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

Winter/ Spring 2022

The Journal of the Federation of Medical Women of Canada

President's Update

Dearest FMWC friends and colleagues,

As we enter the third year of the COVID-19 pandemic, I want to express my deepest gratitude and admiration for your hard work and dedication. Like many of you, I am looking forward to precedented times. Despite harassment and threats directed at physicians and health care workers, surges caused by variants of the virus, and the protests across Canada, FMWC members have continued to look after patients and ensured that the health care system provided care to those who needed it. We have been through a lot over the last two years and many of us still feel emotionally exhausted. Please know that FMWC is both here for you and with you, especially as we navigate our way into a post-pandemic world.

My vision is for FMWC to produce women physicians who will have a positive impact on health care and change the world. This year, each board meeting has been accompanied by a board development session to hone each director's governance skills and knowledge so we can continue to fulfill FMWC's mission. As we near closer to FMWC's 100th anniversary in 2024, we will continue to strengthen our organizational foundation and deliver on the vision that FMWC will be the networking and professional development home for all Canadian women physicians, while being the preeminent advocate for women's health across Canada.

You may have noticed something different with this issue: in recognition of the high quality of published content, the FMWC newsletter has now been renamed the Journal of The Federation of Medical Women of Canada. The new Journal will continue to look to members for submissions to fulfill FMWC's mission to the advancement of women physicians and to promote the health and well-being of women. We want to extend a sincere thanks to Dr. Elissa Cohen, who has stepped down as Chair of the Communications Committee.

She spearheaded the re-naming of the Journal, and her vision of an even more impactful publication continues to motivate us. Make sure you follow the FMWC e-blasts as we revamp the Communications Committee and re-imagine our communications strategy.

On March 8th, 2022, Dr. Stephanie Smith, Region IV Co-Representative, moderated a virtual panel entitled Breaking Barriers and Leading Change in honour of International Women's Day. Our inspiring panelists were Brigadier General (Retired) Hilary Jaeger, MSc, MD., retired Surgeon General of the Canadian Armed Forces and Dr. Shannon Ruzycki, General Internist & Clinical Assistant Professor, University of Calgary. They shared their stories of leadership and their strategies to empower others.

On February 26, 2022, the FMWC board was honoured to be host the first ever virtual retreat with the boards of the Black Physicians of Canada and Indigenous Physicians Association of Canada. The intent of the retreat was to build organizational relationships, seek out opportunities for collaboration, increase board capacity through strengthening corporate governance knowledge, media skills, advocacy training, and hone our digital intelligence.

Mark your calendars! Led by FMWC President-elect, Dr. Shelley Zieroth, we are optimistically planning for an in-person AGM and Educational Conference on October 1-2, 2022, in beautiful Vancouver B.C. at the Coast Coal Harbour Vancouver Hotel. The theme of the meeting is "Evolving with Confidence" to inspire you as we evolve our post-pandemic lives and careers. Should public health restrictions change for Fall 2022, we will pivot and adapt, but for now, planning for an in-person meeting is a GO. Stay tuned as more meeting information will follow in the coming months.

I will leave you with one of my favourite quotes from English scholar Dame Mary Beard's book *Women & Power: A Manifesto*: "You cannot easily fit women into a structure that is already coded male; you have to change the structure."

Let's get to work.

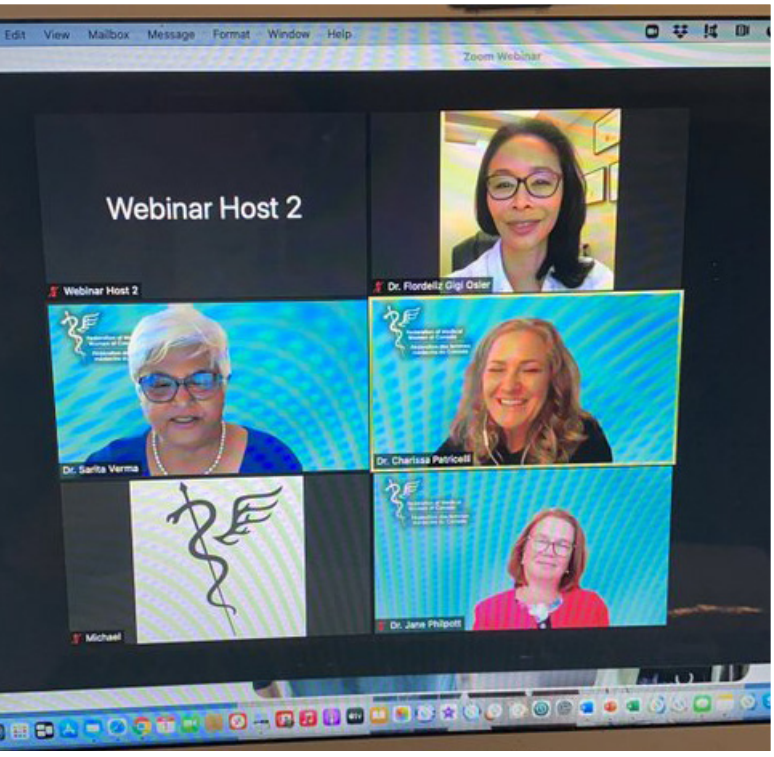
Gigi

AGM REVIEW

A Better Future: the Federation of Medical Women of Canada Virtual AGM & Education Conference in Review

Michael Read, PhD
National Executive Coordinator

When the COVID-19 pandemic was declared back in March 2020, we, like the rest of our peers, quickly decided to cancel our in-person AGM and Educational Conference for the fall of that year. We would still hold a business only annual general meeting over our Zoom account, but the accredited education sessions were cancelled. With so many unknowns about what was to come, it felt simultaneously rash and prudent. History would show it would be the latter.



Fast forward another year when we were deciding what to do for 2021. Many of the same unknowns faced us, the biggest of which was if we could even host an in-person event (itself an unknown) would anyone show up? I often write about how amazing and resilient our members are, but part of resiliency is knowing your limits and respecting them. If we somehow got the Hollywood ending we wanted and beat this virus back by summer, would we want to travel in the fall? Probably not.

Knowing a bit more than the year before, we once again decided to go virtual. This time, however, we would hold a full AGM and accredited educational conference. While this was a first for us, we had observed how our peers pivoted and reached out for lessons learned.

There would be some shortcomings to going virtual. No amount of gamifying can replace the social interaction of bumping into a long-time fellow member in the sponsor hall or at the reception.

The benefits, however, far outweighed the shortcomings. We were able to offer an incredibly deep and diverse program, with concurrent sessions. For those who were unable to attend live or had to choose one session over the other, we would have on demand viewing of the sessions beginning the following day. The sessions were available for registered participants until December 31st.

In all, we had over 150 registered participants and 30 amazing presenters that highlighted the diversity of both our Federation and the medical profession. We also honoured longstanding members for their contributions. None of this would be possible without the leadership of our then President, Dr. Charissa Patricelli, and President-Elect, Dr. Gigi Osler, and the team of volunteers on the planning committee. The company we selected as the virtual platform provider, Unity Event Solutions, was also a dream to work with and made national office's job a lot easier than it could have been.

As great as it is to host a successful event for the first time, we also hope it is one of the last times we host a virtual conference. We want to see you in person again. To that end, planning has begun for our 2022 Annual General Meeting and Educational Conference. We are looking forward to welcoming you to the Coast Coal Harbour in Vancouver, BC, on October 1st and 2nd, 2022. Registration and more details will be coming later in the spring.

MEMBER NEWS

Women of Impact

Congratulations to Federation members **Dr. Ojistoh Horn**, Board of Directors Region III Representative; **Dr. Wendy Normand**, Vancouver Branch member; and **Dr. Gigi Osler**, FMWC President; on their selection as one of 100 inductees to the Government of Canada's Women of Impact in Canada gallery.

Dr. Ojistoh Horn

These distinguished members join FMWC members **Dr. May Cohen**, Past President (1990-1991) and **Dr. Roberta Bondar**, Member and the first Canadian Woman in space. The Women of Impact in Canada is an online gallery celebrating women who have made significant contributions in five fields: Arts, Human Rights, Politics, STEM (Science, Technology, Engineering and Math), or as the first in their fields as trailblazers. As academics, activists, artists, politicians, business leaders, and various innovators, women have helped shape Canada into a thriving, diverse and prosperous country through their desire to make a difference.

Click here to view the gallery

International Women's Day

On March 8th, 2022, **Dr. Stephanie Smith**, Region IV Co-Representative, moderated a virtual panel entitled Breaking Barriers and Leading Change in honour of International Women's Day. Our inspiring panelists were **Brigadier General (Retired) Hilary Jaeger, MSc, MD**., retired Surgeon General of the Canadian Armed Forces and **Dr. Shannon Ruzycki**,

General Internist & Clinical Assistant Professor, University of Calgary. They shared their stories of leadership and their strategies to empower others.

Dr Hilary Jaeger is a former Surgeon General of the Canadian Armed Forces and National Medical Officer of Veterans Affairs Canada. Starting out as a primary care physician, during her 30-year military career she served in many locations across Canada, and overseas in Germany, Croatia, Bosnia, and Afghanistan. Beyond hands-on care, she developed skills in health system leadership, development of health human resources, management of health-related research, and health policy development as she progressed to increasingly senior levels. Her principal professional interests at present concern the effect of health systems design and health policy decisions on population health outcomes. Until recently, Dr Jaeger was Chair of the Health Technology Expert Review Panel, which develops evidence-based recommendations on the value of selected health interventions. She has volunteered since 2011 with Osteoporosis Canada in various roles, including as Board chair from 2015 to 2017. She holds a BSc in Mathematics from Acadia University; an MD from the University of Toronto; and an MSc in Health Economics, Policy and Management from the London School of Economics.

