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

S.C.C. No. 35591

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION and GLORIA TAYLOR

Appellants

- and -

ATTORNEY GENERAL OF CANADA
and ATTORNEY GENERAL OF BRITISH COLUMBIA

Respondents

- and -

ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF QUEBEC, ALLIANCE OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF LEGAL ASSISTED DYING SOCIETY, ASSOCIATION FOR REFORMED POLITICAL ACTION CANADA, THE CANADIAN CIVIL LIBERTIES ASSOCIATION, THE CANADIAN HIV/AIDS LEGAL NETWORK AND THE HIV & AIDS LEGAL CLINIC ONTARIO, THE CANADIAN MEDICAL ASSOCIATION, THE CANADIAN UNITARIAN COUNCIL, THE CATHOLIC CIVIL RIGHTS LEAGUE, THE FAITH AND FREEDOM ALLIANCE AND THE PROTECTION OF CONSCIENCE PROJECT, THE CATHOLIC HEALTH ALLIANCE OF CANADA, THE CHRISTIAN LEGAL FELLOWSHIP, THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, THE COLLECTIF DES MÉDECINS CONTRE L'EUTHANASIE, THE COUNCIL OF CANADIANS WITH DISABILITIES AND THE CANADIAN SOCIETY FOR COMMUNITY LIVING, THE CRIMINAL LAWYERS' ASSOCIATION (ONTARIO), DYING WITH DIGNITY, THE EVANGELICAL FELLOWSHIP OF CANADA, THE FAREWELL FOUNDATION FOR THE RIGHT TO DIE and THE ASSOCIATION QUÉBÉCOISE POUR LE DROIT DE MOURIR DANS LA DIGNITÉ, and THE EUTHANASIA PREVENTION COALITION AND THE EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA

Interveners

FACTUM OF THE INTERVENER
THE CANADIAN MEDICAL ASSOCIATION
Rules 37 and 42 of the *Rules of the Supreme Court of Canada*

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

CMA's Submission to the Senate Standing Committee on Transport and Communications

Bill S-4: An Act to amend the Personal Information Protection and Electronic Documents Act and to make a consequential amendment to another Act

June 9, 2014

Submitted by: Canadian Medical Association

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

CMA POLICY

THE FUTURE OF MEDICINE

CMA Policy Index

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


CMA POLICY

Corporate Privacy Policy Respecting the Collection, Use and Disclosure of Personal Information

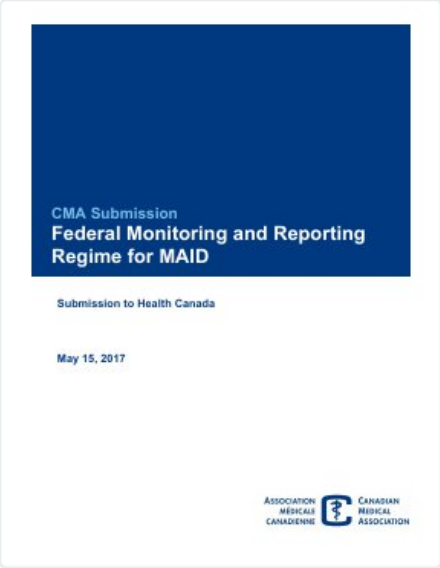
(Update 2012)

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

CMA POLICY

ADVANCE CARE PLANNING

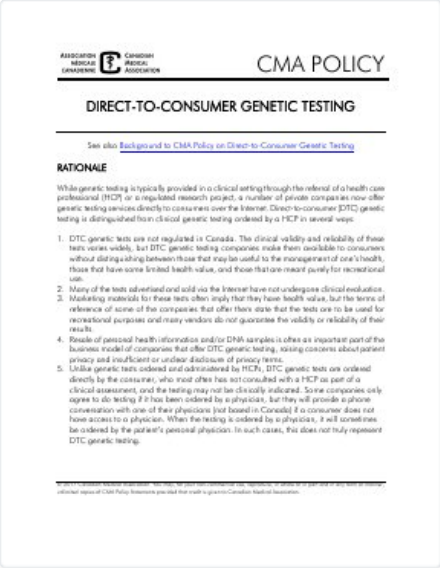
RATIONALE

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. Resale 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 conversation 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.

