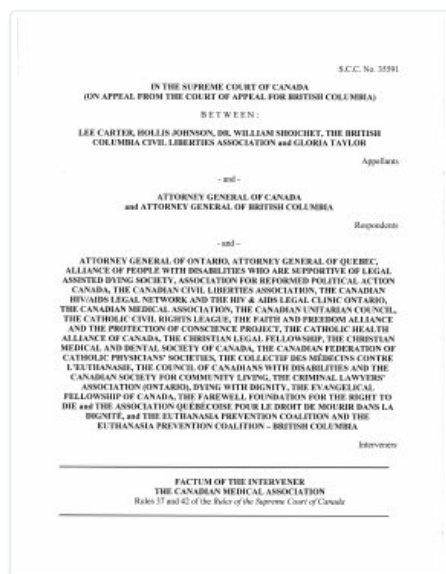


Carter: CMA submission regarding euthanasia and assisted death

<https://policybase.cma.ca/link/policy13935>

POLICY TYPE	Court submission
LAST REVIEWED	2011-03-05
DATE	2014-08-27
TOPICS	Ethics and medical professionalism Population health, health equity, public health

Documents



Amendments to PIPEDA, Bill S-4

<https://policybase.cma.ca/link/policy11194>

POLICY TYPE Parliamentary submission

DATE 2014-06-09

TOPICS Health information and e-health
Ethics and medical professionalism

Documents



The future of medicine

<https://policybase.cma.ca/link/policy209>

POLICY TYPE	Policy document
LAST REVIEWED	2017-03-04
DATE	2000-08-12
TOPICS	Health systems, system funding and performance Ethics and medical professionalism

Documents



Corporate privacy policy respecting the collection, use and disclosure of personal information (Update 2012)

<https://policybase.cma.ca/link/policy10633>

POLICY TYPE	Policy document
LAST REVIEWED	2017-03-04
DATE	2012-10-20
REPLACES	Corporate Privacy Policy Respecting the Collection, Use and Disclosure of Personal Information (Update 2007)
TOPICS	Ethics and medical professionalism

Documents

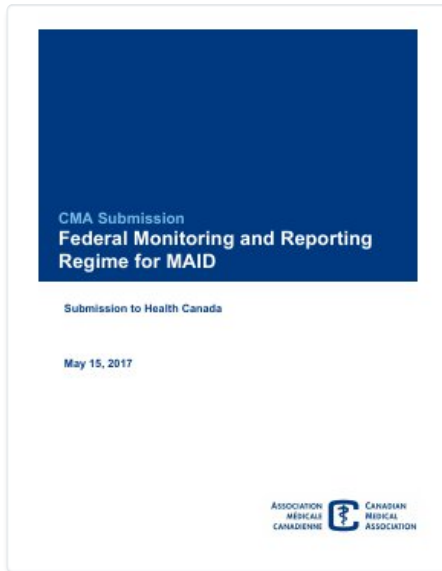


Federal Monitoring and Reporting Regime for MAID

<https://policybase.cma.ca/link/policy13853>

POLICY TYPE	Response to consultation
DATE	2017-05-15
TOPICS	Ethics and medical professionalism

Documents

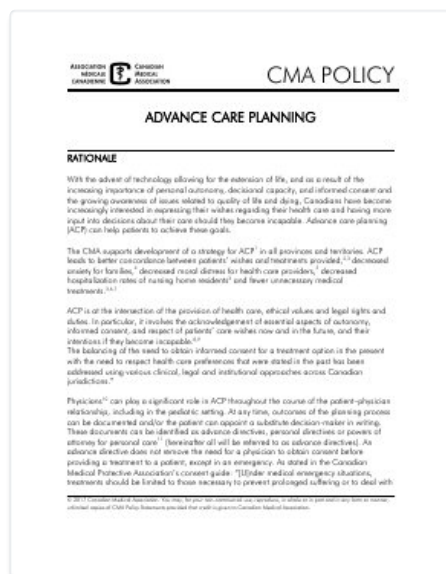


Advance care planning

<https://policybase.cma.ca/link/policy13694>

POLICY TYPE	Policy document
DATE	2017-05-27
REPLACES	Advance care planning (2015)
TOPICS	Ethics and medical professionalism Population health, health equity, public health

Documents




Direct-to-consumer genetic testing

<https://policybase.cma.ca/link/policy13696>

POLICY TYPE Policy document
DATE 2017-05-27
TOPICS Ethics and medical professionalism

