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

Summer 2020

The Voice

of Women in Medicine

President's Update

Greetings to All,

Where have the last six months gone!? With the COVID-19 pandemic, many of us have had to pivot and adapt our practices. PPE, sanitation requirements, mental health and financial concerns are major worries for many physicians. After the well-publicized police murder of George Floyd, the Black Lives Matter movement resurged to protest anti-Black racism and policy brutality against the Black community in the United States and supportive protests exploded across the globe. This movement shines a light on the racist behaviour and policies which creates systemic racism perpetrated not only towards Blacks, but, particularly in Canada, also towards Indigenous communities and people of colour. The time for talk is indeed over. It is time for real change and actions to fix this deeply entrenched system. Peoples of all races are "awakening" to their unconscious biases, micro-aggressions, deeply held stereotypes and unwitting privilege. This reckoning, while profoundly uncomfortable and perhaps humbling, can lead to a keen appreciation for the richness imbued in diversity, inclusion and an open heart. This anti-racism movement is not about a media trend. It is a watershed moment that is long overdue. I wrote a message via the OMA Women's Committee with embedded references for additional learning for those who are interested. How can we as an organization "galvanize" our power and resources, as one member asked me, to advocate in this realm? Remember, systemic biases affect not only race. As women physicians, we know well that by virtue of our gender women and girls routinely face discrimination, bias, bigotry and violence. There is power in collaboration.

> ***"There is power in collaboration.***

Shifting slightly, Federation members have been engaged in various activities. From students

using the time made available by the interruption of their studies to volunteer to help frontline healthcare workers to senior members hosting weekly support sessions on Zoom, our members have truly shown how extraordinarily supportive they are.

Let me also recap what has been going on with the Federation this year. In addition to the rapidly changing world, it continues to be a very active year for the Federation. At the end of January, just as the previous edition of this newsletter was going to press, the Board of Directors gathered in Toronto for the annual Interim Board Meeting. This was a chance for the Board to meet in person and plot out direction for our organization for the remainder of the year.

With Parliament back in session this winter, our 2019 HPV Prevention Week campaign held a Day on the Hill to meet with Parliamentarians one-on-one and hosted a reception for Parliamentarians, FMWC members, and guests. Led by Dr. Vivien Brown, it was a hugely successful day of building relationships across party lines and sharing the message of HPV elimination.

My heartfelt thanks to President-elect Dr. Charissa Patricelli and all who worked on planning our AGM and National Conference in Vancouver later this year, ***Empowering Justice Peace & Health 2020***. As we have previously announced, due to Covid-19 concerns, our National Conference will be postponed until 2021. Our Annual General Meeting, however, will be held virtually on October 3rd . We are looking forward to working with our presenters and to rescheduling them for next year. More details regarding the virtual AGM will be forthcoming.

Our Women, Peace and Security Committee has been very actively advocating for Gun Control, the health effects of Climate Change, and the need for medical education to include abortion care in the curriculum.

Our Gender-Based and Family Violence Committee, headed by Dr. Anne Niec and Dr. Kathee Andrews, supported sessions on sex trafficking with students at University of Toronto on March 1st. Dr. Niec also organized a conference themed, ***Resilience: Equity in Gender, Health and Water*** that was held on March 6th and 7th at the Hamilton Art Gallery.

Looking at the remainder of my term, I will continue to advocate for Gender Equity and Anti-racism at every opportunity. We also know this pandemic has disproportionately affected women physicians. Partnerships

and collaboration can go a long way to elevating our message locally, nationally and globally.

I will also be focusing on directing our energies on determining a clear vision and direction for our future. We have a proud history of accomplishments. One of our founding members, Maude Abbott, was recently honoured by Historica Canada, the makers of the Heritage Minutes, with a vignette on her accomplishments as part of their **#INSPIRINGINNOVATORS** series.

Summer is finally here. Please safely take care of yourselves. Continue to open your hearts, souls and humanity. Love for each other can never be underestimated… Neither can handwashing, masks in public, physical distancing and emotional & social connectedness.

With Love in my heart and gratitude for all that we have and all of you,

Clover Hemans, BScN, MD, MScQIPS, CCFP, FCFPC
President, Federation of Medical Women of Canada

AGM Review

President-Elect's Report
Charissa Patricelli, MD, CCFP, DABAM

Under normal circumstances, the President-elect would be updating you as to the upcoming Annual General Meeting and Education Conference: ***Empowering Justice, Peace and Health 2020***. It has been far from a normal year. Faced by a dual state of health emergencies here in British Columbia and elsewhere in Canada, the Opioid Crisis and the Covid-19 pandemic, each day sometimes is a struggle for calm or normalcy in the many aspects of our lives.

Like many of our peer organizations, we made the decision to postpone an in-person meeting this year. Even as we see provinces begin to ease restrictions, it is

still difficult to determine what the state of the country will be like come the fall. As of this writing, very few jurisdictions allow for gatherings of more than 10.

We will still have our AGM, but it will be a virtual meeting on October 3rd at 3 pm ET/12 pm PT. The AGM, be it in person or virtual, is an important time for us to gather and reflect on the year past for our organization and chart the course for the year ahead through the passage of resolutions and the electing of a new board. The call for resolutions and nominations for the Board of Directors will be published shortly.

The Education Conference has been postponed until 2021. Even if we have to wait a year to do so We are so looking forward to welcoming you to Vancouver in Fall 2021. This year's theme of ***Empowering Justice, Peace and Health 2020*** will be as relevant, if not more so, next year as this year. We will broadly highlight female physician's accomplishments and inspire transformational change in gender equity, mental health, interprofessional opportunities, resiliency and innovation in delivery of medicine and healthcare locally and remotely. This year's conference is hosted on the traditional, ancestral and unceded territory of the Coast Salish peoples also known as Vancouver. We will bring some of the latest information in many areas of women's health and wellness to empower and support our delegates to make their mark in medicine, healthcare and the social services field. We are in the process of contacting our confirmed speakers and rescheduling them for 2021.

May each of you know you make a difference in this world every day,

Ask us how you can sponsor a student. It only costs $25 to gift a FMWC student membership.

CALL FOR NOMINATIONS

FMWC 2020-2021 BOARD OF DIRECTORS

The FMWC is looking for members to join the Board of Directors for 2020-2021. All roles will be assigned at the first meeting of the 2020-2021 Board of Directors to be held following the AGM in Ottawa on October 3rd, 2020. In addition to a general call for directors, the position of President-Elect is also up for election. If you are interested in this position, please contact Dr. Kathee Andrews, Past-President via the National Office

WHO ARE WE LOOKING FOR?

We're looking for a diverse group of women physicians who share the vision and commitment of the FMWC of advancing women physicians professionally, socially, and personally; while also promoting the well-being of women both in the medical profession and society at large. Ideal candidates will have leadership experience and expertise in some of the following areas: Financial Management, Risk Management, Legal/Governance, Non-profit/Public Sector Management, Strategic Planning, Media/PR, Communications, Government Relations.

