completely.

Dr. Sawchuk (CFPC)

- Worked in Bella Bella BC initially, then Community Health Centre in Winnipeg, got MBA, currently works at a community suburban health centre. Current honorary secretary and treasurer for the CCFP.
- What looks good on a residency application: A real interest in that speciality in that discipline. Principles for the College: Comprehensive, continuous care for patients. And additional principle is “community adaptive.”
- Community adaptive- responding to the needs of your community. In Winnipeg they weren’t giving out licensing numbers and you had to go out into the community. That is why I went to Bella Bella. How you are responding to your community. He was happy to go out and fill that need. People get a specific idea on what they want to do and are worried they won’t get that job. What does my community want from me?
- Lifelong learning: continual professional development, going back to school, going back to do more surgical skill, palliative care. “This is how family physician work.” A lot of variety when you get out in your careers.
- Reassurance: there are great opportunities and you have to work hard

Questions

- Han (Toronto): PGY1 in Neurosurg, partner in PGY1 in gen surg. Thank you for making the commitment for service vs. learning in residency. Remember, as residents, we are forced to do a lot of service for our staff. In neurosurgery, I am getting zero infectious disease or medicine. We are stuck in ORs and clinics and the psychology behind staff is that we NEED to be there. Hard to step back and do some reading. We are physicians providing service, but there must be an element for advocating for ourselves. This should be a focus in the future.
 - Dr. Harris: Some of the points are separate from the Entry Route discussion. We can’t forget that you’re being paid to provide service. Many of us have worked to ensure that you are not charged tuition during residency. You should engage with your staff to push them. Within individual programs, we have to look at educational environment and push the standards. We will be faced with a reduction in the number of residents. Our hospitals & ministries have to look at alternate service provides
- Adam (Alberta): The number of entry routes someone can apply to is limited by the diversity of the electives. There is a policy that encourages program directors to look at diversity of electives. Anecdotal evidence of program directors who prefer 16 vs 12 weeks of electives in a specialty. What is being done to ensure that program directors are adhering to this policy?
 - Dr. Moineau: One big issue we know that goes on. That is one of the key areas that we want to be able to revisit. If the current policy strong enough? We see this as the unmatched question. There is an elective working group that is working on that question right now. They are looking at setting a policy that may be as strict as no more than a couple few electives in a given specialty. That is assuring that program directors know that is a rule and follow it. Before we implement that everyone needs to understand the rules and it will help you in diversity and be flexible in your plan.
 - Adam: What is this timeline?
 - Dr. Moineau: It won’t help you.
 - Dr. Harris: There used to be a limit of 2 experiences in a field for the elective to ensure generalism. UK: independently licensed nurses practicing surgery.

- Sylvia (Western): students are being forced to make decisions much earlier because certain specialties are becoming more competitive and because previous subspecialties are now primary entry routes. What are thoughts on bringing back the rotating internship?
 - Dr Harris: One of the things you need to be aware of if we go back to a rotating internship that will increase the time to become a specialist. People gravitate to where you want to end up. Internal medicine once you go on to a specialty they don't go back to practicing internal. Output vs intake needs to be taken into consideration.
 - Dr Sawchuk: from a Family Med perspective, we feel like our residency is already short. We are continuing to look at this and monitor this. Do Canadians want a longer training period? This is the only way we could make a rotating internship work (1 year internship + 2 year family practice residency). Difficult in terms of funding. That would be a very big bite to chew to bring back internships and extend the amount of training years.
 - Sylvia: Now it's necessary to do fellowships and extra training anyways...
 - Dr. Harris: The issue of fellowships is a very complex one in fulfilling the society's need. I don't see a lot of people giving up fellowships. Our philosophy is that the end of residency you should be able to go into practice. The Americans have a different attitude that your residency prepares you for fellowship. We should be preparing you at the end of residency you should be able to go into practice.
- Rishi (Mac): We currently have very specialized entry routes, so electives are very focused to strengthen their applications. Recommendations to do broad electives and apply broadly. Are specialized entry routes hindering people to do electives broadly? What are thoughts to broader entry routes to facilitate that moving forward?
 - Irving: I think that rational is why we are looking at this. I think it is important to talk about the community of the hidden curriculum. How things really roll out. Even if you are encouraged to use your electives to study broadly, it doesn't seem to be what program directors are actually looking for. There are a few things at play. Mandatory diversity instead of encouraging people to be diverse because it doesn't work that way. We can say the same things over and over but until they see it.
 - Dr. Moineau: One of the points we are making in the Entry Routes Working Group is that it makes no sense for students to have to pick an area that they may not have been exposed to.
- Shreya (Ottawa): As far as I understand, AFMC and learner group seem to agree on societal needs, generalism & flexibility. However, this isn't the status quo when we are creating entry routes that are subspecialties (ex: Pediatric Neuro, Vasc Surg). It is dissonant for many med students. Why do we have direct entry routes that are subspecialties? Was there some overwhelming societal need that was met? What are we going to do to reconcile these two things, or are we heading to an output model instead of an intake model?
 - Dr. Harris: Peds Neuro is not an entry discipline. Would you rather be a pediatrician or a neurologist? Vascular surgery - as there was a move from blood & guts to interventional radiology guiding imaging. There was a thoughtful process. Whether it was correct, I'm not sure. Vascular surgery really isn't a subspecialty. Let's define the problem and we'll work on a solution.
- ..Walia (McGill): Who determines how many doctors we need? Is it the program? Independent analysis? College? What's the evidence?
 - Dr. Harris: it is not the Royal College we do not determine the numbers.
 - Dr. Moineau: Provincial government decides the number of funded residency positions. They pay the salaries. How many of each entry discipline is determined in collaboration with PG deans and other admin at the sites. The people who need to be helped to make the change are the leaders in the provincial governments. We are helping to inform the government that this may not be the right construct through PRPAC.

- Irving: Provinces have more or less sophisticated modeling tools. Substantial physician mobility throughout the country. It is hard to have a national strategy, but it was necessary. The needs of the Canadian public are not well understood. Even if we could do it well, there is a delay effect. You have to be predicting needs in 5-10 years. System is not nimble. Playing with numbers has a big delayed effect.
- Jessica (Western): I'm a recent emerg gunner. The only way I can demonstrate that is through my electives because I pick electives. I would love to do more diverse electives, however, I have to demonstrate that I'm interested in emergency medicine. Extends to family medicine, etc. I like the idea of restricting electives. However, this may force students to decide what they want to do earlier and may increase residents switching. Is there agreement between the schools to agree on the fixed number of elective opportunities? What do the program directors want?
 - Dr. Moineau: Diversity of electives should help you. There is usually some flexibility. I have rarely experienced someone who has explained how they have changed their mind. Yes, it's not the usual portfolio, but you can still demonstrate passion to a specialty. AFMC represents the 17 schools, and the decision has to be made at the level of the board, in collaboration with PG deans and program directors. It all comes back to the level of the deans. Faculty leadership must enforce.
 - Dr. Harris: As far as the program directors go they will have to live with it. *"It's for your good."* It is for the good of the students and the program. We will get an idea of how you will do with a couple of electives and giving you the opportunity to see more electives. For Family medicine the electives and letters are shared.
- Christina (Calgary): it is important to diversify and you do that with your electives. Your ability to do your electives are different based on where you do your medical school. Some schools make you do 2 or 4 weeks and there are differences between the number of electives you can do. Are program directors aware of the variability between the schools and your ability to do the electives?
 - Dr. Moineau: We have to be aware of the difference between the schools and the lengths of the electives. We have to be thoughtful on the policy each school has. It has been said that everyone has to fall in line with the option they create for electives.
- Kaylynn (NOSM): Who should decide what the entry routes? Why is it only the RCPSC right now?
 - Dr. Harris: RCPSC was a default as we moved from internship → specialties, to requiring earlier matching to various specialties. CFPC had their specialties, RCPSC had the rest. Who should be responsible? The RCPSC is charged with reviewing specialties/subspecialties. This is a membership-based organization with a committee structure. To think we can do that without appropriate consultation (governments, regulatory authorities, medical schools), it becomes complex. It needs to be a discussion with many people so it is right for learners, societies, and financial restraints. RCPSC and specialties need to set guidelines for training and standards that people exit with. Less about individual rotations as we move to CBME.

Summaries

- Irving: We are known for having an exceptional, innovative education system. We can come up with innovative ways of doing things without prolonging medical education. There is always a reason not to do something, but we should challenge ourselves to be innovative. If you want your message heard, talk to the deans. AFMC is the deans. They bring the votes to the board table.
- Dr. Moineau: I would also suggest that once we have this discussion on the entry routes take a look at them and let Henry know what you think. Your voice is a very important one. You should not be asked to enter into a discipline that you do not have exposure to.
- Dr. Harris: Be vocal with your deans. Be cognisant of your end goal as opposed to the process.

- Dr. Sawchuk: There has been flexibility. There was a time when you did 2 years pre-med, 4 years med, 1 year internship. Expansion has been a good thing. In the CBME, we have to know what it is we want to produce. It gives me confidence that we will find better solution.

