Spring General Meeting 2017
Canadian Federation of Medical Students (CFMS)

DATE: April 28 – 29, 2017
LOCATION: RBC Convention Centre - Winnipeg, Manitoba

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April 28, 2017

SGM Introductions

Dr. Carl White Ulysse (SGM Chair 2017, CFMS)

- Carl: Welcome to the SGM! Welcome to Barbara & Clarence Nepinak, Elders from Pine Creek First Nations
    - Clarence: Ojibwe prayer asking for guidance & blessing and care and health to those we left at home to travel to this conference
    - Barbara: Thank you for the traditional tobacco offering, acknowledge the spirit of water, the future of people all over the world
    - Carl: It is customary to provide tobacco ties to thank elders for sharing their wisdom, and we would also like to thank you for coming and sharing with us
- What is the CFMS?
    - 8000 medical students from 15 medical schools
- What is the SGM?
    - Guests & speakers from across the country (RDoC, OMSA, CFPC)!
    - Agenda available at www.cfms.org, including resolutions & executive reports
    - Resolutions: Saturday
    - Social Events
    - Social Media:
        - @CFMSFEMC (Twitter, Instagram)
        - #SGM2017
        - Snapchat Filter
        - Humans of Medicine

Keynote Address: “The Real Power of Research”

Dr. Glenn Regehr (Inaugural CFMS National Research Chair in UME)

- Intro by Tavis Apramian:
    - We have been working to develop the research infrastructure of the CFMS, and developing the CFMS National Research Chair is an important first step for guidance & mentorship for MedEd research
    - Glenn is a giant in the MedEd field!
    - There is always a better question than “Did it work?” and a better answer than “Yes”!
    - Think about the role of MedEd research as we
- Imagine a scenario: you are a medical student that has been allowed to attend the CCME. You have negotiated time off, your MedSoc & CFMS have funded you, and you have been given the opportunity to speak in front of the group about your project. You call your parents to tell them what’s going on, and they don’t understand why you’ve taken vacation to come to CCME in Winnipeg!
    - Many forces at play that make it difficult to explain why you’re here!
    - They call you back a week later. We did a scientific survey of your family with 100% response rate that they miss you and you should go home instead of going to the conference! We surveyed your neighbours, 29% response rate, out of 3.5/5 that you should come home. Does this change your action? Probably not… Even if they continue to facilitate your trip home, it makes the decision even more difficult.
    - *Where is the power?* The program, your family, CaRMS, you?
    - *Can you make this decision alone?*
    - What if you surveyed medical students, got a 29% response rate with 4.5/5 agreement that students don’t feel prepared to manage opioid seeking behaviour? What do we do with this information?
- “No one should ever be forced to see how we make sausages and how we make laws.” - we should add curriculum to this list
- The higher you go in the system, the less power you have, and the more complexity you manage
    - The course directors end up having more power
    - Undergraduate deans have to manage all of the course directors
    - We should never tear down fences unless you know why they were built in the first place
- No single group is powerful in any advocacy situation
    - Data is not a particularly powerful force for change, especially data that seeks to prove a particular point
    - Data should help to figure out better solutions to the problems that people are dealing with
- Example problem: There is great variation amongst preceptors in their approaches to a particular clinical scenario

    - How can we deal with this variation in a more productive way?
    - Variation comes from developing the nuances that allow you to be an expert
    - Expertise isn't about convergence on the same thing, but the evolution of individualized nuances in approaching a scenario
    - Then, let's reframe the problem: Given the variation, which makes the system robust, how can we should teach students how to embrace the variability in order to develop their own expertise?
    - This is possible if you engage in research to try to solve the problem, instead of trying to prove a point
- It is important to think about the big picture goal of our research, and to explore the terrain that you are trying to build upon so that you can perform research that will last for a long time

Questions:

1. Franco, Calgary: Thank you for this talk! We know what the 'rubs' are, but there is a roadblock in discussing with faculty/deanship: their mandate differs from our's. How do we reconcile these differences?
    - A: We tend to think about research in too formal a way. This form of data collection for purposes of understanding happens in many contexts. My perspective is that because there are so many forces that come at a given problem, systems will have inherent differences. Applying more pressure will not make a difference; system will react. It isn't that a person is for or against: they are for something that will require a different solution that what you are arguing for. Everyone is arguing FOR something different. Use research (formal or informal) to come to understand the various forces and goals that people are working towards. Rather than screaming louder about your goal, understand how to co-construct goals that move everyone in the same direction. If you can align these forces, then the system can move quickly! Help other stakeholders see how what you want to do is in alignment with what they want to do so they can see how they can accomplish both your goal and their goal at the same time. More productive than negotiation & compromise.
2. Xin, McGill: Formal research has many constraints, making the process more difficult. How can we perform informal data collection?
    - A: As a PhD, I am not in the world, but part of the world! Informal data collection: listen to what people have to say, frame it, and give it back to you. Excavate implicit assumptions, and reflect on them. Examples & stories are more powerful than data/statistics. No one ever learned anything from a survey. How you frame questions will get you the answers that you expect.
3. Victoria, Toronto: "A pile of facts is not science". Med Ed is trying to drink from a firehose, memorizing a lot of facts. Does critical thinking have a place in medicine? What does it look like?
    - A: Yes. What do you need in order to think critically as a physician (vs. any other profession)? Researchers asked physicians, nurses & pharmacists what critical thinking is, and every profession has a different answer, but it boils down to

“Think like a doctor/nurse/pharmacist.” What is the unique perspective (not skills!) that a health care professional brings to the team? In my opinion, a unique biomedical perspective, combining professional role (social contract), healer role (contract with patient) and scientific role (contract with science). You are learning the language of medicine - not just listing of facts, but a culturation process that allows you to speak & think in new ways! This shapes what you’re allowed to think about. All of these facts are part of the critical thinking process that we are being indoctrinated into. What are we losing our ability to think about because of using this language? Caring, spirituality, and therefore healing. Healing is reduced to treating. Your critical thinking is being shaped radically without you knowing.

President's Report

Franco Rizzuti (President, CFMS)

- Thanks to Rosemary, the CFMS Executive, SGM planning committee
- The CFMS: We are tomorrow's physicians leading for health today
    - We represent, support & connect
- How are we doing as an organization?
    - Member engagement: We are at the end of a strategic plan. We are doing well, but how do we keep this going? How do we engage people between General Meetings?
    - Support: capacity is our limiting factor
    - Excellence in Med Ed & Mobilizing Student Voice: our biggest struggle!
    - Organizational Effectiveness: Our largest limiting factor is our capacity
- History: This is our 40th year!
    - 40 years ago: The Association of Canadian Medical Colleges (precursor to AFMC) had one seat for a student, but we were not getting our voice across
    - 1983: Canadian Intern Matching Service (precursor to CARMS) was co-designed by students
    - 1986: CFMS passed a position paper for clerkship stipends
    - 1990's: formation & growth of CFMS-IFMSAS electives through Education portfolio
    - 1991: First partnership with MD Financial, allowing us to grow our annual meeting
    - 2001: CFMS created a position on rural and urban medical education, now adopted by AFMC
    - Now: AFMC Single immunization form for all electives
    - We are making meaningful change in the MedEd
- Finances:
    - We are growing financially by 25% in the last 10 years
    - Interestingly, AFMC and other important stakeholders have increased their budgets by 30-50%
    - However, programming has doubled in the last 10 years!
    - Our organizational capacity is the same (one part-time staff)
    - Where do we need to go in the next 40 years to meet needs of our membership?
- Major projects of 2016-17
    - Lobby Day 2017 & Advocacy plan: Opioid crisis
        - Parallel processes: indigenous health, antimicrobial stewardship
    - Inaugural Research Chair
    - Curricular Advocacy
    - Partners: Choosing Wisely Canada, RDoC, FMEQ, FMRQ, CMA, CMF…
    - Transition to Residency:
        - CaRMS: Members working with other learner organizations to negotiate a new trainee contract on behalf of all trainees

        - Non-registered electives letter
        - Inquiry into unmatched Canadian Medical Grads
            - Increasing every year
            - How do we support students in career planning and those who go unmatched?
        - Physician Resource Planning Committee: looking at national health-human resourcing
            - Alberta: capping new doctors and restricting licenses
            - Developing tools for students to know more about supply & demand
        - Privacy: there are a few groups that want to link undergrad to post-grad data, including MCAT scores, mental health concerns, etc.
            - What are the processes that can be in place to ensure we have proper privacy principles?
            - RDoC, FMEQ and FMRQ have developed framework, and we are working closely with them
    - Wellness: CFMS_FMEQ National health & wellbeing survey data is being aggregated to be published in peer-review article
        - We can't guarantee a timeline for school-specific data
        - Wellness Challenge: successful 2nd year
        - Financial Literacy & Support: students collaborating with MD Financial Management
    - Internal:
        - Our organization needs to meet the needs of our membership
        - It takes a long time to accomplish many projects in our organization
        - How do we ensure we are running effectively? How do we restructure?
        - Capacity, organizational growth, governance changes, fiduciary liquidity, sustainability, compliance, transparency, accountability
- Next Steps:
    - Strat Plan 2017-2020 & Governance!

Questions:

1. Shreya, Ottawa: As we look forward and understand that what we produce is increasing exponentially, how do we draw the line on where our limitations are, and how much we can do well? Quality vs. Quantity
    - A: This has been a struggle. As we look forward, where can we divest? Are there projects that we can delegate? Structurally moving work towards committee work.
2. Alyse, McMaster: There are a lot of great position papers. Does CFMS have a role in managing information in position papers and how we can bring it back to the schools?
    - A: Sarah & Jovi are working on getting policy tracker (list topics & our actions). We are hoping this will help MedSocs to see what other schools are doing, and how we can move forward. We are hoping for fewer position papers & more collaboration via Task Forces.

3. Kiefer, Saskatchewan: Please elaborate on the privacy concerns. Is this an advocacy issue that we should be bringing back to the local level?
    - A: Dealing with how much information should follow you in your training, who should have access to your various files (ie student affairs, etc.). How “arms length” is the matching process? Who is at play? Should they be at play? Example: MINC number links credentials, but there are other people (ie app developers) who have access to this. This isn’t the Prime Time for this: we don’t have enough to go back to schools, but we hope to be able to come back to this after the Privacy Policy Paper is developed this summer.
    - Follow up: What will move this into “Prime Time”?
    - A: Evolving! Hopefully there isn’t a big tipping point that begs the need, but this will be an evolving process.

Small Working Groups

Han Yan (VP Student Affairs & SWG Chair, CFMS)

Topic: Transition to 3rd/4th Year and Residency

- What CFMS currently does:
  - CFMS advocates for immunization form in regards to feedback that students have to AFMC
  - CFMS offers discounts for lodging and flights during CaRMS/electives
  - Working on updating elective databases and CaRMS interview question/resource databases à needs to be moved on to the new website (timeline TBD)
- How to improve:
  - Resources for clerkship:
    - Provide information (presentation, video) on the resources for clerkship and electives to students going into Year 3
    - Guideline to writing a consult
- Electives database:
  - Increase traffic to the elective resources because the electives are very variable
    - Suggestion: incentive for students to fill out feedback (e.g. each feedback form filled is a ballot for raffle draw)
  - Students could have option to add a thumbs up/down with comments in the elective feedback
- Resources for CaRMS:
  - Guideline to writing a CV and personal letter for schools that don't have these documents available to their students
- Financial planning:
  - A dedicated financial officer at each university:
    - At MUN, they have a dedicated financial officer who students have mandatory financial advising planning meeting(s) with. This officer is available to MUN students for the entire course of their degree.
    - At UBC, there is a dedicated financial officer who provides information and hosts financial information events, but students do not have to meet with them.
  - Think about timing of financial learning:
    - Financial events are often held early in the year when there are already a lot of events happening.
- CFMS website:
  - Utilize the local VPX to disseminate information from the CFMS

- CFMS currently offers:
  - Portal with AFMC to improve elective system, sends out anonymous student feedback survey to get info for AFMC to help push forward
  - Discounts and offers for students ie. flights, textbooks, etc.

    - Transitioning into new website but resources currently on old website
    - Database for interview and electives (on old website): google forms sent out filled out by 3rd/4th year students about electives and their experience, data compiled for consultation by students (underused). Similar database exists for interviews organized by specialty (resources used by students to prepare for specific specialties, tips and tricks)
- What is uptake for surveys and are there more responses for certain schools?
    - Response rate is scarce and lots of it needs to be updated.
    - Having an incentive for students to answer the surveys? Increase in responses, more students will use it because currently there is not great feedback
        - Ideas for incentives: gift cards (Starbucks, Tim Hortons)
        - People motivated by helping people in the class behind them, so maybe each school is already doing this sort of mentorship within their schools unofficially
        - Connect with Rep to see what they had passed on to their students for all schools across Canada and this can be published for all schools - > consolidation of resources
- Student Wellness Survey results – should try and involve 3rd years in wellness initiatives because of their spike in suicidality
    - CFMS wellness campaign this year was great, more involvement.
    - 3rd years: hard to sign up, don't have time to figure things out. Instructions need to be very clear and concise to decrease time
- Financial Planning
    - MD financial is quite forthcoming for some schools but others find their resources are underutilized
    - People sign up for LOC before starting school and MD Financial makes presentation at the first week of Med
    - Overwhelming when being introduced to many services at the beginning of school
    - Need to remind people that MD financial can help regardless of what bank you are with
    - Maybe create a package pre-med with basic details about budget so students have an example -> a little resource ie. this is what the typical student spends, this is what CaRMS costs, electives, helping keeping track, etc.
    - University of Manitoba created this resource this year with: ways to finance education, how to apply for student, return of service agreements, how much each year costs on average
    - Saskatchewan also has this.
    - Perhaps there could be a resource pre-med about finances and have financial information relevant to each year given to students so they aren't overwhelmed during o-week. Relevant info given each year to guide students through their studies by year, so by the end they have all the knowledge and info to transition into Residency. Perhaps have a looking forward document in 4th year for them to use as they move forward in their career.

