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## General Council Procedure

### Proposed 2014 CMA General Council Agenda

**Sun., Aug. 17**
- **8:30 – 9 am**
  - Opening of General Council

**Mon., Aug. 18**
- **9 – 10:15 am**
  - Canadian Medical Foundation education session (TBD)

**Tues., Aug. 19**
- **8:30 – 9 am**
  - End-of-life care issues

**Wed., Aug. 20**
- **8 – 8:15 am**
  - MD Financial Management stewardship report – Q&A with CMAH Board Chair and MD President/CEO

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</thead>
<tbody>
<tr>
<td>8:30</td>
<td>Opening of General Council</td>
<td>Education session: End-of-life care issues</td>
<td>Strategic session 2: End-of-life care issues in Canada (Committee of the Whole)</td>
<td>Emerging issues and Delegates' motions</td>
</tr>
</tbody>
</table>
| 9:00 | Keynote address: Social responsibility and the medical profession, Dr. Brian Goldman | Delegates' motions | Elections | 11:50 am – 12:15 pm
| 10:50 | Delegate coffee debrief | 11:15 am – 11:45 am | 12:15 – 12:30 pm | Inaugural address of incoming president Closing of General Council |
| 11:15 | Social responsibility and the medical profession (Committee of the Whole) | 11:45 am – 12:25 pm | President's valedictory address | CMA Annual Meeting
| 12 – 12:45 pm | Lunch | Lunch | Lunch | "Grab & go" lunch |
| 12:45 | Workshop session: Defining the physician unique value proposition | Education session: Marijuana for medical purposes | 1:45 – 2:30 pm | "Grab & go" lunch |
| 3:15 | Information session: MD Physician Services | Information session: Members' Forum | Education session: Election 2015: CMA election readiness | Joint CMA/CMPA information session |
| 4:30 | Orientation for GC participants | Orientation for GC participants | Installation ceremony and awards |

*CMA Board Business and Stewardship Report includes a question and answer period (Q&A) for Governance (including bylaws), Archives and Awards and core committees.
Conduct of meetings of CMA General Council

The basis for orders and rules of procedure is to be taken in accordance with the current edition of Wainberg’s Society Meetings including Rules of Order. Should any problem arise for which this authority does not provide a solution, the chair of the meeting may, at his or her discretion, accept the latest edition of Beauchesne’s Parliamentary Rules and Forms of the House of Commons of Canada, or Bourinot's Rules of Order as a guide.

The speaker shall open the meeting and outline the format for the proceedings of General Council. Business should be transacted in an orderly manner to enable members to express opinions within limits of decorum, to prevent waste of time and to prevent any action being taken on sudden impulse. At all times during the meetings and events of General Council and the CMA Annual Meeting, members and participants will support a respectful and collaborative environment.

The speaker will assume that all members of Council have read and are familiar with all reports. Resolutions approved at last year’s General Council and their dispositions are included in the reports. Members of General Council may raise questions relevant to those resolutions during the presentation of the appropriate report.

At the beginning of the meeting of General Council, a resolution will be introduced to the effect that all narrative sections of the reports be received for information.

Representatives are expected to bring forward the opinions of those whom they represent. However, decisions should be made and voting carried out on the basis of merit and in the interests of the CMA after hearing the discussion.

Members wishing to speak during debate should proceed to a microphone and, after being recognized by the speaker, identify themselves by name and representation, state whether they are speaking for or against the motion, and address General Council.

The best authority for the speaker is the judgement of General Council.

When a main motion has been moved, seconded and read from the chair, it is regularly before the meeting.

Members are requested to try to limit themselves to speaking only once to a motion unless permission is granted to speak further. If a member rises to speak only to agree with the previous speaker, the intervention is expected to be brief unless there is new material to be added or a point to clarify.

When the mover of the motion speaks a second time, it shall be with the understanding that this closes the debate.

During General Council, a delegate may request on a ‘point of procedure’ that a particular discussion or session be held in-camera. The delegate must specify which level of in-camera (listed below) is requested. A vote will be taken and a majority will be required. The three levels of in-camera are:

- Level 1 – Exclusion of media
- Level 2 – Exclusion of media and non-member observers
- Level 3 – Delegates only

Should General Council approve to deliberate in-camera, the speaker will seek additional clarification as to the appropriateness of staff and/or technical crew remaining in the room to facilitate business.

These in-camera procedures were developed at the request of the Board of Directors and are consistent with Beauchesne’s Parliamentary Rules and Forms.
## Motions in order of precedence and their characteristics

<table>
<thead>
<tr>
<th>Motions</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Closing motions (highest precedence)</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Concluding meeting</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>(a) Only as to time and place, not as to date.</td>
</tr>
<tr>
<td>2. Adjourning to fixed date</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(a)</td>
<td>(a)</td>
<td>Majority</td>
<td>(b) Demands are not true motions. They have no order of precedence among themselves, and must be disposed of as soon as they arise.</td>
</tr>
<tr>
<td>3. Adjourn without fixed date</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td></td>
</tr>
<tr>
<td>4. Recessing meeting</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(a)</td>
<td>(a)</td>
<td>Majority</td>
<td></td>
</tr>
<tr>
<td><strong>Demands (points) (b)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Quorum count</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
</tr>
<tr>
<td>6. Point of personal privilege</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
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<tr>
<td>7. Point of general privilege</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
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<tr>
<td>8. Point of information</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
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<tr>
<td>9. Point of procedure (c)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
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<tr>
<td>10. Point of order</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
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<tr>
<td>11. Correcting error</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Vote</td>
<td></td>
</tr>
<tr>
<td><strong>Procedural motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Objecting to consideration</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2/3 (d)</td>
<td>(e) Only as to date and time for reopening discussion on the main motion.</td>
</tr>
<tr>
<td>13. Tabling motions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(e)</td>
<td>(e)</td>
<td>2/3</td>
<td>(f) Only as to the limitations on discussions.</td>
</tr>
<tr>
<td>14. Postponing discussion to fixed time</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(e)</td>
<td>(e)</td>
<td>2/3</td>
<td>(g) Only as to the terms of reference.</td>
</tr>
<tr>
<td>15. Postponing discussion indefinitely</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(f)</td>
<td>(f)</td>
<td>2/3</td>
<td>(h) Only as to the scope of the subject and the selection of the chair.</td>
</tr>
<tr>
<td>16. Limiting discussion</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>(i) Only as to the amendment.</td>
</tr>
<tr>
<td>17. Voting immediately</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>(j) Only as to the subamendment.</td>
</tr>
<tr>
<td>18. Referring or referring back</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(g)</td>
<td>(g)</td>
<td>2/3</td>
<td>(k) Requires the same majority as does the main motion or resolution to which it refers.</td>
</tr>
<tr>
<td>19. Resolving into Committee of the Whole</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(h)</td>
<td>No</td>
<td>Majority</td>
<td>(l) Only as to the wisdom of dividing.</td>
</tr>
<tr>
<td>20. Suspending the rules</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>(h)</td>
<td>No</td>
<td>Majority</td>
<td>(m) A motion may be informally withdrawn by the mover before it has been seconded or stated by the chair.</td>
</tr>
<tr>
<td><strong>Motions amending motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n) Simple majority unless a higher majority is required by the constitution.</td>
</tr>
<tr>
<td>21. Amendments</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>(i)</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td>22. Subamendments</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>(j)</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td>23. Dividing a motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>(l)</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td>24. Withdrawing a motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>(k) (m)</td>
<td></td>
</tr>
<tr>
<td>25. Reconsidering defeated motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td><strong>Motions amending resolutions</strong></td>
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<tr>
<td>26. Reconsidering resolution</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td>27. Rescinding resolution</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>(k)</td>
<td></td>
</tr>
<tr>
<td>28. Making resolution unanimous</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Unanimous</td>
<td></td>
</tr>
<tr>
<td><strong>Main motions</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. Main motions</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>(n)</td>
<td></td>
</tr>
<tr>
<td><strong>Elections and appointments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30. Nominations</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>31. Closing nominations</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td></td>
</tr>
<tr>
<td>32. Acclamations</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td></td>
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<tr>
<td>33. Appointments</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td></td>
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</tbody>
</table>
Procedures

Consent agendas

The use of consent agendas allows non-controversial motions as well as procedural motions to be approved by General Council ‘en bloc.’ The intent of the consent agenda process is to increase the amount of time available at General Council for motions that require delegates’ full discussion and debate.

The criteria for placing motions on the consent agenda will include:

1. motions that are not likely to initiate debate or dissent among delegates or the profession;
2. motions that are in keeping with the CMA’s strategic direction and its strategic plan; and
3. motions that require little to no resources to implement.

A consent agenda will be presented to General Council, for adoption, at the beginning of the delegates’ motions session. At that time, any delegate may request that a motion be removed from the consent agenda for reasons of dissent. The motion(s) in question will be considered, if time allows, following the debate of all motions in that session.

Strategic sessions

General Council’s Strategic session 1 on Social responsibility and the medical profession (Aug. 18) and Strategic session 2 on the End-of-life care in Canada (Aug. 19) will be held in Committee of the Whole format enabling delegates to provide input for ongoing policy development in these areas.

Should motions be submitted on topics related to Committee of the Whole sessions, they will be discussed as much as possible within a special Delegates’ motions session. CMA will subsequently report on policy developed from these discussions in the 2015 Reports to General Council.

Delegates’ motions

Motions received by the July 14 deadline will be considered and presented to General Council as follows:

- The Resolutions Committee will review and clarify motions, eliminate duplication by combining similar motions, and categorize delegates’ motions by groupings.

- The Resolutions Committee may establish a particular grouping for an emerging theme(s) within the Delegates’ motions session to facilitate the flow of discussion and debate of a particular themed area. Motions classified within an established themed area/grouping will be debated according to the date and time of their receipt by CMA.

- The Resolutions Committee will consider motions for inclusion in a consent agenda which will be prepared for the delegates’ motions session and presented for adoption by General Council.

- Delegates will receive, at the time of registration, a link via email to access:
the list of consent agenda motions, for consideration; and
all delegates’ motions in their order of debate – established according to the date and time the motions were received by CMA.

Motions received after the **July 14 deadline** will only be considered by General Council after all the motions received prior to deadline have been considered in the order that they are received and time permitting. Resolutions Committee members will be available on site at General Council to answer questions and assist delegates with this process.

**Approach to delegates’ motions, strategic sessions motions and emerging issues**

In consultation with the CMA Board and provincial/territorial medical associations (PTMAs), there is expressed concern on forming binding policy with delegates’ motions passed during General Council. The issue relates to the limited time provided to delegates for review, consultation and discussion of motions prior to the start of General Council.

As a result, the speaker and deputy speaker will ask General Council in 2014 to consider making the majority of delegates’ motions advisory to the Board, rather than binding as policy. The Board will continue to provide information about the disposition of all delegates’ motions. General Council’s support of this approach would be a procedural decision and could be reversed at any time.

This approach is not suggested for strategic session motions as these motions relate to topics where General Council has received advanced notice and documentation to support decision-making. This approach is also not suggested for emerging issue motions which present a compelling reason for CMA to take action within the context of such issues.

**Procedural rules/motions of the speaker**

The following are motions proposed to facilitate the work of General Council.

**Electronic voting**

**MOTION SP 0-1**

*General Council approves the use of electronic voting during its 2014 meeting unless manual voting is requested by the speaker or General Council for a specific vote.*

**Use of Consent Agenda**

The use of consent agendas will continue at General Council in 2014 and will allow motions that meet the consent agenda criteria outlined under the procedures section, noted on page 4, to be approved by General Council ‘en bloc’ and without debate.
MOTION SP 0-2

General Council approves the use of consent agendas at its 2014 meeting for delegates’ motions as proposed by the speaker and outlined on page 4 of the 2014 Reports to General Council.

Other motions

It is proposed that procedural motions SP 0-4 to SP 0-8 be considered and approved ‘en bloc.’

MOTION SP 0-3

General Council approves ‘en bloc’ the procedural rules/motions of the speaker as outlined on pages 5 and 6 of the 2014 Reports to General Council.

Approval of agenda

MOTION SP 0-4

General Council approves the proposed 2014 agenda as outlined on page 1 of the 2014 Reports to General Council.

Strategic and delegates’ motion sessions

MOTION SP 0-5

General Council adopts the rules relating to strategic session and delegates’ motions as proposed by the speaker and outlined on pages 4 and 5 of the 2014 Reports to General Council.

Other

MOTION SP 0-6

In keeping with Canadian Medical Association bylaw 18.1, the rules of conduct for this meeting as outlined on pages 2 and 3 of the 2014 Reports to General Council are adopted.

MOTION SP 0-7

The Proceedings of the 146th Annual Meeting (2013) of the Canadian Medical Association are approved as circulated.

MOTION SP 0-8

The narrative sections of the 2014 Reports to General Council – 147th Annual Meeting of the Canadian Medical Association are received for information.
### DECEASED MEMBERS 2013-2014

#### Honorary members

Aaron, Theodore Herschel, Edmonton, Alta.
Anthony, Francis René, Moncton, NB
Augustine, John Ross, Ottawa, Ont.
Bherer, Robert, Falardeau, Que.
Bridge, Henry William, Vancouver, BC
Clayden, Gerald Rosborough, Fredericton, NB
Dominic, Rufus Gerard, St. John’s, NL
Fairfull-Smith, John, NB
Gareau, Paul-Emile, Verdun, Que.
Harley, Brian John Sturmey, St. John’s, NL
Heimbecker, Raymond Oliver, Collingwood, Ont.
Hevenor, Donald William, Tillsonburg, Ont.
Holmes, Richard Brian, Toronto, Ont.
House, Arthur Maxwell, St. John’s, NL
Hudson, Arthur James, London, Ont.
Kennedy, Richard F., St. John’s, NL
Kumar, Krishna, Regina, Sask.
Lemay, Guy, Gatineau, Que.
Lindsay, Peter Keays, Grande Prairie, Alta.
McCaughey, Thomas Joseph, Westmount, Que.
McDonald, Ian MacLaren, Saskatoon, Sask.
Molgat, André Louis, Winnipeg, Man.
Morgan, John Colvin, Calgary, Alta.
Myland, Wallace Elton, Calgary, Alta.
Nicholson, Allan, Ottawa, Ont.
O’Connor, Denis Anthony, Corner Brook, NL
Passi, Ronald Bernhart, London, Ont.
Pinto, Cuthbert Joseph, Moncton, NB
Purdie, Francis John, Brandon, Man.
Romalis, Garson, Vancouver, BC
Surkan, Metro, Prince Albert, Sask.
Sylvestre, Jacques, Sherbrooke, Que.
Tanner, Aubrey Charles, Surrey, BC
Terwiel, Marco, Maple Ridge, BC

#### Members

Adolph, Inge, Etobicoke, Ont.
Aldridge, Douglas, Oakville, Ont.
Amyot, Gilles, Outremont, Que.
Anholt, Leroy Mathew, Edmonton, Alta.
Ansari, Ziaul B., Wetaskiwin, Alta.
Anselmo, John Edward, Edmonton, Alta.
Arkan, Ali Ibrahim, Allentown, Penn.
Bale, Michael, Abbotsford, BC
Banister, Philip Gerald M., Brockville, Ont.
Barr, Robert Murray, London, Ont.
Barrett, Joyce Louise, Ont.
Barrette, Gregoire Joseph, Claremore, Okla.
Batarseh, Samir John, North York, Ont.
Beauchesne, André, Que.
Bélanger, Raymond E., Laval, Que.
Benoit, Jacques J.G., Austin, Que.
Bent, Wilfrid Irving, Bridgewater, NS
Berthaume, Marcel, Laval, Que.
Bitenc, Igor Andrej Stevo, Victoria, BC
Black, Douglas Gordon, Annapolis Royal, NS
Boeske, Margarete, Edmonton, Alta.
Bolduc, Alain, Moncton, NB
Boparai, Gurdev Singh, Vancouver, BC
Bosch, Jan Willem, Ajax, Ont.
Botha, Johan Hendrik, Medicine Hat, Alta.
Brown, Ian Scott, Calgary, Alta.
Burns, Charles Mackay, Winnipeg, Man.
Bury, Robert James, Edmonton, Alta.
Bus, Mihaly, Coquitlam, BC
Butler, Kenneth Rupert, Scarborough, Ont.
Carignan, Louise S., Ottawa, Ont.
Carlisle, James Strathearn, St. Thomas, Ont.
Carmichael, Catherine Ann, Toronto, Ont.
Cassimjee, Mahomed Ismail, Ont.
Catzavelos, Gregory Charles, Cornwall, Ont.
<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>Province</th>
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<tbody>
<tr>
<td>Chandarana, Prafulchandra</td>
<td>London</td>
<td>Ont.</td>
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<tr>
<td>Chandu-Lall, Jangbahadur Anand</td>
<td>Kingston</td>
<td>Ont.</td>
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<tr>
<td>Chisholm, Ian Andrew</td>
<td>Salt Spring Island, BC</td>
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<tr>
<td>Chiu, Ray Chu-Jeng</td>
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<td>Que.</td>
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<td>Clark, John</td>
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<td>Clark, Nigel</td>
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<td>Cockburn, Douglas Wright</td>
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<td>Comeau, Yves</td>
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<td>Connery, Mervin Allan</td>
<td>Napanee</td>
<td>Ont.</td>
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King, Michael Robert, Englehart, Ont.
Kirkpatrick, Fenwick, New Westminster, BC
Kiszkiel, Krzysztof Marek, Cornwall, Ont.
Koch, Eduard Adriaan, Edmonton, Alta.
Komaromi, Gabor, Hampstead, Que.
Krekorian, George Dennis, St. Catharines, Ont.
Kurowski, Zbigniew T., Mississauga, Ont.

Lambert, Yvan, Jonquière, Que.
Lamoureux, Esther G., Montréal, Que.
Landy, Philip John, Eden Mills, Ont.
Lapko, Paul Ward, Hamilton, Ont.
Laudan, John Carl Harold, Vancouver, BC
Lavender, Sara Joanne, Millarville, Alta.
Leblanc, Gérard Léo, Québec, Que.
LeBlanc, Joseph Lorenzo, Guelph, Ont.
Lemire, Paul Guy M., Saint-Lambert, Que.
Lepage, Denis J.-B., Sherbrooke, Que.
Lessard, Camille, Québec, Que.
Librach, Sydney Lawrence, York, Ont.
Lidkea, Marlene Rose, St. Albert, Alta.
Liem, Sek Kong, Regina, Sask.
Lindsay, William Richard, Toronto, Ont.
Liu, Shinmen, Scarborough, Ont.
Lombard, Jan Hendrik, Fort Qu’Appelle, Sask.
Loomer, Franklin Stephen, Victoria, BC
Low, Donald Edward, Toronto, Ont.
Luck, Donald Edgar Ramsay, Oshawa, Ont.
Lyons, Jessica, Calgary, Alta.

MacDonald, Charles Henry Nolan, Fairview, Tex.
MacDougall, Peter Lee Robert, Saskatoon, Sask.
MacFadyen, Donald John, Chilliwack, BC
Macoomb, Richard Kent, Winnipeg, Man.
Magee, Donald Robert, Winnipeg, Man.
Maharaj, Deodath, Guelph, Ont.
Maharaj, Deonarine, London, Ont.
Maltas, Gérard, Alma, Que.
Manners, Douglas Oakley, London, Ont.
Marcellus, James Amos, Mission, BC

Markus, Arthur Joseph, Montréal, Que.
Marsh, Gerard Stewart, Sydney, NS
Martin, John Matthew, Delta, BC
Mathew, George P., Winnipeg, Man.
Mbolekwa, George Mtuzeli, Paris, Ont.
McDermot, Rebeca Stewart, Ottawa, Ont.
McGeough, Vincent Lawrence, London, Ont.
Mehlomakulu, Mtimkulu Charlton, Kingston, Ont.
Meloche, Rolland, Saint-Lambert, Que.
Melvin, Roy, North York, Ont.
Mertens, Gustaaf Adolf, Bridgewater, NS
Meszaros, George, Peachland, BC
Metcalf, James Overgard, Edmonton, Alta.
Meunier, Pierre, Varennes, Que.
Meunier, Pierre-E., Que.
Middleton, William George, Toronto, Ont.
Midgley, Robert Dobson, Stratford, PEI
Mihic, Iva Praprotnik, Toronto, Ont.
Mills, George Franklin, Ont.
Mirabel, Ludwik, Vancouver, BC
Monckton, George, Alta.
Moorhouse, John Allan, Winnipeg, Man.
Moran, John Henry, Wellesley, Ont.
Morar, Parbhoo, Scarborough, Ont.
Moscarello, Mario A., Toronto, Ont.
Mueller, Charles Barber, Hamilton, Ont.
Muttitt, Eldon Leonard, Edmonton, Alta.

Nelson, James William, Oshawa, Ont.
Nett, Alvin Elizabeth, Edmonton, Alta.
Nicholls, Peter John, Calgary, Alta.
Nieto, Alvaro, Oviedo, Spain
Nix, Nelson William, Fallis, Alta.
Nixon, Lloyd, Kamloops, BC
Nkut, Alfred Ndenkeh, Sudbury, Ont.
Nurse, Michael Charles, St. John’s, NL

Opie, Clarence Hall, Pinawa, Man.
Osborne, Ronald Julian, East York, Ont.
Ouimet, Alain André, Montréal, Que.

Parson, Christopher James, North Vancouver, BC
Patenaude, Nicol Henri, Sturgeon Falls, Ont.
Pazuki, Kasra, North York, Ont.
Pedvis, Sydney, Que.
Perkins, Laurie Kim, Burns Lake, BC
Perzow, Sidney Michel, Vancouver, BC
Phillips, Godfrey Keith, Ont.
Picard, Aline Gilberte, Saint-Laurent, Que.
Polo, Rafael Francisco, Brandon, Man.
Pontifex, Alexander, White Rock, BC
Popkin, David Richard, Saskatoon, Sask.
Popovic, Ilija B., Calgary, Alta.
Price, John Whitaker, Ont.
Price, Norman Earl, Hamilton, Ont.
Pritchard, Ruggles Bernard, Peterborough, Ont.
Proulx, André, Laval, Que.
Purvis, James Raphael, Kingston, Ont.
Rahn, Raymond James, Napanee, Ont.
Rankin, Alastair, Edmonton, Alta.
Raphael, Julian M.C., Lethbridge, Alta.
Rewcastle, Neill Barry, Sechelt, BC
Richards, Albert Gerald, Victoria, BC
Riddle, Gordon, Bracebridge, Ont.
Rogers, Olha Kotyk, St. Catharines, Ont.
Rosenblatt, Jacob, Vancouver, BC
Ross, Gerald Harvey, Bountiful, Utah
Rubinger, Morel, Toronto, Ont.
Rutherford, Reginald White, North York, Ont.
Ryan, Peter William, Windsor, Ont.
St-Pierre, Paul, Québec, Que.
Sanborn, Clare Shannon, Windsor, Ont.
Sasseville, Réal, Roberval, Que.
Schatz, Stanley Walker, Oakville, Ont.
Schoeman, Stefan, Comox, BC
Schwalter, Bruce Harold, Ottawa, Ont.
Schulze, Werner Bernhard, Edmonton, Alta.
Sears, Ronald Sydney Ralph, Lindsay, Ont.
Seland, Thomas Peter, Kelowna, BC
Selhi, Brahman Datt, North Battleford, Sask.
Shack, Leo, North York, Ont.
Shapiro, Samuel Joseph, North York, Ont.
Sharpe, James Arthur, Toronto, Ont.
Shnider, Maurice, Winnipeg, Man.
Simard, Yvan, Québec, Que.

