Delegate Motions

1.	DM5 -	26	18.	DM5 -	36
2.	DM5 -	28	19.	DM5 -	52
3.	DM5 -	29	20.	DM5 -	53
4.	DM5 -	66	21.	DM5 -	21
5.	DM5 -	69	22.	DM5 -	6
6.	DM5 -	30	23.	DM5 -	22
7.	DM5 -	15	24.	DM5 -	10
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10.	DM5 -	18	27.	DM5 -	41
11.	DM5 -	19	28.	DM5 -	50
12.	DM5 -	20	29.	DM5 -	23
13.	DM5 -	31	30.	DM5 -	45
14.	DM5 -	32	31.	DM5 -	24
15.	DM5 -	33	32.	DM5 -	11
16.	DM5 -	34	33.	DM5 -	64
17.	DM5 -	4	34.	DM5-	13

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-26
MOVER Dr. William Cunningham
SECONDER Dr. Adam Steacie

The Canadian Medical Association recognizes obesity as a chronic medical disease.

MOTION DM 5-28
MOVER Mr. Denis Yahiaoui
SECONDER Dr. Pierre Harvey

The Canadian Medical Association recommends the development of a national compensation program for people with debilitating injuries associated with vaccination.

MOTION DM 5-29
MOVER Dr. Michel Welt
SECONDER Dr. Pierre-Charles Gosselin

The Canadian Medical Association recommends the development of a structured screening program for cervical cancer that includes detection of high-risk human papillomavirus in vulnerable groups.

MOTION DM 5-66
MOVER Dr. Yun Jen
SECONDER Dr. Bruno L'Heureux

The Canadian Medical Association will conduct a campaign to urge governments to restore and increase public health budgets.

MOTION DM 5-69
MOVER Dr. Yun Jen
SECONDER Dr. Chris Simpson

The Canadian Medical Association recommends that governments authorize elementary and secondary schools to require a declaration of immunization status, to be followed by a conversation between public health officials and parents where children are shown to be inadequately immunized.

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-30
MOVER Dr. Darcy Johnson
SECONDER Dr. Carolyn Lane

The Canadian Medical Association recommends patient populations that fall under federal jurisdiction should have access to the same effective and appropriate care as all other Canadians.

MOTION DM 5-15
MOVER Dr. Chris Simpson
SECONDER Dr. Adam Steacie

The Canadian Medical Association urges the pan-Canadian Pharmaceutical Alliance to invite the federal government and private health insurance industry to participate in its price negotiations for prescription drugs.

MOTION DM 5-16
MOVER Dr. Kieran Moore
SECONDER Dr. Adam Steacie

The Canadian Medical Association endorses the concept of a basic income guarantee.

MOTION DM 5-17
MOVER Dr. Kieran Moore
SECONDER Dr. Adam Steacie

The Canadian Medical Association supports the development and implementation of a national strategy on the use of naloxone.

MOTION DM 5-18
MOVER Dr. Kieran Moore
SECONDER Dr. Adam Steacie

The Canadian Medical Association supports the development of an equitable and comprehensive national pharmacare program.

MOTION DM 5-19
MOVER Dr. Bill Mackie
SECONDER Dr. Alexander Frame

The Canadian Medical Association supports divestment of holdings in fossil fuel investments.

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-20
MOVER Dr. Peter Barnsdale
SECONDER Dr. Charles Webb

The Canadian Medical Association supports the organization, centralization and management of cradle-to-grave medical records for patients living in Canada.

MOTION DM 5-31
MOVER Dr. Don Milliken
SECONDER Dr. Lloyd Oppel

The Canadian Medical Association calls for regulations on the marketing of direct-to-consumer genetic testing for health purposes.

MOTION DM 5-32
MOVER Dr. Granger Avery
SECONDER Dr. Raj Bhui

The Canadian Medical Association supports the development of a national strategy to integrate precision medicine into clinical care.

MOTION DM 5-33
MOVER Dr. Ian Gillespie
SECONDER Dr. Don Milliken

The Canadian Medical Association calls for a review of national, provincial and territorial informed-consent and privacy legislation to reflect the challenges created by the introduction of genetic testing.

MOTION DM 5-34
MOVER Dr. Charles Webb
SECONDER Dr. Lloyd Oppel

The Canadian Medical Association recommends that primary care telemedicine investments, policies and regulations support comprehensive and continuous patient-centred care.

MOTION DM 5-4
MOVER Dr. Cindy Forbes
SECONDER Dr. Chris Simpson

The Canadian Medical Association will provide information and tools to physicians to promote the medical profession's critical role in supporting immunization.

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-36
MOVER Dr. Cindy Forbes
SECONDER Dr. Chris Simpson

The Canadian Medical Association calls for immunization registries that can accept information directly from the electronic medical records of health care providers.

MOTION DM 5-52
MOVER Dr. Courtney Howard
SECONDER Dr. Ewan Affleck

The Canadian Medical Association will divest its reserves of investments in energy companies whose primary business relies upon fossil fuels.

MOTION DM 5-53
MOVER Dr. Courtney Howard
SECONDER Dr. Steve Kraus

The Canadian Medical Association will explore investment opportunities, for its reserves, in renewable energy solutions.

MOTION DM 5-21
MOVER Dr. Courtney Howard
SECONDER Dr. Monika Dutt

The Canadian Medical Association will promote a strong, predictable price on carbon emissions.

MOTION DM 5-6
MOVER Dr. Alan Ruddiman
SECONDER Dr. Granger Avery

The Canadian Medical Association will advocate for a generalist approach across the medical career life cycle.

MOTION DM 5-22
MOVER Dr. Gail Beck
SECONDER Dr. Deborah Hellyer

The Canadian Medical Association will develop workplace guidelines for physicians who have or develop disabilities or disease.

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-10
MOVER Dr. Gary Chaimowitz
SECONDER Mr. Mathew Nicholas

The Canadian Medical Association will promote the development of clinical tools to assist physicians and physicians-in-training improve their understanding of the specific health care needs of individuals who identify themselves as lesbian, gay, bisexual, transgender and/or queer.

MOTION DM 5-40
MOVER Dr. Alison Freeland
SECONDER Dr. Doug Weir

The Canadian Medical Association promotes increased knowledge amongst physicians in the practice of trauma-informed care.

MOTION DM 5-49
MOVER Dr. Allan Studniberg
SECONDER Dr. Ken Arnold

The Canadian Medical Association will work with the insurance industry to develop guidelines for physicians who provide patients with information related to travel insurance.

MOTION DM 5-41
MOVER Dr. Gary Chaimowitz
SECONDER Dr. Doug Weir

The Canadian Medical Association will consult with Health Canada to discuss the effects of online gambling.

MOTION DM 5-50
MOVER Dr. Allan Studniberg
SECONDER Dr. Laurent Marcoux

The Canadian Medical Association will create a working group to evaluate federal forms used by physicians.

148th GENERAL COUNCIL
DELEGATES' MOTIONS
(Note: Motion pages attached)

MOTION DM 5-23
MOVER Dr. Gary Chaimowitz
SECONDER Dr. Rob Swenson

The Canadian Medical Association calls on the federal government to amend the Criminal Code by making it a specific criminal offence to assault health care providers performing their duties.

MOTION DM 5-45
MOVER Dr. Alika Lafontaine
SECONDER Dr. Richard Johnston

The Canadian Medical Association will convene a national roundtable to eliminate jurisdictional barriers and establish best-care practices that acknowledge the unique circumstances of Aboriginal communities.

MOTION DM 5-24
MOVER Dr. Alika Lafontaine
SECONDER Dr. Richard Johnston

The Canadian Medical Association will promote practical advocacy strategies to support the health and well-being of First Nations communities in Canada.

MOTION DM 5-11
MOVER Dr. Bryce Durafourt
SECONDER Dr. Salina Teja

The Canadian Medical Association supports in principle the right of Canadian medical students and medical residents to vote in the election of their medical association representatives.

MOTION DM 5-64
MOVER Dr. Chris Ekong
SECONDER Dr. Mark Brown

The Canadian Medical Association will work with the Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada to provide a unified voice when advocating on issues of common interest.

MOTION DM 5-13
MOVER Dr. Salina Teja
SECONDER Dr. Natasha Snelgrove

The Canadian Medical Association affirms its support for the continued use of the arm's-length, anonymous pre-accreditation survey as an integral component of the national system of accreditation for postgraduate medical education.

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. William Cunningham

SECONDER Dr. Adam Steacie

MOTION

The Canadian Medical Association recognizes obesity as a chronic medical disease.

1. SUBSTANTIVE RATIONALE

In 2013, the American Medical Association adopted policy that recognized obesity as a chronic medical disease and urgent medical health problem with the goal that it will help change the way the medical community tackles this complex issue. Many argue that obesity is a pathophysiologic disease. There is a treatment for this disease, which involves behavioural modifications, medications and surgery. Recognizing that obesity is a disease will reduce the stigma of obesity that stems from the widespread perception that it is simply the result of eating too much or exercising too little. Additionally, obesity fits medical criteria of a disease in that excess body fat, which results from myriad genetic, behavioural, and other environmental factors, impairs a number of normal body functions. Classifying obesity as a disease would lead to more appropriate treatment, resources and research that can improve health outcomes at a population health level.

2. KEY STAKEHOLDERS: Public Health Agency of Canada, provincial/territorial health ministries, health charities and patient groups

3a. SUGGESTED IMPLEMENTATION: CMA will incorporate this in its Parliamentary advocacy and in its participation with various advocacy alliances such as the Chronic Disease Prevention Alliance of Canada. Links to patient materials could be added to cma.ca in the clinical resources area.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): We can promote this resolution within our own health care communities and local medical societies.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x		**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 6/5/2015 5:54:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Mr. Denis Yahiaoui

SECONDER Dr. Pierre Harvey

MOTION

The Canadian Medical Association recommends the development of a national compensation program for people with debilitating injuries associated with vaccination.

