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*

A Doctor for Every Canadian - Better Planning for Canada's Health Human Resources: The Canadian Medical Association's brief to the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities - Addressing Existing Labour Shortages in High-Demand Occupations

https://policybase.cma.ca/link/policy10387

POLICY TYPE	Parliamentary submission
DATE	2012-05-09
TOPICS	Health human resources

Documents

A Doctor for Every Canadian – Better Planning for Canada's Health Human Resources

The Canadian Medical Association's brief to the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities – Addressing Existing Labour Shortages in High-Demand Occupations

Presented by:

Dr. John Haggie, MB ChB, MD, FRCS
President

May 9, 2012

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

Check against delivery

A healthy population and a vibrant medical profession
Une population en santé et une profession médicale dynamique

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

Accessibility: the solution lies in cooperation

https://policybase.cma.ca/link/policy11518

POLICY TYPE	Parliamentary submission
DATE	2015-03-25
TOPICS	Health human resources

Documents

BD-INFO 15-33

AMQ

ACCESSIBILITY: THE SOLUTION LIES IN COOPERATION

Joint Brief of

The Quebec Medical Association
and
the Canadian Medical Association

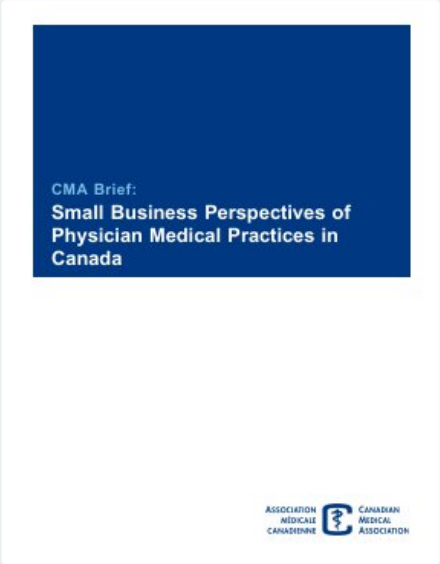
BILL no. 20:
An Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation
March 25, 2015

Small business perspectives of physician medical practices in Canada

https://policybase.cma.ca/link/policy11846

POLICY TYPE	Parliamentary submission
DATE	2016-03-21
TOPICS	Physician practice, compensation, forms Health human resources

Documents

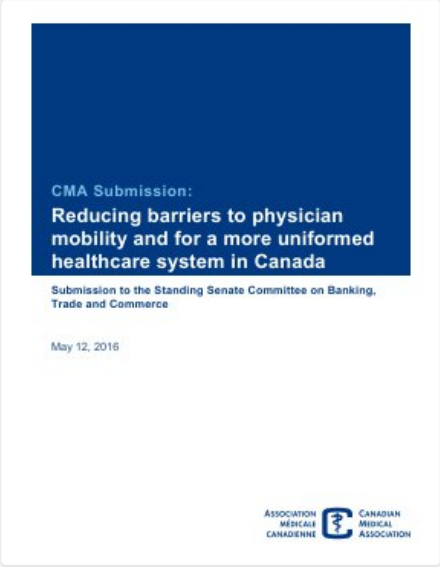


Reducing barriers to physician mobility and for a more uniformed healthcare system in Canada

https://policybase.cma.ca/link/policy11850

POLICY TYPE	Parliamentary submission
DATE	2016-05-12
TOPICS	Health human resources

Documents

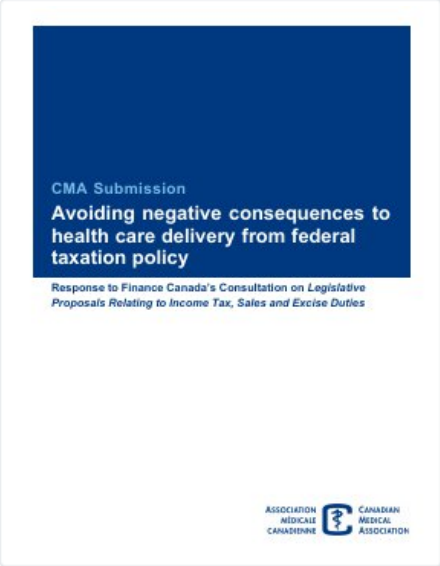


Avoiding negative consequences to health care delivery from federal taxation policy

https://policybase.cma.ca/link/policy11957

POLICY TYPE	Response to consultation
DATE	2016-08-31
TOPICS	Health human resources Physician practice, compensation, forms

Documents



The physician appointment and reappointment process 2016

https://policybase.cma.ca/link/policy13564

POLICY TYPE	Policy document
DATE	2016-12-03
TOPICS	Health human resources Physician practice, compensation, forms

Documents

CMA POLICY

THE PHYSICIAN APPOINTMENT AND REAPPOINTMENT PROCESS 2016

Executive summary

Beginning in the 1990s most jurisdictions established regional health authorities (RHAs) with consolidated medical staff structures and there has been a trend toward requiring all physicians practising in a region to hold an appointment with the RHA in order to access health resources such as diagnostic imaging and laboratory services, irrespective of whether they hold hospital privileges or not. Subsequent to the consolidation of medical staff governance there have been several developments over the past decade that have implications for where and how physicians can practise, and for their ability to advocate freely on behalf of their patients. These include:

- the establishment of formal physician resource plans that link the appointment process to the ability to participate in the provincial/territorial medical insurance plan;
- a greater focus on clinical governance that includes detailed attention on scope of practice and privileges;
- a growing concern about the ability of physicians to advocate on behalf of their patients and the communities they serve; and
- an increase in the number of physicians entering into employment or contractual arrangements.