Brigadier-General (retired) Hilary Jaeger MSc, MD

Dr. Shannon Ruzycki

Shannon Ruzycki is a general internist and clinical assistant professor at the University of Calgary. She has a Masters in Public Health from Johns Hopkins and her research focus is in equity, diversity, and inclusion in the physician workforce and in perioperative quality improvement.

Check out this FMWC member who has been selected by the Canadian Medical Protective Agency (CMPA) Nominating Committee as their proposed candidate to fill a position on CMPA Council scheduled for nomination and election in 2022.

Dr. Jennifer Clara Tang

Jennifer Clara Tang
MD, FRCPC, MHSc (Bioethics), ARCT
Area 5, Division B (Ontario)

"Dr. Jennifer Clara Tang is an emergency physician in Hamilton and a medical educator (assistant clinical professor, McMaster University) in her first 10 years of practice. As an Inquest and Investigating Coroner she has extensive experience working with the justice system and various levels of government.

Dr. Tang is active in health advocacy and has experienced and understands the medico-legal challenges faced by the profession. She brings a unique expertise in bioethics (Masters of Health Sciences (Bioethics)) and a legal lens from her work with Inquests.

Dr. Tang has substantial involvement in policy-making and governance in both the Canadian Medical Association (CMA) and the Ontario Medical Association. Having served on the CMA Ethics Committee, she has been involved in creating CMA policy on topics including the revised modern CMA Code of Ethics.

The CMPA Nominating Committee values Dr. Tang's governance and healthcare system experience, as well as her skills, experience, and diverse perspective that are valuable in fostering the long-term success of the Association."

You can read the report of the CMPA Nominating Committee here: https://www.cmpa-acpm.ca/en/about/governance/2022-report-of-the-nominating-committee

MEDICAL WOMEN OF CANADA FOUNDATION UPDATE

Medical Women of Canada Foundation

The Medical Women of Canada Foundation is a registered charity incorporated in 2015, per Canadian Revenue Agency (CRA) guidelines to separate the charitable goals from the advocacy role of the Federation of Medical Women of Canada.

The Medical Women of Canada Foundation manages and administers the Maude Abbott Scholarship Fund (MASF) and the Maude Abbott Research Fund (MARF).

The Awards Committee of the Foundation receives and reviews applications for the awards and recommends the successful applicants to the board of the Foundation which makes the final decision.

The Maude Abbott Scholarship Fund provides educational grants for deserving female medical students. It was started in 1939 as a loan fund and named after Dr. Maude Abbott who was the founding member of the FMWC. Over the years the fund accumulated sufficient income from investments and donations to change it to a scholarship fund. The number of awards depends on the annual investment income and the donations received in each fiscal year. The 2021 recipient was Lolade Shipelou, University of Ottawa.

The Maude Abbott Research Fund was set up as an incentive for practicing female physician members to get involved in clinical research in women's health. As evidenced by the excellent applications received every year. It has generated a great deal of interest. The number of awards is limited by the annual investment income and donations received each fiscal year. The 2021 recipient was Gayathri Naganathan MD, MSc, University of Toronto; Princess Margaret Cancer Centre, Mount Sinai

Health System, and Women's College Hospital, for her project documenting the lived experiences of Black Canadians with breast cancer.

Applications for both awards are available on the awards tab of the FMWC website.

Applications for 2022 are now closed and the successful recipients will be decided shortly. Applications for 2023 are now open.

Fundraising for the awards is our challenge! There are active fundraising events at each FMWC annual meeting, however, since we did not meet in person the past year was a missed opportunity.

We are counting on your direct donations through the DONATE section of the FMWC website and by cheque addressed to the MWCF, c/o the FMWC National Office. Donations to the Foundation are tax deductible and a charitable receipt will be sent to you.

As part of your financial planning please consider a legacy donation to MWCF.

Contact information for ideas for fundraising and other communication: mwcfdn@gmail.com.

Submitted by: Dr. Shajia Khan, Chair, Medical Women of Canada Foundation
Dr. Charmaine Roye, Treasurer, Medical Women of Canada Foundation

"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!

Women's Cardiac and Cerebrovascular Health Advocacy Committee

Members: Drs. Fahreen Dossa, Shahin Jaffer (co-chair), Rajni Nijhawan (co-chair), Varinder Randhawa. Medical students: Kameela Alibhai, Celina DeBiasio, Sweta Jayachandran, Shereen Khattab, Emily Lerhe, Janhavi Patel, Rebecca Seliga

When most people think of heart disease, they don't usually think of women. The prototypical picture in everyone's mind is of a middle-aged man clutching his chest and reaching out, asking someone to call 911 - despite the fact that cardiovascular disease is the #1 killer of women worldwide and the leading cause of hospitalization and premature death for women in Canada. The reasons for this are likely multifactorial, and it is often said that women are 'under-aware, under-diagnosed, under-treated, under-researched, and under-supported' when it comes to cardiovascular disease[1].

The disparity between the cardiovascular health of women and men can be, in part, explained by the disparity in knowledge. Over two thirds of cardiovascular research studies are focused predominantly on men. This is despite the fact that women have many sex-specific risk factors for heart disease, including breast cancer, pregnancy, menopause, and a higher rate of sedentary lifestyle. In fact, some of the traditional risk factors for cardiovascular disease, such as smoking, hypertension, diabetes, obesity, inactivity and depression are even more detrimental in women than men[1].

Women are also less likely to be aware of their symptoms than men: up to 80% of women miss the early signs of heart attack. Many women do present, like men, with chest tightness and pressure during coronary ischemia, but they are also likely to experience symptoms such as nausea, epigastric discomfort, profound fatigue, shortness of breath and jaw or upper back discomfort[2,3]. If a woman does present with any of these symptoms, she is less likely to have a critical diagnostic ECG completed within the recommended timeline. She is also less likely to receive the appropriate drug treatment, to undergo coronary angiography and invasive intervention if required, and to be

discharged on appropriate medications. After a cardiovascular event, Canadian women are less likely to be referred to cardiac rehabilitation, more likely to experience clinical depression, and are ultimately more likely to die within 1 year of the event[4].

These statistics may be "disheartening" however we are working towards improving knowledge and education of women's cardiovascular health. This year, on February 13, 2021, we celebrated Wear Red Canada Day nation-wide. The goal of the campaign is to increase awareness, and to encourage Canadian women to become more involved in managing their own heart health and wellness. The Federation of Medical Women of Canada (FMWC) Women's Cardiac and Cerebrovascular Health (WCCH) committee was heavily involved in promoting the event and spreading the message #HerHeartMatters across Canada.

The group coordinated innovative events spanning from coast to coast. Here are a few of the highlights…

Co-chairs of the WCCH committee, Drs. Shahin Jaffer and Rajni Nijhawan, actively led team members through a variety of endeavours. On January 28, 2021, Dr. Jaffer delivered an engaging presentation entitled, Women's Cardiovascular Health: A Journey Across the Lifespan, to a group of FMWC members. The presentation discussed the inequities and challenges facing women in cardiovascular health, sex and gender-specific risk factors, and advocacy strategies to support improvements. Dr. Jaffer also conducted a radio interview about the increased risk of heart disease and stroke in South Asians and wrote an article in the Vancouver lifestyle magazine, DRISHTI. Dr. Nijhawan alongside Dr. Kelsey McLaughlin, 3 clinical trainees and a community contributor, spearheaded a project to generate a quiz that aimed to improve awareness and education about women's cardiovascular health. The quiz (completed over 750 times) was distributed among 10 Canadian medical schools, to the community through social media and websites and among women with lived experiences with heart disease. Many quiz respondents said that it opened their eyes to the inequities surrounding women's cardiovascular health. In collaboration with the Canadian Women's Heart Health Alliance Advocacy group, East and West regional group members Drs. Varinder Kaur Randhawa and Najah Adreak helped to disseminate Key Messages and Wear Red Canada promotional videos in multiple languages.

Student members of the WCCH committee were also very actively involved in promoting women's CV health. At the University of British-Columbia (UBC), third-year medical student Emily Lerhe

helped set into action proclamations in Victoria and the district of Saanich for Wear Red Canada Day to be recognized on February 13. Lerhe also participated in interviews with local news stations, created social media articles for the Island Medical Program at UBC, and wrote an article for The Weekly, an e-newsletter for Island Health employees at UBC.

At the University of Toronto, first-year medical student Shereen Khattab engaged her peers by creating a Wear Red Canada Day Facebook page to post messages from the Canadian Women's Heart Health Alliance surrounding women's cardiovascular health. Khattab also collaborated with Dr. Nijhawan in creating the aforementioned quiz and sharing it on social media.

At the University of Ottawa (uOttawa), second-year medical students, Sonia Dancey and Kameela Alibhai launched a Wear Red Canada Activity Challenge. They rallied students and community members to track 10k steps per day leading up to Wear Red Canada Day. They also coordinated a group photo of first- and second-year medical students at uOttawa wearing red on February 13 and, with the FMWC Ottawa branch members, created a social media platform to share information and updates related to women's cardiovascular health. uOttawa medical students and WCCH committee members: Céline Sayed, Celina DeBiasio and Rebecca Seliga helped spread the word by sharing the FMWC Ottawa branch activities with classmates, friends and colleagues. Sayed and DeBiasio liaised with FMWC National student representatives to share the online quiz and Seliga further reached out to local radio stations for promotion of #HerHeartMatters and Ottawa's activities.

At Dalhousie University, medical student co-chairs of the Dalhousie Women in Medicine group, Sarah MacDougall and Laura Davidson promoted the event through their group's Facebook page and by contacting class representatives. They also organized a virtual photo collage of students wearing red to show their support.

Lastly, Drs. Randhawa and Jaffer both were part of planning committees and presented on implicit bias and sex and gender gaps in CV research at the 2021 Canadian Cardiovascular Congress in October.