1. SUBSTANTIVE RATIONALE

Immunization programs are some of the most effective public health measures in Canada. Vaccines have led to a major decline in the incidence of preventable diseases. Nonetheless, despite best practices by vaccine manufacturers and health care professionals during preparation and administration of the vaccines, some individuals develop serious side effects, even death.

Individuals who are vaccinated not only protect themselves, but also protect the general public thanks to the herd immunity phenomenon. These individuals, therefore, contribute to the public health by getting vaccinated. If a person develops side effects, it is the government's duty to compensate them, on the ethical principle of reciprocity since the side effects occurred while the person was contributing to the public health. Among the G8 countries, only Canada and Russia have yet to adopt a federal compensation program for debilitating vaccine injuries. Such a program would result in a rise in vaccinations, since people afraid of developing serious side effects and no longer being able to work would be more inclined to get vaccinated.

2. KEY STAKEHOLDERS: Federal ministry of health, Public Health Agency of Canada

3a. SUGGESTED IMPLEMENTATION: n/a

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being		x		
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: Currently in Canada (except for Quebec), if individuals want to obtain compensation for a sequel caused by a vaccine, they must file civil lawsuits. The civil courts are based on the principle of indemnifying victims of negligence, so they are restored to the state they were before commission of said negligence. Since vaccines are prepared following best practices of manufacturing and administration, vaccine manufacturers prevail because there is no negligence on their part. — **Received on:** 6/19/2015 2:36:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Michel Welt

SECONDER Dr. Pierre-Charles Gosselin

MOTION

The Canadian Medical Association recommends the development of a structured screening program for cervical cancer that includes detection of high-risk human papillomavirus in vulnerable groups.

1. SUBSTANTIVE RATIONALE

Advanced cervical neoplasia is an all too common cause of suffering, morbidity and mortality among Canadian women, considering that the vast majority of cases of advanced neoplasia can be prevented by organized screening programs.
Current provincial and territorial screening programs are often expensive or inefficient, if they exist at all, and they differ widely from one jurisdiction to the other. The programs also have difficulties reaching high–risk and/or disadvantaged groups.
Recent studies show that early screenings for cervical cancer based on the detection of high–risk human papillomavirus (HPV) are clinically and economically superior, compared to screenings based on cervical cytology.
In April 2015, a group of recognized experts published guidelines for cervical cancer screenings based on the detection of high–risk HPV.
Considering the enormous positive effects of cervical cancer screening programs, CMA strongly urges provinces and territories to invest in research and development for a screening program.

2. KEY STAKEHOLDERS: Provincial/territorial governments, CMA, provincial/territorial medical associations, the Society of Obstetricians and Gynaecologists of Canada, provincial/territorial obstetricsgynecology associations

3a. SUGGESTED IMPLEMENTATION: Collaborative work from CMA and provincial/territorial medical associations must be undertaken to reach and educate government officials from the provinces and territories.

National, provincial, and territorial obstetrician/gynaecology associations could be mobilized in the process by sharing their expertise and recommendations. A committee could be set up in order to facilitate this implementation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care				
➢ Maximize strategic relationships				
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: References

-Use of primary high-risk human papillomavirus testing for cervical cancer screening: Interim Clinical Guidance. Warner K.

Huh & al. Journal of Lower Genital Tract Disease. April 2015;19(2).
-Ronco G. & al. Efficacy of HPV-based screening for prevention of invasive cervical cancer: follow-up of four European randomised controlled trials. Lancet. 2014;383:524-32
-Wright TC & al. Primary cervical cancer screening with human papillomavirus: end of study results from the ATHENA Study using HPV as the first line screening test. Gynecology Oncology. In press.
-Zhao FH & al. Performance of high risk human papillomavirus DNA testing as a primary screen for cervical cancer: a pooled analysis of individual patient data from 17 population-based studies from China. Lancet Oncology, 2010;11:1160-71
- Katki GJ & al. Reassurance against future risk of precancer and cancer conferred by a negative human papillomavirus test. J Natl Cancer Inst, 2014; 106:1-4 — **Received on:** 6/19/2015 2:37:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Yun Jen

SECONDER Dr. Bruno L'Heureux

MOTION

The Canadian Medical Association will conduct a campaign to urge governments to restore and increase public health budgets.

1. SUBSTANTIVE RATIONALE

In Canada public health is a shared responsibility between the federal, provincial, and territorial governments and also involves the private sector and NGOs (7). In recent years, however, those in the field have noted a tendency for governments to considerably scale back their support for public health. Major federal cutbacks were announced in the 2012–2013 budget, with spending slashed by 11% ($68 million) and nearly 500 jobs eliminated for that single year (1,2). Provincial and territorial governments are also making big cuts in public health spending. In Ontario, budgets have been drastically reduced and jobs eliminated in recent years (3). In Quebec, only 2% of health care spending goes to public health (4,5), and regional public health branches saw their budgets slashed 30% effective April 1, 2015. The situation has become sufficiently dire for the Canadian Public Health Association to intercede with the Quebec government and express its concerns that the cuts could have an impact right across the country (5). Many have criticized the fact that Canada's chief public health officer is relegated to the role of advisor to the minister of health and has no decision-making authority (4,6). Considering how each dollar invested in prevention generates an average savings of $5.60 on avoidable health care costs, it is vital that budgets are reinstated and increased to guarantee the health of Canadians.

2. KEY STAKEHOLDERS: CMA, federal, provincial, and territorial governments, provincial and territorial medical associations

3a. SUGGESTED IMPLEMENTATION: Organize meetings with the offices of the Prime Minister, health minister and Treasury Board, and health, finance, and education ministries. Organize meetings with Opposition parties. Organize an awareness campaign to educate the public and build support for reversing public health cuts.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x				**x**

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: (1) Canadian Public Health Association. Analysis: The 2013 Federal Budget from the public health perspective http://www.cpha.ca/en/about/media/budget20130321.aspx

(2) Parliamentary Debates of March 25th, 2014 https://openparliament.ca/debates/2014/3/25/rona-ambrose-1/
(3) Ottawa Sun. Jon Willing. Jan. 19, 2015. Public Health cuts jobs. http://www.ottawasun.com/2015/01/19/public-health-cuts-jobs
(4) Canadian Journal of Public Health. Nov.-Dec. 2014, p. 401-403. Canadian public health under siege. http://journal.cpha.ca/index.php/cjph/article/view/4960/2995
(5) Annulation des coupures imposées aux directions régionales de santé publique https://www.assnat.qc.ca/fr/exprimez-votre-opinion/petition/Petition-5153/index.html
(6) Charlie Fidelman. Montreal Gazette. Apr. 29, 2015. Quebec's proposed health cuts threaten nutrition, school programs and the control of infectious illnesses, and could lead to injury, illness or death, a national public health association warned. http://montrealgazette.com/news/local-news/liberal-governments-cuts-to-health-may-lead-to-injury-illness-death-public-health-experts
(7) Public Health Agency of Canada. The role of the Chief Public Health Officer. http://www.phac-aspc.gc.ca/cpho-acsp/cpho-acsp-role-eng.php
(8) Trust for America's Health. Investments in Disease Prevention Yield Significant Savings, Stronger Communities. http://healthyamericans.org/reports/prevention08/ — **Received on:** 6/19/2015 2:43:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Yun Jen

SECONDER Dr. Chris Simpson

MOTION

The Canadian Medical Association recommends that governments authorize elementary and secondary schools to require a declaration of immunization status, to be followed by a conversation between public health officials and parents where children are shown to be inadequately immunized.

1. SUBSTANTIVE RATIONALE

The debate over vaccination has occupied much of the public space in provinces in recent months. Many experts have recommended that public and private schools be allowed to require certificates of immunization status for all students from kindergarten to the end of high school (1). The purpose is not to make vaccines compulsory, but to have an accurate picture of how well protected the children at the school are (2). Such information is useful in the event of an outbreak, since it can be used to quickly remove unvaccinated children for their own protection and the protection of others (1). Studies also show that requiring proof of immunization status can boost vaccination rates by several percentage points. Just having to declare their children's immunization status makes parents more aware of the importance of vaccination and has a social conformity effect (1). Some provinces such as Ontario make it a legal requirement that all children enrolled in school provide proof that they have been vaccinated against diphtheria, tetanus, polio, rubeola, mumps, and German measles, unless they have a valid written exemption (3,4). However, the debate is not at the same point in every province, and many experts have doubts about making vaccines compulsory. Other mechanisms, such as compulsory certificates of immunization status for all students, can achieve positive outcomes for public health and safety without creation of a legal requirement (5).

2. KEY STAKEHOLDERS: CMA, Canadian Paediatric Society, Health Canada, Canadian Public Health Association, provincial and territorial health and education ministries, provincial and territorial medical associations

3a. SUGGESTED IMPLEMENTATION: n/a

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism				x
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x		**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: (1) Le Devoir. Amélie-Daoust-Boisvert. Feb. 21, 2015. Avant d'en arriver à la vaccination obligatoire. http://www.ledevoir.com/societe/sante/432554/avant-d-en-arriver-a-la-vaccination-obligatoire (2) Institut national de santé publique du Québec. Dec. 2014. Comité d'éthique de santé publique. Avis sur un projet de

mesures législatives obligeant la documentation du statut immunitaire des élèves du primaire et du secondaire. http://www.inspq.qc.ca/pdf/publications/1924_Statut_Immunitaire_Eleves.pdf
(3) Settlement.Org. What immunizations does my child need. http://settlement.org/ontario/health/family-health/children-s-health/what-immunizations-does-my-child-need/
(4) Radio-Canada. Trois vaccins obligatoires pour les écoliers. http://ici.radio-canada.ca/regions/ontario/2014/09/04/012-vaccins-ontario-ecoles.shtml
(5) Paediatr Child Health, May 2014, Vol. 19 Issue 5: 237-238 Childhood immunization rates in Canada are too low: UNICEF http://www.pulsus.com/journals/abstract.jsp?jnlKy=5&atlKy=12830&isuKy=1206&isArt=t — **Received on:** 6/19/2015 2:46:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Darcy Johnson

SECONDER Dr. Carolyn Lane

MOTION

The Canadian Medical Association recommends patient populations that fall under federal jurisdiction should have access to the same effective and appropriate care as all other Canadians.

