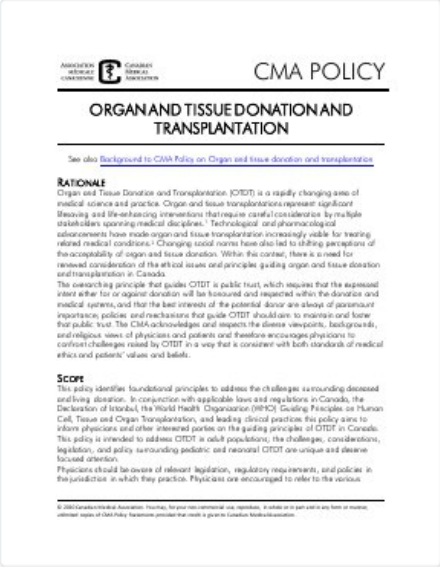
Organ and tissue donation and transplantation

https://policybase.cma.ca/link/policy14126

POLICY TYPE	Policy document
DATE	2019-12-07
REPLACES	Organ and tissue donation and transplantation (update 2015)
TOPICS	Ethics and medical professionalism Health care and patient safety

Documents



CMA POLICY

ORGAN AND TISSUE DONATION AND TRANSPLANTATION

See also Background to CMA Policy on Organ and tissue donation and transplantation

RATIONALE

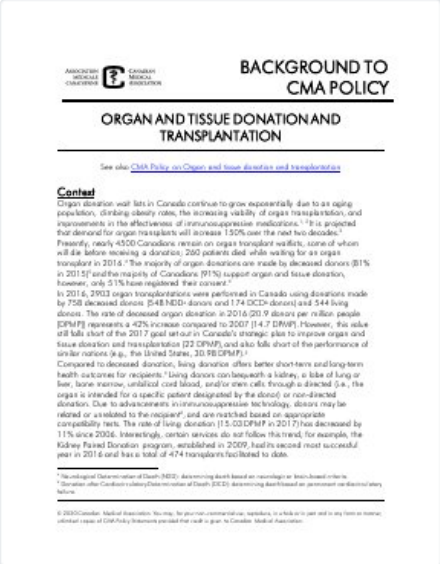
Organ and Tissue Donation and Transplantation (OTDT) is a rapidly changing area of medical science and practice. Organ and tissue transplantations represent significant lifesaving and life-enhancing interventions that require careful consideration by multiple stakeholders spanning medical disciplines.[1] Technological and pharmacological advancements have made organ and tissue transplantation increasingly viable for treating related medical conditions.[2] Changing social norms have also led to shifting perceptions of the acceptability of organ and tissue donation. Within this context, there is a need for renewed consideration of the ethical issues and principles guiding organ and tissue donation and transplantation in Canada.

The overarching principle that guides OTDT is public trust, which requires that the expressed intent either for or against donation will be honoured and respected within the donation and medical systems, and that the best interests of the potential donor are always of paramount importance; policies and mechanisms that guide OTDT should aim to maintain and foster that public trust. The CMA acknowledges and respects the diverse viewpoints, backgrounds, and religious views of physicians and patients and therefore encourages physicians to confront challenges raised by OTDT in a way that is consistent with both standards of medical ethics and patients' values and beliefs.

SCOPE

This policy identifies foundational principles to address the challenges surrounding deceased and living donation. In conjunction with applicable laws and regulations in Canada, the Declaration of Istanbul, the World Health Organization (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation, and leading clinical practices this policy aims to inform physicians and other interested parties on the guiding principles of OTDT in Canada. This policy is intended to address OTDT in adult populations; the challenges, considerations, legislation, and policy surrounding pediatric and neonatal OTDT are unique and deserve focused attention.

Physicians should be aware of relevant legislation, regulatory requirements, and policies in the jurisdiction in which they practice. Physicians are encouraged to refer to the various



BACKGROUND TO CMA POLICY

ORGAN AND TISSUE DONATION AND TRANSPLANTATION

See also CMA Policy on Organ and tissue donation and transplantation

Context

Organ donation wait lists in Canada continue to grow exponentially due to an aging population, climbing obesity rates, the increasing viability of organ transplantation, and improvements in the effectiveness of immunosuppressive medications.[1,2] It is projected that demand for organ transplants will increase 150% over the next two decades.[3] Presently, nearly 4500 Canadians remain on organ transplant waitlists, some of whom will die before receiving a donation; 260 patients died while waiting for an organ transplant in 2016.[4] The majority of organ donations are made by deceased donors (81% in 2015)[5] and the majority of Canadians (91%) support organ and tissue donation, however, only 51% have registered their consent.[6]