Documents

 **CMA POLICY**

DIRECT-TO-CONSUMER GENETIC TESTING

See also [Background to CMA Policy on Direct-to-Consumer Genetic Testing](#)

RATIONALE

While genetic testing is typically provided in a clinical setting through the referral of a health care professional (HCP) or a regulated research project, a number of private companies now offer genetic testing services directly to consumers over the Internet. Direct-to-consumer (DTC) genetic testing is distinguished from clinical genetic testing ordered by a HCP in several ways:

1. DTC genetic tests are not regulated in Canada. The clinical validity and reliability of these tests varies widely, but DTC genetic testing companies make them available to consumers without distinguishing between those that may be useful to the management of one's health, those that have some limited health value, and those that are meant purely for recreational use.
2. Many of the tests advertised and sold via the Internet have not undergone clinical evaluation.
3. Marketing materials for these tests often imply that they have health value, but the terms of reference of some of the companies that offer them state that the tests are to be used for recreational purposes and many vendors do not guarantee the validity or reliability of their results.
4. Release of personal health information and/or DNA samples is often an important part of the business model of companies that offer DTC genetic testing, raising concerns about patient privacy and insufficient or unclear disclosure of privacy terms.
5. Unlike genetic tests ordered and administered by HCPs, DTC genetic tests are ordered directly by the consumer, who most often has not consulted with a HCP as part of a clinical assessment, and the testing may not be clinically indicated. Some companies only agree to do testing if it has been ordered by a physician, but they will provide a phone consultation with one of their physicians (not based in Canada) if a consumer does not have access to a physician. When the testing is ordered by a physician, it will sometimes be ordered by the patient's personal physician. In such cases, this does not truly represent DTC genetic testing.

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 **BACKGROUND TO CMA POLICY**

DIRECT-TO-CONSUMER GENETIC TESTING

See also [CMA Policy 2017-05 Direct-to-Consumer Genetic Testing](#)

Some direct-to-consumer (DTC) genetic tests, such as "compatibility testing" for online dating, are purely recreational. Other tests, however, are marketed both as being for recreational use and as producing results that are useful to the management of one's health. This document concerns the second category of tests. The characteristics of these tests differ widely, and some of the companies that offer them clearly state that they do not guarantee the validity and reliability of their tests. As of January 2016, 246 companies offered some form of DNA test online. Many DTC genetic tests have entered the Canadian market, especially after the U.S. Food and Drug Administration issued a warning letter instructing some companies in the U.S. to cease providing unreliable health information that could potentially lead consumers to make uninformed decisions about their health, which caused some of these companies to seek out alternative markets.¹

The increasing availability of DTC genetic tests in Canada presents several challenges, as the predictive value of most of the DTC genetic tests currently on the market is very low. Moreover, there is no standard model for the delivery and interpretation of the results of these tests. Greater regulatory guidance and protection is needed to ensure that individuals who choose to submit samples to DTC genetic testing companies are not adversely affected by information that is not necessarily predictive or even accurate.

Survey research indicates that the general public is overwhelmingly interested in genetic testing technologies. Researchers predict that increasing number of individuals will use DTC genetic testing as testing technologies continue to become more affordable and efficient.² Some genetic tests tend to cross medical specialties, it often falls on primary care physicians to understand the role of genetics in clinical care.³ In fact, genetic testing companies often direct patients to discuss their results with their primary care physician.⁴ Patients not only seek out their primary care providers to discuss their genetic test results and obtain appropriate follow-up, but also expect them to be able to answer questions about personal genome test results.⁵ Despite these expectations, health professionals' awareness and knowledge of DTC genetic tests remains low.⁶

Although DTC genetic tests are marketed under similar names, the genetic tests available in Canada have very different characteristics. Three types of tests are offered: (1) single-nucleotide polymorphism (SNP) analysis, which assesses an individual's risk for common