1. SUBSTANTIVE RATIONALE

Ensuring equitable access to effective and appropriate health care services (both in terms of availability and quality) is a key strategy to help mitigate health inequities resulting from differences in the social and economic conditions of Canadians. Yet major service inequities occur for those populations falling under federal jurisdiction including First Nations and Inuit, veterans, refugees, military personnel and federal inmates. Many fall through the cracks between federal and provincial/territorial health systems and/or experience varying levels of access to care. This can lead to inequities in care among residents who reside in the same communities. Many of these groups are unable to advocate for equitable access to care--CMA must be an advocate for them.

2. KEY STAKEHOLDERS: Federal government (departments responsible for administering health care to federal populations), provincial/territorial Premiers and health ministers

3a. SUGGESTED IMPLEMENTATION: This would be incorporated into CMA's advocacy work with the federal government, its work with the Wait Time Alliance and meetings of the Council of the Federation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/2/2015 8:43:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Chris Simpson

SECONDER Dr. Adam Steacie

MOTION

The Canadian Medical Association urges the pan-Canadian Pharmaceutical Alliance to invite the federal government and private health insurance industry to participate in its price negotiations for prescription drugs.

1. SUBSTANTIVE RATIONALE

In 2011 Canada had the second highest per capita spending on pharmaceuticals behind the U.S. in the Organization for Economic Cooperation and Development (OECD) at $690 - 60% above the OECD average of $430. The prices that Canada pays for both patented and generic drugs relative to other countries is a contributing factor. It has been well documented (see below) that other countries pay less for both brand name and generic drugs. In 2010 the Council of the Federation (Premiers) established the pan-Canadian Pharmaceutical Alliance to negotiate prices for public drug plans. In September 2014, health ministers reported that negotiations have resulted in reductions on 10 generic and 43 brand name drugs, resulting in annual savings of over $260 million. In 2014 the private health insurance sector spent almost as much as the provincial/territorial programs on prescription drugs ($10.3 billion vs. $12.1 billion) and the federal government spent an estimated $0.6 billion on prescription drugs. Moreover the federal government funds the Patented Medicine Prices Review Board and supports the Canadian Agency for Drugs and Technologies in Health. Additional savings could be realized if private insurers and the federal government were invited to participate in the pan-Canadian Pharmaceutical Alliance.

2. KEY STAKEHOLDERS: Provincial/territorial Premiers and health ministers, Health Canada, Canadian Life and Health Insurance Association

3a. SUGGESTED IMPLEMENTATION: This would be incorporated in CMA's advocacy in upcoming events such as the annual meeting of the provincial/territorial health ministers and meetings of the Council of the Federation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: According to the Patented Medicine Prices Review Board, in 2013 the average foreign-to-Canadian price ratio for brand name drugs was .72 for France, .77 for the U.K. and .79 for Italy. In terms of generic drugs, the average foreign-to-Canadian price ratio for 25 OECD countries in 2013 was .56 in terms of the median foreign price. See www.pmprb-cepmb.gc.ca. — **Received on:** 7/6/2015 6:47:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Kieran Moore

SECONDER Dr. Adam Steacie

MOTION

The Canadian Medical Association endorses the concept of a basic income guarantee.

1. SUBSTANTIVE RATIONALE

The basic income guarantee is a cash transfer from government to citizens not tied to labour market participation. It ensures sufficient income to meet basic needs and live with dignity, regardless of work status. A significant number of Canadian people, 4,812,120 or 14.9% of the population live in low income according to the 2011 National Household Survey after-tax low-income measure. A basic income guarantee has the potential to alleviate or even eliminate poverty. This is a powerful rationale, in times of growing economic inequality and persistent poverty in rich countries. Given that basic income is designed primarily to bring individuals out of poverty, it has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system. With the well-established relationship between low income and morbidity and mortality from a wide range of causes, it could reasonably be anticipated that a basic income guarantee would have important health-promoting effects at the individual level. There was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes. The costs of poverty in Canada are high and could be alleviated with a basic income guarantee. In 2007 the poverty gap was estimated to be $12.3 billion, while the total indirect cost of poverty, using the most cautious estimates, was double or more.

2. KEY STAKEHOLDERS: Key leadership at the national and provincial/territorial levels as the CMA sees fit

3a. SUGGESTED IMPLEMENTATION: That CMA urge the Government of Canada to prioritize consideration and investigation into a basic income guarantee as a policy option for reducing poverty, income insecurity and for providing opportunities for those in low income. That CMA advise key stakeholders at both the provincial/territorial and national levels of this recommendation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): As physician leaders, the mover and seconder can lobby appropriate groups to ensure widepsread support of instituting a basic income guarantee.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 11:36:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Kieran Moore

SECONDER Dr. Adam Steacie

MOTION

The Canadian Medical Association supports the development and implementation of a national strategy on the use of naloxone.

1. SUBSTANTIVE RATIONALE

Opioids are prescription pain medications that can be addictive and, if taken in high doses, fatal. Few Canadian provinces/territories actively report overdose fatalities, so it is difficult to gauge the extent of opioid-related mortality across the country. In Ontario, 4,984 opioid-related deaths occurred between 2002 and 2013. The annual number of deaths rose over that period from 156 deaths in 2002 to 652 deaths in 2013. As a cause of death among 25-34 year olds, opioid-related deaths rose from 3.3% in 1991 to 12.1% in 2010.

Naloxone is a medication that can reverse the symptoms of an opioid overdose. Naloxone has no addictive properties and no abuse potential. The current provincial Naloxone program in Ontario, for example, severely limits the number and nature of clients that are able to receive this medication. Currently, only eligible agencies [public health units that manage a core Needle Exchange Program (NEP), community-based organizations contracted by the local public health unit's to manage a NEP, and ministry-funded Hepatitis C teams] have the ability to receive Naloxone programming at no cost. These agencies are further limited to only provide Naloxone to those who are existing NEP clients. Some at-risk populations that are not reached by the current provincial/territorial programs include those who have been untreated for opioid addiction and individuals recently released from prison. The current models do not allow Naloxone access among many who may need it, and without change, will continue to limit the level of positive impact the program can have on overdose reversal rates.

Increased availability and expansion of distribution programs would include: not-for-profit agencies, emergency departments and in-patient services, pharmacies, correctional facilities, methadone providers, addiction treatment and withdrawal management facilities, and organizations that help people at risk of experiencing or witnessing an opioid overdose, individuals who support and/or care for those at risk of opioid overdose, and any person in Canada who is 16 years or older and is dependent on opioid drugs.

2. KEY STAKEHOLDERS: Key leadership at the national and provincial/territorial levels as the CMA sees fit

3a. SUGGESTED IMPLEMENTATION: That the CMA urge the Government of Canada to move forward with the development and implementation of a national Naloxone program.

That the CMA advise key stakeholders at both the provincial/territorial and national levels of this recommendation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): As physician leaders the mover and seconder can lobby appropriate groups to ensure widepsread support of the motion.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 11:37:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Kieran Moore

SECONDER Dr. Adam Steacie

MOTION

The Canadian Medical Association supports the development of an equitable and comprehensive national pharmacare program.

1. SUBSTANTIVE RATIONALE

The Canada Health Act has long enshrined the value of equitable, public health care access in Canada, but without pharmacare this claim is hypocritical. Many Canadians face drug costs that they cannot afford, forcing them to forgo doses of their medication or go without them entirely. Canada is the only industrialized country with a universal health care system that does not provide universal coverage for prescription drugs. Canada is an anomaly among Organization for Economic Cooperation and Development (OECD) countries because of its fragmented provincial/territorial system that relies on private insurers to cover most of the population. Each provincial/territorial model for financing pharmaceuticals involves multiple private and public payers, and considerable direct costs to patients by way of deductibles, co-payments and co-insurance. It was reported in CMAJ that one in ten Canadians cannot afford their prescriptions. Canada, at present, is unable to contain drug costs, making our current regime unsustainable. Not only do many Canadians, unlike citizens of other OECD countries, have to pay either partially or fully out-of-pocket for prescription drugs, they pay as much as 30% more than the OECD average. A single-payer system, achieved with a national pharmacare program, would consolidate purchasing power for the entire population. In comparison to the multi-payer system that is currently in place, the single-payer system gives managers increased bargaining power, and thereby the ability to reduce stock shortages and lower prices. An article published in CMAJ estimated that the net government saving would be about $2.9 billion annually with a national pharmacare program.

2. KEY STAKEHOLDERS: Key leadership at the national and provincial/territorial levels as the CMA sees fit

3a. SUGGESTED IMPLEMENTATION: That CMA urge the Government of Canada to move forward with the development and implementation of a national, universal pharmacare program.

That CMA advise key stakeholders at both the provincial/territorial and national levels of this recommendation.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): As physician leaders, the mover and seconder can lobby appropriate groups to ensure widepsread support of the motion.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?		
No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.
7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 11:38:00 AM		

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Bill Mackie

SECONDER Dr. Alexander Frame

MOTION

The Canadian Medical Association supports divestment of holdings in fossil fuel investments.

1. SUBSTANTIVE RATIONALE

Climate change has profound implications for human health. It is widely recognized as being one of the most serious threats to global public health over the coming century. It is crucial that health organizations such as CMA take meaningful action in order to limit the health consequences of climate change by taking a stance on fossil fuels. In 2014, the British Medical Association became the first health organization to divest itself from fossil fuel holdings.

