

Canadian Federation of Medical Students Spring General Meeting

Halifax, NS

April 27-28, 2018

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Minutes Recorded by:

Cory Lefebvre, CFMS Ontario Regional Representative
Odell Tan, CFMS Western Regional Representative
Victor Do, CFMS Western Regional Representative
Chris Briggs, CFMS Vice-President Global Health
Lauren Griggs, CFMS Vice-President Finance
Sarah Zahabi, CFMS Quebec Regional Representative

Friday, April 27th, 2018

Welcome & Introduction

- Jessica Bryce welcomes everyone to SGM and goes over her goals for the meeting
- Everyone is approachable and accessible; Break times will be adhered to
- Informative, efficient, actionable, fun

President's Report

- Welcomes everyone to Halifax, his town
- Hackathon + Strategic plan is our marching order
- Once the Board was formed, we met in Ottawa for FBM. Hackathon gave us general themes
- Governance
 - Created governance committee, position paper submission guidelines, finance committee

- Still working on robust gov structure, GA from 2 to 3 votes, elections timelines, update ToRs. review school absences, ensures students on each AFMC committee
- Past-president as board chair now a thing
- Working on changing board member titles, Regional Rep as RRT, adopt dyad model
- Working on appropriate budgets, new sponsorships, transition manager, hire admin
- Successes
 - Trial of dyad model at Board model -- worked well for both Regional reps and VPs
 - Increased decentralization of decision-making -- relied on PRT, RRT, and ART
 - Insights provided by governance committee
 - Objective increase in membership engagement -- signups for website from 200 to 2000, more engaged on social media
- Challenges
 - Infrastructure still not in place for growing demand
 - Best avenue to reach our members
 - Fleshing governance structure
 - Delegation of authority network
- Education
 - uCMG Crisis
 - All-encompassing topic this year
 - uCMG student mentor network, military supernumerary spots
 - Very visible on mainstream media
- Advocacy
 - Day of Action - indigenous mental wellness
 - Over 70 students met with MPs, to advocate for accountability framework, first time CFMS invited for budget stakeholder lockup (valued as national stakeholder)
 - speaks to us growing in relevance;
 - Pharmacare report; CFMS has been advocating for this for several years
- Wellness
 - Redid wellness, wellness month to longitudinal process, over 800 members signed up, first time WestJet discount has been expanded from carms to electives time
- Global Health
 - post-GA IFMSA meeting in Montreal in August 2018 with three itineraries
- Presidential Tour
 - Visited all the schools in Canada (Moncton is in May); got a better idea of challenges at each school but also informed him of the cool initiatives at each school
 - Report from presidential tour for AGM

Roll Call

Present: UBC, UofA, UofC, USask, UofM, Western, NOSM, Queens, Mac, Toronto, Ottawa, McGill, Moncton, MUN, Dal

Panel Discussion 1: Optimizing the medical learner experience - Discussing the AFMC Electives Portal, CaRMS Online and MCQE

AFMC Student Portal Steering Committee - Dr. Robert Whyte (Chair)

Canadian Residency Matching Committee - Mr. John Gallinger (CEO)

Medical Council of Canada - Yves Lafortune (Director, Evaluation Bureau)

Moderated by CFMS Past-President - Dr. Franco Rizzuti

- Panel to give information on things that impact medical students
- Each group will give a 10 minute presentation then a Q&A after that.
- Dr. Robert Whyte
 - *slides*
 - Tries to engage and learn the medical student experience as an undergrad dean.
 - Contrast between before and after the panel
 - Before the portal - would have to go to each schools' website - was a lot of work - messy websites, inconsistent requirements and documents, and a paper process
 - Now on the portal - all 17 schools online w/ common documents and electronic submission
 - Able to produce national report
 - In 2017, AFMC heard the issues, re: timing.
 - Also get notification about cancelled electives (email and electronic) - home school is responsible to cover the student for a cancelled elective
 - Data from the Portal
 - Can see trends in the system
 - Can establish national benchmarks - creates competitiveness between schools and motivates them to do things
 - Eg Mac was behind in responding to electives - they took that data and made a change the very next year
 - Improving the student experience
 - Students on every committee
 - Steering Committee, Immunization Working Group, Data Analysis Working Group, Working Group on Application Fees and Refunds, and Enhancement Working Group
 - Creating a system to standardize things:
 - Eg immunizations - used to be that different schools had different requirements. We've standardized them as a result of bringing everyone together.

- Where to next?
 - Predictive data to make policy decisions
 - Equal access to electives
 - Processing Times
 - Application Fees and Refunds
- Help Desk
 - If you have any questions or need support, contact the desk
 - I encourage questions!
- Mr. John Gallinger
 - *slides*
 - CaRMS is a member-based organization. Each organization contributes people to the Board. 3 seats from the CFMS on the Board out of 18.
 - Important to have a way to communicate and have dialogue
 - Partners with learners, AFMC, and other stakeholders
 - High stakes process - we want to make the process as easy as valuable. Want to make sure that we provide value to students.
 - Matching is a big process - faculty, Ministries of Health, students, etc.
 - Specific to the CaRMS platform and process
 - System performance
 - User analytics - eg can see if people keep going back and forth between pages then that suggests there is confusion
 - Service hours - track the help desk questions and try to build that in in future years. That can be communication, the system, etc. Service hours are built around med student schedules.
 - Feedback
 - In-system ratings - direct user feedback
 - Face-to-face
 - Committees - reviews the applications seen
 - CaRMS Forum in the afternoon on sunday - discuss mechanics of the system and the system at large
 - Results
 - Enhancements to CaRMS Online
 - 23 system enhancements in the last year
 - New opportunities identified and in process (interview communications, BPAS)
 - New Website
 - Engaged stakeholders problem solutioning
 - New digital experience launching end of May 2018
 - New Help Desk Tools
 - Extended Hours
 - Self-serve tools
 - Look forward to Q&A and to engaging one-on-one
- Yves Lafortune

- *slides*
- We prefer to be discreet
- Mandate of MCC has evolved over the last few years
- On council, we have faculties, students, residents, and public members are represented - student reps are from FMEQ and Yipeng Ge (VP GA)
- We have processes to internally evaluate things
- We've been evolving to make changes to the exam
- The committee has representation from faculty and practising physicians - they know what they should access and how.
- Life cycle of content changes quickly. Guidelines change on a regular basis. If a change comes in yesterday, then we can't use that - we have to give an opportunity for those things to filter through to everyone.
- We've made a blueprint for the examination
 - More slicing and dicing on the examination
 - Blueprint applies to both Part 1 and Part 2, but focus varies between the two
- This year:
 - New examination is April-May 2018
 - Standard setting process is longer b/c of the new exam this year
 - Stringent process. It's done after the exam b/c they need the data
 - need to reflect the difficulties of examsmanship - standards of passing must be defended
 - In the end, it's judgement where the pass mark is, but it's an informed decision
 - Instead of June, the results may come at beginning of July
 - We have a full team of physicians looking at things
- In 2019
 - Part 1 is same in Canada and internationally
 - They will offer 4 time periods
 - Made to have the same standards across the country and internationally - international medical students and grads will not have to finish MCCEE before writing MCCQE Part 1
 - There are variance in sites - some are on campus, some are via Prometric - still working to standardize everything about this
- Various prep materials made for candidates (see slides)
 - Launch of new communications and
 - cultural competency modules – free
 - Clinical decision making video – free
 - Online OSCE orientation (May 2018) – free
 - Multiple-Choice Question Test (January 2018)
 - Clinical Decision Making Test (Fall 2018)
 - Preparatory Examination (January 2019)
- Practice tests

- Look on the website! Mcc.ca

Q&A Period

- Nathan Rider (UofC) - changes to the exam re: health prevention. How do we know what the test is testing if there is variance across schools? Difficult to prepare for an opaque exam. Difficult to study w/o adequate study materials. The feedback is not valuable. Objectives are not accurate.
 - MCC: knowing we were introducing this change, we've been working w/ faculties to figure out what the changes will be. Must organize the content. All areas assess the same things, but the way we assess is what has changed. We brought in psychosocial factors - we had content reflecting this in the past, but we're formalizing the numbers around this. We've come up with the questions in collaboration. Most importantly, we have prep examinations (full - multiple choice and CDM) in January 2019. We will have access to answers and the supporting data. This is likely be a very good tool for most people. Will help people understand what's on the exam. Eg we will be testing on Indigenous Health - we have always had questions assessing this, but this will formalize it. We will communicate the numbers here
- Ben Cassidy (NOSM) - in Matching problem, many rural places still experience problems. W/ the one-time positions, we know that those who are trained rurally are more likely to stay there. I was wondering what your different bodies could do to support the committees?
 - AFMC: bring your opinion via the student reps to the committees. If there is a national will to change things, then that is an electives theme that can be built into the portal. This is a decision-maker thing but you should bring it to them.
 - CaRMS: we can bring the data forward.
- Silvia (Western) - for the Portal. This centralized the process. Either can't contact the program via the portal or can't contact them at all. People are being encouraged to explore things outside of the portal. So what is being done for the portal in this case?
 - AFMC: one of the things we're starting to work on is that we are asking the Portal people at each school to make relevant changes. Data is useful for this - eg if there's an old elective that doesn't exist but people can apply for, we should force that to be taken off. We want to house all the information in one place. Have to separate the policy issues from the elective
- Kaylynn (NOSM) - registration for the MCCQE. Why do we register and sign-up for a site w/o knowing the location. We have to pay to sign up then pay to move the date. We may not be able to write where we want to or where we can write.
 - MCC: scheduling will be changing in 2019. How they will up is the most challenging part. In the future, you will schedule with Prometric. Starting next year, people can register 15 months in advance and schedule the exam 12 months in advance. On the Prometric website, all available sites will be listed. The faculties will still likely direct when and where people will write. We have to collaborate with them. If your school/program doesn't let you do something then

we can't guide that - we have to work within program guidelines. Life will be easier in terms of selecting the exam.

- Liang (McGill) - portal fees. Some people will select 2-3 electives at the same time. People apply for elective w/o knowing if they'll get them. It's a barrier to applying. Also reimbursement policy is varied. What is the plan for the reimbursement fee?
 - AFMC: Portal collects the fees, but schools sets the costs and determines their policies. We've been consulting students along the way. We've been analyzing the data and we agree with you - they are reasonable, known, and common concerns. We are now forming the recommendations now and we hope decisions will come in the fall. We will collaborate with the CFMS at that time - if you invite us back in the future, we will be happy to give you the detail. Question to students: are you willing to limit the number of applications you submit to make things more equitable.
- Debbie (Mac) - How will you work with PGME to facilitate better descriptions? For interviews, how will you accommodate people who have challenges due to weather.
 - CaRMS: descriptions are being reviewed and programs will have to put on their specific 'must-do' criteria. For the interview part - the notification process is moving away from emails and towards a different system. We're working on the communication piece first to stabilize the software aspect, then we'll look at the programs.
- Brittany (UofA) - students won't find out if they passed the exam until after they start residency.
 - MCC: we worked with the stakeholders so that students are not impacted. For the results themselves, we hope to get them out by end of June but we can't promise anything. We have to look at performance and ensure it's standardized. We will work to try and make things available as soon as possible.

REMINDER: President-elect nominations are due at 2:00pm ADT.

CMA National Physician Health Survey: Emerging Findings and Next Steps

Canadian Medical Association - Dr. Taylor McFadden

- Over the past year, CMA conducted National Physician Health Survey
- Overview
 - Higher risk of experiencing adverse outcomes (burnout, depression)
 - Attributable to personal, socio-cultural and system factors
 - Increasingly voicing distress + calling for resources/support/action
- Lack of recent Canadian national data, most recent data since 2007
- Series 1: National Snapshot: prevalence and demographic breakdowns
- Series 2: Occupational and Behavioural predictors
- Series 3: Comparisons with existing datasets - physician/general population
- Survey Development
 - Expert working group established (CMA, PHPs, RDoC, RCPSC, AFMC/Academica)

- Constructs assessed: Demographics, Burnout, Mental Health, Resilience, Depression (screening), Suicidal Ideation, Health Services, Physical Activity, Diet Habits, Alcohol/Substance Use, Sleep Hours, Work Hours, Career Satisfaction, Workload Satisfaction, Collegiality, Efficiency, Resources Satisfaction, Work-Life Integration, Impact on Patient Care (Perceived)
- Occupational variables has previously been ignored in surveys
- Emerging findings
 - 30% reported high levels of burnout (two-item Maslov index for burnout -- more conservative scale which may be under what is reported in the mainstream media)
 - 34% screened positive for depression (two question assessment)
 - 18.6% considered taking their own lives (lifetime); 8.4% in the last year
 - Females reported higher prevalence of burnout, depression, and suicidal ideation
 - Physicians with 5 or less years in practice were more likely to experience burnout and have low resilience, than all other physicians
 - 4% classified as 'languishing', 63% 'flourishing', 33% 'moderately mentally healthy', 82% highly resilient
 - Females had lower resilience compared to males
 - Physicians <=5 years in practice had lower resilience, compared to all other physicians
 - Instant analysis
 - Relatively few significant difference in other demographics (specialty, province, pop served)
 - At a glance, CAN/US/Intl data have comparable prevalence of burnout, depression, SI
 - Physicians are generally resilient
 - Help-seeking behaviour
 - 49% +32% are aware or somewhat aware of programs
 - Reasons for not accessing
 - 78% belief that situation not severe enough
 - 76% ashamed
 - 71% not aware of services available
 - Physicians may not be aware of broad range of services available through PHP
 - Stigma related to help-seeking and mental illness
- Sneak peek: series 2
 - Logistic regression and odd ratio of occupation and behavioural predictors
- Where we are
 - New CMA policy on physician health (online)
 - 2018 Intl Conferenc on physician health (Tor)
 - Active Collab w stakeholders
 - Med prof strategic initiative

- Cma wellness ambassador program - looking to engage students leaders with interest in wellness
- Key Messages
 - Physician health is complex issue and growing priority
 - Assessing should be done at more regular intervals
 - Strengthening phys health is shared responsibility
 - Encourage collab among stakeholders at all levels of health system to promote healthy, engaged and vibrant profession

Steph Smith, VP SA, and Victor Do, Western Rep

- CFMS National Wellness Program
 - Feedback from GA wanted more approaches to wellness other than wellness challenge
 - Advocacy work
 - Health promoting learning environments -- working at each school for cultural changes
 - Cultural change
 - Programming
 - Longitudinal wellness initiative : every two months has a new theme, good buy in from across country
 - Spotlights : recognize people with each theme
 - Safe Spaces : provide platform for students to talk about whats going on
 - Resiliency/Prof Dvpt
 - STRIVE program : simulated training for resiliency in intensive environments; trial at OMSA AGM
 - Longitudinal Curriculum
 - Awareness
 - Wellness Spotlights
 - Themed Campaigns
 - Advocating to get funding and support for local level initiatives

Questions & Answers

- Vic (Toronto): data showing young female physicians struggling more is that general population or specific to profession? How do you quantify resiliency? Culture change work?
 - A: (Taylor) trend for young physicians and female physicians, in physician populations and general populations. Resiliency - Connor-Davidson scale to measure resiliency - best one out there - but positively skewed. Out of 8 but gen pop tends to hit 6 or 7, self-reported scale
 - A (Steph): starting student mistreatment file, ensure those who want to be involved are involved, talking about cultural changes in small working groups, normalization of accepting failures is important
- David (Dal): future data analysis: practice setting (urban vs rural) or structure (academic, etc).