Simons, Ian William Coates, Killarney, Man.
Simurda, Michael Andrew, Kingston, Ont.
Singh, Ram R., Calgary, Alta.
Sippy, Rajinder, Brampton, Ont.
Sloan, Wilfred George, St. Thomas, Ont.
Smith, David Meredith, London, Ont.
Smith, James Bruce, Knowlton, Que.
Spector, Joel Robert, Toronto, Ont.
Spika, Otto Victor, Calgary, Alta.
Spring, William Bernard, North York, Ont.
Stather, David Ryan, Guelph, Ont.
Stock, Marvin, Toronto, Ont.
Sutherland, Donald Alan James, Toronto, Ont.
Swanson, Marjorie Cameron, Toronto, Ont.
Sylvestre, Guy, Saint-Laurent, Que.
Tahan, Pramil, Woodstock, Ont.
Takahashi, Joseph Haruo, Picture Butte, Alta.
Tan, Weiping Michael, Coquitlam, BC
Taor, Richard Ernest, Channel-Port-aux-Basques, NL
Thompson, William Allen Peter, Rothesay, NB
Thurston, Peter Russel, Ottawa, Ont.
Titus, Jolene, Meadow Lake, Sask.
Ugnat, François Antoine, Gloucester, Ont.
Van Husen, Josefine Elisabeth, Rockcliffe, Ont.
Vavruska, George William, Victoria, BC
Vey, Albert George, Victoria, BC
Waddell, Walter Govan, Perth, Ont.
Waldmann, Hans, Abbotsford, BC
Webster, Russell Duncan, Rothesay, NB
Weir, Donald Andrew, Dartmouth, NS
Wilson, Gerald Leslie, Lubbock, Tex.
Wilson, Ian Chisholm, Stittsville, Ont.
Wojski, Anna Maria, Merrickville, Ont.
Wong, George L., Grand Bend, Ont.
Wurzel, Menachem, Nepean, Ont.
Yendt, Edmund Reinhold, Kingston, Ont.
Youwakim, Bassem Hakim, Mississauga, Ont.
Zaidan, Anthony Raymond, Sask.
1. The Board of Directors acts for General Council between meetings and assumes all fiduciary responsibilities on behalf of the CMA. It is responsible for managing the affairs of the association in accordance with policies established by General Council, and reports annually on its stewardship.

2. This report, presented by the Chair of the Board of Directors, Dr. Brian Brodie, provides highlights of activities and decisions over the past year and a look ahead at 2014-15. It is organized by key strategic area (advocacy, knowledge services, financial services and governance).

3. Board administrative motions are presented under Board business, at the end of this report. The disposition of resolutions passed at General Council 2013 can be found in the Dispositions section.

Highlights

- A new mission, vision and values (see sidebar)
- Planning ahead – CMA unveils its 2015-17 strategic plan
- A new way of thinking – One Member initiative
- A new way of operating – A new subsidiary structure
- A record high number of physicians join CMA
- Two new membership fee categories
- Health care transformation – opportunities to effect change
- Care at the end of life – what’s next for CMA
- Choosing Wisely Canada hits the ground running

Planning ahead – CMA unveils its 2015-17 strategic plan

4. The Board initiated a strategy refresh process last fall culminating in the approval of a new strategic plan (2015-17) in March 2014. The process comprised a comprehensive environmental scan and extensive strategic thinking by the Board.

5. The environmental scan revealed that growth continues to be the universal challenge for the majority of organizations across all economic sectors domestically and on a global basis.

Mission

Helping physicians care for patients.

Vision

The CMA will be the leader in engaging and serving physicians, and the national voice for the highest standards for health and health care.

Values

We are known for…

Professionalism – Uniting physicians on fundamental tenets important to the medical profession.

Integrity – Honesty in representing our members and conducting our business.

Compassion – Caring for physicians, patients and each other.

Community building – Bringing diverse communities together to pursue common goals.
Membership organizations in particular are facing the challenge of changing demographics and expectations/needs – for example, 56% of CMA members are generation X and Y. The key challenge for membership associations can truly be summarized as a race for relevance. Relevance is the pathway to growth and extends directly to an organization’s value proposition. Our busy physician members expect value from their national association.

6. The new CMA mission statement is clearly focused on physicians and the patients they care for. Through extensive member insight research we learned that each member segment (students, residents, practicing and retired) identifies in virtually equal proportions with three key roles for CMA:
   - advocating for an improved health care system for Canadians
   - representing the medical profession at the national level
   - supporting individual physicians in their personal, professional and practice life

### 2014 Key strategic initiatives
- Member offering and experience
- Digital strategy
- Physician reputation campaign – phase 2
- CMA/PTMA Leadership Institute
- Practice management curriculum
- PTMA relationship strategy
- Member marketing
- Canadian Physician Health Institute
- Quality agenda
- Physician unique value proposition
- End-of-life care
- Choosing Wisely Canada
- Strategy refresh
- Program Management Office
- Technology road map
- Financial strategy
- Human resources strategy
7. Clearly, the CMA value proposition must be responsive to member expectations. While the strongest single driver of satisfaction is advocacy, member satisfaction increases with each core benefit that they use – advocacy, knowledge resources including online clinical tools and CMAJ, and financial planning and advice from MD Financial Services (MD).

8. It goes without saying that provincial/territorial medical associations (PTMAs) are integral to the successful delivery of CMA’s strategic plan. PTMAs and CMA in tandem provide a unique value proposition to the members they serve.

9. The Board is confident that the new strategic plan will move the association toward breakthrough performance in terms of relevance to members. At the same time, CMA needs to better organize and integrate its businesses to ensure the efficient and effective delivery of its value proposition and an exceptional member experience.

10. In terms of next steps, the Board has directed staff to move immediately into the execution phase of the strategic plan which will entail the development of a strategy map and performance measures and targets. The Board will work closely with staff to examine how CMA is organized to ensure that it is structurally positioned for successful execution of the new strategic plan.

A new way of thinking – One Member

11. The One Member initiative was launched in 2013 as a means to strengthen the working relationship between CMA and MD.

12. The objectives of the One Member initiative are to grow CMA membership through improved retention of existing members and efforts to recruit new physicians to the CMA. The initiative also seeks to improve the CMA member experience and to ensure alignment and integration with PTMAs’ joint value propositions.

13. An important milestone in the history of the One Member initiative was a joint meeting of the CMA and CMA Holdings (CMAH) Boards last December. At this event, a number of ideas to strengthen the working relationship were tabled and both boards supported the notion of continued efforts to explore and capitalize on opportunities as they arise.

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<td>• Joint growth opportunities</td>
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<td>• Shared value proposition</td>
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<td>• Operational efficiencies</td>
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14. As part of this initiative, a working group consisting of senior leaders from both organizations continues to seek out and act upon opportunities in the following areas:
   - joint growth opportunities
   - a shared value proposition
   - operational efficiencies
   - employee education

A new way of operating – A new subsidiary structure

15. The CMA Board has approved the creation of a new corporate entity under the CMA umbrella as a means to address a number of opportunities before the organization. CMA revenue-generating activities would be grouped together under this new structure. These activities include cma.ca, our publishing businesses (including CMAJ) and accreditation services. CMA also holds real estate that would be placed within this new structure.

16. Why is this change proposed? This change to CMA’s operating model addresses three areas of opportunity.

17. The creation of this new entity (name to be announced) more accurately reflects CMA’s value proposition: advocacy, knowledge services and financial services. Under this new structure, CMA is enabled to more sharply focus on advocacy on behalf of physicians and the profession. The new entity will focus exclusively on CMA’s revenue-generating areas of business (knowledge and clinical products and services, rental), and MD will continue its focus on delivering best of class financial services to members.

18. As noted in the February 2014 federal budget, the Canada Revenue Agency has been looking more closely at the activities of not-for-profit entities, in particular those activities that generate revenue for the entity. Under this initiative, CMA is looking to take the necessary steps to reduce the risk of losing its not-for-profit status by moving revenue-generating activities into a taxable corporation.

19. This new entity will allow CMA and its subsidiaries the opportunity to improve overall tax efficiency.

20. It is proposed that the new structure be up and running by Jan. 1, 2015. Between now and then, the Board will continue to very carefully examine the risks and opportunities associated with this change in operating model. In particular, areas such as governance, leadership and stakeholder impact are at the forefront of the Board’s thinking.
How CMA works for and with members

A record high number of physicians join CMA

21. CMA has undertaken a number of activities and initiatives to deliver and communicate a unique and compelling value proposition to its 80,000 members.

22. CMA recruitment programs and campaigns resulted in 6,022 new members joining the CMA in 2013 – the highest total in association history. Although new member growth remains consistent year over year, contributing to CMA’s stable market share, the membership lapse rate continues to grow and has increased as a proportion of the overall member base.

23. Each year, CMA undertakes active member recruitment and retention activities in collaboration with MD and PTMAs. Using a segmented approach, activities are targeted at recruiting and retaining members at various stages of the physician lifecycle: student, resident, practising and retired. To attract and retain members, CMA provides an integrated value proposition that highlights key benefits of membership and access to products and services offered through CMA, MD and PTMAs.

24. Earlier this year, the Member Value Working Group recommended to the Board membership pricing changes, based on evidence to support long-term membership growth,
including a 50% discount for members entering their first year of practice and complimentary lifetime membership for those who are retired and have been members for at least 35 years. The proposed changes do not necessitate bylaw changes and would take effect in 2015.

25. Information and key insights from member research serve to inform decision-making at all levels of the organization to ensure products, programs and services remain relevant to members. Activities include:

- leveraging member data to inform decisions on programs, products and services
- disseminating findings and insights from key member research studies throughout the organization
- holding strategic discussions with the Committee on Finance and the Board on CMA’s approach to membership, based on evidence from market experience, research and member insight

26. CMA member feedback continues to point to a desire for more information and higher levels of engagement. CMA has responded by providing rich content via multiple communication channels:

- 18 issues of the *CMA Bulletin* (informing members about various activities, products and services) are published in *CMAJ* and since January 2014, a targeted, streamlined version is sent out monthly with content specific to medical students, residents or practising physicians (available in French and English)
- president’s messages, cma.ca, PTMA publications and online channels also serve as communication channels
- nine member outreach events, including six member dialogues on end-of-life care, were held with several hundreds participating
- in addition, an online member consultation on end-of-life care took place this spring to inform debate at this year’s General Council – with over 1,100 registrants
- the 3,700 member e-panel (aka CMA’s member voice) provided input into policies and programs, including Choosing Wisely Canada, use of social media, CMA’s new strategic plan and online modules of non-clinical topics
- the annual Members’ Forum provides an opportunity for members to raise issues with CMA’s elected officials

27. CMA will continue its work to refine its value proposition to support physicians and trainees at various stages in their career life cycle.

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### CMA value proposition

#### MD Financial Management
- wealth management
- retirement planning
- cash flow planning
- debt management | net worth
- risk management
- estate and trust planning
- wills | incorporation

#### *CMAJ* (print | online | mobile app)

#### Practice management & wellness
- practice management curriculum for residents
- New in Practice guide
- CME cruises
- physician health podcasts
- Canadian Conference on Physician Health

#### Online clinical resources (incl. mobile apps)
- point-of-care resources
- publications
- e-journals | e-textbooks
- DynaMed | AccessMedicine
- STAT!Ref | POEMS | CMAJ
- clinical practice guidelines
- literature searches
- online clinical CME

#### Advocacy and representation
- grassroots advocacy
- health care transformation
- political action
- end-of-life and palliative care
- streamlined government forms and administration
- pensions for the self-employed

#### Leadership and learning
- leadership courses (some courses offered online)
- Canadian Conference on Physician Leadership
- leadership coaching
- Canadian Certified Physician Executive Leadership Credential

#### Member discounts
- Car rentals | hotels
- business services | cellular
- travel | sports | leisure

Visit [cma.ca](http://www.cma.ca) for details
28. Health care transformation continues to be CMA’s main policy research and advocacy priority and several initiatives have been undertaken since the beginning of this quest (see sidebar). This initiative is directed by a Board working group that includes PTMA representatives and an early-career physician. In May, CMA released a progress report outlining work to date, which measures progress toward each of the six guiding principles of health care transformation on a series of indicators, including a comparison to “best in class” internationally.

29. This year, in light of the significant implications of an aging population, the CMA’s Health Care Transformation initiative will focus on seniors care in the lead up to the 2015 federal election. Public opinion data (released in August 2013) indicate that there is overwhelming public support for a pan-Canadian approach to seniors’ care. In support of this research, CMA conducted a non-partisan awareness campaign in the four ridings involved in the 2013 federal by-elections that included letters from CMA President, Dr. Louis Hugo Francescutti, to each of the candidates about the importance of a national seniors strategy – an opportunity to fine-tune CMA’s strategy and tactics in preparation for the 2015 federal election.

30. In support of health care transformation priorities, the President-Elect, Dr. Chris Simpson, participated in an NDP-sponsored roundtable focused on social determinants of health, where he also communicated CMA’s policies on the need for a national seniors care strategy. In March, the NDP released a policy paper citing CMA about social determinants of health and the need for a national strategy on seniors care. The Liberal party was also receptive to the seniors care message and will work to integrate this into its strategy.

31. CMA’s annual Doctors in the House Lobby Day, held April 8, was an opportunity for Board and core committee members as well as MD-MP contact program members to meet with parliamentarians from all political parties to discuss CMA’s recommendations for health care transformation – with an emphasis placed on the need for a national seniors strategy and health impact assessments. CMA advocates met with some eighty officials that day, including Cabinet ministers, ministers...
of state, parliamentary secretaries, party leaders and health critics. The event included a multi-stakeholder breakfast where Nanos Research presented its findings of recent polling, which indicated that almost six in 10 voters would support another party if their current political brand fails to make seniors care a priority in the next federal election.

Care at the end of life – What’s next for CMA?

32. For the past couple of years, the Committee on Ethics and the Board have been actively engaged on the issue of care at the end of life. Over time, the focus has evolved to place an emphasis on three main areas (advance care planning, palliative care and medical aid in dying), recognizing that there is overlap and that there are other areas of interest and concern.

33. Last year’s education session on advance care planning featured an overview of American and Canadian initiatives designed to promote the uptake of advance directives, while a panel discussion covered topics ranging from access to palliative care to physician-assisted death. Several resolutions were adopted and policy statements on palliative care and advance care planning are in preparation.

34. CMA and various partners have engaged in numerous activities and initiatives, including:

- a series of public town halls co-hosted with Maclean’s magazine as well as member consultations
- an online dialogue hosted by CMA and online member polling about end-of-life care issues – over 1,100 registrants
- collaboration with PTMAs, Canadian Society of Palliative Care Physicians, Quality End-of-life Care Coalition of Canada and other partners
- meetings with politicians from all parties
- revisions to update CMA policy in this area (life-saving and -sustaining interventions, euthanasia and assisted suicide – terminology, organ and tissue donation and transplantation, advance care planning and palliative care)
- intervening in the Carter Supreme Court Case concerning physician-assisted death
- educational and strategic sessions at this year’s General Council to continue the discussion and assist further policy development (see Appendix 2)

End-of-life care issues

Public town halls
- St. John’s, Feb 20
- Vancouver, Mar 24
- Whitehorse, Apr 16
- Regina, May 7
- Mississauga, May 27

Member consultations
- St. John’s, Feb 21
- Edmonton, Mar 15
- Fredericton, Mar 28
- Vancouver, Apr 2
- Whitehorse, Apr 17
- Regina, May 10

Questions for discussion
- What is needed to facilitate discussions on advance care directives?
- What is your vision of good palliative care services?
- What is the state of palliative care in your community?
- Do you feel you have access to palliative care services?
- What needs to be done to provide the palliative care services you feel are needed?
- What are your thoughts on physician-assisted death?
- If you had access to good quality palliative-care services, would that influence your position on euthanasia or assisted suicide?
35. **Quebec Bill 52, An Act respecting end-of-life care**, was reintroduced with all-party consent when the National Assembly reconvened under the new Liberal government. On June 5, 2014 the bill passed by a free vote in the Quebec National Assembly (94 in support, 22 opposed). The bill establishes requirements for certain types of end-of-life care, including terminal palliative sedation and medical aid in dying. At the time of writing, the bill had not yet come into force. It is anticipated that the federal government could mount a legal challenge to Bill 52 on constitutional grounds.

36. In January 2014, the Supreme Court of Canada agreed to hear an appeal in the case of Kay Carter and Gloria Taylor. CMA, in its application to seek intervenor status, has highlighted the outcome of its end-of-life care dialogue, town halls and member meetings on advance care directives, palliative care and physician-assisted death. The hearing is scheduled for Oct. 14.

**Choosing Wisely Canada hits the ground running**

37. CMA collaborated with a team from the University of Toronto to create **Choosing Wisely Canada**. Originating in the United States and now an international movement, it is a program designed to support physicians and patients to have evidence-informed conversations about tests and treatments that may confer little benefit or even cause harm in specific clinical situations. It is intended to enhance the quality of care, not to reduce costs; however, by eliminating marginal care it will secure better value for the health care dollar.

38. Choosing Wisely Canada was officially launched on April 2, when nine national medical organizations released lists of 40 tests, treatments and procedures that patients do not need in all circumstances. The lists are based on definitive evidence that these specific interventions provide no benefit to patients in particular instances.

39. To this end, materials were created for both physicians and patients to support such decisions. The overall goal of Choosing Wisely Canada is about changing the culture — more is not always better when it comes to medical tests and procedures and to ensure provision of high quality care while avoiding unnecessary tests and procedures.
40. Key CMA activities in this area have included:

- facilitating the recruitment of specialty societies to develop lists of clinical activities in their fields that often are of little benefit
- connecting with a large number of patient and community groups to support the initiative
- developing a communications plan for Choosing Wisely Canada securing exposure for the program in print and on radio and television
- working with Consumer Reports to develop Canadian versions of patient brochures linked to lists which are available at www.choosingwiselycanada.org
- working with PTMAs on communication and implementation strategies
- collaborating with the Québec Medical Association to adapt French materials for the ‘Choisir avec soin’ campaign

41. To date, the initiative has been well received by various public and patient advocacy groups, many of whom praised the effort to provide information for patients that will allow them to better engage with physicians in the management of their care.

42. Currently, 30 national specialty societies are engaged in the campaign – 20 of which expect to release their lists later this year. Choosing Wisely Canada is participating in the development of evaluation strategies to gage the impact of the program on both physician practice and the patient experience.

**How do we define the physician’s unique value proposition?**

43. The Physician Unique Value Proposition Working Group has developed a discussion paper to capture the attributes that are considered unique to physicians as well as those that are considered valuable to patients. These attributes have been grouped into three categories:

- the comprehensive knowledge that physicians acquire through their extensive training
- the ability of physicians to apply this knowledge and tailor it to individual patient circumstances and preferences
- the high levels of accountability to which physicians are held

44. The discussion paper, which has been prepared to foster debate during a Committee of the Whole session at this year’s General Council, is found in Appendix 1.
Prescribing issues – What’s new for physicians

45. A significant number of federal government initiatives related to prescribing issues are underway, including prescription drug abuse and the use of marijuana for medical purposes.

46. CMA has seized the government’s focus on the misuse of prescription medication initiatives as a “policy window” to advance its recommendations for improved patient safety and healthy outcomes and to secure commitments for clinical practice tools. CMA appeared before the House of Commons Health Committee during its study of this issue last November. Dr. Francescutti attended the Ministerial Symposium on Prescription Drug Abuse in January, which was co-hosted by the health minister. CMA was quoted in a news release issued following the symposium calling on federal and provincial/territorial governments to further engage with stakeholders to address the issue.

47. In December 2013, the federal government introduced Bill C-17, the Protecting Canadians from Unsafe Drugs Act, which proposes many measures CMA has long sought to improve the legislative framework governing prescription pharmaceuticals. CMA appeared before the Senate Social Affairs Committee in March, as part of the final phase of Senate study, encouraging action to improve the legislative framework governing prescription pharmaceuticals as well as a study of drug shortages.

48. The new regulatory regime governing marijuana for medical purposes, which came into effect April 1, did not address physician concerns. Following CMA’s advocacy efforts, Health Canada indicated a willingness to explore these concerns. CMA welcomed the health minister’s comments and indication of a shared objective: that marijuana for medical purposes be treated as a prescription pharmaceutical. CMA continues to urge Health Canada to support the development of rigorous research on the effects, both positive and adverse, of marijuana for medical purposes.

CMA’s input into the 2014 federal budget and budget day

49. As part of the 2014 pre-budget consultation, CMA submitted recommendations to the House of Commons Committee on Finance and issued a more detailed brief that was presented to the Standing Committee on Finance on Nov. 6, 2013.
50. CMA’s pre-budget brief, which was circulated to members of Parliament, senators and cabinet ministers, outlined tangible recommendations for federal action in three important areas:
- seniors care, including dementia, long-term care facilities and injury prevention
- social determinants of health and health equity
- health care productivity and innovation

51. At the invitation of the Prime Minister’s Office, CMA participated in a pre-Throne Speech reception where CMA’s policy priorities for federal action, particularly the need for a pan-Canadian seniors care strategy, were raised.

52. CMA was pleased that the 2014 federal budget included:
- new investment for research on dementia
- an increase on tobacco taxes
- $44.9 million set aside over five years to expand the focus of the National Anti-Drug Strategy from illicit drugs to also include prescription drug abuse
- $70 million earmarked over three years for a new fund to boost health service delivery in the three territories in priority areas while reducing medevac flights and expenses

Other advocacy initiatives

53. On behalf of CMA, Dr. Gail Beck participated in a Family Violence Symposium in March, to address child abuse and family violence; the symposium was co-hosted by the health minister. The federal government has since committed to a process to develop further guidance for health care practitioners to better support patient care.