Directors will serve a term of one year, unless otherwise stated, with eligibility for reappointment for consecutive terms. These positions commence in October 2020.

For more information, please consult the By-Laws of the Federation or reach out to the National Office

WHAT IS EXPECTED OF DIRECTORS?

Directors meet in person twice a year, including at the Interim Board Meeting (typically held in January) and the Annual Board Meeting held prior to the AGM (typically September). Directors are expected to also participate in regular teleconferences. Directors are also expected to be committed to the mission and vision of the FMWC. Additionally, board members should plan to be accessible for personal contact in between board meetings.

APPLY NOW!

The next election for the FMWC Board of Directors will take place virtually at the AGM on Saturday, October 3, 2020. **The deadline for receipt of nominations/applications is Friday, August 30, 2020 at 4:00pm EST.**

Please complete the FMWC 2020-2021 Board Nomination Form and submit to the National Office at fmwcmain@fmwc.ca, with the subject line "Board of Directors Nomination 2020-2021." Or print off the form and mail it to the National Office at the following address:

FMWC Attn: Nominating Committee
1021 Thomas Spratt Place
Ottawa, ON
K1G 5L5

We look forward to receiving your nomination or application!

FMWC Operations and COVID-19

By Michael Read, National Executive Coordinator

In my previous field, politics, they say timing is everything. That phrase has been at the back of my mind since joining the FMWC in late January. I would have introduced myself sooner, but the timing was off. We were putting the winter newsletter to bed and I didn't want to have alter the layout for the sake of a few sentences about myself. The timing is really off now, but it also presents the opportunity to share an introduction, however late.

I come to the FMWC with several years of experience in financial services and fourteen years on Parliament Hill. On the Hill, I worked for the Honourable Noël A. Kinsella, both during his time in Opposition and during most of his tenure as Speaker of the Senate. During this latter role, my multitude of responsibilities included representing the office on the Continuity of Operation Committee, the committee responsible contingency planning on how to keep constitutional governance going during times of crisis. More on that later. In addition to the work in politics, I earned a PhD in Politics from the Catholic University of America. During my academic years, I organized a number of conferences where the scope ranged from local to international.

It has been a rather interesting couple of months since I began. It's not my fault, I swear. As the last issue of this newsletter was hitting your inbox, I was in an ultimately fruitless scramble to make alternate arrangements to get to Toronto for our Interim Board Meeting. The rail blockade erected in solidarity with the Wet'suet'en First Nation the evening before kept me in Ottawa.

What a minor inconvenience compared to our current state of affairs that turned out to be. As the COVID-19 epidemic became a global pandemic, we quickly pivoted operations. Like many Canadians, work has moved from the office to the home. Our landlord, the Medical Council of Canada, requested non-essential staff to work from home and that includes tenants. We have a system in place for our mail to be collected for us. We can also request access to the office to retrieve files if needed.

One of the first decisions that had to be made soon

after we moved operations was the status of the Annual General Meeting and Education Conference. Given its October date, I will admit to a certain amount of wishful thinking when I began to research contingency scenarios. As I was reviewing the logistics and forecasts, the cancellations of various meetings from our peer organizations on the CMA CEO's Roundtable moved from a trickle to a flood. Three days before our executive meeting to discuss options, the first cancellations started coming in for October. By the time we met to discuss our decision, six of our peers had cancelled October events.

We will, of course, virtualize the AGM for October 3rd, but the Education Conference will be postponed until 2021. We are very thankful at our vendors generosity in allowing our agreements to carry forward until 2021 without penalty. It may be a little further away, but we are still looking forward to seeing our members gather when it is safe to do so.

Our communications strategy has shifted to pumping up and amplifying offers of support for our members. Our student members in several cities have volunteered to do everything from walk pets, fetch groceries, and watch the kids while our practicing members are working on the frontlines. Members in psychiatry and psychotherapy have hosted sessions for members on how to cope with the stress of the crisis. If you have any support you wish to offer or need any support, let us know and we'll help you get your message out. That's why we're here.

Over the next few months, we hope you will remain engaged with the Federation both nationally and through your local branch. We will be announcing further details of our virtual AGM shortly. We are presently exploring efficient, yet cost-effective models for meeting and collaboration that will empower members across the country to participate in their federation. We are also looking at new models to potentially deliver training sessions, both accredited and unaccredited, throughout the year. We are already using our Zoom account to facilitate virtual events for the branches and recently hosted a national session for our members, ***Coping with Covid*** with Dr. Mamta Gautam.

The Federation is in good hands: yours.

OUR MEMBERS RESPOND TO COVID-19

By Kathee Andrews, MD MCFP NCMP,
Past-President, FMWC

These are unprecedented times for the medical profession and for society as a whole. Some of us remember working during the SARS outbreak in 2003. We had our temperatures taken before we entered hospitals and wore masks while we examined patients. Sadly, many of us lost colleagues during that time. Until the COVID-19 pandemic, however, never before has an outbreak caused such an interruption in the care of our patients, impacted our day to day lives, and threatened our economic stability as we have experienced since March.

For over two months, we have anxiously listened to our political and public health leaders (many of whom are women) for guidance as to what to do, who to test, how long to self-isolate, who needs PPE, etc. Like everyone inside and outside our profession, we want to know how long will this last?

As physicians, we are taught to be resilient and cope with the stresses in our profession well. As a result, we have found ways to rise these challenges and do the best we can for our patients, families and communities.

Even we need support, though. In times like these, we lean on the support of our loved ones and our peers.

Mere days before the lockdowns began, Dr. Vivien Brown, North American Vice-President of Medical Women International Association and a past president of the FMWC, was in Ottawa for the Federation's HPV Prevention Week Awareness Day on Parliament Hill. Even then, the oncoming storm was apparent even if the extent was still unknown. Since returning from that day, she has continued her family practice both in person and virtually and has been regularly providing national and local media updates on health-related issues regarding COVID-19.

Our national president, Dr. Clover Hemans, did an immediate pivot and signed up to work in the COVID-19 assessment centre in her health region. There, she sees dozens of patients daily who are symptomatic and present with respiratory and other symptoms suspicious of coronavirus, and are anxious to be tested. She has selflessly taken on this job while she waits for her hospital to resume its regular elective surgery schedule in the future.

There is a joke amongst doctors that betrays a stark reality: an ER or doctor's office is a horrible place to treat an illness. It's not the office, per se, but the waiting rooms with the cocktail of symptoms of those waiting to be seen. As such, many physicians, myself included, have taken it upon themselves to be trained in virtual and telemedicine so they can provide ongoing primary care to patients in their homes without risking coronavirus exposure to either patient or doctor. This has not been an easy transition. Some physicians are older and less technically savvy! It also relies on patient's honesty and frankness at a time when they likely don't even know what details we need to make a diagnosis. An additional challenge is many patients are now choosing to stay at home with symptoms of serious diseases and conditions such as cardiac illness or stroke which do need to be managed in the emergency department.