In 2016, 2903 organ transplantations were performed in Canada using donations made by 758 deceased donors (548 NDD+ donors and 174 DCD+ donors) and 544 living donors. The rate of deceased organ donation in 2016 (20.9 donors per million people [DPMP]) represents a 42% increase compared to 2007 (14.7 DPMP). However, this value still falls short of the 2017 goal set out in Canada's strategic plan to improve organ and tissue donation and transplantation (22 DPMP), and also falls short of the performance of similar nations (e.g., the United States, 30.98 DPMP).[7]

Compared to deceased donation, living donation offers better short-term and long-term health outcomes for recipients.[8] Living donors can bequeath a kidney, a lobe of lung or liver, bone marrow, umbilical cord blood, and/or stem cells through a directed (i.e., the organ is intended for a specific patient designated by the donor) or non-directed donation. Due to advancements in immunosuppressive technology, donors may be related or unrelated to the recipient[9], and are matched based on appropriate compatibility tests. The rate of living donation (15.03 DPMP in 2017) has decreased by 11% since 2006. Interestingly, certain services do not follow this trend; for example, the Kidney Paired Donation program, established in 2009, had its second most successful year in 2016 and has a total of 474 transplants facilitated to date.

[1] "Neurological Determination of Death (NDD): determining death based on neurological or brain-based criteria.
[2] "Donation after Cardiocirculatory Determination of Death (DCD): determining death based on permanent cardiocirculatory failure.

Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience

https://policybase.cma.ca/link/policy14165

POLICY TYPE	Policy endorsement
DATE	2019-10-17
TOPICS	Health care and patient safety Population health, health equity, public health

Documents

GUIDELINE VULNERABLE POPULATIONS

Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience

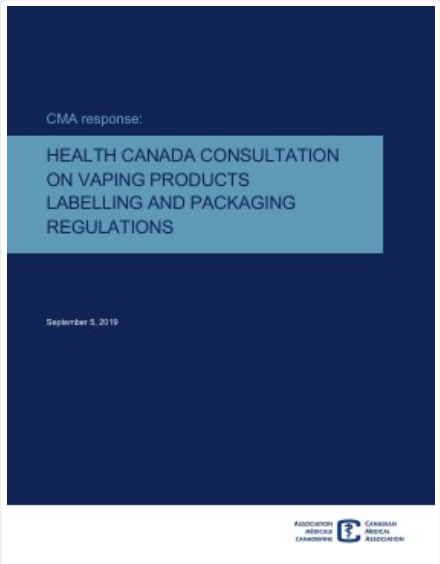
KEY POINTS

Health Canada consultation on vaping products labelling and packaging regulations

https://policybase.cma.ca/link/policy14124

POLICY TYPE	Response to consultation
DATE	2019-09-05
TOPICS	Health care and patient safety Population health, health equity, public health

Documents

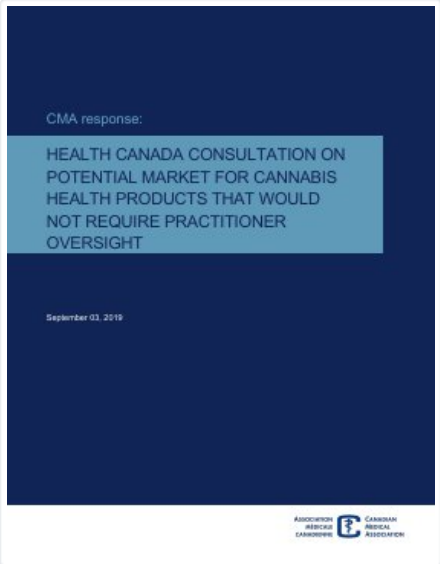


Health Canada consultation on potential market for cannabis health products that would not require practitioner oversight

https://policybase.cma.ca/link/policy14125

POLICY TYPE	Response to consultation
DATE	2019-09-03
TOPICS	Health care and patient safety Population health, health equity, public health

Documents



Standing Committee on Health's study on violence faced by healthcare workers

https://policybase.cma.ca/link/policy14052

POLICY TYPE	Parliamentary submission
DATE	2019-05-14
TOPICS	Health care and patient safety Ethics and medical professionalism Health human resources Physician practice, compensation, forms

Documents

May 14, 2019

Bill Casey, M.P.
Chair, Standing Committee on Health
House of Commons

Re: Standing Committee on Health's study on violence faced by healthcare workers

Dear Mr. Casey:

I am writing on behalf of the Canadian Medical Association (CMA) to submit recommendations for consideration by the Standing Committee on Health (the Committee) as part of the study on violence faced by healthcare workers.