54. In October 2013, CMA, Canadian Nurses Association (CNA), Health Action Lobby (HEAL) and Canadian Pharmacists Association (CPhA) sent a proposal for Phase III of the Council of the Federation’s Health Care Innovation Working Group to Premiers Kathleen Wynne, Alison Redford (who has since resigned) and Darrell Pasloski. The proposal acknowledged that in the third phase of its work, the working group had an opportunity to accelerate the implementation of innovative practices and new technologies. In response, the Premiers reaffirmed that the working group will continue to address the three themes of appropriateness of care, pharmaceuticals and seniors’ care. At the request of the Deputy Minister of Health, the CMA along with representatives from HEAL, CNA and CPhA were invited to participate in a teleconference last March, to discuss current and future work

Health-related investments announced in the 2014 federal budget
- New investment for dementia research
- Increase on tobacco taxes
- Additional funding for the National Anti-Drug Strategy
- New funding for health services delivery in the territories
within the three priority areas. CMA continues to support collaboration to improve health outcomes and the delivery of quality health care through the efforts of the Council of the Federation and ensure that physicians are part of the solution.

55. CMA created an online consultation to validate patient expectations which emerged for each of the five foundations for integrated care (patient access, patient-centred care, informational continuity, management continuity and relational continuity) from the Health Providers Summit Series on the continuum of care. The bilingual online survey was sent to over sixty patient groups. The next steps of the Health Provider Summit Steering Committee will be to review the results and potentially develop a tool that patients could use to assess their actual experiences against these expectations.

56. More than 450 CMA members in 234 federal ridings are now part of the MD-MP Contract Program – CMA’s grassroots advocacy initiative. Members are encouraged to meet their MPs regularly, and will be mobilized during the next federal election campaign to participate in local campaign activities.

57. CMA also continues to deliver advocacy training workshops as part of its value proposition. This service has now been expanded to include training via webinar and videoconference; online advocacy training and a one-day workshop are in development.

CMA’s work with PTMAs and other stakeholders

58. Strengthening our alliances with key stakeholders is a cornerstone in achieving the goals set out in CMA’s strategic plan. The CMA/PTMA Relationship Strategy centers on building and strengthening this critical strategic and operational partnership. This past year, the strategy focused on operational efficiencies, defining specific outcomes and establishing guidelines for working together. CMA, MD and PTMAs collaborated to define several initiatives including PTMA outreach, joint value proposition development, member communications, products and services collaboration.

59. The Presidents Forum, which met three times over the past year, focused on health care transformation, physician leadership, system-wide efficiencies and savings, and participation in the Council of the Federation Health Care Innovation Working Group.
60. The CEOs Forum met three times and held teleconferences to discuss issues related to association management, emerging policy and negotiation issues. This past year, the forum focussed on member engagement challenges and opportunities, system-wide efficiencies and savings, and the challenges faced in response to provincial/territorial government tactics to contain health care expenditures.

61. CMA signed a formal Memorandum of Understanding with the Association of Faculties of Medicine of Canada, American Medical Association and Association of American Medical Colleges on a joint commitment to medical education and accreditation of Canadian medical schools. The agreement was signed in Washington, DC on Dec. 12, 2013.

62. CMA participated in the production of the first set of medical school accreditation standards which will be customized for the Canadian context, and currently has input to this process through its representation on the Committee on Accreditation of Canadian Medical Schools. Input was also provided by the Committee on Education and Professional Development.

63. CMA participated in the implementation and governance of the Future of Medical Education Postgraduate recommendations and contributed to eight of its 10 working groups; outcomes which will have significant impact on the practice of the current and next generations of physicians.

64. CMA continues to provide support to the Canadian Medical Forum, which met in November and June. The forum is currently working on a multi-year project that will outline a collective vision on the evolving role of physicians both at the clinical and health system levels.

65. The Specialist Forum met in February to discuss quality improvement and the development of a Quality Collaborative, alignment of advocacy strategies (Wait Time Alliance report card and seniors care as a federal election issue), scopes of practice (collaboration with pharmacists and other allied health professionals), drug shortages and physician supply issues. A joint meeting of the Specialist and General and Family Practice Issues fora featured an “unconference conference” format facilitated by Misha Glouberman. CMA has since developed a leadership structure, Charter and initial work plan for the Quality Collaborative.
66. Several Wait Time Alliance meetings were held jointly with provincial wait time staff to assist in the collection, reporting and adoption of wait time benchmarks to improve access for patients. This year’s Report Card on Wait Times was released in early June and focused on assessing access-related outcomes of the 2004 Health Accord.

67. In addition, the 2014 Taming of the Queue conference focused on how appropriateness in primary care can improve timely access to care across the patient’s journey.

68. CMA also hosted a CEO roundtable of national specialty societies in March to share information and strategies on administrative matters, namely around legal and human resources risk management.

69. Lastly, CMA continued outreach to affiliates and other national medical organizations to seek support and coordinate collaboration for health care transformation and related principles.

World Medical Association (WMA) – Leadership on international issues

70. The WMA General Assembly met in Fortaleza, Brazil in October 2013 and Tokyo, Japan in April 2014. Past CMA Board member Dr. Andre Bernard is CMA’s representative on the WMA Council. Dr. Bernard also chairs WMA’s working group on person-centered medicine and advocacy advisory committee.

71. CMA is extremely active in WMA advocacy, governance and strategic planning issues and continues to lead the WMA in its advocacy and communication efforts. The WMA is in the process of integrating the work of the advocacy advisory committee into its strategic plan and formalizing its role and mandate.

72. CMA also:
   • was instrumental in several recent WMA policy initiatives (in addition to those previously mentioned), including conflict of interest, medical professionalism, clinical and professional autonomy, self-regulation of the profession, task shifting, and the international Code of Medical Ethics

World Medical Association policies

- Declaration of Helsinki - Ethical Principles for Medical Research involving Human Subjects
- Statement on Forensic Investigations of the Missing
- Statement on Fungal Disease Diagnosis and Management
- Statement on Human Papillomavirus Vaccination
- Statement on Natural Variations of Human Sexuality
- Statement on the Right to Rehabilitation of Victims of Torture
- Statement on the United Nations Resolution for a Moratorium on the Use of the Death Penalty
- Resolution on Criminalisation of Medical Practice
- Resolution on the Healthcare Situation in Syria
- Resolution on the Prohibition of Chemical Weapons
- Resolution on Patient Safety and Standardisation in Medical Practice
- Resolution in Support of the Brazilian Medical Association
- Resolution on the Women’s Right to Health Care and How that Relates to the Prevention of Mother-to-Child HIV Infection
continues to provide a leadership role in the WMA Business Development Group and has been instrumental in assisting the organization in revamping its website

participates in a group of CEOs and senior staff from national medical organizations, whose efforts are focused on strengthening their organizations by exchanging information and experiences

participates actively in WMA issue-specific meetings when topics are relevant to the CMA membership (e.g., global health human resources, health and the environment, the use of placebos in medical research, health care in danger)

provided expert ethical consultation on the revision of the WMA’s Declaration of Helsinki, the pre-eminent international research ethics document

is providing expert consultation and assistance in planning a global meeting on social determinants of health

Physician health

73. The Canadian Physician Health Institute (CPHI), a national program promoting physician health and wellness, was created in 2012 in collaboration with PTMAs and the Canadian Medical Foundation. In 2013, the institute continued to implement its communication plan, including an official launch which was held in conjunction with the Newfoundland and Labrador Medical Association’s annual meeting. At this time, CPHI also released a powerful promotional video that underlines the need to do away with the stigma associated with asking for help. Watch the video and learn more about the CPHI.

74. The steering and advisory committees were engaged in developing a conflict of interest policy as part of their roles to evaluate and select special projects for funding. Two rounds of funding were completed; receiving a large diversity of projects and outcomes focused on primary prevention of mental health problems among physicians and/or their health. All projects addressed at least one of the four CPHI goals.

75. CPHI’s secretariat also provided support to the Forum of Canadian Physician Health Programs, which brings together provincial/territorial physician health programs, to provide an environment where mutual support, resource sharing and promotion of ideas and innovation on behalf of physician health and well-being can occur among providers. Key activities include:

CPHI Goals:

- Support increased equitability of access to resources for the emotional, psychosocial and mental well-being of physicians.
- Raise awareness and improve understanding of the importance of physicians’ emotional, psychosocial and mental well-being.
- Reduce the stigma associated with physician mental health issues.
- Develop and support primary prevention activities related to mental health for physicians.
• to develop and implement strategies for collection and
  compilation of data regarding services provided by
  provincial physician health programs
• to improve services to physicians by sharing ideas and
  experiences and learn from other physician health
  programs
• to collaborate with CPHI on health promotion and primary
  prevention with the goal of decreasing physician morbidity
  and improving physician health and wellness

76. The 2013 Canadian Conference on Physician Health, presented
    by CPHI and co-hosted by the Alberta Medical Association and
    its Physician and Family Support Program, was held in Calgary
    last November; 93% of evaluations from 224 participants
    reported that they would recommend this type of conference to
    a colleague. This event was also a major success in sponsorship
    with support from the Canadian Medical Foundation, the
    Canadian Medical Protective Association and fourteen other
    exhibitors/sponsors. A series of podcasts translating best
    practices and emerging knowledge in physician health will be
    released in 2014.

77. Planning is well underway for the joint 2014 Canadian,
    American and British medical associations’ International
    Conference on Physician Health, to be held Sept. 15-17, at
    BMA House in London, UK. The number of research abstracts
    received more than doubled from the last international
    conference held in Montreal in 2012. The conference theme is
    “Milestones and Transitions: Maintaining Balance” and the
    opening keynote speaker will be Dame Sally Davies, Chief
    Medical Officer for England and Chief Medical Advisor for the
    UK government.

Canadian Medical Foundation

78. The Canadian Medical Foundation, founded by CMA in 1987,
    is a national charitable organization focused solely on
    supporting Canada’s physicians and health care system.

79. In 2013 the foundation:
• raised more than 1.3 million dollars, thanks to the support
  of our generous donors, a year-over-year increase of
  $200K, or 15%
• invested more than $220K in physician health and will-
  being initiatives, such as the Canadian Physician Health
  Institute and ePhysicianHealth.com

2014 International Conference on Physician Health
Sept. 15-17, London

Canadian Medical Foundation priority areas:
• Funding physician health and well-being initiatives
• Funding bursaries for medical students
• Funding physicians’ philanthropic, research and
  medical outreach priorities
• provided more than $17K in the form of bursaries and scholarships to deserving university students who often come from challenging socio-economic backgrounds and are striving to further their medical education
• invested more than $73K in physicians’ medical outreach priorities including education, poverty alleviations and health care both in Canada and internationally

80. The foundation is also pleased to continue providing CPHI with funding to support Canadian physician health and well-being initiatives.

How CMA supports physicians in their personal, professional and practice life

What’s new in knowledge services

81. CMA continues its work in support of its knowledge-for-practice vision – “the CMA will be the first choice for members to access customized clinical, leadership and practice knowledge resources to support the provision of quality patient care.” The following outlines key initiatives undertaken in support of that vision this past year.

A new cma.ca

82. The new cma.ca will be launched mid-June and includes a new look but more importantly provides an enhanced online member experience based on new capabilities such as mobile accessibility, improved navigation, enhanced clinical searching, streamlined sign-on and social media connectivity. A major marketing strategy was developed to accompany the launch including online and print media and a microsite.

83. The new site was designed based on extensive consultation with members and other key stakeholders, as well as feedback from the Physician Advisory Group and CMA e-Panel.

Clinical products and services

84. Clinical products and services continue to be one of the most highly valued member offerings.

85. The point of care tool, BMJ Best Practice was discontinued last September due to a very significant increase in licensing fees. A
comprehensive communications strategy was put in place to ensure members were redirected to DynaMed so that their clinical information needs continue to be met.

86. MDConsult is scheduled to be discontinued at the end of 2014 and replaced by a new product called Clinical Key. MDConsult has been a staple in the clinical products offerings for over 10 years and is one of the most popular products with members. Negotiations are currently underway with Clinical Key publisher, Elsevier, to build a customized package of content to address the gap left by the loss of MDConsult. The Physician Advisory Group will work with staff to evaluate the content included in the offer.

87. A major marketing effort was undertaken over the course of the year to raise awareness of new and existing knowledge-for-practice clinical products and services. A number of highly successful campaigns resulted in a significant increase in product usage such as the record number of DynaMed app downloads (120% increase over 2012).

Physician leadership development

88. CMA’s first facilitated online leadership course “Leadership begins with self-awareness” was launched in early 2014. Intended primarily for medical students and residents, it is also available to practising physicians upon request. A second facilitated online course “Effective communication” is being developed for launch in early 2015.

89. Two 30-minute online modules, “Social Media Primer for Physicians” and “Advocacy Primer for Physicians,” are scheduled for launch in August. Two further modules will be developed for launch in Q4.

90. The Physician Management Institute (PMI) program had another successful year. Through open enrolment offerings, a total of 522 physicians were trained (42% first time attendees) over the course of 16 events. In-house, 1,213 health professionals (82% physicians) were trained over the course of 49 individual events in partnership with 26 health delivery organizations. Overall, PMI earned 96% participant satisfaction; 88% would recommend PMI to a colleague. For 2014, 18 open enrolment courses are planned and 33 in-house courses have been booked.

91. Through the CMA/PTMA leadership collaboration agreement, CMA has contributed more than $500,000 to support physician

Eight of the top 12 most accessed pages on cma.ca are clinical resources and include:

- POEMS
- MDConsult
- DynaMed
- Lexicomp
- CMA InfoBase of Clinical Practice Guidelines
- textbooks

Physician Management Institute – member feedback:

“A perfect start to my leadership training.” – Aly Abdulla

“It was an excellent program, fair and balanced views and solutions.” – Adam Vinet

“I think all physicians should participate in these courses and not wait until they are in specific leadership roles to learn from the courses.” – Nicole Johnson
leadership training locally, via PTMAs. Also in collaboration with PTMAs, CMA is pleased to launch ‘Integrative Thinking for Collaborative Decision-Making.’ This 5-day program, launched in June 2014, supported advanced leadership training for 40 physicians from across Canada. The program was delivered by the Rotman School of Management.

92. Fifteen new online clinical continuing medical education (CME) modules have been released, including “Heart failure,” “Social determinants of health” and “Canadian opioid guidelines for chronic non-cancer pain.” In 2013, 1,670 members enrolled in modules.

93. The “Actionable Nuggets” micro-credit program on treating patients with a spinal-cord injury has now come to an end on cma.ca. During the first nine months of the program, 221 unique participants had completed modules, leading to the automated transfer of 1,734 CME micro-credits to the College of Family Physicians of Canada.

94. The 5th Annual Canadian Conference on Physician Leadership, co-hosted by the Canadian Society of Physician Executives, was held April 9-12, 2014 in Toronto. Over 150 physicians participated in pre-conference PMIs; a total of 401 participants registered for the conference. Keynote addresses included Dr. Aidan Halligan (National Health Service, UK), Dr. James Merlino (Cleveland Clinic), Dr. Jay Kaplan (Studer Group) and Bonnie Blakely (Shared Services Saskatchewan). In 2015, the conference will take place in Vancouver on April 22-25.

Publications

95. CMA publications continue to be popular with members and efforts to provide these publications in electronic format remain a priority:

- *CMAJ* is now published in 5 formats – print, online at cmaj.ca, as an iOS app, as an Android app and in flipbook format
- two guidelines from the Canadian Taskforce on Preventative Health Care were published in 2014; also published were the Clinical Practice Guideline for Timing the Initiation of Chronic Dialysis and the Canadian Cardiovascular Harmonized Guideline Endeavour (C-CHANGE) update
- cmaj.ca launched a new home page design that includes listings for Most read and Editor’s picks, online polls, a daily news feature and links to CMAJ blogs

Journals and publications

- *CMAJ*
- *CMAJ Open*
- *Canadian Journal of Surgery*
- *Journal of Psychiatry and Neuroscience*
- *Canadian Journal of Rural Medicine*
- *CMA Driver’s Guide*
- *New in Practice Guide | Guide des residents*
- *Future Practice magazine*
- *CMA Bulletin*
- *Santé Inc.*
- *Sélection*
• *CMA* Open, CMA’s online-only open access journal launched in 2013, published 22 articles in 2013 and is on track to publish twice as many in 2014; articles are attracting media interest

• new revenue streams for journals include publication fees, colour fees and submission fees; these will help offset some of the declines in advertising revenue

• CMA’s digital publication for French members, titled “Sélection: une compilation d’articles pour nos membres francophones” includes CMA news and features, *CMA* practice articles, obituaries, and financial and practice management content from MD Financial Management

• *New in Practice* and *Guide des résidents* were redesigned and published in April; these guides, aimed at medical residents, cover subjects such as financial planning and insurance, how to evaluate practice opportunities, overhead costs, medical billing and remuneration and are very popular with our younger members entering practice

• *Future Practice* magazine, which informs physicians about the growing world of health information technology, is published quarterly and has received very positive reviews from the Knowledge for Practice Physician Advisory Group

• the *Canadian Journal of Surgery* launched a new website at canjsurg.ca; the journal is now sent in digital format to over 10,000 Royal College of Physicians and Surgeons of Canada members

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**MD Financial Management Inc. – working for you**

CMA is the only medical association in the world to offer comprehensive financial services to members through a wholly owned financial services subsidiary. The MD Group of Companies is governed by the CMAH Board, composed of physician and business directors and chaired by Dr. John Rapin. The Board meets quarterly to engage in oversight and strategic planning discussions, as well as partake in committees. The strong governance culture at MD is further strengthened by an executive leadership team that promotes the adoption of industry-leading business practices. See Appendix 3 for a complete report.
Governance

General Council ‘refresh’

96. Efforts have been made to modernize General Council to ensure relevance, impact and inclusivity to better serve the needs of delegates, members and the organization, including:
   - streamlining opening ceremonies and shortening presentation time to allow more time for debate
   - changing the layout of Chambers to allow better networking
   - increasing the use of multi-media to better engage delegates and inform members
   - moving toward a paperless meeting with all documents posted on cma.ca (delegate/observer webpages)
   - this report itself

97. Delegates will have an opportunity to provide feedback on the changes introduced this year and we appreciate delegates’ openness and acceptance to ‘go with the new flow’ in 2014. Further changes are expected in 2015.

What committees have been working on

Committee on Ethics

98. The committee, chaired by Dr. David Gass, is responsible for interpreting and recommending amendments to the CMA Code of Ethics, addressing problems related to ethics referred to the association, advising the association on matters pertaining to ethical issues that arise from scientific and technological progress in the health sciences, and ethical issues of interest or concern to the medical profession and those related to its core strategies and priorities.

99. Much of the focus of the work of the committee this past year was in the area of care at the end of life. Further details on this initiative can be found earlier in this report.

100. The committee otherwise focused its efforts on several priority projects:
   - revising CMA’s organ and tissue donation and transplantation policy (approved by the Board in May 2014, following extensive stakeholder consultations)

2014 Award recipients

F.N.G. Starr award – Dr. Anne Fanning

Medal of Service – Dr. David Butler Jones

Medal of Honour – Ms. Juliet Guichon

May Cohen Award for Women Mentors – Dr. Barbara Stubbs

Sir Charles Tupper Award for Political Action – Dr. Margaret MacDiarmid

Dr. William Marsden Award in Medical Ethics – Dr. Eric Wasylenko

Physician Misericordia Award – Dr. Ted Boadway

John McCrae Memorial Medal – Lieutenant Colonel Bethann Meunier

Young Leaders (student) – Mr. Peter Gill

Young Leaders (resident) – Dr. Farhan Asrar

Young Leaders (early career physician) – Dr. Samir Sinha

(Biographical information will be available on cma.ca in July)
• developing a white paper outlining the ethical and legal issues related to assisted reproductive technology in consultation with the Canadian Fertility and Andrology Society and Society of Obstetricians and Gynecologists of Canada – owing to the ramifications of the Supreme Court of Canada’s decisions on assisted reproductive technology in 2010; the latest draft was reviewed at the spring meeting
• revising CMA’s policy on complementary and alternative medicine, currently of interest and concern to many Canadian physicians, so as to embed ethical considerations based on previous General Council resolutions and other CMA statements; the latest draft was reviewed at the spring meeting
• working on developing a repository of ethical decision-making tools for use by practising physician, as directed by General Council in 2013; efforts to date were reviewed at the spring meeting

Committee on Education and Professional Development

101. The committee, chaired by Dr. Janice Willett, is responsible for issues pertaining to medical education at all phases of the medical career life cycle, as well as for professionalism, including inter-professional care and relationships with other providers.

102. The committee focused its efforts this past year on several priority projects:
• developing a policy statement on the management of physician fatigue (approved by the Board in May 2014)
• holding a joint session with the Committee on Health Policy and Economics to discuss physician human resource issues including revisions to the policy on physician resource planning
• conducting an environmental scan on remuneration models for clinical teachers
• providing feedback on revised Canadian standards for accrediting Canadian medical schools
• providing feedback on the Royal College’s project – CanMEDS 2015 Physician Competency Framework
• keeping apprised on the implementation and governance of the Association of Faculties of Medicine of Canada’s Future of Medical Education (postgraduate) project
• providing input on the physician unique value proposition
• providing feedback on CMA leadership and online CME offerings

New CMA policies

• Life-saving and -sustaining interventions (Update 2013)
• Physician compensation (Update 2013)
• Health and health care for an aging population
• Ensuring equitable access to health care: Strategies for governments, health system planners, and the medical profession
• Built environment and health
• Euthanasia and assisted suicide (Update 2014) – terminology section
• e-Cigarettes
• Management of physician fatigue
• Organ and tissue donation and transplantation
• providing feedback on the Federation of Medical Regulatory Authorities of Canada’s draft document entitled “Physician Performance Enhancement System”
• providing feedback on the Royal College and Mental Health Commission of Canada’s Mental Health Core Competencies for Physicians and recommending endorsement (May 2014)
• keeping apprised of the Choosing Wisely Canada initiative

Committee on Health Care and Promotion

103. This committee, chaired by Dr. Adam Steacie, is responsible for awareness raising, advocacy and promotion of best practices in matters pertaining to disease treatments and prevention, health protection and health promotion.

