



CPSnews

CANADIAN PAEDIATRIC SOCIETY | SPRING • SUMMER 2022

Advocating for changes to child and youth mental health policy

The COVID-19 pandemic exposed cracks in Canada's mental health care system, and governments at all levels have announced increased investments to cope with increased needs. Still, the CPS believes much more is required to meet the needs of children and youth.

The establishment of a Mental Health Task Force in 2017 helped bolster the CPS capacity to advocate for improvements to paediatric mental health policy. During the 2021 election campaign, the CPS called on all parties to:

- Ensure that a full array of publicly funded and evidence-based mental health programs, services and supports are equitably available to all children and youth, when and where they need it;
- Commit \$25 million over five years for the development of stepped care patient-centered clinical practice guidelines, which would support evidence-based mental health care for children and youth;
- Commit \$50 million over five years to fund multidisciplinary educational resources and training programs to increase competencies in paediatric mental health care.

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COVER STORY

Since then, the CPS has continued to press Members of Parliament and other stakeholders and has seen cross-party support for prioritizing mental health.

One positive sign is the creation of a new Minister for Mental Health and Addictions, who is tasked with ensuring that “mental health care is treated as a full and equal part of our universal health care system.” The mandate letter for Minister Carolyn Bennett, who heads this new department, identifies several opportunities for CPS advocacy and impact, including:

- mental health standards, with a particular focus on health equity;
- timely access to perinatal mental health services;

- a three-digit suicide prevention hotline;
- a distinctions-based strategy to meet the needs of First Nations, Inuit and the Métis people;
- mental health supports for children and youth recovering from the impact of the pandemic; and
- a permanent, ongoing Canada Mental Health Transfer to expand the delivery of high-quality, accessible and free mental health services, including prevention and treatment.

Emphasizing the unique needs of children and youth and the importance of ensuring timely and equitable access to mental health care early in life, the CPS is advocating for a dedicated percentage of the mental health transfer funding be earmarked for children and youth.

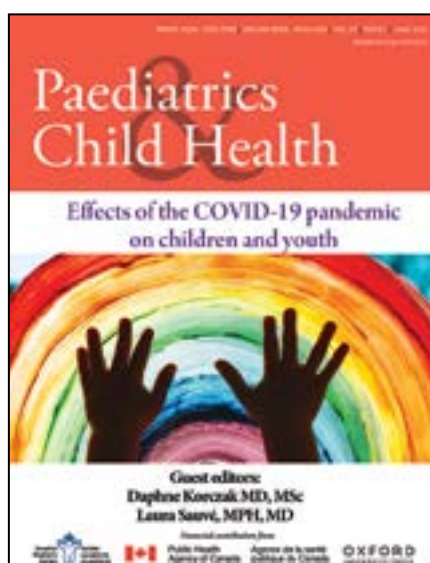
New research sheds light on impact of pandemic on Canadian children and youth

A special online supplement of *Paediatrics & Child Health* contains new insight into the range of effects the pandemic had on children and youth.

The pandemic and associated public health measures have left a major mark on children, youth and their families. Social isolation, school closures, lack of access to activities, friends, family, and health/community services have resulted in a different sort of crisis for children and youth, affecting their mental health, physical health and behaviour.

Featuring new papers from researchers in Canada, this online supplement explores important issues, including mental health, the impact of the pandemic on children and youth with underlying disabilities or other health issues; the relationship between socio-economic factors and COVID-19 hospitalizations; the effects on poisonings in the paediatric emergency department, and more.

“As clinicians and scientists, we have observed the multitude of ways that the pandemic has impacted the lives of children, youth and families,” said Dr. Daphne Korczak, Director of the Children’s Integrated Mood and Body (CLIMB) Depression



Program, and a Child and Adolescent Psychiatrist and Clinician-Scientist in the Department of Psychiatry at SickKids and University of Toronto.

“In this supplement we share some of the excellent work that Canadian child health scientists have been doing to help us understand how children and youth with and without previous health problems have been feeling and managing over the last two years. Their work is critical in informing clinical care, research, and policy initiatives to improve the lives of children and their families.”