Dr. Brian Goldman: Disruptive Innovation in Medicine

Robin introduces Dr. Brian Goldman, Emerg Physician at Mt. Sinai, host of *White Coat, Black Art*

- I'm going to try to talk at a higher level on disruptive innovation. The system is the system and we have talked about the hidden curriculum. I can give you few hints on them and if you aren't coping maybe he was right. I say this humbly as reality do change. Outline- some examples in and outside of health care on disruptive innovation. Trends to keep an eye on. No conflicts of interest
- Disruptive Innovation: it has a formal def
 - Innovation that created a new market/value network and eventually disrupts existing market... Displacing established market leaders and alliances
 - Often by introducing simplicity, convenience, accessibility & affordability where complication & high cost are the status quo
 - Picture of a large computer -> IBM smaller computer -> iphone is more powerful than Big blue
- The age of disruption: **ADAPT OR DIE**
 - In 1992: 1 million transistors cost \$222; today \$0.06
 - 1960- company's lifespan was 56 years now 2014 15 years
- Icons of disruptive innovation:
 - James Comey - FBI director fired by Trump
 - Clayton Christenson- disruptive
- How do disruptors disrupt?
 - The innovator has a product that is outside the existing market
 - Lack the means or knowledge to access and use the incumbent solutions
 - They offer a version of the leading product that performs *worse* compared to the leader on the market
 - They capture the market because their product is simpler, more convenient, cheaper
 - Uber & Taxis
 - You are disruptive innovators
 - Uber cab 2009 → 2011 NY → 2012 London → 2014 Beijing → 2015-16 UberPool, UberX, Uber eats
 - Yellow cab bankruptcy in 2016
 - Taxi License medallions -> you needed this to operate a taxi and what they find was that there was a small amount of people that owned a lot of these license and passed them onto their children and new immigrants. They were very expensive. 1.32 million and now dropped in half
 - What did Uber do?
 - Inferior product; they have less experienced drivers
 - The first thing they did was not go head to head with limo drivers. They went after people who would not normally take a taxi. There was an app which younger people like and how they operate. They may take public transport they don't have to exchange money, cheaper than a taxi. With taxi you don't know where they are or when they are coming when you call the dispatcher. With Uber you can watch them coming towards you and text if they have questions. The GPS nullified the benefit of taxicab drivers. The GPS isn't an advantage for them.
 - What do we need taxi drivers for?

- Expertise (they know the routes, specialized knowledge)
 - The more you know, the more you are bulletproof on being innovated out of a job
 - It is not the GPS it is the business model
 - There have been protest- smart innovators target neglected customers
- Who is preparing for disruption?
 - Majority of companies are struggling or not prepared
- Medicine's hangups about change
 - Risk averse
 - We have a hard time getting a diagnostic imaging study because of privacy!
 - *White Coat, Black Art*: story about a woman who wanted to tell the ED that her son with suicide attempt had visited two other ED's in the preceding ten days. Misconstruing that privacy means not being able to talk to someone. Scared to reveal information
 - Defensive & ultra-sensitive to criticism and threats
 - This is what makes us risk averse
 - He gets criticize a lot as a radio host. They use words to suggest he is intolerant. It is not fun.
 - Get used to being criticized!
 - People in health care want to be the most perfect person they can to indemnify themselves from criticisms
 - We feel ashamed, we shame each other
 - Makes us scared - shy or nervous to get slapped down for our ignorance
 - We think we are suppose to know everything.
 - Think we're supposed to know everything
 - If the person who cleans the floor is the only person who sees that O₂ tubing is not connected to the supply, we probably won't thank that person... We feel embarrassed.
 - "I'm so bad, I needed the guy who cleans the floor to fix this problem."
 - What are yours?
 - Example 1 Laparoscopic surgery
 - 19th century: We had anesthesia and antisepsis
 - 1890-1990s: better instruments, technology increased, CT/MRI, labs ICU
 - 1950s: 1st diagnostic lap; 1981 1st lap surgery
 - Dramatically reduced morbidity, LOS, recovery time and faster turnover patients changed surgical practice overnight
 - Some physicians stayed working and didn't retire when possibly should
 - Example 2: cataract surgery
 - 1966: first phacoemulsification cataract surgery by Charles Kelman
 - Took 4 hours and cause endophthalmitis
 - 1984: phaco < 10% of cataract surgeries; 90% ECCE
 - The next DI:
 - Cataracts caused by damaged crystallin proteins in the lens there is a medication Lanosterol that has been shown to reverse partial blindness in animals

Disruptive Innovation in Healthcare

- The Innovator's Prescription
- Rule: MDs do everything
- DI: transfer of skills from highly trained but \$\$ personnel to more affordable providers often using technology
- Shift from hospital to clinics, offices

- Do we need a doctor all the time?
 - 800 000 Ontario can't find a FD
 - solution-> NP clinics
 - Until it is proven they can't do it they will do it
 - Surgeons can't do enough hip and knee replacements
 - Physician assistants are doing them
 - Hire APTs for better triage of patients- talk about the risks and benefits. Some worry that it will mean that they do less surgeries. It worked well even though they were worried at the beginning.
 - Shorten their wait time
 - Paramedics take too many LTC patients to the hospital
 - Paramedics treat patients on the spot instead of taking them to the hospital
 - Halifax- paramedics can do a history and physical and expanded their scope if the patient needed IVF or sutures. They were not trained to treat people with pneumonia. It reduced the number of LTC patients in the ED and transfer from areas that were treated with nurses or occasional physicians.
 - Bricks and mortars
 - Virtual Doctor visits
 - Rule: MDs can't properly assess patients unless in person
 - Equinox Virtual Clinic in BC
 - BC first province to pay for virtual visits under provincial health care budget
 - Dr. Vim Hofmeyr- audio explaining the virtual clinic in BC
 - Apps where you can take a photo of your rash and a Derm will tell you what it is
 - Virtual CBT
 - CBT effective in multiple conditions
 - Focuses on homework and lends it to virtual care "e-therapy"
 - One in 5 Canadians will have a mental health issue but only 1 in 3 will seek help. Many of our patients cannot make it to their appointments

In 2010: WHO estimates 285 visually impaired people; not enough ophthalmologists

A "Peek" at the future - mobile app, it can check acuity, can diagnose glaucoma, cataracts, MD, and diabetic retinopathy.

- It was tested on > 500 patients in Kenya
- Cost is \$300

Clinical validation of smartphone based adaptor: peak for retinal or optic disc imaging in Kenya

- Study comparing grading of optic nerves from smartphones vs digital fundus camera
- No clinical photographers were able to acquire images at standard that enabled independent remote grading of the images using desktop retinal camera

Another study looked at 301 patients with DM2 had seven field digital fundus photography

- Conclusion: retinal photography using FOP camera is effective for screening and diagnosis of DR and STDR
- This is great for developing countries! They have access to things they never had before
- Is there a value for people living in affluent countries/ Yes! There are not enough ophtho and people are aging. We are not having screening from family members - that is disruptive innovation. This is the trend to watch for.

- You will get the occasional person who will take it to the next level - Hugh Campos: born with heart problem
 - #1 cause of sudden death in young people
 - Implanted defibrillator is the cure which prevents sudden death, but the problem is when it goes off; it's awful.
 - He discovered a device that sensed, recorded, and shocked appropriately. The thing he did was he was gathering data to look at environmental factors of when it was triggering. Companies were not giving him the data, and there was a court case and won the case. He found that scotch was causing his defibrillator to go off, and no other type of alcohol. He fixed his problem. This is disruptive innovation!

- US Optometrists
 - Opternative launched in 2015 - fill out an online questionnaire, do an online vision test, pay for a physician review, and it has a 99% satisfaction rate.
 - The reaction was the same as the taxi cabs for uber drivers. Non-regulated, etc. But they are doing well. There are other jurisdictions doing it differently. They are miles ahead. The UK has partnerships between allied health and have carved out their own piece of diagnostic puzzle. They respect each other.
 - One third of the babies are born with midwives, 1/3 with GP, 1/3 with obs-gyn. Obs-gyn are consultants. They are paid to think.
 - We all talk about team based medicine, this is really it. Taking each other's phone calls, respecting each other.

- Computers threaten these jobs
 - Factory workers, waiters, airline ticket and customer agents. Are we immune? No.
 - Paging Dr. Watson: You are going to tell me this person failed at MD Anderson. Deep learning is coming. AI will not be used to diagnose your patients CT scans. It may look back at the past 10 years to see how fast the cancer grew. Primary interpretation
 - We are going to see a 50% drop in radiologists because of interpretation will start being converted into binary functions
 - 10 professions under big threat: healthcare, insurance, architects, etc. That's a large sloth of society. The jobs with 99% of change of being eliminated: telemarketers, math techs, etc.
 - Who cares?
 - If we enjoy driving, we still won't be driving. Maybe not now. But it will happen. Car may not be this size. They may be smaller. Cars will take you place. It might pick you up later in time. Parking spots will be eliminated.

- I want to talk about us. Who's worried? Let me talk about your situation. 5 million Canadians can't find a family doctor. This is not figures from today. At the time people were getting steamed that physicians were cherry-picking patients. We got someone to talk about this on our radio-show. I don't blame him that he cherry-picked.
- More surveys came that 1:4 residents not confident about job prospects, 4 in 10 aren't satisfied with the career counselling
 - "The underlying expectation was to serve using my knowledge, and make a difference. TO do that you need a job? How is the job search going? Not well. It's a catch 22 situation. There is a job shortage. You cannot get a job after your 5 year residency training. How much of a job shortage is their? Well across Canada there are 3 jobs. By my estimates there are 60 or so new graduates. There are a lot more than 3, that's for sure. What will you do at the end of fellowship if you have no

job? I will double up my efforts. I want to practice in Canada. I grew up here. I owe it to this nation. But if I continue to be unemployed, I will go to the States. There are plenty of jobs down there. I would have to consider this. “