- Transition to Residency/Electives Documents
    - Currently developing a kit with practical information about lifestyle for residency including financial planning, eating well, exercising, relationship divided into programs
    - Would be great to have resources with info about the city for residency programs, what's it like to live in the city, transit, etc. This info would also be important for planning electives -> being there virtually before physically makes you feel more prepared (shared with everyone)
    - Set you up list of upper years that want to host people in their home for students doing electives – currently a Facebook group (Medical Student Housing). Is there a role for CFMS here? If things happen who is responsible… (liability issue)
- Using and Advertising Resources from CFMS
    - Do things that are school specific, have CFMS reps from each school send out specific info that are pertinent to the school and year (people know these people so will be more inclined to read)
    - Facebook posts more likely to be read if they are on the CFMS page versus CFMS Rep Jr email sent out to students

Topic: Dedicated Diversity Curriculum

Questions:

1. Diversity in the curriculum and admissions/recruitment. What does this look like for your school, how this can be improved?
2. Definition: curriculum – Indigenous health courses, LGBTQ, refugee health, etc. How its integrated into the curriculum?

Answers:

- Northern Ontario School of Medicine
    - Admissions: Robust process for diversity in applications process. Based on social accountability mandate. Addresses Anglophone, Francophone, and Indigenous populations that reside in the area: want proportional representation of these populations within the class to reflect Northern Ontario. E.g. Francophone get an extra check on the application, Aboriginal students get additional supports during interview.
    - Curriculum: Thorough Indigenous health components. A lot throughout pre-clerkship, within class time as well as lunch sessions with elders. At end of first year, there is a 4-week cultural placement on a reserve integrated into the curriculum with support from Indigenous Affairs (Federal Government). Elements of LGBT Health integrated into the curriculum. Looking at example cases used in class and making sure that these are written through a diverse lens as well.
- University of Alberta
    - Curriculum: Working to introduce diversity in curriculum so that it is done the right way, i.e. not just more facts with no appropriate integration. Faculty offers 12 hour electives in topics like Indigenous health, Inner city health, sexual and reproductive health. Self-selected, not mandatory. Really try and involve the

community in this – have someone from these specific communities give opportunities in these education topics. Working on the curriculum to have LGBT issues throughout so there isn't just one class on it. Make it relevant to different lectures, spread throughout the entire curriculum as cases.
    - Admissions: Dedicated Indigenous spots and initiatives to support these students throughout their 4 years. Also talks to high school students in rural areas, help recruitment from these sites.
- University of Manitoba
    - Curriculum: Indigenous health curriculum – separate course that runs throughout pre-clerkship. Mandatory lectures and small group sessions with no evaluation. Have members from the community that come as well. Student-run initiatives that promote indigenous health. Physician who is a champion for LGBTQ+ health – facilitates the sessions, provides a lecture on what family physicians can provide in terms of hormone replacement therapy. Also someone who works with Aboriginal health, who is an aboriginal physician, who gives talks in the spheres of Indigenous health.
    - Admissions: Different stream for people who are Metis or Indigenous. Panel interview for these specific students. Socioeconomic factor integrated into the admissions – points for being marginalized, LGBTQ+, having debt, living in a rural area. Coefficient added on top of your admissions score - more things you apply the higher the coefficient.
- University of Toronto
    - Curriculum: Certain cases based on Aboriginal Health issues, working well. Lack of focus on social issues, how to implement them in a way that is actually useful. Second year longitudinal placement in Family Medicine. Sought out people who run specialized clinics so that students may end up in these settings.
        - Great eye-opener for some of these students to better understand the issues faced in these communities.
    - Admissions: Headway in improving application process – Black Students Application program. Application reviewed by black community members and physicians. Same cut offs, but once you are invited for interview you get interviewers who are also black community members and physicians. Using this as a model for the Indigenous application process.
        - This summer starting MCAT prep course – provide people from lower income backgrounds opportunity to help with course and application process for free. Taking 50 students.
- McGill University
    - Admissions: Reserved spots for students of Aboriginal descent.
    - Curriculum: Many hours of teaching on Aboriginal health, cultural competency with regards to Aboriginal populations. Nothing about trans health, very limited exposure to LGBTQ+ health in general.
- Memorial University
    - Admissions: seats reserved specifically for Aboriginal students, however this is not capped – often the number of Aboriginal students exceeds the number of

seats allotted specifically for Aboriginal students. During a community visit in first year pre-clerkship, students give talks to high school students in rural areas to teach them more about medicine, provide more insight into what the application process looks like.
    - Curriculum: Most of the curriculum related to Indigenous Health occurs during the first phase of the 1st year curriculum. This includes panels with members from the Aboriginal community about issues in Aboriginal Health and how to approach Aboriginal patients in a way that is culturally competent and safe. There are also mandatory case assignments related to issues in Aboriginal Health.
    - During our 3-mandatory pre-clerkship family medicine rotations (reduced to 2 rotations as of this year) and during the Family Medicine Core rotation in clerkship, there is the possibility of undertaking this rotation in Labrador, which is home to the majority of the province's Aboriginal population. This exposes students to health care providers that interact mostly with Aboriginal community members, as well as encourages participation in community activities with members of these communities. Similarly have LGBTQ+ panel to address issues experienced by members of that community. Also have opt-in, sporadic "lunch and learn" sessions in the field of LGBTQ+ health. Finally, during mandatory training in "Days in Violence" – a series of sessions teaching students an approach to interviewing and caring for survivors of sexual and physical violence – there is a talk delivered within this sphere related specifically to the LGBTQ+ community.
- General Discussion Points
    - Often in PBLs, there are many stereotypes e.g. black patients used to elicit Sickle Cell diagnosis, and not used in any other context or case example. Need to move away from this, and integrate a more diverse array of patients into every clinical based example.
    - At University of Manitoba students received a talk on how as a family physician you could provide care for transgender patients, and what exactly you can offer these folks. Similar lectures are not given at all universities, but would be beneficial to helping current learners better treat diverse patients in future.

- Toronto: Dedicated office, faculty lead in charge of diversity integration into the curriculum
    - New position (within the last 4-5 years)
    - Curriculum and other elements of diversity – new applications etc
    - Chief diversity officer
        - Lead for specific marginalized community threads
- Want to have a stream to admission dedicated to black students. Separate essay involved in the application, no quotas, no difference in other application elements
    - Goal is to encourage more black applicants
    - Besides that, Toronto does a pretty good job
        - Naturopathy
        - Diverse
        - Externships – clinical time at specific clinics like HIV clinic, LGBTQ clinic, Indigenous

        - Lots of training before these externships
- Western: lacking, dedicated lectures for trans, LGBT, etc. Emphasis on encouraging diverse populations to apply to medical school
- Queen's: Dedicated faculty member. We have a PGH course with lectures about specific populations. Students working towards making it better
- Alberta: LGBT advocacy stuff
    - Diversity officers is a positive things
    - Associate Dean and course coordinators are open to student feedback and innovation ideas
    - Integrated longitudinal LBTQ thread throughout pre clerkship
    - Want a faculty member since students have quick turnover and there isn't always a student who is dedicated to this
    - Physicianship course: each year
        - Lectures about different population groups
        - Threads: ethics, LBTQ, indigenous
        - Students don't like the curriculum
        - Have non-MD content experts come in and give talks in this course
    - Focus on indigenous and rural applicants – overhauled admission process, no specific targets
    - Diversity score might be established within the application process
- UBC: No faculty member dedicated to diversity. Students are the main push. Faculty is open to having this conversation. No specific course to address diversity. Indigenous and rural applications are the focus for admissions reform
- Manitoba: No diversity faculty lead. Separate stream for Indigenous applications. Low SES stream just started.
    - Look at their whole life (family income, option to disclose membership within certain marginalized groups)
- Manitoba: Ability to identify as "indigenous", LGBTQ+" on application, but no real ability to expand on that and can possibly be taken advantage of; there is teaching specifically on transitioning developed by the faculty; specific programming for high schools with indigenous students to try and address the issue with spots reserved for indigenous applicants not being filled
- UBC: Opportunity to mention "diversity" in application; perhaps not enough representation of diversity in the curriculum; A decent amount of teaching on indigenous health
- Dalhousie: Dal has a diversity inclusion committee, has experienced issues regarding teaching; "potential" (organization) partners medical students with kids to allow them to get experience in different areas
- Ottawa: A large focus on care received between French and English population; large indigenous stream (around 10 students); diversity of class is lacking; lots of talk on Indigenous health and social medicine
- McMaster: Class is a bit more diverse than others due to recruitment process; only dedicated stream is Indigenous stream; gaps in curriculum are often filled by interest groups (but it
- Alberta: Really trying to include diversity teaching (brought in a speaker to talk about LGBTQ+ health); not sure if this is a good approach; 5 spots for indigenous applicants; spots for Low SES but this group may not be well-captured through current approach; MD ambassador program gets medical students to give presentations at high schools - there is an issue with getting students to attend in low SES schools
- Western: Hired an indigenous liaison to aid with relationship-building

Topic: CFMS and You: What's Working Well

- Strength to be focused on more – membership benefits like discounts and services for rank and file medical students (CFMS may seem fluffy to cynical/jaded people), engage them this way and increase our profile to them
    - Esp. for 4th year WJ discount, travel discounts
    - Useful valuable discounts ++
- Communication to general members could be done better à we just tag the communique out to students at the end of a email and they ignore it
- How is the communique actually disseminated? Can we synch up all the med soc info dissemination strategies?
- How many new submissions do those medical journals actually get from it? Do we really need to include them? Make them fewer!
  Add an intro! Hook people better!
- 1st year students should be engaged better – try to make these orientation mandatory!!
- Cool if exec did a welcome video!! Who we are and what we do! ß make
- Lobby Day is a good way to include research
- CONNECT everyone: lots of people want to do things that are repetitive in advocacy, need to make sure they are aware of one another –> go on website for e.g. and you can just see what
- Our positions are getting overwhelming and we are not actually advocating for them
    - Need follow-up on all those resolutions and working groups
    - There should always be a deadline/timeline
- If we don't do these justice, then should we be picking them up at all?
- How can CFMS advocate for low SES students?
    - E.g. Toronto does free MCAT prep course?
    - E.g. Manitoba has a stream for it
    - Low SES medical students => purchasing LMCC practice questions etc.
- MDFM: would help with a financial literacy thing – could connect to faculty, train a workshop leader who is coached to not talk about products, or train student leaders at each school to raise questions re: LOCs, repayment, residency salaries, investments
- Shreya: also in addition to above, travel awards for low SES students, support for unmatched students who need to repay loans (forgiveness for a year?)
- Exchanges: working pretty well – keep it up! Lots of resources provided, Kelly & Montana are amazing NEOs – keep that up
- Website: not very good for exchanges, could not see matrix of stuff that is req. to apply for each country
    - Keep it updated
- Dal & MUN: regional representation is key! Keep it!
    - More travel award winners for Atlantic provinces
    - Having a vote matters for the regions, "regional council" is not just enough
- What is the CFMS and what are we trying to accomplish?

    - Too many moving pieces à lack of unity, hard to incorporate added participants, e.g. getting an email that's 30 pages long = students zone out and delete the email
- Advocacy guidance and instruction politically
- Comms need to be way briefer and more succinct:
    - Usman: modifiable and clickable infographic at the start of/to replace communications could be better!
    - Include a rotating exec update at the beginning of each – with actual photo and personal welcome to the communiqué blurb!
- Recently updated links area in each section of the website?
- Introduction to CFMS at the beginning of med school – through an interactive video?