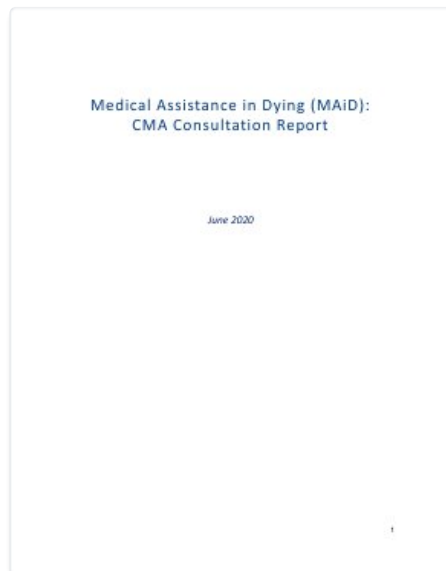
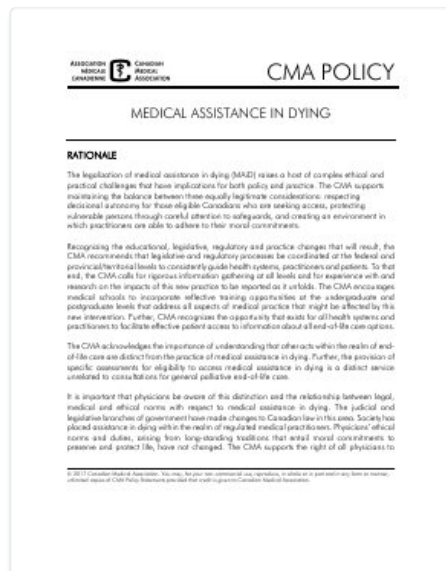
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Medical assistance in dying

<https://policybase.cma.ca/link/policy13698>

POLICY TYPE	Policy document
DATE	2017-05-27
REPLACES	EUTHANASIA AND ASSISTED DEATH (UPDATE 2014)
TOPICS	Ethics and medical professionalism

Documents

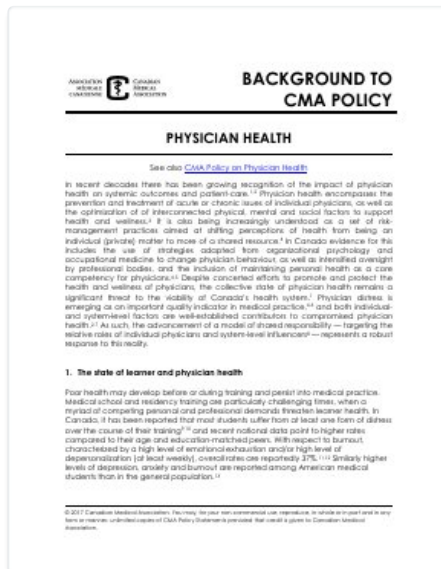
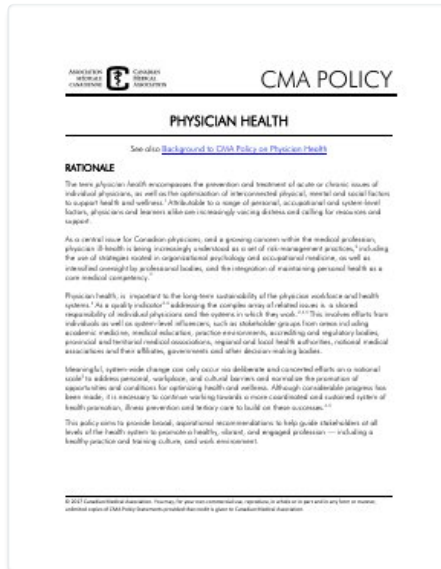


Physician health

<https://policybase.cma.ca/link/policy13739>

POLICY TYPE	Policy document
DATE	2017-10-21

Documents



CMA STATEMENT ON PHYSICIAN HEALTH AND WELLNESS

Guiding Principles and Commitments for a Vibrant Profession



What it is

This statement identifies a set of guiding principles and commitments to provide a vibrant and engaged profession by identifying factors that promote healthy training and practice environments with the view to enhancing physicians' sense of fulfillment and engagement. This statement affirms that all physicians should have access to robust health and wellness resources and is open to address any personal and professional difficulties they may experience.

Why it matters

Physician health and wellness is a critical issue for all physicians, their patients, and health systems. Physicians are at a higher risk of experiencing adverse health outcomes, including personal and professional dissatisfaction, burnout, depression, suicidal ideation and suicide. This has been shown to affect patient care and health system performance. Addressing the factors that affect physician health and the challenges that physicians face in navigating their increasingly complex training and practice environments is not just a policy and practice imperative.