- Most recent data that have significant unemployment: cardiac surgery, hematological pathology, nuclear medicine, neurosurgery, ortho, ENT, OB/GYN, rads onc, urology. I know nephrology has an issue.
 - Cardiac surgery has been in a class by itself for a long time. We had someone on the air speak about this.
 - Reasons for not finding employment: too few positions available, didn't want to move to a new city.
 - Many people who participate in these surveys say they don't have enough formal training for career counselling. The hidden curriculum: it's who you know. It's a predetermined network. Wouldn't you want to hire someone who is reliable? Someone who has the knowledge? Of course you would
- There is nothing disruptive about the way we do this. THE only thing we have done is whether we have too many or too little physicians. We just turn the switch on and off. There is no planning. We use residents as human resources. Yes, they get training. But it is not correlated to real life. It's a waste. It's an obscenity. We cannot lose our graduates.
- We are also cranking out all these specialists that we don't need, while there being a lack of geriatricians. It's a speciality that has continued increasing demand. Here is a tape with Dr. Elizabeth
 - “When I committed to geriatrics, the reaction I got, was overwhelmingly negative. I was wasting my talents. How could I pick a speciality where I wasn't helping people. Amanda you were nodding? Yes, many people have a negative perception on geriatrics.”
 - “Geriatrics is light and you don't do much is the reputation. I found to be defending myself a lot.”
 - “I would not say it's not a respected career. The reaction I get is, good for you, but I would gauge my eyeballs out if i had to spend an hour with a patient.”
- But they are thriving. They have jobs. There is good data that shows that comorbidities:
 - Major disease: diabetes, heart disease mental health etc
 - In the US, there are responsible for % deaths but maybe it's because everyone is going to die
 - They account for 75% of annual spending, if you ask people why they went into ER, it's for shocking the heart or something. It's not about meds reorganization. It's not we aren't calibration or titrating residency positions for what we need. We are not even at the inflow, at the medical students. We aren't even recruiting people who want to manage chronic disease. I know this is depressing, hopefully everyone has prozac! If you spent 40 mins with a patient, your day is awful. A 10 min appointment is laughed at.
 - Wade Peckham: 31 year old, manager of a rental car company -> first stop is an MD, second is an MD and then it's a naturopathic doctor. There are many people who need time with the doctor but they don't get it so they spend the money on who will listen to them.
 - Heather Boon - be mindful of the patients who nobody wants. Care coordinator, RN, APN, navigator, scribe (pioneered in the ED so you can focus on the patient), Population health officer (make healthier meal plans, etc).
 - Dr. Rob stevenson is a cardiologist and MPH, campaigned to get rid of unhealthy diet and fast food at Halifax hospitals.
 - Claire Gignax: RN and tobacco treatment centre. Hospitalist: think about this. Dr. Lou Francescutti, president-elect of CMA at the time. He had interesting take on unemployment: “Do we need doctors, do we need nurses? Are they serving us well today? There are arguments we should have NP led clinics. What do we do about the unemployed physicians? This generation has a real sense of entitlement. They will create their own system. They will work for less money, they will want a pension plan and benefits, the leave. They will create a model saying where the hell did

we come from. If you want to look at threats, this is a real threat. What is the long-term fix? Remove the politics, Ask ourselves what's best for the patient? We love disease. We build bigger institutions. We specialize. A good healthcare beds should be laying off doctors and nurses.”

- I want to say: robots are coming
- Aim for the top and not the bottom not the bottom of your practice. The more you get into the easy cases in your practice the more you are actually creating your demise. You are spending too much time on things we can pay others to do.
- Think not do.
- Be nimble
- Pack a parachute- if you specialize you come out with only some options and that is scary

Questions:

- Pavel (Manitoba): you talked about technology and how we are progressing and have been thinking white coat black art and you are talking about deep learning do you think the networks are capable of creativity
- Answer: book about kindness because in his middle age he has become a shitty person and so he is going out into the world to learn about empathy and kindness. He went to Japan who are creating deep learning and robots . They have the oldest society on the earth and their equality to continuing care. There is an interest in creating kind robots. They ensure that there will be creativity in robots down the road and they think more on what it means to be kind. They don't take it for granted. Another thing he learned in the relationship between a human and robot. We think they the robot has to be nice to us but we project the kindness onto the robot. With a cat it is random if they don't like you or like you. Rumba we project the same kindness as the cat. Can the computer project creativity?
- Gurmeet: What you said about geriatrics resonants with me. What are your thoughts and feedback on how we can be disruptive in getting attention on geriatrics?
- Answer: Once you have a stake it makes you see that we must do a better job with the people in this cohort as well as other subpopulations such as homeless and transgender who should be getting better care. We are all hardwired to be empathic except for some. It can be reignited
- Milani (McGill)- Public health was bashing surgeons and surgeons were bashing other. The infighting needs to end and different personalities gravitate towards what they want.
- Answer- there is a place for everyone. Don't assume there will be a place for everyone in the future. For example radiologist has been changing and now they communicate with patients more. You have to adapt that is part of DI. It is important for us to spend time in other people's shoes. If nurses and doctors spend time it will show they
- (???) Calgary- DI in medical education such as apps. Should we no longer spend time memorizing things apps can do for you?
- Answer: yes, we have to know where to find the information and not memorize the information. In the OR you have to know what things are but medical schools need to change and maybe they are not fast enough. Now when patients have multiple comorbidities you need to look them up and meet them virtually. There may be AI to pull out that information from their file and what the thinking was. Big data is not your enemy, it will tell you who needs care and who doesn't.
- Han (Toronto): Dr. Yang augmented technology in the OR. Having MD but not doing clinical practice. What is a good mix for the future for physicians and technology?
- Answers: Engineers are the way to go. MD/Engineer degree or work together. Engineering and systems such as how many steps does a physician take and can they find a better way for doing what they do.
- Kaylynn (NOSM): How should we use the tax change to improve how physician's function

- Answer: Culture is slow to change unless we are killing patients. How do you communicate with your colleagues? Whatapps? Would you tell your privacy director? Is it unhackable? You are doing something that they are telling you isn't sure about. Nothing to do with tax policy. Does have to do with tax policy. Can see a lot of effort in taking care of physicians being grandfathers in. Using the tax change to enhance the public debate. It won't earn a lot of kudos from colleagues that will lose something from this. You need to think of solutions for aging populations. What does it mean to age at home? You need occasional assistant.
- ??? Ottawa- Innovation- risk averse- what are your thoughts on medical education and your adverse for change. Thoughts on cultures of medical education and his thoughts are negative to mental health.
- Answer- Medical education is a reflection of the cultures and we require scientific proof. The answers can take a lot of time and it is difficult to go against conventional wisdom. Hard to do early on in your career. Change from the inside. Who is the leader in the group? Be smart. There are opportunities to do the work but you might be given all the tasks. You might have an idea that will be squashed. 15 months ago I was asking the rules of professional corporation and a year later we need a plan. You need to have the right plan and timing is everything.

Hack-a-thon

- Vote on your computer
- Response online and from the mic
- What are the current barriers or orthodoxies to innovating medical education at Undergrad Med Education & Post-Grad med ed levels?
 - Old Boys' club
 - Lack of coord between UME and PGME
 - Poor communication
 - Lack of accountability
 - Lack of collaboration
 - Admin is not receptive to getting input from students (willing to innovate if the idea is their idea)
 - Slow moving bureaucratic government
 - Mentality that "(this is how we've always done it)"
 - Focus on didactic learning; material does not meet needs of population
 - Resources are often cited as a reason → human resources too
 - Doctors think that they can do anything
- What is the biggest barrier to creating a physician health & human resource planning framework in Canada?
 - Government
 - Decisions are made by politicians with short terms
 - No long-term sustainable plans
 - Funding is provincial and the match is federal
 - Priorities are elsewhere
 - Lack of data - we don't know what the current data is
 - Used to having the power/making our own decisions; not good at letting others make the decisions
 - Willingness to invest time/money
 - No coordinated system to make a plan

- We don't rely on a laissez faire economy, but we don't have one coordinated system that matches medical needs - med students - residency positions - societal needs
 - Difficult to long term plan human resources
 - Lack of ownership - who will spearhead?
 - Too many decision makers/stakeholders
 - Lack of coordination between groups
 - Single payer system with individual 'companies'
 - Schools make money off of us
- How do we diversify the med student population so that we are more reflective of the Canadian population?
 - Admissions process
 - Quotas
 - Equity positions
 - Socioeconomic diversity in admissions
 - Social accountability mandate (NOSM)
 - Changing applications standards and what we accept in applications standards
 - French, Indigenous, Rural, Refugees & Low SES at Manitoba
 - Financial
 - Reduce tuition costs
 - Greater financial assistance
 - Make post-secondary education free
 - Free Prep101 MCAT for students of low SES
 - Scholarship fund for diverse student populations
 - Social capital- family that is already in medicine. Reaching out to other populations that don't have the social capital.
 - Early mentorship
 - Indigenous health - stronger mentorship programs, relationships with Canadians in poor SES at the level of elementary school
 - Starts in undergrad/high school - increasing mentorship opportunity
 - Covering MCAT fees
 - Outreach in high schools for career planning
 - Pathways to medicine (Calgary)
 - Identifies students in high school from underrepresented groups in medicine
 - Pays for your undergrad medicine
 - Shadowing opportunities
 - Paid summer internships
 - Guarantees admission to med school if you meet the minimum grades
 - 3-day camp for students to do workshops at McGill with different healthcare professions
 - Funded
 - Apply with letter
 - Access to social capital
 - Long term relationship building
 - Get to know different healthcare fields
 - Additional access streams, we need to focus on other populations outside of indigenous
- What is the primary objective of clerkship electives?
 - Career exploration, diversification, learning
 - Program is auditioning for the student & recognizing the value of every med student

- Getting an idea of the full spectrum of a specialty
- Broaden our skills outside of core clerkship
- What obstacles might students face in trying to carry out education research?
 - Time
 - Approval from deans
 - Being understanding of results that may not be flattering
 - Lack of mentors
 - Finding faculty members who are interested in what you're interested in
 - Faculty is "too overburdened" to help you
 - Student participation
 - Access to data
 - Rapid turnover
 - Programs who don't support all students

Henry: Transition to Residency

Kaylynn: Health Human Resources

Amanda: Indigenous Medical Education

Uzair: Career advising during med school

Kim: Transition to clerkship

Stephanie: Changing the culture of healthcare

- Regular staff meetings (include everyone from the environments) and focus on the positive outlook
- Calling by each other's first name (doctors, nurses, other health professionals)
- Recognition of team members (ex. compliment wall)
- Bringing and sharing food
- Personal connections (small talk during work)
- Better understanding of the scope of practice → interprofessional shadowing
- Practical scenarios on how to diffuse tricky situations, conflict resolution
- Team building activities
- Changing the hierarchy model to welcome more feedback
- Clearer definition of each member's responsibility (avoid abuse of power)
- Promote team building activities as well as wellness resources (yoga, sports)
- Have mandated personal days/vacations (take time for yourself)
- Have a common areas in hospitals/centers where all professionals are welcomed
- Stop finger pointing and improve the acceptance of error