104. The committee focused on several important policy areas this past year, including:
• prescription drug abuse and misuse, including participating in meetings with Health Canada and other stakeholders to plan a symposium on prescription drug abuse
• electronic cigarettes (approved by the Board in February 2014)
• built environment and health (approved December 2013)
• equitable access to health care (approved December 2013)
• health and health care for an aging population (approved December 2013)
• physician activity and healthy weights
• use of antibiotics in agriculture
• sports concussions

105. The committee also
• reviewed a draft discussion paper on humanitarian medicine developed to explore professional and ethical issues of Canadian physicians who work or volunteer abroad
• initiated research and the development of discussion papers on population health and on the impact of processed foods on health
• reviewed nominations for the 2014 Award for Excellence in Health Promotion and submitted recommendations to the Committee on Archives and Awards

106. The committee will continue to monitor the following issues:
• health care transformation, including early childhood development and the seniors care strategy

Policies endorsed
• Principles on physician health human resources
• Emergency department overcrowding and access block
• Sport-related concussion prevention & management
• Healthy food policy
• Mental health core competencies for physicians
• pharmaceutical issues, including prescription drug shortages, drug abuse and misuse, drug safety legislation (Bill C-17 - Protecting Canadians from Unsafe Drugs Act), and the Controlled Drugs and Substances Act
• proposed reforms to Health Canada’s medical marijuana access program
• tobacco, particularly e-cigarettes
• nutrition and lifestyle related issues, such as salt content of processed foods, obesity, physical activity, etc.

Committee on Health Policy and Economics

107. The committee, chaired by Dr. Carolyn Lane, is responsible for assessing and formulating policy options relating to the economics, organization and management of the health care delivery system, including health human resources.

108. The committee focused its efforts on several priority projects:
• developing a 10-point action plan on physician human resources to address the growing issue of physician under-employment and unemployment, in collaboration with members of the Committee on Education and Professional Development and CMA’s Canadian Collaborative Centre for Physician Resources
• revising CMA’s policy statement on physician resource planning
• revising CMA’s policy statement on physician compensation (approved by the Board in December 2013)
• developing a new policy statement on improving efficiency in the Canadian health care system (currently out for consultation)
• recommending endorsement of a Canadian Association of Emergency Physicians’ position statement on emergency department overcrowding and access block (December 2013)
• recommending endorsement of the Canadian Association of Internes and Residents’ principles on physician health human resources (December 2013)
• providing oversight to CMA’s strategy on reducing the administrative burden of third-party forms and clarifying the physician’s role in return-to-work requests
• providing input into CMA’s annual National Health Policy and Negotiations Conference

CMA 10-point action plan on Physician Human Resources

1. Identify what career counseling should include
2. Advocate for a career development and mentorship program
3. Update the cost of training physicians
4. Conduct specialty profiles and disseminate to all relevant stakeholders
5. Produce a list of cross-Canada job
6. Explore the feasibility of a survey on untapped health infrastructure resources
7. Highlight how infrastructure shortages affect access and physician
8. Advocate for wider integration of physician assistants and hospitalists into the health care system
9. Assess impact of other professionals on workload of specified specialties
10. Revise CMA’s policy on Physician Resource Planning and develop a policy statement on the impact of emerging technologies and models of care on health human resource planning
The committee, chaired by Dr. Barry Turchen, provides intelligence to the Board on the political environment, leads the ambassador function for the MD-MP Contact Program, and provides advice and direction to staff on advocacy training.

The committee focused its efforts on several priority projects:

- guiding and supporting the implementation of advocacy strategies to educate, engage and advocate with policymakers in support of CMA’s Health Care Transformation initiative focusing on maintaining and increasing awareness among members, the public, politicians, decision-makers and others
- overseeing the revitalization of the MD-MP contact program – CMA’s grassroots advocacy initiative – to make it easy for members to be politically active in their ridings as the 2015 federal election approaches
- providing oversight and strategic direction on CMA’s advocacy training program, including expanding program delivery to provide advocacy training workshops to MD-MP contact program members and affiliates, and developing and implementing online workshops

The Governance Committee, chaired by Dr. Shelley Ross, advises and makes recommendations to the Board and General Council with respect to all aspects of CMA’s governance (excluding nominations and appointments).

The committee focused its efforts in several areas:

- reviewing the merits of lay representation on the Board
- reviewing regional alignments to ensure that committees are well represented
- reviewing proposed changes to the bylaws and operating rules and procedures (see Governance [Bylaws] section)
- reviewing the Board’s continuous governance improvement framework
- reviewing proposals for a new structure to house CMA’s revenue-generating activities

Note that in accordance with the association’s bylaws, proposals for bylaw amendments may be submitted by one or more members. These proposals must be received by the CEO and the chair of the Governance Committee 90 days before the date of the annual meeting for consideration by the Board and
the Governance Committee. Changes put forward this year are mainly housekeeping in nature.

114. In addition, the Board is also responsible for the Operating Rules and Procedures. The Board approved amendments in May stemming from the 2013 governance review and to remove details about committees which are already found in their terms of reference to avoid duplication or confusion.

Appointments and Review Committee

115. The committee, chaired by Dr. Nasir Jetha, supported several initiatives this past year to foster good governance practices. They included:
   - developing a work plan to enhance communications with and increase engagement of core committees and fora
   - reviewing candidates for positions on the CMAH Board
   - considering a variety of mid-year appointments
   - conducting an annual review of all CMA committees, task forces and representatives to outside bodies, including terms of reference and appointments

Committee on Archives and Awards

116. The committee, chaired by Dr. Ruth Collins-Nakai, met in January to:
   - review nominations for CMA awards and honorary memberships
   - consider preparations for celebrating CMA’s 150th anniversary in 2017

117. The committee notes with regret the deaths of CMA members since the 146th annual meeting (see Deceased Members section). General Council delegates will be asked to observe a minute of silence in their memory.

118. The CMA continues to work with the Canadian Medical Hall of Fame under a collaborative agreement that provides financial and in-kind support, such as translation services, support for the Canadian Medical Hall of Fame’s Discovery Days in Health Sciences for students, promotion of the induction ceremony within CMAJ and recruitment of keynote speakers.

Honorary members

Ontario
Dr. David Bach
Dr. Donald Harterre
Dr. Lawrence Patrick
Dr. Gerald Rowland
Dr. David Swales

Québec
Dr. Michel Baron
Dr. Anne-Claude Bernard-Bonnin
Dr. Vania Jimenez
Dr. Roger Laberge
Dr. Michael Malus
Dr. Marek Rola-Pleszcynski

Nova Scotia
Dr. James Fitzgerald

New Brunswick
Dr. Robert Bartlett
Dr. John Carson
Dr. David Marr

Prince Edward Island
Dr. Dagny Dryer

Newfoundland & Labrador
Dr. John Beverly-Sutherland
Dr. George Seviour

(Biographical information will be available on cma.ca in July)
Committee on Finance

119. The Committee on Finance, through the Honorary Treasurer Dr. Jane Brooks, provides the Board with regular updates on CMA’s financial operations, including policies and principles, to ensure a sustainable base for the future. The committee reviews current investment policy to ensure alignment to CMA’s investment goals, manage risk and ensure clear responsibilities for monitoring and reporting. The committee’s report is found under the Finance section.

Audit Committee

120. The Audit Committee, chaired by Dr. Robert Broad, is responsible for overseeing the integrity and credibility of the association’s audited financial statements, the external audit and communication with the external auditor, and reporting the audited financial results to General Council.

121. The committee’s report, including CMA financial statements and CMA Holdings (2009) Inc. consolidated financial statements as at Dec. 31, 2013, is found under separate cover in the 2014 Audit Committee’s Report to General Council.

People and Culture

122. Over the course of this past year, CMA and its staff have certainly experienced change. We have communicated to staff the imperative of being relevant and truly understanding and addressing the unique needs of our membership.

123. We have undertaken numerous activities to support this critical message and to equip staff for success. One such activity was the creation of a speakers’ series that saw us bring in association and membership subject matter experts Sarah Sladek and Andy Steggles. Staff experienced inspiring presentations and conversations with CMA’s president and the CEOs of CMA and MD.

124. We strengthened our leadership team by bringing together the senior management team and directors to strategize and develop action plans that address member needs. We put our focus on “outcomes” rather than “activities.” We are excited about growing and strengthening our partnerships with PTMAs. We are looking in the mirror to see how we can best manage ourselves by asking many questions such as “why are

“CMA named a 2014 top employer in the National Capital Region”
we doing this? Does this add value to our membership? Is this best practice?"

125. It has never been a better time to be a CMA employee – staff are engaged, they are excited and they are focused. CMA has been named a top employer in the National Capital Region.

126. We will continue to create opportunities to develop and grow our CMA talent with the goal of meeting member needs and CMA’s strategic objectives

Summary

127. During General Council, the Board chair and CEO will provide brief verbal reports on developments since this report was written and about plans for the coming year. The format for reporting this year will change to allow more time for questions and will include a brief update by the honorary treasurer as well as proposed bylaw changes.
Board Business

Membership fees

**MOTION BD 1–1**

The Canadian Medical Association full membership fee for the year 2015 will be maintained at $495.

128. The Board’s recommendation was circulated to PTMAs 60 days before the annual meeting in compliance with CMA Bylaws. Please refer to the Committee on Finance’s report for further details (Finance section).

Considerations

129. The Board approved a recommendation to General Council to maintain the full membership fee at $495 in 2015. The Committee on Finance considered a number of factors, including the following, when recommending the 2015 membership fee to the Board:

- the circumstances surrounding last year’s membership fee proposal to General Council
- the scheduled review of CMA programs and activities later this year
- the potential financial benefits associated with the implementation of a new subsidiary structure.
Proposed bylaw changes/revisions

130. The Governance Committee, chaired by Dr. Shelley Ross, met by teleconference May 5, 2014 to review proposed amendments to the bylaws. The amendments proposed are mainly housekeeping in nature.

131. Each amendment is submitted as a motion reading “the bylaws are amended as proposed.” The proposed amendments become effective when adopted by a two-thirds majority vote of delegates to General Council present and voting, and by a majority vote of the business session at the annual meeting.

132. Minor changes were made to the Operating Rules and Procedures to reflect the governance review recommendations adopted by General Council in August 2013 and by the Board in May 2014. The current version, adopted by the Board of Directors in May 2014, is available [here].

<table>
<thead>
<tr>
<th>Proposed changes</th>
<th>Reason for change/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY 02-01– Bylaws are amended as proposed</strong></td>
<td>To reflect a change proposed in the August 2013 Governance Review Report.</td>
</tr>
<tr>
<td>11.1.1 The Board of Directors shall have the executive authority of the Association and shall be responsible for the management of the affairs of the Association, including risk management, in accordance with the policies established by General Council. …</td>
<td></td>
</tr>
<tr>
<td><strong>BY 02-02– Bylaws are amended as proposed</strong></td>
<td>To reflect the new name of the Royal Canadian Medical Service</td>
</tr>
<tr>
<td>10.2.1 Delegates to General Council shall be as follows:</td>
<td>Housekeeping: to reflect the 2008 governance review recommendation regarding past officers.</td>
</tr>
<tr>
<td>(a) Ex-officio delegates … … …</td>
<td></td>
</tr>
<tr>
<td>(v) a delegate from the Canadian Forces Medical Services Royal Canadian Medical Service, at the direction of the Surgeon General; and</td>
<td></td>
</tr>
<tr>
<td>(vi) the past Presidents, the past Speakers, past Chairs of the Board of Directors and the past Secretaries General whose terms of office expired at or before the meeting of General Council in</td>
<td></td>
</tr>
</tbody>
</table>
Proposed changes

2008 are eligible to be ex-officio voting delegates at meetings of General Council in 2009 through 2013; and

(vii)(vi) the past Presidents, the past Speakers, past Chairs of the Board of Directors, and the past Secretaries General and past Chief Executive Officers whose terms of office expired after the meeting of General Council in 2008 are entitled to be ex-officio voting delegates at meetings of General Council for 5 years following completion of their term of office.

BY 02-03– Bylaws are amended as proposed

11.9.1 The Board shall annually appoint a Staffing Committee, comprised as and having the powers and duties provided in the Operating Rules and Procedures of the Association as determined by the Board of Directors.

15.1 The Board of Directors will annually appoint the committees referred to below. Each committee shall determine its own procedure including quorum, unless otherwise provided in the Operating Rules and Procedures of the Association determined by the Board of Directors. Committee members shall be subject to removal by the Board of Directors. The committees shall have the duties referred to below and as provided by the Operating Rules and Procedures of the Association determined by the Board of Directors.

15.2 Subject to 12.4.2 and 15.2.1(d), General Council will elect annually the committees referred to below in accordance with the report of the Committee on Nominations. If there is more than 1 nomination for any position, a ballot shall then be taken for that position in accordance with the Operating Rules and Procedures. Each committee shall determine its own procedure including quorum, unless otherwise determined by the Board of Directors. The committees shall have the duties referred to below and as provided by the Operating Rules and Procedures of the Association determined by the Board of Directors.

Reason for change/notes

Terms of Reference for CMA committees are approved by the Board of Directors on the recommendation of the Appointments and Review Committee.

Removing the Terms of Reference from the Operating Rules and Procedures avoids confusion arising from keeping duplicate sets of Terms of Reference.
<table>
<thead>
<tr>
<th>Proposed changes</th>
<th>Reason for change/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY 02-04</strong>— Bylaws are amended as proposed</td>
<td></td>
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<tr>
<td>Replace “Secretary General” with “Chief Executive Officer” throughout the document, with the exception of 10.2.1(vi) which refers to past Secretaries General.</td>
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<tr>
<td>To reflect change in title from Secretary General to Chief Executive Officer.</td>
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<tr>
<td><strong>BY 02-05</strong> The numbering in the bylaws will be amended and relevant editorial changes will be made as required to facilitate the preceding resolutions.</td>
<td></td>
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</tbody>
</table>
The Committee on Finance reports to the Board of Directors and is responsible for presenting the Board with budget recommendations and investment and other policies to meet the association’s financial needs. The committee exercises this responsibility by:

- studying the immediate and long-term financial needs of the association, including the establishment and use of reserve funds
- presenting appropriate fiscal policies to meet financial needs
- recommending an investment policy for the investment of association funds
- assessing the financial implications of significant programs and projects
- preparing an annual operating budget
- recommending an annual membership fee

The Committee on Finance, through the Honorary Treasurer, provides the Board of Directors with regular quarterly updates on the association’s financial operations.

Financial Operations Overview: 2013

The 2013 audited financial statements (CMA and CMA Holdings [2009] Inc.) are included as Schedules A (page 5) and B (page 19) to the 2014 Audit Committee Report to General Council. In addition to the audited financial statements, a CMA Variance Report for 2013 is included in this report (page 49).

The Board of Directors accepted the audit report and approved the audited financial statements at its meeting in May.

As a result of changes to the Canadian accounting standards for not-for-profit organizations (NPO) and CMA’s subsidiaries adopting International Financial Reporting Standards (IFRS), the CMA Board decided to adopt a new accounting framework for the association beginning in 2011. The CMA adopted Canadian NPO Generally Accepted Accounting Principles (GAAP) except for presenting the investment in subsidiaries on a cost basis.

This option is considered a “special purpose accounting framework” and provides the most useable and understandable financial reporting to the association’s governors. The most significant difference in the financial statement presentation is the change in the reporting of CMA’s investment in its subsidiaries, from an equity basis to a cost basis. This change was necessitated because the association’s subsidiaries are reporting based on IFRS standards which differ from the Canadian NPO standards used by CMA. As a result CMA can no longer take information from the subsidiaries financial statements and use that information in its own financial statements.

Our auditors, PriceWaterhouseCoopers require that the distribution of the “auditors report” appended to these financial statements be more strictly controlled, and as such they recommended the following limitations:
• distribution of the audit report and financial statements to General Council be a report or package separate and distinct from the General Council information report
• the audit report and financial statements not be filed with National Archives of Canada, as is done with the full Reports to General Council
• the audit report should not be posted on the CMA website, but could be made available upon request

140. The most significant impacts on the audited financial statements of this transition to the special accounting framework include:
• accounting for the investment in CMA Holdings (2009) Inc. at cost reduces CMA’s net assets
• accounting for the CMA pension plan as a multi-employer pension plan eliminates the CMA pension asset / liability and moving forward will require the expensing of employer contributions as incurred
• accounting for post-retirement health benefits and the supplementary executive benefit plan using the immediate recognition approach will result in accounting for actuarial gains and losses as they arise
• simpler note disclosure

Statement of operations

141. The 2013 non-consolidated statements of operations (page 9 of Schedule A – 2014 Audit Committee Report to General Council) show an annual deficit of $50,544 compared with the budgeted deficit of $3,008,938. The lower deficit is a combination of higher revenues ($1.35M) and lower expenses ($1.61M). The most significant positive revenue variances occurred in the membership revenues and investments revenues, while the most significant under expenditure occurred because of the deferral of the cma.ca rebuild initiative to 2014. A summary of variances has been prepared and is included in this report (pages 49-52).

Capital expenditures

142. In addition to CMA’s operating expenditures, the association spent $493K on capital items during 2013.

<table>
<thead>
<tr>
<th>Capital expenditures (in 000’s)</th>
<th>2013</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>$54</td>
<td>0</td>
</tr>
<tr>
<td>Furniture equipment</td>
<td>60</td>
<td>26</td>
</tr>
<tr>
<td>Computer equipment</td>
<td>379</td>
<td>419</td>
</tr>
<tr>
<td>Total</td>
<td>$493</td>
<td>$445</td>
</tr>
</tbody>
</table>

Financial position

143. The non-consolidated statements of financial position (page 8 of Schedule A – 2014 Audit Committee Report to General Council) presents the association’s net assets at Dec. 31, 2013. The CMA’s financial position remained virtually unchanged year over the year, as indicated by the total net assets.
The CMA’s net assets are comprised of the following:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted</td>
<td>$21,981,023</td>
<td>$21,420,399</td>
</tr>
<tr>
<td>Capital Assets</td>
<td>21,648,136</td>
<td>22,259,304</td>
</tr>
<tr>
<td>Investment in Subsidiaries- at cost</td>
<td>6,000,070</td>
<td>6,000,070</td>
</tr>
<tr>
<td>Total</td>
<td>$49,629,229</td>
<td>$49,679,773</td>
</tr>
</tbody>
</table>

Reserves

Unrestricted net assets (Reserves)

The unrestricted net assets of $22 million serve as CMA’s reserves. These reserves provide the CMA with financial stability to weather unforeseen financial difficulties and to provide flexibility to invest in new member product and service initiatives. The Committee on Finance reviews the association’s reserves annually.

CMA uses a tiered approach to establish its annual reserve target ($32M for 2013):

i) Minimum threshold reserve — is a long-term financial buffer that provides members, employees and other stakeholders with confidence in the financial stability of the association. The CMA determines this amount in two ways. The first calculation is 50% of the association’s annual operating expenses (net of expenses funded from reserves); this would establish a target of $22.5 million. Alternatively, this minimum threshold reserve could be calculated as one year’s membership revenue; this would establish a target of $22 million.

ii) Contingency reserve — to provide some flexibility to the annual operating budget and to address unanticipated issues that require immediate response from the association. This amount is established at 10% of the association’s annual operating expenses. The target is $4.8 million.

iii) Strategic initiatives reserve — to build a reserve for future strategic initiatives and to provide a base from which the association may consider undertaking future decisions or activities of strategic importance. The target is $5 million.

The reserves can only be used with Board approval.

Net assets invested in capital

The net capital assets ($21.6 M) represent the cost of the association’s fixed assets less their accumulated depreciation. The fixed assets are depreciated over their estimated useful life. The details of the capital assets are provided in the audited financial statements (Note 4 – page 14 of Schedule A – 2014 Audit Committee Report to General Council).
Investment in Subsidiaries (at Cost)

148. The Investment in Subsidiaries ($6M) represents the book value of CMA’s investment in CMAH (2009) on an historical cost basis.

