

Antimicrobial Resistance (AMR)

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

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

Documents

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Antimicrobial Resistance (AMR)

See also [Background to CMA Policy on Antimicrobial Resistance PD19-08](#)

Context

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

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

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

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

* All the policy recommendations made in this document are not meant to be interpreted as clinical practice guidelines. They represent the expert best view on whether should promptly proceed to practice.
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BACKGROUND TO CMA POLICY

Antimicrobial Resistance

See also [CMA Policy Antimicrobial Resistance PD19-08](#)

OVERVIEW

The world is at the tipping point of a post-antibiotic era. "Worldwide, we are relying more heavily on antibiotics to ensure our medical, nutritional, and economic security, while simultaneously causing the decline of their usefulness with overuse and ill advised use."¹ It is estimated that the world's use of antimicrobials increased by 65% between 2000 and 2015 — nearly as fast as middle-income countries.²

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

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

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

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

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

POLICY TYPE

Policy endorsement

DATE

2019-10-17

TOPICS

Health care and patient safety
Population health, health equity, public health

Documents

GUIDELINE **VULNERABLE POPULATIONS**

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

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Use of related articles at www.cmaj.ca/lookup/doi/10.1503/cmaj.141657

Homeless and vulnerably housed populations are heterogeneous and continue to grow in numbers in urban and rural settings on a basis of a combination of the high prevalence and underlying factors. Collectively, they face ongoing living conditions and marginalization in the health care system. However, providers can improve the health of people who are homeless or vulnerably housed, most powerfully by following evidence-based clinical steps, and are being well-served by following evidence-based approaches.

By fully embracing "homelessness" as a complex, multi-faceted condition, providers and organizations can address the needs of these individuals and families by addressing their social, mental, and physical health risks that significantly impact their quality of life. For example, people who are homeless and vulnerably housed experience a significantly higher prevalence of chronic, mental health conditions and substance use disorders than the general population.^{1,2} Canadian research reports that people who experience homelessness face life expectancy that are 10 years shorter and 10 years shorter.³

If population ages, homelessness, Canada, since largely stable, age-specific rates are higher than those of the general population.⁴ Today, the approach to homelessness has shifted to include higher prevalence of chronic, physical and mental health conditions, often with multiple and complex health care needs.⁵ For example, family homelessness (and homelessness experience among other forms of homelessness) is a significant, persistent part of the crisis in 2018, and the estimated 2.5 million homeless people in Canada, 27.5% were women, 18.7% were youth, 6% were racialized (immigrants or refugees), and a growing number were veterans and seniors.⁶

KEY POINTS

- Clinical assessment and care of homeless and vulnerably housed populations should include taking account of a person's gender, age, language, literacy, ethnicity, and history of trauma, and of access to comprehensive primary health care.
- An initial step is to take care of homeless and vulnerably housed populations, primarily by ensuring that they have access to case management services, with access to primary care, mental health, and substance use services, and to support services such as food, shelter, and health, education, and social services.
- Homelessness interventions, such as supported independent housing, and services such as case management, are recommended for people who are homeless.

Practice managers, given support, will lead and primary care providers can work jointly to identify social causes of poor health and provide a solution for a patient's needs.⁷ A patient's medical history is a family practice defined by the patient as the place they live, their social history, and the place they live, their social and family health and medical services.⁸ Medical care is "family practice, not just for the patient, but also for the patient's family, and is usually integrated with other services in the health care system. The community" (Baker) will not be successful if it does not take a primary care approach that is patient-centered, family practice, chronic care, prevention, diagnosis and treatment, and rehabilitation services.⁹

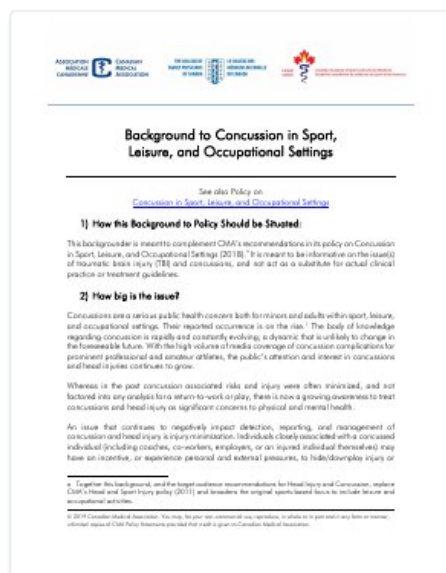
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Concussion in Sport, Leisure, and Occupational Settings