With the highest levels of engagement and participation to date, the 2021 Wear Red Canada Day Campaign was a great success. The event continued to spark important discussions and collaborations between physicians, trainees, allied health professionals, women with lived experience, and the community. It reminded us women to be vigilant, inquisitive, and active participants in our own health. Together we can shed light on the inequities with respect to women's

cardiovascular health and advocate for better recognition, management and research. The WCCH advocacy committee is planning to expand its reach for Wear Red Canada Day by engaging medical students and other health care professionals from Newfoundland and provinces in central Canada. We look forward to seeing what Wear Red Canada Day 2022 brings!

REFERENCES:

1. Ms. Understood Heart & Stroke 2018 Heart Report. Canada; 2018.
2. Lichtman JH, et al. Sex differences in the presentation and perception of symptoms among young patients with myocardial infarction. Circulation. 2018;137(8):781–90.
3. Jaffer S, et al., The Canadian Women's Heart Health Alliance ATLAS on the Epidemiology, Diagnosis, and Management of Cardiovascular Disease in Women—Chapter 2: Scope of the Problem. CJC Open [Internet]. 2021;3(1):1–11. Available from: https://doi.org/10.1016/j.cjco.2020.10.009
4. Norris CM, et al. State of the Science in Women's Cardiovascular Disease: A Canadian Perspective on the Influence of Sex and Gender. J Am Heart Assoc. 2020;9(4).

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

WE'RE LOOKING FOR COMMITTEE CHAIRS!

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

Benefits to support maternity and parental leave

For doctors, it can be difficult to decide on the "right" time to start a family: how will you plan a pregnancy or adoption, take time off with a newborn or newly adopted child, and still care for your patients and career? You may be having these discussions or may have just found out you're expecting.

In either case, you'll be wondering what kind of financial support is available. Here's an overview for both resident and in-practice physicians.

If you're a resident

Employment Insurance benefits: In recognition of the pandemic, there are temporary measures to help Canadians access EI, effective as of September 24, 2021, for one year. You need to have accumulated 420 insured hours of work (down from 600 hours) in the last 52 weeks before the start of your claim or since the start of your last claim, whichever is shorter.

EI maternity and parental benefits cover up to 55% of your pay (up to a set maximum) when you're on leave from work. The maximum payment in 2022 is $638 per week for up to 15 weeks of maternity leave and up to 40 weeks of parental leave. If you choose to extend the parental leave to 69 weeks, the maximum payment is $383 per week.

Residents' association benefits: You may also be entitled to a top-up of your EI benefits through your residents' association. For instance, in Ontario, the PARO-CAHO agreement provides up to 27 weeks of top-up (15 during pregnancy plus 12 parental) for residents who are taking pregnancy and parental leave. Residents who take only parental leave can receive 12 weeks of top-up. The benefit tops your weekly earnings up to 84% (combined with EI) of your regular pay.

Check your residents' association agreement for more information on maternity/parental leave benefits in your province or territory.

If you're an in-practice physician

EI benefits for salaried: If you're a salaried physician, you can receive EI benefits for maternity and parental leave. The eligibility and payment amounts are the same as for residents.

EI benefits for self-employed: In this case, you would need to register for the EI program at least 12 months in advance and pay EI premiums to receive EI special benefits for maternity and parental leave. In 2022, the EI premiums are a maximum of $952.74 per annum ($1.58 in EI premiums for every $100 you earn).

Medical association benefits: Provincial and territorial medical associations across Canada offer programs for physicians taking temporary leave for the birth or adoption of a child. Some treat all physicians equally, while others vary the payout depending on whether you earn fee-for-service payments or salary, or have an alternative arrangement. Keep in mind that benefits may be reduced if you have income from other sources, including from the EI program.

Most medical associations offer benefits for 17 weeks, at an average of $1,000 per week. The New Brunswick association's benefits are the most generous, providing 26 weeks at $2,000 per week. Consult your regional association to find how much you may be eligible for and when you are required to apply.

Talk to an MD Advisor* to learn more about planning for your maternity and/or parental leave.

MD Financial Management

* MD Advisor refers to an MD Management Limited Financial Consultant or Investment Advisor (in Quebec), or an MD Private Investment Counsel Portfolio Manager.

EXPLORING THE "BLACK BOX" SURROUNDING

Female Surgeons' Experiences with Impostor Phenomenon

Jennifer McCall, MD; Afra Mehwish, MA; Jessica Pudwell, MSc, MPH; Zoe Hutchinson, MD; Jamie Pyper, PhD; Romy Nitsch, MD, FRCSC;

Background: Impostor Phenomenon (IP) is defined as a sense of "intellectual phoniness" that persists despite objective evidence of achievement and intelligence (Clance). This sense of intellectual phoniness is accompanied by the fear that one's phoniness will be discovered by others. Sufferers of IP are unable to internalize success, attributing their accomplishments to luck or effort and suspecting they will not be able to repeat their achievement. Over the past decade or so, there has been increasing awareness of IP (colloquially also known as Impostor Syndrome) among physicians and especially among trainees. The prevalence estimates among trainees have been shockingly high, ranging from 32-91.3% (Egwurugwu, Hu, Mascarenhas, Oriel, Villwock).

Though IP is experienced by both men and women, many studies have found a much higher prevalence of IP among women. Oriel found that 41% of women identified as impostor (versus 24% of men) and Villwock found that 49.4% of women suffered from IP compared to just 23.7% of men. While IP has been widely investigated among student populations, very few have been conducted on IP in the workplace, including in health services.

Objectives: This project aims to characterize the extent and nature of Impostor Phenomenon (IP) among female surgeons in Canada. It seeks to identify when IP first affects female surgeons, what the trajectory of IP is over a career, and how IP manifests on female surgeons' professional practices. A compelling aim of this research is to examine the female perspective in surgical practice since surgery is a male-dominated workforce despite the increasing number of women in medicine. Importantly, it looks at the impact of IP on surgical practice and circumstances that might cause a loss of female surgeons from the workplace.

Methods: Female-identified people in Canada who have completed a surgical residency and currently or most recently practiced in Canada were invited to complete an online survey. Distribution was from September 2020 to February 2021 by targeted promotion on social media and direct contact via an email list compiled from professional association and institution directories. The survey consisted of the Clance Impostor Phenomenon Scale (CIPS), several

Likert-scale questions designed by the study investigators, and demographics. CIPS is a cross-culturally validated, internally reliable 20-item scale. A score of greater than 62 on the CIPS represents high impostorism and a score of less than 41 represents low impostorism (Clance).

Results: 387 participants met the inclusion criteria. Median CIPS score was 68 [IQR 53-76], which correlates to high impostorism (Figure 1. Distribution of CIPS scores). 98.7% of participants experienced self-doubt at some point in their career. Experience of self-doubt was reported as often true or very true by 179 (46.3%) of respondents in their academic research and 122 (31.5%) in the operating room (Figure 2. Impact of IP on OR and career). For the majority, onset was before medical school (44.3%), while for others the onset was during medical school (21.8%) or during residency (18.4%). More intense experiences were associated with being early in career (<5 years in practice), worsening feelings of self-doubt, persistent IP, and more self-doubt in each environment.

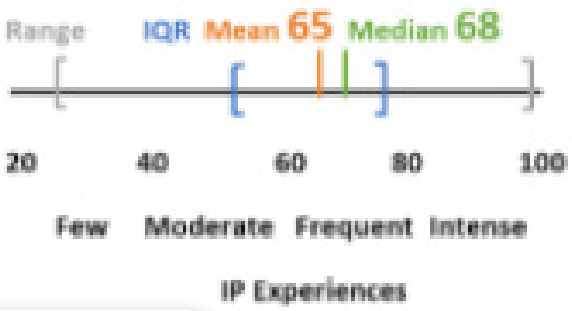


FIGURE 1

Conclusions: IP is experienced by many female surgeons, and they consider IP an influential factor in their professional lives. By understanding how IP affects female surgeons in Canada, this study contributes to scientific knowledge that can advance gender equity in medicine.

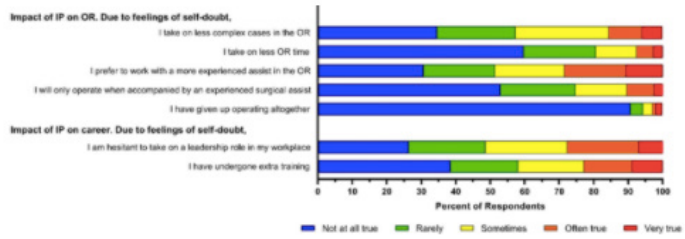


FIGURE 2

REFERENCES:

1. Clance, P. R. (1986). The impostor phenomenon: When success makes you feel like a fake. Bantam Books.
2. Egwurugwu, J.N., Ugwuezumba, P.C., Ohamaeme, M.C., Dike, E.I., Eberendu, I., Egwurugwu, E.N.A., Ohamaeme, R.C., & Egwurugwu U. F. (2018) Relationship between Self-Esteem and Impostor Syndrome among Undergraduate Medical Students in a Nigerian University. International Journal of Brain and Cognitive Sciences, 7(1), 9-16.
3. Hu, K. S., Chibnall, J. T., & Slavin, S. J. (2019). Maladaptive Perfectionism, Impostorism, and Cognitive Distortions: Threats to the Mental Health of Pre-clinical Medical Students. Academic Psychiatry, 1-5.
4. Mascarenhas, V. R., D'Souza, D., & Bicholkar, A. (2018). Prevalence of impostor phenomenon and its association with self-esteem among medical interns in Goa, India. International Journal Of Community Medicine And Public Health, 6(1), 355-359.
5. Oriel, K., Plane, M. B., & Mundt, M. (2004). Family medicine residents and the impostor phenomenon. Family Medicine, 36(4), 248-252.
6. Villwock, J. A., Sobin, L. B., Koester, L. A., & Harris, T. M. (2016). Impostor syndrome and burnout among American medical students: a pilot study. International journal of medical education, 7, 364.