BACKGROUND TO CMA POLICY

DIRECT-TO-CONSUMER GENETIC TESTING

See also CMA Policy PD17-05 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 this 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.[1] Many DTC genetic tests have started to penetrate 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 misinformed decisions about their health, which caused some of these companies to seek out alternative markets.[2]

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.[3] Researchers predict that an increasing number of individuals will use DTC genetic testing as testing technologies continue to become more affordable and efficient.[4] Since genetic issues tend to cross medical specialties, it often falls on primary care physicians to understand the role of genetics in clinical care.[5] In fact, genetic testing companies often direct patients to discuss their results with their primary care physician.[6] 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.[7] Despite these expectations, health professionals' awareness and knowledge of DTC genetic tests remains low.[8]

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

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

CMA POLICY

MEDICAL ASSISTANCE IN DYING

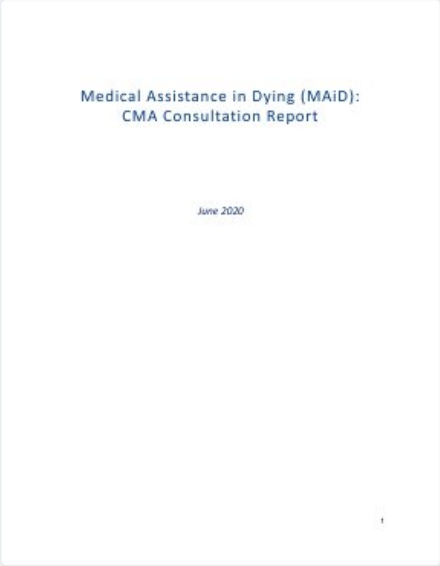
RATIONALE

The legalization of medical assistance in dying (MAID) raises a host of complex ethical and practical challenges that have implications for both policy and practice. The CMA supports maintaining the balance between these equally legitimate considerations: respecting decisional autonomy for those eligible Canadians who are seeking access, protecting vulnerable persons through careful attention to safeguards, and creating an environment in which practitioners are able to adhere to their moral commitments.

Recognizing the educational, legislative, regulatory and practice changes that will result, the CMA recommends that legislative and regulatory processes be coordinated at the federal and provincial/territorial levels to consistently guide health systems, practitioners and patients. To that end, the CMA calls for rigorous information gathering at all levels and for experience with and research on the impacts of this new practice to be reported as it unfolds. The CMA encourages medical schools to incorporate reflective training opportunities at the undergraduate and postgraduate levels that address all aspects of medical practice that might be affected by this new intervention. Further, CMA recognizes the opportunity that exists for all health systems and practitioners to facilitate effective patient access to information about all end-of-life care options.

The CMA acknowledges the importance of understanding that often acts within the realm of end-of-life care are distinct from the practice of medical assistance in dying. Further, the provision of specific assessments for eligibility to access medical assistance in dying is a distinct service unrelated to consultations for general palliative end-of-life care.

It is important that physicians be aware of this distinction and the relationship between legal, medical and ethical norms with respect to medical assistance in dying. The judicial and legislative branches of government have made changes to Canadian law in this area. Society has placed assistance in dying within the realm of regulated medical practitioners. Physicians' ethical norms and duties, arising from long-standing traditions that entail moral commitments to preserve and protect life, have not changed. The CMA supports the right of all physicians to



Medical Assistance in Dying (MAiD):
CMA Consultation Report

June 2020

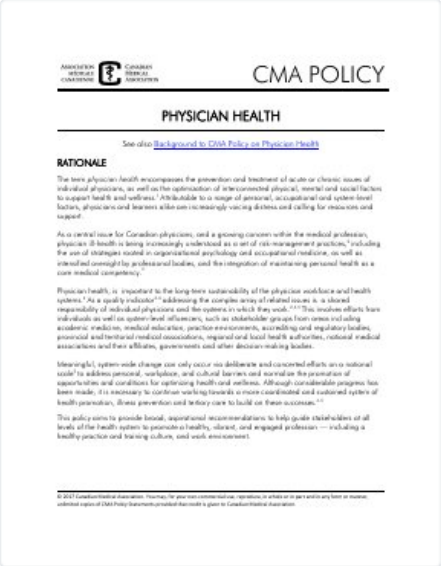
Physician health

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

POLICY TYPE	Policy document
DATE	2017-10-21

REPLACES	PD98-04 Physician health and well-being
TOPICS	Health human resources Ethics and medical professionalism