Victor: student wellness

Victoria: Barriers to innovation in med ed

Laura: breaking the old boys' club

Dawson: Federal tax reforms

Maylynn: Medical student mistreatment

Yipeng: Medical student involvement in politics

Alex: Increasing medical school diversity

Shanza: Global health education in Med Ed

Liang: Interprofessionalism

- 1 week of nutrition on basic things in curriculum
- Didn't learn a lot about healthy eating for counseling for primary care
- Should physicians have the role of counselling on diet or consult dietician?
- Food security

CFMS Hack-a-thon – Medical student involvement in politics

- *Yipeng Ge, Howie Wu, DongHo Lee*
- Building longitudinal relationships with the government (provincial and federal)
 - Not just a one-day lobby day event
- Getting students involved in health politics/advocacy
- Municipal advocacy
 - Better longitudinal relationship
 - Lots gets decided here for patients (ie. zoning, bike lanes, etc.)
 - Smaller victories, and the public sees and appreciates this more
 - Public health and safety
 - Other topics at this level perhaps – climate change, food security
- Sustainable relationships/collaborations
 - Getting medical students involved, have them sign up for specific roles
 - Stable committees – encourage interest in health advocacy
- CFMS best practices
 - Position paper database
 - Research in health policy
 - Rapid issues committee
- Rapid issues student interest
 - Opioid crisis awareness
 - Federal tax changes event – MD financial representative, tax lawyer
 - Reactionary politics – students are very interested in these hot topics
- Municipal public hearings – encourage students to be a part of these discussions

Table 3: Indigenous Medical Education

Who:

Amanda - Western

George - Western

Adrianna - Sask

Nel - NOSM

Vanessa - NOSM

Mentorship:

Memorial

Day Camp for Indigenous students from Labourdour go to a day camp (4th session) - Two camps next summer. Ages 12-17 years old. Many are planning on going to university.

NOSM:

Similar to above, not just Indigenous (However Northern and rural students) - 1 week long summer camp to assess health professional careers. Encouraging students to enter various health fields

Current Curriculum in Med Ed:

Saks:

First year - 'Medicine in Society' 2 lectures of Indigenous Health in first year. Lots of research in the school on racism in the medical system. We need a lot more education. People do not know about residential schools. The population is 80-90%

NOSM:

Does a decent job, in curriculum: cases, and placement in Indigenous community (4 weeks), mandatory for everyone to attend. The focus is cultural. Elders and community members do many preparation lectures. There are community liaisons who assist in organizing accommodations. Required to still attend lectures (watch on your own time. Spend time in the community and they decide what is more important to your learning (Daycare placement, elders, artists, community feasts). Role to complete a project on the community and the community gets to give feedback on the presentation, and all students present about their community and learning in the community. Elders in residence for lunchtime themed topics. Language camps focus on the culture within the language.

Racism and Discrimination faced by Indigenous students:

Memorial:

- Students want to know which students are filling the Indigenous seats at the schools
- There is a belief that

NOSM:

- There is still widespread anger by the general population
- I suspect there is subtle racism
- Lack of understanding about the history about what happened for Indigenous populations and why there is a need for specific seats for Indigenous Students.

Sask:

- 10 seats and 2 fills, the rest of the unfilled spots go to the out of province spots.
- There is lack of understanding about the Aboriginal Admissions Process.
- There is a belief that 'Why should Indigenous people be treated differently'

If the teachers are not educated about residential schools and the history of Indigenous people, and this is from the Eurocentric history taught in younger years.

Janet Smylie out of UofT lab is working on developing Indigenous Standardized Development of Interprofessional days on Indigenous Health

If we ask that students take indigenous cultural safety lectures we need to have the

-

Saturday, September 23, 2017: Annual General Meeting

Welcome to the 40th AGM!

Shreya: Resolution at AGM 2016 to have a

Verna (Algonquin Elder):

- Welcomes the general council to the traditional unceded territory of the Algonquin people
 - Offered tobacco, the traditional gift given from the creator to people.
 - Brought an eagle feather, who soars high, towards the creator.
 - Brought a medicine wheel, representing:
 - The four directions (north, east, south, west)
 - The four colours of people on the earth (white, yellow, red, black)
 - The stages of life (spirit, child, adult, transition to spirit)
 - The balancing of health (spiritual, emotional, mental, physical).
 - Brought a birch-bark canoe, honouring everyone's journey
- As a doctor, when people hit rough waters, you bring them back to peacefulness. Prayer.
- 9 Algonquin groups in Quebec & Ontario
 - Algonquins are known as the nomads
- North America: Turtle Island
 - Teachings of the turtle, tied to governance
- Ottawa: four rivers come together like the four direction
- Algonquin people were Samuel de Champlain's guide
- 1960: you needed a permit to leave reserve
 - At one time, you had to give up your native status in order to attend college/university
- Residential school system likely started in Ottawa with Algonquin people
 - Intergenerational trauma still affects us, and will affect your patients

Amanda Sauv  (NOIH): Thanks Verna for joining us today.

Shreya (Chair):

- Welcome to Ottawa! From Shreya, UOttawa team, and the Mayor of Ottawa
- This is our 40th anniversary!
 - Welcome to many of our past-presidents who have travelled far to join us
 - Membership has grown
- What to expect:
 - Intro to the CFMS (8000 students; 14+1 medical schools. The voice of Canadian medical students)
 - "Tomorrow's physicians leading for health today"
 - Annual General Meeting: business meeting, elections, budgeting, resolutions, strat planning
 - Agenda online
 - Resolutions are still open
 - Socialize!
 - Wellness events this weekend: Yoga, Scavenger Hunt

President's Update

Franco Rizzuti

- To see what the board has done, see full exec reports on the CFMS website

- “Tomorrow’s physicians leading for health today.”
 - The voice of 8000+ students
 - With the residents, we are 20% of physicians in Canada
- Connect
 - Facebook Page growth (5000 likes)
 - Twitter account growth
 - #DearFutureMD
 - Top 40 wins
 - New website
 - FMEQ relationships
 - SGM infographic
 - CMA Ambassador program
- Represent
 - Lobby Day with Advocacy Training
 - Cannabis task force
 - Opioid studentships
 - Invited to Ottawa to present on National Pharmacare
 - IFMSA meetings - 138 students on SCOPE, 29 students on SCORE
 - Amanda (NOIH) - representing us on national front
 - Advocacy toolkit
 - Advocacy tracking
- Support
 - Discounts: Lasik MD, UpToDate, WestJet
 - Student Initiative Grants
 - 40th Anniversary Strategic Initiatives Funds
 - Joule Innovation Challenge
 - CMA family engagement
 - MDFM travel & Leadership Awards
 - Grant & Bursary (\$400,000) for every medical school from CMA foundation
 - National Research Chair
- Transition to Residency
 - Match Book
 - Electives Portal advocacy
 - Couples Match Ranking App
 - Visiting schools database
 - Interview database
 - 15% discount for CaRMS travel
 - CaRMS interactive data and release of data
 - Lowered CaRMS application fees
 - Quarterly meetings with CaRMS
 - CaRMS contract review annually
 - Unmatched CMG - draft forth coming on recommendations from ARMC once approved by AFMC board
 - Privacy of student data and approval of privacy policies upcoming within the year
- PRPAC and CMF - we are members of these files
- Wellness File
 - CFMS-FMEQ Wellness Survey- Data release this fall, roll out has been slow to ensure integrity of data and sure that the roll out is done as an appropriate fashion

- Franco will be transitioning to this file to ensure data release as Past President
- Need to develop a wellness strategy - will be a big piece of the SA portfolio
- Franco and Ali Damji were part of a student mistreatment panel
- Our wellness officer attended the 5th annual Physician Health conference
- CCME
 - Wellness survey
 - Student mistreatment
 - Wellness initiatives
- Need to ensure deans are on our side
- #KeepsmeWell is an initiative for all members to engage in wellness
- Internal Operations:
 - Rosemary!!!! Does the work of 3 employees even though she is not a full time employee
 - Strat planning - First internal board lead strategic plan
- Strategic Plan
 - Took a “deep dive” in order to map out what our next 5 years will look like
 - Very easy to front line portfolios, but Usman and Daniel are the team that makes the CFMS run with finances and infographics/communiques
- Partnerships
 - Would not be possible without the CMA and MD
 - Consistently help us meet the memberships needs
 - Learner partners (FMEQ, FMRQ, Rdoc)
 - The partnerships are essential to helping us advocate for medical students.