ALLYSHIP AND CONSENT

Dr. Unjali Malhotra
Women's Health Medical Officer,
First Nations Health Authority

I grew up in Prince Albert Saskatchewan, daughter of Drs Lalita and Tilak Malhotra. https://www.gg.ca/en/honours/recipients/146-16147 https://panow.com/2017/07/25/p-a-pediatrician-leaves-legacy-of-patient-care/

Prince Albert and surrounding, has a large Indigenous community and my family has the honor to live lives of service. Prince Albert was a site of a Residential School of which we lived next to the grounds. My parents have offered medical care to the community of P.A. for over 40 years. Beyond incredible medical skill, they offered open hearts, respect and a safe space well beyond the scope of practice.

I aim to be an ally in the best way I can based on their teachings and the learnings of my home community in my work as the Medical Officer, Women's Health First Nations Health Authority (FNHA). I also hope to inspire others to answer the call to allyship and work towards change in our health care system that is meaningful and relevant to Indigenous communities.

One thing I define within allyship is that once a story is told, it is truth. When many like stories are told it is well past time to make any needed changes no matter how challenging that can be.

This is the root of the work we are doing on Consent/Shared Decision Making. Honored partners with FNHA on this work are Senator Yvonne Boyer and Perinatal Services British Columbia.

Knowing the truth has been told time and time again, about coerced sterilization and coercive long acting birth control interventions, we created a Shared Decision making document https://www.fnha.ca/what-we-do/chief-medical-office/informed-consent-for-contraception

It is with great pride that I share this work with you. This is only a start and a seed in ensuring freedom of choice, respect and dignity are offered to Indigenous families.

The creation of this document was with the engagement of dozens of Indigenous and non-Indigenous community members and health care providers throughout Canada. The words and questions are based on community voices.

Some vital areas to note in this work are the assurance of knowing where your patient comes from and where are they going home to? What resources are there? Have they been provided the time and supports that could be needed to make decisions? These questions and answers apply to any consent in medicine.

I now look to you to learn of this work with an open heart and open mind. How can it fit into your work remembering that every person and point of contact impact patients' wellness including the forms we use.

And I put a challenge forward – when you consider the touchpoints of a system – big or small – from the person answering the phone at your office, the spot that could hold a land acknowledgment, the room that could carry local cultural art, the workflow, the forms, the system – can you make any change at all big or small? #Allyship

COERCED STERILIZATION AND INFORMED CONTRACEPTIVE CONSENT

Coming soon: a virtual session with Hon. Senator Yvonne Boyer and Dr. Unjali Malhotra (First Nations Health Authority) on Coerced Sterilization and Informed Contraceptive Consent. They will present background and current states regarding Coerced Sterilization in Canada. They will share a British Columbia's Consent/Shared Decision Making tool for providers to learn about coercion and embed Cultural Safety into contraception consent. Check your FMWC E-blasts for the upcoming date and time!

Hon. Senator Yvonne Boyer

Dr Unjali Malhotra

CMA PRESIDENT-ELECT
2022 CANDIDATE SPOTLIGHT

In 2023-2024, the President of the Canadian Medical Association will be from the province of British Columbia. While the Federation remains neutral to the outcome, to encourage interest in the race amongst our members, the Federation reached out to the candidates and asked them for a bio, their letter of intent to run and the following questions:

Organizations are increasingly reflecting on Equity, Diversity, and Inclusion (EDI) considerations. How would you identify and address barriers to improve EDI and achieve better representation from marginalized groups throughout the Canadian Medical Association (CMA)? In Canadian healthcare?

What are your thoughts on climate change being identified as the single biggest health threat facing humanity? In recent years, the CMA has seen a resurgence in its discussions about issues that matter to physicians, and has successfully advocated and lobbied for important matters, particularly changing the criminal code to criminalize harassment of health workers. Why do you believe you are the best candidate to carry that torch forward as the face and voice of the CMA?

Their submissions follow in Alphabetical Order

DR. EVAN TLESLA II ADAMS

Dr. Evan Tlesla II Adams is from the Tla'amin First Nation near Powell River, BC, and is currently working as the Deputy Chief Medical Officer of Public

Health at Indigenous Services Canada. Before joining ISC, Dr. Adams served as the Chief Medical Officer at the First Nations Health Authority in BC. He was also the first-ever Aboriginal Health Physician Advisor in the Office of the Provincial Health Officer in BC from 2007-2012 followed by the role of Deputy Provincial Health Officer from 2012-2014. Evan completed an MD at the University of Calgary, an Aboriginal Family Practice residency at St Paul's Hospital/UBC (as Chief Resident), and a Master of Public Health from Johns Hopkins University (2009). Dr. Adams served as President of the Indigenous Physicians Association of Canada (IPAC) 2005/06 and is now the Vice-President (2016 to present). Dr. Adams has received numerous awards for his leadership in health care, including the U of C Faculty Of Medicine Alumni Award (2012), Indspire Award for Health (2014) and the CFPC TD Insurance Spotlight on Achievement Award (2019). He also has Honorary Doctorates from Thompson Rivers University (2014), Simon Fraser University (2016), Vancouver Island University (2021) and Adler University (2021). Dr. Adams has led or participated in various high-level committees and working groups including the BC Medical Association Aboriginal Health Committee (2004 to 2008), Dean's Task Force on MD Undergraduate Curriculum Renewal at UBC (2009 to 2010), Board Member of Canadian Partnership Against Cancer (2011-2014), Expert Group on the Potential Canadian Healthcare and Biomedical Roles for Deep Space Human Spaceflight at the Canadian Space Agency (2017-2019), GP First Nations Representative Assembly Delegate for Doctors of BC (2017-2019), National Consortium for Indigenous Medical Education, co-chair of the Anti-Racism Working Group, Powell River Division of Family Practice Board, and the Equity Diversity & Inclusion Advisory Group of the Canadian Association of Emergency Physicians. For over 15 years, Dr. Adams has also been involved at various levels in Indigenous health research including several successful Canadian Institutes of Health Research (CIHR) grants as Principal Investigator. He has also co-authored several academic journal articles & various publications. Dr. Adams also took on numerous roles in movies and television over his career. He won a 2011 Gemini Award for co-hosting the National Aboriginal Achievement Awards. But he is best known for his iconic role as Thomas Builds-The-Fire in the movie Smoke Signals.

Letter of Intent

Honest - Leadership - Equity - Fresh Perspective

Twenty-one months into the worldwide pandemic, many of us have stepped up at great cost to ourselves to protect the Canadian public. We are tired. But the pandemic has also presented a rare window of opportunity to reflect, reimagine, and open discussions on resetting physician workplaces, physician

culture and systemic issues to address workload and wellness. I am committed to supporting connection and relationship with one another and with stakeholders, looking within so that we can begin healing and holding one another up. By empowering physicians-as-leaders, we can initiate the transformation needed to address burnout, system burdens and long-term stressors.

Equity, Diversity and Inclusion (EDI) are core to our future as an Association and as a profession. We are diverse. We need to draw on our existing EDI leaders and champions, broaden engagement and opportunities for learning in creative and less traditional ways, and create platforms for sharing stories and lived experiences related to the width and breadth of our patients and colleagues I so that we can create a movement for change.

CMA is well-positioned as a catalyst, enabler, influencer and convener to advance Reconciliation - specifically, to address anti-Indigenous racism and advance cultural safety and humility in the health system. As discussed in the In Plain Sight Report, while those who experience racism in health care must be intimately involved in developing solutions, much of the responsibility of this work lies with us. The CMA can lead change through shifting the culture of medicine and front line care, enabling strong leadership and strategic planning, and championing advocacy within the larger health care system.

As an Indigenous lifelong learner, learning from Knowledge Keepers and medical teachers is part of who we are. Mentorship is incredibly important to me. I aim to advance ways to connect mentors and mentees for accessible, on-going support, guidance and advice, especially throughout medical school and during career transitions.

I will lead in a good way, with humility and an open heart.

Q1. Equity, Diversity and Inclusion (EDI) are core to our future as an Association and as a profession. We are diverse. We need to draw on our existing EDI leaders and champions, broaden engagement and opportunities for learning in creative and less traditional ways, and create platforms for sharing stories and lived experiences related to the width and breadth of our patients and colleagues so that we can create a movement for change. CMA is well-positioned as a catalyst, enabler, influencer and convener to advance Reconciliation - specifically, to address anti-Indigenous racism and advance cultural safety and humility in the health system. As discussed in the In Plain Sight Report, while those who experience racism in health care must be intimately involved in developing solutions, much of the responsibility of this work lies with all of us in healthcare. The CMA can lead change through shifting the culture of medicine and front line care, enabling strong leadership and strategic planning, and championing advocacy within the

larger health care system. The CPSBC is looking at an Indigenous Practice Standard - we might consider a strong stance like that.

Q2. As a First Nations man who grew up on the land, in his own territory, it has always been clear to me that if we can save someone from cancer, but then return them to a land of destitution, have we really done our best? One of the CMA's Strategic Priority Initiatives includes creating a net zero emissions health system. Healthcare's climate footprint accounts for nearly 5%of global net emissions and harms public health. Physicians have an important role to play in climate change and the health of our lands and waters: we are often in leadership positions - and even when we are not, we are often the highest trained person in the room. That's influence. And responsibility. We should be champions of change, innovation, and embracing larger ideas like equity of service, equity of outcomes, the social determinants of health, and doing the knowledge translation of "the health of the land is the health of the people".