In 2004, CMA took a strong stance on tobacco control and asked the Canada Pension Plan Investment Board to stop investing in tobacco stocks and to divest the $100 million it had in these stocks. This sent a strong message to Canadians and governments about the seriousness of CMA's commitment to fighting tobacco in the name of public health. In order to continue investing in health, CMA should support the divestment of fossil fuel investment holdings, including any currently held by MD Management.

2. KEY STAKEHOLDERS: MD Management, fossil fuel investment holdings, federal government

3a. SUGGESTED IMPLEMENTATION: CMA will consider options regarding potential divestment of fossil fuel investment holdings.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism				x
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 7:47:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Peter Barnsdale

SECONDER Dr. Charles Webb

MOTION

The Canadian Medical Association supports the organization, centralization and management of cradle-to-grave medical records for patients living in Canada.

1. SUBSTANTIVE RATIONALE

In Canada, the current situation for maintaining, sharing and storing medical records is inconsistent across provinces and territories. Records are often dispersed in various places, may be discontinuous and incomplete and are sometimes not passed on from one health care provider to another as the patient moves through life. Moreover, medical records may be disposed of while a patient is still alive, thereby losing important early life history that has the potential to impact future decision-making and appropriate care. For instance, a patient with an early treated malignancy, which has implications for life-long follow up may lose their medical records if they move and do not actively request and pay for the previous physician to forward the records to the new physician.

To alleviate this problem, there needs to be a national organizing structure that automatically receives the medical records when a patient moves and forwards the records to the next registered provider. This structure would also act as the repository for all records until a period after the patient's death.

2. KEY STAKEHOLDERS: Provincial/territorial medical associations, electronic medical record vendors

3a. SUGGESTED IMPLEMENTATION: CMA will consider policy options regarding the establishment of a national repository for all records until a period after a patient's death.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism				x
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships			x	
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth			x	

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 7:48:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Don Milliken

SECONDER Dr. Lloyd Oppel

MOTION

The Canadian Medical Association calls for regulations on the marketing of direct-to-consumer genetic testing for health purposes.

1. SUBSTANTIVE RATIONALE

CMA already has an existing framework to encourage government and industry to appropriately regulate direct-to-consumer genetic tests. However, marketing restrictions on direct-to-consumer genetic testing are not yet in place.
Direct-to-consumer genetic testing services are now available to Canadian consumers for health decision-making purposes. Canadian consumers can provide a saliva sample and receive genetic testing services including information about health conditions and traits, inherited risk factors and medication response.
Elsewhere, regulators have halted interpretation of direct-to-consumer genetic test results for health purposes by private direct-to-consumer genetic testing companies because of concerns over their reliability or validity.
Direct-to-consumer genetic testing is marketed to Canadians for multiple uses including as a diagnostic tool for heritable traits, screening for genetic defects, identification of health risks as well as medication response. This information could prompt consumers to make significant health decisions without consulting a provider.
The pharmaceutical industry is limited to how they can market to Canadians and what health benefits or claims they can make. Given the significance of information provided to Canadian consumers, as well as the potential for significant health decision-making, the marketing of direct-to-consumer genetic testing for health purposes should also be regulated.

2. KEY STAKEHOLDERS: Federal and provincial/territorial governments, provincial/territorial medical associations

3a. SUGGESTED IMPLEMENTATION: CMA will incorporate the need for restriction on marketing of direct-to-consumer genetic testing for health purposes in its existing Genetic Testing Regulatory Framework.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth			x	

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 7:56:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Granger Avery

SECONDER Dr. Raj Bhui

MOTION

The Canadian Medical Association supports the development of a national strategy to integrate precision medicine into clinical care.

1. SUBSTANTIVE RATIONALE

Precision medicine has the potential to significantly change Canadian health care services. This includes contributing to more targeted health spending, rapid and precise diagnostics, reduced adverse drug events, and enhanced population health risk screening.

However, as with any new and rapidly evolving technology, there is potential for precision medicine to become a cost driver. Barriers to reducing costs include current inability to predict or determine which genetic tests are less costly than current resources, the lack of longitudinal evidence outlining the relationship between genetic testing and health care cost avoidance, as well as cost of developing tests and gene-targeting treatments.

Currently, over 150 medications have associated genetic tests that can enhance targeted prescribing and reduce adverse drug events. As further discoveries are made, there is opportunity to improve care by rapidly translating research from bench-to-bedside. This is also true in population screening where centralized and coordinated systems measure outcomes, evaluate evidence, and provide information to support early interventions and improved population health. Each province and territory's individual review, evaluation and approval processes delay the speed at which these tests can be integrated into clinical practice. National strategies that aggregate provincial/territorial resources and interests can overcome these challenges.

A Canadian strategy to integrate precision medicine into clinical care, informed by economic analysis, will support better care for Canadians and improved population health.

2. KEY STAKEHOLDERS: CMA, provincial/territorial medical associations, Genome Canada

3a. SUGGESTED IMPLEMENTATION: 1. There is a need for the development of training opportunities in precision medicine for medical students and practicing physicians. Given the rapid rate of innovation, multiple cohorts of physicians completed medical school without being exposed to this new science. With training opportunities, family physicians are well-positioned to support clinical integration of precision medicine. Without training opportunities, providers may be forced to direct patients to specialty care. Family physicians need opportunities and education to provide these services. Family physicians can work with patients to encourage behaviours to support health and avoid testing (where appropriate). Training should include continuing professional development opportunities on the use and interpretation of genetic testing and training on best practices.

2. There is a need for the development of decision-support tools for physicians. Effective use of precision medicine is limited by lack of information and clinical decision-making resources available to providers. Given the large amounts of information related to genomics, optimal use of precision medicine requires decision-support tools for physicians including good clinical practice guidelines, accredited information about precision medicine, and effective integration of genomic data into electronic health records.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being		x		
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			

Growth and relevance	High	Medium	Low	N/A
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: Precision medicine refers to the use of an individual's genomic and epigenetic information, including individual patterns of disease, in order to provide targeted treatment that is tailored to the person's genetic profile potentially leading to better individual treatment. — **Received on:** 7/6/2015 7:57:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Ian Gillespie

SECONDER Dr. Don Milliken

MOTION

The Canadian Medical Association calls for a review of national, provincial and territorial informed-consent and privacy legislation to reflect the challenges created by the introduction of genetic testing.

1. SUBSTANTIVE RATIONALE

As costs decrease, more exploratory genetic testing options are being used including full genome sequences or "panel" tests that explore hundreds of genes at once. As a result, the issue of incidental findings is of greater importance. Results may reveal additional genetic information indicating a risk for other significant health problems unrelated to the original issue. For many, knowing only that they may develop an illness to which there is no known treatment, like amyotrophic lateral sclerosis (ALS), can feel like a "death sentence."

Before undergoing a medical test, patients provide consent that they understand the facts, implications, and future consequences of the test. Direct-to-consumer genetic test providers may also inform consumers that their genetic information may be used for other purposes. When undergoing genetic testing, patients or consumers must also confirm their interest in receiving information about gene markers or mutations that indicate probability of developing illnesses like ALS.

It is important that patients maintain the right to choose which genetic findings they wish to receive or share. In this context, patients must also take responsibility for the consequences. Given the complexity of genetic testing, Canadians may not comprehend the gravity of information that they may receive or that could be shared. Currently, Canadian insurance companies may ask if applicants have undergone genetic testing and, if so, for the results. Regulators, providers, and patients need to collaboratively review current informed consent and privacy legislation.

2. KEY STAKEHOLDERS: Federal and provincial/territorial governments, provincial/territorial medical associations and colleges

3a. SUGGESTED IMPLEMENTATION: n/a

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being		x		
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 8:01:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Charles Webb

SECONDER Dr. Lloyd Oppel

MOTION

The Canadian Medical Association recommends that primary care telemedicine investments, policies and regulations support comprehensive and continuous patient-centred care.

1. SUBSTANTIVE RATIONALE

Telemedicine is the provision of medical expertise for the purpose of diagnosis and patient care by means of telecommunications and information technology where the patient and provider are separated by distance. Primary care physicians across Canada are currently successfully using a variety of telemedicine modalities to better support chronic disease management, improve care coordination, reduce avoidable health system utilization, and increase productivity by allowing clinicians to provide more consultations.

While there are very real benefits to the application of telemedicine in primary care, particularly in rural, remote and other underserved areas of provinces and territories, telemedicine also has the potential to result in fragmented and episodic care. It is therefore important that the use of telemedicine services and any primary care telemedicine investments, policy or regulation, support comprehensive, continuous patient-centred care. This includes family physicians providing continuing care to their patients and building on the patient-physician relationship.

2. KEY STAKEHOLDERS: Provincial/territorial governments, provincial/territorial medical associations and colleges, telehealth system vendors

3a. SUGGESTED IMPLEMENTATION: n/a

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being		x		
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/6/2015 8:02:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Cindy Forbes

SECONDER Dr. Chris Simpson

MOTION

The Canadian Medical Association will provide information and tools to physicians to promote the medical profession's critical role in supporting immunization.

1. SUBSTANTIVE RATIONALE

Physicians have a critical role to play in immunization, even in the provinces/territories where vaccines are given by public health services. The attitude of the physician is very influential in the decision to immunize. Information from physicians counters information received from friends, family and websites. Physicians who are fully immunized and up-to-date model good practices. Physician education could be improved with the development of a national standard for physician education on immunization. It must also be integrated within specialty education, with the recognition of the importance of immunization in various clinical conditions. Education should include strategies to deal with vaccine hesitant patients or parents. Useful tools developed specifically for the frontline practitioner recognizing their needs and preferred formats are needed to support physicians in promoting immunization. Funding models must support engaging vaccine hesitant individuals and families.