Several of our members have successfully converted their psychotherapy practices to online platforms. For those suffering with pre-existing mental health issues, such as anxiety or depression, the added stresses of social isolation, financial hardship, and uncertainty regarding the future has served to intensify symptoms. The incidence of domestic abuse and violence is rising. For women in abusive relationships, social distancing and "staying home" has meant "staying trapped".

For some of us, this pandemic is a crisis on top of a crisis. Dr. Charissa Patricelli, our President-Elect, has been working night and day with at-risk population in perinatal clinics, battling the opioid crisis in Vancouver. These challenging cases are made ever so more complicated by the pandemic.

Fortunately, our members support our members. Dr. Mamta Gautam, psychiatrist and coach, has generously been providing virtual support to physicians on a daily basis with a free daily Zoom drop-in session since the beginning the of the pandemic.

She was recently interviewed by the Canadian Society of Physician Leaders on her observations on the phases Canadian physicians have gone through in response to the pandemic. Her thoughts can be heard here.

We would love to hear from you and what you are doing during this pandemic. No matter how many more positive cases we test and successfully treat, we know until a vaccine is available, 2nd and 3rd waves of this will likely occur. Patients and physicians will feel the economic, physical, and emotional and social effects of this pandemic for months and possibly years after the virus is under control.

Please stay in touch!

Contact our national office fmwcmain@fmwc.ca to share your story.

Women Physicians:

LINKING HEALTHCARE WORKERS IN A PANDEMIC

By Dr. Gail Beck

Healthcare is a pink collar ghetto. According to the World Health Organization, 70% of all healthcare workers worldwide are women and so the burden of COVID-19 has fallen largely on our shoulders. As women physicians in an era when empathy is not our society's collective strength, we are often the only leaders able to understand what our colleagues in other health roles are enduring.

We are the people our allied health colleagues turn to when they need support.

Haven't all women physicians worried about the health of family and loved ones? You know what those Personal Support Workers are suffering, having to abandon their children to ensure their safety. Think of the faces of workers looking out with the elderly from long term care homes. They are the faces of women, the faces of women who are,

with tremendous grace, assisting our elders in their last moments. One of my patients who is a nurse wept as she told me how hard it was to hold an elderly man with dementia who kept calling for his wife until his cries were finally stopped by his passing.

My thoughts are very much with each woman doctor as I write this short reflection for the Federation's newsletter. I know that you are doing triple shifts, looking after your family when your work in your practice is done and then, once everyone is in bed, you are back in your practice, finishing notes and checking prescriptions and making a list for tomorrow. As a psychiatrist, I have always felt lucky that working on 10 files in the evening would be a busy day. I remember stopping by the office of a family physician friend one evening when we were going out to dinner. As we chatted, she stuffed about two dozen charts in her bag. With each new chart, I could feel my brain constricting. I couldn't contemplate her taking all this work home.

As a final thought, if you are reading this and thinking to yourself, "There's nothing new in this essay", you're correct. Women like you and me have been rewriting these exact words for years. It may seem as though there has been no progress, and certainly there has not been enough. I believe that I last wrote an essay for the Federation in 2004, and, leaving out references to COVID-19, the essays would have been identical because women are still fighting for equality.

There is one difference, however. In 2004, most doctors were men and now women clearly make up one half of the profession in many specialties. That is progress. That is the Federation's legacy and I am proud to be a member and very proud to be a Past President.

WE'RE LOOKING FOR COMMITTEE CHAIRS!

Interested in preventing and eliminating Cervical Cancer, or in Education broadly? Reach out today!

UPDATE FROM THE MEDICAL WOMEN OF CANADA FOUNDATION

Medical Women of Canada Foundation

The Medical Women of Canada Foundation was founded by, but is legally separate from, the FMWC. We fundraise for two active funds, administering the Maude Abbott Scholarship Fund (MASF) to support deserving female medical students as well as the Maude Abbott Research Fund (MARF) supporting clinical research activity by women physicians.

The 2020 recipients are:

MASF: Ms. Milani Sivapragasam, an undergraduate medical student at McGill University

MARF: Dr. Jennifer McCall to support her project on the Imposter Syndrome in Female Surgeons

Our main fundraising activity takes place at the FMWC Annual General Meeting and Education Conference. Unfortunately, due to the ongoing global Covid-19 pandemic, the in-person 2020 meeting has been cancelled so we are unable to organize our annual fundraiser. It would not be an understatement to say that it has been an extremely difficult several months for those of us in practice and/or providing care and support to family and friends. Medical students are also in unexpectedly troublesome situations.

Finally, this is a heartfelt appeal to all FMWC members to consider contributing to the Foundation this year in order to fund next year's award recipients. You can donate to the Foundation from the Federation's donation page fmwc.ca/donate. All donations to the Foundation are tax deductible. It would be very much appreciated!

Respectfully submitted

Charmaine Roye, MDCM, FRCSC
Treasurer, Medical Women of Canada Foundation

Induced Abortion:
UPDATED GUIDANCE DURING PANDEMICS AND PERIODS OF SOCIAL DISRUPTION

Dustin Costescu, Edith Guilbert, Marie-Soleil Wagner, Sheila Dunn, Wendy V. Norman, Amanda Black, Regina Renner, Jeanne Bernardin, Brian Fitzsimmons, Konia Trouton

INTRODUCTION

In 2020, the COVID-19 Pandemic has created rapid and significant social disruption, both through illness and social distancing practices. In order to create healthcare capacity, most clinical services have been reduced and many scheduled surgeries have been indefinitely postponed. Furthermore, supply chain disruptions and medication shortages are anticipated.

Preventing unintended pregnancy and accessing abortion may become more difficult during the COVID-19 pandemic, and the need for such services may, in fact, surpass normal demand. Therefore, contraception and abortion care remain essential and time-sensitive.

We wish to provide interim guidance to affirm best practices and, where evidence is limited, provide expert consensus on strategies to maintain abortion access during the COVID-19 pandemic or other periods of major social disruption such as natural disaster, wartime conflict, or significant supply-chain disruption.

RECOMMENDATIONS AND SUMMARY STATEMENTS

Induced Abortion

1. Induced abortion is an essential and time-sensitive medical service that must be maintained in any pandemic or during periods of social disruption.

Induced abortion is both a medical service and a human right[1]. The personal cost of experiencing unintended pregnancy is high, as are the costs borne by the healthcare system to manage people with unintended pregnancy[2]. However, any reduction of abortion services would magnify risk and place additional burden on the healthcare system[3]. Abortion is safer when performed at earlier gestational ages, therefore delays in abortion access increase risk to patients[4,5]. Abortion is also safer than childbirth, increasing risk to those who cannot access induced abortion when desired[6,7]. In countries where safe abortion is not available, unsafe abortion is a major contributor of maternal mortality[1].