Topic: Unmatched Canadian Medical Graduates

- Franco: Here to talk about match process
    - Examining trends that drive UMGs (quotas, "go-fish" matching, differing interest in locations)
    - Once you go unmatched, no consistency in supports, regulatory issues, etc.
    - Mental health as an issue: all students should have CaRMS strategy to follow (not just for "high-risk" students)
- Franco opened floor for discussion

- Western:
    - Proactive should be focus rather than reactive
    - Start in pre-clerkship
    - Queens very successful matching this year and they have a large focus on early career planning
    - Franco: Ottawa has predictive algorithm, identify students who are more likely to go unmatched, predicted 13 of their 14 unmatched students
    - Why is this not widely available? Can this be implemented across the board
    - Alberta: Has similar, but not algorithm
- Alberta:
    - Their fifth year is basically an MBA (non-clinical)
    - Franco: Highly competitive matches, issues with loan repayment, insurance, seeking consistency on fifth year approaches
        - Hoping to generate a series of recommendations
    - Mac: two options for competitive students: enrichment year to build CV to be more competitive (encouraged by faculty), or do a fourth year if unmatched
        - First option prevents inflated unmatched stats
        - Many conditions to enrichment year, structured
    - Manitoba: fifth year of all electives is possible
        - "Extension to clerkship"
        - Have to meet with dean, etc and make it clear you tried to match in a reasonable manner the first time (not just seeking extra opportunities)

    - Alberta: how are these conditions/regulations enforced for these programs?
        - Franco: schools not allowed access to your match results to ensure
            - PG departments have a week where results are available, deans can change list, can see who is matching, no oversight, only stumbled upon this recently (obviously open to abuse)
- How is tuition managed in extra years?
    - Doesn't seem standardized
    - Western: tuition but use line of credit (but lose LoC if extra year)
    - Franco: regulatory rules
        - Not technically under UME insurance, so legal issues for these students
    - Western: clinical electives are discouraged for this reason
        - Students may be forced to do research electives instead
    - Sherbrooke: not insured and not considered a med student
        - Allowed to do research, but have to set it up all yourself
        - No real student support for extra year students
- Franco: hoping to find best practices across the country to stitch together a standardized approach to dealing with UMG students in their subsequent year(s)
    - Also need to focus on identifying why UMG numbers are increasing and how we should stop this increase
- Alberta: in case of students gunning for one specialty, does it become the faculty's job to ensure that student matches?
    - Manitoba: doesn't feel that onus should be put on admin just because students have a dream career in mind, CFMS/admin just wants students to match per se.
    - Franco: admin very focused on match rates, but schools could and should do more with the information they have available to let students know what their odds are, how they should proceed
        - Set up an informed "buyer beware" situation with the student
        - But realizes this info is not always available or reliable
            - Some specialties are becoming more competitive or fluctuating
            - Example with IM this year, some told to use it as a backup, but wound up being hypercompetitive
- Western: specialties resistant to being viewed as back-up options
    - Many specialties setting up initial roadblocks (e.g., X number of electives at their site to even give an interview)
- Franco: need to formulate plans with students early and tweak them as necessary as the system fluctuates
    - Limit number of direct entry specialties and then specialize afterward
        - Then, b/c no specialty wants to be a backup, this could help get people in the door
    - Western: weird that there's a huge focus on having done research in the field you seek, does that show ability or just interest?
        - Seems misguided focus
- What happens to UMGs who never match?

    - Franco: not a conversation people want to have, need to seek out alternatives, but not often spoken about
- Unmatched CMG paper in the works - wanted to get info on this iteration on CaRMS, and want to know what issues are around CaRMS to eventually create a white paper and make recommendations
    - Career advising does not seem to help - average of applications is 18 that they applying to (used to be 10-11) so that's not helping
    - Ontario rollback in seats
    - Quebec adds a unique component - someone who leaves Quebec may not be replaced by someone in Quebec by an "Anglophone"
    - IMGs are competing for spots as well
- Question - what are the rubs/issues that students are seeing at their school with the matching and support the unmatched students
- Primary care vs specialty care - have a lot of unfilled spots in primary care and a lot of unmatched CMGs
    - Students don't want to go rurally - is it that it's not appealing enough, or not selecting the correct students to get into med
    - Should there be a restriction on direct entry programs e.g. peds neurology - should there be more of common programs e.g. gen surg and then go into sub-specialities later?
- Due to professionalism concerns, or a lack of insight into how competitive you are for the specialty you are applying to?
    - A lot of the students who don't match don't come in for career counselling
    - Should there be more efforts to develop relationships with students and career counselling since day one so that they can get a good plan early on
    - Shouldn't do electives counselling after the electives have already been done
- There is a mismatch between what they know and what they should know about residency - pigeon hole yourself early on and then find out about the career landscape out there when they've already done everything
- There isn't much time for students to explore themselves - the advising is a lot of "do what you like" but that doesn't work now because that's not realistic
    - Should give students more time to go shadow/observership in areas that are realistic for you
    - Students don't have time to find themselves
- Mental health with CaRMS is terrible, there isn't enough support/mental health counselling for students
    - CaRMS is high risk, so it's not about individuals that are "high risk students" so there should be support for all students, even the ones that match since the match could be something hard for the students as well - need mental health check ins for everyone
- Admissions should not be a separate thing - who are we recruiting? Should there be more emphasis placed on the expectation that they will go into rural practice
- Teaching is also important - we have specialities teaching students, academic people teaching, and then can't expect students to then go into rural practice

- There isn't enough protection/status for students - if they are unmatched, how are they being treated differently?
    - Schools need to work on de-stigmatizing things for those who don't match
    - Could we make a nationally available panel about unmatched students? Want to show that they are not "leper"
- There are algorithms at Ottawa that help predict students that will not match - very accurate and want to work with them before the match

Topic: Physician Payment Models

- Fee for Service Model (most frequently used across the country)
    - 70% of physicians use this
    - Was about 90% ten years ago
    - The gov't is paying for an itemized list of what they are getting
        - i.e. Consult, small procedure, Pap smear all are different codes
    - It is difficult to come up with values for each service, particularly over time as things change… there are no pressures to change these fees, even if technology changes, specialists change
    - One good thing in the United States is that private insurers will ensure that fees get updated quickly and are relevant to the technological capabilities.

- Salary Model
    - Paid for the year regardless of hours & volume (with some limitations)
    - Takes away incentive to over-produce
    - Means that efficiency is not maximized and costs aren't as concerned
    - Biggest problem with salary?
        - Biggest barrier is you are impinges on the issue of physician autonomy
        - There is this ingrained idea that physicians are "independent contractors" who have their own autonomy and want to be able to work in the way that they want. Choosing their own hours, patients, & etc.
        - Physicians don't like to be told what to do, don't like feeling 'tied down' and that is something difficult to even have a conversation towards that.
        - Flexibility & autonomy in a practice is very valuable... can we have a salaried system without causing physician recoil?
        - We are public servants

- Capitation Model
    - Block payments based on the number of patients rostered in your practice
    - Patients between ages x & y will have a range of problems, producing x number of visits, and x number of costs… the physician is compensated through this
    - Encourages healthy patients only

- Fee for Performance Model
    - Rewards outcomes in a sense

- What are the outcomes, how are we measuring them, what is the timeframe?

- Bundle Model
  - You attach a cost to a case(?)
  - Tries to encourage integrated care
  - If you follow one particular stream, all the costs will be determined
  - Blend between capitation & fee for service

- Problems
  - Incentives aren't where they should be
  - One suggestion is the blend between capitation & fee-for-service, where essentially you are paid for your rosters & there is also a fee for service component

Questions:

1. Have there been good mixed-patient models that have been used yet?
   - There is some evidence
2. Are there gaps in the curriculum where the bigger systems-level picture gets lost in favor of individual benefit?
   - When you are in the medical bubble, it is hard to get exposure to the bigger picture & with what is going on.
   - There is a lot of ignorance and apathy regarding systems-level analysis
3. Why are payments & payment models never talked about?
   - There are cultural differences depending on school, where people either do or do not talk about physician remuneration. We need to get people past the 'taboo'
4. How can we solve some of these issues?
   - Minimum requirements for medical students… some course on financial literacy and physician payment models in our country as well as in other countries.

- Saskatchewan: Frustration from students how you bill, debt management, payment models. Wanted a balanced source of information: not just MD financial, so we invited investors to give presentation but they were presenting their own products.
- Dalhousie: One physician is offended that there is a change in physician models, but students weren't knowledgeable enough to understand.
- Alberta: Currently discussion around fee-for-service to a blended capitation model. Students get no teaching about it at all. Pay equity among different specialities, there is no discussion about that in our curriculum.
- Daniel: One of the issues is that it's hard to get an unbiased opinion. Everyone has an incentive in their own way. Students know little about it. The payment physician models: Fee-for-service is what's used across all provinces (78%). Physicians are rewarded for volume than cost/health outcomes. Capitation ties a dollar amount to a patient per year, that's the amount for amount you get paid a year, mainly for family medicine. There is a bundled approach which includes all other ancillary services that go into treating the patient for x amount of time, it's an all in one process.
  - What do you think a payment system should address? What are the goals in a payment system?
- Memorial: A balanced in physician and patient outcome. It's a challenging conversation.

- Dalhousie: In a fee for service aspect, you can see a scenario where that would really hurt patients to maximize patients seen. However, if you weren't doing a fee for service. May be an incentive to get patients off the waitlist.
- One is if we were building the system from scratch, what would we do.
- Queen's: Perhaps having different payment systems in different specialties. For family practice, a payment method that encourages primary prevention and in surgery, a per service. The way it's implemented varies from person to person.
    - How do we oversee the system?
- Daniel: In capitation model, a preventative bonus, reach a number of patient who are immunized.
- Alberta: I am just wondering about that when we talk about fairness if a doctor worked in an inner city area, it has no bearing on your ability as a physician social determinants of health are getting paid less you can spend two hours with someone; it may take much longer for a prescription refill. A blended capitation models address age range but doesn't address social determinants of health.
- Daniel: In Quebec, a recent bill was presented that stipulated a minimum number of patients for fam doctors but one counterargument was that this could disadvantage physicians with a more complex patient population who require more time and attention.
- UBC: Collaborating with residents (and other trainee organizations) to develop curriculum content in physician payment models.
- Queen's: Creating a national infographic or module to teach students
- Toronto: They planned a panel discussion composed of physicians with varying opinions to help educate students. Not well received by Faculty because they felt it was a system that is always changing.

- What is currently taught/what do you currently know?
    - Manitoba: nothing in curriculum
    - Newfoundland: required to do research project
        - Examining the different models (but this is self-initiated)
- Opinion: Cannot maximize care when trying to maximize revenues, which is encouraged by fee-for-service model
- Different models that exist right now:
    - Fee-for-service: itemizing & invoicing government for reimbursing
        - Enhanced fee for service - top ups available based on certain incentives
    - Salary: salary per year, regardless of number of hours, procedures, etc.
    - Hourly
    - Capitation: paid based on number of patients enrolled
        - Bulk payment based on number of patients
        - Largely exists in family medicine
    - Payment per illness episode
- Would an ideal model be salaried employees with benefits?
- Idea of doctors as a gatekeeper:
    - Potential danger if doctor really has knowledge to know if something goes beyond individual ailment and this patient is sent to a different healthcare professionals.

    - Recognition of overlap between scope of practice
        - Ideal to delegate acts to other professions when possible and appropriate
        - Ex. Wound care Nurses, contraception administration by Nurses
- US: appreciate that doctors are not skilled in business and administration
    - Hospitals may be run by businessmen
    - This is a gap in Canada

Topic: Lobby Day

- Indigenous health, indigenous mental health, indigenous public health (access to water)
- Anti-microbial stewardship
- Opioids again, decriminalization of opioids, decriminalization of all drugs
- Pharmacare again
- Cannabis policy
- Organ-donation - either changing to opt-out policy, or opt-in but more accessibly e.g. on taxes
- HIV criminalization laws
- Universal access to mental health services

- What about student-centred topics like loan deferral or residency seats?
    - If we don't advocate, who will?
    - Worried about the optics, do we look selfish
    - Some groups had no strong preference between this and a public-health topic
    - Timeliness may matter

- Would you be interested in a small team of executive members and/or GAACs conducting a second set of governmental lobbying on a student-centred topic, e.g. loan deferral, targeted at specific ministers and not making it a large public event?
    - All 3 groups were in strong agreement this was a good option

Topic: CaRMS and Interviews

- How are CaRMS Interviews Sent Out?
    - Programs themselves will offer an interview, typically by email. There is no specific time for the distribution of these emails.

- Experiences from students:
    - A lot of anxiety around receiving interview invites.
    - There are issues surrounding the challenges of scheduling interviews due to difficulties with multiple interview communications; this was reflected by some third year students but also during the Medicine subspecialty match. There can be room for increasing both accountability and transparency.
    - As applicants in third year, students from UofC are worried that they may not have been receiving all of the information needed around the CaRMS process

- CaRMS has heard that applicants are encouraged not to contact programs to not be perceived in a negative light which prevents follow up

- CaRMS is engaging in research to see what the challenges are surrounding interview communication, as well as the core requirements for applicants and programs related to interview communications (what they wish to achieve).
    - There may be an eventual movement toward a centralization of the process

- CaRMS itself is a highly stressful process; it is hard for applicants to distinguish the stress surrounding interview invitations from the stress of the residency application process.