2. KEY STAKEHOLDERS: National medical associations (CMA, College of Family Physicians of Canada, Canadian Pediatric Association, Royal College of Physicians and Surgeons of Canada, Association of Medical Microbiology and Infectious Disease Canada), medical schools, provincial/territorial health departments and medical associations, Public Health Agency of Canada

3a. SUGGESTED IMPLEMENTATION: The resolution will be incorporated in the CMA business plan being developed to address immunization issues over the long term. CMA will work with national medical associations and the Public Health Agency of Canada to research and develop and/or disseminate tools to support physicians.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): Same as above

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care		x		
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
		x		**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/7/2015 6:41:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Cindy Forbes

SECONDER Dr. Chris Simpson

MOTION

The Canadian Medical Association calls for immunization registries that can accept information directly from the electronic medical records of health care providers.

1. SUBSTANTIVE RATIONALE

Currently in Canada, no province/territory has an immunization registry system that can capture information directly from health care providers. Capturing data from electronic medical records can facilitate real time data collection, reduce errors and improve accurate surveillance. Comprehensive registries can provide accurate provincial/territorial and local-level data allowing health officials to identify communities potentially at higher risk for vaccine preventable disease transmission, target vaccination efforts and focus communications and other interventions to improve vaccination rates. A provincial/territorial registry must link electronic medical records kept by physicians' offices, public health and community clinics and hospitals, and make them accessible to all providers and patients themselves, especially parents.

2. KEY STAKEHOLDERS: Provincial and territorial governments, Health Canada, Public Health Agency of Canada, Health Infoway/Panorama, electronic medical/health record vendors

3a. SUGGESTED IMPLEMENTATION: CMA will incorporate this into its parliamentary advocacy and its participation with various advocacy alliances such as Immunize Canada and the Canadian Public Health Association. CMA will also engage with other medical associations to encourage consistent positioning from the health community. The motion can be shared with provincial/territorial medical associations to encourage provincial/territorial involvement.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): Same as above

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth			x	

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x		**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/7/2015 6:43:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Courtney Howard

SECONDER Dr. Ewan Affleck

MOTION

The Canadian Medical Association will divest its reserves of investments in energy companies whose primary business relies upon fossil fuels.

1. SUBSTANTIVE RATIONALE

In response to the health threat of tobacco, CMA divested from tobacco. [1] By shifting money away from the industry, CMA reduced its social licence, creating demand for tobacco-control policy.
In response to climate change, the "biggest global health threat of the 21st Century" (Lancet 2009 [2]), CMA has committed to communicating the health and economic benefits of climate-health action to society (GC 14-60) and supports a 10-year phase-out of coal-powered electricity (GC 14-61) [3].
The United Nations [4] and World Bank [5] endorse aligning climate-health vision with action by divesting from fossil fuels and reinvesting in renewable energy. The British Medical Association [6] and the Royal Australasian College of Physicians [7] are doing so—CMA should do the same. Why?
1-"Continued investment in the fossil fuel industry violates health workers' obligations to do no harm." [8]
2-A lower-carbon world means reduced air pollution and immediate health benefits [9].
3-Fossil-fuel free portfolios deliver as-good or better returns than portfolios containing fossil fuels [10].
4-Reducing exposure to carbon risk protects investments as the "Carbon Bubble" pops:
Approximately 80% of the world's economic fossil fuel reserves must remain underground (Intergovernmental Panel on Climate Change) [11], unsold and worthless [12] to avoid runaway climate change.
"We can divest and tax that which we don't want, the carbon that threatens development gains over the past 20 years…Rethink what fiduciary responsibility means in this changing world. It's simple self-interest. [5]" Dr. Jim Kim, President World Bank.
The emergency of climate change is the only diagnosis shared by physicians, their families and their patients. Let the CMA's voice and actions work together in treatment.

2. KEY STAKEHOLDERS: CMA, MD Financial Management

3a. SUGGESTED IMPLEMENTATION: MD Financial Management (MD) has been investigating this issue since last summer when the British Medical Association (BMA) voted to divest, and has consulted with the BMA to learn from their experiences. This motion has been crafted in association with MD, and they believe it to be reasonable to present to delegates. MD has determined that CMA has over $29 million in investments, of which approx. 6% is in the energy sector. Most divestment projects use the Carbon Tracker Initiatives' list [13] of the top 200 most fossil-fuel intensive companies to help determine which companies to divest from, and this is suggested as a guideline in this instance. (In our current fossil-fuel dependent culture, it is otherwise difficult to draw a line, i.e., do we invest in airlines? They use a lot of fossil fuel. What about banks that might themselves invest in fossil fuel development companies?). Acknowledging the global push for concommitant reinvestment in renewable energy [5] in order to build the zero-emissions world we need to have by the latter-half of this century [15], as well as the benefits of a balanced portfolio which includes energy, MD will also source new investments in renewable energy.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): The mover of this motion has been in communication with MD Financial Management (MD) on this issue since last year's General Council and is happy to continue to provide help in terms of linking MD up with international best practices emerging as part of the Global Climate and Health Alliance, as well as continuing to relay the developing evidence base on the topics of climate-health and divestment.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession	x			

Patients and the public	High	Medium	Low	N/A
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth	x			

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x			**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: References:

1-https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Tobacco_Control_Update_2008_PD08-08-e.pdf
2.http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60922-3/fulltext
3-https://www.cma.ca/Assets/assets-library/document/en/GC/Final-Resolutions-GC-2014-Confirmed-Nov-2014.pdf
4-http://www.theguardian.com/environment/2015/mar/15/climate-change-un-backs-divestment-campaign-paris-summit-fossil-fuels
5-http://www.worldbank.org/en/news/speech/2014/01/23/world-bank-group-president-jim-yong-kim-remarks-at-davos-press-conference
6-http://www.medact.org/news/uk-doctors-vote-end-investments-fossil-fuel-industry/
7-http://www.businessspectator.com.au/news/2015/6/4/policy-politics/royal-australasian-college-physicians-divesting-fossil-fuels
8-http://www.theguardian.com/environment/2015/apr/30/fossil-fuels-new-tobacco-health-risk
9-http://www.ncbi.nlm.nih.gov/pubmed/22431656
10-https://www.msci.com/resources/factsheets/index_fact_sheet/msci-acwi-ex-fossil-fuels-index-gbp-gross.pdf
11-IPCC Climate Change 2014: Mitigation of Climate Change. Fifth Assessment Report. Working Group 3.
12-http://carbontracker.live.kiln.it/Unburnable-Carbon-2-Web-Version.pdf
13-http://www.carbontracker.org/wp-content/uploads/2014/09/Unburnable-Carbon-Full-rev2-1.pdf
14-http://www.thelancet.com/commissions/climate-change-2015

— **Received on:** 7/7/2015 4:14:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE	**Policy Motion**
Delegates' Motions	**x Directive Motion**

MOVER Dr. Courtney Howard

SECONDER Dr. Steve Kraus

MOTION

The Canadian Medical Association will explore investment opportunities, for its reserves, in renewable energy solutions.

1. SUBSTANTIVE RATIONALE

In response to the health threat of tobacco, CMA divested from tobacco. [1] By shifting money away from the industry, CMA reduced its social licence, creating demand for tobacco-control policy.
In response to climate change, the "biggest global health threat of the 21st Century" (Lancet 2009 [2]), CMA has committed to communicating the health and economic benefits of climate-health action to society (GC 14-60) and supports a 10-year phase-out of coal-powered electricity (GC 14-61) [3].
The United Nations [4] and World Bank [5] endorse aligning climate-health vision with action by divesting from fossil fuels and reinvesting in renewable energy. The British Medical Association [6] and the Royal Australasian College of Physicians [7] are doing so—CMA should do the same. Why?
1-"Continued investment in the fossil fuel industry violates health workers' obligations to do no harm." [8]
2-A lower-carbon world means reduced air pollution and immediate health benefits [9].
3-Fossil-fuel free portfolios deliver as-good or better returns than portfolios containing fossil fuels [10].
4-Reducing exposure to carbon risk protects investments as the "Carbon Bubble" pops:
Approximately 80% of the world's economic fossil fuel reserves must remain underground (Intergovernmental Panel on Climate Change) [11], unsold and worthless [12] to avoid runaway climate change.
"We can divest and tax that which we don't want, the carbon that threatens development gains over the past 20 years…Rethink what fiduciary responsibility means in this changing world. It's simple self-interest. [5]" Dr. Jim Kim, President World Bank.
The emergency of climate change is the only diagnosis shared by physicians, their families and their patients. Let the CMA's voice and actions work together in treatment.