- A (Taylor): we did look into academic, admin, hours with patients were considered in the collection of data
- Andy (Tor): burnout/prof measure - high levels of burnout but more than 4% than 'languishing', so some of those with high levels of burnout/si were classified as moderatey mentally healthy
 - A (Taylor): mental health and illness are two different concepts, not fully overlapped - burnt out but could still be moderatey
- ??? (McGill): conversation about should resiliency be assessed in CBME
 - A (Steph): resiliency should be there but not something evaluated, reaching out to schools across the country to gather what is happening re: resiliency programs. Learn about individually, to help peers nad to help patients. We should feel confident about integrating
 - A (Talyor): resiliency needs to be looked at and strengthened, but other changes are needed. Even those who are resilient still suffer from mental health issues

MD Financial Management Presentation

Alison Forestell

- She is MD-CFMS lead
- MDFM is here to support CFMS
- As a CMA company, MDFM is designed to care for physicans and families

Jenna Love

- Represents CMA Foundation, MDFM, and Joule
- Playing a game!
- Q1: True or False: It is impossible to hum while holding your nose.
 - TRUE
- Q2: As a division of the CMA, which of the following is not formally part of the 'CMA Family'? MDFM, Joule, CMA Foundation, or PTMAs.
 - PTMAs - they deal with provincial issues and bring things to the national level
- Q3: Which of the following is one of the CMA's present advocacy portfolios? Cannabis, Seniors Strategy, Cannabis, or all of the above?
 - All of the above - CMA evolves to do things as we go
- Q4: The CMA played a major role in the creation of which financial product? RESP, RRSP, SRLOC, TFSA?
 - RRSP - physicians didn't have a plan for long-term savings. RRSP was introduced as a result of CMA's advocacy. Now MDFM manages \$47B+ of physician holdings
- Q5: When can I start to use MD services? When I become a medical student, once I start making an income, when I become a practicing physicians, or anytime?
 - When I become a medical student - right when you get your letter, you can become a member. MDFM currently offers Prime -0.25%.
 - On the MDFM and regarding SRLOC, there is something involving \$500 cash! See them at their table

- Q6: Using one word, what is a common fear when meeting with a financial advisor?
 - Debt, judgement, manipulation...
- Q7: Which company is the world's largest tire producer?
 - LEGO
- Q8: Joule has innovation grants exclusively for medical students and residents?
 - True - as a result of CFMS advocacy
- Q9: Which of the following are available through Joule?
 - RxTx, DynaMedPlus, Clinical Key - all of them!
- Q10: What are the three pillars of the CMA Foundation?
 - Medical education, physician wellness, and outreach
- Q11: Who do CMA Foundation grants support?
 - Medical students, residents, and physicians at every career stage?
 - Communities?
 - All of the above? ← this one! There are CMA 150th Anniversary Bursaries and Awards Program. \$15000 at each school and \$8000 based on financial need. CMA also donated \$20000 to the Humboldt Broncos bus tragedy survivors.

MD Financial Management Leadership & Travel Awards

Atlantic Regional Representative - Victoria Januszkiewicz

- U of A had the most applicants. Every school had more than one applicant. If someone applied but wasn't selected, encourage them to apply!
- MDFM Award Winners:
 - U of A - Derek Fehr
 - U of M - Linda Lam
 - McGill - Olivia Monton
 - Queens - Andrew Dawson
 - Western - Mai Malkin
 - MUN - Michael Curran
 - U of S - Erik Yip-Liang
 - Ottawa - Frank Battaglia
 - Centre de formation médicale du Nouveau-Brunswick - Aimee Bouka
 - UBC - Jenna Smith
 - NOSM - Sarah Mavin
 - U of C - Stephanie Gill
 - U of T - Sujen Saravanabavan
 - Dalhousie - Yaeesh Sardiwali
 - McMaster - Bushra Khan
- MDFM Travel Award Winners:
 - Western Region
 - Sarah Kent - U of A
 - Joshua Nash - U of C
 - Quebec/Ontario Region:
 - Milani Sivapragasm - McGill
 - Emily Yung - McGill University
 - David Wiercigroch - U of T
 - Atlantic Region:
 - Jane Brodie - MUN
 - Wildcards:

- Samuel Bradbrook - U of A
- Qasim Hussain - U of S

Welcome by Dr. David Anderson, Dean of Dalhousie Faculty of Medicine

- Welcome to Halifax!
- 2018 is the 150th anniversary of Dal Medical School
- An exciting time to enter the field of medicine as physicians - technology is a huge factor. Academic and clinical care opportunities are amazing. The challenges are huge and are ours to solve. Caring for disadvantaged populations, escalating healthcare costs, etc. A well-informed public disappointed in their healthcare system.
- To take advantage of the opportunities of tomorrow, we need to be leaders. Student leaders are important. I thank and congratulate you.
- In light of recent events, it is great to see students adding their meaningful and impactful voices, particularly for uCMG and wellness.
- Our society depends on your success.
- Thank you for all of your work.

Finance Report (in camera)

CFMS VP Finance - Lauren Griggs

MOTION: To move in camera

Mover: Odell Tan (USask)

Seconder: Rishi (Mac)

Motion result: PASSED

- In camera.

MOTION: To move out of in camera

Mover: Odell Tan (USask)

Seconder: Chris Briggs (UofM)

Motion result: PASSED

CFMS Board of Directors - 3 Minute Theses

- VP Communications: Advertising all the activities from the different portfolios in the CFMS is major work. Follow on social media, all handles are @CFMSFEMC. New initiative that we started this year: #HowWeAdvocate: to try to highlight some major advocacy work that is happening at local levels. Bilingualism committee is moving and doing great work, led by Sarah. A lot of press releases, open letters and lots of media. Unmatched publications: many radio, tv, media opportunities etc. Annual Review published as of today.
- VP Global Health

- Exchanges: 130 outgoing, 40 incoming, contracts signed in August. Small working group discuss. Full delegation of 16 people to IFMSA in August
- Global health case files: now publishing
- Social media certification: now ready to go
- Survey of global health education across the country
- Global health mentorship is lacking and we are working on profiling different physicians who focus on
- Indigenous health curriculum report card being worked on
- NORP, also works with HEART, core competencies in health environment and looking at curriculum
- Reproductive and Sexual Health: did a letter writing campaign. Also works with non-profit groups in the community.
- Working to obtain more public health internships
- VP Student Affairs
 - Fun activity
 - The focus this year is on wellness, NWP and LWI which we have already discussed. In terms of services there are quite a few different discounts going on, big one was Westjet having the 10% off
- VP Government Affairs
 - National Day of Action: Indigenous Mental Wellness, a lot of great work went into this process. Many interviews and consultation went into developing the ask document. Schools are going to do follow-up work, bunch of different projects. CFMS specifically we are having a studentship focused on this work.. Also a virtual forum hosted by COHP and Assembly of First Nations. Day of Action 2019 to gather more ideas for next year. Government letters: ratio of 1:1.2. Part of lobby day with OMSA as well. Congratulate local schools for their lobby days etc. COHP has done amazing work, including position paper submission process which has been revamped. Did a lot of great policy work as well. Examples given. Rapid Response, Pharmacare and others
- VP Education
 - UCMG issues: main focus, developed task force lead by unmatched task force to try to advise us on our work. MOTP Surge funding for extra spots. Ontario also created spots so advocacy directly led to spots
 - Worked with CaRMS to try to ensure process is fair and easy
 - Portal: Issues around this, asking for refunds, need to get people to agree to a two-step model (don't pay until get a spot)
 - MEDSKL: Access to free question bank from this group, will send it out
 - Royal College: engaging with medical schools, CBME summit, engage with us on their fellowship and regional committees
 - MCC: trying to make changes, want changes to obviously be favourable not just to them but to students as well.
 - Accreditation: lots of great work in trying to help schools when going through ISA's etc.

CFMS Board of Directors Q&A

- Debbie (Mac) - VPC - changing the newsletter re: privacy laws. ON thinks that it's hard to sign-up b/c website isn't user friendly.
 - A: Christina - Key priority for me. Transition to a new way of delivering the newsletter - will start with the new members. We will have to change it and for legal reasons we do have to change it. We are just finishing transitioning to the new website. NO IT were great in managing this.
- Dawson (Queens/OMSA) - anybody relevant - with regards to CarMS release of information, Queens students were contacted the night before if they were left unmatched. This year, it's no longer allowed. Queen's clerks are asking for an opt-in version so that they can find out beforehand
 - A: Franco - Backstory- 5 years schools never had access to pre-release, pre-release contract is being done now. Dean, UG and PG deans had access so that they have information if CaRMS went down. Deans started using this outside of contract. Concern of equity - both students and deans are paying into this. CFMS and learner groups have asked multiple times to meet with AFMC, AFMC refused to meet with us. AFMC and CaRMS kept going on with contract negotiations. CFMS advocates for more supports for students but there was no forum to do so. We need all three players - AFMC, CaRMS and CFMs/Learners. We were not afforded the forum to have these discussions.
- Brittany (UofA) - VP Ed or anyone relevant - at the portal, good to hear there's progress on refund. What about the equity of the fees? Two week elective might be \$x, but 4 week elective at another cost might cost the same. How can administrative costs vary so much?
 - A: Kaylynn - I agree with you and have the same questions. The dean at Mac has this on his radar and understands the equity. Some people may not be able to apply outside of home school b/c they can't afford it. When we ask to reduce....: some people don't know where the money goes. Some schools are accountable and talk about that, but others have no idea why they have their fees at the amount they are at. They won't lower the fees b/c it might overwhelm systems if everyone applies for an elective. One way to address that is to limit the number of electives per cycle. They say it's still a concern. Reality is that the money is a barrier.
 - A: Maylynn - good news! Fees and refunds committee sent a draft report of recommendations. Calls for transparency - schools will be required to breakdown where the fees are going to (eg. processing costs, setting up the elective itself). Also potential limit on number of electives able to apply for in a single block. We don't know if those will pass - hopefully at the end of the weekend.
- Kaylyn (UofA): elaborate on the other day of action?
 - A : Yipeng - Second lobby day will happen MAr 29th with only about 5 -10 members - Maylynn Ding (Ed rep), Henry Annan (President), Sarah Silverberg

- (uCMG lead), Sarah Zahabi (Quebec Rep), uCMG student - TBD - purpose is to advocate nationally to make strategy to address uCMG and physician workforce planning. Get residency ratio closer to 1:1.2 - paper passed in fall. Target specific ministries and MPs.
- Derek (UofA): is there a way that we can create a system so that applying students will know how many available spots per elective?
 - A: Kaylynn - we asked about that. Administrative requirements of this. Eg. we ask UofA and they try and coordinate with departments. But they can't tell students until the department gives their own response. Other departments have their own policies. Communication mode is not clear. Updating the portal may not be accurate b/c of all of these problems.
 - A: Victoria - Also have to account for potential sick preceptors, etc.
 - A: Maylynn - plan to have the success rates of electives and average time available to students.
 - ?Emilione (Dal): used to be electives database where there is informal way to get information. CFPC working with rural medicine to create family medicine electives database (place, living arrangements, etc.). What happened? Are we still using it?
 - A: Henry - the understanding is that it was a longtime service CFMS used to provide - preceded the Portal. Once the Portal happened, it was tricky. When we transitioned from the old website to the new - it was a long process - we haven't had the talk about what the Electives database would look like.
 - Q: Is the Portal more academic?
 - A: Henry - yes, what you described is different than what it looked like before.
 - A: Victor - Steph and I are reviewing the process and recruiting people to look into this. We're open to feedback. There is role for a database like that
 - Julie (UofA): what is your stance on pan-Canadian Health Human Resource planning and what is your plan to help schools?
 - A: Henry - I sit on PRPAC (Physician Resource Planning Advisory Committee) + other learner orgs + other stakeholder which tackles the issue of pan-Canadian planning system to address HR issues. WE're helping schools via Education portfolio by talking with different provinces and get feedback to incorporate into our work
 - Sarah (NOSM): in my opinion, point of privilege, issues surrounding the release of the schedule and agenda for CFMS meetings. The start time and end dates. Relevant for us at NOSM - we have stricter deadline to meet and we have to apply for time off. Will the board consider implementing stricter timelines for the availability of the agenda.
 - A: Henry - dates are advertised in January, general idea of agenda is usually known - RTs , Friday and Saturday days. SGM follows CCME and AGM is penultimate weekend of September, generally. We can do a better job at communicating the exact dates to schools. Actual start times tried to be sent out at least a month ahead of time. The agenda always changes based on board availabilities. SGM runs parallel to CCME and thus board members often have to