This special issue of the journal was guest edited by Dr. Korczak and Dr. Laura Sauvé, Clinical Assistant Professor in the Division of Infectious Diseases at the University of British Columbia.

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To read the supplement visit: <https://academic.oup.com/pch/supplements>

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“Considering each youth’s developmental stage and capacity as well as patient and family needs and circumstances are essential for a successful transition.”

Dr. Alène Toulany

Action is needed to improve transition to adult care for youth with complex health care needs

The process of transitioning youth with complex health care needs to adult care poses unique challenges for all involved.

A recent document released by the Canadian Paediatric Society’s Adolescent Health Committee recommends that parents and caregivers start transition planning as early as possible, to ensure youth with complex health care needs receive continuous care during what can be a vulnerable time.

Because treatment for many childhood conditions has advanced, the number of youth with complex health care needs is increasing. Complex health care needs can include physical, developmental and mental health conditions, as well as medical complexity.

“Despite our vast knowledge of the challenges associated with transition to adult care, we have not made significant advancements to streamline and safeguard care for youth transitioning to adult services,” says Dr. Megan Harrison, an adolescent health physician at CHEO, and co-author of the CPS position statement.

Youth with complex health needs often face poor outcomes when transitioning from paediatric to adult care, due to gaps in access. Poor health outcomes after moving from paediatric to adult care have been documented for youth with type 1 diabetes, cystic fibrosis, congenital heart disease, organ transplants, and other conditions.

As there is no universal, legally-defined age of consent for health care decision-making in Canada, flexibility is critical when it comes to transition planning. Youth should be given increasing levels of responsibility over their health care—at their own pace—as they move through adolescence.

“We need to think outside the box and advocate for more flexible age cut-offs for transfer to adult care,” says Dr. Alène Toulany, an adolescent medicine specialist at The Hospital for Sick Children and co-author of the statement.

“Considering each youth’s developmental stage and capacity as well as patient and family needs and circumstances are essential for a successful transition.”

A successful transition ensures care that is continuous, coordinated, and adapted to each youth’s development and maturity, while improving (or at least maintaining) disease management, patient satisfaction, quality of life, and social participation throughout young adulthood.

Primary care providers are key to ensuring continuous care in the transition process. Specialized transition education and training among primary care providers is critical, as many feel ill-equipped to manage the level of care required for complex needs.

To ensure the well-being of youth with complex care needs, the CPS recommends that health care providers, caregivers and policy-makers support successful health care transitions by:

- Ensuring care is continuous, comprehensive, coordinated, developmentally appropriate and meets the needs of everyone: patients, families and health care providers.
- Preparing youth for transition with a stepwise plan that increases their autonomy, considers their development and capacity and recognizes changing parent and caregiver roles.
- Collaboratively developing strategies between paediatric and adult care providers that streamline and safeguard care for youth transitioning to adult care. Health care providers should advocate in support of integrated care models across tertiary, community, and primary care settings, taking youth-centered approaches.
- Supporting new educational initiatives to increase capacity of care for youth with complex care needs in diverse clinical settings. A collaborative, national approach to education that involves youth, families and paediatric, adult, and primary health care providers is imperative.
- Funding adaptable programs and physician compensation systems that support continuous, shared, and integrated care during the transition period are essential. Models should be flexible regarding age cut-offs and shared care between paediatric and adult health services.



Perhaps now, we have the opportunity and collective will to scale up evidence-based, mental health diagnostic and treatment services. We need to take every opportunity we can to hold government accountable to these commitments.

Improving access to mental health is critical

Mark Feldman, MD, FRCPC, President, Canadian Paediatric Society

Like many of you, I battle each day to find resources for our patients with unmet mental health needs.

Too often, whether a young person has access to the care they need is determined by whether or not their parents or guardians have the means to pay for services. When class barriers intersect with racial barriers, the challenges are only compounded.