The current pandemic impairs access to both contraception and abortion health care services. The

result is increased demand on existing services, which must not only be maintained but must adapt to meet local need.

2. Clinicians and patients should select the most appropriate method of abortion. Clinicians should balance the risks and benefits of in-person procedural abortion with those of medical abortion, which can be provided in a virtual setting.

In early pregnancy, medical abortion (MA) and procedural (surgical) abortion are both first-line options for pregnancy termination[8,9]. While procedural abortion is slightly more effective with lower complication rates than medical abortion, it requires at least one in-person assessment in a healthcare facility[8-10]. As healthcare resources change, it may be difficult to obtain tests that are typically performed prior to MA in keeping with previous guidelines.

All clinicians providing abortion services should exercise resource stewardship regardless of the method of abortion chosen. MA can safely be provided by telemedicine or virtual visits[11]. Several "no-touch" or "no-test" medical abortion regimens have recently been developed, which guide clinicians in the provision of abortion care without testing (or when testing is unavailable)[12].

It is critical that patients have 24/7 access to a knowledgeable provider who can provide the appropriate care for those undergoing medical abortion. Because many emergency department visits can be avoided through telephone triage, clinicians able to support abortion patients (directly or through an on-call coverage model) should be the first point of contact for patient questions or concerns.

3. Patients and clinicians should adhere to local infection control regulations and strategies, including deferring appointments if a patient has influenza-like illness, or is suspected or confirmed to be COVID-19 positive.

While abortion is an urgent medical issue, the safety of other patients and healthcare workers is also important. Because most patients can defer an abortion for a two-week isolation period without significant risk of adverse outcomes, local infection control policies should be followed.

If a patient is ill and is suspected or confirmed to have COVID-19, and the abortion cannot be delayed, a hospital-based procedural abortion is recommended. This option will limit the required exposure to a single visit and should be performed

by healthcare workers with adequate training and personal protective equipment to manage patients with SARS-CoV2 infection. Ultimately, an individualized approach is needed for such scenarios.

4. Where equipment and competent providers are available, hospitals and abortion facilities should extend gestational age limits by two weeks to ensure continued access to first and second-trimester abortion.

Most hospitals have a policy on whether abortions are permitted and stating their upper gestational age limit. Gestational age limits should be based on provider competence and available resources whenever possible. Therefore, if resources permit, hospitals should extend gestational age limits by two weeks to ensure continued access to patients whose care has been deferred due to the COVID-19 pandemic. Hospitals with skilled providers should increase the gestational age limit to 24 weeks as some second trimester services may be limited due to hospital constraints.

Procedural (Surgical) Abortion

1. Procedural abortion with a paracervical block and procedural sedation is NOT an aerosol-generating medical procedure. Procedural sedation should be strongly considered over general anaesthesia for surgical abortion.

When compared to general anaesthesia, local anaesthesia with procedural sedation is associated with lower pain and complication rates9. Furthermore, light procedural sedation with spontaneous respiration and avoidance of bag-mask ventilation is NOT considered an aerosol generating medical procedure, and therefore does not require the use of N95 respirators. Procedural sedation may permit fewer personnel and/or greater physical distancing than a traditional operating room[13]. It is inappropriate for hospitals to limit abortion access based on aerosolization risk or respirator conservation as an anaesthesia machine and ventilation should not be required.

2. Nitrous Oxide should NOT be used during procedural abortion, owing to the possible risk of contamination with SARS-CoV2.

Given emerging evidence of asymptomatic carriers, and uncertainty about the integrity of nitrous oxide/oxygen circuits, the use of Entonox may pose a health hazard to patients and healthcare workers. Furthermore, given that nitrous oxide is minimally effective for pain

relief during procedural abortion, its use should be discontinued[9].

3. Repeat Rhesus Factor (Rh) testing is NOT required prior to procedural abortion.

Given the low probability of Rhesus alloimmunization, repeat Rh testing is not needed. The decision to administer Immune Globulin (RhIG) may be based on previous results.

4. Induction abortion should be considered for patients who are unable to access second-trimester surgical services.

If patients cannot access second-trimester (Dilation and Evacuation) programs, induction abortion remains an option for patients. Pre-treatment with mifepristone 200 mg PO 24-48 hours prior to misoprostol reduces time in hospital. A misoprostol regimen is described in the SOGC Induced Abortion guideline[9]. To minimize time in hospital, the first dose of misoprostol (which is provided with combination mifepristone/misoprostol) can be taken at home and the patient is admitted when contractions start, or a second dose is required.

Medical Abortion (MA)

1. Medical abortion with mifepristone and misoprostol should be offered as a first-line method of induced abortion for pregnancies up to 70 days.

Combination mifepristone/misoprostol is indicated for 63 days, and the existing SOGC guideline states that it can be used up to 70 days[8]. We continue to recommend these gestational age limits for the majority of MA providers.

2. For experienced providers where close surveillance is possible, medical abortion with mifepristone and misoprostol can be offered as an alternative to procedural abortion up to 77 days.

Emerging evidence and consensus opinion support the use of mifepristone medical abortion to 77 days (11 weeks) with repeated doses of misoprostol[10]. However, this should be reserved for experienced providers who can provide adequate coverage and backup should urgent care be needed. Patients should be informed that mifepristone use beyond 63 days is off-label, that they will likely expel and see an intact fetus, and that there is a higher risk of complication. For these reasons, and the possible higher risk of Emergency Department visits, we continue to recommend procedural abortion beyond 70 days in most cases.

3. Mifepristone 200 mg PO followed by 800 mcg misoprostol buccal/vaginal is the preferred

method of medical abortion. If mifepristone is unavailable, procedural abortion services must be restored or increased to address demand.

As the proportion of induced abortions that are medical abortions increase, surgical services are decreasing in many jurisdictions. In the event of shortages of mifepristone, surgical services must be restored and/or expanded to ensure access to abortion on humanitarian grounds.

4. Clinicians should prescribe an additional dose of misoprostol 800 mcg (buccal or vaginal) to be used on direction of a healthcare provider in the event of suspected incomplete or failed abortion.

To minimize patient visits to pharmacies, and to reduce complications, MA prescriptions should include an additional dose of misoprostol 800 mcg so that patients have medication on hand if an additional dose is required. Typically, a second dose of misoprostol is given at higher gestational ages, if by history a failed MA is suspected (minimal bleeding or expulsion), or to manage an incomplete abortion or ongoing pregnancy[8].

Affirming best practice, the initial prescription should also include any contraception to be initiated at the time of medical abortion. Additional analgesics and STI prophylaxis can be prescribed based on clinician judgement and patient request.

5. Medical abortion can be provided based on a home pregnancy test and Last Menstrual Period (LMP) dating alone if the patient has no risk factors for ectopic pregnancy, is reasonably certain of her LMP, is not using hormonal contraception, has regular menstrual cycles, and has no other contraindications.