If meaningful, sustained improvement is to be achieved, the profession and other stakeholders will need to make deliberate commitments to reduce personal, cultural, and occupational barriers and to promote well-being, practice, and conditions that optimize health and wellness. The CMA is committed to promoting a model of shared responsibility engaging individual and systemic factors that influence and contribute to health and wellness through advocacy and collaboration. This statement is based on the [CMA Policy on Physician Health and Long-term Success](#).

GUIDING PRINCIPLES



A broader understanding of physician health

In the past, addressing physician health often focused on individual issues. Today, our understanding encompasses the complex interplay of individual, socio-cultural, occupational, and systemic factors and includes efforts to develop preventive measures and strategies to address these issues. This new understanding invites us to look at physician health issues broadly to take into account, and seek to address, the array of factors that influence medical training and practice.



Physician health as a quality indicator

Physician health and wellness outcomes are becoming a significant quality indicator in the practice of medicine and the overall functioning of health systems. Physician health has been identified as an additional component of the "Triple Aim," renamed the "Quadruple Aim," which seeks to optimize health system performance through enhancing the patient experience, improving population health, reducing costs, and supporting physician wellness.



Physician health as a shared responsibility

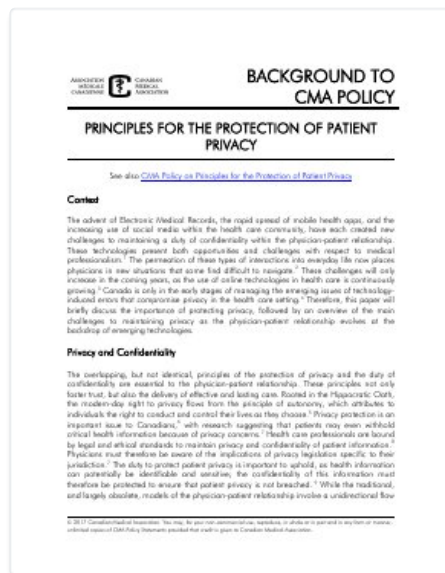
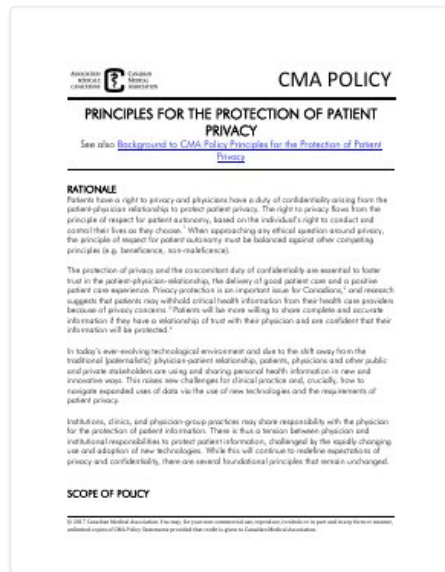
It is increasingly recognized that the complex range of factors that contribute to health and wellness need to be addressed at both the individual and systemic levels. While initiatives targeted to individual physicians remain relevant, there needs to be a greater focus on occupational and system-level initiatives and collaboration between stakeholders and physicians to produce meaningful and sustainable change, in a model of shared responsibility.

Principles for the protection of patient privacy

<https://policybase.cma.ca/link/policy13833>

POLICY TYPE	Policy document
DATE	2017-12-09
REPLACES	PD11-03 Principles for the Protection of Patients' Personal Health Information
TOPICS	Health information and e-health Ethics and medical professionalism

Documents



Charter of Shared Values: A vision for intra-professionalism for physicians

<https://policybase.cma.ca/link/policy13858>

POLICY TYPE	Policy document
DATE	2017-12-09
REPLACES	CMA Charter for Physicians (Update 1999)
TOPICS	Ethics and medical professionalism

Documents

Charter of Shared Values:
A vision for intra-professionalism for physicians

What is it?
The CMA Charter of Shared Values aims to identify shared values and common needs in each other and to the profession to which physicians and business are united to promote trust and respect within the profession and for each other, and identify opportunities for engagement and leadership to promote civility and conduct accordingly within the profession.

Why does it matter?
The Charter is intended to further strengthen professional responsibilities in support of a united and aligned profession. We achieve the highest degree of both individual and collective success when we work together, connect together and believe together; when we share a clearly articulated set of common values, vision and purposes, and when we subscribe to the same register and explicit understanding.