The CMA is deeply concerned with the state of workplace safety in all health care settings, including hospitals, long-term care, and home care settings. As in all experiences of violence, it is unacceptable for healthcare workers to be victims of violence in the provision of care to patients. While there is limited data nationally to understand the incidence of violence against healthcare workers, anecdotal evidence suggests that these experiences are increasing in frequency and severity.

A 2010 survey of members of the College of Family Physicians of Canada shockingly found that, in the previous month, nearly one-third of respondents had been exposed to some form of aggressive behaviour from a patient (90%) or patient's family (70%). The study concluded that "Canadian family physicians in active practice are subjected to regular abuse from their patients or family members of their patients."[1]

These concerns were brought to the CMA's General Council in 2015, where our members passed a resolution calling for:

> "the federal government to amend the Criminal Code by making it a specific criminal offence to assault health care providers performing their duties."

The CMA is prioritizing initiatives that support physician health and wellness. Increasingly, there is a recognition of the role of the workplace, primarily health care settings, and safe working conditions as having an important influence of physician health and wellness.

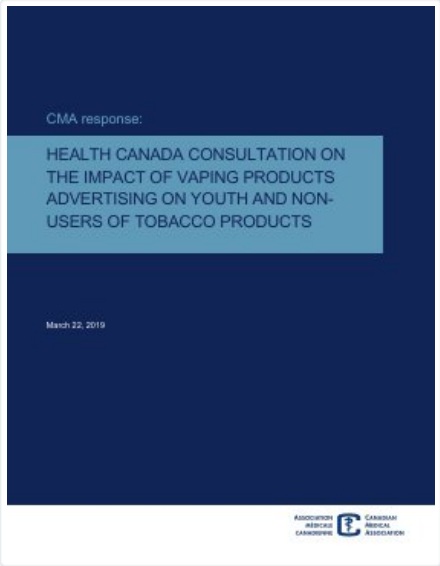
.../2

Health Canada consultation on the impact of vaping products advertising on youth and non-users of tobacco products

https://policybase.cma.ca/link/policy14022

POLICY TYPE	Response to consultation
DATE	2019-03-22
TOPICS	Health care and patient safety Population health, health equity, public health

Documents



Putting Patients First : Comments on Bill C 6 (Personal Information Protection and Electronic Documents Act) : Submission to the Senate Standing Committee on Social Affairs, Science and Technology

https://policybase.cma.ca/link/policy1979

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1999-11-25
TOPICS	Ethics and medical professionalism Health care and patient safety Health information and e-health

Documents

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

BRIEF

MÉMOIRE

"Putting Patients First"

Comments on Bill C-6
(Personal Information Protection and Electronic Documents Act)

Submission to the Senate Standing Committee on Social Affairs, Science and Technology

Nov. 25 1999
Ottawa, Ontario

For further information, contact
CMA's Public Affairs Directorate : 1 800 267-9703

Leadership for Physicians – Health for Canadians
Leadership pour les médecins – Santé pour les Canadiens

"Putting Patients First"

Comments on Bill C-6
(Personal Information Protection and Electronic Documents Act)

Submission to the Senate Standing Committee on Social Affairs, Science and Technology

Nov. 25 1999

Executive Summary

CMA commends the federal government for taking this important first step that begins the debate on privacy and the protection of personal information. The issues are complex and the interests at stake significant. CMA welcomes the opportunity to provide comments on Bill C-6 and hopes that its input will strengthen the Bill by ensuring that patient privacy and the confidentiality of medical records are adequately protected.

CMA's chief concern with Bill C-6 is the inadequacy of its provisions to protect the right of privacy of patients and the confidentiality of their health information. The right of privacy encompasses both the right to keep information about ourselves to ourselves if we so choose and to exercise control over what subsequently happens to information we confide in trust for the purpose of receiving health care. In recent years, this right, and the ability of physicians to guarantee meaningful confidentiality, have becoming increasingly threatened.

Computerization of health information facilitates easy transfer, duplication, linkage and centralization of health information. Captured in electronic form, patient information is potentially more useful for the purpose of providing care. However, thus captured, it also becomes much more valuable and technically accessible to various third parties -- private and public, governmental and commercial -- wishing to use this information for other purposes unrelated to providing direct care. An additional concern is that the demand for health information, referred to by some commentators as 'data lust', is growing, partly as a consequence of "information hungry" policy trends such as population health. There is also a disturbing tendency toward 'function creep', whereby information collected for one purpose is used for another, often without consent or even knowledge of the individual concerned and without public knowledge or scrutiny.