- attend meetings at CCME. We can do a better job at communicating dates, agenda (a month ago)
- A: Christina - dates are sent out in January because travel awards applications are announced by then. We can do a better job
 - A: Franco - if any school needs a letter for the Dean's office we can send out that
 - A: Victoria - we send out letter to schools
- Dave (UofA): what can people do locally to help solve the uCMG crisis?
- A: Kaylynn - going to provincial authorities is very helpful. ON is unique with 6 schools and OMSA, we do our best to contact our appropriate health authorities. Announcement ON - that money was left-over from PGME ----
 - *interrupting* Victoria (UofT) : correction, the money came from provincial govt with some money from PGMEs, making local grassroots guide/toolkit
 - A: Kaylynn - work with Deans - PGME and UGME - to get that money and turn it into seats. Many schools have the money leftover.
 - A: Yipeng - all students are members of OMA and OMSA, OMA thus represents Ontario medical schools. PTMAs are negotiating bodies with provincial governments and federal government via CMA. Healthcare spending are allocated based on provincial government. Encourage all students to check if you are member of PTMAs and make it a priority of residency spots for PTMAs and CMA.
- Sam (UofA): finance question -- we'll talk with Lauren offline.
- Jessica (Chair) - please remember that all finance-related questions should be made in-camera (which we can do anytime) or talk offline
- Melissa (UofM): communications and transparency. As the representative body for all student members, is there any plans to livestream the conference to make things more available?
- A: Christina - we have looked at extensively for this meeting. The challenge is technical. It depends on the ability of internet of the conference centre. That limits the ability to livestream. Social media is being updated constantly with quotes, albeit time delay, to keep people abreast. Minutes are being taken as fast as possible. We try to livestream as much as possible and engage with students as much as possible
- Jeff (USask): At Ottawa AGM, we voted that the CFMS will work with the CMA with regards to the tax changes, are we continuing to work on this issue? Are there any updates with this issue?
- A: Victoria - in fall, we talked with MDFM. We used their resources. MDFM has this available online for everyone. They have a summary of everything. Yipeng and I felt they were unbiased, so we distributed them via RRT. We were also waiting for the changes to be actually implemented and see what happens. SGM came and I was busy. That is my project for Summer Board Meeting. MDFM has great resources - can target towards people and certain populations.
 - A: Yipeng - the proposed tax changes announced back in summer have mostly been rolled back. We'll wait to see the real changes

- Victoria (UofT): Thank you for the board and all work. Why do we do all our budget sessions in camera?
 - A: Franco - history has been to have the financial numbers for the members only. In keeping with most of the meded organizations. It's for the members. The concern is that - especially at this meeting - we have lots of external organizations and we aren't privy to their statements, so we do the same. It complicates partnerships. The finances are not designed for only the 150 in the room, so you can always reach out to Lauren to make the finances available to their other people
- Victoria (UofT): How does that complicate things?
 - A: Franco - It can influence sponsorships if they see the amount that comes out.
 - A: Henry - Lauren made high-level infographics with broad trends that can be made available to the membership. We will work with RRT and PRT for this. We can work on that.
- Victoria (UofT): What about the website? Can we make things available on the website?
 - A: Yes we can do that behind the log-in.

Royal College Interactive Session: Competency Based Medical Education (CBME)

Royal College of Physicians and Surgeons of Canada - Dr. Ken Harris

CFMS CBME File Lead - Silvio Ndoja

- Presentation: Path of medical training; Medical school, then residency (outcome is certification), either by College of Family Medicine or Royal College which oversees 68 different programs; hospitals need further certification before you can practice.
- Teaching system developed long time ago and we have not changed even with changing times. Quality improvement opportunity. What you have in skills at residency determines your future practice. Really want to get people to proficiency and expertise before finished residency.
- CBME: outcomes-based approach to the design, implementation assessment, and evaluation of a medical education program using an organizing framework of competencies. Used around the world. Family medicine has a Triple C
- Competency program needs to be based on a framework, in this case we use CANMEDS.
- Changes as you go through different stages of training during residency. You start with transition to discipline and get through the core foundations of the discipline before you start transitioning to practice. Propose moving the exam forward, want the latter stages to be focused on independent practice while still having safety net of close observation.
- Milestones: qualities expected of a health professional at a stage of development
- Entrustable Professional Activities (EPAs): The key tasks of a discipline that a practitioner needs to be able to perform.
- Each EPA integrates multiple milestones
- Example of EPAs given.

- Work based assessment: want to provide more feedback and coaching, have multiple low stakes observations that will get closer to your true level of competencies, not so much about passing and failing. Having competency committees to review things.
- Key concepts that residency is for learning, and in order to learn you need to know how to improve. Different mindset, assessment for learning.
- July 1st 2017: anesthesiology, ENT launched
- Six more disciplines set to launch soon.
- Impacts on clinical experience: CBD is a hybrid approach to competency-based/outcomes focused teaching
- Not anticipated that time will change.
- Silvio: A lot of people don't know much about CBME (info not readily disseminated...so how do we get more information about it out.
- For next bit, work with members in your schools and other schools; those who attended workshop, start to work together on a dissemination plan with respect to CBME.
- Small group work: no minutes
- Q: CBME, one of questions is that certain trainees may be able to achieve competencies earlier, likewise there could be some extension to the process. Can you go shorter, longer?, funding implications
- A: Unusual for people to finish earlier, maybe someone who is a transfer or who has some additional training beforehand. more funding from ministries, don't want to lengthen training, at the same time they are responsible to ensure that people who graduate are competent.
- Q: Differences of competency based education in different specialties, further the difference between theory and practice.
- A: Will evaluate as we go, have already learned from the first few programs that are starting. For example anesthesia has too many EPAs, other concerns has been the need for further faculty development.
- Q: The need for trainees to get competencies through different rotations.
- A: Internal medicine competencies that you need for other specialties like general surgery. Remove the very rigid structure that you say need to spend 3 months in internal medicine, more flexibility, focus is on competencies vs the need to go through different specialties
- Q: Any data that CBME would be more expensive to train residency
- A: No data currently, there will be some upfront things that need to be considered, feedback is important part of training process.

Resolutions Marketplace

CFMS National Officer of Health Policy - Shanza Hashmi

- No minutes.

Saturday, April 28th, 2018

Keynote Address

CFPC President - Dr. Guillaume Charbonneau

- It's a pleasure to have been invited. First got involved as medical student and got so much out of it.
- CFPC certifies family medicine residents, and accredits family medicine faculties
- UdeM med student, pres of medsoc, pres of fmeq, founded ifmsa-qc, sherbrooke residency, president of fmrq
- Rural med in maniwaki, ED/IC/PrimCare
- Pres of QCFP, founder of GMF VG (Groupe Med Familles)
- Born to be a Leader? I don't think so
- You can build your skills (the sail) but you have no control over the political context (the wind) -- boat metaphor
- I was not expected to be a leader - I was a regular teenager - but my grades were good; and I wanted to do good things
- When I got into medicine, I could have been a 99% student, but instead I decided I would give some of that up to contribute. Global health was a good entry
 - There's a lot of problems in other countries but we have problems too
- I started by creating a bioethical committee. Did events, wrote things for the journal, etc. I then moved to the board of the organization and wanted to change things. One of the things was that the student experience was not equal to the higher-level experience - so I advocated for this.
- After this advocacy, my peers encouraged me to run, so I did! And I won! But I had to learn a lot more things - finance, governance, etc.
- Once you're the president, you're not a leader - you're a follower. It's a very different role. I came to CFMS and presented a project 14 years ago.
- Before I came to the CFMS, we had a little war between CFMS and FMEQ. The project was to create IFMSA-Quebec.
- I was hesitant - was this the best thing? I had spent years rebuilding connections, but then I would be asking to separate Quebec.
- Their response was that it would be more efficient! It would allow us to have our own position
- Now we have a critical connection between IFMSA Canada and IFMSA Quebec. The annual meeting is in Montreal again this year and it was there in 2010
- It's a competitive bid - just like bidding for the Olympics - with posters and campaigning
- Treasurer is important - they need to get money!

- I was on the negotiating body of the body representing Residents in Quebec. I was President of the negotiating body. I experienced burnout.
- I made the choice to take a step back - when you're in that situation you feel tired. You don't value yourself.
- But it was at that time when I learned most. I learned from doing too much and not taking care of my wellbeing. I am stronger and better because of this,
- People asked me to be President of the body. I said no. But important work was being done - organizing family medicine as a specialty.
- I agreed to be Treasurer.
- I got involved... Then I became President and that's where I am now
- There's sacrifice when you get involved - people around you have to be on-board with that
- As a student, medicine is a great field - lots of great opportunities. Make sure not to take-on too much stress. If you engage, you'll do it well and you'll be happy.
- I think Family Med is the best field - we has global vision of health, diversity, flexibility, and FM is important for the healthcare system
 - Diversity - you see lots
 - Flexibility - you can be anywhere in the word
- Family medicine is more than just family care.
- We need to be able to adapt to the needs of the community
- When you get a good generalist and family physician, you have better outcomes
- Medicine is an exciting career - lots of things to do
- Learn to say no, but also learn to say yes
- Learn to know yourself - you're your worst enemy
- Learn to make things better
- Learn to say tank you
- Build your network - people in positions of leadership will remember you.
- Believe in yourself
- Get motivation from success and learn from failure - If that's the message, that's fine - but if you want to deliver a message then that's not good enough
- Have fun and continue to develop your skill
-

Regional Marketplace

CFMS Ontario Regional Representative - Cory Lefebvre

Regional Minutes

- Western Region
 - General update
 - Western Dean's Conference was in October - we focused on uCMG, career planning, and wellness in Clerkship

- Highlighted things from schools, like USask's 5th Year Curriculum or Manitoba's opportunity for uCMG's by producing new spots for them - we advocated for others schools to duplicate these things
- We're also exploring opportunities for more intra-Western Region interactions - potentially Western Dean's Conference and AMSCAR
- In regards to the dyad partnerships:
 - Odell was with the Finance Portfolio - helped with Finance Committee, Strategic Initiative Fund, and Governance Committee
 - Victor was with Student Affairs - created the National Wellness Program
- Experience with the dyad model
 - Positive experience - helped to engage the Regional Reps at a new level so that they can actually participate in portfolio - something that wasn't there before
 - What about the perspective that the dyad partner is perceived as getting the 'inside track' to the VP role?
 - We often have past VPs come back to the role and that hasn't prevented lively elections. This could encourage that more by having another person similarly engaged in the portfolio
 - It's an opportunity for leadership development and continuity in the organization
 - National Officers, other Chairs, and Board members in general already have that disadvantage
- Increasing engagement → Western Dean's Conference and AMSCAR
 - This year, Victor and I will try and get CFMS funding to get students to the Western Dean's Conference - perhaps the wellness reps so that they can interact with the Student Affairs Deans?
 - Reminder that we're able to do this b/c the USask planning committee is willing to have students at all of these sessions - future Presidents need to work with the planning committee to ensure this opportunity is maintained moving forward
 - This is a starting point for us to grow from - but we need to grow it slowly so that it's meaningful
- Bringing more people - VPAs and GH - to our interactions, even over just a teleconference, so that they can share information and learn how to advocate
- Try to engage more than just the people who have a MedSoc position - we want to utilize all of the membership to advocate for things from a variety of angles
 - We want to make sure there's clear lines of communication so that we're not unnecessarily duplicating work
- Ontario
 - Q: How are CFMS and OMSA working together on Advocacy and uCMG
 - CFMS at MPP Gila Martow Press Conference in March

- Retweeting #Spots4Docs and OMSA press releases relating to uCMG
- Working closely between CFMS and OMSA regarding advocacy strategies
- CFMS Board Members very involved in OMSA and advocacy, e.g. Maylynn Ding (Ontario Regional Representative and Education Attaché), Yipeng Ge (VP Government Affairs)
- Q: Update from Dawson (OMSA Chair) on gov't contract negotiations
 - A: Dawson provided update on progress in negotiations as student rep on OMA
- Quebec
 - Inward facing lobby day discussion
 - Would like clarification on the Pan-Canadian Federal level asks
 - Would like to discuss with FMEQ and determine whether or not a representative from that learner organization should be present
 - Discussion on the incentives for the open family medicine rural spots and making these spots more attractive to students
 - Queen's student from Quebec mentions that a lack in financial aid afforded to medical students from Quebec who study outside Quebec might be a contributory factor; a disincentive to return to Quebec
- Atlantic Region
 -

Small Working Groups

CFMS Quebec Regional Representative - Sarah Zahabi

- Small Working Group individual minutes

Table 1 - uCMG (Cory Lefebvre)

- First Discussion
- **Michael (BC)** - Cost of medical student is v. high. Medical students are more expensive than residents and government should happily cut student spots to reduce demand save money. However, UGME programs are hesitant to start that discussion because it puts them at risk. Nobody really wants to open that conversation but everyone knows that it is an important issue.
- **(Dal)** - Makes sense schools don't want to cut spots. But it's up to government anyways to see if they want to fund those spots. If ratio gets worse, government looks worse.
- **(UoA)** - Cutting entering classes is a quick fix but unsure if its on the table
- **Cory** - Quebec cut ~17 spots over the last 2 years? Ministry of Health pays for residency spots and Ministry of Education pays medical students. Very little communication and two very different areas leading to difficulty in coordinating changes.
-

- **Q: What is the demand like for doctors? If we need more doctors, cutting medical student spots doesn't seem correct.**
- **Cory** - For Ontario, they have enough doctors and will always be producing enough doctors. Shortcomings of the system are seen more as resources than physician shortage.
- **(Dal)** - Atlantic provinces definitely need more doctors.
- **Maichael (BC)** - One issue is convincing PGME and Dean's that it should be seen as a problem to them. Residency has become a buyer's market. These are publicly funded students and it is a public responsibility to ensure they match.

- Second Discussion

How to improve:

Approach of PTMAs vs CFMS on supporting uCMGs

- Gov affairs portfolios plan on setting up a second lobby day with fed gov to talk about uCMGs, unsure on if there is anything in the works for PTMA work to bring this up provincially for lobby days

At the various schools, how do various faculties look at uCMGs? Is there any stigma?

- Dal - there has been a distinct institutional shift from blaming students to supporting them; 5th year option after 2nd iteration, well supported in setting up extra electives and research, getting a support group
- Having a good strategy, is that something to blame students on?
 - Sask - not the students' faults
 - UBC - deviation from back ups is more high risk, going unmatched is probably going to happen

Ottawa - standardizing how students are evaluating fourth years, ca

- Memorial - looking at strategies to extend clerkship
- U of A - approaching the PGME directors can provide student feedback for the electives from that school, could be beneficial to standardize across the country
- Giving feedback to students who do not match would be beneficial to those students, to help them realize how they can improve

Queen's - our 5th year program pays full tuition, and it's a lot of \$\$\$, what do other students do

- U of T - reduced tuition
- Dal - don't know
- U of S - full tuition
- Ottawa - full
- Western - reduced
- MUN, UBC, McGill do not have 5th year
 - Memorial has a semester available to uCMGs, not the full year

U of T - getting more advocacy to government provincially on solving this issue

- Third Discussion

Background info:

- Current funding coming from individual programs and government (not sure about the division of this contribution)
 - There is a second lobby day developing at the federal government level to create

- a strategy to work across the provinces
- UofT has taken a leading role in lobbying at the provincial level
- We are attempting to develop a pan-Canadian strategy

Discussion points:

- remember that this is an election year which may influence the steps that the government does take
- It would be helpful if there was a document or website for unmatched grads that direct them to programs that they can do (eg Queens masters program), other opportunities, research positions, etc
 - CFMS puts out graphics to explain what to do if you go unmatched, there is program where grads get matched to previously unmatched students, match book etc
- Maybe the solution is reducing the number of medical students
 - Contra: there is still a need for medical students
- There are issues with 1st iteration spots being saved for IMGs and Spots for french speaking students
- French speaking spots - having educational support to bring up proficiency in French

Table 2 - Electives Diversification (Avrilynn Ding)

Electives Diversification/ Restriction

Moderated by Avrilynn Ding

Round 1

Schools Present

Queens, Manitoba, uOttawa, Dal, UBC, McGill, Queens, U of A, U of S, Calgary

Questions:

1) Have these discussions going on with Deans of the medical schools and what is happening with them?