Commitments to Each Other:
Our most important shared values

- RESPECT**
As a physician, I will strive to be respectful. I will recognize that everyone has inherent worth, a worthy of dignity, and has the right to be valued and respected and to be treated ethically. I will respect others and their personal and professional dignity and I will aim to promote and model respect through collaboration, training and practice.
- INTEGRITY**
As a physician, I will strive to act with integrity. I will act in an honest and lawful manner, with consistency of intentions and actions, and will act with moral courage to promote and model effective leadership and to achieve a good outcome for patients.
- RECIPROCITY**
As a physician, I will strive to cultivate reciprocal relationships. I will be kind with my physician colleagues, and expect them to respond similarly. I will share and exchange my knowledge and experience with them, and I will be generous with them in spirit and in time.
- CIVILITY**
As a physician, I will strive to be civil. I will respect myself and others, regardless of their role, even those with whom I may not agree. I will extend civil communication with my physician colleagues with an attitude of respect and open listening, whether it be in person, in writing, or virtually, and I will accept personal accountability.

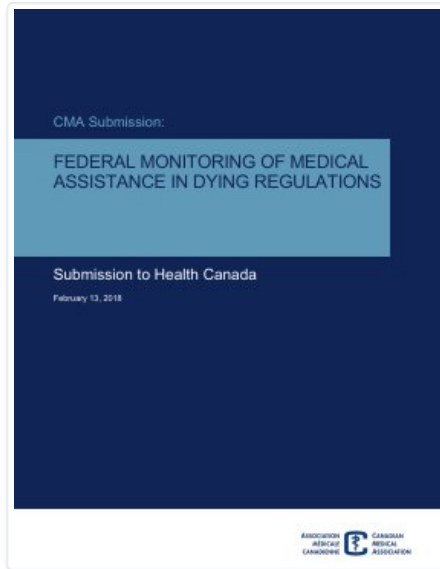


Federal monitoring of medical assistance in dying regulations

<https://policybase.cma.ca/link/policy13856>

POLICY TYPE	Response to consultation
DATE	2018-02-13
TOPICS	Ethics and medical professionalism

Documents

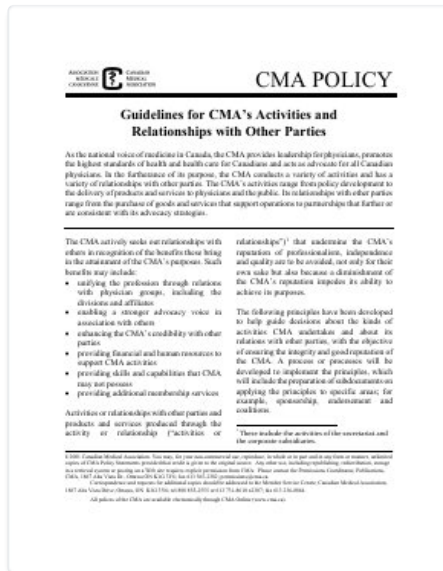


Guidelines for CMA's activities and relationships with other parties

<https://policybase.cma.ca/link/policy234>

POLICY TYPE	Policy document
LAST REVIEWED	2018-03-03
DATE	2001-05-28
TOPICS	Ethics and medical professionalism

Documents



Medical professionalism (Update 2005)

<https://policybase.cma.ca/link/policy1936>

POLICY TYPE	Policy document
LAST REVIEWED	2018-03-03
DATE	2005-12-03
REPLACES	Medical professionalism (2002)
TOPICS	Ethics and medical professionalism

Documents

CMA POLICY

Medical professionalism

(Update 2005)

The commitment to which medicine is grounded in Canada is undergoing rapid and profound change. There are new societal expectations for the medical profession to provide leadership for our patients, our communities and our colleagues through our regulated professionals. The Canadian Medical Association (CMA) is strongly committed to medical professionalism and has developed this policy to inform physicians and others about its meaning and value and to promote its preservation and enhancement. This document outlines the major features of medical professionalism, the opportunities which exist in this area and the challenges which lie before us.

Why Medical Professionalism?

The medical profession is distinguished by a strong commitment to the well-being of patients, high standards of ethical conduct, mastery of an ever-expanding body of knowledge and skills, and a high level of clinical independence. As individuals, physicians' personal values may vary, but as members of the medical profession they are expected to share and uphold those values that characterize the practice of medicine and the care of patients.