Documents

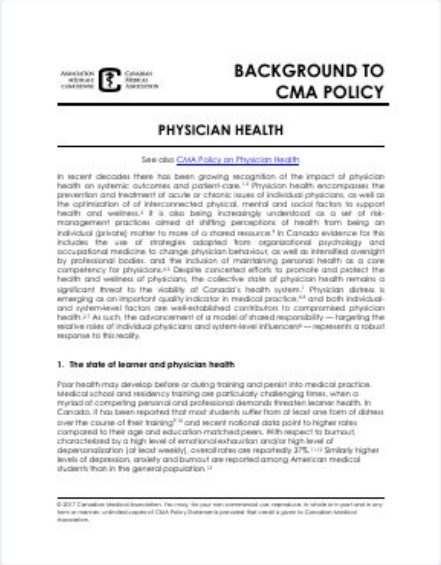


CMA POLICY

PHYSICIAN HEALTH

See also Background to CMA Policy on Physician Health

RATIONALE



BACKGROUND TO CMA POLICY

PHYSICIAN HEALTH

See also CMA Policy on Physician Health

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 promote a vibrant and engaged profession by identifying key 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 services and supports 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 has become a policy and practice imperative.

If meaningful, sustained improvements are to be achieved, the profession and other stakeholders will need to make deliberate commitments to reduce personal, cultural, and occupational barriers and to promote behaviours, practice, and conditions that optimize health and wellness. The CMA is committed to promoting a model of shared responsibility targeting 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 Background Document.

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 range of individual, socio-cultural, occupational, and systemic factors and includes efforts to develop preventive measures and treatments to address these issues. This new understanding enables us to look at physician health more 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

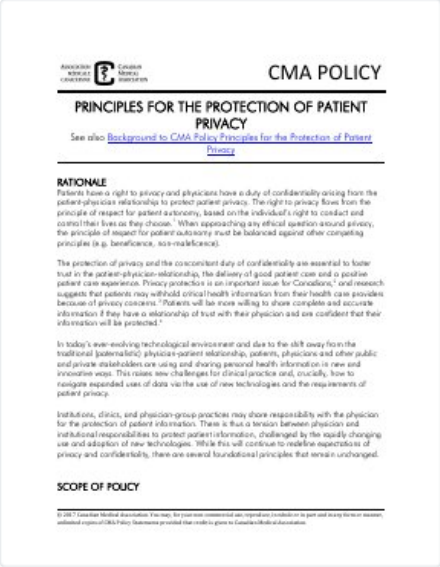
It is increasingly recognized that the complex range of factors that contribute to health and wellness need to be addressed at both the individual and systemic levels. While initiatives targeted to individual physicians remain relevant, there needs to be a greater focus on occupational and system-level 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



CMA POLICY

PRINCIPLES FOR THE PROTECTION OF PATIENT PRIVACY

See also Background to CMA Policy Principles for the Protection of Patient Privacy

RATIONALE

Patients have a right to privacy and physicians have a duty of confidentiality arising from the patient-physician relationship to protect patient privacy. The right to privacy flows from the principle of respect for patient autonomy, based on the individual's right to conduct and control their lives as they choose.[1] When approaching any ethical question around privacy, the principle of respect for patient autonomy must be balanced against other competing principles (e.g. beneficence, non-maleficence).

The protection of privacy and the concomitant duty of confidentiality are essential to foster trust in the patient-physician relationship, the delivery of good patient care and a positive patient care experience. Privacy protection is an important issue for Canadians,[2] and research suggests that patients may withhold critical health information from their health care providers because of privacy concerns.[3] Patients will be more willing to share complete and accurate information if they have a relationship of trust with their physician and are confident that their information will be protected.[4]

In today's ever-evolving technological environment and due to the shift away from the traditional (paternalistic) physician-patient relationship, patients, physicians and other public and private stakeholders are using and sharing personal health information in new and innovative ways. This raises new challenges for clinical practice and, crucially, how to navigate expanded uses of data via the use of new technologies and the requirements of patient privacy.

Institutions, clinics, and physician-group practices may share responsibility with the physician for the protection of patient information. There is thus a tension between physician and institutional responsibilities to protect patient information, challenged by the rapidly changing use and adoption of new technologies. While this will continue to redefine expectations of privacy and confidentiality, there are several foundational principles that remain unchanged.