A: Preliminary discussions, very informal. Deans are involved. CFMS polled students very informally: What do you think the purpose of electives are? How many should we have?

2) Is anyone consulting the PGME leadership in this?

A: One of the points brought up by Maylynn during her meeting this morning is that for this restriction to work, the post graduate programs need to be on board and need to develop alternative means of evaluating people's interests in a specialty (since number of electives can no longer be used).

3) If this change happens, there is a potential that students will take on additional roles/ shifts/ extra opportunities to be involved in a specialty. This could lead to burnout and exhaustion.

Thoughts?

Response: Burnout happens already when people do all electives in surgery. So at least in this model, people will get a diversity of experiences, with the risk of also getting burnt out.

4) Strongly encourage that we go with number of electives (i.e. 4 elective weeks) as opposed to percentage of weeks since each school has a different number of elective weeks.

A: The sentiment is that it will be an absolute number. This has been a concern raised on multiple occasions.

5) What is the current number of electives that is being thrown around currently?

Number of weeks per rotations varies per school so we would need to standardize number of weeks per rotation. Right now we are talking about 3 or 4 rotations being the number (number of weeks unknown).

6) Are PGMEs involved yet?

A: Have not bought in yet (to my knowledge).

Round 2

Schools

UBC, McMaster, MUN, UofC, UOttawa, USask, DAL, UofT, McGill, Queens, Manitoba, Western

Questions

- 1) Manitoba: they should be some degree of standardization, so that there is an equal playing field between schools and programs, and ultimately, program specialties
 - a) Chair: accreditation requires that students be encouraged to do electives in at least 3 fields, intended to prevent overloading with a certain discipline
- 2) Calgary: we only get 12 weeks (8 weeks Pre-CaRMs), our concern is that PGME programs are not always aware of the restrictions placed on us in choosing electives. How will schools ensure standardized trajectories for students?
- 3) Importance of defining discipline as subspecialty
- 4) Challenges with 2-rotation proposal: core rotations sometimes does not include certain specialties at certain schools (e.g. UBC distributed site)
 - a) One way UBC addressed it is by relaxing restriction at distributed sites
 - b) 12 weeks in 1 specialty is a cap
- 5) Western: concern with going down to 2 weeks, it may be insufficient for educational and professional progression (more difficult to be a meaningful elective, and harder to get a strong letter of support)

Round 3

Schools

Queens, MUN/Sherbrooke, Memorial, Ottawa, UofT, Emily, UofS, UofA, McMaster

Intro: AFMC wants to recommend the restriction of “2 rotations in one discipline”

Rationale: Career exploration - learn skills they haven't learned in preclerkship and to provide students with opportunity for effective career planning

Limitations: definition of 'rotation' and 'discipline' is varied between schools

Questions

- 1) UofS: when AFMC brought up this idea, where did they get the idea it has to be 2 rotations?
 - a) Queens: very preliminary stages of being discussed, AFMC = all the deans of the medical schools, they are consulting CFMS and the Deans and surveying students (VP external at Queens sent out a survey to get an idea of how students feel about what the restrictions should be); very informal consultation at this point; PGME have not been included on the discussion much to my knowledge
- 2) Sherbrooke: Faculty strongly recommends not to do more than 2 electives in a certain speciality - do other schools do this as well?
 - a) UofT: UofT has not policies like this, but who advises this?
 - b) MUN: Must be through student advising and career planning
 - c) UofS: Students have to complete 3-different entry specialities (national rule), so this is sometimes a restriction on students or they go around system (ie. peds surg and peds)
- 3) UofA: Schools have different number of electives (ie. 12 weeks vs 24 weeks at UBC), and some have more restrictions but how does this correlate to the match rates? As of right now it looks like schools have similar match rates
 - a) A: Queens - as of right now data shows no correlation between the number of electives a school gives and better match rates
 - b) A: worry that the number of schools with such restricted electives “policies” (formal or informal) is so few that the data from that type of analysis will not give meaningful info
 - c) Queens: Every school for accreditation must advise students to complete 3 different specialities in their rotations
- 4) UofS: who is going to mandate this for all schools since some schools are not following it - some schools have student advisors to oversee this per student (UofS and Memorial)
 - a) Major theme from this working group is concern about checks in place to ensure that all schools are actually following the new policy if implemented

Table 3 - CFMS Board (Dyad Model) (Odell Tan)

- No uptake

Table 4 -AFMC contract and student information/data sharing / Disability Accommodations in Medical Training (Franco Rizzuti)

It was very information sharing, no significant action items coming from it.

Table 5 -Day of Action 2019 Topic Selection / Federal Health Policy Issues for Medical Students (Yipeng Ge)

Notes from session 1

- Issue - is it federal? Is the issue - does it have traction to the public? (using constituents' issues), a strength using the medical student perspective (nurses, physicians) - how is our voice different? What can we bring to the table as medical students in medical education?
- Federal vs provincial - indigenous health
- Medical issues in the past, and now more SDoH
- Indigenous housing
- Provincially - of longitudinal follow up of the issue
- Jumping from issue from year to year, may decrease the
- Specific ask to follow up - what can we do with this? -MP from Nflnd
- Ideas
 - Indigenous health x2
 - Self governance in indigenous community
 - Opioids
 - uCMG
 - Migrants
 - National resource planning
 - Items 18-24 TRC calls to action
 - Mental health - other aspect - youth services,
 - Prisoners health
 - Cannabis?
 - Legalization of drugs? Decriminalization of other drugs - broad policy for med students to advocate
 - Pharmacare?
 - Minimum basic income?
 - Health issues related to sentencing and jail time
- Group of students - look at the federal party platforms and create summary information (look at top 3 priorities or highlight the priorities)
- Physician impact of federal policy - CMA follows this

- Contact Vivian Tam - about the strategy for election year advocacy work
- Broad mental health consultation in manitoba in the province

Table 6 -Burnout & Learner Suicide: what can we do? (Victoria Januszkiewicz)

Burn out is high due to high stress and fast paced scenarios we are placed in
Discussing the fact that this may be leading to learner suicide – we have had 2 Canadian medical students this year that have committed suicide.

CFMS transparency and advocacy efforts about suicide and learner mental health... led to the birth of Safe Spaces. CFMS does not want to be reactive to these topics.

New curriculum in Sherbrooke, there was a suicide attempt.

- Moncton campus felt something should have been done
 - o They had a pizza night with older years and “speed dating” .. they talked about things that stressed them and how they dealt with it all.
 - o A chance to speak about things that people don’t want to admit: that they are stressed or that they are struggling
 - o Simple concept of sharing food and common struggles that we all have as medical students

Alex from McGill

- Pulse Tracker
 - o Password protected website
 - o Can post your stresses and concerns online in a safe place
 - o Whole medical school is on one page
 - o Anonymous
 - o How is it moderated? Wellness committee checks post before they are allowed
 - o Posted password for 24 hours then deleted it from FB
 - o Liability issues??
 - o Alexandra Cohen – to send a one pager on the Pulse Check

Mentors and Mentees

- Wellness activities shouldn’t be mandatory
 - o Whatever works for you

Nick from DAL

- Stress comes from opinion of those above you

Victoria Reedman, U of T

- Shielding students from uncertainty
- Knowledge gap of how to deal with suicide when it happens

- Preparing schools for when it happens
- Mental Health/Suicide being a VERY different session from Wellness/Burn Out
- Task Force to see how the CFMS can help??

PROACTIVE vs REACTIVE

Session II Speakers List:

Ashley Cerqueira – Ottawa

- Students going through a hard time feel like there is no way out
- Lost sight of the whole world and only see the bubble of medicine
- Option for students to take unquestioned leave of absences
 - o Leave policy for other schools
 - o Do you need to submit any additional paperwork?
 - o Manitoba , NOSM, McMaster
 - § Separate from UGME
 - § Confidential as to why the student leaves
 - o

Erin Marshall

QUESTION FOR WELLNESS COMMITTEE à Wellness Mentorship Programs across the country??

- Wellness
 - o Painted as “fluffy”
 - o We don’t necessarily confront the nasty stuff and realities of harsh debt, patient death, etc
- Staff matched with student?
 - o Does happen at McMaster
 - § Not necessarily well implemented
 - § Similar at NOSM
 - o Ottawa has a group of fourth years to one year
- U of A
 - o You used to be matched with the Residents ; closer in age and experience
 - § Its limited though because there are only a few residents
 - o Now you are placed with community
- RDOC + CFMS PARTNERSHIP ??? Wellness Mentor/Career Advising etc
- NOSM
 - o Need to keep talking about resources throughout the year
 - o They love the idea of the pulse checks that MUN is doing in person with the wellness consultant
- Ottawa
 - o Critical Incident Debriefing at end of each rotation in clerkship
 - o Options for that in pre clerkship

SESSION 3:

Speakers List:

Leanne – McGill

- Work hour caps
 - o People go over them and then the next person feels like they have to do so that they can keep up
 - o You are looked upon poorly if you go by the cap
 - o You can report attendings for mistreatment if they ask you to go above and beyond the hour cap
 - o Attendings not fulfilling
 - o Steph – “protecting medical students from themselves”
 - § At Queens
 - Enforcing the hours that clerks can work
 - The Attending says No you have to go at this time – you have to track those hours and get them signed
 - If you go over ; you may have to go talk with them at progress and promotions
 - They have had fair success with this
 - Trouble with complete by in

Kale – Queens

- Peer Support group
 - o Formalized training if you want to take it so that you are prepared to support your peers
 - o Has been pushback from wellness; worried about those providing support will get burn out... wondering about things at other schools?
 - o Willem – DAL = Mental health readiness at DAL
 - § Mental health wellness training
 - § Will be mandatory for new students in the fall

-

Mehdi – Moncton

- No limitations on

Derek Fehr – U of A

- There are no weekly work limits at U of A
- College guides it in AB; but it is not enforced (this is province dependent)

Table 7 -Financial education in undergraduate medical education (Lauren)

McGill - SA 1-2 lectures in first year, student associations bring in financial firms

Dal - MD Mgmt in O week, I'n'I session in first year, wellness week 2 financial planning sessions (value questionable - panel of resident/physician/bank/independent financial advisors), longitudinal financial sessions

- SA office, class president approached to bring them back in (school focused)
- Some groups bring in others (FM group); online modules that people can access

Ottawa - 4 year curriculum developed by students, 12 lecture series (based on appropriate level), interdisciplinary projects (comp sci) (Noah Lewis -)

- o Being integrated into curriculum
- 4 categories - physician led, have background in finance; lunch time talks, planning for lectures
- Health care mgmt (running practice), career planning, remuneration/what different docs make, medical innovation (docs who own businesses); debt management, investing, decisions in career, getting involved in medical innovation
- M-Life (Management, Leadership, Education, Finance Education) - created objectives, had them approved; creating website, resources, etc.
- CMA/MD - content good, students aren't engaged b/c didactic -> better to have it come from students
- Workshop based, engaging to students; want to expand to schools
- Becoming mandatory part of curriculum

Sask - MD/MBA program; tapping into network, creating student network (Kate Morrison)

- MD one hour session (Yifan Han)

NOSM - nothing formal in curriculum (George Payne - gpayne@nosm.ca)

- COI policy; MD mgmt

Queens - IG/formal UME work - managing LOC, investing it, creating budgets, managing small scale operations, continuing education

- Hoping to start MBA adjunct program
- LOC - investing?
- Debt management

U of T - MD mgmt - debt management, budgets, paying back loans/residencies; too much for one session, overwhelming, would be better in smaller chunks

- Would like something more formal, more continuity across years
- Nothing formal from UME; financial advisor brought in
- IG - payment models, physician salaries; something that should be integrated into faculty; managing financing past med school
- Emily Chen - emilyj.chen@mail.utoronto.ca

U of M - local med student body organizes sessions, bring in people from MD, MNP, organizations, financial advisor on staff - sessions teaching about different concepts that are important

- Budgeting, saving, spending during med school; tax changes; spreadsheet of costs in medical school and how they add up
- Once every 2 months; a few a year

U of A - business in medicine IG, other groups that bring in MD; not part of curriculum (Sam Bradbrook)

- Run into reputational issues, what is process for getting people

Would be nice to have a breakdown is x amount, how does it impact life during residency and beyond

Step by step how things are going to change

Table 8 -Position paper process renewal / Committee on Health Policy Updates (Shanza)

-As opposed to there being students who attended the roundtable session for the Committee of Health Policy for the entire duration of the period, there were students who posed some questions on the overall process of the position paper process.

-These questions were in regards to the timeline of paper research/writing/review. I discussed an infographic that included these soft deadlines, along with encouragement on touching base with NOHP regularly with this process.

-I also received a question on the difference between the three proposed papers: position papers, policy statements, and discussion papers. I discussed the new policy guide created by COHP Position Paper Task Force that touched base on the three definitions, their formatting, process, and overall purpose.

-I also received questions on what happens of the papers - i.e. are they only just uploaded on the website? To this I discussed different ways the paper could act as vehicles for advocacy initiatives.

Table 9 -Indigenous health curriculum (Willow)

Table 10 -Global health exchanges (Chris)

Table 11 - Clerkship examinations & evaluations (Rishi)

How are clerkship evaluations taking place?

USask – varies/rotation, final OSCE & MBME at the end of the rotations, students feel that they are studying more for the MBME rather than learning. Adrianna: currently working on survey to stop using MBME. MBMEs are standardized American board exams (cons:

guidelines vary, American units/ pros: standardized & even playing field). Deanship states MBMEs are predictive of LMCC success & thus are a potential reason for their use.