Since its founding 100 years ago, the CPS has strived to “*work together to advance the health of children and youth by nurturing excellence in health care, advocacy, education, research and support of its membership*”. Through its efforts in professional education, advocacy, public education, surveillance and research, there is so much for the CPS to be proud of but, still, so much more to do.

In June, I began as the 101st President of the Canadian Paediatric Society, a daunting role with a daunting set of challenges. One of the greatest is the inequitable access to mental health services faced by children across our country.

Canada's pursuit of a universal, publicly funded health care system began in Saskatchewan in 1947 before expanding nationally, initially to become the *Hospital Insurance and Diagnostic Services Act*, a publicly funded system for hospital and diagnostic services. In 1962, Saskatchewan again led by example through the *Saskatchewan Medical Care Insurance Act*, which established cost-sharing of physician services, including outpatient services. This helped to pave the way for a more comprehensive national system. In 1985, the *Canada Health Act* (CHA) was created to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”

Over 30 years have now passed since the CHA's creation and we still have a long ways to go towards truly facilitating “reasonable access to health services” – especially when it comes to mental health. There is hope, though.

The recent Speech from the Throne (November 23, 2021) and subsequent mandate letter (December 16, 2021) to the Minister of

Mental Health and Addictions, Carolyn Bennett, directed her to deliver on commitments which, among others, include:

- permanent transfer of **funding to provinces** to expand delivery of accessible and free mental health services
- investment in mental health interventions and supports for people disproportionately impacted by COVID-19, with a particular focus on Indigenous Peoples, Black Canadians and vulnerable Canadians.

Perhaps now we have the opportunity and collective will to scale up evidence-based, mental health diagnostic and treatment services. We need to take every opportunity we can to hold government accountable to these commitments.

There is more hope.

Changes at the Royal College through the new Competence by Design curriculum for paediatric residency training has placed an intentional focus on mental health care. Moreover, for practicing paediatricians, there has been a growth of continuing professional development opportunities in paediatric mental health care.

COVID-19, virtual care and distance-learning have forced us to find new ways to function as paediatricians. Perhaps now, more than ever, we need to upscale our own mental health care competencies through continuing professional development opportunities. We also need to influence medical learners, and indeed curriculum, to prioritize multidisciplinary training programs and educational resources in paediatric mental health care – recognizing that increasing the quality and accessibility of services will take a broad and collaborative effort.

With all of us pushing, maybe we can open the paediatric mental health care access gates a little bit wider, for entry by children and youth from any postal code and any tax bracket.

I look forward to finding additional strategies, to hearing your ideas, learning from your initiatives and sharing with you more about the CPS's efforts to positively influence equitable access to evidence-based mental health care for children and youth. This will be a top priority for me as CPS president.

From care to share: Looking back on a legacy of paediatric guidance

The Canadian Paediatric Society's centennial is being celebrated this year in big ways and small. One intriguing approach to the CPS story (and the members writing it) is now underway, in the form of an historic look back at early position statements.

The first CPS statement on record was *The epidemiology and prevention of ski injuries*, released in 1968. Based on Canadian Ski Patrol System data and written by the Safety Promotion Committee (later the Injury Prevention Committee), it recommended improving education, enforcement, and operational research. Grounded in best evidence and promoting best practice, this initial statement was a fitting prototype for the hundreds of guidance documents developed and written since.

Active longtime or retired CPS members have been invited to take a retrospective view of defining statements from years past. These mentors have been asked to write short,

personal blog posts reflecting on the differences between then and now.

Representative statements include: *The adolescent mother and her baby* (circa 1978), *Treatment decisions for infants and children* (1986), *Canadian guidelines for antenatal diagnosis of genetic disease* (1974), and *Lead poisoning – Menace or myth?* (1986), to name but a few. They were selected because their content arcs so clearly into present day concerns.

Writers were asked to consider whether there was anything surprising about the statement, to reflect on the state of practice at the time the guidance was published, and what lessons it carries for modern-day practitioners.