MINC Overview

Stephen Abraham, Chief Information Officer of MINC

MINC= Medical ID number for Canada

Title: MINC 2017: Reliable ID for the Medical Community

MINC:

- Unique lifetime identifier for every physician/student who enter the Canadian medical education or practice systems
- Serial number with no encoded info
- Provided through MCC via physiciansupply.ca
- NPC established in 2000
- Owners are FMRAC and MCC
- Contracted operations and run by a volunteer board

Objectives and Challenges:

- Want to ensure all member sof the medical community are involved
- We wanted the identifier to recognized and sued across canada - common currency
- We wanted the identifier to available to all non commercial organizations
- Nothing done with information that is not contest based

MINC Approach

- Consent driven
- Limited points of entry
- Centrally coordinated by independent body
- Only provided to licensed users

Privacy and Security

- Privacy
 - Consent driven
 - Minimum personal data stored
 - Agreements with all user organizations
- Security
 - Full IT security features
 - Assigned data integrity officer
 - External security audits
 - Have done testing to ensure that all data is safe and secure

Where is MINC now

- Implemented by MCC and all provincial regulators
- Over 165000 physicians
- 26 licensed users, including
 - 11 faculties of medicine
 - CaRMS, Casper
 - CMA

Contact: John Swiniarski, executive director (jswiniarski@minc-nimc.ca)

Questions

- Tavis: Thank you for coming and talk about a number that identifies us. It is a serial number with no encoding information, how is the number is generated for each students? Is there any way that this number can be linked back to the student in question?
- R: MINC is not meant to be identifiable, information is not public. Info is attached internally with the system (MCC) has MINC. Cannot publically gather information from the MINC itself.
- Are there multiple levels of authorities looking at the info attached to MINC? Fear of transferring data from CaRMS to the AFMC, are we able to know that this data would be available to the Deans (electives, interview locations)?
- R: No data data is attached to MINC when it is transferred. CaRMS identifies you through MINC, anything they gather is related to your consent with CaRMS. When AFMC asks about your MINC, there is CaRMS no data attached. No concern that there is data moving from an organization to another organization. Every organization is obliged to tell you what they are doing with your information.
- Philippe Simard (FMEQ): there is no current MINC in Qc currently, is there any advantage of having a MINC?
- R: MINC will be created at the time of taking the MCCQE step 1 exam. Advantage is to facilitate the process of identification, streamline information across all organizations. MINC cannot be used to follow medical students across their education and career path. No organization has all these information to create a overview of each student's path.
- Franco (CFMS): MINC is abstract for many medical students. What are the approval process for a licensed user, are there any restrictions?
- R: there is a full contract signed between the organizations, how the data is used/exposed. Governance is important, medical regulatory authorities ensures that MINC is secure, private and that the contract is respected.
- Ahmer (McGill): where can we get a MINC?

- R.: Go and log in onto physiciansapply.ca
- Tavis (CFMS): I understand that there is no info is stored and transferred with our MINC. But, once we consent, all user have accessed to MINC and potentially the information that is attached to it.
- R: Actual MINC database only contains your identifying info, no other information is contained. You are able to decline getting a MINC and has no effect on your licensing.

CMA/MDFM/Joule Panel

John Feeley CMA

- Empowering and caring for patients, a Vibrant medical profession
- Working on big issues such as physician health, seniors care, tax issue, indigenous health → public policy forums
- CMA wants to bring in member perspectives into the organization

Sheila Beehler-Walsh- Joule

- Launched in april of 2016
- “Making it easier for you to be at your best.”
- Want to understand medical student needs to build programming
- “Journey of innovation”--> want to help entrepreneurs to better health care
- Supporting early, late and social innovation
- Want more student engagement
- Leadership programming free to medical students
- Clinical tools, likely more important after medical school given the overlap in medical schools
- “Ask a librarian service”
- Always have access to CMAJ

Allison Seymour - MD Financial

- Fundamentally different that a financial institution bank
- Membership driven, here to support education, resources, tools and advice
- Have a team called a “meded council” for early career advising .
- Not only financial aspects, but things that concern medical students such as CaRMS
- Reduce financial worries.
- Help with transition points
- The CMA foundation scholarships

Q: Ben Cassidy (NOSM), How do we work around COI policies

A: We are looking at COI policies across the country and to ensure that we align with these policies. We are fundamentally different than other financial institutions and we want schools to see that, and you can help us to get your school's to see that and interpret it that way. “If you don’t understand how we are different then were are not explaining it well.”

Q: Victoria MUN: Who will be eligible for the new CMA Foundation Scholarships

A: \$15, 000 medical professionalism scholarship, \$8,500 needs based bursary. Each school determines eligibility

Q: Christina S (uCalgary): Will there be smaller funding challenges for Joule for students?

A: Will bring back to the table, we may need to look at different strategies and criteria

Q: Frank (Ottawa): Have you looked into having grants specifically for medical students?

A: We are new to this grant giving program, if we are creating limitations then we need to re-examine, get an advisory group, and craft either a new stream or new criteria.

Alyese (Mac): Stuck by the CMA and its messaging power. The messaging around physician wellness is not as strong as it should be. In the 2010 report, you suggested you have a strong social marketing campaign, I think now would be a good time. What is will that look like?

A: continuing to evolve our health and wellness strategy, Christopher Simon is the intellectual brain power behind the physician wellness conference last week. Looking to amplify positions at the provincial level. We are actively working to increase opportunities, and getting funding behind existing initiatives.

Nathan (uCalgary): Md Financial: I understand you work with the national bank to provide services to students, how do you continue to advocate for our needs as students and fulfill our needs and balance our needs for the bank?

A: The bank is very different as a partner, they are unique in the structures that they provided us. Other banks would be in conflict to where our values lie, National bank is alignment with that, and keeping our rates as low as possible. They actively look to bring more solutions to our clients

Nathan (MUN): Hacking health partnership, what are your ideas? Specifically expanding to areas that don't have these initiatives yet.

A: It is very new. It is a very open system, partners like hacking are people who want to go into different areas to get different voices and get people heard. Target practicing physicians, but also students and residents. Currently looking at how to get that voice to different areas.

Kaylynn (NOSM): How do you plan to get our voice and engage with students?

A: One of our challenges is that we over communicate with students. We feel that we have a lot of offerings, but how do we get to you. We have set up panels, we have set up ways to communicate. There is a willingness and strategy to do that, would like to figure out how to engage.

We let members define how they engage with us, there are members engaged

yourvoice@cma.ca → we will respond to this if you have thoughts or questions. You can join the CMA epanel, and MD voice, we want to you hear your voice.

MD started an innovation lab called "Dragon Fly." -> looking for ways to bring students to solve challenges that you face.

You have a CMA board member (CFMS president), maybe the barriers are more perceived, use that channel.

Dr. Michael Arget - Resident Doctors of Canada

- Resident Docs works with CFMS, FMEQ. Represent 10,000 residents across the country. Work with national health organizations and over 20 stakeholders. They have ~110 reps/volunteers who represent RDoc to external stakeholders. Over 60 RDoc Committees do the work. Board consists of reps from across the country and has executive within the Board with previous CFMS members. Irving is Executive Director and a team of staff that support all activities. Members for provincial housestaff associations represent.
- Resiliency working group developing curriculum for residents and training across the country.
- Currently in the process of revising their strategic plan - 3 main directions
 - Training - optimize continuum of medical education
 - Wellness - resiliency working group
 - Representation - support liaisons and reps to meet with stakeholders

- Work closely with AFMC, CaRMS, CFMS, Royal College, CWC and other groups
- If have questions, please get in touch

Anthea Lafreniere: What has RDoc been doing to protect learner data and privacy?

- RDoc put out a position last year and have been working with MINC and Colleges to ensure learners' data is protected
- As CBME develops, working with Royal College because not known at this time where data will go and how it will affect learners

Election of 2017-18 Board of Directors (announced at dinner by Chief Electoral Officer Dr. Anthea Lafreniere)

VP Communications Christina Schweitzer

VP Education Kaylynn Purdy

VP Finance Lauren Girgis

VP Global Health Chris Briggs

VP Government Affairs Yipeng Le

VP Student Affairs Stephanie Smith

Western Rep Victor Do & Odell Tan

Ontario Rep Maylynn Ding, 2nd rep not elected

Quebec Rep Sarah Zahabi

Atlantic Victoria

Dr. Lafreniere- This is the early release of 2017-18 board election results, the 2017-18. Board will take effect immediately upon the close of AGM 2017.

Sunday, September 24, 2017: Annual General Meeting

Intro & Robert's Rules Review

Shreya introduces Robert's Rules and Nemo Contradicente voting.

Strategic HR & Operations Plan

Franco Rizzuti (intro)

- Why we undertook the strategic planning process
- Strat Plan 2014-2017: We did not have the expertise or staff support to drive the change we wanted
- We wanted to make our new plan actionable
- We identified who the leaders were from each school, and let them feel empowered to make decisions
- Discussed with auditors, lawyers, and other stakeholders
- Many of the changes in our strat plan will take many years
- Strat Plan 2017-2022: Blueprint for the upcoming years, up to interpretation by the board

Anthea Lafreniere (Where we've been: Strat Plan 2014-2017)

- Laid out directions that were actionable, priority setting
- SGM 2016: mid-point evaluation
 - We were not hitting marks from original plan
- Winter 2017: Tap Strategy & HR Consulting to do a review of the CFMS
- Spring 2017: Strategic Plan Writing Task Force
 - Anthea Lafreniere, Franco Rizzuti, Henry Annan, Dan Peretz, Kaylynn Purdy, Vivien Ng, Daphne Lu, Jacqueline Carverhill
 - More consultative process
- Group Feedback over 18 months over many groups

Vivien Ng (Operational Direction 1: Improve efficiency of committees & GA)

- Empowering students to work at the board
- Having information easily laid out
- Setting guidelines
- Decentralize decision making power from the board to the membership

Kaylynn Purdy (Operational Direction 2: Engaging & developing member volunteers)

- Restructuring timing of elections
 - Half of board members elected in fall
 - Half of board members elected in spring
 - National Officers selected in the spring
- Handover
- Increasing support for members to engage
- Undergraduate medical education being more supportive of leadership roles

Henry Annan (Operational Direction 3: Enhance board structure & regional representation)

- Suggesting a dyad board model (Appendix 2)

Franco Rizzuti (HR & Enabling Direction 4: Increase human resources & financial health)

- Mixed model of revenue generation
- Supporting volunteers
- Staff

Anthea: Where are we going?