This statement affirms the current MA guideline[8]. Patients who are reasonably certain of their LMP and have regular menstrual cycles are very likely to accurately predict being within the gestational age limit for MA. No further testing is required.

6. All patients with uncertain pregnancy dating, risk factors for ectopic pregnancy, or symptoms consistent with ectopic pregnancy, should undergo ultrasound evaluation prior to medical abortion.

Ultrasound remains the gold standard for pregnancy assessment, regardless of pregnancy intention. Because unrecognized ectopic pregnancy is a rare but serious risk in periods of limited healthcare resources, it is important to remember that patients with risk factors (such as previous ectopic pregnancy

or tubal surgery) or signs/symptoms of ectopic pregnancy should have an ultrasound. Those patients who are uncertain of their gestational age (by LMP or conception dating) should have further assessment of gestational age[8].

7. If ultrasound is not used prior to medical abortion, close surveillance and follow-up is required until completion.

All MAs performed without ultrasound are, by definition, pregnancies of unknown location (PULs). Though the risk of unrecognized ectopic pregnancy is low, close follow-up is required to ensure completion of the MA8. Clinicians should not initiate an MA if they are not reasonably certain that they will be available (directly or through an on-call service) to provide rapid assessment until confirmed completion of the abortion.

8. Rh testing and Immune Globulin (RhIG) administration may be withheld for medical abortion prior to 70 days.

Current evidence supports withholding Rh testing and RhIG for medical abortions up to 56 days (8 weeks) gestational age given the very low probability of Rh-antigen expression on fetal cells.

There is only expert opinion evidence to guide Rh management for MA between 56 and 70 days[14,15]. In keeping with other national guidelines, the low probability of alloimmunization, and whereas testing and RhIG administration requires one or two additional patient visits, we recommend that Rh testing and RhIG may be withheld for MA during the COVID-19 pandemic. We recommend a return to the current MA guidelines following resolution of the COVID-19 pandemic[8], and further guidance will be provided when this guideline is due for renewal.

9. Medical abortion can be provided a tiered approach (minimal resource, limited resource, and on-label provision with full resource utilization). The decision to offer medical abortion should be made based on clinician competence, resource availability, and patient preference.

"On label" provision of mifepristone medical abortion requires the most resources when compared to other evidence-based protocols[8]. However, resources such as imaging and laboratory testing may vary widely and in an unpredictable manner during a pandemic or period of social disruption. Clinicians should exercise resource stewardship when possible and recognize when a lack of resources or clinician comfort precludes the safe provision of MA.

Several new MA guidelines have been published to provide experienced providers with protocols to manage MA at higher gestational ages and using a "no-touch" or "no-test" approach[12]. Striking a balance, this interim guidance identifies tests that can be safely excluded while maintaining a high degree of safety. Providers must consider their own competence and experience with MA prior to using these protocols, must inform patients that these are new protocols based on low-resource availability and that this is an off-label indication. If a clinician does not feel that resources permit safe medical abortion, a procedural abortion or referral to a more experienced clinician is advised.

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HPV Prevention Week on Parliament Hill 2019

Dr. Vivien Brown MDCM, CCFP, FCFP, NCMP
Chair, HPV Prevention Week

Traditionally, the FMWC hosts a reception on Parliament Hill during HPV Prevention Week in October. It's the opportunity for members of our organization to meet with Members of the House of Commons and the Senate of Canada to talk about HPV prevention and elimination of HPV-related cancers. This past October, the country was in the midst of general election, so other than local candidates, there were no politicians to meet.

While we still honoured HPV Prevention Week in October with our grass roots screenings of Lady Ganga, we nonetheless had a re-scheduled reception on March, 10, 2020. We were once again hosted by the Honourable Peter Kent, PC, MP, himself a survivor of HPV-related throat cancer. Before our reception, we spent the day having one on one meetings with MPs and Senators. We had some great meetings and chance encounters with MPs and Senators. (photos)

All of this was against the background of the still unfolding COVID-19 crisis. Physical distancing was just beginning. Word had gotten out that more than one MP had attended events in Washington, DC, during the last break in the parliamentary calendar from which there were now confirmed cases. While Parliament was still sitting, guidelines restricting interactions were in effect. One of the more surreal restrictions was no handshakes. Imagine: two chambers of politicians that would not shake your hand. By Friday, Parliament had suspended for five weeks.

Despite this, we were able to keep a full day of meetings along with the reception and met with over a dozen parliamentarians and their staff. We brought the message that Canada can be the second country in the world

to eliminate cervical cancer through HPV vaccination. Our reception was moderated by two young members, Dr. Chloe Rozon and now Dr. Sara-Michelle Gratton, who spoke about what HPV in their patients has already meant to their early careers as a resident and soon to graduate medical student. (photos) Their exposure as health care workers taking care of women with preventable illness was reflective of both a professional experience and a powerful personal journey. I spoke about our initiative briefly at the reception and acknowledged the many collaborations we share with others, supporting our valued efforts.

Between direct meetings and the reception, we met with over a dozen parliamentarians. We were very lucky to be able to bring our message to Parliament Hill. It is still unknown if and how we will be able to access parliamentarians come this fall, and we are planning accordingly. The Federation will continue to promote HPV awareness and encourage policies that seek to eliminate HPV related cancers.

"When I was a medical student at McMaster University, I was introduced to the Federation of Medical Women of Canada by Dr. May Cohen.

I was taken aback by the warm welcome we received and the support for us 'lowly' (as we saw ourselves) medical students by the inspirational and successful women present. Over the years I have had the pleasure of attending wonderful educational events that helped me grow both personally and professionally and to network with other like-minded women in my medical community. It is a gift I felt very strongly about passing on to the next generation of medical women. As I see the passion and keen intelligence in these young Women, I know that the profession will continue to be in good hands, and that the Federation will continue to grow."

Dr. Claudia Hubbes, MD, FCFP
Proud sponsor of 5 medical students for FMWC, Family Physician at the Rosemount FHO Assistant Professor, Dept. of Family medicine at the University of Ottawa.

Visit our website for more testimonials!

WEAR RED CANADA

CAMPAIGN BLOG

THE "UNDER'S":

How the FMWC advocated for Women's Heart Health in the Wear Red Canada campaign

Emily Lerhe
UBC Class of 2022,
Island Medical Program

What image comes to mind when you hear the term "heart attack"? Do you think of someone clutching their chest, with chest pain radiating to the jaw and arms? Or do you think of someone experiencing nausea and sweating? Do you think of a man or woman?

On February 13th, 2020, thousands of Canadians raised awareness for women's heart health through a nationwide campaign called the Wear Red Canada (WRC) campaign using the hashtag #HerHeartMatters. The goal of this campaign is to educate medical professionals and the public on women's heart disease.

Heart disease is the leading cause of premature death in Canadian women[1] with 78% of early heart attack signs missed[2]. There are many discrepancies in presentation, risk factors, diagnosis, treatment, outcomes, research and funding between men and women with cardiovascular disease[3,4]. Heart disease is largely preventable with lifestyle modifications like exercise and nutrition, however women are half as likely to engage in cardiac rehabilitation compared to men[2].