Q3. I have been working in public health and system transformation for 15 years. I have championed Indigenous people's health at a health authority, provincial and federal level. I am accustomed to this level of work, and its style of influence, advocacy, policy development, and relationships with stakeholders. I have extensive experience listening to primary stakeholders, responding to their concerns (in the moment, and over months of work), and enabling the 3 parcels of work: commitments, emergencies, and core sensible work. Our workforce has just saved the day and our workplaces need to evolve their structures to support new realities. COVID has changed how we work; where we work must change too. At its worst, our workplaces were toxic, bureaucratic & slow to change. At its best, our workplace can embrace change, nurture its workforce, and even be an exemplar of compassion and clinical excellence better than we can currently imagine

DR. WILLIAM J. CUNNINGHAM

Who am I? :

i) Values: Equity, Kindness, Courage.

ii) The Health Care system I want to see: "Excellent care for everyone, everywhere, every time."
iii) My style: Observe, Listen, engage others/develop coalitions and make change happen. Work hard, persevere. I don't just talk about it, I do it.

My training for the position of President Elect of the CMA:

1. Academic:
   - B.Sc. UBC Honours Biochemistry
   - MD.CM. McGill University
   - Rotating Internship Royal Jubilee Hospital
   - CCFP
   - CCFP(EM)
   - CCPE (Canadian Certified Physician Executive): Many courses and years of practice
   - Sauder Business School (UBC) Physician Leadership Program
   - UBC Appointment: Clinical Associate Professor (founding member of Dep of EM)

2. Clinical:
   - Rural: Whitehorse, Yukon. Community Full Service FP (FSFP), in patient MRP, EM at . Whitehorse GH, Maternity, LTC, First Nations Community Carmacks, Medevacs
   - Semi rural: Duncan. FP and then mostly EM at Cowichan District Hospital.
   - Urban FSP in Langford and then FSP in Rock Bay (Inner city on FFS).
   - Urban EM at SPH (Saanich Peninsula Hospital)

3. Leadership:
   - CMA Board of Directors (past)
   - Canadian Medical Foundation Trustee (past)
   - President of the BCMA/Doctors of BC (2013/2014)
   - BCMA Secretary Treasurer, Chair of General Assembly and Past President.
   - Delegate to CMA General Council (many years).
   - BCMA/Doctors of BC Board, many years (past)
   - SSPS Council Rep.
   - Section of EM, Executive and Economics Rep.
   - Chair of APPIC and Member of the SNC
   - Medical Services Commission member
   - Department Head Primary Care Island Health (current)
   - HAMAC Member, Chair of Department Heads Council etc. (current)
   - Medical Director Urban Victoria Community and Primary Care (current) &
   - CSC (Collaborative Services Committee) member and core to PCN.

- Re-inventing Primary Care in Victoria including Team Based Care
- COVID Leader, in beginning "Voice of Primary and Community Care."

4. Awards/Rewards:
   - Great satisfaction in being able to make things better and leaving things in a better state, especially for others by removing barriers and creating opportunities in organizations so that there is more equity and diversity.
   - Being part of re-inventing Primary Care, the kind of forgotten part of the Health Care system and moving BC into a new era of doing different and Team Based Care.
   - Being allowed to be an Ally with Indigenous leaders to fix what our colonial system broke recognizing the harm we have done and our responsibility.
   - Being the dad of 3 happy and successful children Richard 25, David 22 and Elizabeth 17.
   - Being recognized by my peers: Winner of the rarely given out Dr. David Haughton Leadership award "Recognizing the exemplary achievements as a Physician, Leader and Teacher in the Section of EM of the Doctors of BC.

Letter of Intent

The election for a President-Elect of the CMA, presents a unique opportunity for 12,000 BC Physicians, both Specialists and Family Physicians, both Rural and Urban, both Community and Hospital-based, to send a BC informed voice to the CMA.

The position is not only about being the voice of Canada's 80,000+ physicians, as the spokesperson for the CMA, but it also an opportunity to influence health care in Canada from a BC perspective, through the CMA. We need to embrace the opportunity and the privilege. Knowing how to influence counts. As a Past President of the BCMA/Doctors of BC (2013/2014) and CMA and BCMA Board member, numerous committees, SGP/ BCFP and SSPS member, and now also a Department Head and Medical Director, I understand influence and advocacy. I am an experienced leader, who doesn't just talk about things but brings about real change. Let us not waste the opportunity.

The opportunity is only 3 years long, so we should send the individual who has the track record of having brought about significant and long-lasting positive change many times. A leader who listens and observes, feels/experiences the system (as an Emergency Physician and FP, rural and urban), a leader who knows how to develop the coalitions and push through, persevering, to make real change happen.

It is difficult to represent if one has not experienced and felt what those physicians that one represents feel.

My career journey has given me those experiences. I have also had the privilege in being an ally to groups not as privileged as I am and spent my career moving barriers to equity, creating a voice for the voiceless. My leadership journey has trained me well.

I try to live my values of equity, kindness, and courage. I don't just talk, I do.

As President-Elect and then President and Past President, I would focus on three priorities:

The Human Resource Crisis. It occurs in specialties, but it is worst in Primary Care. It creates moral distress in Family Physicians and Specialists alike and harms patients and their health and wellness. Fix that, and it is very fixable in short order and we can get to happy (or at least happier) physicians and happy patients.

Indigenous Health. Let us listen to Indigenous peoples. Let us be allies and act. First, we need to recognize the harm caused by settler peoples and colonialism on the health and wellness of indigenous peoples. As Physicians we then need to work to surface the truth, recognize our collective responsibility, participate in healing and reconciliation, and address systemic racism, to ensure that indigenous people can receive equitable and culturally safe health and wellness care. As an organization, we need to be a champion ally. Listen, hear and act.

COVID Recovery. Let us learn from the COVID pandemic. Let us come back better. Yes, let is continue managing the experience and Long term effects and yet not forget the opioid crisis made worse by COVID and the increased suicides. Let us not forget the consequences of delayed care. Just as, or even more important, are the inequities that became so obvious in our society and our health care system and fix them. The spotlight is on the harm done to Indigenous and racialized/BIPOC Canadians, the elderly, women, and girls, now let us stop just talking and act.

Climate change is a Health Emergency. Health care contributes significantly to Green House Gas (GHG) emissions which are associated with preventable harms. The impacts of environmental changes exacerbate health and wellness inequities. We need to transition to a low-carbon, sustainable, resilient health care system. The greening of hospitals and medical practice is in our control. Canada's Physicians can make a difference, not only individually, but also collectively.

There are many more issues and I work on other initiatives as well, but let us focus and be successful.

All of this can be done with the right physician leader, the right CMA President-Elect, who is experienced and focused and knows how to harness the knowledge and wisdom of 12,000 BC Physicians, and knows how to work with others to

bring about real and meaningful and lasting change, as the voice of 80,000 Canadian Physicians.

That is my intention. That is my promise.

Q1 I am a settler on the unceded territories of the Songhees and Esquimalt First Nations. Canada has millions of settlers. I believe in "excellent care for everyone, everywhere, every time," seen through the lens of my values of "equity, kindness and courage." To achieve this we need to focus on the care of First Nations, Metis and Inuit peoples. We need to listen and then follow and make reality, the recommendations as articulated, as an example, in the "In Plain Sight" document. Also we need to embrace "Equity, Diversity and Inclusion" and enable that in who practices health care and who leads it. As Doctors of BC President I led and achieved, with profound effect in BC, the essential tool of how nominations to all committees are made and changed how voting was done, leveling the playing field and with others, put Medical Students and Residents on all Committees. Leadership of Primary Care in my area, as I know as the Department Head, is now majority female and I am working on removing financial barriers to participation, as well as supporting the creation of a policy on "Medical Staff Pregnancy and Parenthood." Canadians need to see themselves in leaders as we have in the Public Health and topic Experts Leadership during COVID. That is something to celebrate.

Q2. Climate change is the greatest single health threat facing humanity. Period. It is an Emergency now. Even worse, it exacerbates health inequities. Physicians can create massive change with the tip of their pen and prescribe and make "Greening of Health Care" wise choices in all facets of care. We need to transition very quickly to a sustainable, resilient, low carbon health care system. Metered Dose Inhalants, by themselves, contribute 3.5% of GHG in health care! It is a privilege to be involved in changing BCs Guidelines for Asthma and COPD, support changing the provincial formulary, re-write order sets with a green lens, and advocate for formal supportive "Greening of Health Care" leadership structures. We can do this as individuals and even better together. We can to this now.

Q3 The face and voice of Canada's over 80,000 Physicians, as represented by the CMA, needs to be someone who is genuine and can speak with passion on what is important to Canadians and Canada's Physicians. I am an experienced, visionary, creative and courageous leader, who listens, creates alliances and has a record of bringing about transformational change. As an Emergency Physician and Family Physician, I have practiced in remote and rural, suburban and city and community and hospital. I understand the diverse perspectives. I see and feel how our system works in my clinical practice and affects all specialties, including Family Practice, and where the opportunities for improvement lie. As a Medical Leader,

who believes that organizations need to be relevant and accountable to members, I have participated at many representative levels including national, provincial, in my society and section and in my Health Authority and community. I have been trained and have honed the craft, through real lived experience. I am ready to serve and be CMA President Elect.

For more info: drwilliamcunningham.com
Twitter: @williamcunninghamMD

DR. SANJIV KARAMCHAND GANDHI

Sanjiv K. Gandhi has been the Chief of Pediatric Cardiovascular and Thoracic Surgery at British Columbia Children's Hospital since July 2010 and is a Clinical Professor of Surgery at the UBC School of Medicine. He is experienced in all aspects of congenital heart surgery, with particular expertise in pediatric electrophysiology, cardiopulmonary transplantation, and mechanical support for pediatric heart failure. Prior to joining BC Children's Hospital, Dr. Gandhi was an Assistant Professor of Surgery at the University of Pittsburgh School of Medicine in Pittsburgh, Pennsylvania from 2001-2004 and an Associate Professor of Surgery at Washington University School of Medicine in Saint Louis, Missouri from 2004-2010.