Topic: MD Financial Management

- There is an arrangement between CFMS & MDFM, but we don't want to leave it within a box
- Mike (MDFM): What keeps you up at night as medical students? What do you wish you knew? What should we be doing in this partnership that we aren't already doing?
- Allison (MDFM): Wellness is a big deal! How can we help with this?
- Xin (McGill): Broad consultation of students at McGill.
    - For 3rd and 4th year students, needs are very different. CaRMS, electives keep students up at night
    - Our students suggested resources to help review their CV, practice interview skills, HR-like approach to their applications. Faculties and students do not have capacity for this
    - Mike: CMA was arranging mock-interview process, but this could be done better
- Laura (UBC): the electives process is very expensive and this is a real stress for upper year students- the AFMC portal is very costly. Transport and accommodations are also very expensive. This really stresses students because they are still paying tuition. CaRMS tours are also so expensive and students are not prepared for the costs. People are already so stressed and then the unexpected finances add an extra stress.
- Alyse (McMaster): MDFM could play a role in coming in and speaking to MedSocs/students to present financial options that the banks are offering in a non-confrontational/more relaxed way. Students want to know about investments, managing line of credit.
    - Mike: Our obligation is to give students advice! We have products, but advice is the important part. We're not selling - it should more about advice
    - Orientation week is a good way to get into it, providing literacy talks
- Alexandra (Dalhousie): Orientation week is a lot of information at once. Financial literacy is taught later on in the year, given in smaller sessions with wellness & mental health. MDFM comes in at that point. Insurance, line of credit information is given throughout pre-clerkship
    - Karlene: Do your peers find it as valuable?
    - Some of the talks are above our heads
    - More information about post-grad finances. What is incorporation? As a resident, you're lost!
- Laura (UBC): Baseline financial literacy, give us terms/definitions, infographics!!

- Alyse (McMaster): Funding for private mental health!! Waterloo campus has a dedicated psychologist, but this is not true of other campuses. Can MDFM provide a grant to help with this?
    - Allison: Will they go?
        - Yes! People access the psychologist on campus.

Topic: How medical students can get most out of their provincial medical associations?

- What do we view to be advocacy?
    - Have to give students the forum to come and learn - can't tell the students that you want to help but then stay away, so need to create more space for people to interact e.g. invite the PTMA to one of your meetings
    - Don't be that token student in the room, encourage them not to say "now let's hear from the student" because that puts you at a different level, should be able to speak up any time during the meeting
    - The board should try to teach the student things, but the student also needs to learn - read the materials, lend your different opinions
- Manitoba - have a very good relationship, run a lot of town halls, have lost some of the funding and Docs has helped navigate some of that to help students advocate and know what is going on
    - They also cover the fees for CMA, waive the fees for the province
- Ontario - OMSA, section of the OMA, work within the system of the OMA and have delegates that go to the general assembly, have seats at the board and non voting,
    - Recently a lot of controversy around students being part of OMA due to conflicts that arose with the contracts between government and physicians - led to some trying to push students out of being part of OMA GA (relationship is a little tense)
    - Many competing interests within OMA because it is so big, makes it hard to develop a good working relationship
    - Students are a way for the OMA to sell their ideas to the student - communication tool between OMA and the rest of the students, although OMSA is relatively independent from OMA
    - Have you had issues engaging the general membership (other medical students - disconnect between what the exec think and what the students actually need)?
        - Pay all the student fees/expenses for students who want to participate in general assembly meetings
        - The PTMA needs to find relevant topics for the students, and then iron out logistics
- Dal - students and PTMA work together well, supportive, have a voting members in docs NS but not docs PEI
    - Any student from PEI that is from PEI is part of PEI Docs
- NB - have a good relationship, have students on almost all of their committees, e.g. paid summer internships that are paid for by NB Docs, fund some student activities
- SK - have a good relationship, they cover lots of fees, lots of sponsorship

Topic: Doctors of Manitoba

- Kiefer (Saskatchewan): SMA sponsor students to go to rural community (helpful in getting to know SMA and integrating into the community, organized by rural community),

free to go to representative assemblies (being invited, treated as a colleague, getting a seat at any table we have asked about)

- Shima (Toronto): students have a poor relationship with the OMA. Ontario health policy climate is very hostile. People within the OMA harassing students about provincial policy. Subgroups flood students' emails inappropriately (email fatigue). A lot of mistrust with OMA.
- Sujen (Toronto): VP Externals via Ontario Medical Students Association have more interaction with OMA. Students have a vote currently in OMA. Many people are trying to remove our vote. Very aggressive. Many students have interest in issues that OMA is not open to discussing.
- Laura (UBC): Docs of BC provides free disability insurance for first year students. They provide voting seats at CMA GC caucus. We don't get to vote in Docs of BC matters; rationale is that because we aren't paying membership dues, we don't get to vote.
- Matthew (Manitoba): We represent the medical profession, not just people with an MD. Your membership should have the same weight as a practicing physician. Don't be the token medical student in the room - groups tend to fill seats just to 'have a medical student'. Be an equal member of the committee & contribute outside of the 'token' context. Take advantage of that.
- Sujen (Toronto): Power structure between students and physicians. In a small working group, I was put into a group with well known OMA doctors. Chair of the department approached the student and said "Don't be too idealistic; a soldier has to earn its stripes." In some spaces, it's hard to be able to say anything.
- Shima (Toronto): Professionalism committee. Shima didn't agree with an outcome of a professionalism hearing. Associate dean 'surveyed' her more after this. It's hard when you're talking to faculty leadership. Hard to rock the boat.
- Matthew (Manitoba): Be diplomatic, especially with faculty. It's a way bigger problem when it's with your PTMA. Put your personal agenda aside in order to be a successful board member.
- Kiefer (Saskatchewan): What is your perspective on where the tokenism stance comes from?
- Matthew (Manitoba): Ignorance - you're new, you're young, I don't get what your world is all about now, it's an old boys' club. Your silence/tokenism won't help us in breaking apart the old boys' club. PTMA should have an environment where you're breaking down walls. We don't want residents/students to immerse themselves in what we do; we want to immerse ourselves in what the residents/students do. This is how we can get students and early career physicians involved.
- Sujen (Toronto): OMA General Assemblies are usually 50/50 men/women. The higher you go, the more men there are (ie more committee members are men, board members are almost exclusively men). If a medical student points this out, will they care? We need a physician to value our voice in order for us to get our voices heard.
- Matthew (Toronto): Chicken vs Egg. We must both advocate for ourselves and also find an internal champion within the PTMA (staff or board member) to allow it. Students have to get to know physicians outside of the clinical environment. Bringing students to CMA GC.

- Kiefer (Saskatchewan): What are Ontario's strategies to creating a more collaborative environment?
- Shima (Toronto): Attacks end up being personal. It's scary! Unclear what we can do.

Topic: Global Health Certificate Implementation Toolkit

- Issues GHP sponsored events - Makes the toolkit seem like it is specific to global health
    - Suggestion of Collaboration between Interest Groups around
    - This may be difficult to coordinate to individual schools
    - Would need to process for event submissions
    - How does someone's participation in events get monitored & tallied
    - There may be some confusion about that the GH Sponsored events - is there going to be quality control, schools have different levels of faculty supports (Solution of having event at school but availability to submit the reflection to another school for evaluation of the certificate approval) - Example UofA certification & Calgary Not certified → Could Calgary students get the certificate from UofA after evaluation of their projects.
- Increased participation in events related to Global Health
    - May result in more students but less engagement in these events (Showing up to)
- Issue of how to evaluate the success of a student's learning in the certificate, whether or not students will
    - The certification would be given by the given school if it becomes accredited through their school
- Is there an option of having a single school distribute the information and certificate to all students in the country (particularly the online components)
    - Could we have a centralized online portal (particularly in schools with a very limited global health program; example Mun partnering with Dal)
- McGill has a Department involved in the Global Health department that is involved in development of curriculum can we use that
    - This would be the gold standard, but not all schools have faculty support
- UBC Global Health Course Platform:
    - 9 Online courses for students already (Can participate in as non-students)
    - Possibility

MD Financial Management

Ms. Alison Forestell (Brand Awareness & Advocacy Lead, MD Financial Management)

- Introduction by Carl:
  - Lead - brand awareness, MD financial Management
  - Invested in student wellness and education
  - Canadian Medical Foundation, partnership with MD ended last year
- "I have so much respect for learners in Medicine", wish to support students with the help of MD, CMA, Joules
  - Consider herself as the "mom" of CFMS
- Exciting news: sneak peak from the board meeting
  - CMA private foundation will be launched next week → directly support physicians and physician-learners (CMA, MD, Joules)
  - Why CMA foundation: believing in company social responsibility, support Canadian physicians (raison d'etre).
  - Direct granting will be the focus → invest in causes that we care about as medical students and doctors

Granting strategies: 3 pillars

1. Medical education: directly supporting medical students
   - Leadership awards, travel awards
2. Physician wellness: directly support physicians
   - Augment to go beyond the mandate of each school in offering wellness-related activities
   - Connect with PhP & PHA, working with Chris
3. Outreach: direct support communities
   - Ms. Allison has worked previously with homeless shelter, grew up in Ottawa, got a glimpse into social determinants of health
   - Work closely with Dr. Jeff

- National bursary and reward program, 1 award and 1 bursary program to each medical school every year
  - Award: want to be impactful, make sure that the gifts are meaningful
  - Bursary: based on financial need (academic standing may be considered)
  - Vote: all years of medical student vs only select med year (most students raised hands for the awards/bursary to be offered to all years of med students)

Questions:

1. Franco, Calgary: Allison has humbly downplayed this award/bursary program, stems from our past conversation, in response to schools saying they do not have enough resources. On behalf of CFMS, thank you! This will be transformative!
2. Laura, UBC: how is this working with faculty, UBC is struggling with sponsorship, how is it working so far?

- A: used to fundraise a lot, development committee work on fundraising in each school. Private foundation is working closely with the dev committee, not really a sponsorship.
- Support physician and physician-learners, wish to be impactful and meaningful and reaching to the most number of students. Schools have been receptive to that.
- It is not sponsorship: visible and brand-awareness

IFMSA Exchange Updates

Jessica Bryce (VP Global Health, CFMS)

- Massive issue over the past 2-3 years. Went over the financial states of exchanges with the GH sessions.
- Show of hands: who has gone/applied to IFMSA exchange, who has never heard about these exchanges?
- Increase visibility of IFMSA exchange, over 500 applicants each year
- IFMSA = International Federation of Medical Student Association
- SCOPE & SCORE: Standing committees on
- NEO: leads of IFMSA exchange program
- Exchanges started 1991, from 60 to 150 exchanges now
- Provide opportunities to professional or research exchange abroad
- Unilateral: send students abroad
- Bilateral: we send student abroad and the other countries send us their student
- Constraints: not being able to offer many bilateral exchanges as we want to
- 45 for SCOPE, 17 for SCORE (countries)
- Benefits: well described in literature, also good feedback from students going to exchange (overall positive)
    - Student reps have heard about negative experiences, keep in mind that the majority of students had good experience
- AGM 2016: Montana and Kelly discussed with med society presidents
    - Poor organization and communication in host countries
    - Misconception (fluency in English, quality of medical education, housing)
    - As a result of this feedback, the NEO have:
        - Tailored our partner countries → improve quality of exchanges
            - No longer signing contracts with countries receiving poor ratings
        - Compilation of all past exchange feedback
        - Clear communication on what to expect on language, med ed and housing
            - Address discrepancy between student expectation and the purpose of IFMSA exchange
            - Ensuring that we exceed international & global exchange ethic standard
- Finances
    - What do student pay?
        - Bilateral: $1000, do not have to pay fees to host country
        - Unilateral: $400 + fees to host country ($200-450 euros)
        - Flights, food, vaccinations, med malpractice insurance fees (maybe in the future)
    - What do we use the money for?
        - Housing for incoming exchange students (fee vary depending on city)

        - 100$ for pocket money
        - 100$ of social program
        - Total: $842 for most cities $992 for Toronto
        - Cover costs for IFMSA membership, meeting attendance, CFMS meeting for NEOs, contingency funds, banking processing fees
- We are currently making a profit on these exchanges?
    - Focus on quality on quantity, exchange spots will diminish in the future
    - Adjust fees to cover the cost will be in discussion
    - Exchange reduction fee: 50$ now, $50 potentially @ AGM (working closely with VP Finance)

Questions:

1. Gurmeet, Manitoba: how much profit did we make? how much the reduction will decrease this profit margin?
    - A: Exact number is hard to quantify
        - 1. Incorporation of other GH costs (IFMSA exchange fees and GH costs are intertwine)
        - 2. Other expenses hard to define (budget plan overlaps the incoming and outgoings)
    - More info to come
2. Sarah, Toronto: what types of support is the CFMS providing students going to exchange? Who should they contact?
    - A: Kelly and Montana (NEOs) are our points of contact for now, acknowledging that this is not enough, they do what they can as students
    - Going forward: point person that is a staff member helping to address these issues
    - Schools are able to access support GH exchange from their faculty, not available for all schools

CFMS Education Portfolio Projects

Tavis Apramian (VP Education, CFMS)