Women with cardiovascular disease are considered to be the under's: under-aware,

under-diagnosed, under-treated, under-researched and under-supported[2]. The Wear Red Campaign hopes to change these statistics with advocacy, information sharing and collaboration.

This year for the WRC campaign, there was a huge increase in participation and action. 80+ centres and organizations were involved in the campaign compared to 34 last year. A grand spread in

social media coverage was seen with a 38% increase in reach (the number of individuals viewing content) and 36% increase in impressions (the number of times content was viewed) on Facebook and Twitter, with **#HerHeartMatters** trending to #6 and #2 in Canada and Ottawa, respectively.

The FMWC Women Cardiac and Cardiovascular Health Committee (WCCH) organized 14 events across Canada between February 12th-20th. Below is a summary of the events.

Starting on the west coast, there were three events hosted in Victoria hosted by Emily Lerhe, a second year UBC Island Medical Program (IMP) student and FMWC WCCH member. On February 12th, IMP medical students joined Dr. Jesse Pewarchuk, an internist and cofounder of Aroga (Revive) Medicine, for a chat about women's heart health in the lens of lifestyle prevention.

On February 14th, Take Heart, a community cardiac rehabilitation program at Saanich Commonwealth Place recreation centre, hosted a blood pressure clinic with fliers and handouts from the Heart and Stroke. Following this clinic, the staff and clients at Take Heart wore red together during their exercise session.

In the Vancouver area, there were also three FMWC WCCH events. A community "dinner and learn" event with Dr. Shahin Jaffer, an internist and FMWC WCCH Chairperson, was held on February 13th at the Season's in the Park restaurant. In New Westminster, Dr. Jaffer also hosted an information booth with MOAs, pharmacists and physicians wearing red at the Indigo Health Clinic and Indigo Health Pharmacy. At Vancouver hospital, Dr. Fahreen Dossa, a Vancouver family physician and hospitalist, also organized an information booth with pins and posters.

Jumping across the country, multiple events were held in Ontario. University of Ottawa medical students and FMWC WCCH committee members Amy Yu (2nd year), Julia Kinahan (2nd year), Sara-Michelle Gratton (2nd year), Dalia Karol (4th year) and Kameela Alibhai (1st year), rallied both their first- and second-year classmates to wear red on February 13th. In Hamilton, Janhavi Patel, a first-year medical student at McMaster and fellow FMWC WCCH member, hosted a yoga session followed by a presentation on the impact of lifestyle and incorporation of wellness activities on women's cardiovascular health for McMaster medical students.

There were 7 events hosted in Toronto organized by Dr. Rajni Nijhawan, a primary care physician working in the department of Physical Medicine and

Rehabilitation (PMR) with the University Health Network (UHN)/Toronto Rehab Cardiovascular Prevention and Rehabilitation Program, and member of the advocacy group for the CWHHA. Two of these events were attended by almost 100 participants. On the morning of February 10th, Glory Hart instructed a chair yoga session to Toronto Rehab/ UHN women-identifying patients facilitated by Dr. Nijhawan. After yoga, a session for rehab staff and patients called "Beyond the Heart: Women's Mind Matters" was hosted by Dr. Carolina G. Carvalho and facilitated by Dr. Nijhawan. On February 13th, Dr. Paula Harvey hosted a presentation for North Cluster UHN staff called "Protecting Women's Hearts: Unique Considerations Across the Lifespan". Following this presentation, a lunch and fun hosted by GAGGLES provided a brief update on CWHHA and raised $1400 for Women Habitat Shelter. In the evening, the Toronto Doctors' Lion club hosted a community "Her Heart Matters" event presented by Dr. Nijhawan and facilitated by Marilyn Sarin, the president of the Toronto Doctors' Lion's Club. Alex McDougall, a University of Toronto PMR resident, organized the PMR classmates to celebrate on February 14th during their academic day. On February 20th, Dr. Sherryn Rambihar, a cardiologist and Heart and Stroke spokesperson, presented to the Toronto Rehab Program graduates in a public and community event: "Listen to Your Heart – Her Heart" while Dr. Nijhawan and Dr. T. Colella facilitated.

Through the Wear Red Canada campaign, a wonderful partnership of physicians, medical students, allied health professionals, patients and the general population was created to continue advocating for the thousands of women in our community.

For more information on the topic, please see the references below:

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COVID-19 Does Discriminate, and So Does The Government's Response

Authors: Maria Leis, Miranda McDermott

"COVID-19 DOES NOT DISCRIMINATE."

From the beginning of COVID-19 we have all heard the familiar catch phrase touting the great equalizing capabilities of the virus, and we have watched cascades of celebrity faces smeared across our screens as an offering of definitive evidence. Slogans such as "we are all in this together" have found their way into popular media. However, it has become evident that the exact opposite is true: COVID-19 is fractioning our communities along lines of privilege and marginalization, and our government's response is further entrenching these divisions.

As the virus spreads, we are witnessing the women of our societies bear the disproportionate burden. We know that 80% of front-line healthcare providers in Canada are women[1], emphasizing the gendered risk of our workforce. New data from the United Nations in Asia and the Pacific is already demonstrating the gendered-effects of the virus, with women facing greater barriers to medical care, having less insurance coverage, receiving less necessary information about the virus, and experiencing greater mental and emotional health impacts[2]. Further, the closure of schools disproportionately places childcare responsibility on women, thus impacting their work and economic opportunities[2]. Importantly, the reduced provision of sexual and reproductive healthcare for women - combined with decreased financial capabilities during crises to access contraceptives - will have disastrous consequences in the months to come, including rises in maternal morbidity and mortality[3].

Global organizations such as the United Nations have warned from previous infectious disease outbreaks - such as Ebola and Zika - that specific policies must be put in place to actively combat gender and health inequities[3]. However, no policies specifically addressing gender in the face of the virus exist, and we are already beginning to see the devastating

consequences. Although a necessary attempt to alleviate potential catastrophic spread of the virus, mandatory stay-at-home measures may have deadly impacts. Across the country we are seeing shocking reports of increases in domestic violence rates - a Stats Canada study found that 1 in 10 women reported being very or extremely concerned about violence at home during the pandemic[4], and the Ontario Transition of Interval and Transition Houses - representing over 70 shelters across Ontario - reported over 20% of their shelters are receiving an increase in calls reporting domestic violence[5].