Mac – varies by rotation as well, NBMEs for some & in-house exams for others. Students also are required to complete MacDOTs (Direct Observation Tool) – basically objectives that need to be completed & observed by a preceptor (e.g. Student needs to perform a DRE & be observed & given feedback, student then gives preceptor feedback on their teaching skills). This was instituted to incorporate CBD-style learning/teaching into the clerkship curriculum.

MUN – clerkship is EPA-based, EPAs need to be witnessed but often they are not. Quality of feedback is poor. Certain # of skills/experiences need to be undertaken per core (e.g. see 10 CHF patients). CBD style is very learner driven, need to have the onus to push for feedback/assessment. MBMEs also used, but many students fail (e.g. 40% of students fail surgery MBME) so they keep lowering the threshold.

Ottawa – need bilingual exams so they do not MBMEs. They use in-house exams for their clerkship evaluations.

How are clerkship evaluations taking place?

Queens – getting away from NBMEs, but very difficult. Wanted to get rid of the peds MBME this year. Very cumbersome to create in-house exams. Trying to start an ongoing LMCC-style progressively test.

Dal – Used to have NBMEs, everything is in-house. No issue with writing questions because they use overlapping questions – issue then becomes that students sometimes know the answers to the questions. Transitioning to new comprehensive exam at the end of clerkship that simulates LMCC. Have core rotation exam be formative + comprehensive exam. Will be rolled out in 2-year timeline.

Mac – PPI (progressive performance index) that is done 3 times/year and simulates the LMCC. Written by all class levels and is a marker for how students are doing & their preparedness for the LMCC. Falling below cutoff (which is based on your class' average requires remediation).

How are clerkship evaluations taking place?

UofT – going through reform to move towards integrating CBD into clerkship.

McGill – some in-house exams.

Ottawa – exams every 2 rotations (every 12 weeks) and all are in-house. Not usually directly observed on rotations. Each rotation, needs 2 forms to be filled out. Don't explicitly go by EPAs. Evaluated by preceptors & vice-versa. Have personal checklist. Comments end up on your MSPR. Never receive a number on their MSPR.

USask – NBMEs for 5 of 8 blocks. Family has in-house exams. Have things similar to EPAs, checklist that preceptor has to sign off on.

Calgary – exams at the end of core rotations. Final OSCE, written exams, ITERs all go towards evaluation.

Manitoba – all NBMEs, EPAs built into clerkship (online & preceptor name beside it, but preceptors don't sign off on it – thought to be due to logistics of having preceptors log in). Paper evaluations for some rotations. Evals done at the end of rotation. Grades don't go on MSPR. Can choose to have them displayed, but all are qualitative.

MUN – All NBMEs, Canadian in-house exam for family. EPAs are built into clerkship, based on AAMC EPAs. Students have to complete their own clinic card. Comments are handpicked for MSPR, and states whether student passed/failed NBME.

Queens – NBMEs (except for peds). MSPR has qualitative & quantitatively (students pick qualitative comments)

Mac – NBMEs for some & in-house exams for others. Students also are required to complete MacDOTs (Direct Observation Tool) – basically objectives that need to be completed & observed by a preceptor (e.g. Student needs to perform a DRE & be observed & given feedback, student then gives preceptor feedback on their teaching skills). MSPR displays all qualitative comments from transcript, no grades/numbers.

Table 12 - H-a-T: Medical student mistreatment & H-a-T: Changing the culture of healthcare (Victor Do)

Session Background:

CFMS National Wellness Program developed, this work falls under some of the things we are doing.

We know student mistreatment is a very prominent issue

Major areas are in advocacy and we are looking at creating health-promoting learning environments

Further at the end of the day what we need is culture change, beyond just things like mistreatment...work hours in general, accepted that we do crazy things etc

https://afmc.ca/sites/default/files/documents/en/Publications/2017_GQ_National_Report_en.pdf

Notes:

Round 1:

Not comfortable with how to report, trying to encourage people to report by creating methods that they can report and ensure that they are anonymous

Don't know where information is going, when you say this it goes to SA, doesn't just go back to the UGME's etc-scheme, dean of student affairs....not directly going to department head, first approach and start collecting information, so not dealt with right away but is something

Valuable to report even when something might not happen instantly

Info is kept anonymous

Confidential process, not anonymous necessarily if it is a major issue, need to be able to substantiate your claims

Long term data collection, on iters this question is asked

Spreading student awareness of anonymous ways to report....really want people to know about things, promotion of the protocols and
Identifying mistreatment
Use the form, going to talk to student affairs

Separate body, if you have concerns go to them, pulse checks, little 10 minute meeting with one of docs there every semester to have a check-in, do you have any specific concerns, but in 10 minutes it kinda feels like it is just a check-off
Are students actually comfortable

Flow charts that are outlined: well officer, triaged into three categories: significant (not big enough to report right away....up to 6 months)

For students there is still a perception issue, anecdotally
Feedback loop, then process will not be anonymous
Give stats and that kinda of thing

School specific issues
Mistreatment is reported way more in graduation questionnaire and there is a disconnect between the two levels, what is the breakdown there
Ensuring there is confidentiality

Increase awareness that reporting is important, its o.k. Overall when you look at the discussion overall, really isn't going to affect your CaRMS match overall at end of day
Position papers

Round 2:
Unit assessment: where mistreatment is a major issue, what happens when it is an egregious issue that is raised right away, in terms of size, people know each other so how do you separate

DoSA and Associate dean working on a flow chart to help people go through differently

Can report anonymously, but encouraged not to do it anonymously then it can't really be acted on
There are two sides to it since if people aren't told about things
But then uncomfortable if you can't report anonymously anymore, really need to be confident to have the change, people are not really comfortable being named
student , mediator, preceptor together with a central person
They knew this was an issue behind before that

Huge power differential, when you do report

Red apple and green apple

Defining what mistreatment is, are these concerns actually a valid reason

Round 3:

Can we have more separated from them in the process, can it be easier to get out of the process

Anonymous and non-anonymous

Not wanting to go and be non-anonymous

Departments

Position paper: how do we define mistreatment: mistreatment to the students, but broad enough that residents, learners to each other

AFMC level

Culture change with how the teaching staff interacting with students, want to positive reinforce that type of work

Education vs service, what are your responsibilities in clerkship and trying to perform tasks but also receiving education from preceptors....

Table 13 - Unmatched CMGs - Table 2 (Christina)

Information sharing and Q&A about scope of unmatched CMGs, CFMS advocacy on this issue, what students need to be aware of, and key areas for future advocacy.

Table 14 - H-a-T: Career advising during medical school (Silvio)

NOSM

- Student set up shadowing. Round tables where they bring people in. Mandatory electives pre-clerkship
- Would like: more transparency looking at where the jobs are.

McGill

- Longitudinal Family medicine program
- Mentorship program- within practice, palliative care, and then anything your mentor can set up
- Last months pre-clerkship- get to do mandatory shadowing

UBC:

- Career counselling at student affairs office with a set physician
- Shadowing- open and updated. Residency shadowing

Moncton

- Interest groups. Challenge with interest groups→ that everyone is quite busy trying to do it own. Difficult to shadow on their own.

U of A

- Set career counselling in the curriculum.
- Dinners, speed dating, etc with different careers
- Interest groups

U of C:

- Does job shadowing in any discipline

Other challenges: students would like different initiatives and programs but are limited by human resources, finances, location, and other barriers. Question posed: Could CFMS have a role in providing funds for some of these barriers for these obstacles

Members: Silvio, Emily Chen (UofT VP External), Mac VP Education, Meera Shah (Western VP Global health)

McMaster:

- Looking to improve their career planning
- Haven't really looked into options outside residency w/ an MD degree
- U of T: Held a non-clinical career info night (see attachment)
- o Think that it's helpful to expose students to these opportunities at an early stage in their training
- Silvio: OMSA is working on this
- Mac: This could be parallel planning
- Students paired w/ a student advisor as well as other resources. Mandatory career planning – dean doesn't think it will help because the student advisor (random pairing) they're paired with isn't the most compatible. Students often find their own mentor.

Mandatory Career planning?

- Western: Thinks that formal career planning is very much necessary especially with the difficulty in matching
- Lots of advice is given but how many people are actually acting on it.

U of T: (first year career planning process)

- Large group career planning sessions; mandatory
- Students to complete AAMC 'career planning' quizzes before the session. Session analyzes & releases results.
- These quizzes are all free with an AAMC account

Queens (not present): has 1-on-1 career planning

Table 15 - H-a-T: Health & human Resources (Adam)

Table 16 - H-a-T: Medical student involvement in politics (Shreya)

Presentation: New Position Paper Guidelines

CFMS VP Government Affairs - Yipeng Ge

- Call out to committee on health policy members - Sarah, John, Helen on all their work
- COHP took on the position paper taskforce from the resolution task force. Position paper comes to the floor and takes time to make them, passed on the floor, posted on the website. Students aren't adequately supported in the writing process, unaware of the

writing process and no follow-up of the papers. Team created strategy to support the writing

- Timeline with resources (Idea -> Reading -> Writing -> Consultation)
- Brandon Chau was formal lead
- Two versions of papers in the past - policy paper and policy statements; Introduced three definitions
 - Position papers: heavily researched document with official stance
 - Policy statement: brief statement that already represents an organization and CFMS recognizing. Typically shorter and less researched
 - Discussion Paper: typical backgrounder document, no position or stance
- Steps for students in the Idea phase - list of tools and guidelines on the website
- Policy guide on website -- definitions are heavily expanded; templates included, collaborated with GHA for writing recommendations;
- Policy Tracker to have an idea of what's going on; encourage students to consult tracker to see if the topic is currently being worked on, tracker is currently on the website; summary and status; review status every five years
- Infographic on the website about paper timeline
- Submit statement of intent - if you have an idea but don't know how to start, who to talk to, relevant to CFMS - a good start to writing a paper
- Phase 2 - looking at recommendations; the guide goes over our take of the recommendation;
- Revamped the online tool to see the papers; updated status; contact people; recommendations will also be present

Robert's Rules Review

- Franco is official Parliamentarian - he will resolve any rules consultations
- Chair presides
- Resolution accompanies a motion; motion can be brought forward at any time
- To make a motion to accept a resolution, the resolution has had to have been submitted
- Order of resolutions determined by resolution committee (Chair, VP GA, NOHP, COHP, volunteers) - prioritize internal documents especially functioning of the CFMS - less controversial resolutions at the beginning so most of resolutions can be gone through
- Chair doesn't vote
- Motion will be read (only BIRT/BIFRT); mover/seconded is given two minutes to speak and then debate/discussion
- Nemo contra voting - we only debate motion if people desire
- At the microphone, name and medical school, speaking for or against
- Points of _____
 - Order: when procedure is not being followed
 - Information: clarification question
 - Personal preference: something wrong with the room
 - Parliamentary inquiry: clarification of procedural rule

- Decision on resolution; speakers list (5 people) only open if direct contradiction to the motion; any delegate can request a secret ballot (at least three people must agree)
- Each school gets two vote (except moncton which gets 1)
- Who gets to vote?
 - President and another school delegate votes (generally VPX)
- Postponing a motion (Tabling a motion)
 - Bring the motion up at the next meeting. If motion is rejected, can't be brought up for another year
- You can amend a motion, you cannot amend a paper
 - If an amendment is proposed, the movers determine if it is friendly or not
 - If not friendly, we vote
- Question - if someone is voting as direct negative, then we open a speakers list - the first one raised
- Question - does a point of information count as a direct negative?
 - Yes, we will consider any question or point of information to be a direct negative as we interpret them to mean we are not nemo contradicente on something
- If you are considering doing a secret ballot, please let us know ASAP so we can get prepared

Members Resolution Session #1

Roll Call

Present: *Western, McMaster, Toronto, NOSM, Queens, Ottawa, UBC, Calgary, Alberta, Saskatchewan, Manitoba, Sherbrooke-Moncton, MUN, McGill, Dalhousie, Global Health, Communications, Education (proxy), Finance, Student Affairs, Government Affairs, Western Rep 1, Western Rep 2 (proxy), Ontario Rep 1, Quebec Rep, Atlantic Rep*

Absent: *President, Student Affairs, Ontario Rep 2*

Resolution #1: Nemo Contradicente Voting Rules for 2018 Spring General Meeting

Moved by: Shanza Hashmi (Ottawa)

Seconded by: Yipeng Ge (Ottawa)

Result: MOTION PASSES

Resolution #2: Omnibus By-laws Update

Moved by: Victoria Reedman (Toronto)

Seconded by: Henry Annan (Dalhousie)

Victoria: Reps representative to the Governance Committee; regular version and tracked changes to see the differences. Main changes - language changes to be in line with non-profit act; number of votes will increase from 2 to 3; if concerns, please bring them up; first step to more member engagement; by-law changes reference policies that don't yet exist but give governance committee permission to create, election policies, board tors, delegation of

authority, those documents need to exist, they will be ratified at ga, and open to broad consultation

- Direct negatives: McGill
- Open Speakers List 1:
 - James (McGill) - Point of Information (POI) - policies part of the by-laws are not currently existing, in voting for this, how will be this done? Speak to the timeline
 - Victoria - Policies being developed will hopefully be done by the end of the summer, but for sure by the end of the year
 - James (McGill) - **motion to amend motion** to include “BIFRT that the governance committee bring the referenced policies in the new bylaws to general assembly no later than the SGM of 2019”
 - Victoria - Friendly amendment
 - Willow (UBC) - POI - omnibus bylaws are being passed on the assumption that the dyad model will be approved
 - Franco - parliamentary privilege
 - Set of bylaw changes at AGM 2017 which were the first part of the strategic plan process
 - What the dyad model looked like was not specified and had no reference documents therefore it is in the old by-laws
 - What the dyad looks like is what is being brought today
 - From a parliamentary perspective the dyad is already in there
 - Victoria (UofT)
 - From the GC side, the governance structure would be reflected in the by-law that is passed and operationally it would not change much
 - Ben (NOSM) - Point of Parliamentary Inquiry (PPI) - amendments should be prepared in advanced and submitted
 - Franco - moving forward, all amendments need to be written in advance (on paper or email) to Jess or Franco
 - Called to question by Jess
 - 1 minute for discussion given

Result: MOTION PASSES UNANIMOUSLY

- Victoria (Toronto) - PPI - do schools not get three votes since we passed the by-law changes?
 - Franco - these by-law changes need to be approved by corporations Canada; vote changes will occur for AGM 2018

Resolution #3: Approval of SGM2017 / AGM 2017 Minutes

Moved by: Franco Rizzuti (Board Chair)

Seconded by: Yipeng Ge (Ottawa)

- Jess (Meeting Chair) - Needs true majority

- It was an oversight so we're correcting by having both minutes here. They are on the website. This is procedural. Move to transparency means we will make these minutes available on the website upon adoption by the GA

Result: MOTION ADOPTED NEMO CONTRA

Resolution #4: Motion to grant uCMGs continued service to CFMS member services and benefits

Moved by: Lauren Griggs (Calgary)

Seconded by: Kaylynn Purdy (NOSM)

- Lauren - motion together for CFMS members who didn't match should still be able to access CFMS resources
- Direct negative - Debbie (Mac) - speakers list opened
 - Q: will students not paying tuition still have access?
 - A: not all fees are paid for by schools, and are often paid for by individual members. But no, unmatched students will not have to pay an additional CFMS membership.