Medical professionalism includes both the relationship between a physician and a patient and a social contract between physicians and society. Society grants the profession privileges, enabling medicine to practice responsibly for the promotion of human welfare and a high degree of self-regulation. In return, the profession agrees to use those privileges primarily for the benefit of others and only secondarily for its own benefit. These major features of medical professionalism are:

- Commitment to the ethics of care, clinical independence and self-regulation:** In family physicians, these patients and society value of care. This is characterized by the values of some patients, beneficence, non-maleficence, respect for persons and justice (CMA's Code of Ethics). Society benefits from the ethics of care inherent in the provision of medical services, physicians give the interests of others ahead of their own.
- Devotion and commitment to the well-being of others is clearly in the interests of patients, who are the primary beneficiaries.**
- Clinical independence:** Medicine is a highly complex art and science. Through thoughtful training and experience, physicians become medical experts and leaders. When patients have the right to decide in a large sense which medical interventions they will undergo, they expect their physicians to be free to make clinically appropriate recommendations. Although physicians recognize that they are accountable to patients, funding agencies and that process for their recommendations, on reasonable grounds an ethical autonomy imposed by governments and administrators, whether public or private, are not to the best interests of patients, nor does it compromise the trust that is an essential component of the patient-physician relationship. Concretely, physicians are not morally obliged to provide inappropriate medical services when requested by patients despite their respect for patient autonomy.
- Self-regulation:** Physicians have traditionally been granted the privilege by society. It includes the control of entrance into the profession by establishing educational standards and setting requirements, the licensing of physicians, and the

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ASSOCIATION OF MEDICAL PROFESSIONALS **CANADIAN MEDICAL ASSOCIATION**

FD06/02

Best practices for smartphone and smart-device clinical photo taking and sharing

<https://policybase.cma.ca/link/policy13860>

POLICY TYPE	Policy document
DATE	2018-03-03
TOPICS	Health information and e-health Ethics and medical professionalism

Documents



CMA Policy Endorsement Guidelines

<https://policybase.cma.ca/link/policy14021>

POLICY TYPE	Policy document
DATE	2018-03-03
TOPICS	Ethics and medical professionalism

Documents



Association
of
CANADIAN
OPHTHALMOLOGISTS
&
OPTOMETRISTS



CMA
BOARD
APPROVED

CMA Policy Endorsement Guidelines ("Substitutes") CMA Board Approved March 2018

These Guidelines constitute an implementation tool of seven recommendations and are informed by [Guidelines to CMA's Structure and Method of Approval with Other Parties](#) (aka CMA's Corporate Relationship Policy) and [CMA's Authority as a Professional Body](#).

1. Scope
These Guidelines apply to the Canadian Medical Association (and not to its subsidiaries). As these are Guidelines, exceptions may be necessary from time to time where a staff may use their discretion and judgment.

2. Definition
Endorsement is an umbrella term encompassing "policy endorsement", "sponsorship" and "lending".

Policy endorsement includes:

- (a) CMA endorsing any public report, non-proprietary public report or, which may include the use of CMA's name and/or logo, of an organization's written policy, or an issue that aligns with CMA policy, where there is no conflict of interest, or
- (b) CMA adopting the policy of another organization as our policy or
- (c) CMA asking another organization to publicly support our policy.

3. Process

- (a) Criteria for policy endorsement requests from another organization to endorse their policy¹ (the following criteria shall be applied):
 - i. we have a policy on the subject matter and
 - ii. we are actively working on a document that policy position and
 - iii. the organization has a follow-up action plan associated with it request.
- (b) Approval: Where policy needs approval requires a policy staff member (with portfolio responsibility) and the VP of Medical Professionalism, or the policy staff member (with portfolio responsibility) and the Chief Policy Advisor. Where no policy needs approval, approval of the Board of Directors is required.
- (c) Annual confirmation: Where CMA adopts the policy of another organization², CMA staff will confirm annually, or more frequently if circumstances dictate, that the policy has not been altered by the other organization.
- (d) Requests: Pursuit of potential endorsement requests are not appropriate. If where possible, requests should come from an organization and not an individual.

4. Results

- (a) Where CMA adopts the policy of another organization, the adopted policy shall become CMA policy, and will include a notation in the document as being an adopted policy of judgment or
- (b) all adopted policies will be housed in an accessible online database.
- (c) All requests for organizations for CMA to endorse their policy will be tracked in a central location, along with any responses.