Furthermore, initiatives concerning health information technology tend to be dominated by those who seek access to this information for secondary purposes. From this perspective, privacy may appear less as a fundamental right than as a hindrance or even roadblock. As we move further into the information age there is some danger that we will become so spell-bound by the promise of information centralization and database linkages that we lose sight

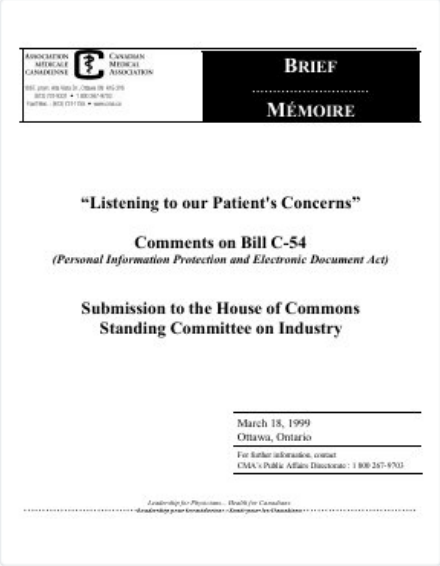
Bill C-6 (Personal Information Protection and Electronic Documents Act), Nov. 25, 1999

Listening to our Patient's Concerns : Comments on Bill C 54 (Personal Information Protection and Electronic Document Act) : Submission to the House of Commons Standing Committee on Industry

https://policybase.cma.ca/link/policy1980

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1999-03-18
TOPICS	Health care and patient safety Health information and e-health Ethics and medical professionalism

Documents



BRIEF

MÉMOIRE

"Listening to our Patient's Concerns"

Comments on Bill C-54

(Personal Information Protection and Electronic Document Act)

Submission to the House of Commons
Standing Committee on Industry

March 18, 1999
Ottawa, Ontario

For further information, contact
CMA's Public Affairs Directorate : 1 800 267-9703

"Listening to our Patient's Concerns"

Comments on Bill C 54
(Personal Information Protection and Electronic Document Act)

Submission to the House of Commons Standing Committee on Industry
March 18, 1999

Executive Summary

Over the last year, CMA has become increasingly concerned that debate on the issues concerning health information have been framed in terms of access to information with an attendant erosion of privacy and confidentiality. This one-sided approach comes at a time of expansion in our capacity to collect, store, merge, transfer and access information, coupled with trends both in the health care sector and generally related to the use of information. To address these concerns and to ensure that privacy and confidentiality in the medical context are valued, protected and preserved, CMA developed and adopted a Health Information Privacy Code. This Code should form the basis of all legislation governing the collection, use and disclosure of health information.

Health information is special by its nature. Rules relating to health information must be developed in recognition of its special nature. Ensuring protection of privacy and confidentiality of the patient record must take precedence over other considerations. Bill C-54 fails to do this. Bill C-54 is written from the perspective of encouraging commerce. It appears to have access to information as its dominant value. CMA considers the world of health care to be very different from that of commerce and consequently requiring distinct rules.

Health information use must, in all but exceptional and justifiable circumstances, occur only under the strict control of the patient. The patient must be able to exercise control through voluntary, informed consent. Bill C-54 permits the collection, use and disclosure of information without knowledge or consent on grounds such as expediency, practicality, public good, research, offence investigation, historic importance and artistic purpose. The evident lack of protection accorded health information based on such ground, is unacceptable. The absence of protection undermines the integrity of the patient-physician relationship and has the potential to erode the trust patients have in their physicians - a trust that is essential to patients' willingness to provide the complete information needed to provide them with care. Moreover, distinctions must be made between a patient's right to know what use or must happen to health information and the right to consent to such use.