- What does the CFMS do?
    - Quote from student platform in Can university, running for position on med soc: largest budgetary issue, sending delegates to our GM ⅓ of our budget, not meaningful return on our investment, should integrate position paper into curricula → make sending delegates to AGM worthwhile
    - Connect members through events, support through discounts, database, represent through position papers
- What can we do to ensure students know what we do?
    - Communication strategy is necessary, communicate to students on what we are accomplishing
    - Serve members in a new way, here is what we are proposing:
        - Clinical expertise related programming
            - Longitudinal, evolving, student-generated
            - Start right at the 1st year
        - Means of reliably representing what our membership believes
            - Scientific, broadly-based, impactful
            - Ability to advocate for our members
- CFMS National Survey Platform
    - Longitudinally track demographic and experiential data
    - Provide a means for targeted research
    - Bring forward concerns of the students to the Deanery
    - AFMS took out the question on debt on the GQ this year, no one will be tracking it, we should have the responsibility to track this
    - Hard to communicate to the students the work that is happening on the discussion regarding the portal. Anonymized student survey was distributed and the feedback was sent to the AFMC. (Document can be found on the CFMS SGM website)
- Remaining questions
    - Do we have the will/means/trust of our stakeholders?
    - Will require money to run the survey
    - Will require email addresses of students to send them the survey (mixed responses from student leaders)
    - Present the prospectus document
- CFMS Question Bank
    - Means of engaging students from their first week of med school in an area they all care about, can draw on our greatest resource
    - Ambitious project, multi-year endeavor

- Create a bank of questions as a teaching/learning tool, we have more capacity to create more questions than our faculty (most students are already doing it anyway)
- Moving forward: programming started, 1 year pilot started in September, need web design help
- The question bank will function as a curator process, students can upvote vs downvote the questions depending on what they found useful
- RDoc might be interested to improve the questions to bring them up to LMCC level

Questions:

1. Juliana, Alberta: Some students have spent thousand dollars on question banks, this Q bank project would help alleviate student burden
    - A: Other companies already offer this
2. Pavel, Manitoba: involved in IT, is the Q bank going to be accessible to the general public vs on a separate platform.
    - A: Will be on our website using our log in
    - If we have to spend a lot of money to keep it up and running, will be reserved to our members only. For now, it will be opened for all
3. Shreya, Ottawa: cognisant that we lack the human resource, capitalize on research that is being done. Maybe we can work together with other organizations who has already a strong HR support in regards to surveying our members?
    - A: Rapid turnover, dependent on exec to develop programs. If 1 link is broken, things might fall through. If the demands from our members are strong, will have to think about the legacy we will be
4. Adam, Western: worry that we are not communicating that we need data collection, not communicating with members that we are requesting feedback. How can we make sure that we will be better engage our membership?
    - A: Offer a simple survey, ask for an annual survey, there is however no guarantee

Federation of Medical Regulatory Authorities

Ms. Fleur-Ange Lefebvre (CEO, Federation of Medical Regulatory Authorities)

- Used to work at the CMA, when the 1st member of CFMS was appointed to the board (Joshua Tepper)
- Now working on the regulatory authorities, delegated authority to protect the public (govt delegate this authority), NOT of physicians
- Work a lot with federal government: what can you prescribe
- Medical Cannabis: proposed legislation will not include medical cannabis
- Medical assistance in dying: pulling the data into a national database, 3 outstanding issues to discuss
    - Mental health nature
    - Mature minors (not yet 18)
    - Advance directive (cognitive declining patients)
    - In US, it is all physician assisted suicide and not euthanasia (the contrary for Canada)
    - Working with PGME, must collect certain types of information: does not address the issue of statutory. Legistlation is legistlation, hard to open 13 pieces of them at the
- 2 CFMS rep is invited to the, organization will be turning 40, next meeting in Charlotte Town

Questions:

1. Tavis, Western: Have you been looking into learner privacy?
    - A: Were asked to address this by the PGME, some say that thresholds should be lower for trainees
    - We develop drafts: we are not a regulatory authority, no authorities over our members
    - Not quite there yet
2. Sarah, Toronto: Information sharing on unrelevant student information.
    - A: We have not asked for that info, only collect info concerning the professionalism related. Must justify absence of practice for physicians, should extend to learners.
    - They have statutory obligations.

Lobby Day Topic Selection

Sarah Silverberg (CFMS VP Government Affairs)

- Over the last year, revamp how we discuss and select our Lobby Day topic. Usually a very stressful time of the year to pick the topic, process is different each year (consultation, survey), process is not transparent necessarily
- Proposal is to find a policy window and consult the students
    - Idea generation at SGW at SGM. Allows for feedback from engaged CFMS members
    - Following SGM, a survey will be sent out to the GAACs allowing their input on lobby day topics, allow them to consult students from their own school to gain broad-based input of ideas
    - In the first GAAC meeting following SGM, there will be opportunity to discuss lobby day topics.
    - Research committee will re-form in the summer to flesh out suggested topics (feasibility, policy windows, connect with experts, dev proposals)
    - At SEM, the execs will have the opportunity to provide input to these topics
    - The research committee will reflect the feedback received and work to pick a single topic
    - The final lobby day topic will be revealed at the AGM in September
- If topics require more info, have the opportunity of doing that within the 6 months
- Caveat: should an emergent issue affecting the membership develop, the research committee reserves the right to modify the topic, in consultation with the exec and GAAC (in very exceptional circumstances)
- Research committee: mix of GAACs, GHAs, and some additional members (part of the Winter Call)

Questions:

1. Nicole, Calgary: is there any room for flexibility for the proposal? What is the role of the GHA in this new proposal?
    - A: GAAC and GHA has been working already collaboratively and will compose most of the research committee in April.

Association of Faculties of Medicine of Canada

Dr. Genevieve Moineau (President & CEO, AFMC)
Dr. Sarita Verma (VP Education, AFMC)
Ms. Melissa Shaheen (Operations and Strategic Initiatives Director, AFMC)
Mr. John Kimball (Data and Information Services Director, AFMC)

Dr. Genevieve Moineau:

- Love for medical students as a clerkship director and undergrad dean, continue to want to help and support students.
- How to help you understand to be good advocates, you are already there. Over the last year, a series of very unfortunate events happened in Ontaria (bullying). Your leadership was comfortable coming to the AFMC board (deans of 17 faculty of medicine). Asked for support to move forward to ensure that this never happens again. Make sure that our environment is a professional and supportive for learners.
- Better management of electives, wished for the single portal. With a lot of hard work, now all 17 schools are on the portal.
- Physician resource planning: now a very important topic, working with all learner reps. Unmatched Canadian graduates, unacceptable for deans as well as the funders, the provincial gouv (AFMC matching committee)

Dr. Sarita Verma:

- Lawyer, family medicine
- Delighted to work with the dream team
- When the CFMS talks, the AFMC listens
- Entrustable professional activities
- Help from CFMS to the CCME, topic this year: transitions to post-grad, transition to another program, transition into practice
- Next year, topic on wellness
- Opioid crisis involvement. Developping a best prospectus.
- A lot of things impacting
- AFMC would like to hear from you
- The CFMS leadership is recognized, our commitment to change
- Canada is a leader and innovator, we will have an impact

Ms. Melissa Shaheen:

- Highlight an activity that we are working on, WAMC has a MCAT assistance (fee waiver)
- AFMC and CFMS wish that this benefit should be available for Canadian students, available through AFMC website. Work in progress with all deans.

Mr. John Kimball:

- Take data and present it to the shareholders
- Also the privacy officer

- Background in health care system, worked on prescribed registry (personal information on privacy).
- Look forward to working with us and able to secure the information collected in a proper manner.

Questions:

1. Adam, Western: what is your opinion regarding mental health information sharing with deans and admission committee?
    - A: 1st time that Dr. Moineau is hearing about this, would need to hear more.
    - Board chair (Michael Strong), he is also the dean of Western. He is a big advocate for students on many issues.
    - If there is a particular issue at a school, AFMC may be able to help setting principles in an anonymous way. Put out there how schools should behave.
    - Will communicate w
2. Jessica, Western: What you see as the main issues with the portal and what needs to be done to address those?
    - A: Pleased with the launch of the portal in all 17 schools
    - School function in different ways regarding to electives
    - Portal is a 1 stop shop to manage document and requests for electives
    - Hearing that the portal does not work because "I did not get accepted in my elective". The decision is still from the faculty itself. Misunderstanding of what the portal actually does.
    - Make sure that we get your feedback and make the portal work for you.
3. Sarah, Toronto: A lot of students have anger surrounding the portal. The financial cost that students have to invest into the portal and the lack of the refund (partial or full). Who is collecting this money, is it the AFMC or the schools.
    - A: Students are asked a 1 time fee (150$), access to the system
    - Fees charged by the faculty itself, that is the faculty's decision and how they manage their refund policy is their own.
    - Need to improve communication around the fees
    - Invite you to come to the talk on the portal given at the CCME later today
4. Tavis, Western: Unmatched students, submitted data requests for CaRMS, 1% increase in unmatched students each year. Now a growing body of students who have to manage this complexity. One of the crucial thing that student get feedback when they get unmatched. Want to hear the AFMC thoughts to exert collateral pressure to get support for the unmatched students.
    - A: Get goosebumps, that should never happen, a travesty
    - 159 unmatched after the 1st iteration (2nd iteration happen on April 12th, haven't receive the data yet)
    - When a student is unmatched, faculty of med are in a challenging position to help. Not a single student affairs dean will not help the unmatched
    - An unmatched student is competent, received MD, suffered through a system that does not address their needs.
    - We should be supporting all students. This is an epidemic from our perspective

- 2009: 11 unmatched, since then, there has been a 5x increase (system is the issue, we have the power to do that if we work together in changing how the system is set up)

Finance Report

Daniel Peretz (VP Finance, CFMS)

Roll Call:

- UBC, Calgary, UoA, Sask, Manitoba, Western, MAC, Toronto, NOSM, Queen's, Ottawa, McGill, Dal, Moncton, MUN
- Execs: Western, Ontario, Quebec, Atlantic, President, VP ed, VP Govt Affairs, VP Student Affairs, VP GH, VP Finance
- Everyone is here

- Motion to go in-camera with Carl and Rosemary seconded by Franco
- Motion to move out of Camera seconded by Kaylyn

Annual General Meeting – Ottawa, 2017

Shreya Jalali (Ontario Regional Representative, CFMS)

- AGM 2017 will be held in Ottawa this fall, for our 40th anniversary (in 21 weeks!)
- Presentation will be a virtual tour of the AGM
- AGM 2017 will be held on Sept 22-24th, 2017
- A welcome from our Mayor, Jim Watson. Happy to have the city's support in this event.
- Why Ottawa? It is the capital; it is also Canada's 150th Anniversary (also CMA's 150th)
- Hotel: Courtyard Marriot, romantic and pleasant
- Heart of the historic Byward Market: enjoy the Beavertails while you are there
- Schedule
    - Day 1 (Friday): 40th anniversary celebration, a giant birthday party, vote for birthday cake (champagne cake vs actual cake)
        - Welcome address: hint at Justin Trudeau, Jane Philpot
        - Interactive panels with leaders in med ed
        - Small Working Groups
        - CFMS past presidents: alumni receptions & award
        - CFMS: a historical perspective photo montage & toast during the Day 1 dinner
        - Socials for Friday: prepare for a glamourous night
    - Day 2 (Saturday): fall elections & resolutions
        - Unveiling the next CFMS strategic plan 2017-2020
        - Mexicali Rosa's at Dow's lake for dinner
        - Social part 1: Gatsby themed as well
    - Day 3 (Sunday until 3PM): interactive workshop (wellness, leadership, education and many more)
        - The year ahead 40th edition (president's address)
- Stay tuned for updates on AGM!

Resident Doctors of Canada

Dr. Terry Colbourne (Vice-President, RDoC)

- Has been 5 years since the last SGM held in Winnipeg at Fort Garry
- Interesting to sit through some of the sessions today, great to see the amount of first-timers.
- Data and privacy
    - Was not a big part of the conversation before, but now it has been a big part of the convo this year. Happy to hear that we are asking the big stakeholders these questions.
    - Based on what privacy law is, a number of violation has been existing in the past.
    - Ways of formalizing this collaboration will be held during the CCME with all the 4 learners group (FMRQ, RDoc, CFMS, FMEQ)
- Resiliency committee of the RDoc will be presenting at the CCME
- For all final years students: we are on our call for involvement with the RDocs. Applications can be found online and are due on may 18th. All PGY1 are invited to get involved with RDoc.

Questions:

1. Jess, Western: As a resident and member of RDoc, what is the #1 med student should advocate now to make our life easier as a resident?
    - A: Hard to answer. We live in a complex system. RDoc works to change the lives of residents, changes in future generations of learners.
    - More collaboration with groups sitting
    - Competency by design: focus on what does this mean for residency training program (Anesthesia, ENT)
    - Becoming part of the convo in the local context, make implementation that makes sense in
2. Anthea, Ottawa: what is RDoc doing with regarding to entry discipline?
    - A: Try to eval what makes sense, things has been changing in the past few years.
    - Entry discipline working group by the PGME, part of the large gouv led project to look at the syst as a whole. Before we had an internship year, fam med or specialty.
    - Some have a 2nd CaRMS (peds), some embark on a long training journey for surgical programs
3. Han, Western: how can we build a longitudinal plan for student resiliency and how can CFMS collaborate with RDoc?
    - A: RDoc has adopted a curriculum from the mental health commission of Canada. Try to evaluate if the curriculum has made meaningful changes before implementing it in other schools. Keep it small to eval properly → quality improvement cycle.
    - Some relates to wellness, some relates to the fact that we have a tough career.