Dr. Gandhi received his medical degree from McGill University in Montreal. He completed a general surgery residency at St. Louis University School of Medicine, a cardiothoracic surgery research fellowship at Washington University School of Medicine, a cardiothoracic surgery residency at the University of Pittsburgh, a pediatric cardiothoracic surgery fellowship at the Children's Hospital of Pittsburgh, and a pediatric cardiovascular surgery fellowship at the Hospital for Sick Children in Toronto. Dr. Gandhi is certified by the American Board of Surgery, the American College of Surgery, the American Board of Thoracic Surgery, and the Royal College of Physicians and Surgeons of Canada - Cardiac Surgery. Dr. Gandhi is a member of several prestigious clinical societies, including the American Association for Thoracic Surgery, the Congenital Heart Surgeons Society, the Society for Thoracic Surgeons, the International Pediatric Transplant Association, the International Society of Heart and Lung

Transplantation, and the American College of Surgeons.

Dr. Gandhi has been actively involved in numerous local, regional, and national medical organizations throughout his career and has a keen interest in improving the health care delivery system for all patients across Canada.

Letter of Intent

As a Pediatric Cardiothoracic Surgeon, I have spent my career, both in Canada and the United States, caring for some of the most acutely ill children that present to tertiary medical care. Why would I want to assume the role of President of the CMA? Much of my impetus to return to Canada in 2010 was due to the glaring inequities I observed in American healthcare. The altruistic goal of wanting to care for fellow human beings that led most of us to medical school was not fully attained in the US. Socioeconomic status made a huge difference in health care outcomes, not just for advanced therapy like congenital heart surgery but for more basic medical care, like primary, prenatal, and emergency room care. The return to Canada was, in one sense, extremely gratifying. To be again immersed in a system where all members of society had equal access and where the encumbrances of the private insurer were not in play was a pleasure. However, the Canadian system is far from perfect. There are many challenges to offering the best care for patients, challenges created by a system enveloped in bureaucracy, layers of red tape far too thick, and government and hospital leaders and administration that often know little about actual clinical care. Capacity is lacking, ERs are too full, surgical wait times are too long, and the list of problems continues. Most ascribe problems in government-controlled systems to lack of money. However, substantial improvements in the health care system can be accomplished by changes that improve efficiency and hence improve care, without increasing cost but rather decrease cost. Another myth about health care access is that the system requires more doctors. Some super specialists are in high demand but more doctors are not always the answer. We need to think outside of the traditional box of doctors and hospitals. Modern hospitals have evolved into technologically advanced and very expensive institutions, designed for caring for ill patients requiring intense medical, nursing, and other supports. They are terrific places to get treatment for a congenital heart defect or if one is involved in a serious MVA. However, they are not ideal locations for caring for those whose degree of illness can legitimately be managed at home. Many health problems require innovative approaches to assure adequate treatment and monitoring that is focused on the home which could offer better care for patients in a more friendly, familiar environment, provides far less disruption to family dynamics, and provides financial savings to the health care system and strengthens the general economy by minimizing

lost family wages when employment is disrupted by inpatient management of a loved one. Reallocation, rather than addition, of resources, can quickly transform theory into practice. There is tremendous work happening all over the Canadian health care system and much to be proud of. This system is perhaps one of the most cherished social programs of its citizens but major improvements do not require reinvention of the wheel. The vision of the CMA ("achieve a health system that's sustainable, more accessible and patient partnered, a new medical culture... focused on physical and mental well-being, and a society where every individual has equal opportunities to be healthy") aligns perfectly with my observations and goals for the future.

Q1 Identification of disparities in EDI is not difficult; unfortunately, such inequality remains ubiquitous, both in healthcare organizations and in Canadian society at large. Though there has been more recent attention focused on the Indigenous population of Canada and the need for reconciliation, EDI is an issue for many racial minorities, women, and for the LGBTQ community. We will only make progress on these issues by leading the way through both example in the CMA, by encouraging and promoting involvement at every level from marginalized groups, and by active engagement with the Federal and Provincial Ministries of Health, to enact a fundamental change in culture; this is not a simple task but a goal that is imperative to achieve. It is the essence of the Canada, a country characterized by multiculturalism and diversity.

Q2 The mountain of scientific evidence that demonstrates an association between many of the health challenges faced by humanity and the global change in climate is compelling and unequivocal. Most ostensibly, increasingly frequent severe weather events, such as heatwaves, major storms, and floods, all of which we have seen in BC just in the past year, cause direct illness and sometimes death. In addition, these events have secondary consequences such as the disruption of food systems, increases in zoonoses and food-, water- and vector-borne diseases. The argument can be made that climate change directly contributed to the COVID-19 pandemic. In addition, many of the social determinants for good health, such as livelihoods, equality, and access to health care and social support structures are negatively impacted by climate change. Though climate-sensitive health risks disproportionately disadvantage the most vulnerable citizens, climate change has an impact on every human being and changing the trajectory of climate change is paramount to optimizing the health of any population.

Q3 I have spent the past 3 decades immersed in intense clinical care, caring for the most fragile of our patients. Since returning to Canada in 2010, optimizing care and outcomes for my patients has

involved not only the improvement of clinical care but constant negotiation with hospital administrations and government to establish the foundation for excellence. A substantial portion of the administrative side of my job has been lobbying for system improvements at every level, including at the hospital level and at the provincial level. These improvements ultimately benefit those who matter the most – our patients.

With respect to the specific issue of harassment of health care workers, the advent of social media has unfortunately made such attacks easy and all too frequent. The COVID-19 pandemic has obviously magnified this problem. The CMA statement in November 2021 brought focus to this issue and, without tangible legislative action, it threatens to damage the very fabric of Canadian healthcare.

As a long time dedicated clinician, I appreciate the real problems, know the real solutions, and the heart surgeon background is a huge advantage - my mentality has never been one of indecisiveness or wavering, but just to get the job done and get it done right.

DR. JASON KUR

For the past 16 years, Dr. Jason Kur has practiced rheumatology in Vancouver, BC. He is a medical director of the Artus Health Centre in Vancouver, a large, multidisciplinary rheumatology practice in BC. He is a member of the clinical staff of Vancouver General Hospital and a Clinical Associate Professor at the University of British Columbia. For more than 14 years Dr. Kur also provided rheumatology traveling clinic outreach services to Terrace, BC.

Dr. Kur has served as the president of the BC Society of Rheumatologists since 2010. In that role, he has championed multi-disciplinary care, creating a sustainable outpatient nursing model of care in BC that has transformed this sub-specialty of medicine.

Dr. Kur has recently chaired the Canadian Rheumatology Association National Fellows Review Course. He is a member of the BC Specialist Services Committee and a past delegate to the Doctors of BC Representative Assembly. Previously he had served as the President of the Canadian Federation of Medical Students and a student member of the Board of Directors of the Canadian Medical Association.

Dr. Kur is a recent graduate of the UBC Sauder Physician Leadership Program. He was also the recipient of the 2019 Canadian Rheumatology Association Practice Reflection Gold Award as well as the 2019 University of British Columbia Rheumatology Advocacy Award.

Letter of Intent

As a future President of the Canadian Medical Association, I will advocate for improved access to care for Canadians and I will inspire my colleagues to adopt innovative models of care delivery.

My vision for health care strongly resonates with the CMA's Impact 2040 Strategy, which envisions that we must concomitantly address (i) the health of our system, (ii) the health of our physician colleagues, and (iii) the health of our communities. It is only by addressing and being cogniscant of all three of these integral aspects that fundamental improvements can be made.

One important priority for the CMA, in my opinion, is we need to continue to advocate for inclusion, and diversity in medicine. Inclusion in the sense that all members of the profession have the chance and realistic opportunity to participate in the decision-making process. Diversity in terms of a vibrant workforce that reflects more accurately the populations we serve in Canada.

Inclusion and diversity are necessary, in order to promote access to health care, and to produce safe environments for all people in Canada who need to receive care. Through promoting awareness of educational needs around inclusion and diversity, and of the importance of trauma informed practice, this can bring about transformative change. Education, and support from the CMA for members, to strive for ideals, and best practice, based on equity, fairness, human dignity, current research, has the capability to address many issues facing our system.

I hold that we are still in the very early stages of addressing inclusion and diversity in medicine. It is only in the past decade or so, that concerted reflection on the need to bring about change has really come to the fore. We, in 2021, might say that we have finally a much more heightened awareness that we need to provide culturally safe care spaces, for our Indigenous; First Nations, Inuit and Métis Peoples, and for our LGBTQ2S+ communities, and all other Canadians who have faced stigma and racism. But even with this heightened awareness, without real effort and commitment, there can be

regression, all of this dependent on the tides of cultural and political dynamics.

One practical aspect in terms of improving equity, inclusion, and diversity, is in assertive action vis-a-vis health care workers being reflective of the population they serve. Twenty years ago, in our student battle against tuition deregulation, we expressed this idea, that medical students ought to emerge from diverse communities. As students we hoped to ensure equitable access to medical education for all Canadians regardless of socioeconomic and cultural backgrounds. Now, even two decades later, when more awareness has arisen, that principle still must continue to be articulated, in order that what is gained will not be lost, and what is still absent can be gained.

There needs to be ongoing commitment to diversity and inclusion in all aspects of medicine, and ways to do this include ensuring the CMA builds stronger connections with underrepresented groups in medicine.

I commit myself wholeheartedly to work for diversity and inclusion, for the betterment of all my colleagues, and for our evolving system.

Q1. We must strive to identify EDI barriers in Canada. Inclusion in the sense that all members of the profession have a chance and realistic opportunity to participate in the decision-making process.

Diversity must constitute our vibrant workforce and be an accurate reflection of all the populations we serve in Canada.