The first article to publish was written by Dr. Denis Leduc on the topic of SIDS. Watch the CPS blog for new articles in the series: <https://cps.ca/en/blog-blogue>

Dr. Kent Saylor Bursary for Indigenous Medical Students

In 2021, Healthy Generations established a new initiative, the Kent Saylor Bursary for Indigenous Medical Students. Dr. Saylor is the first Indigenous paediatrician in Canada, and has worked to increase the ability of health professionals to care for Indigenous children and youth in a culturally safe way.

This annual bursary will provide an Indigenous medical student interested in paediatrics with the opportunity to apply for up to \$2,500 in funding. The funding will assist them in exploring and gaining knowledge, and hopefully lead to them choosing paediatrics as a career.

More information regarding the Dr. Kent Saylor Bursary for Indigenous Medical Students can be found on healthygenerations.ca. Healthy Generations will be accepting applications for the bursary in the fall.



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Since 1996, the CPSP has looked at more than 50 conditions and contributed to changes in policy, practice, and outcomes.

25 years of the CPSP: Mobilizing knowledge to improve policy and practice

The Canadian Paediatric Surveillance Program (CPSP) marked 25 years of surveillance and research in 2021. Founded to collect data on childhood disorders low in frequency but high in terms of disability, morbidity, mortality and/or economic costs to society, the CPSP is a joint project of the Public Health Agency of Canada and the CPS.

Since 1996, the CPSP has looked at more than 50 conditions and contributed to changes in policy, practice, and outcomes. Here are some of the highlights from over the years:

Hemorrhagic disease of the newborn: Initiated in 1997 after concerns in Germany, the UK, Sweden, and Australia that oral vitamin K may be associated with increased incidence of late HDNB. Only five cases were confirmed in Canada where intramuscular vitamin K injection is recommended to prevent HDNB.

Necrotizing fasciitis: This 2001-2003 study identified varicella as the most frequent risk factor among patients with group A streptococcal-related NF infection, and supported the addition of varicella to the routine immunization schedule.

Neonatal hyperbilirubinemia (severe): Between 2002-2004, this study identified 258 cases, and led to CPS advocacy that all newborns be evaluated for risk factors of hyperbilirubinemia and for bilirubin to be measured before discharge. A follow-up study (2011-2013) revealed a significant decrease in cases.

Vitamin D-deficiency (VDD) rickets: Between 2002-2004, over 100 cases were identified, supporting the CPS recommendation to supplement exclusively breast-fed children. A 2015 follow-up survey showed that VDD rickets and severe symptomatic VDD remain problematic and are linked to serious health outcomes and even death.

Lap-belt syndrome: Over 2003-2005, there were 28 cases of abdominal or thoracolumbar spine injuries associated with improperly fitted seat belts. Results stimulated provincial/territorial advocacy for proper car seat and booster seat legislation.

Baby walker injuries: This 2005 survey identified 132 children under the age of 18 months with injuries associated with baby walkers, and contributed to the total ban on the sale, import, and advertisement of baby walkers in Canada.

Medium-chain acyl-coenzyme A dehydrogenase deficiency (MCAD): Over 2005-2008, there were 46 cases, and 74% were identified through newborn metabolic screening. Results confirmed the efficacy of newborn metabolic screening for detecting asymptomatic MCAD deficiency and for identifying other asymptomatic cases through family screening.

Childhood tuberculosis (TB): From 2013-2016, 200 cases were identified, with First Nations, Inuit, and non-Canadian-born children most affected. Results informed policy-level decisions, and helped to strengthen interventions for Indigenous and foreign-born children.

Medical assistance in dying (MAID): This 2016 survey found that discussions with, and requests from, parents about MAID outnumbered those from minors by more than 5:1. Many discussions involved infants and/or neonates. Results were shared with the Council of Canadian Academies, providing evidence to inform a Parliamentary report.

Vaping-related injury and illness: This 2019 survey identified 88 vaping-related injuries/illnesses associated with the routine use or malfunctioning of a vaping device or the ingestion of vaping substances, highlighting the need for policy measures to protect youth.