149. The subsidiaries are subject to regulations of securities commissions and are required to maintain specified minimum financial conditions and reserves. Because of these regulatory restrictions and the need for the subsidiaries to respond to the members’ needs for financial services and products, the investment in subsidiaries does not represent financial resources readily available for the general purposes of the association.
2013 Variance Report

<table>
<thead>
<tr>
<th></th>
<th>Budget 2013</th>
<th>Actual 2013</th>
<th>Variance Favourable (Unfavourable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Membership fees</td>
<td>$22,010,000</td>
<td>$23,065,056</td>
<td>$1,055,056</td>
</tr>
<tr>
<td>2. Interest income</td>
<td>1,200,000</td>
<td>1,736,565</td>
<td>536,565</td>
</tr>
<tr>
<td>3. Dividend from subsidiaries</td>
<td>5,889,000</td>
<td>6,514,000</td>
<td>625,000</td>
</tr>
<tr>
<td><strong>Departments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Strategy and Org. Effectiveness</td>
<td>5,742,035</td>
<td>5,046,275</td>
<td>(695,760)</td>
</tr>
<tr>
<td>5. Professional Services and Leadership</td>
<td>8,273,345</td>
<td>7,310,916</td>
<td>(962,429)</td>
</tr>
<tr>
<td>6. Community Building</td>
<td>1,723,651</td>
<td>1,757,461</td>
<td>33,810</td>
</tr>
<tr>
<td>7. Health Policy and Research</td>
<td>125,950</td>
<td>181,098</td>
<td>55,148</td>
</tr>
<tr>
<td>8. Advocacy and Public Affairs</td>
<td>0</td>
<td>129,033</td>
<td>129,033</td>
</tr>
<tr>
<td>9. Miscellaneous/Gain on Sale Trademark</td>
<td>20,000</td>
<td>592,293</td>
<td>572,293</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>$44,983,981</td>
<td>$46,332,697</td>
<td>$1,348,716</td>
</tr>
</tbody>
</table>

|                      |             |             |                                   |
| **Expenses**         |             |             |                                   |
| 1. Committees        | $3,702,000  | $3,742,393  | (40,393)                          |
|                      |             |             |                                   |
| 2. Executive Office  | 1,333,148   | 3,247,670   | (1,914,522)                       |
| 3. Professional Services and Leadership | 13,710,735 | 12,385,889 | 1,324,846                        |
| 4. Community Building | 5,155,229 | 5,135,785 | 19,444                            |
| 5. Health Policy and Research | 4,473,103 | 4,045,200 | 427,903                           |
| 6. Advocacy and Public Affairs | 5,656,700 | 5,629,788 | 26,912                            |
| 8. Amortization/Depreciation | 300,000 | 315,000 | (15,000)                          |
| 9. Knowledge for Practice-cma.ca rebuild | 3,200,000 | 1,593,955 | 1,606,045                        |
| **Total expenses**   | $47,992,919 | $46,383,239 | $1,609,680                        |
| **Operating Deficit – Total Variance** | $(3,008,938) | $(50,542) | $2,958,396                        |
2013 Variance Report

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Annual Budget/13</th>
<th>Actual Dec 31/13</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Membership fees</td>
<td>22,010,000</td>
<td>23,065,056</td>
<td>1,055,056</td>
</tr>
<tr>
<td>Revenue was higher because CMA membership was higher than budgeted. The active membership at Dec. 31, 2013 was 80,630 (2012 – 78,380); the paid membership was 80,433 (2012 – 77,667). This was 4,433 members more than the 76,000 budgeted for 2013. The CMA has discounted fees for some membership categories, its full-pay equivalent membership is approximately 65%.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Investment revenue</td>
<td>1,200,000</td>
<td>1,736,565</td>
<td>536,565</td>
</tr>
<tr>
<td>The investment revenue was higher because CMA investments earned a return of approximately 5.6 % compared to the 4% budgeted return on an average balance of $32M invested during the year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Dividend from CMAH</td>
<td>5,889,000</td>
<td>6,514,000</td>
<td>625,000</td>
</tr>
<tr>
<td>The dividend was higher than budget because an additional special dividend was paid during the year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Department Revenues

<table>
<thead>
<tr>
<th>Department</th>
<th>Annual Budget/13</th>
<th>Actual Dec 31/13</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Strategy and Org. Effectiveness</td>
<td>5,742,035</td>
<td>5,046,275</td>
<td>(695,760)</td>
</tr>
<tr>
<td>The revenue in this department is generated primarily from the building lease revenue; however, it also includes service revenues generated from human resources, meeting planning, annual meeting and the cafeteria. The building revenues were below budget because the building was vacant during the year as a result of a fire.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Professional Services and Leadership</td>
<td>8,273,345</td>
<td>7,310,916</td>
<td>(962,429)</td>
</tr>
<tr>
<td>The revenue activities in this directorate include CMA Publications, Leadership Conference and PMI. The revenues were under budget primarily because of lower than expected CMAJ advertising revenues.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Community Building</td>
<td>1,723,651</td>
<td>1,757,461</td>
<td>33,810</td>
</tr>
<tr>
<td>The revenue is primarily from providing conjoint accreditation services to allied health professions, with other revenues generated from the Physician Health conference.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Health Policy and Research</td>
<td>125,950</td>
<td>181,098</td>
<td>55,148</td>
</tr>
<tr>
<td>The revenue is primarily from the annual Taming of the Queue conference.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Advocacy and Public Affairs</td>
<td>0</td>
<td>129,033</td>
<td>129,033</td>
</tr>
<tr>
<td>The revenue is primarily from the annual CMA Media Awards event.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Miscellaneous/Gain on Sale Trademark</td>
<td>20,000</td>
<td>592,293</td>
<td>572,293</td>
</tr>
<tr>
<td>This revenue was budgeted to cover refunds and rebates related to sales taxes and insurance premiums. However, the revenue in 2013 resulted from the sale of a trademark related to the electronic medical records sale.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Total Revenues  
44,983,981  46,332,697  1,348,716
## 2013 Variance Report

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Annual Budget/13</th>
<th>Actual Dec 31/13</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Committees</td>
<td>3,702,000</td>
<td>3,742,393</td>
<td>(40,393)</td>
</tr>
<tr>
<td>The expenditure is primarily due</td>
<td>to the Board,</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Executive and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Executive Office</td>
<td>1,333,148</td>
<td>3,247,670</td>
<td>(1,914,522)</td>
</tr>
<tr>
<td>Expenses were over budget</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>because of changes resulting</td>
<td></td>
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<tr>
<td>from the reorganization of the</td>
<td></td>
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<tr>
<td>department.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Professional Services and</td>
<td>13,710,735</td>
<td>12,385,889</td>
<td>1,324,846</td>
</tr>
<tr>
<td>Leadership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses were lower than</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>budget in the areas of Knowledge</td>
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</tr>
<tr>
<td>for Practice, Leadership and PMI</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>program, Clinical Products and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services and CMAJ.</td>
<td></td>
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<tr>
<td>4. Community Building</td>
<td>5,155,229</td>
<td>5,135,785</td>
<td>19,444</td>
</tr>
<tr>
<td>Expenses were on budget. An over</td>
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<tr>
<td>expenditure in the Members and</td>
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<tr>
<td>PTMA area was offset by savings</td>
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<tr>
<td>in Professional Affairs (</td>
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<tr>
<td>Accreditation, Physician Health</td>
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<tr>
<td>and activities relating to</td>
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<tr>
<td>practice and training issues and</td>
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<td>relationships with national</td>
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<tr>
<td>medical stakeholders).</td>
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</tr>
<tr>
<td>5. Health Policy and Research</td>
<td>4,473,103</td>
<td>4,045,200</td>
<td>427,903</td>
</tr>
<tr>
<td>Expenses were lower than</td>
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<td>budget because of savings in</td>
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<tr>
<td>Research, Ethics and Public</td>
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<td></td>
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</tr>
<tr>
<td>Health policy areas.</td>
<td></td>
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</tr>
<tr>
<td>6. Advocacy and Public Affairs</td>
<td>5,656,700</td>
<td>5,629,788</td>
<td>26,912</td>
</tr>
<tr>
<td>Expenses were on budget.</td>
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<tr>
<td>The department includes the</td>
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<td>following administrative and</td>
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<td>operational areas (Legal,</td>
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<td>Governance, Human Resources,</td>
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<tr>
<td>Finance, Meetings and Travel,</td>
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<tr>
<td>General Council, Annual Meeting,</td>
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<tr>
<td>Buildings, Print Shop, Cafeteria)</td>
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<tr>
<td>The over expenditure were</td>
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<tr>
<td>primarily in the areas of Strategy</td>
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<tr>
<td>and Legal.</td>
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</tr>
<tr>
<td>8. Amortization/Depreciation</td>
<td>300,000</td>
<td>315,000</td>
<td>(15,000)</td>
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<tr>
<td>The expense for depreciation was</td>
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<tr>
<td>on budget. The depreciable assets</td>
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<tr>
<td>include furniture, fixtures and</td>
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<tr>
<td>computer equipment. The</td>
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<tr>
<td>depreciation expense for the</td>
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<tr>
<td>buildings is included in</td>
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<tr>
<td>Strategy and Organizational</td>
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<tr>
<td>Effectiveness department (</td>
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<td></td>
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<tr>
<td>building expenses).</td>
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<td>2014</td>
<td>2013</td>
<td>2012</td>
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<td>----------------</td>
<td>---------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Knowledge for Practice-cma.ca rebuild</td>
<td>3,200,000</td>
<td>1,593,955</td>
<td>1,606,045</td>
</tr>
</tbody>
</table>

The under expenditure is a result of the decision to defer the completion of the project to 2014. The investment in the Knowledge for Practice – cma.ca rebuild initiative was undertaken in 2012 in response to members’ needs and requests for easier access and use of the clinical practice products and services.

<table>
<thead>
<tr>
<th>Total expenses</th>
<th>47,992,919</th>
<th>46,383,239</th>
<th>1,609,680</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Deficit – Total Variance</td>
<td>(3,008,938)</td>
<td>(50,542)</td>
<td>2,958,396</td>
</tr>
</tbody>
</table>
150. The Board of Directors approved a balanced budget for CMA’s 2014 financial operations.

151. The executive summary of the CMA’s 2014 operating budget is provided for your information.

### 2014 Operating Budget

<table>
<thead>
<tr>
<th>Revenues</th>
<th>Budget 2013</th>
<th>Actual 2013</th>
<th>Budget 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Membership fees</td>
<td>$22,010,000</td>
<td>23,065,056</td>
<td>25,500,000</td>
</tr>
<tr>
<td>2. Interest income</td>
<td>1,200,000</td>
<td>1,736,565</td>
<td>1,200,000</td>
</tr>
<tr>
<td>3. Dividend from subsidiaries</td>
<td>5,889,000</td>
<td>6,514,000</td>
<td>7,742,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Departments</th>
<th>Budget 2013</th>
<th>Actual 2013</th>
<th>Budget 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Professional Services and Leadership</td>
<td>8,273,345</td>
<td>7,310,916</td>
<td>8,226,248</td>
</tr>
<tr>
<td>6. Community Building</td>
<td>1,723,651</td>
<td>1,757,461</td>
<td>1,656,763</td>
</tr>
<tr>
<td>7. Health Policy and Research</td>
<td>125,950</td>
<td>181,098</td>
<td>5,000</td>
</tr>
<tr>
<td>8. Advocacy and Public Affairs</td>
<td>0</td>
<td>129,033</td>
<td>0</td>
</tr>
<tr>
<td>9. Miscellaneous</td>
<td>20,000</td>
<td>592,293</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total Revenues** | **$44,983,981** | **46,332,697** | **49,863,673** |

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Budget 2013</th>
<th>Actual 2013</th>
<th>Budget 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Committees</td>
<td>$3,702,000</td>
<td>3,742,393</td>
<td>3,957,934</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Departments</th>
<th>Budget 2013</th>
<th>Actual 2013</th>
<th>Budget 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Executive Office</td>
<td>1,333,148</td>
<td>3,247,670</td>
<td>1,233,203</td>
</tr>
<tr>
<td>3. Professional Services and Leadership</td>
<td>13,710,735</td>
<td>12,385,889</td>
<td>15,686,816</td>
</tr>
<tr>
<td>4. Community Building</td>
<td>5,155,229</td>
<td>5,135,785</td>
<td>5,792,306</td>
</tr>
<tr>
<td>5. Health Policy and Research</td>
<td>4,473,103</td>
<td>4,045,200</td>
<td>4,060,929</td>
</tr>
<tr>
<td>6. Advocacy and Public Affairs</td>
<td>5,656,700</td>
<td>5,629,788</td>
<td>6,167,639</td>
</tr>
<tr>
<td>7. Strategy and Org. Effectiveness</td>
<td>10,462,004</td>
<td>10,287,559</td>
<td>11,399,551</td>
</tr>
<tr>
<td>8. Amortization/Depreciation</td>
<td>300,000</td>
<td>315,000</td>
<td>300,000</td>
</tr>
<tr>
<td>9. Knowledge for Practice-cma.ca rebuild</td>
<td>3,200,000</td>
<td>1,593,955</td>
<td>1,100,000</td>
</tr>
</tbody>
</table>

**Total expenses** | **$47,992,919** | **$46,383,239** | **$49,698,378** |

**Operating (Deficit) / Surplus** | **$-(3,008,938)** | **$-(50,542)** | **$165,295**
## 2014 Operating Budget

### Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget/13</th>
<th>Actual Dec 31/13</th>
<th>Annual Budget/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Membership fees</td>
<td>22,010,000</td>
<td>23,065,056</td>
<td>25,500,000</td>
</tr>
<tr>
<td>The budget is based on 81,000 members, a full membership fee of $495 and a full-pay equivalent of 65% due to discounted fees for some membership categories.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Investment revenue</td>
<td>1,200,000</td>
<td>1,736,565</td>
<td>1,200,000</td>
</tr>
<tr>
<td>The investment revenue is based on investments of $32M with a return of 4.0% during the year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Dividend from CMAH</td>
<td>5,889,000</td>
<td>6,514,000</td>
<td>7,742,000</td>
</tr>
<tr>
<td>The budget includes the dividend from CMAH, increased by 5% per year in accordance with the dividend policy and adjusted for member activities (CMA Media, Practice Curriculum, Clinical Product licenses) transferred by MD to CMA.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Department Revenues

4. **Strategy and Org. Effectiveness** 5,742,035 5,046,275 5,533,662

The revenues are generated primarily from the lease of the building but they also include a variety of other areas such as human resources services, meetings and travel services, annual meeting revenues, legal services and cafeteria services.

5. **Professional Services and Leadership** 8,273,345 7,310,916 8,226,248

The Professional Services and Leadership department provides for the professional development needs of physicians throughout their careers. The departmental services include publications (*CMAJ*, *CJS*, *JPN* and a number of client journals) and physician education activities (PMI, Leaders’ Conference, CMA Infobase: Clinical Practice Guidelines).

6. **Community Building** 1,723,651 1,757,461 1,656,763

The departmental revenues are primarily from Accreditation activities, but some revenues are generated from the Physician Health conference.

7. **Health Policy and Research** 125,950 181,098 5,000

The 2013 revenue is for the Taming of the Queue Conference; for 2014, revenues have been netted against expenses to simplify budgeting.

8. **Advocacy and Public Affairs** 0 129,033 0

The 2013 revenue is for the CMA Media awards event; for 2014, revenues have been netted against the expenses to simplify budgeting.

9. **Miscellaneous** 20,000 592,293 0

The 2013 revenue was the result of the sale of a trademark associated with the electronic medical records business. There are no plans for a similar transaction in 2014.

**Total Revenues** 44,983,981 46,332,697 49,863,673
## 2014 Operating Budget

### Expenses

<table>
<thead>
<tr>
<th>Department</th>
<th>Annual Budget/13</th>
<th>Actual Dec 31/13</th>
<th>Annual Budget/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committees</td>
<td>3,702,000</td>
<td>3,742,393</td>
<td>3,957,934</td>
</tr>
</tbody>
</table>

These expenses are the direct costs of members governing, advising and representing the association. The budget is prepared on a zero-based full-cost basis. The budget and actual expenditure may vary based on the level of meeting activity required in any given year.

### Department Expenses

2. **Executive Office**

   The Executive Office provides leadership and directs the management of CMA and its subsidiaries. The Executive Office supports CMA’s elected leaders in the discharge of their official duties, fosters internal communications, and facilitates the information flow between CMA and its stakeholders.

3. **Professional Services and Leadership**

   The department is responsible for knowledge products and leadership programs. This includes products and services offered as part of the Knowledge for Practice strategic initiative and continuing professional development programs and courses.

4. **Community Building**

   The department is responsible for maintaining and strengthening relationships with our members, provincial/territorial medical associations (PTMAs), affiliates, associates, and other medical and health stakeholders. The department undertakes a variety of activities, including member engagement and outreach, member insight, stakeholder engagement, collaborative initiatives and accreditation services.

5. **Health Policy and Research**

   The department is responsible for research and policy development and environmental scanning in the areas of physician workforce, medical ethics, public health, health information technology and health system financing and reform issues.

6. **Advocacy and Public Affairs**

   The department is the voice of CMA and the lead on developing and maintaining positive relationships with stakeholders and partners. The department is responsible for all aspects of communications, government relations and public affairs, as well as social media, physician reputation management and brand management. It also oversees CMA’s translation services and public opinion research.

7. **Strategy and Org. Effectiveness**

   The department includes Strategic Planning, Monitoring and Evaluation, Governance and Legal Services, Human Resources and Organizational Development, Finance, Operations, and Meetings and Travel. The department brings together the enabling services and functions with its primary responsibility to facilitate and deliver organizational excellence across the dimensions of People, Finances and Operations.
8. Amortization/Depreciation

The budget expense reflects the allocation of the purchase price of computer equipment and furniture over their estimated useful life. The amortization of the buildings is included with the building expenses in the Strategy & Organizational Effectiveness department’s Operations budget.

9. Knowledge for Practice-cma.ca rebuild

The amount budgeted for 2014 is for the completion of the digital rebuild of cma.ca – CMA’s website, which includes user interface redesign, web content review, content enrichment and web content management. The investment in K4P (Knowledge for Practice) was initiated in 2012 to respond to members’ needs for clinical practice products and services.

<table>
<thead>
<tr>
<th>Total expenses</th>
<th>47,992,919</th>
<th>46,383,239</th>
<th>46,698,378</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating (Deficit) Surplus</td>
<td>(3,008,938)</td>
<td>(50,542)</td>
<td>165,295</td>
</tr>
</tbody>
</table>
2015 Membership Fee

152. In May, the committee met to review the 2015 membership fee.

153. In making its recommendation to the CMA Board regarding the 2015 full member fee, the Committee on Finance felt the following factors were the most important:
   - the circumstances and feedback regarding the 2014 fee proposal at last year’s General Council
   - CMA has communicated to a variety of stakeholders including General Council, the Board and PTMAs its desire to freeze the membership fee for 2015
   - CMA is planning a comprehensive program review of CMA activities in 2014
   - the potential financial benefits associated with the implementation of a new subsidiary structure proposal
   - CMA will be preparing its new 3-year financial strategy to support and complement CMA’s 2015-17 Strategic Plan

154. The Committee on Finance concluded it would recommend to the CMA Board that it maintain the CMA 2015 Membership Fee at $495.

155. The Board’s recommendation to General Council can be found in the Board’s stewardship report (see Board Business on p. 40).
<table>
<thead>
<tr>
<th>Resolution</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative/Finance</strong></td>
<td></td>
</tr>
<tr>
<td>GC 13-9</td>
<td>The Canadian Medical Association (CMA) approves the Canadian Academy of Sport and Exercise Medicine’s application for CMA affiliate status. Completed. The Academy was officially informed.</td>
</tr>
<tr>
<td>GC 13-16</td>
<td>The Canadian Medical Association full membership fee for the year 2014 will be $495. Completed. Provincial/territorial medical associations (PTMAs) were notified.</td>
</tr>
<tr>
<td>GC 13-10</td>
<td>The Canadian Medical Association adopts the Board of Directors’ final report and recommendations on governance review as outlined in Appendix 4 to the 2013 Reports to General Council. Completed with the exception that some governance changes will be phased in during the course of 2014.</td>
</tr>
<tr>
<td><strong>Strategic Session 1 – End-of-life Care in Canada</strong></td>
<td></td>
</tr>
<tr>
<td>GC 13-13</td>
<td>General Council directs the Canadian Medical Association (CMA) Board of Directors to ensure the content of the Committee of the Whole discussion on the document entitled &quot;End-of-Life Care in Canada&quot; is reflected in the development of CMA policy. In progress. Policy work in this area is ongoing.</td>
</tr>
</tbody>
</table>
Strategic Session 2 – Physician Resources

GC 13-18
The Canadian Medical Association will investigate the impact of changes to resident duty hours on physician resource planning.

In progress. The Committee on Education and Professional Development has a draft policy out for review and the pertinent recommendations of the final policy will be incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) (to be sent for consultation and ratification this fall).

GC 13-19
The Canadian Medical Association supports supply-and-demand projection models for health human resources using standardized methodology.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall. CMA is also represented on the steering and technical committees of the Physician Resource Planning Task Force that is charged with developing a pan-Canadian physician planning tool.

GC 13-20
The Canadian Medical Association supports measures to facilitate the acculturation of international medical graduates.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall.

GC 13-21
The Canadian Medical Association supports curriculum development within Canada’s medical schools that ensures trainees are educated on the importance of gender-sensitive care.

Completed. A letter was sent to the Association of Faculties of Medicine of Canada, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. This resolution was also included in comments provided by the Committee on Education and Professional Development on the Committee on Accreditation of Canadian Medical Schools’ revised standards for accreditation.

GC 13-22
The Canadian Medical Association will work with stakeholders to help new graduates of Canadian residency programs seek job opportunities across Canada.

Completed. CMA has updated its specialty profiles based on the 2013 National Physician Survey results and posted them online. CMA also compiled a summary of available opportunities by specialty and province in October 2013 and subsequently in March 2014 based on government recruiting websites (e.g., Health Force Ontario). CMA will meet with the Canadian Association of Internes and Residents to determine what other supports may be useful.

GC 13-23
The Canadian Medical Association supports strategies that will utilize untapped health infrastructure resources to better meet Canadians’ health care needs.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall. CMA is also exploring the means to measure available capacity in the current infrastructure.
GC 13-24
The Canadian Medical Association will investigate reports of and implications of unemployment and underemployment within all specialties.

In progress. The Royal College of Physicians and Surgeons of Canada released its report on under/unemployment among new certificants in September 2013 and hosted a national summit on this topic in February 2014. Results of the 2013 National Physician Survey, which focused on employment, were released in October and are available online. CMA’s committees on Health Policy and Economics, and Education and Professional Development are reviewing this information to make recommendations on the implications of these data, and advise on the collection of other necessary information.

GC 13-25
The Canadian Medical Association will review the current physician human resource needs of psychiatry in Canada.

Completed. The Canadian Collaborative Centre for Physician Resources prepared updated projections for the supply of physicians for the Canadian Psychiatric Association in fall 2013. CMA is also participating on the Association of Faculties of Medicine of Canada Physician Resource Planning Task Force.

GC 13-26
The Canadian Medical Association encourages family physicians to maintain their skills in comprehensive family medicine, while supporting their choice to acquire additional skills that will better serve the needs of their community.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall.

GC 13-27
The Canadian Medical Association will establish a national working group identifying key gaps in Canadian physician human resources and propose plans for action.

In progress. Physician human resources are an ongoing priority of the Committee on Health Policy and Economics and Committee on Education and Professional Development. A 10-point action plan was presented to the Board in December 2013, and execution is underway.

GC 13-28
The Canadian Medical Association will develop a policy statement on the impact emerging technologies and models of care are having on health human resource planning.

In progress. Following their joint session in April, members of the Committee on Health Policy and Economics and Committee on Education and Professional Development agreed to incorporate the impact of emerging technologies and models of care into CMA’s draft policy on Physician Resource Planning (update 2014) (to be sent for consultation and ratification this fall).

GC 13-30
The Canadian Medical Association supports the development of more structured mentorship programs featuring a formal career counselling component as part of all residency curricula in Canada.

Completed. A letter was sent to the Association of Faculties of Medicine of Canada, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.
The Canadian Medical Association supports in principle the transfer process suggested in the Canadian Association of Internes and Residents’ "Principles on Resident Transfers."

Completed. A letter was sent to the Association of Faculties of Medicine of Canada, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

The Canadian Medical Association will establish and maintain a national repository of physician professional opportunities in Canada.

Completed. CMA examined all provincial/territorial government websites in October 2013 and determined that there were 2,500 opportunities advertised (summary posted here). An update was prepared in March 2014 with 3,056 opportunities advertised; the profile was presented to a variety of medical organizations for feedback.

Referred to the Board:

The Canadian Medical Association supports the six guiding principles in the Canadian Association of Internes and Residents’ “Resident Principles on Physician Health Human Resources to Better Serve Canadians” informing the realignment of the postgraduate medical education system supporting a national strategy to meet future societal health care needs.

Completed. The CMA Board endorsed the principles in December 2013.

The Canadian Medical Association will advocate for adequate physician input in the selection of evidence used to address costs and quality related to clinical practice variation.

Completed. The Specialist Forum and CEOs Forum kept up-to-date on the Choosing Wisely Canada initiative. CMA staff are working with the Specialist Forum to initiate a Quality Collaborative and a motion will be considered within this context. The initial activity will involve compiling a compendium of quality initiatives underway by national specialty societies. Reduction of practice variation is expected to be a prominent theme.

The Canadian Medical Association will work with stakeholders to develop standardized processes to ensure access to comprehensive psychiatric assessment and treatment for people detained within the correctional system.