Result: MOTION PASSES UNANIMOUSLY

Resolution #5: Motion to adopt the position paper titled "Learner Privacy in Canadian Medical Schools"

Moved by: Kaylynn Purdy (NOSM)

Seconded by: Nathan Rider (Calgary)

- Nathan - this paper was submitted at AGM 2017. It did not pass. I spoke against the paper at that time. We have rewritten the paper almost in its entirety. All problems brought up have been addressed. One of the issues was how information should be used and disclosed. Sometimes schools are not following, in our view, the legal requirement of what should happen. For example when you match to residency there is a file transfer. After you match, that file, which can include MSPR and other things can include mental health or other things not on MSPR (eg. you need to remediate) - when you give records to CaRMS, the new AMFC contract passes on data and we don't know what happens there. This paper will help with advocacy there too to know if things are used properly. CFMS will also be helped to advocate for knowing how their own data is used. For example if you go for counselling, how is that data used? It's inconsistent between schools. Adopting this will not negatively impact the people making match decision.

Result: MOTION ADOPTED NEMO CONTRA

Resolution #6: Motion to adopt position paper: "Responding to Canada's Opioids Crisis"

Moved by: David Wiercigroch (Toronto)

Seconded by: Matthew Downer (MUN)

- David (Tor) - Members of the opioid task force. Follow-up paper from 2017 Lobby Day to further momentum of advocacy efforts and update standards of CFMS and to broaden recommendations. Consulted across Canada, came up with 5 recommendations.
 - PMP - we think every province should have one to have national data
 - Multidisciplinary Pain Care - Ask of Lobby Day 2017
 - Harm reduction and addiction services
 - Med Ed for PCP in context of recommendations from AFMC
 - McGill - direct negative - speaker's list opened
 - Speaker's List #1
 - Ziyu (McGill) - motion to amend motion "BIFRT a working group works on a short position paper in favour of criminal justice reform in order not to further stigmatize populations.
 - David - unfriendly amendment, task force is planning to sunset because we don't have the numbers to continue this work.
 - Franco - can we get a written copy of the amendment
 - Victoria - PPI - is the amendment in the scope of the working group
 - Jess - this is not within the scope, i think it should be a separate motion
 - Franco - you will have to move the amendment as a separate motion
 - Ziyu - motion to amend is withdrawn
 - Avri Lynn (Queens) - POI - I would like to propose an amendment to the paper
 - Chair - amendments to the paper cannot be made. If it is a grammatical or structural error, then Chair can change the paper. If it is not that kind of error, then you can move to table it and it will be brought up at the next meeting.
 - Avri Lynn (Queens) - POI - would adding a concluding statement counts as content addition or grammatical/structural changes?
 - David - can't speak to it
 - Chair - it needs to come to me ahead of time so that I can tell you whether it is structural. Adding a paragraph is NOT structural
 - Franco - once a paper is passed it is passed. Any revisions go through COHP to see if it requires revisions. Not out practice to accept than immediately reviewed. If paper is voted down than there is one-year moratorium. If paper is tabled, then can be brought up at next general meeting
 - Jeff (Sask) - POI - recommendations section - it says "to develop" - does that mandate the CFMS to develop these programs or does it support provinces to make these programs. Currently it seems the CFMS is taking these on. It is just adding a word to clarify if it is the provinces or the CFMS
 - Franco - clarification of intent would be structural, will let the movers speak to that
 - David - that will not change the intent
- Cale (Queens) - i would like to make a Motion to table the paper until Fall AGM to get the opportunity to add a concluding summary.**

- **Seconded:** Sherbrooke-Moncton
- Speakers List #2:
 - Victoria (Toronto) - AGAINST - against the motion to postpone. While a summary is helpful I think a summary can be written and distributed though the different way. Rather than postponing over and over I think we should pass.
 - Yipeng (Govt Affairs) - AGAINST - the work done on this paper will really help inform advocacy efforts, CFMS has no stances on the opioid crisis, the recommendations from this paper are key driving points, a conclusion/summary/background isn't crucial
 - Emma (Calgary) - POI -
 - Craig (Queens) - FOR - connecting general members to taskforce, need time to engage general members
 - Ben (NOSM) -POI- Did you have enough time to respond to Queen's issue with the paper?
 - Mover and seconder first heard of issues at Resolutions Marketplace, too late to add a conclusion at that time. Were unable to amend paper as it had already been submitted.
 - Proceed to a vote about whether we are tabling the motion.

Cale (Queens) - I withdraw my motion.

Cale (Queens) - Motion to suspend Robert's Rules for the duration of this motion

- **Seconded:** Sherbrooke-Moncton
- Ben (NOSM) - POI - there is a reason for Robert's Rules. We need to be careful about using this option because it will set a precedence
- Chair - call to question

Result: MOTION FAILS

- We are now discussing the original motion.
- Chris (UofM) - **Motion to Call the Question**
 - Seconded by Saskatchewan

Result: MOTION PASSES

- Minute of discussion

Result: MOTION PASSES

Shanza: Can movers speak towards the motion?

Franco: Yes, they have the opportunity to do so after the BIRT clauses are read.

Resolution #7: Motion to adopt policy statement "Solitary confinement and Health Delivery in Canadian Correctional Facilities

Moved by: Joshua Nash (Calgary)

Seconded by: Syeda Shanza Hashmi (NOHP)

Joshua (Calgary): Policy statement developed in active collaboration with CFPC, contacted to see if they were willing to endorse their policy. 2016 prison health program statement was released. Spoke against solitary confinement. Stance of CFMS that prisoners deserve humane treatment, solitary confinement is in violation and should be abolished. Further healthcare responsibilities should be transferred to Ministers of Health and taken from the minister of justice. Relevance because students will be working with these populations.

- Direct negative - NOSM- speakers list opened
- Speakers List #1:
 - Warren (NOSM) - POI - was correctional facilities consulted in the process of writing the paper
 - Josh - Yes
 - Emily (U of A): Point of information: The paper asks for students to have more opportunity to interact with students in prison population, is this feasible to do?
 - Josh - varies from institution to institution, part of correctional health team, instituting student group may be institution specific question
 - Warren (NOSM): poi: What did the prison system say about solitary confinement, are they against?
 - Shanza - Abide by UN rules: solitary confinement over 15 days is unethical. So overall in favour of abolishing
 - Pavel (IT Sr./Manitoba): POI: cfpc approached you to write paper, wondering about specific recommendations about education and those other parts of it. Is this just support of CFPC, did they ask you to add additional points.
 - Josh - I think the intent of the statement is to create awareness in medical students and curriculum. I think we can advocate what the CFPC is saying in those routes
 - Shanza: Reason we do that is because CFPC brought forward many recommendations about the states of the prison system and solitary confinement, so we felt it was important to raise awareness about these issues.
 - Pavel: Point of clarification: Are we supporting CFPC or creating awareness?
 - Shamza: Support the CFPC, for example the language and the intent of abolishing solitary confinement and the awareness is part of this.
 - Jaymie (Manitoba): recommendations includes things in adding curricular changes? What will happen when the paper is voted in? How will these recommendations be mandated at the schools?
 - Shamza: recommendations are not meant to mandate anyone, simply suggestions brought forward by organization and students who are interested. If there are students who would like to pursue further this would be favourable
- Speakers List #2:
 - Willow (NOIH/UBC): POI: Are we voting on recommendations that seem to be separate from CPFC

- Shanza - Both. Recommendations are supposed to be heavily researched but are meant to be flexible. You're not bound to the recommendations
- Franco: Parliamentary privilege: If document is attached to a motion we are voting on everything. Another point is that the resolution says position paper but what is attached is a policy statement.
- Jess: This is a mistake I made, will change.
- Odell (USask): Motion to amend the BIRT clause to change the wording from position paper to policy statement.
 - Joshua: Friendly amendment, accepted.
- Motion to Call to Question:
- Rishi: POI: Recommendations made from paper, are they endorsed by CFPC?
- Jess: Can not ask that question as we have called vote to question.

Result: MOTION PASSES

Resolution #8: Motion to adopt a position paper "The Health of Immigrants and Refugees in Canada"

Moved by: Sarah Maden (Dal)

Seconded by: Helen Teklemariam (U of M)

Update of current position paper, collaboration between COHP and GHAs. Very important since this group is significant and diverse, with unique healthcare needs. Addresses determinants and barriers. Since 2015 many more refugees, also regulatory changes have been made. Note that there has been a few grammatical changes

- First line in Page 6:
- Won't go through the rest of grammatical changes
- Jess: Need to overview the different changes that have been presented to decide if they are grammatical
- Franco - another ten minutes of debate in this session,

Direct Negative - MUN - Speakers List Opened

- Speakers List #1
 - Mais (Memorial): POI: Concerns about wording, particularly as it relates to page 6 "research has demonstrated poor health" In general the recommendations are vague. How do we proceed?
 - Jess (Chair): Make it more clear, first part is grammatical, second part please speak to
 - Helen - that was one of our grammatical changes, rering to immigrants and not healthcare providers thus changed it to newcomers
 - Page 8: clarify "self-sustaining"
 - Helen: In the context of that paragraph it could refer to gaining supports so that they are able to become self-sustaining.
 - Mais: Concern is that this means that they need to become financially independent
 - Helen: We feel that this is o.k. When interpreted in context

- Ben (NOSM) - POI - i think the spirit of the paper is good but recommendations are extensive, why you chose to include all recommendations on curriculum and advocacy in one paper rather than two? And how will it be implementable at schools?
 - Two papers is quite redundant for a lot of the points that we are making. Spirit of the paper, keeping in mind it is an update. Recommendations are there for schools so that if they have a new initiative these are some guidelines. Not meant to bind students but give information for those involved in curriculum
- Emily (McGill) - POI - Recommendation 2.4 To incorporate the SafeTalk Assist training. Is there any work right now to see about other programs/resources that are available to help with refugee wellness
 - Helen - Im not aware of any additional resources that can be used. Listed these as examples and not exhaustive. If there was one more appropriate, then that would be sufficient
- William K (Calgary) - AGAINST - Concerned about feasibility about using reimbursement procedures for lectures. UG committees are burdened by adding lectures, there is already a lot of curriculum. Second point is the cultural sensitivity training, should it be cultural humility
- Shanza (Ottawa) - FOR - Paper was already passed in 2013, this is an update to the paper. This is not a binding document of any kind, need to understand that there does need to be accomodations for each school.

Address by Dr. Peggy Leighton, Vice-President of Dalhousie Medical Alumni Association

- As an alumni association, we want to represent all our members. As you become alumni, want to address about future participation. Once you are in practice, you will be busy, but thoughts, opinions, is welcome. Welcome! Best wishes for future success!

Election of CFMS 2018-19 President

CFMS Past-President - Dr. Franco Rizzuti

- No minutes.

Panel Discussion 2: Tomorrow's Physicians Leading for Health Today - The Importance of Developing Leadership Skills in Medical School

AFMC - Dr. Maureen Topps

College of Family Physicians of Canada - Emma Leon (Student Representative)

Resident Doctors of Canada - Dr. Michael Arget (Vice-President)

Upstream - Dr. Monika Dutt (Executive Director)

Canadian Federation of Medical Students - Dr. Jesse Kancir (Alumni Liaison)

Moderated by CFMS Past-President - Dr. Franco Rizzuti

- Dr. Topps (AFMC): I would like to share some thoughts. I do think out medical schools do a pretty good job about creating leaders but are not explicit. CanMEDs being explicitly stated helped with the leadership. Misconceptions about how to become leader. Its gotta be learned, maintained, practiced over and over again. It requires personal growth. Management is part of leadership but leadership development is another level. Struggles of medical school to teach the soft skills of leadership. Medical school has the mandate to start the requirements of leadership development. Need to further encourage those who have aptitude in leadership. Executive leadership skills are very useful in clinical, personal environment. What should our medical schools do for teaching leadership? Starts with the individual and understanding who you are. Explore and validate your own strengths. Understand where your blind spots are. Develop a team around you to support you when the blind spots become an issue. Learning to see yourself as others see you is difficult but critical. Medical schools can be helpful by providing a supportive environment where students can experiment and attempt risks in leadership. Accountability - personally involved in and answer for, not personally obliged to keep. Achieving results require ability to articulate, negotiate, innovation. It involves being part of a team, mentor. Fundamental leadership development requires learning to be part of a team. Need to be accept change and adopt to it. Retain capacity for empathy while building resilience. Being leader isn't often seen as being doctor or academia - that's cultural issue. Medical school needs to work on leadership development by starting at top. Self-awareness, teamwork, identification of issues, accountability, safe environment to take risks and learn from mistakes.
- Emma (CFPC): CFPC section medical students junior rep. Kirsten, is the senior. Thank you for hard work that you did advocating for medical students across the country. Family doctors represent massive demographic. Nature of family medicine in itself represents a gigantic scope of practice especially when factoring in accountability. Need a strong voice to represent our interest to support society. CFPC advocates for family medicine, family physicians and their patients. Ensures they are serving their patients from across the coast. want to ensure comprehensive patient care. Major responsibility is to establish standards for certification and training of family doctors which they do through exams etc. Also the plus 1 specialty training programs. Family docs are generalists but this extra work is done to help focus practice based on population. Canadian family medicine journal also a publication and forum for what they do. Also family medicine forum every year. This year will be held in Toronto, Nov. 14-17, students discounted registration fee. Over 37 000 members which includes physicians, allied health professionals, residents, students etc. Sign-up for free CFPC membership. Scholarship every school has one recipient which is selected by your school. Local family medicine interest group (FMIG), organize events to increase exposure (including lunch events, rural family practice opportunities, skills nights etc). Want to ensure people learn about how great family medicine is. Two FMIG representatives from each medical school on the section of medical students council. National committee of students, provide opportunities to provide impactful feedback and ideas. There are many

opportunities to get involved. SHARC-FM cards, free online, example of CFPC providing input to create some resources. CFPC learning modules are also things that you can check out as a learning resource. Moving into residency, there is section of residents, cool initiative this year: medical assistance in dying clinical cards. After two year residency, have to go into practice, kinda intimidating. First 5 years in practice group which is a group to help support people in early career, including financial advice etc. A variety of communities of practice in different areas of medicine without CFPC, can join as a student. Every two years or so there is a meeting of medical students, residents and this first 5 years in practice group. Partnerships with CFMS, section of medical students really want to collaborate on an elective database (want it to address other things like accomodations, services and leisure activities etc). This year at Dalhousie worked with GAAC and did lobby day, worked on blended payment model