One practical aspect where equity, inclusion, and diversity, can be improved, is in equitable access to training. Twenty years ago, in our student battle against tuition deregulation, we expressed the idea, that medical students ought to emerge from diverse communities and be reflective of the Canadian context. As students we had hoped to ensure equitable access to medical education for all Canadians regardless of socioeconomic and cultural backgrounds. Now, even two decades later, when more awareness has arisen, that principle still must continue to be articulated, so that what is gained will not be lost, and what is still absent can be gained.

I hold that we are still in the very early stages of addressing inclusion and diversity in medicine. It is only in the past decade or so, that concerted reflection on the need to bring about change has really come to the fore. We, in 2022, might say that we have finally a much more heightened awareness that we need to provide culturally safe care spaces, for our Indigenous; First Nations, Inuit and Métis Peoples, and for our LGBTQ2S+ communities, and all other Canadians who have faced stigma and racism. But even with this heightened awareness, without real effort and commitment, there can be regression. Within the profession, we have seen many examples which

illustrate that significant bias exists; whether that is the gender pay gap in medicine, or recent examples of gender based surgical referral bias.

Education, and support from the CMA for members, to strive for ideals, and best practice, based on equity, fairness, human dignity, and current research, has the capability to address many issues facing our system. We need to support those doing the work in this area and build stronger connections with underrepresented groups in medicine. The focus of the CMA needs to be on the dissemination of these activities, and to take the leap from knowledge to implementation.

Q2. Climate change must be a top priority for the CMA, as it is having profound impacts on the health of our populations. In BC within the past 12 months, we have experienced the heat dome, devastating forest fires, intense smoke, and massive flooding. The environmental impact of these events has led to significant health consequences for our population. From the obvious like medication supply chain interruptions, over 500 tragic and preventable heat related deaths, to more insidious impacts such as the impact of the forest fire smoke on lung health, diminished physical activity and mental health. Not to mention the people who lost their homes and need to recover from such a traumatic event.

Unfortunately, for many Canadians, the link between climate change and health, is not yet to the fore of their minds or self-evident. I believe it is the role of the CMA and its leadership to step forward, and explain these connections more effectively. Only with such efforts, can more effective collective action be taken to lessen the impacts of climate change.

Q3. My range of experience over the past sixteen years in practice has provided me with the capability to represent a wide range of members with diverse interests. As a fee for service community specialist, I appreciate the challenges and autonomy provided by managing a busy rheumatology practice. For most physicians, office-based care delivery is still the backbone of healthcare in Canada. Traveling to remote parts of BC (Terrace) to deliver specialist care to rural and First Nations communities for 15 years has made me aware of the challenges of care delivery outside urban centres. These communities and their providers face immense barriers accessing equitable services.

Through the COVID pandemic I have worked alongside my colleagues caring for hospitalised COVID patients and witnessed the sacrifice made by front-line providers and realised how fragile our hospital system is to the whims of nature. And over the past ten years I have championed a provincial team-based model of care in rheumatology that has transformed clinical practice. On a personal note, I have seen health care through the lens of fertility and surrogacy – the struggles and the barriers of loss, the

power and gift of surrogacy; throughout this process, has had a profound effect on our non-traditional family.

My leadership style is based on listening and consensus. As a profession we must strive to speak with a unified voice that is enriched with views across the profession and country. Stacey Abrams, an American politician, summed it up well, when she said, we must "fight for what we want, and work with what we have". There is much yet to fight for in our healthcare system.

DR. KATHLEEN ROSS

\Dr. Kathleen Ross is a Family Physician in Coquitlam and New Westminster with clinical work in community primary care, obstetrics and surgical assist work, including cardiovascular surgery, at Royal Columbian Hospital. She is a wife and mother of two. She holds a M.Sc. in Pathology and a M.D. from UBC and continues to teach in the UBC Department of Medicine Undergraduate and Postgraduate Programs.

Numerous leadership roles have provided Dr. Ross opportunity to establish healthcare policy and lead grassroots improvement to both community and acute care services, including: Past President of Doctors of BC; Founding member and Chair of the Fraser Northwest Division of Family Practice, RCH Collaborative Services Council, and FNWDFP Shared Care Committee; and President of the RCH Medical Staff.

Dr. Ross is recognized for her interest in advancing technology in front line clinical care. She has served as the Physician Lead and Chair of the Pathways Patient Referral Association from inception to its current state as an irreplaceable online clinical and referral resource directory tool for Physicians in BC and the Yukon.

Volunteerism is important to Dr. Ross. She has twice been recognized by Rotary International District 5050 for her healthcare educational training project work in remote Andean regions of Peru. She is a board member of Rotary World Help and the International Affairs Committee Chair for Rotary Club of Coquitlam. Dr. Ross works to awaken and empower young women and girls to their possibilities via Girl Guides of Canada. In

recognition of long standing community and international service work, Dr. Ross was inducted into the Terry Fox Wall of Fame in Port Coquitlam in 2019.

In pursuit of her commitment to ongoing quality improvement in healthcare, Dr. Ross recently completed the IHI Physician Quality Improvement Certificate Program targeting increased antenatal awareness of fetal movement changes to reduce adverse pregnancy outcomes at RCH.

As a founding member of Doctors of BC Diversity and Inclusion Advisory Group in 2018 and Physician Lead for the RCH Antiracism and Unconcious Bias Working Group in 2021, Dr. Ross remains commited to learning, increasing awareness, education, and ongoing implementation of inclusive, diverse, and antiracism practices in healthcare.

Letter of Intent

The COVID-19 pandemic is fundamentally shifting the delivery of health care in Canada, an unprecedented disruption opportunity. My many interactions with Canadians and all levels of government reveal that we have their attention. The pandemic's exposure of systemic inequalities, deficiencies and racism demands a major shift in our approach to care. The impact of climate change on health can no longer be ignored.

Healthcare Reform: To be most effective and efficient, healthcare should be rooted in the community, guided by nationally established expected standards of care. Our commitment to collaboration and respectful relationships with indigenous people and communities is essential to this reform. Services should be accessible, high-quality and delivered in a culturally safe fashion close to home. Yet, primary care is in critical overload and acute care waitlists are growing. Smart integration between community and acute care, primary and consultant care, and home and residential care will be needed. New models to address the multiple root causes of the primary care crisis and to address the backlog of acute care services will require new investment. I will use my experienced voice to advocate for new resources in primary and community based care infrastructure and enhanced acute care services, including imaging and surgical procedures. Continued development and leveraging of enabling technologies to empower patients, enhance patient care and reduce physician workload is required to address such burdens as: continuity of medical records; information sharing between providers; team based care; virtual support for longitudinal primary care; and real time access to specialty consultation to improve patient care and smooth the patient's journey.

Physician Wellness: The tenuous nature of our healthcare workforce is now highlighted, in particular the systemic and medical culture issues driving burn out and moral distress. Urgently addressing our physical and psychological

safety as we deliver healthcare is long overdue. Together physicians, patients, communities, and governing bodies can proactively define our new Canadian healthcare system and the evolving role of Physicians to optimize use of our skills in a safe environment to the benefit all.

Physician Advocacy and Leadership: CMA's Impact 2040 outlines aspirations for a healthcare system that works better, smarter. Engaging frontline physicians to actively share their real time issues is critical to attaining ongoing system improvements. In my 18 months as Doctors of BC President, I actively captured critical physician voices in understanding, and addressing, evolving systemic barriers and limitations in healthcare delivery. I intend to use my skills to further enhance physician leadership, advocacy, and engagement at all stages of their careers, particularly in residency and early career, our future.

The need for authentic, frontline, grassroots, and experienced perspective in both community and acute care has never been greater. My extensive medical and community leadership and advocacy experience is unique. I have strong skills in engagement and facilitating discussions on key issues, policies, and media. I am a servant leader who has demonstrated the ability to act on behalf of my colleagues to lead meaningful system improvements. I will bring my experience as an inspirational leader, strategic planner and passionate physician advocate to my work as CMA President Elect.

Q1. Making Equity, Diversity, and Inclusion a priority for health care organizations is not just about doing the "right thing" but also about doing the "smart thing".

There have been numerous examples of when homogeneous leadership, with like thinking and predictable behaviours, has resulted in decisions being made that underserve and actually harm the diverse populations we serve as health professionals.

The first step in increasing EDI is to capture new demographic data and properly interpret existing demographic data to better understand where representation gaps exist in leadership. It is understood that there is likely decreased engagement based on gender, ethnicity, Indigenous status, socio-economic status, geographic status, and sexuality. We must capture data on the multiple barriers that exist precluding members from leaning into leadership opportunities, including the balancing of professional responsibilities with personal and family obligations. Capturing data on these barriers will support the development of initiatives to address these barriers. This may include programs to offer support the in the realms of childcare, practice coverage and financial compensation so that leaders can engage

in meaningful participation. Data on gaps in necessary governance and quality improvement knowledge and skills would lead to the development of robust training for resident and new-to-practice physicians. Support for leadership training and multiple avenues for engagement will be necessary to expand the pool of candidates willing and able to step forward and contribute.

Finally, to truly benefit from a diverse membership, we need to be bold and willing to step outside of our comfort zone to build in evidence-based mechanisms to establish diversity in healthcare organizations including medical school admissions, residency programs, health authorities, professional associations, and regulatory authorities. We need to be brave enough to openly identify and name gaps and institute evidence-based policies that allow those gaps to be proactively filled.

Q2. There is no question that climate change is a rapidly increasing risk to our health and healthcare systems. These past few years identified multiple sequential climate related disasters in British Columbia, and across Canada, foreshadowing future events and their health impacts.

Extreme weather events are occurring with rising frequency causing illness and costing lives. British Columbia's heat dome in July 2021 was associated with 740 deaths. Emergency Medical Health Services were overwhelmed and at times people were lined up in the heat outside of emergency departments seeking treatment for the heat. Our healthcare system was not fully prepared.