COVID-19: Over 2020-2021, 572 cases hospitalized with confirmed SARS-CoV-2 infection and 405 cases hospitalized with paediatric inflammatory multisystem syndrome [PIMS] were captured. Data provided insight on how COVID-19 and PIMS present, and risk factors for severe disease and outcomes within specific age groups.

For more information, visit cpsp.cps.ca.

BLACK HISTORY MONTH

Throughout Black History Month, the CPS used its social media streams to highlight just some of the many Black paediatricians who have helped shape paediatrics in Canada. In case you missed it, here are a few of the physicians who were featured:



Dr. Kwadwo Asante was one of the first physicians to identify children with Fetal Alcohol Spectrum Disorder in Canada. His work earned him many awards and honours, especially in his home province of British Columbia.



Dr. Natasha Johnson is a leader in adolescent medicine who is also Associate Chair of Equity, Diversity & Inclusion in the Department of Paediatrics at McMaster University. Dr. Johnson is a former member of the CPS Adolescent Health Committee, where she authored and reviewed position statements.



Dr. Sharon Smile is a developmental paediatrician at Holland Bloorview Kids Rehabilitation Hospital and a clinical study investigator in the Bloorview Research Institute. An Assistant Professor in the Department of Paediatrics at the University of Toronto, Dr. Smile is doing innovative work in the area of feeding problems in children with autism spectrum disorder.



Dr. Mark Awuku, longtime chair of the Canadian Paediatric Society Continuing Professional Development Committee, retired from paediatric practice in June after 40 years of serving children and families in Windsor. Dr. Awuku is continuing his work with the CPS as co-chair of the medical education working group of the Antiracism Strategy.



Dr. Jared Bullard is a paediatric infectious diseases specialist at the University of Manitoba and the Children's Hospital in Winnipeg, and is Associate Medical Director of the provincial public health laboratory. He's currently one of the principal investigators on a Canadian Paediatric Surveillance Program study on congenital syphilis.



Dr. Yvette Bonny is a Haitian-born paediatrician-hematologist who made history in 1980 when she performed the first bone marrow transplant on a child in Quebec. From 1980 to 1998, while at Hôpital Maisonneuve-Rosemont in Montreal, she led the province's paediatric bone marrow transplant program.

Lifelong Learning in Paediatrics (LLP) is back!

This fall, join us in person in Niagara-on-the-Lake for a Lifelong Learning in Paediatrics course.

Delegates can engage with leading experts in the fields of **dermatology**, **gastroenterology**, **genetics** and **rheumatology**, learn new approaches and tools, and network with colleagues experiencing similar challenges.

For more information, visit <https://cps.ca/en/llp>

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IN MEMORIAM: DR. RICHARD GOLDBLOOM



Dr. Goldbloom with granddaughter Ellen, a paediatric endocrinologist, and one of 11 great-grandchildren.

He was a pioneer in family-centred care who recognized the importance of parents and caregivers in treatment and healing.

‘He just had that magic about him’

Dr. Richard Goldbloom—a giant in paediatrics whose warmth, humour and generosity earned the admiration of generations of students, colleagues, and families—died in November 2021 at the age of 96.

“He just had that magic about him,” said former student Dr. Andrew Lynk, chief of paediatrics at the IWK Health Centre and chair of pediatrics at Dalhousie University.

Indeed, Dr. Goldbloom’s magic changed the face of paediatric care in Canada. He was a pioneer in family-centred care who recognized the importance of parents and caregivers in treatment and healing. And to involve families in their children’s care meant interacting differently with them.

“Communication is [at the] core of medicine” he told the Halifax Chronicle Herald in 2013.

“It’s learning how to observe, how to listen to people, and that’s more important than the talking a doctor does—the listening and the looking.”

Dr. Goldbloom was born in Montreal to another trailblazing paediatrician, Alton (a founder of the Canadian Paediatric Society), and Annie (Ballon). Richard and his brother Victor—who would also become a paediatrician—grew up surrounded by the stuff of medicine: His father’s office occupied the ground floor of their three-storey home.