¹ Requests must, in order to be eligible, meet the following criteria: (a) the organization has a follow-up action plan associated with it request; (b) the organization has a follow-up action plan associated with it request; (c) the organization has a follow-up action plan associated with it request; (d) the organization has a follow-up action plan associated with it request.

² This is part of the definition of endorsement.

³ This is part of the definition of endorsement.

1587, press Affairs Unit, Ottawa (ONTARIO) K1N 9K9 cma.ca | amco.ca

Health Care Coverage for Migrants: An Open Letter to the Canadian Federal Government

<https://policybase.cma.ca/link/policy13940>

POLICY TYPE	Policy endorsement
DATE	2018-12-15
TOPICS	Population health, health equity, public health Health systems, system funding and performance Ethics and medical professionalism

Documents



**Health Care Coverage for Migrants:
An Open Letter to the Canadian Federal Government** December 2018
Sign here: <https://policybase.cma.ca/link/policy13940>

The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Ginette P. Taylor, Minister of Health
The Honourable Ahmed D. Hassan, Minister of Immigration, Refugees and Citizenship
CC: Mr. Dariusz Pionek, United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health

Dear Prime Minister, Trudeau & Ministers Taylor and Hassan,

We are writing to you today as members of the health community to urge your action on a crucial matter pertaining to health and human rights. You will no doubt be aware that the United Nations Human Rights Committee (UNHRC) recently issued a [landmark opinion](#) condemning Canada for denying access to essential health care on the basis of immigration status based on the case of Nell Toudreau.

Nell is a 49-year-old woman from Grenada who has been living in Canada since 1999, and who suffered significant negative health consequences as a result of being denied access to essential health care services. The UNHRC's decision condemns Canada's existing discriminatory policies, and finds Canada to be in violation of both the right to life, as well as the right to equality and freedom from discrimination.

Based on its review of the [International Covenant on Civil and Political Rights](#), the UNHRC has declared that Canada must provide Nell with adequate compensation for the significant harm she suffered. As Nell, they have called on Canada to report on its review of national legislation within a 180-day period, in order to ensure that regular migrants have access to essential health care to prevent a reasonably foreseeable risk that can result in loss of life. The United Nations Special Rapporteur has urged for the same, [calls on the government](#) to protect health-related rights to life, security of the person, and equality of individuals and groups in situations of vulnerability.

Nell is one of an [estimated half million people in Ontario alone](#) who are denied access to health coverage and care on the basis of their immigration status, putting their health at risk. As members of Canada's health community, we are appalled by the details of the case as well as its broad implications, and call on the government to:

1. Comply with the UNHRC's order to review existing laws and policies regarding health care coverage for regular migrants.
2. Ensure appropriate resource allocation, so that all people in Canada are provided universal and equitable access to health care services, regardless of immigration status.
3. Provide Nell Toudreau with adequate compensation for the significant harm she has suffered as a result of not receiving essential health care services.

For more information on this issue, please see our background here: <https://policybase.cma.ca/link/policy13940>.

Sincerely,
Arvin Aggarwal MD, Internal Medicine Resident, University of Toronto, Toronto ON
Nisha Kaural, BSc, MD Candidate, McMaster University, Hamilton ON
Michaela Breen, MD, Psychiatrist, Toronto ON
Rishi Goyal MD, Family Physician, Toronto ON

Joint statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care

<https://policybase.cma.ca/link/policy202>

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	1998-12-05
TOPICS	Ethics and medical professionalism

Documents



Principles concerning physician information

<https://policybase.cma.ca/link/policy208>

POLICY TYPE	Policy document
LAST REVIEWED	2019-03-03
DATE	2002-06-02
TOPICS	Health information and e-health Ethics and medical professionalism

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

"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: 1 800 287-8700

Leadership for Physicians - Modèle for Canadians
Leadership pour des médecins - Modèle 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 stakes are high. 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 oneself to oneself if so wished and to exercise control over what subsequently happens to information so critical to trust for the purposes of receiving health care. In recent years, this right and the ability of physicians to guarantee meaningful confidentiality, have become increasingly threatened.

Computerization of health information facilitates easy transfer, duplication, linkage and consolidation of health information. Copied in electronic form, patient information is potentially more useful for the purposes of providing care. However, this captured, if also becomes much more valuable and technically accessible to various third parties - private and public, governmental and commercial - wishing to use the 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, litigation concerning health information technology tends 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 spellbound by the promise of information centralization and database linkages that we lose sight