Saturday, April 29

Partner Student Organization Updates

Djamila Saad (President, IFMSA Quebec; VP Global Health, FMEQ)
Justin Cottrell (Co-chair, OMSA)
Kristen Kukula (SoMS Representative, SoMS)

Djamila Saad:

- FMEQ represent 3900 students across 7 campuses
- Our services: uptodate (99$ USD), textbook, ViaRail, Strom spa, CanadaQbank and others
- Info FMEQ: news letter, USB key containing guide for CaRMS matching
- Events: FMEQ party = back to school party, held in Montreal, promotion of FMEQ
- CaRMS day: held in autum, workshops on interview, CV, personal statement
- Wellness day: for clerkship students, yoga, meditaiton, wine tasting
- Lobby day: go to Qc national assembly, this year's subject (taxation on sugary drinks, physician resource planning)
- Informative document on cannabis: give a few recommendation on health regulations
- FRESque: annual forum reuniting all health student from Qc, invite health
- Physician and Human campaign: positive examples of doctors, inspirational role model for med students
- Campaign against intimidation and harassment: share resources online through social media
- Wellness month: month long challenges and activities, active Insta
- Priorities: student wellness (1st time electing wellness council in the exec council), pass/fail implementation (all francophone schools lack it), CaRMS preparation, Bill 20, family med promotion
- Close partnership with IFMSA
    - IFMSA international meetings participation
    - Will be organizing the August meeting in 2018 in Montreal

Justin Cottrell:

- CFMS has been extremely supportive to the OMSA this year
- OMSA: serve med students in Ontario, presentation of the exec members and different portfolios
- Yearly events: health quality transformation: 1st year health quality conference, dev health quality initiatives at their respective schools, pair up with leads
- Annual wellness retreat: weekend in March, build resiliency factors
- Mental Health lobby day: self funded, many political parties were invited, advocacy survey for students to pick the topic

- Position papers & lobbying: evidence based way to guide the org
- Scrub-In: communication, publication
- Med student ed research grants (MSERG): conference grants, innovator grants, wellness initiative grants (~ 5000$ total)
- OMA ambassador program: students attend the OMA general meetings, can see how the prov organization works
    - OMA has had not a contract, groups trying to take away student vote at the general meetings, able to advocate on the behalf of the med students
- New resources: Insights into physician workforce trends in On: competitiveness in diff fields as well as the trend for job market
- Ontario doctors “distressed” over wave of bullying infigting: Ali had threats made against him for his match, OMSA was very supportive
- Suicide prevention workshop
- OMSA leadership summit and annual general meeting: review of constitutions and election (call for application to a position if you are in Ontario!)

Kristen Kukula:

- Family medicine: 50% of physicians are fam physicians, all students will have to go through a fam med rotation during clerkship
- Represent a huge demographic (35 000 members), work with prov chapters, advocate for family physicians, defines the role of family medicine, work towards ensuing everyone in canada can have access to primary physicians
- Only peer reviewed family med journal
- Education dev and accreditation for postgrad family medicine programs across the country
- Establish standards for clinical practice in fam med
- Training, certification and accreditation of continuing professional development
- Our reach: med students, fam med, interprofessional, residents
- Section of medical students (SoMS): national committee, go to headquarter for meetings 2x/yr, provide input on how fam med is ran through the country, FMIGs increase exposure to fam med by promoting clinical skills workshops, info and training sessions and professional networking events.
- Promoting family medicine: help showcases the diverse opportunities available within fam med, goal is to provide students with tools to make an informed decision about pursuing a career in family medicine
- CFPC/SOMS partnership with CFMS: always welcoming ideas, collaboration and joint projects
- Connect with us and join the club: email soms@cfpc.ca, join us on Facebook, come to family medicine forum in Montreal (Nov 8-11 2017).
- Become a member, it’s free. Sign up on online at www.cfpc.ca

Questions:

1. How feasible is it to develop a similar health resource guide in other provinces of Canada
    - Work strongly with other medical student organizations, able to utilize partnership with diff program directors to gather the data for the guide. Maybe you can reach to your provincial contacts to get that information. Track the residency information
        - Sarah response: Tavis and I are struggling to get data on the national scale, dev health resource guide, may not have data available at AGM
2. Han, Western: can you share what dean Michael Stronly is doing to tackle bullying?
    - A: There was a very specific threat to Ali, writing to other dean to make sure that he does not match
    - Dean Stronly is looking for a long-term solution, have yet to receive any strongly correspondence on concrete action items
3. Kaylyn, NOSM: what is your plan to tackle decrease in jobs
    - A: Don't know what job actions will look like, put pressure on gouv to get to a contract. Reach out physician activity working group, committee dev the job action plan → get reassurance that any action they take will not affect med students, only verbal reassurance
    - If there is some type of job action in academic centers → will potentially have an impact on students

College of Family Physicians of Canada

Dr. David White (President, College of Family Physicians of Canada)

- Intro by Carl
- Addressing health human resource planning through distributed medical education
- The need for a better distributed workforce
    - Canada's physician pop grew 3x faster than the general population between 2011-2015 (growth in med school classes to compensate for the lack of physicians)
    - Last of 11 dev countries on ability to get the same or next day appointment
    - Access in rural areas is especially challenging
- Effects of distributed educations
    - Those who do undergrad training in rural areas are 34% more likely to practice there
    - NOSM has been very successful in training physicians practicing in northern & rural areas

Questions:

1. Christina, Calgary: rural clerkship placements, Alberta can have a longitudinal rural fam med elective, how to better enable students who want to go rural to go rural?
    - Most schools usually have elective capacities in more remote setting, not the whole clerkship
    - Interesting fact: most recent CaRMS match, rural fam med spots were less likely to get filled
2. Alyse, McMaster: for MAC, 2 streams out of 16 has rural med rotation, more exposure → more likely to rank theses sites. Vision or idea to expand teaching in rural sites?
    - Amongst residents who go to rural/indigenous community: ppl trained at intercity sites are more
    - Infrastructure: related to funding, expensive to get ppl there and ppl back. Many communities arrange for cheap accommodations (but students may have to also pay for their appt in city). Will try to address this issue at the level of schools.
    - Partner with a truly remote place to arrange for travel and accommodation to allow students to get the exposure.

Resolutions Session #1

- Chair explains Robert's Rules of Order, Nemo contra voting, voting on motions
- State your name, medical school, and whether you're in favour or against

Motion 1: Nemo Contradicente Voting

- Moved by Tavis Apramian (Western)
- Seconded by Adam Forester (Western)
- Mover speaks for 2 minutes, chair asks for direct negatives, if no negatives motion carries unanimously. If direct negative, can proceed directly to vote or open speakers list (5 x 2 min speakers).
- Motion PASSES unanimously

Motion 2: Terms of Reference of the CFMS Bilingualism Committee

- Moved by Lucy Luo (McGill)
- Seconded by Vivian Ng (McMaster)
- CFMS Bilinguilism Task Force was temporarily instated in 2013, adopted as a committee in 2016
- Motion PASSES Nemo Contra

Motion 3: Terms of Reference for Nominations Committee

- Moved by Laura Kim (UBC)
- Seconded by Gurmeet Kaur Sohi (Manitoba)
- Nom Com was established in 2013, all external reps sit on the Nom Com to evaluate applications
- ToR has not been updated since, review by the VP externals, regional reps and exec
- Motion PASSES Nemo Contra

Motion 4: Terms of Reference of the HEART

- Moved by Ashely Cerqueira (Ottawa)
- Seconded by Itai Malkin (Ottawa)
- Moving to create a permanent position under the VP Global Health portfolio
- Laura Kim (UBC): VP GH has to sit on the committee but the VP Ed and VP Government Affairs "may" sit on this committee, could you please clarify that
    - It will depend on the respective VPs. choose to give the option to the VPS

- Sarah Silverberg (Toronto): Can you please clarify whether the VP Global Health must be part of the committee vs. sending a representative?
    - VP Education and VP GA may sit on the committee, or may send a representative
    - To the discretion of the VP
- Motion PASSES unanimously

Motion 5: Free Open Access Medical Education

- Moved by Kaylynn Purdy (NOSM)
- Seconded by Tavis Apramian (Western)
- Medical education is becoming more and more open access, and the CFMS should look into on whether we should give open access to our resources (ex: future questions banks, publications)
- Adam Forester (Western): Point of Information - If the author group is unclear about whether they would
    - Vote would be brought to executive
- Adam Forester (Western): Point of Information - If it were to be sent to executive, would the authors be included on the vote?
- Motion PASSES (two against, one abstention)

Motion 6: Seniors Care Resolution

- Moved by Sarah Silverberg (Toronto)
- Seconded by Henry Annan (Dalhousie)
- Many prominent medical associations have created a position on a National Seniors' Care strategy. Many members have participated in activities promoting a National Seniors' Care strategy, but we do not have a formal position.
- Vivian Ng (McMaster): Point of Information - What partnerships are you envisioning? What steps are we going to take? Where are the 50 hours going?
    - Promoting CFMS Demand a Plan activity, working with CMA and OMSA, Canadian Nurses' Association
- Geoffrey Leblond (NOSM): Point of Information - Who would be responsible for following through with the elements of this motion?
    - VP Government Affairs
- Vivian Ng (McMaster): Point of Information - Why is this being brought forward as a motion?
    - So that we can pass a formal position on behalf of the entire CFMS
- Gurmeet Kaur Sohi (Manitoba): Speaking FOR: It's important as we do not have currently positions on Seniors' Care. It is an important emerging issue. If we want to flesh out details, that can come later within a position paper. It's simple and gets to the point.

- Victoria Reedman (Toronto): Point of Information - Are these short motions with no attached position papers how the VP Government Affairs portfolio wants?
    - Vast majority of motions in GMs used to not have attached position papers. For straight-forward issues (ie broad statements of support), positions papers like this are appropriate.
    - Carl: Nothing in bylaws states whether position papers should be attached to motions.
- Daniel Turski (McMaster): Point of Information - Normally position papers are accompanied by a strategy/vision that guides the organization. What is trying to be accomplished with this motion?
    - As VP Government Affairs, it is important to field inquiries on behalf of the CFMS without any position on the topic. The goal with statements like these is that we are not adopting a significant set of actions that the CFMS is going to be working towards (ie no task force), this is simply a tool that allows us to lend our voice to the national table with the support of our membership.
- Victoria Reedman (Toronto): Speaking FOR: While I wish the motion had a list of recommendations for a senior care strategy, National Seniors' Care strategy is important. I think this should be followed by a formal list of recommendations for what we would like to do.
- Carl: Call the question
- Motion PASSES (two abstentions)

Motion 7: Mental Health & Suicide in Indigenous Communities

- Moved by Kai Homer (Alberta)
- Seconded by Ali Sumner (Toronto)
- Another version from initial paper presented at AGM 2016: changes focus on how we can align ourselves and promote mental health concerns in aboriginal communities, including information about resiliency. Consultation with a range of important stakeholders, including indigenous communities. NOIH & Adriana Cappalleti also informed the paper.
- Motion PASSES Nemo Contra

Motion 8: Establishment of a Position on the National Marijuana Legislation

- Moved by Sarah Silverberg (Toronto)
- Seconded by Shreya Jalali (Ottawa)
- What position the CFMS should be taking is not clear. We want to establish a task force to research the topic and develop a CFMS stance (if any) on Marijuana Legislation. This is a question that we have been asked more than any other topic this year from many government stakeholders (Federal ministries, media). The task force would be broad and consultory. This may include

- Chris Briggs (Manitoba): Point of Information - will the position have to come through GA?
    - Yes. Recommendations would come back to GA
- Yasamin Mahjoub (Alberta): Friendly Amendment - Change terminology to say “Cannabis” instead of “Marijuana” to reflect language of the national government.
    - Considered friendly, and added to BIRT clause
    - Point of Order: Anthea: If you are going to propose any amendments, it must come
    - You can amend the operative clause (BIRT)
    - You can not amend preambulatory clauses (“Whereas”)
- PA Bilodeau (McGill): Friendly Amendment - include “Cannabis teaching”
    - Considered friendly, and added to the BIRT clause
- Alyse Schacter (McMaster): Speaking AGAINST: Perhaps this paints a biased picture. Add something about how the benefits are not known. Will bring an amendment.
    - Whereas clauses are relatively unbiased
    - Alyse: We don’t know about the health benefits
- Geoff Leblond (NOSM): Speaking FOR - Assuming the taskforce would look at the research out there that would examine the health benefits of marijuana. These biases would be addressed in any position paper presented to the CFMS.