“By the time I was old enough to write, I would scrawl my name ostentatiously: ‘Richard Goldbloom MD,’” he wrote in his 2013 autobiography, *A Lucky Life*. “No one in the family, or the profession, objected.”

Dr. Goldbloom married the love of his life, Ruth Schwartz, while studying medicine at McGill University in Montreal. Known to many simply as “Ruth and Dick,” they were married for 66 years until Mrs. Goldbloom’s death in 2012.



Richard and Ruth Goldbloom on their wedding day in 1944

“Ruth was his energy source and he was forever weakened by her death,” reads Dr. Goldbloom’s obituary. “She said the only disease he would ever die of was optimism. His optimism was not fatal but rather a sustaining life force for nine decades.”

After training in Montreal and Boston, Dr. Goldbloom was recruited to the brand new Izaak Walton Killam Hospital for Children in 1967, and he would spend the rest of his rich life and career in Halifax.

Dr. Goldbloom’s list of accomplishments and honours is almost endless: IWK’s inaugural physician-in-chief and director of research for 18 years; Chancellor of Dalhousie from 2001 to 2007; author on more than 140 scientific papers; visiting

professorships and distinguished lectureships around the world; Order of Nova Scotia, Order of Canada, and Canadian Medicine Hall of Fame.

Outside of medicine, Dr. Goldbloom was an accomplished pianist, and he and Ruth were dedicated supporters of arts and culture in Halifax. Together they founded the Canadian Museum of Immigration at Pier 21.

A past president of the CPS and a fixture at annual conferences for decades, Dr. Goldbloom received the Alan Ross Award in 1997. The Goldbloom Journal Club, a can’t-miss conference event that he hosted for many years, was re-named in his honour.

Dr. Goldbloom is survived by his children, Alan, Barbara and David, seven grandchildren, and 11 great-grandchildren. According to his obituary, “He was happiest surrounded by the four generations of his family – each one a new audience for his oldest jokes.”



Wherever he was, there was always someone coming to him and thanking him for the care he had given or the lessons he transmitted.

Neonatologist, volunteer, teacher

Dr. Claude Paré passed away in November at the age of 91. Dr. Paré was a past president of the CPS and leader in neonatology in Quebec. We thank his daughter and CPS translator, Dominique, for sharing with us the obituary she wrote for her father. An excerpt is below.

Dr. Claude Paré grew up in Châteauguay in a family of 12. His father was a teacher and his mother, a nurse. After completing a classical education at the Collège Sainte-Marie, medical studies at the Université de Montréal and a specialty at the Verdun Hospital in Montreal, the Hospital for Sick Children in Toronto and the University of Pennsylvania, Dr. Claude Paré pursued his career in paediatrics at the Verdun Hospital from 1960 to 1970. Dr. Gilles Pigeon then invited him to join a new team of paediatricians at the Centre hospitalier universitaire de Sherbrooke, where he was a physician and professor for 27 years.

In 1974, Dr. Paré co-founded the neonatology unit, which he headed for over twenty years, and was head of the department of pediatrics for eight years. On a plaque hung in the neonatology unit, he is referred to as the father of neonatology in the Eastern Townships.

Like many doctors, Dr. Paré had a broad range of professional activities. He took part in approximately 30 specialized papers, presented at many scientific conferences and lectured around the world, including in Lyon, France, and China. He was called upon to contribute to the Royal College of Physicians and Surgeons of Canada examinations for several years.

Dr. Paré was also an active volunteer. He helped found the Sherbrooke's Plein-Soleil primary school, which he chaired for a year, was a member of the Canadian Paediatric Society's board of directors, including a term as President (1991-92), and chaired the Provincial Committee of Inquiry into Perinatal Mortality and Morbidity from 1992 to 1998.

He was very proud of the holistic patient approach, which became part of the medical education at the Department of Pediatrics and became a model in the province. In acknowledgement of his work, the Association des pédiatres du Québec awarded him the Letondal Prize in 1995 for his exceptional contribution to the development of paediatric care in the province.