Rising numbers of forest fires contribute directly to poor air quality, increasing pulmonary and cardiovascular disease, but also increase risk of flooding due to loss of the soils' ability to retain heavy rainfall or melt waters. Urban generation of greenhouse gases, drought, and wind all contribute to increased particulate matter, pollens, and toxins in our air driving down air quality and increasing Asthma, COPD, and heart disease exacerbations. Human and other health care resources will need to adapt and evolve to keep pace with these unprecedented demands.

Flooding of the Sumas Prairie and many other regions in BC resulted in significant damage to agricultural lands that will directly impact crop and livestock capacity in the coming years, threatening food security and driving up costs. These issues are occurring not just in British Columbia, but nationally and internationally.

Mental health impacts housing displacement, lower availability of healthy foods and loss of employment opportunities will worsen overall population health and increase healthcare utilization.

Vulnerable populations, including seniors, children, lower socioeconomic

status, rural, remote, and Indigenous communities, are at greater risk of the impacts of climate change.

Health Authorities, all levels of government, healthcare leaders and patient representatives will need to collaborate on adaptations to our healthcare infrastructure and systems of care to better prepare for increasing extreme weather events and rising incidence of climate change related medical conditions. Our healthcare system has the ability to design and model solutions to lessen the impact we have on the climate. Potential high impact areas could include: updated heating and cooling systems to lessen GHG; supporting more care at home were appropriate; reduced use of single use plastics; increased recycling of reusable materials; increasing green space on our healthcare facility grounds; and reduction in food wastage by improving hospital food services. While these adaptations may take time and resources at the outset, there will be substantial downstream resource savings. The CMA has an important role in sharing the evidence and supporting governing bodies to lead the necessary system adaptations.

Q3. Our most effective leaders are authentic. We see ourselves reflected in their values, beliefs and behaviors. Truly great leaders engage with members, mentor and empower others to invoke meaningful change by becoming part of the process in whatever way they are able contribute.

Throughout my 29 year career I have practised in multiple settings including rural and urban community Family Medicine offices, Obstetrics, and surgical assists in Cardiac Surgery. These varied experiences have broadened my understanding of, and respect for the significant systemic workflow issues that affect primary and secondary patient care in Canada.

I have a long track record in advocating for, and leading, meaningful change in multiple arenas of healthcare delivery. I am able to confidently share the grassroots' perspective and a systems level understanding with all levels of healthcare and political leadership.

I believe in the power of promoting physician leadership and advocacy skills. By successfully leveraging my knowledge and the knowledge and experience of physician colleagues in my various director roles I have encourage professional growth of the next generation of leaders and effective succession planning.

My work leading the development team of Pathways, a clinically based technological solution to improve patient care and physician workflow, has enhanced my capability to identify and leverage new technology to streamline healthcare delivery.

It has been my honour to earn the trust and respect of those I have worked with. I believe that the next CMA President

Elect will need to understand and respect Family Physician and Consultant Specialist perspectives across a range of practice settings, with experience levering new technology and workflow streams, to meet the challenges of our evolving healthcare system. My unique combination of skills and experience will facilitate the necessary work of the CMA over the next 3 years.

The leaders we value most make the time to listen to our voices and perspectives, process and reflect on what they have heard. I can assure you this may mean opening yourself up to harsh criticism or complaints at times, but the process forces us to refocus on someone else's perspective as well as our own unconscious biases. I believe that Humans do better when we find common ground and seek to connect with each other on a deeply personal level.

The most challenging part of this process lies in being willing to truly listening and accept opinions that do not necessarily agree with our own. Leaders need to be able to accept that they do not have all the answers but are willing to listen and adapt.

This is a critical juncture for Canadian physicians, as our ability to lead and guide health care now will impact the wellness of Canadians for many generations.

DR. CAROLINE Y. WANG

Dr. Caroline Wang is a family physician in Richmond and Vancouver, BC since 1986 with extensive leadership positions in organized medicine, community non-profits, and senior administrative experience. After graduating from UBC in1984, she was in full time practice with active staff hospital privileges at Richmond Hospital for over 20 years. In 2014 Dr Wang obtained a Master degree in Public Administration (MPA) from Robert F. Wagner Graduate School of Public Service, New York University, ranked No. 2 in Health Policy by USA Today. Her courses included strategic leadership, non-profit governance, health policy and management, conflict management and negotiations.

Dr. Wang was elected as a director on the BCMA (now DoBC) for ten years (1998-2008) including 9 years as district delegate and one year on the executive as Honorary Secretary Treasurer. She was on the CMA General Council for 5 years (2002-07). She served as President of the Vancouver Medical Association (2000-02), Chair of the Area Medical Advisory Committee, Richmond Health Services (2002-05), and numerous committees on BCMA and Vancouver Coastal Health Authority. Her community leadership roles include as Founding President of Assocation of Chinese Canadian Professionals BC (2000-02), President of the Chinese Canadian Medical Society BC (1996-97), and President of the Federation of Chinese Amercian and Chinese Canadian Medical Societies (2002-03). She is the founding President of the Coalition for Better Health Care Society (2018-).

Dr. Wang was honored with the Primus Inter Pares Award, Vancouver Medical Association (2015) and is a Fellow of the New York Academy of Medicine.

Letter of Intent

After two years of the Covid-19 pandemic pushing the Canadian healthcare system to the brink of collapse, the need for effective physician leadership at the national level to strengthen the voice of the medical profession through physician and patient advocacy has never been greater. My intent in running for the position of CMA President-elect is rooted in my passion to serve and represent all Canadian doctors to support them in practicing good medicine, and promote physician wellness by addressing root causes of burnout after decades of devaluation of our services. The CMA offers an important opportunity to harness the collective wisdom of physician members through grassroots engagement in the co-creation of system-level solutions and health system reforms for better health.

Q1 I believe that diversity, equity, and inclusion are inherent to strengthening the democratic process to represent and engage all physicians to fulfill their highest potential in serving patients and the public. As one of few women physicians in BC and Canada having served in medico-political leadership roles for over two decades, and ten years on the BCMA Board as the only woman of Asian descent, I am encouraged by CMA's strategic priority to enhance the participation of minority and traditionally under-represented groups in physician leadership.

I understand the unique challenges faced by women physicians, having juggled multiple roles as a physician, mother of four children, wife, and daughter of elderly parents. We need to promote effective system-level solutions with fair remuneration, flexible work schedules, reduced administrative burdens, and increased systemic resources and support for all physicians.

A high priority is removing barriers of discrimination and stereotyping based on identity politics. This can be achieved by supporting mentorship with outstanding physician role models for medical learners and physicians throughout all career stages for life-long learning. Together we can transform the culture of medicine to promote excellence, equality of opportunity, and compassion.

Q2 While climate change and their longterm health impacts are important issues for world governments and development of health-in-all policies, the mandate of the CMA is to address the needs and challenges faced by Canadian physicians and empower their voices as advocates for patients to have timely access to safe, effective health services in Canada.

Q3 I believe that my unique learning journey and service over three decades have prepared me for this important role: as a family physician and longtime physician advocate in Vancouver, extensive leadership experience in organized medicine, including ten years as a director on the BCMA board (1998-2008), five years on CMA General Council (2002-07); in senior administration as Chair of the Area Medical Advisory Committee of Richmond Health Services (2002-05); community leadership as founder of several non-profit organizations; academic training in evidence-based health policy, governance, and strategic leadership having earned a Master degree of Public Administration (2014) from New York University, Robert F. Wagner Graduate School of Public Service.

In addition to potential legislative solutions to prevent harassment of health care workers, I support evidence-based policy approaches to identity and address problems and their root causes, to design better incentives and innovative solutions, and fostering collaboration with medical provincial/territorial associations, government and policymakers, academic institutions, and community partners. My goals are to strengthen the foundation of primary care for integrated systems of patient-centered care that enhance quality, value, and sustainability. Some examples of initiatives and opportunities include implementing the recommendations of the OMA Burnout Task Force "Healing the Healers: System-Level Solutions to Physician Burnout", and the Virtual Care Task Force "Virtual Care in Canada: Progress and Potential."

Board of Directors 2021–2022

EXECUTIVES

President
Dr. Gigi Osler

Past President
Dr. Charissa Patricelli

President Elect
Dr. Shelley Zieroth

National Co-Treasurers
Dr. Susan Wilkinson
Dr. Melanie Bedard

Honorary Secretary
Dr. Debra Boyce

MWIA National Coordinator
Dr. Anne Niec

BOARD MEMBERS

National Resident Representative
Dr. Dalia Karol

National Student Representatives
Maria Leis
Abigail Burrows
Celina DeBiasio

FMWC Member At Large
Dr. Mamta Gautam
Dr. Paule Bertholet
Dr. Joelle Thorgrimson

REGIONAL REPRESENTATIVES

Region I – British Columbia & Yukon
Dr. Shahin Jaffer

Region II – Alberta, NWT, Saskatchewan, Manitoba & Nunavut
Dr. Kimberly Williams

Region III – Ontario, Québec
Dr. Ojistoh Horn

Region IV –Atlantic Provinces
Dr. Tanis Adey
Dr. Stephanie Smith

COMMITTEE CHAIRS

Chair of HPV and PAP
Dr. Vivien Brown

Chair of Women, Peace and Security
Dr. Nahid Azad

Chair of Women's Cardiac and Cerebrovascular Health
Dr. Shahin Jaffer
Dr. Rajni Nijhawan

Chair of Gender Based Violence and Family Violence
Dr. Kathee Andrews
Dr. Anne Niec

Chair of Awards
Dr. Debra Boyce

Chair of Education
VACANT

Chair of Communications
VACANT

Chair of Membership
VACANT