- Specific changes will require individual resolutions to the bylaws
- Passing the strategic plan does not change the bylaws
- Five year strategic plan (instead of three)
 - We need to give the organization some space to accomplish these goals
- Next 18 months will include a lot of changes, to be presented to GA
- Goals from 2014-2017 will still be important in driving us
- This document is a roadmap - it gives many ways to get to the same goal, driving our organization forward

Resolutions Working Group Update

- Struck after SGM
- Looked at observed problems identified by membership
 - Unexpected feedback
 - Lack of transparency
- Need for new direction
 - Systems-level complacency with respect to adhering to critical assessment processes
 - A clear, thoroughly outlined submission process not previously communicated
 - Limited time for discussion at GM
- Recommendations:
 - Guiding documents reviewed by core stakeholders
 - Documents submitted 6 weeks before GM for feedback
 - Broad engagement targeting specific CFMS group
 - Allows feedback to be incorporated before the GM
 - Republished online 2 months before the meeting
 - List of papers that are being developed available online
 - Consent Agenda
 - Non controversial motions
 - Can move to have motions removed from the consent agenda
 - Create a Marketplace discussion model
 - Authors of motions can discuss with GA
- Phase II
 - Adopting “Emerging Issues” model
 - Definition of “fit”
 - Clarification of types of guiding documents
 - Review of Modified Robert’s Rules
 - Education of Robert’s Rules to GA

Resolutions Part I

Shreya calls the meeting into order: All schools present. All executives present (Jess and Alexandra by proxy, Kaylynn absent).

Shreya explains rules of the resolutions.

Resolution #1: Nemo Contradicente Voting

Moved by Sarah Silverberg (Toronto)

Seconded by Han Yan (Toronto)

Resolution passes unanimously.

Resolution #2: Adoption of CFMS Human Resources and Operations Strategic Plan 2017-2022

Moved by Franco Rizzuti (Calgary)

Seconded by Henry Annan (Dalhousie)

Direct Negative: NOSM

Franco: The documents proposed with the appendices, if approved today, the plan will undergo a revision process. Mission, vision, values and needs to be built into a preamble as the biggest change. The motion outlines year 1 implementation very quickly with work-plans built. There needs to be a process for priority setting. Henry will be doing this at the fall board meeting, The membership will know what's going on. Happy to take questions.

Discussion

- Nell Vandermere (NOSM): Dyad Model. Increased number of committees being proposed. We have difficulty with filling the positions, and want to ensure that there is adequate NOSM representation.

Shreya calls the question.

Passes with one abstention (CFMS).

Resolution #3: Creation of the CFMS Governance Committee

Moved by Franco Rizzuti (Calgary)

Seconded by Henry Annan (Dalhousie)

Franco: This is something me and Anthea did not speak to earlier. There are items that comes to Resolutions Working Group that do not need to be approved by the entire General Assembly. Connection point between the general assembly and the board. There lacks a linkage point. Governance committee developed with a composition that favours the membership (greater weight of these members than board). Appointed by PRT and Reps Round Table, with Nominations Committee selection of other members.

Direct Negatives: None

Passes by Nemo Contradicente Voting unanimously

Resolution #4: Change in Name for the CFMS Finance Committee

Moved by Daniel Peretz (McGill)

Seconded by Henry Annan (Dalhousie)

Daniel: The change reflects the current practices that will be in place with the new strat plan.

Direct Negatives: None

Passes by Nemo Contradicente Voting Unanimously

Resolution #5: Omnibus Bylaws Update

Moved by Franco Rizzuti (Calgary)

Seconded by Henry Annan (Dalhousie)

Franco: This is usually how we do bylaw amendments to do it all at once. \$20 is processing fee. No significant changes to spirit or organizational flow. Reflected new strat plan and just addresses new language.

Direct Negatives: None

As there is an associated cost to this motion, this can not pass by Nemo Contradicente Voting.

Passes unanimously

Resolution #6: Motion to Adopt the Position Paper Titled: “Support for Unmatched Canadian Medical Students”

Moved by Tavis Apramian (Western)

Seconded by Han Yan (Toronto)

Tavis: Over the year, didn't always communicate what we were doing about unmatched. Press release sent out after the AFMC published. Contacted the Toronto Star for articles. Created (marginally) successful network of unmatched students across Canada. Franco represented us on the Residency Matching Committee. They took the problem very seriously. Submitted prospectus to AFMC in July regarding feedback for unmatched CMGs. When you account for the American students who apply in the first round and the migration from Quebec, ratio of available spots in the first round has dropped below one. The drop in spots is the message we need to be sending. Tavis to send information to PRT regarding the messaging.

Direct Negatives: None

Passes by Nemo Contradicente Voting Unanimously

Resolution #7: Resolution to Adopt the “Curricular Advocacy Guidelines” Document

Moved by Tharshika Thangarasa (Ottawa)

Seconded by Silvia Njoda (Western)

Tharshika: We created a set of curricular advocacy guidelines. This is to provide document for curricular reform. Similar outlines exist. However, this is specific for medical curricula. Helpful for engaging in discussion if faculty curriculum reform is required. Consultation happened with faculty members and other stakeholders.

Discussion:

- Frank Battaglia (Ottawa): Point of Clarification.
- Ben (NOSM): Point of Order: Do you have to ask for direct negatives first?
 - Sarah (Toronto): Point of clarification can be spoken regardless of whether there is a direct negative
 - Anthea (Ottawa): When you open in a speaker's list, you are speaking to the question that is called. Point of Information often pertains to question at hand. You are welcome to have a point of information. If the Point of Information becomes a debate on the question, we can open a speakers list. We tend to use more Point of Information more than speaking for or against a motion.

- Frank Battaglia (Ottawa): Point of Clarification. For this motion, how do you plan to ensure it is accessible for first-time advocates?
 - Tharshika (Ottawa): Helpful to have a step-wise approach after this text document in the near future for students who are just starting to become involved in curricular advocacy in the form of a graphic.

Direct negatives: none

Passes by Nemo Contradicente Voting Unanimously

Resolution #8: Impact of Federal Tax Reform on Medical Students

Moved by Victoria Reedman (Toronto)

Seconded by Ben Cassidy (NOSM)

Victoria: Intent of this motion, not to be prescriptive, we don't want where, how what. We want more information on what the tax changes means for students. There has been a lot of "propaganda", and we don't know what the facts are. Members are asking for unbiased information. I am not a tax lawyer. CFMS cannot afford tax lawyers. We cannot unpack this ourselves. We are not confident in our abilities. We want to approach the CMA because we are their members. They have the resources for getting us a financial and legislative analysis. We recognize the CMA has taken a formal position. We want them to find us resources that are unbiased. I want to clarify CFMS partners not CMA partners. Open to question, amendments. I might make it unfriendly, so we can change have the membership vote on it to ensure everyone is heart. We didn't put it in the BIRT, we didn't put specific instruction, but rather vague.

Direct Negatives: McGill

Discussion:

- Christina (Calgary): Point of Personal Privilege. Would it be possible to send this to the general membership?
 - Shreya: It has been sent to the MedSoc presidents who were suppose to share it with everyone at your respective schools.
- Odell Tan (Sask): Point of Personal Privilege: can this be postponed until everyone has this?
 - Shreya: Who doesn't still have this?
 - Christina raises hand.
- Sarah (Toronto): Point of order. Can we amend whereas statement of BIRT?
 - Shreya: I will refer to our parliamentarian, Anthea.
 - Anthea (Ottawa): Since we only take action on the BIRT statements, we only amend those.
- Henry (Dalhousie): Open a speakers List. Point of information: CMA has officially signed on to the Coalition of Small Businesses. Against the tax reform portfolio. While we can request an unbiased report, the CMA is already against it. Happy to ask, but these groups have already said they are against it.
 - Ben (NOSM): Rationale is that we are members of the CMA and they have resources that we can access readily. Hoping for an unbiased report from the CMA, but also encouraging the CFMS to reach out to other organizations. Some kind of information would be helpful.
 - Victoria (Toronto): We can move to amend it if you don't agree.
- Brenden (Mac): Point of Clarification. I understand that you don't want to be prescriptive, but can you clarify if you have intentions on who on CFMS would take charge of this?
 - Victoria (Toronto): Government Affairs. President (sits on CMA board). Could also be a passion project of the regional reps.. Based on vision of individual passions.

- Kaylynn (NOSM): Point of Clarification. Why is the level of effort 20 hours?
 - Victoria (Toronto): Arbitrarily. I don't expect CFMS to create this document. This is more about the communication.
- Koray (McGill): Speak Against. Although it has been addressed, the CMA has expressed that they are against the tax reform. I don't think we should include the CMA because their position is expressly against. Bias is inalienable from information. I don't think the CMA should be involved in any capacity.
- Kaylynn (NOSM): Propose Amendment. Change number of hours to 1 hour.
 - Victoria: Friendly amendment.
- Sarah (Toronto): Propose Amendment. "The CFMS shall request that a diverse group of partners of the CFMS..."
 - Victoria (Toronto): Unfriendly Amendment as I would like the membership to vote on it.
 - Seconded by Liang (McGill)
 - Sarah (Toronto): I am speaking proposing this amendment with Franco and Daniel and careful careful monitoring of this situation. I am asking to remove the direction that we must provide information to our GA but perhaps see what CMA has to say. CFMS can independently decide what they would like to provide their membership in regards to information. As a separate organization, as an observer, we should be able to provide independent analysis. I am very much in favour of education our membership. What material is considered unbiased is very controversial as previously seen in Ontario.
 - Ben (NOSM): Point of Clarification. What resources do we have? It sounds like all of the sudden, the CFMS would be take on a lot of work to put together a lot of information. Does CFMS have the resources to turn this around in 2-3 weeks?
 - Victoria (Toronto): ceded to Sarah
 - Sarah (Toronto): the CFMS does have other groups that it could speak to. I would put that question back to you Ben, why are you asking the CFMS to ask CMA to provide information, why don't you go directly to them? You are going through us because you want unbiased opinion. There are other groups such as MDFM we can turn to. Other grassroots organizations and provincial medical associations. The time it would take, if the membership wants a lot of time in this, then that is what we will do.
 - Yipeng (Ottawa): Open a speaker list on this amendment. Point of information. I would like to the CFMS organization we are a non partisan organization. We want to represent all the student views. Getting a perspective on this is important. But having a stance on something that doesn't directly affect us, there are other means to focus on such as debt, tuition reform. There are other areas to work on and we have finite resources.
 - Shreya: no more speakers on this amendment. Shreya calls the question to adopt the amendment.
 - Amendment passes with abstentions.
- Franco (Calgary): Opens a speakers list. Speaking FOR. The amendment gives the CFMS the flexibility to work with the various stakeholders. Since has this gone out, the CFMS has been working and aware of what's going on at the CMA. Until the end of the consultation, the CMA has been opposed to the tax changes. As someone who sits on the board, regardless of the outcomes of the government, they will continue to work with all members to support them in whatever the change in legislation looks like. Current advice: meet with MDFM advisor or tax specialists to identify what is the most appropriate choice for you. We should be aware that advice will not be as unbiased as we want.
- Christina (Calgary): Speaking FOR. I would argue that medical students are aware of this information. Especially for mature students, when they are going to start a family. Tax changes would affect them significantly. This is information they need now. Information at this time hasn't been medical student focused. This is a problem and an urgent need. The CFMS asking for this information would be faster, especially with consultation approaching so urgently.