Prior to the pandemic, Indigenous women and girls were already experiencing staggering levels of discrimination and marginalization, which COVID-19 has merely shone a spotlight on. The 2019 National Inquiry into Murdered and Missing Indigenous Women and Girls found Canada guilty of a "persistent and deliberate" gender and race-based genocide[6]. As a result of historic and ongoing human rights abuses and systemic discrimination, Indigenous women and girls are overrepresented in many of the most vulnerable populations during this pandemic, including the homeless and underhoused, those in prison or corrections facilities, children in foster care, and sex workers[6]. As reports of COVID-19 outbreaks in homeless shelters and prisons across the country continue to come out, it is hard to draw the conclusion that COVID-19 is the great equalizer. Indigenous communities, despite being far from the major urban hotspots, have been identified by Dr. Theresa Tam as "among the most vulnerable to COVID-19 due to distances, access to necessary resources, and underlying health conditions"[7]. Health Canada identified these same risk factors 17 years ago during the SARS outbreak, and again in 2009 with H1N1, where we saw similar trends of Indigenous communities being hit the hardest[8,9]. Although Canada has approved a $305 million Indigenous Community Support Fund for COVID-19, the funding does not address the specific needs of Indigenous women or the ongoing genocide (10).

The Canadian government has taken commendable steps to create a network of supports for our population. Notably, the Canada Emergency Response Benefit (CERB) program was designed to help residents facing unemployment due to COVID-19. However, for individuals facing precarious work, this program is inhibitory.

Many workers who do not feel safe filing their taxes don't qualify. For example, this scenario directly applies to female sex workers and victims of human trafficking, who feel they have been left out of Canada's COVID-19 response. Some sex workers have completely lost their source of income, and are now forced into dangerous positions to provide for their families.

Importantly, Women and Gender Equality Canada received $40 million to support the women being hit hardest by COVID-19[11]. Moving forward, it is imperative that the Canadian government work with community organizations to develop appropriate systems-based approaches to actively combat ongoing discrimination and support the invisible women of our societies. If COVID-19 does not discriminate, we need to ensure our policies reflect that.

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The COVID-19 pandemic has caused stress and uncertainty for all Canadians and has hit physicians hard. For those working with or near COVID-19 patients, there's the worry about getting sick or passing the virus to their families. For others, there's the reduced practice hours and loss of income because of physical distancing. And to top it off, there was the precipitous drop in the markets.

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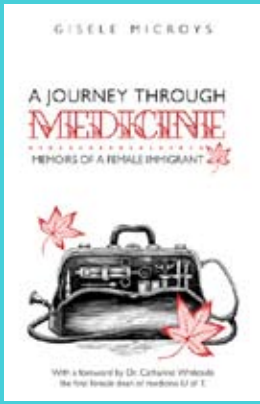
* MD Advisor refers to an MD Management Limited Financial Consultant or Investment Advisor (in Quebec).

[1] As of May 13, 2020.



A JOURNEY THROUGH MEDICINE

MEMOIRS OF A FEMALE IMMIGRANT

by Dr. Gisele Microys
Book review submitted by Sunjeet Brar

A narrative that begins during her early years in Germany, Dr. Gisele Microys leaves school at a young age to enter an apprenticeship as a seamstress. Through determination, hard work, and self-awareness, she earns a place as a pre-medical student in Canada (one of very few women admitted in 1957) and goes on to complete her medical degree at the University of Toronto. Dr. Gisele Microys' advocacy and contributions to physician mental health make her a pioneer in her field. Her work in creating the Physician Telephone Helpline in Ontario and in establishing the Canadian Physician Health Network during her time in Alberta has profoundly destigmatized mental illness amongst health care providers in medicine. She recognizes that being a physician is rewarding, yet due to demanding training and practice standards, the added stress and challenges pose a risk of personal and professional burnout and dissatisfaction. Recognizing the range of obstacles that physicians face, her advocacy creates a pathway of meaningful and shared responsibilities in improving the overall well-being of physicians.

Her captivating writing style paints a vivid picture of her life, and her attention to detail elicits intriguing insights that make this book an influential read. Her memoir offers an honest account of what life was like for a female physician pioneer. Dr. Microys works hard to redefine physician roles in the medical field, and she emphasizes the importance of diversity in medicine. She demonstrates her resilience in many ways, and her commitment to creating a path for more women in medicine through mentorship is well received.

Dr Microys draws on her personal experiences and shares memorable anecdotes from her professional life; this is an inspirational book filled with wisdom. Her well-deserved success as a family physician has everything to do with her commitment to her patients and the supportive relationships she builds with her colleagues. She is a wonderful example of what it means to be an immigrant, a physician, a wife, and a mother. On behalf of the FMWC Vancouver book club, thank you, Dr. Microys, for allowing us to share in your journey through medicine.

Fentanyl Crisis in BC

by Charrissa Patricelli, MD, CCFP, DABAM

The perinatal substance-using population may be one of the most stigmatized groups of people. Yes, women who are pregnant use drugs. The courage and resiliency of these women is humbling. They seek help to recover, the opportunity to safely give birth, and to parent their children. Our lives are touched with grace to be able to serve them. Sometimes the many impacts of poverty, lack of food and safety, as well as the fentanyl crisis is too much. Not all survive trying to navigate these issues. The fentanyl crisis, after all, exists and persists and we don't know when it will end. Why have we not decided to end it?

When the COVID-19 pandemic was declared just over 3 months ago, a wave of urgency and emergency operations took command. The rallying and streamlining of information, funds and big decisions occurred quickly and without hesitation, for it was a matter of life and death. Nationally we closed borders and restricted visitors. Locally, provinces closed all but essential businesses, and postponed all but essential medical procedures. Here in British Columbia, 30,000 surgeries were postponed. The leadership of our province's Chief Public Health Officer, Dr. Bonnie Henry, and Minister of Health Adrian Dix has been outstanding in managing and leading this response in order to mitigate the risk of transmission.

The risk of COVID-19 is not over; we continue to see mounting effects and high daily rates across the US and other areas of the world. Over the last 6 months the world has seen 10 million cases and 500,000 deaths. Social distancing has saved lives from this pandemic.

While the COVID-19 public health crisis continues to be front of mind across Canada, what about our first and ongoing public health emergency, the opioid crisis? 2020 marks the fourth anniversary of the declaration of a public health emergency to respond to the opioid crisis in British Columbia. Between January, 2016 and December, 2019 opioids have taken over 15,000 lives in Canada. We are still in the opioid crisis and the effects of the pandemic on the fentanyl crisis are severe. Fentanyl is a synthetic opioid approximately 100 times more potent than morphine. While the total COVID-19 deaths in BC equal 174, the province recorded 170 overdose deaths in May of this year

alone. This represented the highest number of overdoses in a single month yet.

Social isolation has also driven up the death toll in our first state of emergency. This has led many government and community organizations to take action to mitigate harm for our most vulnerable. What is the risk of overdose with isolation? How many more lives will be impacted by the impact of COVID-19 on the fentanyl crisis? Several months before the pandemic, the street drug supply became increasingly unsafe with carfentanyl and methamphetamines.

The ability of people who use drugs to safely access their drug source during COVID-19 restrictions increased the level of violence for women as well as increased the risk and cost of obtaining substances. On March 26, 2020, Judy Darcy, BC's Minister of Mental Health and Addictions, announced "safe supply", or access to prescription medications such as hydromorphone and Dexedrine for people who use drugs.