After caring for some 5,000 newborns, Dr. Paré retired in 1997, but continued his volunteer work for a long time, including at the Montreal Dietary Dispensary, whose mission was in line with his convictions.

He was aware of the importance of his work, but also of all the teams working with him, from janitors to nurses and secretaries. He treated everyone with the same interest and respect. Many students were influenced by his teaching. Wherever he was, there was always someone coming to him and thanking him for the care he had given or the lessons he transmitted.

Dr. Paré travelled extensively and maintained many friendships. Always one to laugh and have fun, he and his wife gave memorable parties. Ornithology and fly fishing filled him with happiness. He loved Claire, his beloved wife of over 66 years, deeply, as well as his children and grandchildren. His last years were more difficult, but everyone will miss him and remember him with love and pride.

Production of this issue was just wrapping up when we learned of the death of another past president. **Dr. Frederick Baker** of Canmore, AB was CPS President from 1984-85 and was also former chair of the First Nations, Inuit and Métis Health Committee. The CPS is thankful for Dr. Baker's contributions and offers its condolences to his family.



Paediatricians, including Department Chief Full Time & Locum Opportunities Bluewater Health, Sarnia, Ontario

Bluewater Health is recruiting a progressive Chief to provide leadership to the Department. The Chief remuneration is 0.5 day/week, and it is expected that the physician leader will also have a clinical practice.

The Chief will work in collaboration with the Medical Director and Administrative Director of the Maternal Infant Child Program, to provide leadership in program visioning, planning, resource allocation, service excellence, research, and quality improvement. In addition, the Chief is responsible for ensuring that quality medical care is delivered, that professional medical practice is advanced, and that physicians function as partners in the care of patients within the program.

A Paediatrician interested in practicing at Bluewater Health will find:

- An Ideal opportunity for full spectrum community paediatric practice
- Exciting opportunity to develop a chronic disease centre of excellence
- A level IIB NICU
- State of the art equipment
- Child & adolescent psychiatry available
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The ideal candidate for the position will have:

- FRCPC or acceptable equivalent in Paediatrics
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Practicing at Bluewater Health from a physician perspective: https://youtu.be/xLmrdZm4j_c

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“The existence of a long-standing culture of ‘medical colonialism’ and the fact that cultures can be changed are definitely two key elements I’m hoping that readers will take away after reading the book.”

Dr. Samir Shaheen-Hussain

Existence of medical colonialism ‘undeniable’

Dr. Samir Shaheen-Hussain is an emergency paediatrician at the Montreal Children’s Hospital whose 2020 book, *Fighting for a Hand to Hold: Confronting medical colonialism against Indigenous children in Canada* has won two awards from the Quebec Writers’ Federation. He spoke to *CPS News* about writing the book, and what he thinks paediatricians need to know—and do—about medical colonialism.

CPS News: What issues does the book explore?

Dr. S-H: *Fighting for A Hand to Hold* exposes the Canadian medical establishment’s role in the displacement, colonization, and genocide of Indigenous Peoples — colonial genocide. The book argues that this history and ongoing medical colonialism prevent Indigenous communities from attaining internationally recognized measures of health and social well-being because of a pervasive culture of systemic anti-Indigenous racism that persists in the Canadian public health care system, and in capitalist settler society at large.

CPS News: Why did you write the book?

Dr. S-H: The idea started germinating during the 2018 #aHand2Hold campaign, which took on the Quebec government’s long-standing practice of separating children from their families during medical evacuation airlifts. This practice disproportionately affected remote and northern Indigenous communities in the province, specifically Eeyou (Cree) and Inuit children.

During the campaign, I was invited to testify as an expert witness at the Public Inquiry Commission on Relations Between Indigenous Peoples and Certain Public Services in Quebec. My presentations relied on the contributions and feedback provided by impacted families, as well as members and supporters of the campaign. The research, interviews, exchanges, and discussions that went into preparing my testimonies made it possible to write the manuscript for the book over the summer of 2019.

CPS News: What do you hope readers take away from book?