SCOPE OF POLICY

BACKGROUND TO CMA POLICY

PRINCIPLES FOR THE PROTECTION OF PATIENT PRIVACY

See also CMA Policy on Principles for the Protection of Patient Privacy

Context

The advent of Electronic Medical Records, the rapid spread of mobile health apps, and the increasing use of social media within the health care community, have each created new challenges to maintaining a duty of confidentiality within the physician-patient relationship. These technologies present both opportunities and challenges with respect to medical professionalism.[1] The permeation of these types of interactions into everyday life now places physicians in new situations that some find difficult to navigate.[2] These challenges will only increase in the coming years, as the use of online technologies in health care is continuously growing.[3] Canada is only in the early stages of managing the emerging issues of technology-induced errors that compromise privacy in the health care setting.[4] Therefore, this paper will briefly discuss the importance of protecting privacy, followed by an overview of the main challenges to maintaining privacy as the physician-patient relationship evolves at the backdrop of emerging technologies.

Privacy and Confidentiality

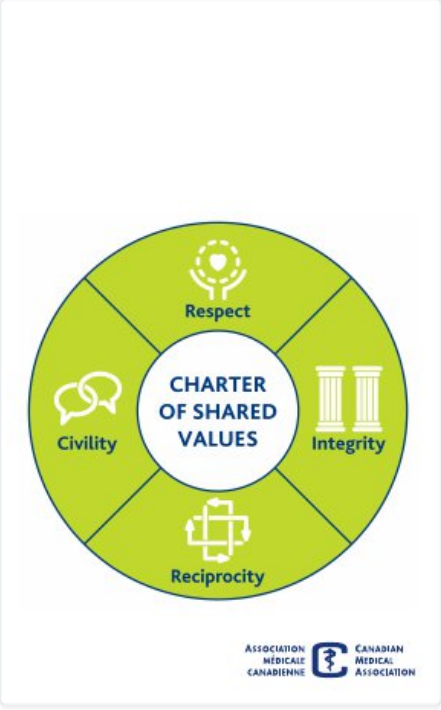
The overlapping, but not identical, principles of the protection of privacy and the duty of confidentiality are essential to the physician-patient relationship. These principles not only foster trust, but also the delivery of effective and lasting care. Rooted in the Hippocratic Oath, the modern-day right to privacy flows from the principle of autonomy, which attributes to individuals the right to conduct and control their lives as they choose.[5] Privacy protection is an important issue to Canadians,[6] with research suggesting that patients may even withhold critical health information because of privacy concerns.[7] Health care professionals are bound by legal and ethical standards to maintain privacy and confidentiality of patient information.[8] Physicians must therefore be aware of the implications of privacy legislation specific to their jurisdiction.[9] The duty to protect patient privacy is important to uphold, as health information can potentially be identifiable and sensitive, the confidentiality of this information must therefore be protected to ensure that patient privacy is not breached.[10] While the traditional, and largely obsolete, models of the physician-patient relationship involve a unidirectional flow