Make no mistake, "safe supply" is a rear-guard action to mitigate harm. If anything has become clear, it is that we need a full national action plan on the opioid crisis. While it is a declared public health emergency in BC, the crisis is present throughout Canada in varying forms.

We have the capacity to treat the opioid crisis with full emergency operations and to pull together the many leaders we need to take charge of the opioid crisis, just as we have with the COVID-19 Pandemic. This affects all of us, all communities and disciplines (forensics psychiatry, law, nursing, medicine, public health, housing, etc..). This generation and the next need us to step up the game. We can do this. Will we?

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In Memoriam

Since our last publication, we lost two stalwarts of our organization and the medical profession in Canada.

DR. CAROLE GUZMAN:

1933-2020

The photographs of our Past Presidents used to hang outside the Boardrooms of both the OMA and the CMA. Very few physicians have been President of both organizations, and only two women have done so. Carole Guzman was one of them. She was also a Past President of the FMWC.

After a long and illustrious career in clinical, administrative, leadership and community practice, Dr. Carole Guzman passed away in Ottawa on March 21, 2020. I wish to take this opportunity to share some reflections on my past interactions with her.

Carole remained very approachable, despite all her awards and accomplishments. Whenever we crossed paths she was always interested in my ongoing activities and my future plans. Happy to discuss career issues, she never told me what to do, but would clarify with a few pertinent questions, then ask: "Do you think you will have regrets if you don't do this?" Problem solved!

I recall being seated at her table for dinner one evening at the CMA's General Council when she discovered that I was going to present my first ever motion at GC. She asked me about the content, provided significant encouragement and gave me a quick "how to make an impact" session. Vintage Carole: willing to take the time to coach a rookie.

It is indeed ironic that Canada has lost a leading respirologist at a time in history when a respiratory virus is taking its toll. Although that was not the reason for her leaving us, it will certainly delay our opportunity to celebrate her life. May her memory live on for years to come.

Submitted by
Charmaine Roye, MDCM, FRCSC
FMWC Past President 1998-99

JOANNA MARGARET BATES:

Honorary Member
July 13, 1950 -
January 18, 2020

Dr. Joanna Bates received the Honorary Member Award of the FMWC in 2018; she passed away from ALS in Vancouver on January 18, 2020. She was born in London and grew up in Montreal, where she attended McGill University. She interned at St. Paul's Hospital in Vancouver. After internship she practised family medicine and emergency medicine in Vancouver for some years, then devoted herself to medical education. In academic medicine at the University of British Columbia she established the family practice residency at St. Paul's Hospital. As an associate dean of UBC she created the Aboriginal Admissions Program. She expanded medical education to Prince George and Victoria, B.C. She established and then directed the Centre for Health Education Scholarship. She continued to do research and work in the field of medical education locally, nationally and internationally. She was a model of hard work, intelligence and integrity for all women in medicine.

Joanna loved camping, skiing, swimming, bicycling, travelling and spending time at the family cabin. She is survived by her husband Gary, her two sons Michael and Robbie and their partners Christina and Holly.

A memorial service was held in Vancouver on February 7, 2020.

Submitted by Dr. Patricia Warshawski

FMWC VANCOUVER BRANCH REPORT

By Dr. Patricia Warshawski

The Vancouver Branch hosted a dinner lecture on February 13, 2020, which was Wear Red Day. Dr. Shahin Jaffer spoke on "Her Heart Matters - Understanding and Managing the Gaps in Women's Cardiovascular Health." We had planned to have a retreat at Harrison Hot Springs on May 2nd, but this was postponed because of the pandemic.
We had also hoped to have another mentorship get-together with the students, but this was postponed as well. Dr. Patricelli has put a lot of work into organizing the AGM and conference, which was to be in October in Vancouver. This has been postponed until next year and the Vancouver Branch is looking forward to hosting this.

Student Board Representative Updates

Maria Leis and Meera-Nirusha Mahendiran

On the FMWC side, our much-anticipated "Dr. Parent" panel at the end of March had to be cancelled, but it will be rescheduled once things begin returning to normal. We were able to host a "Human Trafficking Lunch and Learn" in early March in collaboration with Canadian Medical Students Against Human Trafficking; it was a hugely successful event in which medical students learned hands-on harm-reduction strategies for identification of human trafficking victims. Dr. Kadar (a human trafficking expert from Sick Kids), facilitated the discussions and brought a nurse practitioner from the Lotus Clinic (a clinic which serves human trafficking populations) and she did the presentation about the work there at the clinic; they adopted a harm-reduction and patient-centered approach that dispelled a lot of myths about trafficking and gave some practical advice on how students can help identify and support victims.
We also sent out resources ahead of time to the students about the importance of harm-reduction in trafficking populations. We hope to run more of these lunch-and-learns in the future!

Maria also wrote an article for FMWC's June Newsletter with another medical student colleague entitled: "***COVID-19 Does Discriminate, and So Does the Government's Response***." It highlighted the discriminatory nature of the virus using an intersectional lens (with a focus on sex workers and indigenous populations, specifically) and called on our governments to develop policy to address these barriers. Maria has also collaborated with the residents of Ob/Gyn at the University of Toronto to call on the provincial government to call for universal cost coverage of all contraception during this crisis (which they hope to continue after the crisis), and she's founded a national working group across the CFMS (Canadian Federation of Medical Students) to advocate for federal universal contraceptive access during the pandemic.

From the onset of the pandemic in late March, all pre-clerkship and clerkship students at the University of Toronto have been pulled from in-person learning, and online courses have been introduced. In-person clerkship will be resuming on July 6 for Meera (4th year), and mid-September for Maria (3rd year). All learning for our first- and second-year students will be online until at least January 2021.

Dr. Dalia Karol

As far as student group activities, there has not been too much to report in recent weeks. However, since the CARMs residency match, I've been asked to speak on a number of uOttawa interest group organized panels. On these panels I spoke about the positive impact that the FMWC had on my experience in medical school, from both a personal and professional perspective. The values of the FMWC seemed to register with many of the junior medical students who have not yet been exposed to the FMWC, and I am excited to report that many of these students have become members, and have even started joining the various committees!! I also had a very productive conversation about the mission and values of the FMWC with a 1st year medical student in Halifax, who is currently in the process of trying to start a new FMWC branch there. While Covid-19 has had an impact on some of the larger events that we may usually run, the spirit of the FMWC and the values of the FMWC continue to resonate strongly with trainees, and I am so excited by the many conversations I've had with my medical student colleagues who have now become new members of this incredible organization!! On a personal note, I've officially graduated from medical school and am very, very, very excited be starting my residency in obstetrics and gynecology at the University of Toronto in July!

I'm very excited for when we can all reconnect in person again! And excited to now officially be part of the Toronto branch!!

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