The Canadian Medical Association (CMA) puts forward the following recommendations for governments, regulatory authorities, RHAs and medical staff structures within RHAs and hospitals.

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

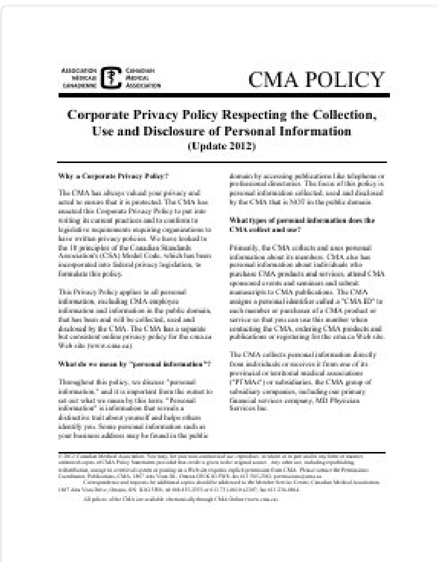
THE FUTURE OF MEDICINE

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

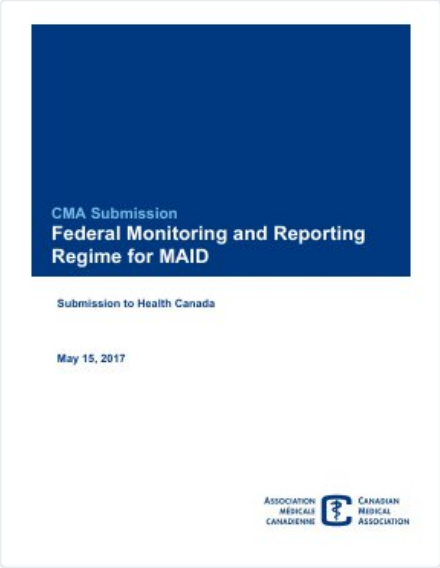
Corporate Privacy Policy Respecting the Collection, Use and Disclosure of Personal Information
(Update 2012)

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

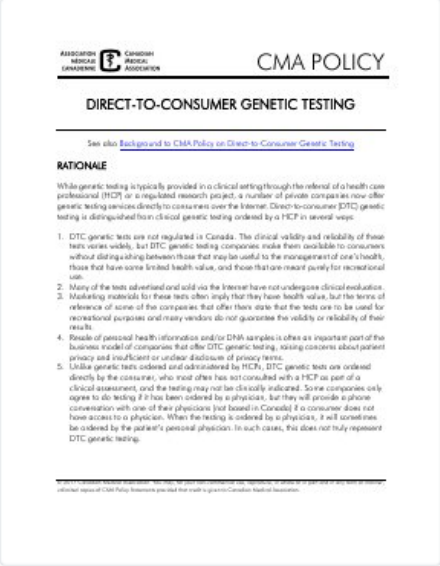
RATIONALE

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

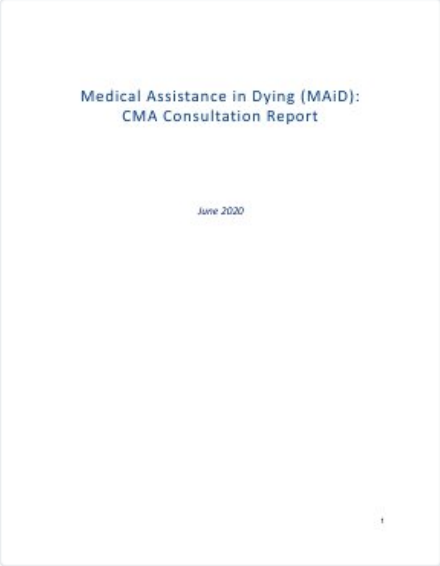
RATIONALE

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 otherwise 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