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

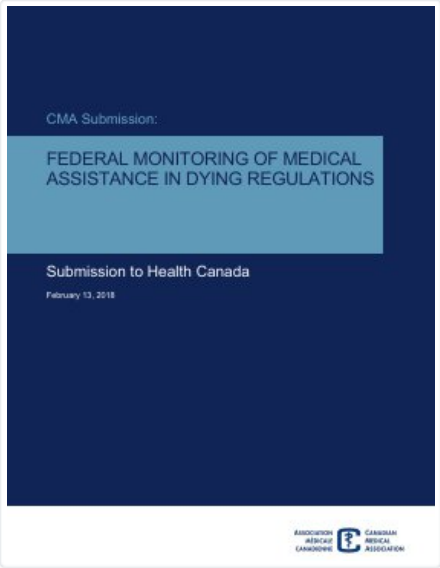


Federal monitoring of medical assistance in dying regulations

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

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

Documents

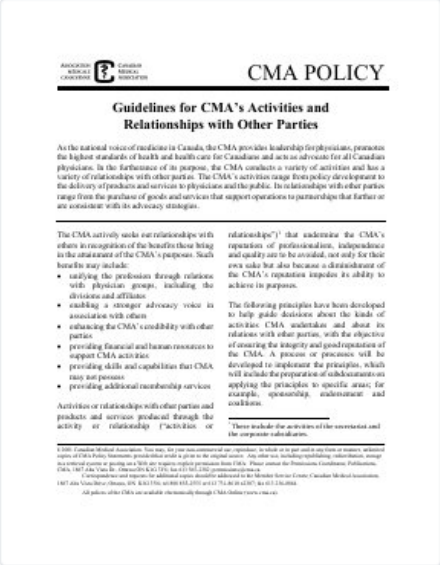


Guidelines for CMA's activities and relationships with other parties

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



CMA POLICY

Guidelines for CMA's Activities and Relationships with Other Parties

As the national voice of medicine in Canada, the CMA provides leadership for physicians, promotes the highest standards of health and health care for Canadians and acts as advocate for all Canadian physicians. In the furtherance of its purpose, the CMA conducts a variety of activities and has a variety of relationships with other parties. The CMA's activities range from policy development to the delivery of products and services to physicians and the public. Its relationships with other parties range from the purchase of goods and services that support operations to partnerships that further or are consistent with its advocacy strategies.

The CMA actively seeks out relationships with others in recognition of the benefits these bring in the attainment of the CMA's purposes. Such benefits may include:

- unifying the profession through relations with physician groups, including the divisions and affiliates
- enabling a stronger advocacy voice in association with others
- enhancing the CMA's credibility with other parties
- providing financial and human resources to support CMA activities
- providing skills and capabilities that CMA may not possess
- providing additional membership services

Activities or relationships with other parties and products and services produced through the activity or relationship ("activities or relationships")[1] that undermine the CMA's reputation of professionalism, independence and quality are to be avoided, not only for their own sake but also because a diminishment of the CMA's reputation impedes its ability to achieve its purposes.

The following principles have been developed to help guide decisions about the kinds of activities CMA undertakes and about its relations with other parties, with the objective of ensuring the integrity and good reputation of the CMA. A process or processes will be developed to implement the principles, which will include the preparation of subdocuments on applying the principles to specific areas; for example, sponsorship, endorsement and coalitions.

[1] These include the activities of the secretariat and the corporate subsidiaries.

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)

Why Medical Professionalism?

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

BEST PRACTICES FOR SMARTPHONE AND SMART-DEVICE CLINICAL PHOTO TAKING AND SHARING

BACKGROUND

Clinical photography is a valuable tool for physicians. Smartphones, as well as other devices supporting network connectivity, offer a convenient, efficient method to take and share images. However, due to the private nature of the information contained in clinical photographs there are concerns as to the appropriate storage, dissemination, and documentation of clinical images. Confidentiality of image data must be considered and the dissemination of these images onto servers must respect the privacy and rights of the patient. Importantly, patient information should be considered as any information deriving from a patient, and the concepts outlined therefore apply to any media that can be collected on, or transmitted with, a smart-device.

Clinical photography can aid in documenting form and function, in tracking conditions and wound healing, in planning surgical operations, and in clinical decision-making. Additionally, clinical photographs can provide physicians with a valuable tool for patient communication and education. Due to the convenience of this type of technology it is not appropriate to expect physicians to forego their use in providing their patients with the best care available.

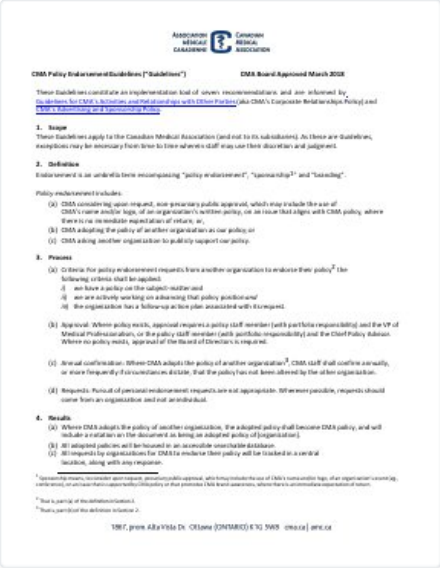
The technology and software required for secure transfer, communication, and storage of clinical media is presently available, but many devices have non-secure storage/dissemination options enabled and lack user-control for permanently deleting digital files. In addition, data uploaded onto server systems commonly cross legal jurisdictions. Many physicians are not comfortable with the practice, citing security, privacy, and confidentiality concerns as well as uncertainty in regards to regional regulations governing this practice. Due to concern for patient privacy and confidentiality it is therefore incredibly important to limit the insecure or undocumented acquisition or dissemination of clinical photographs.