In progress. CMA consulted with the Canadian Psychiatric Association and the Mental Health Commission of Canada to determine what processes might be in place. The intent of the resolution has been incorporated into a draft CMA policy on access to mental health care. The policy is expected to be ratified this fall. CMA will continue its stakeholder relations activities on mental health and mental illness issues to support the development of standardized processes to ensure access to comprehensive psychiatric assessment and treatment.
GC 13-36

The Canadian Medical Association believes that fiscal benefits and cost savings of exercises in accountability and appropriateness in clinical care are a by-product rather than the primary focus of these exercises.

In progress. The sentiment of this resolution forms the core message of Choosing Wisely Canada: it is a campaign about enhanced quality of care; and reduction in cost is a by-product of that focus (see www.choosingwiselycanada.org). This resolution has also been incorporated in a draft policy paper on appropriateness that will be sent for consultation after the May Board meeting. It is expected to be ratified this fall.

GC 13-37

The Canadian Medical Association adopts the following definition for appropriateness in health care:

It is the right care, provided by the right providers, to the right patient, in the right place, at the right time, resulting in optimal quality care.

In progress. A briefing paper on appropriateness capturing the core ideas of a longer policy paper was presented at Taming of the Queue 2014 and received widespread support for its approach. The CMA Board will be asked in May for permission to send the policy paper out for consultation with plans for revision over the summer and Board ratification in the fall.

GC 13-38

The Canadian Medical Association will form a collaborative working group to develop specialty-specific lists of clinical tests/interventions and procedures for which benefits have generally not been shown to exceed the risks.

In progress. Choosing Wisely Canada, a collaboration between CMA, the University of Toronto, and national specialty societies, was launched on April 2, to significant media attention. Eight specialties released lists and another 20 are at various stages of list preparation for the next wave this fall. Patient and public groups are being recruited as collaborators. All provincial/territorial medical associations are supportive and some (Ontario, Alberta, Nova Scotia, Quebec) have played very active roles in the launch and implementation (see www.choosingwiselycanada.org).

GC 13-39

The Canadian Medical Association will revise its proposed framework for a National Dementia Strategy to include education on the assessment and management of pain prior to the initiation of anti-psychotic therapy.

In progress. CMA’s framework for a National Dementia Strategy calls for research into treatment options improving quality of care for those with dementia. The intent of the resolution will be included in talking points regarding the strategy, as well as into ongoing policy activity on optimal prescribing. At the request of the House of Commons Finance Committee, CMA submitted a brief on a framework for a national dementia strategy. New funds were provided in the 2014 federal budget for this activity.

GC 13-40

The Canadian Medical Association will make recommendations regarding training in and the use of standardized processes for assessing risk for violence in persons with mental illness.

In progress. CMA is conducting an environmental scan by contacting key stakeholders in the mental health field to ascertain what policies or guidelines are in place, and will consider the results this fall with a view to developing recommendations.
GC 13-41
The Canadian Medical Association supports the development of data on health care delivery and patient outcomes to help the medical profession develop an appropriateness framework and associated accountability standards provided that patient and physician confidentiality is maintained.

In progress. This resolution has been incorporated in a draft policy paper on appropriateness that will be sent for consultation after the May Board meeting. It is expected to be ratified this fall.

GC 13-42
The Canadian Medical Association advocates that should outsourcing of medical services by health authorities or hospitals occur, Canadian training and certification standards must be met.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall.

GC 13-106
The Canadian Medical Association supports the full use of national medical services instead of international outsourcing.

In progress. This resolution was incorporated in CMA’s draft policy on Physician Resource Planning (update 2014) which will be sent for consultation and ratification this fall.

Delegates Motions – End-of-life care

GC 13-66
The Canadian Medical Association advocates for the integration of accessible quality palliative care services into community and chronic care service delivery models.

Completed. CMA positioned palliative care as a key pillar in its National Dialogue on End-of-life Care issues. The town halls gathered perspectives on palliative care from across the country and will be summarized in a report with recommendations for health providers and governments. CMA incorporated palliative care as part of the theme and messaging for its 2014 Doctors in the House Lobby Day on Parliament Hill. CMA tweeted on the health minister’s palliative care research announcement calling for concrete action. This resolution will also be integrated into a new stand-alone CMA policy on palliative care, which is currently being developed by the Committee on Ethics.

GC 13-67
The Canadian Medical Association supports the integration of the palliative care approach into the management of life-limiting chronic disease.

In progress. This recommendation is being integrated into a new stand-alone CMA policy on palliative care which is currently being developed by the Committee on Ethics.

GC 13-68
The Canadian Medical Association supports efforts that will assist physicians in helping patients and families understand and develop advance care plans.

In progress. The CMA has positioned preparation of advance care directives as a key pillar in the National Dialogue on End-of-life Care issues. During the public and member town hall events, information is provided to participants linking them with a suite of
GC 13-69
The Canadian Medical Association supports the development and availability to all physicians of training in advance care planning.

GC 13-70
The Canadian Medical Association recommends that all relevant legislation be amended to recognize that any person whose medical condition warrants it is entitled to receive palliative care.

GC 13-71
The Canadian Medical Association requests that all Canadian faculties of medicine create a curriculum for training in palliative care suitable for physicians at all stages of their medical education and in appropriate settings to the locale in which they practice.

GC 13-72
The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying.

In progress. This recommendation will also be integrated into a revised CMA policy on advance directives which is currently being developed by the Committee on Ethics.

In progress (to be completed prior to General Council). CMA positioned palliative care as a key pillar in its National Dialogue on End-of-life Care issues. The town halls gathered perspectives on palliative care from across the country which will be summarized in a report with recommendations for health providers and governments. CMA incorporated palliative care as part of the theme and messaging for its 2014 Doctors in the House Lobby Day on Parliament Hill. CMA tweeted on the health minister’s palliative care research announcement calling for concrete action. CMA identified the relevant legislative/regulatory framework governing access to palliative care; this will be captured as appropriate in future advocacy. This resolution will also be integrated into a new stand-alone policy on palliative care which is currently being developed by the Committee on Ethics.

Completed. Letter sent to the Association of Faculties of Medicine of Canada. This resolution will also be incorporated in a policy statement on palliative care.

Completed. Noted as CMA policy.
GC 13-73
The Canadian Medical Association believes that every person nearing the end of life who wishes to receive palliative care services at home should have access to them.

GC 13-74
The Canadian Medical Association encourages all members to complete their own advanced care plan.

GC 13-75
Referred to the Board:

The Canadian Medical Association will replace the term “physician-assisted suicide” with “physician-assisted death” and use it in all future communications.

GC 13-76
Referred to the Board:

The Canadian Medical Association advocates for the inclusion of advanced care directive functionality as an electronic medical record vendor conformance and usability requirement for all approved digital charting software.

In progress. This recommendation will be integrated into a new stand-alone CMA policy on palliative care which is currently being developed by the Committee on Ethics.

Ongoing. An article on this topic was published in the April CMA Bulletin. The issue is currently highlighted as part of the End-of-life Care Online Member Dialogue. This resolution will also be integrated into a revised CMA policy on advance directives which is currently being developed by the Committee on Ethics.

Completed. This is part of the revised policy on euthanasia and assisted suicide.

Completed. This motion was referred to the CMA Board, who referred it to the Provincial/Territorial Medical Association (PTMA) Health Information Technology (HIT) Committee for an opinion on the technical feasibility of including advanced care directive (ACD) functionality in electronic medical records (EMRs), and thus vendor conformance and usability requirements. The HIT Committee’s research concluded that including ACD functionality in EMRs is technically feasible and expected to occur naturally in many jurisdictions and recommended that CMA encourage and advocate accordingly. The CMA Board, agreeing with the HIT Committee’s recommendations, adopted the motion at its February 2014 meeting. As such, in the course of negotiations between PTMAs and EMR vendors to create conformance and usability requirements, CMA, in its capacity as a facilitator of those negotiations, will advocate for the inclusion of enhanced EMR functionality, including ACD functionality for all approved digital charting software.
Delegates Motions – Environment

GC 13-53
The Canadian Medical Association supports the development of a national strategy for the creation of community and regional maps that track noise levels in Canada.

In progress. This resolution was incorporated into the new policy on the built environment and health. Organizations concerned with noise levels as well as regulatory agency and relevant federal initiatives/programs will be identified and advised of CMA’s position.

GC 13-54
The Canadian Medical Association supports integration of the concepts of population health and impact assessment into urban planning and design.

Completed. The resolution was incorporated into CMA’s policy on the Built Environment and Health ratified by the Board in December 2013.

GC 13-55
The Canadian Medical Association will advocate for more federal assistance to support ongoing, systematic efforts to mitigate, prevent, respond to and recover from extreme weather events and their consequences on human health.

In progress (to be completed prior to General Council). Staff engaged officials at Public Safety Canada and submitted a letter to communicate this resolution for government consideration.

Delegates Motions – Collaborative practice

GC 13-56
The Canadian Medical Association recommends strengthening collaborative approaches to mental health care for children and youth.

In progress. The resolution has been incorporated into a CMA policy on access to mental health care, currently in development. It is expected to be ratified by the CMA Board this fall. CMA will also continue its stakeholder relations activities on mental health and mental illness issues.

GC 13-77
The Canadian Medical Association recommends that conflict-of-interest issues be considered when any scope-of-practice expansion that allows allied health professionals to both prescribe and dispense medication is considered.

Completed. CMA incorporated this recommendation into its submission to Health Canada on the modernization of the Controlled Drugs and Substances Act. CMA will also incorporate this recommendation in its brief and presentation to the House of Commons Standing Committee on Health during its study of scopes of practice later this spring or in the fall.

GC 13-78
The Canadian Medical Association encourages that changes to the scope of practice for allied health professionals occur only in the presence of a defined, transparent evaluation process that is based on clinical criteria and protects patient safety.

Completed. Position incorporated in our work with the Health Care Innovation Working Group. CMA incorporated this recommendation into its submission to Health Canada on the modernization of the Controlled Drugs and Substances Act. CMA will also incorporate this recommendation in its brief and presentation to the House of Commons Standing Committee on Health during its study of scopes of practice later this spring or in the fall.
GC 13-79
The Canadian Medical Association urges the Canadian Medical Protective Association to develop a comprehensive strategy to minimize the liability risk of physicians due to the changing scopes of practice of other health care providers.

Completed. A letter was sent to Dr. James Sproule of the Canadian Medical Protective Association (CMPA). CMPA intends to continue to work with the various health care organizations, including CMA and health care professional associations, to advocate that all members of the health care team should have adequate liability protection based on the clinical duties they are likely to perform. CMPA will also continue to educate its members about the medico-legal risks associated with working alongside other health care providers, and the importance of ensuring that all health care providers have adequate liability protection to address the medico-legal risk.

GC 13-80
The Canadian Medical Association supports the implementation of a collaborative palliative care model.

In progress. This recommendation will be integrated into a new stand-alone CMA policy on palliative care.

GC 13-81
The Canadian Medical Association will develop a strategy to improve understanding of scope of practice and roles for and by all members of a multidisciplinary health care team.

Ongoing. CMA is part of the Committee on Health Workforce on Team-based Models of Care to optimize the skills and scopes of practice of health care professionals, taking into account their roles and responsibilities.

GC 13-82
The Canadian Medical Association supports the creation of provincial/territorial councils on eye health.

Completed. A letter was sent to Alberta’s Minister of Health with a copy to all other provincial/territorial ministers of health. CMA also submitted a letter to the Health Care Innovation Working Group’s scope of practice working group chair and sent a copy to other provincial/territorial ministers of health.

Delegates Motions – Health care delivery and access

GC 13-57
The Canadian Medical Association will advocate for the development of an accreditation process for mobile applications for health.

In progress. CMA has explored the feasibility of this work with Canada Health Infoway, and will collaborate with Infoway, Accreditation Canada, and others to explore accreditation frameworks or appropriate alternatives.

GC 13-83
The Canadian Medical Association will support the establishment of national triage guidelines for prioritizing magnetic resonance imaging appointments.

Completed. The Canadian Association of Radiologists (CAR) has developed appropriateness referral guidelines for Magnetic Resonance Imaging (MRI). They have also established wait-time benchmarks for MRI, based on urgency level. The implementation is CAR’s main focus through the Wait Time Alliance and it is working with individual provinces to get the
GC 13-84
The Canadian Medical Association calls for biennial testing of disaster management planning in hospitals.

GC 13-85
The Canadian Medical Association calls for timely and efficient referral processes to link workplaces with primary care physicians.

GC 13-86
The Canadian Medical Association supports appropriate data collection and analysis to monitor the equitable distribution of health services and the appropriateness of care in all provinces and territories.

GC 13-87
The Canadian Medical Association supports the right of family members of Canadian military personnel and retiring/releasing military members and their families to have continuous access to local physicians as they relocate to new military bases and communities across Canada.

GC 13-88
The Canadian Medical Association strongly advocates for continued governmental investment to support interoperability and connectivity of e-health systems.

GC 13-89
The Canadian Medical Association supports the exploration of a complementary patient-controlled electronic health record.

GC 13-90
The Canadian Medical Association recommends that physicians be encouraged and adequately supported to participate in community-based interventions that target the social determinants of health.

benchmarks implemented. The guidelines have also been included in the CMA Infobase of Clinical Practice Guidelines.

Ongoing. CMA has shared the resolution with the Canadian Healthcare Association representing health care institutions across the country. The intent of the resolution is also included in CMA messaging on emergency preparedness and disaster response issues.

Completed. This resolution has been brought to the attention of the Occupational and Environmental Association of Canada and will be addressed in ongoing discussions surrounding return to work.

Completed. This resolution was incorporated into the Ensuring Equitable Access to Health Care: Strategies for the Medical Profession policy paper ratified by the Board in December 2013.

Completed. An article on the topic was published on March 31, 2014. An article will also be included in a newsletter to provincial/territorial medical associations in April 2014. This resolution was also shared with Canadian Forces Resource Centres. CMA will follow up to identify potential alignment and joint outreach opportunities.

Completed. CMA made this recommendation as part of its pre-budget submission to the federal government in fall 2013 and incorporated the resolution in its submission on the Controlled Drugs and Substances Act.

In progress. CMA will canvas the Health Information Technology Committee on the current uptake of personal electronic health records that operate in conjunction with physician electronic medical records and will also discuss this issue with Canada Health Infoway.

In progress. The recommendation is addressed in a background paper on population health that is being prepared under the direction of the Committee on Health Care and Promotion. This will be reviewed by the committee in the fall with the intent of sending it for consultation in spring 2015.
Delegates Motions – Health promotion and disease prevention

GC 13-58
The Canadian Medical Association recommends that there be an increased emphasis on public health-oriented approaches by regulatory authorities responsible for psychoactive substances.

Ongoing. This resolution was noted in CMA’s response to Health Canada’s consultations on the Controlled Drugs and Substances Act in March 2014 and incorporated into CMA’s advocacy efforts on addressing the misuse and abuse of prescription medication. CMA will continue to liaise with the Canadian Public Health Association and others who are conducting policy work in this area.

GC 13-59
The Canadian Medical Association supports programs and services that help people with mental illness find and maintain employment.

In progress. This resolution was incorporated into a draft CMA policy on access to mental health care. The policy is expected to be ratified by the Board this fall. CMA will continue its stakeholder relations activities on mental health and mental illness issues and support those who are also developing policy in this area.

GC 13-60
The Canadian Medical Association will advocate for a pan-Canadian strategy to support the care of seniors that is based on the Principles to Guide Health Care Transformation in Canada.

In progress (will be completed prior to General Council). CMA advocated for a seniors’ care strategy as part of its submission and outreach during the federal pre-budget consultations, federal by-election campaigns and in media outreach. Seniors’ care was the central theme of CMA’s 2014 Doctors in the House advocacy day. CMA is developing a pre-election strategy that will promote the need for a seniors’ care strategy and position the health of our aging population as a key federal election issue in 2015.

GC 13-61
The Canadian Medical Association will advocate for legislation to protect Canadians from continued exposure to bisphenol A.

Completed. This resolution is captured in the CMA’s 2011 Policy Statement on Determining the Impact of Chemical Contamination on Human Health. Under the Chemical Management Plan, the government of Canada has committed to action on bisphenol A.

GC 13-62
The Canadian Medical Association calls for a strategy to combat obesity that includes requiring package and retail display warnings about health risks associated with excess consumption of high-calorie, low-nutritional-value junk foods/drinks.

In progress. The intent of the resolution was incorporated into the Physical Activity and Healthy Weights policy (update 2014) to be finalized this fall. It will also be reflected in a draft background paper on the food industry and healthy eating, to be considered by the Committee on Health Care and Promotion this fall. CMA will continue to support provincial/territorial medical associations and other stakeholders (i.e., the Hypertensive Advisory Committee) who are also working in this area.
GC 13-63
The Canadian Medical Association advocates for a national standard of support for the family caregivers of individuals living with mental and physical disabilities.

GC 13-91
The Canadian Medical Association calls for a reconsideration of proposed federal legislation that restricts supervised consumption (safe injection) sites.

In progress (disposition cannot be finalized until Parliament rises). CMA commented to this effect via media statement when this legislation was first tabled. CMA will convey its policy position on this bill as the legislation progresses through the Parliamentary process. This will include a committee appearance and the submission of a brief to the House of Commons Public Safety Committee studying the bill following passage at second reading. CMA incorporated key messages into briefing materials for its 2014 Doctors in the House advocacy day; CMA representatives conveyed these messages in meetings with Public Safety Committee members.

GC 13-92
The Canadian Medical Association condemns the National Hockey League executives and owners regarding violence within their sport.

Completed. A letter was sent to the National Hockey League (NHL) and NHL Players’ Association. A response was received from the NHL in early March. CMA’s French spokesperson, Dr. Pierre Harvey, has conducted numerous media interviews regarding this resolution. CMA communicated this resolution publicly during General Council 2013 and in several follow-up interviews.

GC 13-93
The Canadian Medical Association supports a ban on the sale of energy drinks to Canadians younger than the legal drinking age in their jurisdiction.

Completed. The resolution was conveyed to provincial/territorial medical associations and federal/provincial/territorial health ministers and included in CMA advocacy and messaging on health and nutrition issues.

GC 13-94
The Canadian Medical Association will conduct an analysis with recommendations on the effect of industry advertising promoting the consumption of alcohol and energy drinks on the youth of Canada.

In progress. The impact of advertising unhealthy food and beverages was addressed in CMA’s policy on Marketing of Unhealthy Foods and Beverages to Children and Youth. Marketing practices will also be addressed in a draft background paper on the food industry and healthy eating, to be considered by the Committee on Health Care and Promotion this fall. An analysis is not contemplated at this time.

DISPOSITION OF 2013 RESOLUTIONS  71
GC 13-96
The Canadian Medical Association calls for a strategy to combat obesity that includes restrictions on the sale of high-calorie, low-nutritional-value junk foods/drinks in recreational facilities frequented by young people.

In progress. The intent of the resolution has been incorporated into the Physical Activity and Healthy Weights policy (update 2014) to be finalized this fall. It will also be reflected in a draft background paper on the food industry and healthy eating, to be considered by the Committee on Health Care and Promotion this fall. CMA will continue to support provincial/territorial medical associations and other stakeholders (i.e., the Hypertensive Advisory Committee) who are also working in this area.

GC 13-97
The Canadian Medical Association supports the development of a national system to identify and report the identities and quantities of antibiotics acquired domestically or imported for use in food animals.

Completed. The resolution has been reflected in a position statement on antibiotics in agriculture (currently in development).

GC 13-98
The Canadian Medical Association supports campaigns to prevent fetal alcohol spectrum disorder in Aboriginal communities in Canada.

Completed. This resolution was shared with the Assembly of First Nations. Dr. Reid informed the UN Rapporteur during a face-to-face meeting in Oct. 2013.

GC 13-99
The Canadian Medical Association recommends that the Food and Drugs Act and its regulations be amended to close the "own use" provision for the unmanaged importation of antibiotics for agricultural use.

Completed. The resolution is reflected in a position statement on antibiotics in agriculture (currently in development).

Delegates Motions – Leadership and advocacy

GC 13-65
The Canadian Medical Association supports the proclamation of a specific annual date as "Doctors’ Day in Canada."

In progress and will be completed by end of 2014. This item was discussed with provincial/territorial medical associations (PTMAs). It was determined in consultation with PTMAs that in 2014, CMA will support two provincial-based initiatives. Based on this experience, CMA will develop a proposal for consideration by all PTMAs to establish a national “doctors’ day”.

GC 13-100
The Canadian Medical Association will advocate for the inclusion of health as a required consideration in decision-making by the federal Cabinet.

Ongoing. CMA has discussed this resolution with senior officials in the Privy Council Office during its pre-budget submission and advocacy day in 2013. CMA further developed this resolution, taking into account a provincial/territorial assessment on the
GC 13-101

The Canadian Medical Association will develop and implement a strategy to encourage collaborative action on the recommendations raised during its recent town-hall consultations on the social determinants of health.

In progress. Work continues on developing a strategy to engage stakeholders and secure action to address the social determinants of health.

GC 13-102

The Canadian Medical Association will develop a suggested curriculum for advocacy skills training for medical students and residents.

In progress (to be completed in November). CMA has developed a project scope and initiated a review of formal and informal advocacy training opportunities for medical students and residents. An update was presented to the Political Action Committee at its April meeting. The final suggested curriculum will be presented for approval to the committee at its fall meeting. In addition, staff are developing a three-hour accredited workshop – Advocacy primer for physician leaders, students and residents as well as a 30-minute online learning module on advocacy for students and residents that will be accredited and launched this fall.

GC 13-64

The Canadian Medical Association supports timely public access and transparency to the results of and information from government-funded research.

Completed. This resolution has been conveyed by letter to the Tri-Council (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council, Social Sciences and Humanities Research Council of Canada) for leadership on this issue to ensure a shared approach for improving access to the results of publicly funded research.

GC 13-103

The Canadian Medical Association will create and distribute an inventory of existing documents to guide physicians facing ethical dilemmas within the context of their professional practices.

In progress. The Committee on Ethics will be updated at its next meeting.

GC 13-104

The Canadian Medical Association condemns the Russian Federation’s legislation banning "propaganda of non-traditional sexual relations."

Completed. CMA worked with the World Medical Association (WMA) to develop a strong statement condemning all forms of stigmatization, criminalization and discrimination of people based on their sexual orientation. The statement was issued at the WMA meeting last October.
Delegates Motions – Emerging issues

GC 13-105

The Canadian Medical Association expresses its deep concern about the safety of Dr. Tarek Loubani as well as Mr. John Greyson, and urges Canadian officials to ensure due and fair process as well as physical and emotional safety for those two individuals.