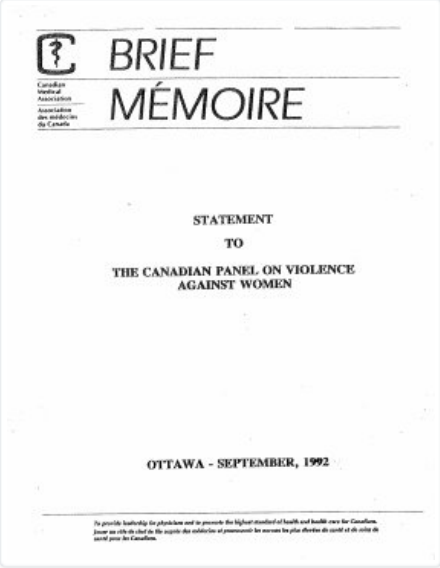
Not all purposes for the collection and use of health information are equal. Collection and use beyond the therapeutic context should be subjected to rigorous scrutiny before they are permitted to occur. Bill C-54 fails to make such a distinction and treats all purposes that could be identified for information collection or use as equal. Moreover,

Statement to the Canadian panel on violence against women Ottawa - September, 1992

https://policybase.cma.ca/link/policy11956

POLICY TYPE	Parliamentary submission
LAST REVIEWED	2019-03-03
DATE	1992-09-15
TOPICS	Health care and patient safety Ethics and medical professionalism

Documents



BRIEF
MÉMOIRE

STATEMENT
TO
THE CANADIAN PANEL ON VIOLENCE
AGAINST WOMEN

OTTAWA - SEPTEMBER, 1992

Concussion in Sport, Leisure, and Occupational Settings

https://policybase.cma.ca/link/policy14023

POLICY TYPE	Policy document
DATE	2019-03-02
REPLACES	Head injury and sport (2011)
TOPICS	Health care and patient safety Population health, health equity, public health

Documents

Concussion in Sport,
Leisure, and Occupational Settings

See also: Background to
Concussion in Sport, Leisure, and Occupational Settings

Context:

Concussions and head injuries are a common occurrence in sport and leisure activities, and frequently occur in occupational settings as well. While the majority of individuals who suffer from a concussion will recover with time, others may be at risk for serious and lasting complications. These include (1) children; (2) previous history of head injury or concussion; (3) prior mental health symptoms; and (4) missed diagnosis and management.[1]

This aim of this advocacy and policy document is to improve safety during activity by raising awareness of concussions, and by working to improve the detection and safe management of concussions when they occur. It is not a clinical practice guideline. It should not be perceived as a plea to avoid sports or leisure activities, but rather as a call for safer sporting, leisure, and occupational practices. The documented health benefits that result from establishing an active lifestyle in youth and maintaining it throughout life cannot be overstated.

Achieving balance of safe play in sport, leisure and occupational activities while promoting greater physical activity levels for Canadians would have the effect of reducing health care costs in Canada, while promoting a healthier concussion recovery culture for all Canadians.

Therefore, to promote better concussion and head trauma awareness and prevention, as well as better management/treatment practices, the following policy recommendations for key target audiences across all levels of sport, leisure, and occupational activity are made.[a]

a. All the policy recommendations made in this document are not meant to be interpreted as clinical practice guidelines. Any individual who suspects they may have sustained a concussion should promptly consult a physician.

Background to Concussion in Sport,
Leisure, and Occupational Settings

See also Policy on:
Concussion in Sport, Leisure, and Occupational Settings

1) How this Background to Policy Should be Situated:

This background is meant to complement CMA's recommendations in its policy on Concussion in Sport, Leisure, and Occupational Settings (2018).[a] It is meant to be informative on the issue(s) of traumatic brain injury (TBI) and concussions, and not act as a substitute for actual clinical practice or treatment guidelines.

2) How big is the issue?

Concussions are a serious public health concern both for minors and adults within sport, leisure, and occupational settings. Their reported occurrence is on the rise.[1] The body of knowledge regarding concussion is rapidly and constantly evolving; a dynamic that is unlikely to change in the foreseeable future. With the high volume of media coverage of concussion complications for prominent professional and amateur athletes, the public's attention and interest in concussions and head injuries continues to grow.

Whereas in the past concussion associated risks and injury were often minimized, and not factored into any analysis for a return-to-work or play, there is now a growing awareness to treat concussions and head injury as significant concerns to physical and mental health.

An issue that continues to negatively impact detection, reporting, and management of concussion and head injury is injury minimization. Individuals closely associated with a concussed individual (including coaches, co-workers, employers, or an injured individual themselves) may have an incentive, or experience personal and external pressures, to hide/downplay injury or

a. Together this background, and the target audience recommendations for Head Injury and Concussion, replace CMA's Head and Sport Injury policy (2011) and broadens the original sports-based focus to include leisure and occupational activities.