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

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

Documents

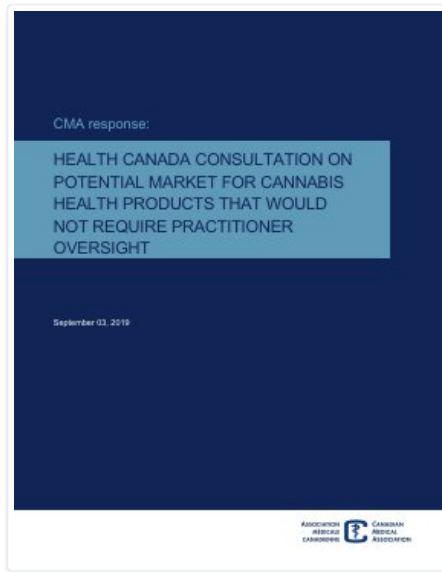


Health Canada consultation on potential market for cannabis health products that would not require practitioner oversight

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

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

Documents

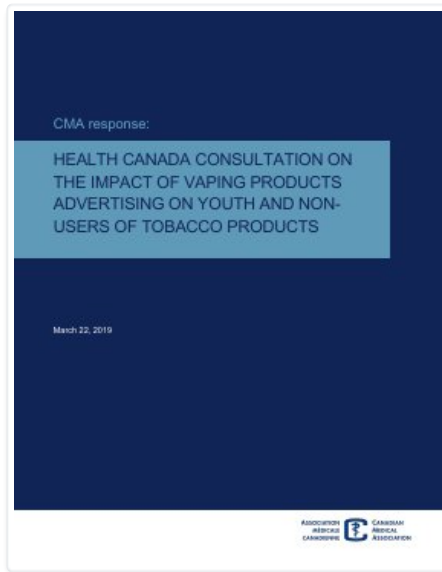


Health Canada consultation on the impact of vaping products advertising on youth and non-users of tobacco products

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

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

Documents

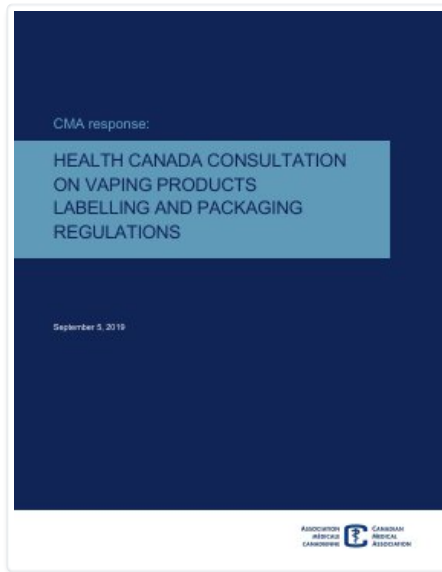


Health Canada consultation on vaping products labelling and packaging regulations

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

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

Documents



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

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

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

Documents



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

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

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

Documents

“Listening to our Patient’s Concerns”

Comments on Bill C-54

(Personal Information Protection and Electronic Document Act)

Submission to the House of Commons Standing Committee on Industry

March 18, 1999

Ottawa, Ontario

For further information, contact
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Leadership in Prevention • Health for Canadians
Leadership pour la Prévention • Santé pour les Canadiens

“Listening to our Patient’s Concerns”

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

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

Executive Summary

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

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

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

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

Organ and tissue donation and transplantation

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

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

Documents

The cover page features the CMA logo at the top left, followed by the text 'CMA POLICY' and the title 'ORGAN AND TISSUE DONATION AND TRANSPLANTATION'. Below the title is a link to the background document. The 'RATIONALE' section discusses the rapidly changing area of medical science and practice, the need for renewed consideration of ethical issues, and the overarching principle that guides CTD in public trust. The 'Scope' section identifies foundational principles to address challenges surrounding deceased and living donation.

The cover page features the CMA logo at the top left, followed by the text 'BACKGROUND TO CMA POLICY' and the title 'ORGAN AND TISSUE DONATION AND TRANSPLANTATION'. Below the title is a link to the policy document. The 'Context' section discusses organ donation wait lists in Canada, the increasing viability of organ transplantation, and the effectiveness of immunosuppressive medications. It also provides statistics on organ donation and transplantation in Canada and compares it to the United States.

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



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

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

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

Documents



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

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

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

Documents