Completed. CMA engaged the Office of the Minister of Foreign Affairs to convey concern and encourage Canadian pursuit of a resolution. This engagement included meeting with the Parliamentary Secretary to the Minister of Foreign Affairs and ongoing collaboration with political staff, the Ontario Medical Association and the World Medical Association. CMA’s efforts contributed to Canada’s pursuit of the resolution of the illegal detention.

Strategic session and delegates’ motions not considered by General Council

The Board of Directors has agreed that all motions not tabled and that do not reach the floor of General Council are not the property of General Council and are therefore deemed to have “died on the Order Paper.”
INCUMBENTS AND ATTENDANCE

General Council Speaker and Deputy Speaker 2014

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Speaker</td>
<td>Blake Woodside, MD</td>
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<tr>
<td>Deputy Speaker</td>
<td>Maria Alexiadis, MD</td>
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CMA Board of Directors 2013-14 (7 meetings)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chair</td>
<td>Brian Brodie, MD*</td>
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<tr>
<td>President</td>
<td>Louis Hugo Francescutti, MD*</td>
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<tr>
<td>President-Elect</td>
<td>Christopher Simpson, MD*</td>
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<tr>
<td>Past President</td>
<td>Anna Reid, MD* (regrets February)</td>
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<tr>
<td>Honorary Treasurer</td>
<td>Jane Brooks, MD (NS)*</td>
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<tr>
<td>Yukon</td>
<td>Ngozi Ikeji, MD*</td>
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<tr>
<td>Northwest Territories</td>
<td>Ewan Affleck, MD</td>
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<tr>
<td>British Columbia</td>
<td>Nasir Jetha, MD</td>
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<td></td>
<td>Shelley Ross, MD</td>
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<tr>
<td>Alberta</td>
<td>Christopher (Chip) Doig, MD (regrets Aug 2014)</td>
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<td></td>
<td>Linda Slocombe, MD (regrets February)</td>
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<tr>
<td>Saskatchewan</td>
<td>Boyd Stewart, MD</td>
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<td>Manitoba</td>
<td>Margaret Speer, MD</td>
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<td>Ontario</td>
<td>Gail Beck, MD</td>
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<td></td>
<td>Christopher Jyu, MD</td>
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<td>Stewart Kennedy, MD</td>
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<td>Tim Nicholas, MD</td>
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<td>Virginia Walley, MD (regrets October)</td>
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<td>Québec</td>
<td>Pierre Harvey, MD</td>
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<td></td>
<td>Laurent Marcoux, MD</td>
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<tr>
<td>New Brunswick</td>
<td>Ann Collins, MD (regrets Aug 2013)</td>
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<tr>
<td>Nova Scotia</td>
<td>Jane Brooks, MD*</td>
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<tr>
<td>Prince Edward Island</td>
<td>Frank MacDonald, MD (regrets Aug 2013)</td>
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<td>Newfoundland &amp; Labrador</td>
<td>Brendan Lewis, MD</td>
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<tr>
<td>Residents</td>
<td>Kaif Pardhan, MD</td>
</tr>
<tr>
<td>Students</td>
<td>Jesse Kancir, MD</td>
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</tbody>
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* Members, CMA Executive Committee (3 meetings / 4 teleconferences)
Governance / stewardship committees 2013-14

Appointments and Review Committee (2 meetings / 3 teleconferences)

Reviews and recommends appointments to and terms of reference for CMA committees.

| Chair | Jane Brooks, MD (NS) (until January)  
|       | Nasir Jetha, MD (BC) (effective January) |
| Members | Ann Collins, MD (NB) (regrets June)  
|         | John Haggie, MB (NL) (regrets December and April)  
|         | Christopher Jyu, MD (Ont.) (regrets June)  
|         | Susan King, MD (NL)  
|         | Christopher Simpson, MD (Ont.) (regrets November and December)  
|         | Linda Slocombe, MD (Alta.)  
| (Board Chair) | Brian Brodie, MD (BC) (regrets April)  
| (Governance Committee Chair – non voting) | Shelley Ross, MD (BC) (regrets June) |

Audit Committee (2 meetings)

Oversees the integrity and credibility of CMA’s audited financial statements, acts as the liaison with CMA’s external auditor and oversees the audit financial reporting to General Council.

| Chair | Robert Broad, MD (Alta.)  
| Members | Mark Corbett, MD (BC)  
|         | François Gobeil, MD (Que.)  
|         | Darcy Johnson, MD (Man.)  
|         | Renwick Mann, MD (Ont.)  
|         | Pravinsagar Mehta, MD (Man.) |

Committee on Archives and Awards (1 meeting)

Advises and recommends on historical materials of interest to CMA and the profession, awards and related nominations.

| Chair | Ruth Collins-Nakai, MD (Alta.)  
| Members | Gregory Athaide, MD (Ont.)  
|         | Henry Haddad, MD (Que.)  
|         | John O’Brien-Bell, MD (BC) (regrets January)  
|         | Hugh Scully, MD (Ont.)  
|         | Celina White, MD (NS) |
Committee on Finance (4 meetings)

Studies CMA’s immediate and long-term financial needs, assesses the financial implications on all programs and projects and makes recommendations to the Board.

Chair (Honorary Treasurer)  
Jane Brooks, MD (NS)

Members
Pierre Harvey, MD (Que.)
Christopher Jyu, MD (Ont.)
Brendan Lewis, MD (NL)
Frank MacDonald, MD (PEI)
Tim Nicholas, MD (Ont.)

(Board Chair)  
Brian Brodie, MD (BC)

Committee on Nominations (1 teleconference)

Seeks out candidates and reviews nominations for all elected positions prior to their presentation to General Council.

Chair  
Anna Reid, MD (NWT)

Members
Rao Tadepalli, MD (Yukon)
Peter McArthur, MD (NWT)
Shelley Ross, MD (BC)
Christopher Doig, MD (Alta.)
Janet Shannon, MD (Sask.)
Maurice Roy, MD (Man.)
Scott Wooder, MD (Ont.)
Ruth Vander-Stelt, MD (Que.)
Lynn Hansen, MD (NB)
John Finley, MD (NS)
Stephen O’Brien, MD (PEI)
Tony Gabriel, MD (NL)
Carter Thorne, MD (Affiliates)
Chris Little, MD (Residents)
Robin Clouston, MD (Students)

Governance Committee (4 teleconferences)

Advises and makes recommendations to the Board and General Council on all aspects of CMA’s governance (excluding nominations and appointments).
Chair

Members

Shelley Ross, MD (BC)
Ewan Affleck, MD (NWT) (regrets May)
Garth Campbell, MD (Man.) (regrets February and May)
Ann Collins, MD (NB)
Deborah Hellyer, MD (Ont.) (regrets May)
Ngozi Ikeji, MD (Yukon)
Virginia Walley, MD (Ont.)
Brian Brodie, MD (BC)
Nasir Jetha, MD (BC)
Michael Omichinski, MD (Man.) (Observer) (regrets May)

Journal Oversight Committee (1 meeting)

Enhances the quality of *CMAJ* as a credible, editorially independent, peer-reviewed medical journal by:
(a) reviewing the overall performance of the Editor-in-Chief based upon pre-established criteria that will include editorial, content, strategic and business domains; and 
(b) assisting in maintaining harmonious relationships between the Editor-in-Chief, CMA and other outside parties.

Chair

Members

Jean Gray, MD (NS) (until December)
John Wootton, MD (Que.) (Medical) (effective January)
Elly Alboim (Journalist)
Christopher (Chip) Doig, MD (Board)
Cy Frank, MD (Scientific)
Tim Smith (CMA Staff)
TBC (Contributor, Editorial and Peer)

Resolutions Committee (1 meeting / 1 teleconference)

Reviews motions for debate by General Council delegates.

Chair

Members

Maria Alexiadis, MD (NS)
Alan Gow, MD (BC)
Ernst Schuster, MD (Alta.)
Daniel Tardif, MD (Que.)
Blake Woodside, MD (Ont.)
Joel Yelland, MD (Sask.)
Staffing Committee (7 meetings)

Makes recommendations on recruitment, compensation, evaluation, performance management and succession planning for the CMA CEO.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Brendan Lewis, MD (NL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>Gail Beck, MD (Ont.)</td>
</tr>
<tr>
<td></td>
<td>Stewart Kennedy, MD (Ont.) (regrets February)</td>
</tr>
<tr>
<td>(Immediate Past President)</td>
<td>Anna Reid, MD (NWT) (regrets February)</td>
</tr>
<tr>
<td>(Honorary Treasurer)</td>
<td>Jane Brooks, MD (NS)</td>
</tr>
<tr>
<td>(Board Chair – non voting)</td>
<td>Brian Brodie, MD (BC)</td>
</tr>
</tbody>
</table>

Canadian Physician Health Institute (CPHI) Steering Committee (2 meetings)

Takes responsibility for all components of any CPHI programs, including determining priorities, monitoring programs and evaluating results.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Martin Vogel, MD (CMA Staff)</th>
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<tbody>
<tr>
<td>Members</td>
<td>Manon Charbonneau, MD (Que.)</td>
</tr>
<tr>
<td></td>
<td>Jeff Hans, MD (NB)</td>
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<td></td>
<td>Bill Hnydyk, MD (Alta.)</td>
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<td></td>
<td>Margaret Speer, MD (Man.)</td>
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<td></td>
<td>Ian Warrack MD (Ont.)</td>
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</tbody>
</table>

Policy / advisory committees 2013-14

Committee on Education and Professional Development (2 meetings)

Deals with issues pertaining to medical education at all phases of the medical career lifecycle, and professionalism, including inter-professional care and relationships with other providers.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Janice Willett, MD (Ont.)</th>
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<tbody>
<tr>
<td>Members</td>
<td>Ian Schokking, MD (BC/Yukon)</td>
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<td></td>
<td>Chris de Gara, MD (Prairies/NWT)</td>
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<td></td>
<td>Serge Dubé, MD (Que.)</td>
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<td></td>
<td>Elizabeth Callahan, MD (Atlantic)</td>
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<td></td>
<td>Gillian Shiau, MD (Residents)</td>
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<td>Ian Brasg (Students)</td>
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<tr>
<td></td>
<td>Linda Slocombe, MD (Board)</td>
</tr>
</tbody>
</table>

INCUMBENTS 79
Committee on Ethics (2 meetings)

Studies and advises on ethical matters of concern to CMA and elaborates, interprets and amends the *Code of Ethics*.

**Chair**
David Gass, MD (NS)

**Members**
J. William Mackie, MD (BC/Yukon)
Ian Mitchell, MD (Prairies/NWT)
Christopher Cressey, MD (Ont.)
Paul Robinson, MD (Que.)
Kathy Bigsby, MD (Atlantic)
Sabira Valiani, MD (Residents)
Martin Rotenberg (Students)
Christopher (Chip) Doig, MD (Board)

Committee on Health Care and Promotion (2 meetings)

Raises awareness, advocates and promotes best practices pertaining to disease management and prevention, health protection and health promotion.

**Chair**
Adam Steacie, MD (Ont.)

**Members**
Isabelle Gagnon, MD (BC/Yukon)
Peter Nieman, MD (Prairies/NWT)
Yun Jen, MD (Que.)
Chris Millburn, MD (Atlantic)
Laura Bourns, MD (Residents)
Jane Thornton (Students)
Margaret Speer, MD (Board)

Committee on Health Policy and Economics (2 meetings)

Assesses and formulates policy options relating to the economics, organization and management of the health care delivery system, sustainability and health human resources.

**Chair**
Caroline Lane, MD (Prairies/NWT)

**Members**
Donald Milliken, MD (BC/Yukon)
Deborah Hellyer, MD (Ont.)
Françoise Chagnon, MD (Que.)
Rachel Kassner, MD (Atlantic)
Catherine Dickson, MD (Residents)
Ben Frid (Students)
Tim Nicholas, MD (Board)
Political Action Committee (2 meetings)

Provides intelligence on the political environment, leads the ambassador function for the MD-MP Contact Program and outreach activities, and advises on CMA’s advocacy training program.

Chair
Barry Turchen, MD (BC)
Ngozi Ikeji, MD (Board Yukon/NWT)
Noel Grisdale, MD (Alta.)
Boyd Stewart, MD (Board Sask.)
Jason Scott, MD (Man.) (regrets October and April)
Alicia Donahue, MD (Ont.)
Gail Beck, MD (Board Ont.)
Daniel Tardif, MD (Que.)
Ed Doherty, MD (NB)
Jane Brooks, MD (Board NS) (regrets October)
Frank MacDonald, MD (Board PEI) (regrets October)
Brendan Lewis, MD (Board NL)
Arun Jagdeo, MD (Residents)
Mélanie Béchard (Students)

Members

Committee on Conjoint Accreditation (2 meetings)

Governs CMA conjoint accreditation on behalf of the Board and develops accreditation policy, program accreditation requirements and assessment procedures.

Chair
Jean-Paul Soucy, MD (Que.)
Clément Arsenault (NB)
Nancy Chouinard (BC)
Tom De Boeck, MD (Ont.)
Elaine Dever (Ont.)
Louise Gordon (Man.)
Brian Hardy, MD (Man.)
Bill Leverett (BC)
Rod MacGregor (Alta.)
Marie Matte (NS)
Anna Pizzi (Que.)
Tricia VanDenakker (Man.)
Gail Beck, MD (Ont.) (Board)

Members

INCUMBENTS 81
**Working groups (time limited) 2013-14**

**CEO Search Committee (2 meetings / 2 teleconferences)**

Provides advice/recommendations to the Board on the selection of a new CMA CEO.

<table>
<thead>
<tr>
<th>Chair</th>
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<tbody>
<tr>
<td></td>
<td>Brian Brodie, MD (BC)</td>
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<td>Pierre Harvey, MD (Que.) (regrets May)</td>
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<td>Chris Jyu, MD (Ont.)</td>
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<td></td>
<td>Jesse Kancir, MD (Student)</td>
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<td>Anna Reid, MD (NWT)</td>
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<td></td>
<td>Joanne Vézina (CMAH Board)</td>
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<td></td>
<td>Owen Adams (CMA Staff)</td>
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**Health Care Transformation Working Group (2 meetings / 4 teleconferences)**

Deals with all elements and principles of the Health Care Transformation initiative.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Members</th>
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<tr>
<td></td>
<td>Anna Reid, MD (NWT)</td>
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<td>Christopher Doig, MD (Alta.)</td>
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<td></td>
<td>Louis Hugo Francescutti, MD (Alta.)</td>
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<td></td>
<td>David Milne, MD (NS)</td>
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<tr>
<td></td>
<td>Jessica Otte, MD (Early Career Physician)</td>
</tr>
<tr>
<td></td>
<td>Shelley Ross, MD (BC)</td>
</tr>
<tr>
<td></td>
<td>Chris Simpson, MD (Ont.)</td>
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<td></td>
<td>Douglas Weir, MD (Ont.)</td>
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</table>

**Physician Unique Value Proposition Working Group (4 meetings)**

Provides the Board with advice/recommendations with respect to the physician unique value proposition initiative and provides oversight on the creation of a position paper on the unique value proposition of physicians and on CMA’s contribution to and positioning on the Canadian Medical Forum initiative on the Future of Physicians and the Medical Profession in Canada.

<table>
<thead>
<tr>
<th>Chair</th>
<th>Members</th>
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<tbody>
<tr>
<td></td>
<td>Tim Nicholas, MD (Ont.)</td>
</tr>
<tr>
<td></td>
<td>Robin Clouston, MD (Student)</td>
</tr>
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<td></td>
<td>Chris de Gara, MD (Alta.) (regrets October)</td>
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<tr>
<td></td>
<td>Vincent Demers, MD (Que.)</td>
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<tr>
<td></td>
<td>Alicia Donohue, MD (Ont.)</td>
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<tr>
<td></td>
<td>Arun Jagdeo, MD (Resident)</td>
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<tr>
<td></td>
<td>Carolyn Lane, MD (Alta.)</td>
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<td></td>
<td>Ian Mitchell, MD (Alta.)</td>
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<td></td>
<td>Lloyd Oppel, MD (BC)</td>
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</tbody>
</table>
Knowledge for Practice Physician Advisory Group (1 meeting)

Provides physician member input and perspective to the Knowledge for Practice management team with respect to the relevance of the CMA clinical, leadership and practice knowledge strategy, business model, products, services and programs.

**Chair**
Ewan Affleck, MD (NWT)

**Members**
Naheed Dosani, MD (Ont.)
Kendall Ho, MD (BC)
Doug Kavanagh, MD (Ont.)
Andrea Kermack, MD (Que.)
Darren Larsen, MD (Ont.)
Ashley Miller, MD (BC)
William Parker, MD (Alta.)
Steve Pomedli, MD (Ont.)
Michel Sauvé, MD (Alta.)
Robert Tremblay, MD (Que.)

Fora (include PTMA or external representation) 2013-14

**CMA / PTMA Presidents Forum (2 meetings)**

Advances the interests of the medical profession and the public and provides enhanced service for Canadian physicians and patient advocacy through cooperative and collaborative activity.

**Chair**
Suzanne Strasberg, MD (Ont.)

**Members**
Louis Hugo Francescutti, MD (President)
Tim Smith (Interim CEO)
Brian Peters (President and CEO, MD)

**Canadian Medical Forum (2 meetings)**

Consults, builds consensus and develops strategies on matters of interest among national medical organizations.

**Members**
Louis Hugo Francescutti, MD (President)
Tim Smith (Interim CEO)
Forum on General and Family Practice Issues (2 meetings)

Promotes the exchange of information, identifies issues of concern and focus on health economics as they pertain to general and family practice.

**Chair**
Lisa Bonang, MD (NS)
Sarah Cook, MD (NWT)
Lawrence Welsh, MD (BC)
Ann Vaidya, MD (Alta.)
Rizqui Ibrahim, MD (Sask.)
Darcy Johnson, MD (Man.)
Garrett Foley, MD (Ont.)
Marie Hayes, MD (Que.)
Paulette Marie LeBlanc, MD (NB)
Celina White, MD (NS)
Rachel Kassner, MD (PEI)
Patrick O’Shea, MD (NL)
Jean Chen, MD (Canadian Association of Internes and Residents)
James Simpson (Canadian Federation of Medical Students)
Lawrence Groves, MD (Canadian Medical Protective Association)
Francine Lemire, MD (College of Family Physicians of Canada)
Braam de Klerk, MD (Society of Rural Physicians of Canada)
Cyd Courchesne, MD (Canadian Forces)
Chris Jyu, MD (Board)

**Members**

Specialist Forum (2 meetings)

Provides a forum of CMA affiliate and associate representatives for the purpose of working collaboratively, sharing information on issues of common interest, and providing a unified voice to influence policy on these issues.

**Chair**
Geoffrey Blair, MD

**Members**

Association of Faculties of Medicine of Canada (observer)
Geneviève Moineau, MD

Association of Medical Microbiology and Infectious Disease Canada
Mark Joffe, MD
Canadian Academy of Geriatric Psychiatry
Canadian Academy of Sport and Exercise Medicine
Canadian Anesthesiologists’ Society
Canadian Association of Emergency Physicians
Canadian Association of Gastroenterology
Canadian Association of General Surgeons
Canadian Association of Internes and Residents
Canadian Association of Medical Biochemists
Canadian Association of Nuclear Medicine
Canadian Association of Paediatric Surgeons
Canadian Association of Pathologists
Canadian Association of Physical Medicine and Rehabilitation
Canadian Association of Physicians for the Environment
Canadian Association of Physicians with Disabilities
Canadian Association of Radiation Oncology
Canadian Association of Radiologists
Canadian Cardiovascular Society
Canadian Critical Care Society
Canadian College of Medical Geneticists (observer)
Canadian Dermatology Association
Canadian Federation of Medical Students
Canadian Forces Medical Services (observer)
Canadian Geriatrics Society
Canadian Life Insurance Medical Officers Association
Canadian Medical Protective Association
Canadian Neurological Society
Canadian Neurosurgical Society
Canadian Ophthalmological Society
Canadian Orthopaedic Association
Canadian Paediatric Society
Canadian Psychiatric Association
Canadian Rheumatology Association
Canadian Society of Addiction Medicine
Canadian Society of Allergy and Clinical Immunology
Canadian Society of Cardiac Surgeons
Canadian Society of Clinical Neurophysiologists
Canadian Society of Colon and Rectal Surgeons
Canadian Society of Endocrinology and Metabolism

Kiran Rabheru, MD
Pierre Frémont, MD
Patricia Houston, MD
Bruce McLeod, MD
TBD
Garth Warnock, MD
TBD
Elizabeth MacNamara, MD
Christopher O’Brien, MD
Geoffrey Blair, MD
Laurette Geldenhuys, MD
Rodney Li Pi Shan, MD
Kapil Khatter, MD
Vera Krejcik, MD
Ross Halperin, MD
James Fraser, MD
Heather Ross, MD
Mithu Sen, MD
Gail Graham, MD
Richard Langley, MD
Nadia Clarizia
Hugh Mackay, Colonel
Frank Molnar, MD
Douglas Gat, MD
Hartley Stern, MD
Richard Desbiens, MD
Derek Fewer, MD
Geoff Williams, MD
Brendan Lewis, MD
Robert Moriartey, MD
Fiona McGregor, MD
Carter Thorne, MD
Ron Lim, MD
Paul Keith, MD
Gregory Hirsch, MD
Mano Javidan, MD
Ahmer Karimuddin, MD
Christopher Kovacs, MD
Sunsetting

The following is a list of committees and/or working groups which were sunset during the year:

- Board Working Group on Member Value
- Board Chair Search Committee
- *CMA*J Governance Review Working Group
CMA Secretariat

Interim Chief Executive Officer
- Tim Smith
- Joseph Mayer
- Torindo (Tony) Panetta
- Jacques Lefebvre
- Steve Wharry
- TBA

Chief of Staff and Senior Advisor to the CEO
- Owen Adams
- Conrad Amenta
- Jeff Blackmer, MD
- TBA

Chief Financial Officer and Director of Operations
- Samuel (Sam) Shortt, MD
- Stephen Vail
- Lynda Buske
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- Jean Nelson
- Nancy Crain
- Michelle Gravelle
- Terrance (Terry) Albert
- Deborah Scott-Douglas
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Vice President, Advocacy and Public Affairs
- Director, Communications
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Chief of Staff and Senior Advisor to the CEO
- Tim Smith
- Joseph Mayer
- Torindo (Tony) Panetta
- Jacques Lefebvre
- Steve Wharry
- TBA

Chief Financial Officer and Director of Operations
- Owen Adams
- Conrad Amenta
- Jeff Blackmer, MD
- TBA

Vice President, Health Policy and Research
- Chief Technology Officer
- Jeff Blackmer, MD
- TBA

Executive Director, Office of Ethics, Professionalism and International Affairs
- Director, Public Health
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Public Health
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Quality Initiatives
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Research and Policy Development
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Workforce Research
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Community Building
- Director, Members and PTMAs
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Professional Affairs and Strategic Health Alliances
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Strategy and Organization Effectiveness
- Director, Governance and Legal Services, Senior Legal Counsel and Chief Privacy Officer
- Martin Vogel, MD
- John Feeley
- Charmaine Roye, MD
- Steve Mortimer
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Human Resources and Organizational Development
- Director, Meetings and Travel Management
- Michelle Gravelle
- Terrance (Terry) Albert
- Deborah Scott-Douglas
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Director, Strategic Planning, Monitoring and Evaluation
- Michelle Gravelle
- Terrance (Terry) Albert
- Deborah Scott-Douglas
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor

Vice President, Professional Services and Leadership (Acting)
- Editor-in-Chief, CMAJ
- Director and Editor-in-Chief, CMA Online Content
- Director, Leadership and Professional Development
- Director of Publications and Publisher
- John Fletcher, MD
- Patrick (Pat) Rich
- Emily Gruenwoldt-Caulkner
- Glenda Proctor
## CMA’s Group of subsidiary companies

### CMA Holdings (2009) Inc. Board of Directors

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
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<tbody>
<tr>
<td>Director and Chair</td>
<td>John Rapin, MD</td>
</tr>
<tr>
<td>Director, President and CEO</td>
<td>Brian Peters</td>
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<tr>
<td>Directors</td>
<td>Brian Brodie, MD</td>
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<td></td>
<td>Jane Brooks, MD</td>
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<td></td>
<td>Jeffrey Gandz, PhD</td>
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<td>Robert Hollinshead, MD</td>
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<td>Eric Howatt, MD</td>
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<td>Mark Norton</td>
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<td>Frank Penny</td>
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<td>Courtney Pratt</td>
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<td>Tim Smith</td>
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<td>Suzanne Strasberg, MD</td>
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<td>Joanne Vézina</td>
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<td>Wendy Watson</td>
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<td>Patricia Croft</td>
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<td>George Davie</td>
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### CMA Holdings Foundation

<table>
<thead>
<tr>
<th>Role</th>
<th>Members</th>
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<tbody>
<tr>
<td>Director, Chair and President</td>
<td>John Riviere</td>
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<tr>
<td>Directors</td>
<td>William Horton</td>
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<td>Paul Mason</td>
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### MD Physician Services Inc.