Resolutions Session #2

Motion 8: Continued

- Motion to Amend: Alyse Schacter (McMaster)
  - Seconded by Vivan Ng (McMaster)
  - Unfriendly: narrows it down to the harms and benefits, then we can't make a statement on whether we support the legislation or not
  - Victoria Reedman (Toronto): Point of Information - Why does investigating the harms/benefits prevent you from taking a position?
    - This is how I read it
  - Geoffrey Leblond (NOSM): Speaking AGAINST - too prescriptive in what the working group would discuss, and doesn't need to be the focus of the motion today.
  - VP Academic (McMaster): Point of Information -
    - I read it as prescriptive on the previous clause to develop a position on the matter
  - Brandon Chau (Western): Speaking AGAINST - the amendment changes the scope of the motion. Instead of teaching students about benefits/harms, it reads like it's commenting on the government's legislation on marijuana, which is outside of the scope of the CFMS and the realm of academia.
  - Alyse Schacter (McMaster): Speaking FOR - to ensure that this is a broad scope of research, not prescriptive
  - Daphne Lu (UBC): Friendly amendment: "To investigate the potential harms and benefits"
  - Samik Doshi (Toronto): Speaking FOR - I don't think the amendment is prescriptive. In order to make a position, it is reasonable that we look at the potential harms and benefits
  - Favour 16
  - Against 23
  - Motion FAILS
- Stephanie (Calgary): Point of clarification - the goal of the motion is to allow a team to be developed to get a better understanding of the new legislation that is coming out. If we do not support this, then VP GA would be tied hands and not be able to start this task force.
  - If the motion failed, it would indicate that General Assembly would not want VP Government Affairs to start a research committee on this matter. Intention was to be broad to allow the task force to do everything that has been discussed so far, without being prescriptive regarding our position.
- Samik (Toronto): Point of clarification - to confirm, is this motion is to create a position on the legislation?
  - Yes

- Stephanie (Calgary): Speaking FOR - Very timely. It would not be in the best interest to postpone this to AGM to start the research process. Intent is positive. It would be beneficial to do research and take a stance. Ideally, by the time of AGM, we will have a position.
- Motion PASSES unanimously

Motion 9: Harm Reduction Strategies

- Moved by Kaylynn Purdy (NOSM)
- Seconded by Benjamin Cassidy (NOSM)
- Growing need for access to harm reduction programs. Alcohol misuse is more prevalent in homeless populations.
- Vivian Ng (McMaster): Point of Privilege - Is it possible to give a bit of time before asking for direct negatives?
    - Carl: You can raise your placard to ask for some time at any time and ask for Point of Privilege
- Brandon Christianson (Alberta): Point of clarification - What does the 0h level of effort indicate?
    - Carl: People at NOSM who are not directly involved in CFMS want to bring a paper on this topic.
- Yasamin (Alberta): Point of clarification - Resolution calls for a working group. Should that be included in the BIRT?
    - Ben (NOSM): We meant through NOSM's GAAC
- Shima (Toronto): Point of information - can someone clarify why we are moving away from position papers and just moving ?
    - Carl: nothing in bylaws mandate that we must have a position paper to make a political statement. Motions are something that has been done to flesh out positions. CMA never discuss position papers at general council, and then CMA committees discuss the details of the position paper. This is kosher from our bylaws perspective.
- Amok (Queen's): Friendly amendment: "Support government funding" (strike "prioritization")
    - Considered friendly
- Geoff Leblond (NOSM): Speaking AGAINST - I am pro harm-redution, but the way the motion is written commits the CFMS to a very strong stance, and I disagree with that being in the motion now. The motion should be about creating a position paper, and not taking a position on it today.
- Vivian Ng (McMaster): Speaking FOR - Because I think that this paper would come forward regardless of whether it's struck today, and takes no CFMS effort. Reflect: are these motions within our scope and actionable by the CFMS?
- Daphne Lu (UBC): Point of clarification - There is a lack of clarity in the motion. Whereas clause says research is necessary, but BIRT clause says that we will support the communities that are identified as in need. Can that be clarified?
    - Kaylynn: I can not answer that question

- Sarah Silverberg (Toronto): Speaking FOR - encourage assembly to pass motions like this to ease the passing of papers once they come.
- Vivian Ng (McMaster): Friendly amendment
    - Intention of motion is to create a position paper, so BIRT should reflect that
- Motion PASSES (One opposed, one abstention)

Royal College of Physicians & Surgeons of Canada

Dr. Ken Harris (Member, Royal College of Physicians & Surgeons of Canada)

- Introduction by Carl
- As leaders in the medical school community, it is important to have anidea of the direction of the College
- Movement towards student and learner empowerment, while still remembering our patient-focus
- We are implementing a competency-based education process, meant to look at educational continuum from residency onwards
- Between 8-10 programs may be ready for 2018, depending on universities, college and specialty. This will be announced before CaRMS match

Questions:

1. Shreya (Ottawa): As we anticipate the shift to competency based education, will there be supports in place for students to make this transition and get feedback in new ways?
    - A: The system depends highly upon this feedback
    - We often conceptualize feedback as being very formal where the people giving & receiving feedback are very uncomfortable.
    - We are trying to promote low stakes, frequent observations.
    - Follow Up: Will CBD increase the administrative workload on students/trainees?
    - A lot of the current feedback & forms required are not focused on what will help you improve.
    - Forms should take less than 90 seconds
2. Tavis (Western): Thanks for including students this year. We appreciate being involved. Students want to be involved in the knowledge around how these interventions are implemented. I would love to see a student work with Royal College doing education research. What do you think?
    - A: We are often asked how we know that it will work.
    - It must be done iteratively. It will not be done perfectly the first time.
    - I think it's a good idea to engage with learners.
3. Shima (Toronto): Results of our residency survey in Toronto demonstrated that certain ethnic groups had the highest rates of discrimination and harassment. Is this something on your radar? How is it being addressed?
    - A: Concerns are increasingly on people's radar, but not a simple question. We are taking it seriously.
    - We are trying to implement corrective measures. It isn't something that the royal college can do alone. Students, universities, CFPC and RCPSC should all be involved.
    - Working to provide modules for how we provide feedback to learners.
    - We want to provide learners with information on how to provide feedback up the chain without getting in trouble.

Medical Council of Canada

Dr. Yves Lafortune (Evaluation Bureau Director, MCC)
Mr. Pierre Lemay (Repository & Registration Centre Director, MCC)

- We are working hard to meet blueprints
- All new content that we present in our exams must go through piloting
- MCC Exams: two qualifying exams taken by Canadian medical students. Other assessments are also present for international graduates. Part One: done in final year, near graduation. Multiple choice component, then clinical decision making (short answer, more difficult). Part Two: assesses clinical skills (OSCE), taken by residents at the beginning of second year, delivered across the country in 17 sites.

Questions:

1. Ben Cassidy (NOSM): There is discussion that results do not provide standard deviation etc., and it is not very informative. Is there anything you can do to change the feedback?
    - A: Results that candidates receive is a letter with total score, pass/fail, and the scale the results the scores are reported on (50 - 950). On that scale, it demonstrates average and pass mark. We break down results into categories by discipline (will be organized by new blueprint categories in the future). We present aggregate data to schools - we are in discussion as to which information will be more informative to the program. We will be expanding this to the schools, but will be unlikely to expand this to the individual students.
    - Follow up: Graphs provided to the deans don't present any variability, so they don't have very much meaning. Deans are trying to assign meaning to this, but it is statistically erroneous.
    - We provide standard deviation on individual score reports.

Canadian Medical Association

Dr. Granger Avery (President, CMA)

- Introduction by Carl
- Many changes in medicine have occurred and CMA has been involved in advocacy in public health issues historically. For example, the CMA began the fight against smoking, have promoted safe injection sites as a means of harm reduction and worked around the issues of medical issues of dying
- Benefits of rural practice are that it requires thorough care of patients and there is a sense of community where you can lead by exampl\]
- Was motivated to become CMA president to move things forward. Our focus on scientifically reproducible science is important but we should remember our main duties as physicians is the humanity of providing care to our patients and always providing comfort. Our profession is changing and we should commit to lifelong learning but there are new pressures. An aging population, appropriate use of tax money are examples. Official rankings re: wait times show we aren't doing well despite all health care service providers doing their best. Reports re: system improvements have resulted in little to no responses with recommendations not being acted upon at large. The issues expands further than the Canadian system and Britain, Iceland, US for instance share these issues.
- Changes are usually imposed and one sided, countered with resistance, which contributes to burnout. The CFMS undergraduate wellness survey reflects this concern. Burnout results to system underperformance which results in a vicious cycle.
- The CMA will be releasing recommendations this fall re: burnout and look forward to active guidance and participation from medical students.
- Policy makers, governments, patients look to our profession to ensure our system is effective and able to respond to needs and contribute to health system reform. The way to do this is partnership and recognizing our interdependence. We can make changes that are impossible to do alone. We can expect to make effective changes without working together with those who not only fund but also participate in these changes.
- Greater collegiality between health professions, compassion to our patients are things we can work on individually as well as through are associations. A collaborative approach on issues such as seniors care, marijuana legalisation and the opioid crisis. It's important that medical students are involved in forging our path
- The CMA Ambassador Program allows for students and early career physicians to not only attend General Council but allows for leadership training opportunities and engaging with government and other stakeholders. The program also provides mentorship and advocacy training and participating in panels. www.cma.ca/advocacy provides more information.
- Incorporate generalist principles such as holism, humanity, teamwork into our work. The profession is the only group in society that can effectively carry out changes.

Questions:

1. Shima (Toronto): Are medical students tokens in physician organizations? Should we have voting privileges? Should these voting privileges be protected? What about bullying/harassment against medical students in these contexts. Doctors Manitoba is awesome. How should PTMA's treat their students?
    - A: Very important series of questions. I have to tell you that that has been the subject of considerable debate at the CMA board. This is a work in progress My feeling is that we should have members voting for all of this but that requires a lot of change in Codes of activity and etc. It takes time. In New Zealand, the medical students/residents are full members of the association. A resident is even running for chair at this point. I beg your indulgence in giving us a little bit more time to sort this out. Don't stop your advocacy. There are many other ways to steer an organization - you can have a significant effect on policy direction right from where you're standing.
2. Gurmeet (Manitoba): Questions about seniors care strategy. There's about 40 hours of geriatrics (compared to 200 in peds) - this is a growing concern. What is the CMA's role to be in communication with faculties and promoting geriatrics curricula?
    - A: I'm told that the discussions at the curriculum level is very bitter. Everyone jostles for "my piece of the pie. These guys have to know this" It is a difficult issue. I would also shine a light on the issue around addictions across the age spectrum. There are a lot of things that need to be addressed here. It cannot be fully done in the undergraduate curriculum. The schools must pick and choose to achieve balance. I think it goes back to your advocacy in a large part. You have a lot of power. You can push universities to listen in many ways. I'm interested in your ideas about how you might think about expanding or extending the training phase.
3. (McGill): You mentioned burnout. I've heard conflicting things about the initiative that have been put into place to reduce physician burnout. Could you elucidate that?
    - A: I think fundamentally it involves respect for learners and those around you. This is something that I found very important when we developed a training program in rural BC. We had a dozen different health professions joining our town. It was an amazing experience. I learned a huge amount and I would not be able to do that without my respect for students, who had important experiences that I wasn't aware of. We need to be pushing this engagement much, much more. Learning is not a top down process. It is a shared process. One of the things that resuscitated my interest in medicine after practicing for 10 years was teaching. Learners taught me that I didn't know it all. It is a fundamental piece that comes back to respect and it is a two way affair. That's part of it.