- Dr. Arget (RDOC)
 - A lot of people who are involved in CFMS transition to end up actively involved with RDOC. I will present what we do and highlight ways for students as you transition after you match into residency and be aware of the work that RDOC does. Did medical school in Calgary. Through my involvement with CFMS and GAAC, I developed advocacy curriculum, awareness day and was involved with lobby day. I think it is important through medical school and residency to be involved. You are in a protected space. Component of learning built into what you do in addition to the service you provide. Look for people who can support you and where to find those people. There are individuals involved in various leadership activities and it just takes some time to find out where they are. We represent 10000+ residents. RDOC is a non-profit organization and is member-driven. All of the work that we do comes from the residents. We have staff to complement and operationalize everything that we do. Work with other national healthcare organizations. Organizational structure is presented on slide. 120 liaison representatives who represent the resident voices. There are core committees. The work is done with PHOs across the country. Wherever you match you will become a member of that group and there are leadership opportunities there. The stakeholders are everyone in the medical education landscape. Strategic plan is laid out on and drives excellence in medical education. Training, wellness and presentation. Leadership skills are not a happy accident. Looking at Irving Gold and others who participated in a study looking at barriers to alumni actively participating in leadership. We become part of RDOC as a hive of developing physician leaders. For anyone who is involved in RDOC, we try to create opportunities for leadership development.
 - Key benefits are listed on slide.
 - Communication
 - Advocacy
 - Collaboration
 - Enablers

- When you have a supportive network of mentors and peers to help you navigate through barriers.
- Barriers
 - We are all busy and do not have control. Lack of time is a big issue. Fear and stigma of being involved in leadership. Might be difficult to ask for reference letters in the medical milieu.
- Formalize and legitimize leadership component within medical education.
- They do a call for volunteers every year.
 - I recommend to watch out for call every spring for applications.
 - There are lots of ways to get engaged.
 - Selection process presented on slide.
- Dr. Dutt (Upstream):
 - Leadership development and opportunities within medicine; storytelling and experience. Background - acknowledge land of ? people; digital atlas of all original names of places in NS. No commercial affiliations, has a non-profit. Speak from position of privilege as HCP, speak as ally and advocate, not for people. Work with organizations that have social justice mandates. This week, felt lost about where she was going, things involved in. Freaked out about talking about leadership when she felt unsure about where she was going. Wonderful community of female physicians. She has authentic leadership. Figuring out position you're in and building on it.
 - Leadership development - messy and people you think have it all together, probably just as confused as you are.
 - Strong network - self care; network is important to lean on
 - 20% family med, rest is public health; Upstream focuses on policies that impact health; Canadian doctors for medicare
 - How we can be leaders within communities - definitions of leadership - CANMEDs roles
 - as leaders, physicians engage with others to contribute to vision of a high-quality health care system and take responsibility for the delivery of excellent
 - Leadership is accepting responsibility to create conditions that enable others to achieve shared purpose in face of uncertainty - Marshall Glanz
 - We're here to do constructive damage to the status quo - Zebedee Nungak (Inuit activist)
 - When you're involved in leadership and advocacy, there is always uncertainty to different degrees; have to enable others to shared purpose
 - All of us can further passion and have issues we care about; could be policy maker or person who is close to one making decisions; part of making changes and have skills to make changes.
 - Mentors are so important and outside of medicine, just as much as in medicine. Find people in community who inspire you beyond medicine. REally helpful. Leadership comes in so many forms. May be following, listening, key person.

Going to events where there is no other medical person there. Will learn so much about health, community, what people care about. Can challenge. Creating opportunities - gap in medical schools on social issues. U of Ottawa students telling her how many social justice programs are happening at their schools, where they are taking medicine. Can always find it. Be ready to be surprised. Not till medical school did she do remote and rural medicine. May know where you are going, important to be open and be open to changing direction.

- Thinking about privilege and how that influences leadership. Physicians tend to come from higher incomes from those we serve. Benefit from similar oppressions that happen in society - affect how we are as leaders and affect if we let others be leaders. Be careful how that influences you
- Dr. Kancir (Alumni Liaison):
 - Helped coordinate leadership awards, and congratulate to the winners, but encourage all applicants to apply again
 - Leadership is not productivity. The importance of being authentic in what you do, Be intentional about what you want to do.
 - You're in the system that is designed to change you into a professional. It's ok to change but don't lose your true self. Authenticity is key in leadership. As you change, don't lose yourself.
 - Be bold! Canada is lucky to have the physicians that we have doing the work that they do. Try to create things you want to do! Best experiences have been from things I dared to ask to do. Dare to ask and dare to dream big!
 - Be authentic. Do things with intent. Dare to dream big.
- Q: Jess - how do we diversify our leadership without going toward tokenism? How do we strike that balance
 - A Dr. Dutt -- people involved in the leadership right now can take steps to change that. At individual level, looking at who is there and encouraging those for seeking those leadership roles
- Q: Nathan - Im interested to hear what each of the panelists think is the most important topic for student advocacy within medical schools today.
 - A - Dr. Topps: Diversity in department heads. From the ground up. Picking up on the commentary around diversity. The medical schools in Canada our leadership is not diverse at all. Women and visible minorities are not well represented. It is important for learners to keep us aware and informed about. Our medical school classes are looking a little bit more diverse speaking to admissions policies. The residents come from our medical schools. In Calgary there is admissions review at this time. Are these students representative of the populations we need to serve and we need to look at the demographics of those coming in.
 - A - Dr. Kancir - short term - advocacy for pharmacare; bigger topic unpacking the drivers behind physician unwellness and burnout -- determine key pieces that can develop into advocacy topics
 - A - Dr. Arget

- Look at your CARMS situation and the match data. There is a great space to do lots of social justice activity. To know that there are a significant number of your peers who do not match to a residency is a huge issue. That is a large issue that affects all of your members and creates a huge amount of anxiety for you and what you do. You are a member driven organization and this should remain the #1 until the results are better.
- A - Dr. Dutt
 - I do worry that medical associations unlike other healthcare representative bodies do not have connections with broader social justice issues. We just are often seen as quite separate and this does physicians a disservice when it is not reflected in what our medical associations are doing. This could be a role of the CFMS to recognize to address health issues that doctors and medical students are a part of that at a broader level.
- Q: Milani (McGill) - We're here to damage status quo and to be bold. As learners who haven't reached stability in our careers, how do we advocate for these things with the risk to our future potential careers?
 - Dr. Arget
 - From the get go taking on the role of VP RDOC. My program was willing to give me "other" days. Some other colleagues on the executive have a lot of difficulty getting away. One of the big pieces around finding the right space is that when you are looking for residency positions to ask those questions and find out what kind of work in leadership and if there are mentors there who can support you. At USask there are lots of people who are there who will back you up. I appreciate that it is a challenge. After sitting in a board meeting with the AFMC this morning and having a good session there are good progressive thoughts coming from AFMC leadership in a lot ways and the culture is changing slowly but surely.
 - Dr. Dutt
 - Wish problem could be solved quickly. Has heard lots of medical student thoughts recently; what does leadership mean, not necessarily putting it above everything else. Going to need ally's, want to find those others through quiet conversations. Others like you who are thinking similarly to you. Programs that have different perspective that align with thinking, that support advocacy. That's part of research that you do to see where you end up going. Hard place to be in, more vocal after med school because your concerns people are talking about you
 - Dr. Kancir
 - Be really competent in what you do. If you're going to be a leader, work hard.
- Q: Christina (UofC) - uCMG crisis - what can we as an organization do to change to change quickly enough so that the next class isn't impacted?
 - A: Dr. Arget

- The media is very interested in rd doc opinion on this. We are in a good place in that the media has picked up on this issue. The provincial governments need to be aware and it needs to be in the interest of the public. Until recently it was not something hugely talked about. It takes time to educate the public as to why this is a problem for Canadians. We are in a good place now to start pushing provincial governments as that is where the change needs to happen. The work that is being done is hitting a point of momentum where the public is picking up on it and that is crucial.
- Q: Balsam (USask) - When did you first take on your leadership role? Any advice in getting involved?
 - Dr. Topps - Don't try to do it alone, need network of support to bounce ideas off of. Leadership can be very lonely, need support mechanisms. Starts the moment you take on leadership positions.
 - Emma - Took on leadership roles in high school/nursing, wasn't going to do anything in med school. Got involved with committees in FM. Don't spread selves too thin, do what you do well.
- Q Jas (UBC) - Leadership in team setting. How does one be a leader among leaders? How do you encourage others to be leaders?
 - A: Dr. Arget
 - Knowing when to follow and being reflective of your skills and knowledge and if there is someone from student group.
 - Dr. Kancir
 - How to be a real leader in the 21st century. Understanding systems and complexity if you want to be a leader in healthcare you will not be able to change everything on your own. The system is so complex if you want to get something done you have to work as a team. Ask really good questions. Get people thinking. It is tough to understand what the actual issue is. If you really want to work in teams and change things, you need to get people to start talking to each other and understanding each other.

Members Resolution Session #2

Roll Call

Present: Dal, MUN, Sherbrooke, McGill, Ottawa, Queens, Toronto, NOSM, Western, Manitoba, Saskatchewan, Alberta, Calgary, UBC, McMaster, President, Communications, Government Affairs, Global Health, Finance, Education, Ontario 1&2, Atlantic, Western 1&2, Quebec, Student Affairs

Resolution #8: Motion to adopt a position paper "The Health of Immigrants and Refugees in Canada" (CONTINUED FROM ABOVE)

Moved by: Sarah Maden (Dal)

(copied from above)

Seconded by: Helen Teklemariam (U of M) **(copied from above)**

- Saskatchewan opened speaker's list
- Dylan (USask) - NOGHE - Speaking for - various points. We have an old statement of the health of refugees - that was on the federal health program That statement does not apply anymore. This is an edit of the provincial statement and is much more comprehensive. In the current world context, we should take a stance on this. I think this paper will have that good stance. Regarding the broadness - this allows individual institutions to advocate using the paper and tailor it to their specific needs. Eg toronto has a lot more refugees and immigrants than NOPM. Allows them to address their own needs. Recommendations, not mandates - if a school can't go into a refugee care clinic, that's okay but it's something we should strive for for the education of our medical students.
- Palki (McMaster) - AGAINST - The paper is well written and I agree with all the points made. One thing I have a little bit of an issue with is recommendation #3. Including community immersion experience. I recognize the importance of service education, what I'd like to see is just a little section about being culturally competent before these experiences are started. I was directed to another recommended 1.3 when I brought this up earlier. What I'd like to see with regards to this specific recommendation #3 is to just have before these immersive experiences are started that they go through a program for the learner's and population.
- Odell (USask/Western Rep) - PC - paper has been significantly longer with many more recommendations
- Henry (Pres) - PP - we missed VP Student Affairs in roll call and quebec rep is now here
 - *Added to roll call.*
- Victor (U of A) - **call to question**
 - Seconder: Victoria (UofT)

Result: MOTION PASSES

Result: MOTION PASSES

Resolution #9: Motion to adopt a new elections timeline

Moved by: Odell Tan (USask)

Seconded by: Henry Annan (Dal)

- Outlined in clauses it is part of the HHR part of the strategic plan. Keeping in line with better governance practices. Has difficulties with governance since it is difficult to transition when everyone is elected at the same time, There is more time to transition so that they can work with the outgoing. Reps come in at a different time, only half turnover at the end of the day. Also outgoing board is who exclusively decides the budget, but now they will be able to help provide input as well. This was we can have a more transparent process.

McMaster - opens speakers list

- Rishi (Mac) - AGAINST - the concern is that we're only transitioning the VPs, with the dyad model, why won't we vote in the reps at SGM?
 - Odell: Governance committee considered things - always someone within the role if the dyad model is approved, difficult operationally to elect so many people at SGM; president on Friday and VP's on Saturday, can run for regional rep at AGM; can still partner in that role
- Steph (UofC; VP SA) - FOR - having that overlap is really beneficial and they can help the regional rep. Having one person there as continuity, and reps can help when there is transition.
- Kaylynn (NOSM; VP Ed) - FOR - One of bigger VP roles really need to spend a lot of time transitioning them beyond the terms of their roles. Having the time to prepare will be critical and very important. Currently she is going to have to spend 2 additional months and this mitigates that and this will be included in her term that will have a fixed end date.
- Chris (UofM; VP GH) - POI - directors elected at SGM 2019, one year term?
 - Odell: AGM to AGM; electing at SGM means a 5m transition period; every term will be 17m long total

Result: MOTION PASSES UNANIMOUSLY

Resolution #10: Motion to adopt Dyad Model

Moved by: Dax Bourcier (Moncton)

Seconded by: Henry Annan (Dal)

- Formalize dyad model, restructuring committee, appropriate changes to bylaws
- Approved at AGM, part of strategic planning; working on functional model of dyad model this year, good feedback. Strat plan - regional representatives being in closer proximity to portfolios (general assembly favourable for)
- Student affairs committees

McMaster - opens Speakers List #1

- Debbie (McMaster) - I move to amend this motion. I appreciate the merit of the dyad model. Concern about the optics. It could be seen as the regional reps are being groomed. I would like to review potential options for safeguarding the democratic process.
 - *BIFRT: The Governance Committee will investigate potential democratic safeguards to this model and present their recommendations or findings at CFMS Annual General Meeting 2018.*
 - Dax: The amendment is friendly.
- Emma (Calgary): POI - Is that going to be separate from the selection process - the matching.
 - Dax: This year the process was done after with a skills matrix. Franco had come up with some algorithms as to who should be match with who according to strengths and weaknesses.