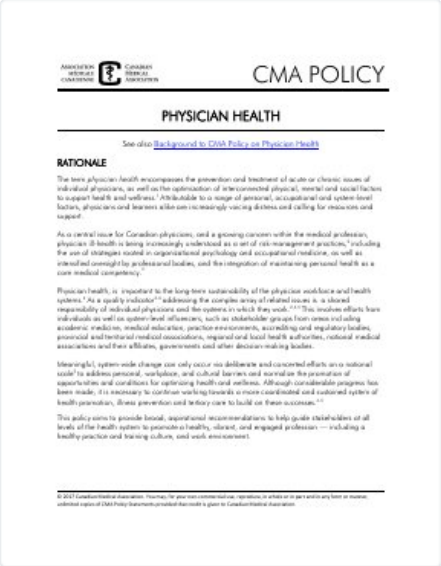
Physician health

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

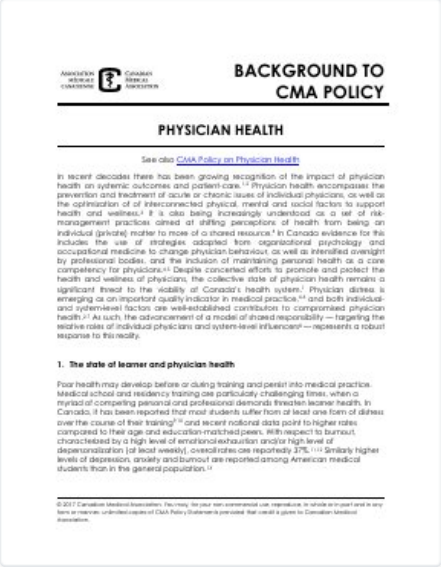


CMA POLICY

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

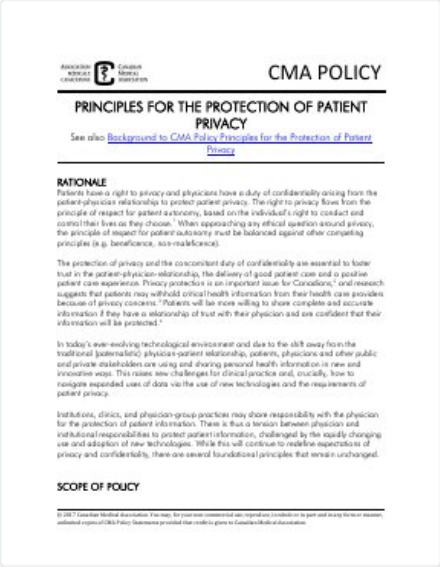
It is increasingly recognized that the complex range of factors that contribute to health and wellness need to be addressed at both the individual and systemic levels. While initiatives targeted to individual physicians remain relevant, there needs to be a greater focus on occupational and system-level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

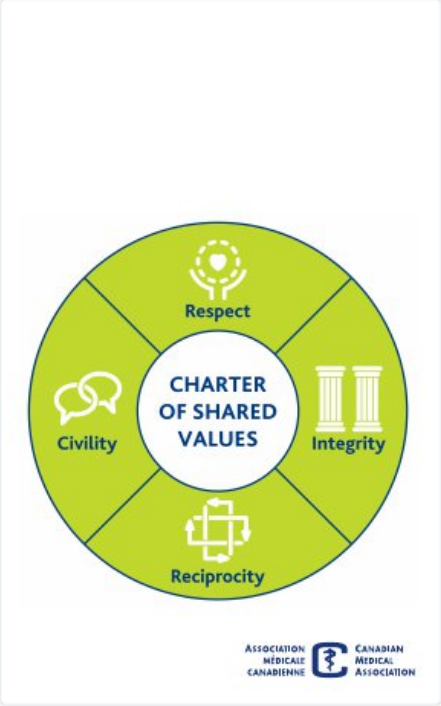
The overlapping, but not identical, principles of the protection of privacy and the duty of confidentiality are essential to the physician-patient relationship. These principles not only foster trust, but also the delivery of effective and lasting care. Rooted in the Hippocratic Oath, the modern-day 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

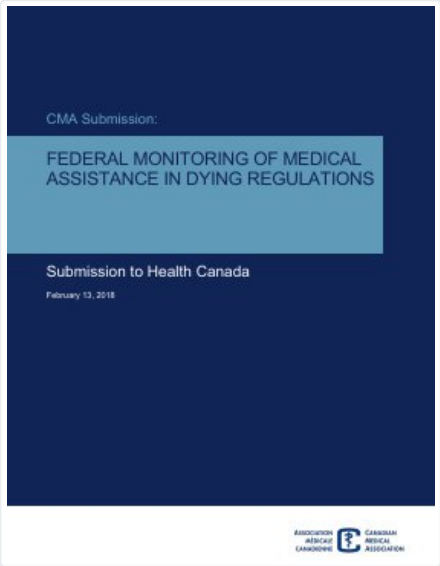


Federal monitoring of medical assistance in dying regulations

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

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

Documents

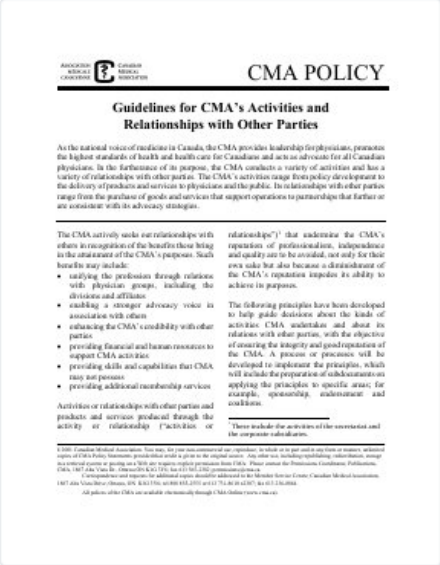


Guidelines for CMA's activities and relationships with other parties

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)