President Elections

Dr. Anthea Lafreniere (Past-president, CFMS)

- Quorum met
- Anthea (Parliamentarian): Describes the process of voting

Accreditation of Canadian Medical Schools

Dr. Danielle Blouin (Secretary, CACMS)
CACMS Secretariat

Dr. Danielle Blouin:

- The burden of the ISA of students is something CACMS is aware of but the process should not be that way. The ISA process is a set of questions that requires answers from years through 1-4 and should be run by students. The intent is to have school support in the logistical aspects such as survey design, administration, distribution and only the analysis is to be executed by students. The Faculty is to not be included in the analysis that an unbiased representation of the student perspective can be highlighted.
    - Misalignment of ISA questions and the documents required by the schools for accreditation but work has been done with the CFMS to help better align that.
    - CACMS is more independent from the LMCE

Questions:

1. Shima (Toronto): Seeking clarification that only the analysis is to be done by students but the schools can be involved in logistics.
    - A: The secretariat also clarified that they are available to support students and participate in a teleconference to address student questions
2. Anthea (Ottawa): Logistical support was not the reason that students in the past were overburdened by the ISA. There were issues with pressures from the dean and is wondering what CACMS can do to address learner safety?
    - A: Students are encouraged to come to secretariat who can support and act as an intermediary
    - Data can be given to the university to do their own analysis

Intra-Professionalism in Medicine

Ms. Taylor McFadden (Physician Health, CMA)

- Introduced by Carl
- Work at CMA is predominantly physician health but recognizes synergies with medical professionalism. Intraprofessionalism is a key aspect of being a collaborator as per the CanMeds role and includes the relationship between physicians but also physicians and medical learners. Despite formal professionalism curriculum, informal and unprofessional behaviours influence medical learners and affect patient care. The context in which physicians interact with each other and includes social media. The CMA voiced in an article concerns about targeted unprofessionalism towards medical learners
- Issues between physicians include incivility, bashing between specialties, and pay relativity. Bashing between specialties has contributed to students changing careers. Income inequities affect social cohesion.
- RDocs reports that a large proportion of residents have been on the receiving end of verbal abuse and is thought to be an underestimation. Lack of reporting is due to assumption that no changes will result from reporting, fear that behaviour will worsen, unaware of reporting procedures, or being perceived as a difficult student.
- These issues matter because they affect patient care. Positive relationships improve job satisfaction and reduce burnout which decreases safety incidents and has positive health care system effects.
- System level factors need to be addressed to promote changes. The CMA has taken a strategic initiative via developing a Charter of Shared Values and revising the CMA Code of Ethics and Professionalism. The development of these two initiatives will include engagement from physicians via e-panels, member forums, member survey, and consultation at the CMA General Council. The CMA also hosts conferences on physician leadership and physician health.
- From an individual level, recommendations to improve intraprofessionalism include being conscious of social media presence, role model professional behaviour, self reflect, embrace collaborations, and hold colleagues responsible by reporting inappropriate behaviour.
- CMA is working on a National Physician Health Survey and more information can be found on the website.
- Physician health recommendations including having a family doc, exercising, eating well, integrate fatigue management behaviours, and role model healthy lifestyle behaviours. Proactive strategies such as mindfulness and resilience training can be helpful for mental health along with knowing wellness services, recognizing early signs of distress and supporting colleagues in distress. Participate in peer support and seek out mentorship opportunities.
- Contact at taylor.mcfadden@cma.ca

Joule

Ms. Lindee David (Joule, CEO)

- Three business lines: Journals, Clinical Resources and Leadership, New Business Development and Innovation. Multiple grants are available. “Challenges” will be presented to residents and students - simple questions that allow feedback to be shared around issues. 8% of grants applications were from medical students and Joule would appreciate greater engagement from students.
- Challenge: How can 3D printing help empower individuals to improve their quality of life (seniors, chronic conditions and pediatrics). Can share challenges we’re interested in to Joule to present.
- What are ways Joule can help students?

Questions:

1. Christina (Calgary): Large $25,000 grants may not be necessary. How about multiple smaller amount grants?
    - A: Something they can look into
2. Stephanie (Calgary): As emerging medical themes come up, if CMA could offer specialists or other services such as podcasts and webinars to address these issues and make them available to medical students that would be helpful
    - A: They have podcasts for other topics but if there are certain ideas we’d like to hear on, let them know.
3. Alyse (McMaster): Support funding for continuing medical education type workshops?
    - A: Response: may be feasible as an award as they don’t have unlimited funding available

Resolutions Session #3

Resolution 10: Improving Service Learning Curriculum

- Moved by Samik Doshi (Toronto)
- Seconded by Tavis Apramian (Western)
- Born from the idea that service learning exists, but it is heterogeneous. No guidelines from LCME or CACMS that mandate service learning structures in medical education. Collaboration has occurred in Ontario and on EdCom. We hope to standardized.
- Andrew Dawson (Queens): Point of Information - this is something that is in the process of being created. What does this motion do? Will it further what we've accomplished? Will it change anything that is already happening? What would failure of this motion mean?
    - If this is voted down, we would not move further with this motion
- Josh Palay (Manitoba): Speaking AGAINST - service learning is a CACMS accreditation requirement, so medical schools have extrinsic motivation to develop service learning curriculum at their school. CFMS should spend resources elsewhere
- Ben Cassidy (NOSM): Point of information - what does standardization of service learning mean, given how different faculties execute differently?
    - To create principles the way that service learning is implemented
    - The way that schools approach it could be different based on institutional & local climate
- Jess Bryce (Western): Speaking FOR - it is not a specific laid out requirement in CACMS (just highly suggestive of). There are no stipulations on what service learning should look like, so it ends up being a 'check box' instead of having objectives. We should make service learning better and not just a checkbox
- Victoria Reedman (Toronto): Speaking FOR - We need guiding principles and we need to recognize how the principles will be applied will be dependent on the school's context. To have guiding principles for implementation and tangibly teaching social determinants of health is important!
- Sarah Silverberg (Toronto): Point of information - how do you see the faculties responding to a list of guiding principles from the students?
    - We just told the UGME deans that we would like to engage them in a process to identify how our curricular advocacy work
- Yasamin (Alberta): Speaking AGAINST - I agree with the motivation and that standards are good. In Alberta's experience, schools tend to be resistant to curricular changes coming externally. This may not be a good use of CFMS' hours. This wouldn't necessarily empower us on the ground.
- Gurmeet Sohi (Manitoba): Point of clarification - as per the 2015 revisions, each medical student must participate in service learning, as per CACMS standards
- Sarah Silverberg (Toronto): Point of order - call to question means that we should move to vote

        - Carl: it was not an official call to question. It was only called because no more speakers were on the list
    - Adam (Ottawa): Standardizing the process may not be feasible because of the difference. The intent of improvement of service learning is good. We propose a friendly amendment to remove 'standardization'.
        - Samik: Accepted as a friendly amendment.
    - Mary (McGill): Point of information - How, given that universities & communities have relationships where universities impose service learning on the communities, how would we approach this using community-centered language? How would we make the guiding principles community-centered?
        - Not entertained
    - Jessica (Western): Call the question
        - Seconder: Tavis
        - Motion PASSES unanimously
    - Motion PASSES

Resolution 11: Trauma-Informed Pelvic Exams

- Moved by Emma Ali (Western)
- Seconded by Vivian Ng (McMaster)
- Patient case: had an IUD, doctor hadn't asked about trauma. Bled consistently, and BP dropped. We should create safe spaces for women. Falls within scope of CFMS interest in representing medical students. CFMS should recognize need for research and advocacy.
- Sarah Silverberg (Toronto): Speak AGAINST - agree with sentiment. What you just described is not reflected in the paper itself. If we adopt the paper, we are bound by the paper, which requires the CFMS executive to conduct a survey that we are not capable of doing. I can't pass ap aper that I can't fulfill the goals of.
- Tavis Apramian (Western): Speak FOR - Happy to support individual students whose research is taken up by the General Assembly & to use the new program we have to connect students with potential PIs, and using our new platform.
- PA (McGill): Speaking AGAINST - Agree with the idea, but there are problems with the policy paper. The background provided for the resolution is not in line with the recommendations. Recommendations do not address loss of follow up, psych support, etc. Given that recommendations are generic, I will respectfully disagree that a national policy will not place patients and learners at risk. There are 17 medical faculties in Canada.
- Chris Briggs (Manitoba): Motion to table
    - Seconded by Jessica Bryce (Western)
    - Tavis (Western): Can we move to table it later in the conversation if this one fails?
        - Carl: No. Motion to reconsider tabling the motion by someone who has voted against tabling, and it requires a ⅔ vote.
    - Adam (Western): Can we abstain?

        - Carl: No.
    - Victoria Reedman (Toronto): If motion fails, and Emma rescinds, would it be a ‘fail’?
        - Carl: No.
    - Motion is TABLED (may be brought back to AGM)

Elections Results

Dr. Anthea Lafreniere (Past-President, CFMS)

- Healthy, contested election is sign of a strong institution. Applause for all!
- VP Communications: Usman Khan
- President-Elect: Henry Annan
    - “Thanks guys! I won’t let you down, and I look forward to next year. Please approach me, contact me.”
- Motion to destroy ballots
    - Moved by Han (Western)
    - Seconded by Kaylynn (NOSM)

Question & Answer Period by General Assembly

All CFMS Executive

1. Shima (Toronto): Thanks for work this year. Question around wellness survey - many med soc presidents feel it's important to have school specific data. Does anyone on exec have plan? Concerns about knowing if schools are outliers and would like to know exec's thoughts on that.
    - A: Han (Western): Limitations to providing school specific data are influenced by limitation of Ethics Review board. Franco and Han would like details by AGM. FMEQ has approached CFMS with specific question re: pass/fail. Encourages specific questions for advocacy from schools. Careful because there has been resistance from deans about analysis process. Appreciates that's not what schools want to hear but are working actively towards this goal. We're working on it!
    - A: Tavis (Western): Saw student (Emma) bring in a paper that had significant effort so should show appreciation for that.
    - A: Carl (Chair): Appreciates that there are flaws to resolutions but the CFMS strongly encourages students to remain engaged despite rules of proceedings. Acknowledges Emma's effort.
2. Alyse (McMaster): The way CMA talked about wellness was jarring for the group re: blanket statements around how to maintain wellness.
    - A: Anthea (Past-president): individuals are receptive to message so if there is feedback, please provide them. The CMA is very engaged - Dr. Avery has been present all afternoon. The CFMS has had wellness activities previously and those are not well attended so if there are ideas on incorporating wellness, please share
3. Stephanie (Calgary): There should be a 2 week deadline before the General Meeting so exec can review papers.
    - A: Carl (Chair): Papers do need to be submitted 2 weeks prior so schools have chance to review. Pre-circulation deadline usually 3 weeks. This meeting was done differently bc lack of VP Comms. If there are procedural issues, the Chair will mention it.
    - A: Anthea (Past-president): Communiques lagged for a month because of Communications portfolio issues so accepts responsibility. Exec sponsorship used to exist but feedback from the general assembly indicated that was not preferred
    - A: Jessica (Western): Communication about deadlines needs to be improved but med students at large also are largely deadline based which makes it difficult.
    - A: Sarah (Toronto): Have been working on a new process to allow passing of papers without critique of a couple sentences shooting down papers and proposing wide motions.

4. Stephanie (Calgary): For AGM, members should know what the portfolios of VPs entail. If VPs feel like there's some work that needs to be done, they should feel free to execute it.
    - A: Sarah (Toronto): More difficult to do with more contentious topics but a balance can be struck
5. Victoria (Toronto): Specific set of recommendations with wide motions would be appreciated with the blanket statements. The exec should focus on what specifically is brought forward and engage with members re: what topics are important to them.
    - A: Kaylynn (NOSM): We try to reach out classrooms but we get limited engagement back.
    - A: Jess (Western): Strategy reflective of CMA with having a targeted advocacy strategy and having the general assembly pick on these specific topics.
    - A: Sarah (Toronto): conflicting between ranking priorities and having thought out recommendations. We identify key topics based on portfolios and their representatives and do focus on them.
6. Brandon (McMaster): having a committee looking over pertinent relevant positions to avoid students bringing position papers and getting promptly denied. Better utilization of reps roundtable, PRT roundtable, to bring forward ideas.
    - A: Anthea (Past-president): board vs executive structure - board can generate ideas but we're working as executives. Hoping that as operations are streamlined, we will be able to address conflict
7. Yasmin, (Alberta): Thanks Manitoba for being a great host. Question for regional representatives on thoughts of a regional council
    - A: Gurmeet (Manitoba): Work closer with regional reps in the portfolios and increase representation in the core VP portfolios
    - A: Laura (UBC): Western and Atlantic Canada have geographic limitations that Quebec and Ontario necessarily don't
    - A: Shreya (Ottawa): Increase utility of regional reps across portfolios. Regions should maintain reps
8. Daphne (UBC): Heard time from time again past exec, that there are communication barriers within the exec. How do you look internally and improve?
    - A: Tavis (Western): It's difficult for all of us as medical students because we're all busy
    - A: Pavel (Manitoba): Takes responsibility for some breakdown of communication with website materials
    - A: Anthea (Past-president): Looking internally, how can we be more effective? Anthea has been looking at trends - have one on one meetings, assess strengths and weaknesses. Losing an exec member this year was definitely difficult
9. Vivian (McMaster): Challenge to Robert Rules - makes distinction of motion to table vs motion to postpone. There was stifling of discussion and didn't feel democratic. When thinking of a motion, does it fit the scope of the CFMS? Feels there should be actionable items. People related to motions should be consulted.
    - A: Carl (Chair): Can argue a decision by the chair and can be voted on. Functionally the only difference between tabling and postponing, the motions that

haven't had time to be addressed can be either withdrawn or gone to the exec for vote
    - A: Tavis (Western): Acknowledge that students who have astute understanding of procedure should be heard from
10. Dr. Granger Avery (CMA): Dr. Avery is impressed with the meeting - heard diverse, kind debate and was impressed with the people running in the elections and the elections process and feels confident that our group of students will bring forward great public health policy
11. Peter (MUN): Wants to hear Atlantic opinion
    - Alexandra (Dalhousie): Agrees that regional representation is very important and that regional reps can be better utilized with increased involvement throughout the VP portfolios. Will be taking the issues back to MUN, Moncton and Dal as was regional reps were just informed of changes at the commencement of this meeting

Daphne (UBC): Moves to adjourn
Shima (Toronto): Seconds the motion
Passes