- Henry: More so people who worked well together. The GA votes for RR and they take into account the qualifications that they need.
- Victoria (MUN; Atlantic Rep) - FOR - Worked officially during pilot model. For me it was areas of weakness that I wanted to learn about and my personality worked with VP Government Affairs. Understand concerns on optics but overall anyone is on the board has more experience and knowledge, they don't think that DYAD would further advantage students. Further there is the increase in general assembly votes to 3 instead of 2. Regional reps now really further empowered. Highly in favour of the motion. Someone to help and lean on when you need to take a break.
- Shreya (Ottawa) - AGAINST - They have traditionally worked hand in hand with RR. This will formalize what they have already been doing for years. The flexibility meant that some people's talents were falling through the cracks. The spirit of implementing and instigating these governance changes and what really became a big issue was the need to re-empower our regions. Our portfolios produce a lot of what we give out to students but the regions are the CFMS. At one point last year RR were debated to be elevated to the role of directorial level and have the VPs be the visionaries. The RR would be the representative roles and be the face of the CFMS across Canada. My only concern for this if this is really empowering the regions which was the entire spirit. Is it potentially codifying them as useful adjuncts to a portfolio that VPs can longer function without.
- Jess (Chair) - comments must be for, against, or a POI. I will allow this comment, but please remember this in the future.
- Leanne (McGill) - AGAINST - McGill's concern, issue with having specific regions being over-represented; not having pan-canadian support

Alberta - opens Speakers List #2

- Adam (Alberta) - POI - will the Executive VP have an impact on how the dyad model and the division of labor between VP and regional rep?
 - Henry - we can bring this back to GC. When this dyad model is approved, there will be different people each year. One way of indicating the Executive VP in the model of a year could be just adding an asterisk or a different colour.
- Koray (McGill) - AGAINST - This could mitigate the democratic process. I am concerned about this. The idea that anyone could apply for these positions. We could be alienating our members. The other members are not at the meetings. I am worried about the democratic aspect and the grooming of it. I am not convinced that the BIRT is enough to guarantee safeguards.
- Victoria (Toronto) - FOR - many opportunities to talk about the dyad model, governance committee will work on developing safeguards. We need a robust governance structure and this is the best solution we have so far but will still work on it to make it better.
- Rachael Weagle (Ottawa) - AGAINST - not an issue with the structure, but we need more communication between the regions and the VPs. It might limit the availability to work on other projects that they are not partnered with. Formalizes it too much and restricts collaboration between various portfolios
- Victor (U of A; Western rep) - FOR - It has empowered RR to do more work. I am much better able to represent Western Canada. That is part of being able to better represent

the West. Doing board level work. RR being groomed happened before. NO were groomed. If you were involved at leadership levels with the CFMS you are more likely to run. Try to make leadership a priority for general members. Absolutely I am better able to represent. I have worked with many other portfolios. I don't just stick with one role I have other opportunities.

- Victoria (MUN; Atlantic) - FOR - getting to work with dyad makes understanding much better. After this meeting, have a much better feel for CFMS. Ready to bring stuff from Atlantic region to SBM, look at what we can do with the different portfolios in the atlantic; gives meaning, not just a secretary

Queens - opens Speakers List #3

- Amok (Queens) - POI - standing committees of the GH portfolio. What about the roundtables with the local officers? Does this allow us to be flexible for those?
 - Henry - the ToRs have not been created so we do have the flexibility. This dyad model formalizes the way we have been operating for the last year. It is made to make things nicer.
- Liang (McGill)- AGAINST - Potential conflict of RR and over-represented in some portfolios within the CFMS. For certain portfolios like education, each context is very different depending on the region. It is a bit concerning to have RR working on specific portfolios when it should be applied to all regions. It is an efficient model that allows the CFMS to do more work. It may be a good time to reassess how we think it's been working.
- Rishi (McMaster) - AGAINST - understand the sentiments from the board about it working. The issue is with optics - why don't we adopt a model where the national officers play a larger role and less one person benefiting?
- Avri Lynn (McMaster) - POI - I think there is a bit of anxiety about this model about the grooming. People do understand that there needs to be a formalized way for RR to get involved. What were other options that you explored other than the dyad model to get the RR involved?
 - Henry: Was approved at AGM the dyad model. I am doing my job! It was heavily consulted. Very positive feedback was the starting point. GC tried to marry current structure with new dyad model. The actual 1:1 ratio for RR and Directors was looked upon very favourably by the GA. We did also think about RR assigned to GH ex. We thought about a rotating model for ex. Every 2 months. We ran that by the GC and they thought that transition would suffer but that passing the Dyad model in that way would not prevent us from doing that. There is a supporting document that came with this. All you are voting on is the actual picture. You are not accepting everything in the document. GC still has to meet. Other types of ways that this could look.
- Franco - parliamentary privilege - in addition to strat plan and consultation, there were by-laws approved in the agm that included the dyad model. If the GA chooses to turn down this motion, there will be need to have quick processes to remediate our by-laws with Corporations Canada.

Ottawa - opens Speakers List #4

- Shreya (Ottawa) - AGAINST - as regional rep from the old flexible model. Since I wasn't tied to any specific portfolio, I was able to collaborate with other portfolios

Jess (Chair) - **Call to question.** No more discussion time.

McGill - motion - I would like 3 more minutes to discuss.

- Provided

Jess (Chair) - vote now

Result: MOTION PASSES

Announcement of the CFMS President-Elect

Franco (Elections Officer) - the new CFMS President-Elect is Stephanie Smith.

Motion to destroy the ballots

Moved by: Odell (USask)

Seconded by: McMaster

Result: MOTION PASSES

Members Resolution Session #2 continued

Resolution #11: Motion to support the "Improving Service Learning Curricula in CME"

Position Paper

Moved by: Kaylynn Purdy

Seconded by: Karen Ngo

- Via phone: Service learning has several benefits to students. Royal college and CANMEDS State that medical students should engage in service learning and most schools are involved already. Propose a standardized curriculum, trying to ensure that students get more perspective on this issue. Not about mandatory service learning hours. Focus is on structured learning opportunities, formal objectives, sustainability. Some of the recommendations are more geared to community, others more to students.

NOSM opens speakers list #1

- Ben (NOSM) - AGAINST - There is outdated information from NOSM and makes me question the integrity of the paper as whole. The paper may need to be amended which cannot be done right now.
- Victoria (Alberta) - POI - Paper addresses much of the social accountability, there are no minimum requirements for what needs to be done in terms of pre-training. Specifically at the end of the paper it says that schools to do need to adopt to all, wondering how we can further ensure that schools do not engage in inappropriate service learning opportunities
 - Karen: Fair point, but it is a framework only

- Brittany (U of A) - AGAINST - Not forming meaningful relationships with the community. A “fly-in, fly-out” model is not conducive to a good service learning model. Also second that there is outdated information from the U of A in this paper.
- Angela (U of C) - FOR - Recognize that a ton of changes were made to the paper. The definition of service learning was adapted. The recommendations care more about the community. Acknowledge students involvement increasing the relationship with the community. I recognize that a ton of work was done on the paper and I think it was a huge improvement.
- Melissa (U of M) - AGAINST - Third concerns forwarded by NOSM; not accurate for U of M
- Odell (USask): POI: What consultative process did you undertake to address the issues raised at AGM for this paper.
 - After AGM, we met with individuals that had raised concerns about papers initially. Detailed concerns, discussed authors of paper and included separate email thread with individuals who had concerns to edit and change paper.

NOSM opens speakers list #2

- Emily (U of A) - AGAINST - Concern regarding the objectives. The aim of the objectives is to incorporate needs based on the community. My concern is that it suggests that it will be done between the mentor and the student and excludes the community and ignores co instruction with the community and developing this relationship.
- Bernadine (U of A) - AGAINST - concerned that it required at minimum; inhibits students ability to use paper to advocate to implement service learning at their schools; could cause serious harms
- Mern (U of Ottawa) - AGAINST - I appreciate the efforts of this paper but would like to support Alberta and NOSM. U of Ottawa’s new program has not been updated in this paper either.
- Dax (Moncton) - AGAINST - Moncton is not represented in this paper and therefore I question the integrity of this paper.
- Brady (U of A)
 - I would like to propose a **motion to table this paper to AGM 2018.**
 - **Secunder:** Saskatchewan

Jeff (Sask) moves to call the question.

- **Secunder:** McMaster
- Jess (Chair) - we are voting to end debate. Any direct negatives? Motion to call the question to vote to table the motion.

Result: MOTION PASSES

- Jess (Chair): We will now vote on the motion to table the paper to Fall of this year. One minute to discuss.

Result: MOTION WITHDRAWN BY MOVER

Resolution #12: Motion to adopt “CFMS Position Statement on Recreational Cannabis Legislation”

Moved by: Yipeng Ge (Ottawa)

Seconded by: Shanza (Ottawa)

Motion passed at AGM to create a task force in order to create this position paper due to the pressing nature of this issue. Broken up into different section on med ed, min age, public education, public consumption etc. Addressed different feedback during the resolution marketplace. One of concerns was around the longitudinal course. Worries about how heavy things were in terms of addition to curriculum. This is addressed by “appropriate and feasible” to areas in the paper when discussing medical education. Why did the medical students create paper with some recommendations that are not necessarily in line with CMA (specifically min age and public consumption). Team worked on it representing medical students and themselves, difficulty with coming to conclusions on these issues.

Result: MOTION ADOPTED NEMO CONTRA

Resolution #13: Motion to establish a position paper on the current state of homelessness in Canada

Moved by: Karim Mithani (U of T)

Seconded by: Shanza Hashmi (Ottawa)

We found a bunch of isolated efforts across the country. Got together to have national cohesion with the approach. Goal of the committee is not to develop national prescription. Goal is to try to learn from each other experiences and build off of them with evidence and work locally. First, publicize this as much as possible. Second, there are already individuals working on this and lack of CFMS backing leads to difficulties in consultation.

Direct negative - Ben (NOSM) - Speakers' List opened

- Friendly amendment to the friendly amendment
 - LGBTQ2SQI+
- Nathan (U of C) - POI - What i would like to know is specifically the measurable deliverables are that this task force would be required to produce?
 - Karim - main deliverable is position paper for AGM 2018
 - Shanza - likely SGM 2019
- Will (Dal) - friendly amendment; Whereas statement changed to “Whereas the Government of Canada has begun to target efforts towards a federal homelessness housing strategy that will prioritize the most vulnerable Canadians, including but not limited to veterans, LGBT2SQQi+ people, indigenous peoples, seniors, those dealing with mental health and addiction issues, and those fleeing from violence.
- Who would make up this taskforce?
 - Shanza - taskforce would constitute students
- Lianne (McGill) - POI - where does 1.7 million figure?
 - Shanza - database from canadian government
 - Liane - **motion to amend to add a source to the figure**
 - Shanza - can we do this?

- Jess (Chair) - will allow the amendment to go through
- Kaylynn (U of A) - POI - Wanted to do a call out to get students involved from across the country. Do you have a plan in place if you do not get students from across the country?
 - Karim: RR and advertising across the country. Cannot make people participate if they do not want to. We already have a diverse team in terms of geographic location. I do agree it is a fair concern. Homelessness is a different issue in different communities. We are going to try to advertise it as much as possible through all the channels that are available to us.

Saskatchewan motions to extend resolutions session until resolutions 13 and 14 are completed.

Seconded by: Toronto

Result: MOTION PASSES

- Odell (Sask) - AGAINST - speaking against this on the principle, not the content. We don't need motions to create task forces. Sets dangerous precedent - we create taskforces all the time without the GA via the Board or NOs or committees. Author has mentioned that the taskforce will be created regardless.
- Victoria (UofT) - FOR - don't think it's useless to have a motion to create taskforce. Homelessness is an important SDoH and we feel strongly about it.

Nathan (Calgary) moves to call the question

Seconded by: Saskatchewan

Result: MOTION PASSES

- Jess (Chair): We will now vote for the motion itself

Result: MOTION PASSES

Resolution #14 - Motion to establish a task force to review criminal justice reform with regards to marginalization and stigmatization of persons who use substances

Moved by: Ziyu Xiao (McGill)

Seconded by: Yipeng Ge (Ottawa)

There was nothing in the resolution about amnesty for those incarcerated for cannabis or opioids. CFMS should take a stance that non-violent crimes should not receive criminal punishment. It would be great to have amendments to the papers adopted today to support this.

- Saskatchewan - Direct Negative - Speakers' List Opened
- Jeff (USask) - PPI - does GA require a motion to create a task force?
 - Franco - will speak to this albeit - kind of procedural. There is no true definitive that we need a motion however there is several year history of GA creating task forces. There is no need for a motion to strike a taskforce. If a motion comes up to strike a taskforce, it's up to the GA to decide this.

- Jeff (USask) - PPI - if this motion is voted down by the GA, are we not allowed to strike a taskforce in the future or could it still be done offline?
 - Franco - If GA votes this down, it would be poor taste for board to circumvent GA to move it forward
- Shanza - POI - when we said this if its upheld by the GA, this won't stop the advocacy efforts for happening. If there is no process in the creation of these task forces and there are taskforces using CFMS label approaching national stakeholders. Caution the GA. I would like to implement a process
 - Yipeng: This motion has come to the table because of discussions around the other 2 papers. This was a motion that came out from deliberation on the motion on opioids and was added to address this very gap. The second point. Keep the CFMS accountable to this work. My term ends in September. To my understanding, any vp CAN create a Task Force and brand it. A general member cannot really do that. In an informal promise to do this carries the same weight in that the CFMS will stay accountable on who will look after such a task force.

Jeff (USask) **moves to call the question**

Seconded by: Victoria (MUN)

Result: MOTION PASSES

- We will now vote on the original motion.

Result: MOTION PASSES

Final Announcements

- June 1st - crazy socks for docs to support for doctors experiencing mental illness
- Phlebotomy Bowl
 - Most donation per capita
 - 1) Dal - NB campus
 - 2) MUN
 - 3) Queens
- Most new
 - 1) Alberta
 - 2)
 - 3)
- McGill won photo scavenger hunt
- Thanks to
 - Resolution Committee - Odell + France + Victoria + others
 - Rosemary
 - Speakers
 - CFMS Board

- Halifax
- MDFM
- Minute takers