2. KEY STAKEHOLDERS: CMA, MD Financial Management

3a. SUGGESTED IMPLEMENTATION: MD Financial Management (MD) has been investigating this issue since last summer when the British Medical Association (BMA) voted to divest, and has consulted with the BMA to learn from their experiences. This motion has been crafted in association with MD, and they believe it to be reasonable to present to delegates. MD has determined that CMA has over $29 million in investments, of which approx. 6% is in the energy sector. Most divestment projects use the Carbon Tracker Initiatives' list [13] of the top 200 most fossil-fuel intensive companies to help determine which companies to divest from, and this is suggested as a guideline in this instance. (In our current fossil-fuel dependent culture, it is otherwise difficult to draw a line, i.e., do we invest in airlines? They use a lot of fossil fuel. What about banks that might themselves invest in fossil fuel development companies?). Acknowledging the global push for concommitant reinvestment in renewable energy [5] in order to build the zero-emissions world we need to have by the latter-half of this century [15], as well as the benefits of a balanced portfolio which includes energy, MD will also source new investments in renewable energy.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): The mover of this motion has been in communication with MD Financial Management (MD) on this issue since last year's General Council and is happy to continue to provide help in terms of linking MD up with international best practices emerging as part of the Global Climate and Health Alliance, as well as continuing to relay the developing evidence base on the topics of climate-health and divestment.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession	x			

Patients and the public	High	Medium	Low	N/A
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth	x			

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x			**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: References:

1-https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/CMA_Policy_Tobacco_Control_Update_2008_PD08-08-e.pdf
2.http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60922-3/fulltext
3-https://www.cma.ca/Assets/assets-library/document/en/GC/Final-Resolutions-GC-2014-Confirmed-Nov-2014.pdf
4-http://www.theguardian.com/environment/2015/mar/15/climate-change-un-backs-divestment-campaign-paris-summit-fossil-fuels
5-http://www.worldbank.org/en/news/speech/2014/01/23/world-bank-group-president-jim-yong-kim-remarks-at-davos-press-conference
6-http://www.medact.org/news/uk-doctors-vote-end-investments-fossil-fuel-industry/
7-http://www.businessspectator.com.au/news/2015/6/4/policy-politics/royal-australasian-college-physicians-divesting-fossil-fuels
8-http://www.theguardian.com/environment/2015/apr/30/fossil-fuels-new-tobacco-health-risk
9-http://www.ncbi.nlm.nih.gov/pubmed/22431656
10-https://www.msci.com/resources/factsheets/index_fact_sheet/msci-acwi-ex-fossil-fuels-index-gbp-gross.pdf
11-IPCC Climate Change 2014: Mitigation of Climate Change. Fifth Assessment Report. Working Group 3.
12-http://carbontracker.live.kiln.it/Unburnable-Carbon-2-Web-Version.pdf
13-http://www.carbontracker.org/wp-content/uploads/2014/09/Unburnable-Carbon-Full-rev2-1.pdf
14-http://www.thelancet.com/commissions/climate-change-2015

— **Received on:** 7/7/2015 4:14:01 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Courtney Howard

SECONDER Dr. Monika Dutt

MOTION

The Canadian Medical Association will promote a strong, predictable price on carbon emissions.

1. SUBSTANTIVE RATIONALE

"Climate change is the biggest global health threat of the 21st Century," (Lancet, 2009) (1)."Tackling climate change could be the greatest global health opportunity of the 21st century," says Lancet's 2015 multidisciplinary follow-up. They find: "The single most powerful strategic instrument to inoculate human health against the risks of climate change would be for governments to introduce strong and sustained carbon pricing, in ways pledged to strengthen over time until the problem is brought under control. Like tobacco taxation, it would send powerful signals throughout the system… that the time has come to wean our economies off fossil fuels, starting with the most carbon intensive and damaging like coal…stabilising the atmosphere…requires reducing net emissions to zero….during the second half of this century."(2)
Dr. Jim Yong Kim, President of the World Bank(2) and 60 academics from across Canada agree: "We unanimously recommend putting a price on carbon.(3)" Carbon pricing will lessen air pollution-related morbidity, mortality and health care costs [International Monetary Fund (4), Nature (5)(6)]. BC's carbon tax has reduced emissions while maintaining economic competitiveness.(7)
Last year, General Council delegates unanimously passed: The CMA will collaborate with other disciplines to ensure that the mutual benefits to health and the economy of climate action are more broadly understood and incorporated into policy."(GC 14-60)(9)
Canada could have 100% clean energy by 2035 and an 80% reduction in emissions by mid-century(3)—with cleaner air and decreased health care costs. Making clear the mutual benefits of a strong, sustained price on carbon could end up being the CMA's greatest contribution to getting us there.

2. KEY STAKEHOLDERS: CMA, Canadian policymakers including provincial/territorial and federal governments, economic and financial policymakers, Canadian public

3a. SUGGESTED IMPLEMENTATION: As noted in the second Lancet Commission on Climate Change and Health--"a siloed approach to protecting human health from climate change will not work." Physicians are the strongest voice for a "human framing of climate change….that is put in terms…..more readily understood by the public…Fostering such public resonance can act as a powerful policy driver." Carbon-pricing proponents often have training in the economic realm but not in the scientific/medical realms needed to explain the rationale for implementation. CMA could:

1-Update its climate-health policy (10) to include carbon pricing.

2-Point out the health and health care cost advantages to putting a price on carbon in conversations with policymakers and the public.

3-Form partnerships with reputable, evidence-based nonpartisan organizations working on carbon pricing (Ecofiscal may be an option) to help provide the rationale for the implementation of their carbon pricing tools.

This has the potential for increased success and satisfaction for all parties. Physicians speak to what they know on an issue that affects their health, that of their family, and that of every one of their patients, and have the satisfaction of seeing a useful treatment implemented. Economists/policymakers are saved from trying to provide a rationale they feel ill-equipped to explain for the tool that credible sources say is necessary.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): The mover and seconder are happy to discuss options for implementation and potential partnerships with the CMA Board.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession	x			

Patients and the public	High	Medium	Low	N/A
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth	x			

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x			**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: 1. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60922-3/fulltext
2. http://www.thelancet.com/commissions/climate-change-2015
3. http://www.worldbank.org/en/news/speech/2014/01/23/world-bank-group-president-jim-yong-kim-remarks-at-davos-press-conference
4. Acting on climate change: Solutions from Canadian scholars :http://biology.mcgill.ca/unesco/EN_Fullreport.pdf No. http://www.sustainablecanadadialogues.ca/files/PDF_DOCS/SCD_short_30marchlr.pdf
5.http://www.theglobeandmail.com/report-on-business/industry-news/energy-and-resources/imf-calls-on-canada-to-raise-carbon-taxes-cut-income-taxes/article19872600/
6 Thompson, A systems approach to evaluating the air quality co-benefits of US carbon policies. Nature Climate Change.4:917-23.http://www.nature.com/nclimate/journal/v4/n10/full/nclimate2342.html
7. West, Co-benefits of Global Greenhouse Gas Mitigation for Future Air Quality and Human Health. Nat Clim Chang 2013. 2013;3(10):885-9.http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4051351/
8. British Columbia's Revenue- Neutral Carbon Tax: A Review of the Latest 'Grand Experiment' in Environmental Policy. 2015.https://nicholasinstitute.duke.edu/sites/default/files/publications/ni_wp_15-04_full.pdf
9. (Confirmed) 2014. 2014.https://www.cma.ca/Assets/assets-libra
10.http://policybase.cma.ca/dbtw-wpd/Policypdf/PD10-07.pdf — **Received on:** 7/8/2015 8:23:00 AM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Alan Ruddiman

SECONDER Dr. Granger Avery

MOTION

The Canadian Medical Association will advocate for a generalist approach across the medical career life cycle.

1. SUBSTANTIVE RATIONALE

The Royal College of Physicians and Surgeons of Canada defines generalism as a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs. There is a growing concern about the loss of generalism in Canadian medicine. There is a growing trend to sub-specialization in both family medicine and among consulting specialists. The College of Family Physicians of Canada now recognizes 19 areas of special interest and/or focused practice (e.g., prison health), and in addition to its 29 specialties and 36 sub-specialties the Royal College has approved 16 diploma programs (e.g., aerospace medicine). General Council has previously adopted resolutions in 2010 and 2014 that support generalism but these do not define what it might encompass.

2. KEY STAKEHOLDERS: Association of Faculties of Medicine of Canada, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, regional health authorities, provincial/territorial medical associations, regulatory authorities, Society of Rural Physicians of Canada and other affiliates

3a. SUGGESTED IMPLEMENTATION: CMA could develop a discussion paper around the principles of longitudinal care, examination of the underlying determinants of illness, patient engagement in decision-making, quality improvement, and generalism with advanced skills, to be used as a basis for consultations with stakeholders identified above. CMA could also survey the membership on attitudes toward generalism.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): I have focused on this issue in my association with the Society of Rural Physicians of Canada and my international work with the World Summits on Rural Generalist Medicine.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being		x		
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
		x	**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: While the loss of generalism cuts across the system, it is useful to see the 2013 Cairns Consensus Statement on Rural Generalist Medicine. http://www.ruralgeneralismsummit.net/wp_rurgen/wp-content/uploads/2015/01/Cairns-Consensus-Statement-FINAL-3-Nov-2014.pdf. — **Received on:** 7/9/2015 3:50:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Gail Beck

SECONDER Dr. Deborah Hellyer

MOTION

The Canadian Medical Association will develop workplace guidelines for physicians who have or develop disabilities or disease.

1. SUBSTANTIVE RATIONALE

This motion addresses the need to develop guidelines for physicians in workplaces provided by others. Outside of medicine, workers with disabilities and/or disease have the option to return to work on a modified scheduled and/or with modified responsibilities. For physicians, there are few if any options to return to work for physicians who have or develop disabilities or disease. It is important for physicians to have viable options to return to work with appropriate occupational health supports.

2. KEY STAKEHOLDERS: Provincial/territorial medical associations, Resident Doctors of Canada, Canadian Federation of Medical Students

3a. SUGGESTED IMPLEMENTATION: Implementation of this motion could include exploring and creating a list of accommodations for physicians based on their needs. Then advise provincial/territorial medical associations on the feasibility of implementing the accomodations. Finally information shared with physicians to advise how to access personal accomodations. In addition, it may be helpful to research other jurisdictions for their management of this important issue.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession			x	
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care			x	
➢ Maximize strategic relationships			x	
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
		x	**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 3:55:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Gary Chaimowitz

SECONDER Mr. Mathew Nicholas

MOTION

The Canadian Medical Association will promote the development of clinical tools to assist physicians and physicians-in-training improve their understanding of the specific health care needs of individuals who identify themselves as lesbian, gay, bisexual, transgender and/or queer.

1. SUBSTANTIVE RATIONALE

Individuals who identify as lesbian, gay, bisexual, transgender and/or queer have faced stigma and discrimination, not only affecting their health care but access to appropriate health care. Although we have made numerous advances in reducing stigma and discrimination, it is imperative that CMA takes a position on this important issue and educates physicians about best practices in the delivery of heath care to meet the specific needs of people who belong to this community.