- Kaylynn (NOSM): Speaking AGAINST. It puts members of the board at risk for being targets regardless of what we ask. We know CMA is against this. Doesn't matter what type of information we ask for. We need to consider this.
- Stephanie (Calgary): Opens a speaker list. Speaking FOR. Many people across the country are trying to figure out what is happening at their school level. They are already doing the work, but if they collaborate, then we could get the info out quicker.
- Sarah (Toronto): Point of clarification for movers. Was the intention of the motion to get information prior to closing the October 2nd while keeping in mind that this process will close. What are we asking for?
 - Victoria (Toronto): Most important information is after the consultation period. We don't have time before the consultation period ends, even though that would be ideal. If people want to start reaching out and sending resources to their students, that's fine. As far as the CFMS, giving information once the actual documents come out. This motion is not something that could wait until SGM. Could inform people's CaRMS decisions
- Henry (Dalhousie). Amendment. I would like to propose an amendment to change the amount of hours required to 10 hours.
 - Victoria (Toronto): Friendly.
- Jeff (Sask): Speaking AGAINST. Leaves a lot of power to the board on who they want to approach, so it may not represent opinions of the entire general assembly. It would be better for us to discuss this as a GA.
- Daniel (McGill): Speaking FOR. It is trying to get information. It is not for us to make a stance. The alternative is not being informed. We should be educated. With regards to bias, these changes do affect us far down the line. The biases don't apply for another 10 years.
- Exhausted speakers' list.

Shreya calls the question.

Motion passes. 4 against and 3 abstentions.

MD Financial

Alison: My well being is your well being. I enjoy being here. I am excited to work with the new executive. Please continue to approach me. A couple things, I want you to understand the relationship between the organizations. CMA is your organization. We ensure we do things that are right for you. Jenna is always here. Connect with her from a CMA perspective. From an MD perspective, we are objective, we are salaried, we are here for you. As a CMA company, there is no charge, its objective, we aren't profit driven. We aren't selling products. Emails at yourvoice@cma.ca if you have any concerns. We would love to have your perspective. We want to hear from you. Please email me. Call me. Text me. All the information is there. We are here to advocate for you.

Resolutions Part II

Shreya calls the meeting into order: All schools present. All executives present (Jess and Alexandra by proxy).

Resolution #9: Motion to adopt the position paper titled: "Learner Privacy in Canadian Medical Schools"

Moved by Tavis Apramian (Western)

Seconded by Kaylynn Purdy (NOSM)

Tavis (Western): Thanks to Olivia Lee (med/law student) for doing the legal analysis of the paper. This is a springboard for your advocacy locally. Current pilot for handing over of medical information will require consent (from med school to residency via CaRMS). As adult learners, it is important to have measure of ability to control this information.

Direct Negatives: Sask

Discussion:

- Rishi (Mac): Point of clarification. Reading about the MSPRs, and introducing provincial aspect. How do you hope to implement a universal process to standardize what constitutes unprofessionalism when working with universities and provincial colleges with own regulations as the matching service is standardized across the nation.
 - Tavis: Ongoing working group for MSPR. They had our position paper from two years ago. Gurmeet has represented us well to that group and three students are working to create this standardization. This matter is slightly different. We have a concrete approach to MSPR and what we want to see in it and what should not be included. Language: not to advocate for single MSPR. More that if the administration at the school doesn't seem interested in using your data fairly, there is another body that you have recourse to.
- Sarah (Toronto): Point of clarification. Please clarify implications from what we learned from MINC yesterday and how that applies to the paper.
 - Tavis: We hadn't understand that the MINC is merely a number of ID. Information can not be transferred with the MINC. That being said, it may provide a way to link databases. What we need is a significant amount of increased clarity about the consent that we sign with CaRMS. Entering a phase where we can negotiate with CaRMS. Principles will guide this conversation.
- Sarah (Toronto): Point of clarification. Please comment on "time limited consent" from sharing of information. MINC shares core pieces of our information (name, year of graduation). Is that in direct contradiction of this?
 - Tavis: This paper is in contradiction to the consent that we sign. Time limited: means that organization does not have omnibus power to share my information for the next ten years. You have the authority to take this from one organization to another.
- Koray (McGill): Point of clarification. We had a question of the clauses where the AFMC and CaRMS should consult with medical students and their respective governments. It's not implicit that the government students will not be able to give consent on behalf of their student but rather their individual students will need to be consulted.
 - Tavis: our power is fractured. AFMC had negotiated on behalf of all the deans. We as individual students have to sign, their able to go around student government and collect the information they want. That tends not to happen because they trust the CFMS and FMEQ. We prefer these organizations come to the students.
- Liang (McGill): Speaking AGAINST. I resonate with the ideals of this paper. Number 4: one of the recommendations has residency matching with goal setting. Dilutes the message of this paper or not relevant to be included here.
- Nathan (Calgary): Speaking AGAINST. We find a number of concerns with the details of the paper, but we agree with the premise. Strong language, especially in the first recommendation. The MSPR is used as a checkpoint for professionalism, so we're not sure how we would get consent for release of the MSPR and how it affects CaRMS. Could lead to a situation where we lose a checkpoint for people with practice concerns. Universities and colleges should both take part in the professionalism.
- Kaylynn (NOSM): Speaking FOR. Recommendation #1. "Students should have an opportunity to see their MSPR and contest." Some schools have this, and others do not.
- Warren (NOSM): Speaking AGAINST. An important issue, but if students choose to withdraw their consent, then the data we receive post-match is going to be wildly skewed for others to make judgements on what residency positions they apply for.
- Liang (McGill): Opens new speaker list. Point of clarification. Please explain your reasoning for adding #4.

- Tavis: Chose to mention learner education. Adult learners should be treated as active agents in their own educational design. Anytime that it's asked of us forego a area of privacy that we once had. Well considered, justified and transparent process that goes into transferring that information. If it turns out that one of your preceptors doesn't like the way you dress or the gender, that should not be passed on to PGME. I believe and adult learner should know what's being transferred and be able to withdraw their consent for what information is transferred or not

Shreya calls the question.

- Franco (Calgary): Speaking FOR. Speaking for some of the strong language we use. In Alberta, MSPR go against Alberta legislation for privacy. There is no exception in legislation. Students have the right not to disclose. Case law and appeals court state that universities are not allowed to supercede constitutional rights. There is actually very strong ground in constitutional rights, that any other employee, they are not allowed, when terminated or fired, their not allowed to provide information to the new person. This should be for healthcare as well. We should protect our students because physicians are protected in a similar manner.
- Nathan (Calgary): point of clarification. What review did you do to find the information.
 - Tavis: We started with the contracts signed by learners when they submit . We investigated those of what is expected of a learner when signed a contract and compared those against relevant privacy legislation. THIS is problem FMRAC ran into when they tried the same thing, you're dealing with provincial legislation, and difficult to draw with a single brush. So we defaulted with the legislation, with AFMC and CARMS, that is Ontario's. This gives us the legal tools to make our argument. As you can see in our paper, in our legislation, if there is concerns at your schools and wish to use the CFMS paper, the language is strong enough to do some advocacy.
- Franco. Point of order. Can you remind the audience of what happens when the paper gets voted down?
 - Shreya: Accepted. If this paper is to fail, it cannot be brought back to the table for a year, September 2018, and in the interim and will leave the CFMS without guiding principles.
- Stefan (Ottawa). Point of clarification. If the paper is edited, would it become a new paper? That way a new motion could be brought up at SGM.
 - This would not come back to SGM.
 - Stefan: On a separate motion, but very similar moton.
 - Shreya: No.
 - Anthea: No. it will be 1 year.
 - Victori. Point of information. Motion to postpone, then next meeting?
 - Anthea: Yes that is okay.
- Cole Thomson (Calgary): Move to postpone the motion
 - Seconded by Warren (NOSM)
- Osman (Ottawa): We have already called the question. Can we still table?
 - Victoria (Toronto): Can we challenge your decision?
 - Shreya: Yes
- Jeff (Sask): Move to challenge the chair to be able to postpone this resolution.
 - Seconded by Osman (Ottawa)
 - Shreya: note that it will take a 2/3 majority
 - Victoria (Toronto): Point of order. Voting on whether this is going to be postponed and not on the motion itself.
 - Shreya: We are voting on appealing my decision to not allow the postponement.
 - Vivien (Mac): Point of clarification. What is currently happening? Are we voting because you've done things correctly and now we're voting to go against parliamentary procedures?