Antimicrobial Resistance (AMR)

https://policybase.cma.ca/link/policy14079

POLICY TYPE	Policy document
DATE	2019-03-02
TOPICS	Health care and patient safety Population health, health equity, public health

Documents

Antimicrobial Resistance (AMR)

See also Background to CMA Policy on Antimicrobial Resistance PD19-08

Context

Antimicrobials (which include antibiotics) are a precious public resource and an essential tool for fighting infections in both humans and animals. Their importance to human medical, nutritional and economic security cannot be understated. Yet globally, antimicrobials are losing their effectiveness more quickly than new such drugs, treatments and therapies are being identified and introduced to market.[1] Over time, this dynamic has eroded the human antimicrobial arsenal, placing the lives and futures of an unacceptable number of people at risk.

Antimicrobial resistance (AMR) occurs when microorganisms such as bacteria, viruses, fungi and parasites come into contact with antimicrobial drugs, such as antibiotics, antivirals, antifungals, antimalarials and anthelmintics, and undergo changes. The drugs are rendered ineffective and cannot eradicate infections from the body.

AMR is an international challenge that threatens to reverse over a century of progress in public health, health care and human development attributable to antimicrobial use. Indeed, the effects of AMR are already being felt across Canada's health care system. Currently, Canada's dedicated investment in solutions to militate against encroaching AMR in the AMR and antimicrobial stewardship (AMS) fields (both federally and provincially/territorially) can only be viewed as wholly inadequate to address the scope of the problem and the risks it poses for the health of Canadians.

Therefore, to: (1) promote awareness of AMR; (2) incentivize investment in AMR mitigation strategies; and (3) support the mobilization of an effective suite of more clinically effective management/treatment practices and policies, the following target audience recommendations are offered.[1]

[1] All the policy recommendations made in this document are not meant to be interpreted as clinical practice guidelines. Any individual who suspects they may have an infection should promptly consult a physician.

BACKGROUND TO CMA POLICY

Antimicrobial Resistance

See also CMA Policy Antimicrobial Resistance PD19-08

OVERVIEW

The world is at the tipping point of a post-antibiotic era. "Worldwide, we are relying more heavily on antibiotics to ensure our medical, nutritional, and economic security, while simultaneously causing the decline of their usefulness with overuse and ill-advised use." It is estimated that the world's use of antimicrobials increased by 65% between 2000 and 2015 — mainly in low- to middle-income countries.[2]

Dr. Margaret Chan, the former head of the World Health Organization (WHO), described antimicrobial resistance (AMR) as a slow-moving tsunami for public health. Other experts have characterized AMR as a looming "antibiotic apocalypse," warning that all countries "will face disastrous consequences if the spread of AMR is not contained."[3] Others are now calling AMR the "climate change" of health care. According to the UK's review on AMR, an estimated 10 million people globally will die annually by 2050, and AMR will surpass cancer to become the leading cause of death.[4]

AMR occurs when "microorganisms (such as bacteria, fungi, viruses, and parasites) change when they are exposed to antimicrobial drugs (such as antibiotics, antifungals, antimalarials, antiviralsand anthelmintics) ... As a result, the medicines become ineffective and infections persist in the body, increasing the risk of spread to others."[5] Microorganisms that develop antimicrobial resistance are sometimes referred to as "superbugs." "Nightmare bacteria," as they have been dubbed, are bacterial strains that no conventional antimicrobial can effectively treat; their incidence is on the rise.[6]

AMR represents a unique challenge for the medical profession as it is estimated that as many as 50% of current antibiotic prescriptions are either inappropriate or unnecessary.[7] In addition, taking an antimicrobial involves potentially considerable exposure to side effects or risk. At stake are many currently routine, and lifesaving, forms of medical treatment. Critically, these include many medications for currently treatable bacterial infections, and many forms of surgery (including cesarean delivery), radiation therapy, chemotherapy and neonatal care.[8]

Joint Submission to the Subcommittee on Sport-Related Concussions in Canada House of Commons Standing Committee on Health

https://policybase.cma.ca/link/policy14080

POLICY TYPE	Parliamentary submission
DATE	2019-01-29
TOPICS	Health care and patient safety

Documents

PUBLIC HEALTH STRATEGIES TO IMPROVE
SPORT-RELATED CONCUSSION CARE AND PREVENTION
IN CANADIAN COMMUNITIES

Joint Submission to the Subcommittee on Sport-Related Concussions in Canada
House of Commons Standing Committee on Health

from the:

1) Canadian Academy of Sport and Exercise Medicine (CASEM)

2) College of Family Physicians of Canada (CFPC)

and

3) Canadian Medical Association (CMA)

Submitted January 29, 2019