2. KEY STAKEHOLDERS: Provincial/territorial medical associations, College of Family Physicians of Canada (compilation of resources on their website), Canadian medical schools (provide these resources to physicians-in-training), Association of Faculties of Medicine of Canada

3a. SUGGESTED IMPLEMENTATION: Conduct a scan of existing Canadian and international resources focussed on the care of the lesbian, gay, bisexual, transgender and/or queer community. Consider creating a resource online for consultation by physicians and perhaps research and produce clinical tools to fill gaps in care this community.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession		x		
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth	x			

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
		x	**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 3:58:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Alison Freeland

SECONDER Dr. Doug Weir

MOTION

The Canadian Medical Association promotes increased knowledge amongst physicians in the practice of trauma-informed care.

1. SUBSTANTIVE RATIONALE

Many patients within the health care system have been victims of violence or have witnessed traumatic events in their life. Six percent of Canadians report spousal abuse, as many as one in four women will experience sexual assault, and one in ten Canadians are reported to have Post-traumatic Stress Disorder. Violence can be experienced throughout the life span, from childhood to old age, and across all cultures. Aboriginal people have particularly high rates of trauma compared to the general population.

As such, health care providers need to be aware of the prevalence and impact of trauma across all patient populations, and need to assume that many of those that they provide services to have experienced trauma. If health care providers lack knowledge and understanding about the effect of trauma on their patients, then provision of effective health care services can be impacted negatively, with subsequent inadvertent retraumatization of the patient. Trauma-informed care does not mean treating specific symptoms of known trauma, but assumes trauma may have been experienced by a patient and ensures that all health care services are provided in a manner that is welcoming and appropriate to the special needs of those who have experienced trauma.

2. KEY STAKEHOLDERS: Provincial/territorial medical associations

3a. SUGGESTED IMPLEMENTATION: Conduct research scan of clinical tools or guides for trauma-informed care. Collating and creating a resource of these documents may be made available and promoted on cma.ca to encourage improved understanding of trauma-informed care. In addition, this motion may involve educating physicians about the prevalence of trauma within patient groups.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession			x	
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships			x	
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x				**x**

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 3:59:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Allan Studniberg

SECONDER Dr. Ken Arnold

MOTION

The Canadian Medical Association will work with the insurance industry to develop guidelines for physicians who provide patients with information related to travel insurance.

1. SUBSTANTIVE RATIONALE

Travel insurance is a minefield of potential liability for our members across the country, can be confusing for our patients but is an essential product for Canadians when travelling.
Travel insurance poses risks to our members. For instance, I am often asked by patients about their fitness to travel. My impression of medical stability may not coincide with the insurance company's particular policy. For example, in the 90-day time period just prior to travel, patients typically decline to accept medication dosage adjustments because it would represent a "change in health status" or loss of "stability". This is not a productive situation and may perversely increase the risk to the patient's health.
This motion is asking CMA to review this issue with the insurance industry in an effort to create guidelines that are mutually beneficial. Guidelines may include clear and simple application form language; gaining an industry understanding that physician assistance is often done without detailed chart review and perhaps developing an agreed upon form for physicians to complete, at industry cost, when clarification is required. It seems to be routine for insurance companies to investigate travel-related claims and they clearly do so in the hope of reducing their own liability. The fee would capture the need for detailed record review, which is often requested with some urgency.

2. KEY STAKEHOLDERS: Insurance Bureau of Canada, provincial/territorial medical associations, Canadian Medical Protective Association

3a. SUGGESTED IMPLEMENTATION: Compile issues affecting physicians and their experience with the insurance industry regarding travel insurance and schedule meetings to discuss the findings, with the goal to improve the situation for patients, physicians and the insurance industry.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): Dr. Studniberg (mover) has been monitoring this issue for some time and could share his findings as a starting point in this work.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care		x		
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth			x	

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x					**x**

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 4:00:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Gary Chaimowitz

SECONDER Dr. Doug Weir

MOTION

The Canadian Medical Association will consult with Health Canada to discuss the effects of online gambling.

1. SUBSTANTIVE RATIONALE

A number of provincial/territorial governments have expanded (or plan to expand) their lottery activities to online gambling. The potential for negative outcomes for vulnerable individuals in Canadian society is high. Greater availability of gambling will increase both the number of gamblers and problem gamblers. Gambling has been associated with numerous health and personal difficulties. Apart from the negative social impact including poverty and crime, more gambling will mean more associated addictions, health issues, depression and suicide. This will create financial difficulties for many and devastation for others. Families will be negatively impacted with increased stress, dysfunction and divorce, with children unfortunately impacted. Certain groups appear more vulnerable to this addiction: the young, the elderly, low socioeconomic groups, Aboriginal populations; all with associated worsening of poverty. Gambling is an addiction. For many it is a manageable addiction. However for a significant number of people including the most vulnerable, online gambling will mean a range of negative effects up to devastating individuals and families. Beyond the individual we believe that the health of our communities will ultimately suffer.

2. KEY STAKEHOLDERS: Health Canada

3a. SUGGESTED IMPLEMENTATION: Consult with Health Canada regarding the effects of online gambling among vulnerable populations both mental and financial. A research scan may be conducted to identify the prevalence of online gambling and the impact this is having on patients. Appropriate supports and measures may be proposed and implemented for patients.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession		x		
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth			x	

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x			**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 4:01:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Allan Studniberg

SECONDER Dr. Laurent Marcoux

MOTION

The Canadian Medical Association will create a working group to evaluate federal forms used by physicians.

1. SUBSTANTIVE RATIONALE

Ontario has a robust process in place regarding current and proposed government forms. In my experience as Chair of the Ontario Medical Association (OMA) Forms Committee and as Co-Chair of the Joint OMA-Ministry of Health and Long-Term Care Forms Committee, I can unequivocally state that every form we reviewed was improved in some manner. At times, such improvement included a reduction in the legal risk to our members which was always a primary OMA consideration.
While I understand CMA does review various forms that are submitted, I believe the creation of a devoted committee may offer a stronger approach. This motions asks CMA to consider creating a national CMA Forms Committee.

2. KEY STAKEHOLDERS: CMA, provincial/territorial medical associations

3a. SUGGESTED IMPLEMENTATION: Establish a National Forms Committee at CMA to identify, review and make recommendations to the federal government regarding national forms that require physician input.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): Dr. Studniberg (mover) was a member of the Ontario Medical Association Forms Committee and could be consulted during the set up of a national forms committee.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism			x	
➢ Improve physician health and well-being			x	
➢ Strengthen the national voice of the CMA for the medical profession		x		
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care			x	
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs	x			
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
		x		**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 4:04:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Gary Chaimowitz

SECONDER Dr. Rob Swenson

MOTION

The Canadian Medical Association calls on the federal government to amend the Criminal Code by making it a specific criminal offence to assault health care providers performing their duties.

1. SUBSTANTIVE RATIONALE

Health care providers, especially frontline providers, are frequently exposed to violence while engaged in the delivery of services. The creation of an offence of assaulting health care providers as they work will signal the seriousness of inappropriate and aggressive behaviours. Health care providers have the right to work in a safe environment and not be exposed to assaulting behaviour. As a separate offence, societal displeasure with assaulting health care providers may then get reflected in judicial sanction not dissimilar to assaulting a peace officer.

2. KEY STAKEHOLDERS: Federal government, provincial/territorial medical associations

3a. SUGGESTED IMPLEMENTATION: Research scan to identify the prevalence of assaulting health care providers and compile information to be used as evidence to establish a need to add assaulting a health care provider to the Criminal Code.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism		x		
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care		x		
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs			x	
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x		**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x Yes If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/9/2015 4:08:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Alika Lafontaine

SECONDER Dr. Richard Johnston

MOTION

The Canadian Medical Association will convene a national roundtable to eliminate jurisdictional barriers and establish best-care practices that acknowledge the unique circumstances of Aboriginal communities.

1. SUBSTANTIVE RATIONALE

Among health planners and delivery organizations in Canada, there is widespread understanding of the health and social challenges facing Indigenous Peoples (First Nations, Metis and Inuit). Attempts have been made to address issues and implement non-indigenous best practices; these best practices often fail, either because they are impeded by jurisdictional boundaries or because they do not reflect the historical, cultural and jurisdictional realities of the communities into which they are transported. There is a lack of deliberate collaboration between jurisdictions, resulting in barriers to the delivery of care. For example, regional service delivery units commonly do not extend service to nearby First Nations communities. And, outside of the major centers (in which there may be opportunities to comment on proposals for programming), the community knowledge, relationships and supports that exist and could be leveraged for better results are lost. What is lacking is a process for assessing environments and communities where care interventions are being contemplated so that best practices can be evaluated by the community and true best practice can be implemented in partnership with the community and the relevant provider organizations. There are mechanisms to ensure this happens in places such as academic institutions, major cities, etc. CMA is well-positioned to participate in a renewed national approach to overcome jurisdictional barriers and develop such a process for best-care in indigenous communities. (Although it may be outside the scope of this current motion, given its importance, First Nations' health could be the focus of a major advocacy initiative for CMA in the future, of a scale similar to that around seniors' care/national seniors' strategy.)

2. KEY STAKEHOLDERS: Health Canada, representative service organizations for First Nations and at least one national First Nations Health organization

3a. SUGGESTED IMPLEMENTATION: CMA shall convene a national round table meeting including the stakeholders noted. The goal will be to (i) agree upon the need for a process for assessing environments and communities in order to implement care interventions in the optimal manner and (ii) to engage the stakeholders involved to carry this message to their respective organizations and /or constituencies. A commitment would be made to report back to CMA table within a specified period of time regarding feedback received and opportunities for positive action identified.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism				x
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships	x			
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x			**x**	

6. Has this motion (or similar) been presented to another organization by the mover/seconder?		
No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.
7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/10/2015 4:34:00 PM		

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Alika Lafontaine

SECONDER Dr. Richard Johnston

MOTION

The Canadian Medical Association will promote practical advocacy strategies to support the health and well-being of First Nations communities in Canada.