- Shreya: Yes. We will now vote to to appeal the decision to not postpone.
 - Sarah (Toronto). Point of privilege. Can we have a minute?
 - Chris (Manitoba). Point of information. Is it an overrule for the call the question?
 - Shreya: Yes. We are now going to vote to appeal.
 - Henry (Dalhousie). Point of order. I don't think the chair should be presiding on a motion to appeal her own decision. Can I request that the parliamentarian now preside over this section of the motion?
 - Shreya: Yes. Anthea will now chair.
 - Anthea: We are now voting to overrule the decision of the chair. To be clear, we need a simple majority of voters to overrule the chair. If you vote yes, then decision that we can not postponement is overruled. If you vote no, then the opinion of the chair stands.
 - Tavis: Point of order. If we are voting to dispute her decision, can we then re-open the speaker's list?
 - Anthea: The question is still called. You can not reopen a speaker's list. A motion to postpone IS debatable. You can debate whether you want to postpone. But you will be unable to discuss this discussion more.
 - Melani (McGill): Point of order. Is this 2/3 or 50+1?
 - Anthea: As per our bylaws, it is a 50 + 1 majority. We will proceed with the motion. You must be affirmative or in the negative as it is in the
 - Motion passes with simple majority. 13 against.
- Nicole (Calgary): Make a motion to postpone this resolution.
 - Odell (Sask) seconds
 - Anthea: We will also bring the chair back.
 - Frank (Ottawa): Point of privilege. Can we have more time?
 - Sarah (Toronto): Point of order. Given how many resolutions are left, would the room like to be efficient with the amount of time we have left?
 - Shreya calls the question to postpone the motion

Passes with simple majority. 15 against.

Motion postponed.

Gurmeet: Point of information. For all future motions, can we ensure that the recess is called before the question?

Shreya: Yes.

Resolution #10: Canadian Medical Students Updating Position on Tobacco

Moved by Paola Moresoli (McGill)

Seconded by James Mattina (McGill)

Paola (McGill): The spirit of this motion is that the CFMS has not made a position on standardized packaging. in Quebec, there has been interference with the tobacco industry and governmental policy. it would be good for CFMS to have an official position on this, like how in 2009, there was a position on smoking in public places, or position on menthol inclusion in cigarettes. Oops. my eyes were closed.

Direct Negatives: NOSM

Discussion:

- Ben (NOSM). Speakers list. Speaks AGAINST. I found this unfortunately I can speak for this. The paper was quite confusing. The spirit was lost on me Any small revisions would not clarify what the intent was.
- Sarah (Toronto): Point of information. As the VP Government Affairs, I worked with FMEQ on work on plain packaging on behalf of the CFMS, as it fit in the scope of the 2009 paper. Work has been done by the CFMS.
- Christina (Calgary): Speaks AGAINST. Incoming VP Comms to think of the language we are using as its posted online. I have a problem with the language. Suggestion that we adopt a WHO policy. THE CFMS cannot do this. The CCAC as a suspect organization can open up us to issues based on media articles. I don't think this a good form of evidence. The CSCAC is lobbying on behalf of tobacco companies. I don't know if that's a fair statement. All Canadian medical students against are against this. We don't represent all of them. We can't speak on behalf of everyone. I would not be comfortable putting this document.
- Howie (Alberta): Point of clarification. One of the recommendations says that the CFMS would oblige associations and other tobacco production sales...etc to disclose financial information. How do you intend to get these organizations to disclose this information?
 - Paola: Within the spirit of the paper, it's really to call on the government, it's not CFMS obliging or submitted. The paper would allow students at a local level or a provincial level as a whole medical school to advocate in the name of that. We call the government to do so. We recall the government respect what they have promised during the elections.
- Yipeng (Ottawa): Wanted to added onto VP Government Affairs. We are already doing work on plain packaging, and I think we can do that without passing this motion. That's possible without this motion. Also for the membership to know, Government of Canada is working on this.
- Adam (Ottawa): Point of information. Point of Information. I would like to acknowledge that this paper was brought forth by a general member. The spirit of the paper is good, even if the language is strong.
- Adam (Ottawa): Motion to postpone.
 - Christina (Calgary) seconds.
 - Anthea (Ottawa): Point of information. Robert's rule is that you can debate a motion to postpone. We have modified the rules at CFMS. We do not debate the motion. But it is up to the chair.
 - Christina (Calgary): Speaking FOR. A lot of work went into the consultation, and it could benefit with further collaboration.
 - Shreya calls the question
 - Motion passes.

Motion postponed.

Resolution #11: Improving Service Learning Curricula in Canadian Medical Education

Moved by Dongho Lee (UBC)

Seconded by Tavis Apramian (Western)

Direct Negative: Alberta

Dongho: Main authors Nakita & Samik unable to be here. SGM moved to create a paper to improve service learning. With authors from OMSA to present them to the national platform. We have worked with other provinces and incorporated their literature. Overall, I would like to point out, there were a bit of a question in the definition of service learning, those definitions will change in the future, but the up to date definition, sustainability, benefits of both communities. With some editing, the heart of the paper is in line with the CFMS.

Discussion:

- Angela (Calgary): Speakers list open. Speaking AGAINST. I appreciate you addressed my concerns. I am still speaking against. I brought up the definition. I have an issue, difference between partnering and

service learning. Service learning is about benefit to communities first but this paper is the other way. The recommendations are not primarily for students as there are only 2 target to the communities.

- Emily (Alberta): against. I do think this paper is student directed. Concerns of ethical training that should be involved. Very important they receive this. Further consultation with the community is needed. It will be determined to learning and strain to the community.
- Kaylynn . Point of information. Service learning to enhance benefit of students learning and secondary to community. Opposite of what the author stated.
- Victoria (Alberta): Speaking AGAINST. Often with school wide programs, the community organizations we have a power differential.
- Shreya: Please do not repeat things that have already been said.
- Angela (Calgary): Literature used in this paper is quite old (1990's-2000's). Service learning is an exploding field of research. Recent literature.
- Alok (Queen's): Point of clarification. Does the CFMS have a position on CFMS learning curriculum in general? Do we support this?
 - Dongho: I don't believe so.
- Tavis (Western): Point of information. Though may not be sufficient, recommendation, not strongly worded, it does cover your concerns. Those with strong feelings, come talk to us if this is postponed
- Nicole (Calgary): Speaking AGAINST. It is an accreditation standard. CFMS should be ethical and innovative.

Mover has withdrawn the motion.

Resolution #12: Motion: Support of Medical Student Parents in Undergraduate Medical Education

Moved by Sarah Silverberg

Seconded by Osman Raza

Sarah: Position paper that is a year and a half in the making. Collaborated with a team from OMSA. Not prescriptive, but to provide options that medical student parents may bring to their faculty in order to advocate for more accommodations. It provides many options for how that can be done. Provides background into what is available at schools as far as we could find. That's all I have to say.

- Dhruv (UBC): Point of clarification. It does not discuss tuition fees or finances. Why are they omitted?
 - Sarah: Those were omitted because they are not first concerns when student parents raised. We did not do an exhaustive consultation. It's one of those things that is difficult to discuss with the faculty. It has to do with accommodation and not this paper.
- Paul (MUN): Point of clarification. What constitutes a dependent vs. a child? Parents, siblings, etc?
 - Sarah: The language in the paper tended to support parents, including adoptive, parents-to-be. We didn't specifically refer to dependent. We can clarify that in the paper if it's passed.

Direct negatives: none

Passes by Nemo Contradicente Voting Unanimously

Resolution #13: Motion: to Adopt a Position Paper "Personal Day Policies at Canadian Medical Schools"

Moved by Meghan Plotnick (Dal)

Seconded by Han Yan (Western)

Meghan: 15 Canadian medical schools survey. Environmental survey of medical students across the country and based it on the policy and not necessarily the way it is implemented. Recommendations were to call to schools to provide students with a clearly defined number of personal days, to grant them, to have the policy clearly written, and pre-arranged absence policy clearly written. Allows for students to advocate for themselves at UGME or deanship.

Discussion:

- Julia (Queen's): Point of information. Should have supports for students who take personal days. Schools should provide makeup days. I would hope that individual schools advocate for those, too.

Direct negatives: McGill

Discussion:

- James (McGill): Open a speakers list. Speaking AGAINST. Does not frame itself as a general principle. Gives three personal days (based on MUN), but doesn't indicate that this is a smart strategy. McGill actually has more personal days. The number comes out of nowhere, and it could serve as a guideline for McGill to decrease the number of days.
- Adriana (Sask): Speaking FOR. Currently, only have a personal day policy in pre-clerkship. We are fighting with our UGME to fight for this policy. THIS would help us to advocate for it.
- Liang (McGill): Point of clarification. Is there a process behind why you recommended three days?
 - Meghan: We chose a minimum so they couldn't go less than that. The reason we chose three was not based on research (there is not much literature), but arbitrarily. Intention was not to advise schools to give students less; just to give a minimum number.
- Milani (McGill): Point of information. Speaking AGAINST. The main issue is that the way each school enforces this policy is different and how they protect student time is also different.
- James (McGill): Point of clarification. Minimum of 3 isn't based on research, but is 3 a good minimum number? Was there communication with MUN that this was a good number?
 - Meghan: No. We chose 3 because MUN actually has a policy.
- Nathan (MUN): Point of information. Personal days are only for our mandatory classes (1-2 days per week). Works well for some people, but there has been pushback.
- Nicole (Calgary). Point of clarification. Is 3 days enough for 3 year schools who don't take breaks in the summer?
 - No. Maybe certain number per module or block.
- Victoria (Toronto). Open speaker list. Favour in this motion. We must get a policy, we only get 3. We have to give 4 weeks notice. I understand your concerns McGill. You have so many that you feel threatened. But I don't see the dean taking away the days. This is such an important paper. This needs to happen now. Thank you for writing it.
- Ben (NOSM): Speaking FOR. Many are talking about pre-clerkship. We don't have protected days in clerkship. I think stating 3 is crucial. A minimum is important.

Shreya calls the question.

Motion passes. 3 against and 4 abstentions.

Motion to destroy the ballots by Sarah (Toronto).

Seconded by Odell (Sask).