CMA Policy Endorsement Guidelines

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

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

Documents

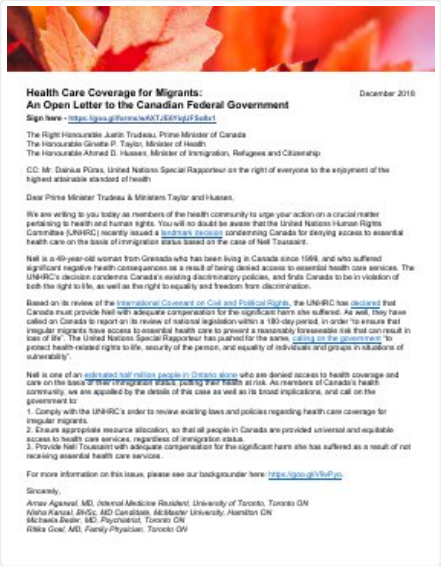


Health Care Coverage for Migrants: An Open Letter to the Canadian Federal Government

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://goo.gl/forms/wAXTJ64YkpUF5o8x1

The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Ginette P. Taylor, Minister of Health
The Honourable Ahmed D. Hussen, Minister of Immigration, Refugees and Citizenship

CC: Mr. Dainius Pūras, 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 Hussen,

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 decision condemning Canada for denying access to essential health care on the basis of immigration status based on the case of Nell Toussaint.

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 well, they have called on Canada to report on its review of national legislation within a 180-day period, in order "to ensure that irregular 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 pushed for the same, calling 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 this 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 irregular 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 Toussaint 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 backgrounder here: https://goo.gl/VvPyo

Sincerely,

Aman Agarwal, MD, Internal Medicine Resident, University of Toronto, Toronto ON
Waha Kanual, BHSc, MD Candidate, McMaster University, Hamilton ON
Michaela Beder, MD, Psychiatrist, Toronto ON
Ritika Goel, 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

JOINT STATEMENT ON PREVENTING AND RESOLVING ETHICAL CONFLICTS INVOLVING HEALTH CARE PROVIDERS AND PERSONS RECEIVING CARE

This joint statement was developed cooperatively and approved by the Boards of Directors of the Canadian Healthcare Association, the Canadian Medical Association, the Canadian Nurses Association and the Catholic Health Association of Canada

Preamble

The needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care. Ideally, health care decisions will reflect agreement between the person receiving care and all others involved in his or her care. However, uncertainty and diverse viewpoints sometimes can give rise to disagreement about the goals of care or the means of achieving those goals. Limited health care resources and the constraints of existing organizational policies may also make it difficult to satisfy the person's needs, values and preferences.

The issues addressed in this statement are both complex and controversial. They are ethical issues in that they involve value preferences and arise where people of good will are uncertain of or disagree about the right thing to do when someone's life, health or well-being is threatened by disease or illness. Because everyone's needs, values and preferences are different, and because disagreements can arise from many sources, policies for preventing and resolving conflicts should be flexible enough to accommodate a wide range of situations.

Disagreements about health care decisions can arise between or among any of the following: the person receiving care, proxies,[1] family members, care providers and administrators of health care authorities, facilities or agencies. This joint statement deals primarily with conflicts between the person receiving care, or his or her proxy, and care providers. It offers guidance for the development of policies for preventing and resolving ethical conflicts about the appropriateness of initiating, continuing, withholding or withdrawing care or treatment. It outlines the basic principles to be taken into account in the development of such policies as well as the steps that should be followed in resolving conflicts. The sponsors of this statement encourage health care authorities, facilities and agencies to develop policies to deal with these and other types of conflict, for example, those that sometimes arise among care providers.

Principles of the therapeutic relationship[2]

Good therapeutic relationships are centered on the needs and informed choices of the person receiving care. Such relationships are based on respect and mutual giving and receiving. Observance of the following principles will promote good therapeutic relationships and help to prevent conflicts about the goals and means of care.

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

CMA POLICY

PRINCIPLES CONCERNING PHYSICIAN INFORMATION

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

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Documents

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

BRIEF

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"Putting Patients First"

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Nov. 25 1999
Ottawa, Ontario

For further information, contact
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Leadership for Physicians – Mobilité for Canadians
Leadership pour les médecins – Mobilité pour les Canadiens

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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