1. SUBSTANTIVE RATIONALE

The Truth and Reconciliation Commission of Canada recently released a landmark report entitled "Call to Action," containing 94 recommendations "to redress the legacy of residential schools and advance the process of Canadian reconciliation." This is an important report. The recommendations will require action in all sectors of society. Some of these are beyond the CMA's purview, yet as the national voice of Canadian physicians, the association is uniquely positioned to advocate for practical strategies and implementation of those recommendations that will best support promotion of healthier First Nations populations across the country. (Although it may be outside the scope of this current motion, given its importance, First Nations' health could be the focus of a major advocacy initiative for CMA in the future, of a scale similar to that around seniors' care and the national seniors' strategy.) See Appendix 2.

2. KEY STAKEHOLDERS: The federal government

3a. SUGGESTED IMPLEMENTATION: CMA shall review the findings and recommendations of the Truth and Reconciliation Commission report http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf (particularly those related to health) and identify areas where CMA advocacy could be applied to expedite or enhance implementation of recommendations or suggest other improvements with the goal to better First Nations' health. As a starting point, a letter could be written to the federal government calling for the identified areas of action. Further opportunities would likely arise thereafter.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism				x
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care	x			
➢ Maximize strategic relationships				x
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth				x

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
	x		**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: The recommendations referenced in this motion appear in the attached Appendix 2. — **Received on:** 7/10/2015 4:35:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Bryce Durafourt

SECONDER Dr. Salina Teja

MOTION

The Canadian Medical Association supports in principle the right of Canadian medical students and medical residents to vote in the election of their medical association representatives.

1. SUBSTANTIVE RATIONALE

This motion supports in principle the right of Canadian medical students and residents to vote in the election of their representatives. Currently, CMA's elections for the position of President-Elect are open to all members in provincial/territorial nominations. The practice, however, is not reflected uniformly in the bylaws of the provincial/territorial medical associations. A patchwork of practices includes barring all learners from voting, allowing only residents to vote, or infrequently allowing all learners to vote. The motion does not bind provincial/territorial medical associations to any action but reinforces CMA's position and the expressed interest of Canadian medical students and residents.

The importance of extending franchise to all members of medical associations is that it builds active particpation in organized medicine at the earliest stages of professional formation. Providing franchise gives students and residents the responsibility of informed decision-making and of increasing their awareness of key political and organizational issues facing the profession. Franchise represents the most basic relationship between medical associations and medical students and residents. Conversely, disenfranching medical students and residents reinforces a hidden curriculum of outdated concepts of hierarchy and disempowerment, misses an opportunity to educate the newest members of the profession, and fails to engage with a core demographic that is vital to the growth and relevance of medical associations. Most importantly, without enfranchisement medical associations cannot claim to truly represent the voice of the entire profession. Thus, the fundamental aim of this motion is to support the strengthening of the medical profession and empower a new generation of engaged learners.

2. KEY STAKEHOLDERS: Provincial/territorial medical associations, especially those with medical schools in their jurisdictions, Canadian medical students, Canadian medical residents, Resident Doctors of Canada, Canadian Federation of Medical Students, Fédération médicale étudiante du Quebec, Fédération des médecins résidents du Québec

3a. SUGGESTED IMPLEMENTATION: This motion if passed should be used by the CMA Board as a guiding principle for increasing the participation of medical students and residents in the activities of their medical associations. It can be used as a tool for advocacy in relations with provincial/territorial medical associations. Further, it demonstrates an active commitment by national medical leaders to medical students and residents in supporting the most basic right of professional membership. Minimal action - if any - would be required on the part of the CMA Board.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): This motion if passed should be used by medical students and residents, their local representative societies, their provincial/territorial representative societies, and their national representative societies to advocate for the right to franchise across all jurisdictions.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being				x
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care				x
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth	x			

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No	Yes x	If yes, please indicate the name of the organization, when it was presented and the outcome. Motion presented to the Canadian Federation of Medical Students executive committee and passed on June 28, 2015.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/12/2015 7:15:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

Policy Motion
x Directive Motion

MOVER Dr. Chris Ekong

SECONDER Dr. Mark Brown

MOTION

The Canadian Medical Association will work with the Royal College of Physicians and Surgeons of Canada and College of Family Physicians of Canada to provide a unified voice when advocating on issues of common interest.

1. SUBSTANTIVE RATIONALE

A recent survey of the Royal College of Physicians and Surgeons of Canada fellows suggest that the Royal College should play a stronger advocacy role. These fellows and fellows of the College of Family Physicians of Canada are also members of CMA and provincial/territorial medical associations. A strong cohesive voice from these national bodies may enhance the sphere of influence.

2. KEY STAKEHOLDERS: CMA, provincial/territorial medical associations, Royal College of Physicians and Surgeons of Canada and he College of Family Physicians of Canada

3a. SUGGESTED IMPLEMENTATION: Create a dialogue with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada to ensure goals are aligned.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): n/a

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession	x			
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care		x		
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs		x		
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: n/a — **Received on:** 7/13/2015 8:22:00 PM

MOTION FORM
CANADIAN MEDICAL ASSOCIATION – GENERAL COUNCIL 2015

MOTION CATEGORY AND TYPE
Delegates' Motions

x Policy Motion
Directive Motion

MOVER Dr. Salina Teja

SECONDER Dr. Natasha Snelgrove

MOTION

The Canadian Medical Association affirms its support for the continued use of the arm's-length, anonymous pre-accreditation survey as an integral component of the national system of accreditation for postgraduate medical education.

1. SUBSTANTIVE RATIONALE

Resident input into the accreditation process is critical to a meaningful national process. Resident Doctors of Canada (RDoC) has been administering a pre-accreditation questionnaire since the early 1980s that ensures that residents' perspectives and concerns are accurately and adequately voiced in a safe and confidential manner. Currently, the process of obtaining resident input into the accreditation process is being examined by the Task Force on Resident Input into the Accreditation Process involving the Royal College of Physicians and Surgeons of Canada, Collège des médecins du Québec and College of Family Physicians of Canada The continued use of the RDoC pre-accreditation questionnaire appears to be at risk. This is of significant concern to learner organizations (i.e., RDoC, Fédération des médecins résidents du Québec) and the residents they represent.

On behalf of our 12,000 resident members, RDoC articulated four principles for resident input into the national accreditation process: namely, that it include (1) an external, third party, confidential survey of residents during accreditation; (2) an arms-length process between the faculties of medicine and the certifying bodies; (3) qualitative data gathering; and (4) the confidential, anonymized collection of feedback. However, RDoC is very concerned that the current direction and approach being taken by the Task Force does not reflect an explicit commitment to these principles, and may ultimately result in the abandonment of the resident pre-accreditation questionnaire.

As the national voice for physicians across Canada, we believe that this endorsement by CMA will help ensure a continued commitment to physician health and wellness and encourage a meaningful focus on professionalism.

2. KEY STAKEHOLDERS: Key stakeholders in the national accreditation process for postgraduate medical education include the accrediting bodies that are represented on the Task Force (i.e., the Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada and Collège des médecins du Québec) and the representative learner organizations (Resident Doctors of Canada and their Provincial Housestaff Organizations, and the Fédération des médecins résidents du Québec).

3a. SUGGESTED IMPLEMENTATION: Suggested implementation would be for the CMA to write a letter to the Task Force to strongly encourage them to continue to use the learner administered pre-accreditation survey that ensures resident input is meaningfully incorporated into accreditation in a confidential manner, and to more generally adopt/commit to the four key principles for a national accreditation process put forward by Resident Doctors of Canada.

3b. SUGGESTED IMPLEMENTATION (by mover/seconder): RDoC would be pleased to provide any additional information/background on this issue as requested/required.

4. RELEVANCE TO CMA STRATEGY

Medical professionalism	**High**	**Medium**	**Low**	**N/A**
➢ Advance medical professionalism	x			
➢ Improve physician health and well-being	x			
➢ Strengthen the national voice of the CMA for the medical profession				x
Patients and the public	**High**	**Medium**	**Low**	**N/A**
➢ Lead national vision for a healthy population and world-class health care			x	
➢ Maximize strategic relationships		x		
Growth and relevance	**High**	**Medium**	**Low**	**N/A**
➢ Develop and market products and services that are highly responsive to member needs				x
➢ Increase member engagement, member satisfaction and membership growth		x		

5. ESTIMATED RESOURCES REQUIRED (money, time, human)

HR less than one person week	HR more than one person week – less than one person month	HR over one person month	Under $5,000	$5,000-$50,000	Above $50,000
x			**x**		

6. Has this motion (or similar) been presented to another organization by the mover/seconder?

No x	Yes	If yes, please indicate the name of the organization, when it was presented and the outcome.

7. ADDITIONAL COMMENTS: The accreditation process is critical to ensuring quality postgraduate medical education (PGME) in Canada.The RDoC pre-accreditation questionnaire has been an instrumental tool used since the early 1980s to ensure that residents' perspectives and concerns are accurately voiced, in a safe manner, to effect positive change on the Canadian PGME system and ensure the development of high-quality medical practitioners who meet societal needs. Throughout the years, RDoC has sought to review and update the questionnaire to ensure it is aligned with changes in PGME standards, and saw the Task Force as an important opportunity to further improve the questionnaire, including increasing its contributions and transparency in the formal accreditation process, without compromising resident confidentiality. For more information/background, please see Appendix 3 "RDoC Pre-Accreditation Questionnaire". — **Received on:** 7/13/2015 11:59:00 PM