Dr. S-H: Drawing on the work of Indigenous and non-Indigenous activists and scholars, I propose that “medical colonialism” refers to “a culture or ideology, rooted in systemic anti-Indigenous racism, that uses medical practices and policies to establish,

maintain, and/or advance a genocidal colonial project”. I think this framing is helpful to move away from the common misconception that medicine is somehow neutral, let alone benevolent. The existence of a long-standing culture of “medical colonialism” and the fact that cultures can be changed are definitely two key elements I’m hoping that readers will take away after reading the book.

CPS News: What would you like other paediatricians to know about medical colonialism?

Dr. S-H: One of the quotes I share in the introduction of the book came from a paediatrician who had trained at the Montreal Children’s Hospital. In 2018 she mailed me about the #aHand2Hold campaign, saying how relieved she was that something was finally being done to disrupt the status quo: “I can’t even recall all the times in my residency that I was in a situation where this policy affected a child I was taking care of. We knew it was the rule, we knew it was awful, and yet we just kept going.” Her words described our complicity – and I definitely include myself in that – in accepting the injustices inflicted on Indigenous communities. The danger with normalizing injustice is that even the most sensitive individual may become desensitized to the suffering.

CPS News: What do you hope paediatricians will do?

Dr. S-H: There are three things having to do with the past, present and future: First, repair the harm that medical colonialism has caused Indigenous communities; second, decolonize the healthcare system to ensure that Indigenous people can access compassionate, competent, safe, and dignified care; and third, support Indigenous-led movements for self-determination and sovereignty so that Indigenous communities can autonomously rebuild health knowledge and systems that have been destroyed by colonialism.

For paediatricians, self-education to understand how medical colonialism operates is a first step. Beyond that, they can push provincial and federal governments to implement the recommendations from the reviews, inquiries, and commissions that those governments themselves created.

For more information: <https://fightingforahandtohold.ca>



“To become an actively antiracist organization, we need to bring this perspective to every conversation and every decision we are making.”

Dr. Kassia Johnson

Antiracism approach will ‘underpin everything we do’

One hundred years after the Canadian Paediatric Society was founded, a diverse group of paediatricians from across the country has come together to change long-standing policies and practices in both the organization and in the wider health care system.

It’s an ambitious goal, and each member of the new Antiracism Steering Committee knows that change will take sustained work.

The committee will be guided by the CPS antiracism policy that was released in December 2021. Three working groups—on advocacy, policy implementation, and medical education—will focus on specific areas.

“The policy needs to underpin everything we do,” says steering committee co-chair Dr. Kassia Johnson, a developmental paediatrician in Hamilton. “To become an actively antiracist organization, we need to bring this perspective to every conversation and every decision we are making.”

This means thinking about everything from leadership to communications, governance to membership.

Dr. Johnson says that even though the group is focused on antiracism, their work will consider the impact of racism on other equity and sovereignty deserving groups. “We’re doing this antiracism work through an intersectional lens,” says Dr. Johnson. “We understand that racism directed toward a woman, or a non-binary person, or a person with a disability may be experienced differently, but it’s still racism and we have to confront it.”

For more information, visit www.cps.ca/en/policy-and-advocacy/antiracism-initiative

Antiracism Steering Committee

Dr. Kassia Johnson, Co-chair
Dr. Sam Wong, Co-chair
Dr. Mahli Brindamour, Caring for Kids New to Canada Task Force
Dr. Mark Feldman, CPS President
Dr. Cheyenne LaForme, First Nations, Inuit & Métis Health Committee
Dr. Tatiana Sotindjo, adolescent medicine specialist
Dr. Mark Awuku, Co-chair, Medical Education Working Group
Dr. Ming-Ka Chan, Co-chair, Medical Education Working Group
Dr. Muna Chowdhury, Co-chair, Advocacy Working Group
Dr. Tehseen Ladha, Co-chair, Advocacy Working Group
Dr. Minoli Amit, Co-chair, Policy Implementation Working Group
Dr. Shazeen Suleman, Co-chair, Policy Implementation Working Group

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