<table>
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<th>Role</th>
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<tbody>
<tr>
<td>Director, Chair and President</td>
<td>Brian Peters</td>
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<tr>
<td>Director and President and CEO</td>
<td>François Durocher</td>
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<tr>
<td>Directors</td>
<td>Mike Gassewitz</td>
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<td></td>
<td>William Horton</td>
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<td>Paul Mason</td>
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<td></td>
<td>Michelle Masson</td>
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<td></td>
<td>John Riviere</td>
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<tr>
<td>Company</td>
<td>Role</td>
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<tr>
<td>MD Management Ltd.</td>
<td>Director, Chair and President</td>
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<tr>
<td>MD Growth Investments Ltd.</td>
<td>Director and Chair</td>
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<td>Director, President and CEO</td>
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<td>Directors</td>
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<td>MD Private Trust Company</td>
<td>Director and Chair</td>
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<td>Director, President and CEO</td>
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<td>Directors</td>
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<td>MD Life Insurance Company</td>
<td>Director and Chair</td>
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<td>Director, President and CEO</td>
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<td></td>
<td>Directors</td>
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</table>
MD Insurance Agency Ltd.

Director and Chair
Mike Gassewitz

Director and President
François Durocher

Director
John Riviere

MD Practice Software GP Inc.

Director and Chair
John Riviere

Director and President
Mike Gassewitz

Director
Paul Mason

Canadian Medical Foundation Board of Trustees

Chair
Ruth Collins-Nakai, MD

Trustees
Jean Schnob
Manon Charbonneau, MD
John Haggie, MD
Mike Gormley
Michelle Masson
Amit Monga
Tim Smith
Ian Warrack, MD
APPENDIX 1 — PHYSICIAN UNIQUE VALUE PROPOSITION

(Backgrounder — Strategic Session 1)

Value in health care

The concept of “value” is being used with growing frequency in the health care field. Porter has proposed that value should be defined around the customer (patient) and that it should be measured in terms of the achieved outcomes and not by inputs or volume of services provided. The term “unique value proposition” is defined as the value that a consumer can expect to receive from the seller or provider, and which they cannot expect to receive from any other provider.

Value in the crowded health care field

Over the past few years there has been a proliferation of formally recognized health professions in Canada. In Ontario, for example, there are 27 regulatory colleges in the human health area that regulate 29 occupations. In addition, there are numerous other unregulated health occupations. A number of non-medical health occupations have some service offering in the area of primary care that has historically been provided by a general practitioner or family physician. Non-physician clinicians such as nurse anesthetists and endoscopists are also emerging in specialty care, particularly in the United States. Some of these professions aggressively promote their value; for example a common claim by nurse practitioners is that they can do 80% of what a family physician does.

Given the numerous competing value propositions in health care, it is not surprising that there exists an apparent erosion in the public’s perception of the value of the physician. A 2013 public opinion survey of Canadian adults reported the following findings:

- 34% of respondents agreed that physicians are the heart of the health care system;
- 23% of respondents agreed that physicians make a contribution to health care that no other provider is capable of; and
- 56% of respondents agreed that “nurses and pharmacists are as knowledgeable as my doctor”.

Additionally, challenges in meeting public expectations of access to care exist and may be contributing to the perception. A 2013 public opinion survey conducted across 11 leading industrialized countries found that at 41%, Canadians were least likely to see a doctor or nurse the same or next day the last time they needed one. At 29%, Canadians were most likely to report that they had waited two months or more to see a specialist.

In further qualitative research with the public, the concepts of knowledge and accountability emerged as best depicting the unique value that physicians bring to health care.
Value and the medical profession

The practice of medicine is defined around the patient through the patient-physician relationship, which is the core of the practice of medicine. The tenets of the patient-physician relationship are set out in the Canadian Medical Association (CMA) Code of Ethics, the first of which is: consider the well-being of the patient.\textsuperscript{vi}

The unique value proposition of the physician lies in the application of a comprehensive set of knowledge about health conditions that affect all body systems to:

- diagnose a patient, whatever the initial symptom(s) might be;
- design appropriate treatment plans; and
- be willing to be held to scrutiny for care provided through professionally led regulation and discipline that begins in medical school and encompasses the medical career lifecycle.

Knowledge

Canada’s medical graduates are trained to uniform high standards that rival the best found anywhere in the world. Entry into a Canadian medical school is subjected to a rigorous, highly competitive process through which fewer than one in five applicants are admitted each year.

Most medical schools require a minimum of three years of undergraduate university education, however, many applicants have advanced degrees at the master’s or doctoral level. In addition to high scholastic achievement in grade point average there is a rigorous interview process to assess applicants’ suitability to study medicine using tools such as the Multiple Mini Interview that assess non-cognitive qualities such as teamwork, empathy and communication skills.\textsuperscript{vii}

Canada’s 17 medical schools offer either a four-year (academic) or three-year (full calendar year) undergraduate medical degree program that must meet the North American accreditation standards of the Liaison Committee on Medical Education.

According to these standards the curriculum must include the following:

- biomedical content in anatomy, biochemistry, genetics, immunology, microbiology, pathology, pharmacology, physiology and public health sciences;
- behavioural and socio-economic subjects;
- coverage of all organ systems and including dimensions of preventative, acute, chronic, continuing, rehabilitative and end-of-life care; and
- clinical experiences in both outpatient and inpatient settings.

In addition to the scientific content, the curriculum must also address skills such as communication, collaboration and cultural sensitivity.\textsuperscript{viii}

Undergraduate medical education in Canada is an active process, not a passive one, and is mainly delivered via intense small group interaction with a trained preceptor focusing on solving real-life patient problems. This education is resource-intensive both in terms of the numbers and qualifications of the teachers. Successful completion of undergraduate medical education results in the conferment of a MD degree, which in itself is the first stage of medical training. Thereafter, virtually all medical graduates enter postgraduate training. This consists of either a two-year family medicine residency that is accredited by the College of Family Physicians of Canada (CFPC) or a four-year (or more) residency accredited by the Royal College of
Physicians and Surgeons of Canada (Royal College), either of which may be followed by further subspecialty training. Prior to entering residency training, medical graduates must pass Part I of the Medical Council of Canada Qualifying Examination (MCCQE), a computer-based test that assesses knowledge, clinical skills and attitudes. ix

Both the Royal College and the CFPC postgraduate training programs are based on the acquisition of the competencies that are necessary to function in each of seven roles effectively. These roles are collectively referred to as CanMEDS.

The central role is that of medical expert, whereby physicians apply their medical knowledge, clinical skills and professional attitudes to provide patient-centred care. The other six roles include:

- Communicator – having effective relationships and exchanges with patients and their families
- Collaborator – working effectively within a patient centered health care team
- Manager – participating in health care organizations and decision-making about resource allocation
- Health advocate – using expertise and influence to advance health and well-being of patients, communities and populations
- Scholar – commitment to lifelong learning and generating and disseminating new knowledge
- Professional – demonstrated commitment to patients through ethical practice, professionally led regulation and high personal standards x

Prior to becoming fully and independently licensed to practice medicine in Canada, medical graduates must pass Part II of the MCCQE which consists of a series of clinical stations involving a standardized patient. Successful completion of this examination confers upon a physician the designation of Licentiate of the Medical Council of Canada. xi At the end of residency training, applicants are eligible to sit for examinations of the CFPC or Royal College and the successful completion of these examinations is the normal requirement for successful licensure by a provincial or territorial medical regulatory authority.

Medical education requires of physicians a lifelong commitment to profoundly intensive learning, examination and continual medical education. It is the policy of the Federation of Medical Regulatory Authorities of Canada “that all licensed physicians in Canada must participate in a recognized revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transferable and formative.” xii

In order to maintain certification, the CFPC requires its certificants to complete a minimum of fifty hours of continuing professional development per year over a five-year cycle, and the Royal College requires four-hundred hours over a five-year cycle with at least forty hours per year.

Application

The practice of medicine is often described as both an art and a science. They come together through the exercise of clinical judgement, which Montgomery defines as “the practical reasoning or phronesis that enables physicians to fit their knowledge and experience to the circumstances of each patient”. xiii

Through the application of clinical judgement the physician is the architect of a comprehensive treatment plan that includes prevention, treatment, supportive care, and assessment or monitoring of treatment results. The treatment plan starts with the differential diagnosis that is the cornerstone of the application of medical knowledge.
Establishing a differential diagnosis is a four-step process:

- taking the patient’s medical history and creating a symptom list;
- assembling a list of all possible causes of the symptoms, with consideration of what is most probable, keeping in mind the atypical and most serious possibilities;
- prioritizing the potential causes by placing the most serious ones at the top; and
- sequentially narrowing the list of possible causes by working through the list, using observations and tests.

Once a diagnosis is established, a treatment plan is developed through a process referred to as “evidence-based medicine” (EBM). EBM is defined as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients”. As it was originally outlined in 1992, EBM involves the following steps:

- precisely defining a patient problem and the information required to resolve it;
- searching the literature to identify the best studies;
- applying rules of evidence to assess the validity of the studies; and
- applying the evidence to the patient, being sensitive to the patient’s emotional needs.

EBM, now more commonly referred to as “evidence-informed decision-making,” is used to inform a treatment plan, but is not the only process at work in the development of the plan. Treatment plans are developed in concert with the values and wishes of patients and their families.

Over the past decades, the application of EBM has been facilitated through the development of techniques such as meta-analyses that enable the amalgamation of results of many randomized clinical trials, which are then translated into tools such as clinical practice guidelines. Nonetheless, the practice of EBM must also recognize individual variation in physiology and pathology as well as patient values regarding quality of life and other issues. Individual treatment plans must be followed-up and evaluated.

**Accountability**

The core accountability of the physician is to the patient. The physician-patient relationship is an integral one. Optimally, this relationship is based on absolute trust and openness and allows for a free exchange of information between patient and physician. Physicians often see patients at their most vulnerable, when they are struggling with illness and disease. While other health care providers make significant and sometimes essential contributions to patient care, none maintain the unique fiduciary relationships that are at the heart of the physician’s role, and which are recognized by law.

Physicians are accountable to their individual patients in many important ways. They provide clinical services to their patients and optimize service availability so that patients can be seen and their needs addressed in a timely fashion. They follow up on test results. They facilitate consultations with other physicians and care providers and follow up on the results of these consultations when needed. They ensure that patients have access to after hours and emergency care when they are not personally available. They are stewards of the patient’s medical record and protect the confidentiality of the patient’s personal health information.

In Canada, physicians are held to account by the Colleges of Physicians and Surgeons in every province and territory. These regulatory bodies are responsible for the licensure and discipline of the medical profession. The colleges are in place to protect the interests of the patient and they are governed by a combination of public representative and physician directors.
It is increasingly recognized that physicians have an accountability to society and the health care system given that they hold responsibility for the majority of decisions surrounding the allocation of health care resources. This accountability is monitored through a variety of mechanisms including institutional review committees and payment agency audits.

With health care accounting for roughly one-tenth of economic activity in many industrialized countries, physicians are being called on to make the most efficient and cost-effective use of scarce resources. Cost is increasingly being recognized as an important element of value in health care. More generally, value is defined with reference to cost, such as “the worth of something compared to the price paid or asked for it.” Hence, Porter adds that value is defined as outcomes relative to costs, i.e., efficiency. The cost dimension of value is most likely to be addressed at a societal level, particularly in a system of universal publicly funded coverage. More recently, efforts are underway to bring value considerations into clinical decision-making. “Choosing Wisely” is one such initiative in which specialty societies are developing “Top 5” lists of tests and procedures that are relatively expensive and which have been shown by evidence to be of little or no benefit for a significant proportion of the patients for whom they are ordered. Choosing Wisely Canada was launched in April 2014.

**Conclusion**

Looking ahead there is an increasing demand for “social accountability” across society, including the business, public and civic sectors. Social accountability is a term that describes the process of how an organization engages with the society it serves to meet societal needs. For example, the World Health Organization defines the social accountability of medical schools as the “obligation to direct their education, research and service activities toward addressing the priority health concerns of the community, regions and/or nation they have a mandate to serve.” However, as it has been defined, the concept of social accountability needs to go farther.

It is recognized that physicians are granted a significant degree of social status, and clinical authority and autonomy within the health care system. In return for this status and authority, as part of what is often referred to as the “social contract,” physicians are accountable for the quality of care they provide to patients. All of this takes place within the ever-changing environment of team-based and patient-centered care. There is concern that there has been an erosion of accountability to the social contract on the part of physicians, evidenced by falling perceptions of physician value when compared to other health professionals. The medical profession must not fail to uphold its end of the social contract, and organizations such as the CMA have an important role to play in ensuring that physicians continue to advance the cause of medical professionalism as the society in which we work changes and evolves.

In conclusion, our research has told us clearly that the public views the medical profession as being unique in terms of the breadth of expert medical knowledge and also in terms of the degree of accountability to the patients themselves. The intensity of medical training, the continuous upgrading as new information becomes available, and the application of the best treatments available has made physicians stand out from other health professions. In addition, the educational, professional and legal oversight of physicians throughout their careers puts physicians clearly foremost in terms of the level of scrutiny to which the medical profession is subjected. In times when there are many players in the health care realm, the communication of these strengths to the public can ensure that patients and governments are in a position to place their trust in health care providers who offer effective care and who take unparalleled responsibility for their patients’ health.
Strategic questions

1. Do we understand sufficiently the unique value of the patient-physician relationship as it is seen through the eyes of the patient?
2. How should the physician unique value proposition be cast in the emerging environment of team-based care?
3. Is the continued reliance on fee-for-service undermining the physician value proposition in the emerging context of team-based care?
4. What does social accountability mean to the individual practicing physician and to medical organizations and is it an essential element of medical professionalism?
5. How will health care transformation enhance the physician unique value proposition?

References

4 Ipsos-Reid. Physicians’ unique value in changing times. Presentation to CMA General Council, August 2013.
5 Schoen C, Osborn R, Squires D, Doty M. Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries. Health Affairs 2013;32(12):2205-15.
7 See http://multipleminiinterview.com/.
17 Oxford Dictionary.
18 See www.choosingwisely.org.
19 See www.choosingwiselycanada.org.
Recent CMA activities

Policy resolution GC12-87 directed the Canadian Medical Association (CMA) to develop a comprehensive framework of end-of-life care policies.

To start, CMA began revising its policies on life-saving and -sustaining interventions, and on organ and tissue donation and transplantation.

Last August, General Council held educational and strategic sessions on care at the end of life, with a focus on advance care planning and palliative care. General Council passed a number of resolutions related to these issues to help form policy.

The Canadian Medical Association advocates for the integration of accessible quality palliative care services into community and chronic care service delivery models.

The Canadian Medical Association supports the integration of the palliative care approach into the management of life-limiting chronic disease.

The Canadian Medical Association supports efforts that will assist physicians in helping patients and families understand and develop advance care plans.

The Canadian Medical Association supports the development and availability to all physicians of training in advance care planning.

The Canadian Medical Association recommends that all relevant legislation be amended to recognize that any person whose medical condition warrants it is entitled to receive palliative care.

The Canadian Medical Association requests that all Canadian faculties of medicine create a curriculum for training in palliative care suitable for physicians at all stages of their medical education and in appropriate settings to the locale in which they practice.

The Canadian Medical Association supports the right of any physician to exercise conscientious objection when faced with a request for medical aid in dying.

The Canadian Medical Association believes that every person nearing the end of life who wishes to receive palliative care services at home should have access to them.

The Canadian Medical Association encourages all members to complete their own advanced care plan.

In October, the Board directed the Committee on Ethics to modify the terminology used in the policy on euthanasia and assisted suicide; these changes were made and were subsequently adopted by the Board of Directors in December 2013 (see page A2-2).
The Committee on Ethics is also overseeing revisions to related CMA policies including advance directives for resuscitation and other life-saving or -sustaining measures and the development of a new comprehensive palliative care policy.

To foster public discussion on end-of-life care issues, CMA co-hosted five public Town Hall dialogues with Maclean’s magazine and six members-only meetings. The meetings focused on advance care planning, palliative care and medical aid in dying. The town halls were held in

- St. John’s (Feb. 20)
- Vancouver (Mar. 24)
- Whitehorse (Apr. 16)
- Regina (May 7)
- Mississauga (May 27)

These meetings were extremely successful and well-attended. They were live streamed and are available for viewing at macleans.ca. A wide variety of views and opinions emerged during the discussions and a full report from the public town hall meetings is available here.

CMA also hosted a members’ online dialogue on these issues. Members were invited to share and discuss their thoughts using a discussion forum or a short poll. Over 1,100 members registered for the online dialogue, which is an exceptional participation rate for this type of initiative. A report from the members’ meetings and online consultation will be available later in the summer and prior to General Council.

**Current CMA policy**

The current CMA policy on euthanasia and assisted suicide states in part:

“Physicians, other health professionals, academics, interest groups, the media, legislators and the judiciary are all deeply divided about the advisability of changing the current legal prohibition of euthanasia and assisted suicide.”

“Canadian physicians should not participate in euthanasia or assisted suicide…”

“For the medical profession to … participate in these practices, a fundamental reconsideration of traditional medical ethics would be required.”

“The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues.”

The policy was last updated in 2014 to include a new section on terminology. This updated terminology states:

**Medical aid in dying** refers to a situation whereby a physician intentionally participates in the death of a patient by directly administering the substance themselves, or by providing the means whereby a patient can self-administer a substance leading to their death.

**Euthanasia** means knowingly and intentionally performing an act, with or without consent, that is explicitly intended to end another person’s life and that includes the following elements: the subject has an incurable illness; the agent knows about the person’s condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.
**Physician-assisted death** means that a physician knowingly and intentionally provides a person with the knowledge or means or both required to end their own lives, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as physician-assisted suicide.

**Palliative sedation** refers to the use of sedative medications for patients who are terminally ill with the intent of alleviating suffering and the management of symptoms. The intent is not to hasten death although this may be a foreseeable but unintended consequence of the use of such medications. This is NOT euthanasia or physician assisted death.

**Withdrawing or withholding life sustaining interventions**, such as artificial ventilation or nutrition, that are keeping the patient alive but are no longer wanted or indicated, is NOT euthanasia or physician assisted death.

**“Dying with dignity”** indicates a death that occurs within the broad parameters set forth by the patient with respect to how they wish to be cared for at the end of life. It is NOT synonymous with euthanasia or physician assisted death.

**Advance care planning** is a process whereby individuals indicate their treatment goals and preferences with respect to care at the end of life. This can result in a written directive, or advance care plan, also known as a living will.

**Palliative care** is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other symptoms, physical, psychosocial and spiritual.

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**Legal and legislative developments** (see Schedule A for overview)

**Ongoing Supreme Court appeal in Canada on physician-assisted death**

On Oct. 14, 2014 the Supreme Court of Canada will hear an appeal in the Carter case which concerns the legality of physician-assisted death in Canada.

CMA has applied to be an intervener in this case. In its application, CMA has noted that:

- if granted intervener status, CMA would appear before the Supreme Court as a “friend of the court”— not to offer a polarizing view on an already divisive issue
- this is a societal issue as noted in our current policy
- CMA will share a narrative of insights on the physician’s perspective. The goal is to provide the Court with a deeper understanding and appreciation of the findings from the 2014 dialogue on end-of-life care, the spectrum of options, the tensions and interplay in the current CMA policy perspective which is currently opposed but envisions further discussions on the policy such as access to palliative care and societal debate and discussion
- CMA as an intervener will not draw a black and white portrait for the court but highlight the complexities of this critical social, legal and ethical dilemma. We will also highlight the challenges posed to physicians’ understanding of their traditional roles if the Court were to change the law. At the time of writing, a decision on CMA’s application was not yet known but will be by the time General Council takes place
In the Carter case, the Supreme Court will be asked to decide whether the existing prohibition on physician-assisted death in the Canadian Criminal Code is unconstitutional under the Canadian Charter of Rights and Freedoms. The Supreme Court in the 1993 case of Rodriguez upheld the existing prohibition by a narrow margin of 5 to 4. A majority of the British Columbia Court of Appeal did the same in October 2013, citing the legal precedent from Rodriguez. The trial judge in Carter had reversed Rodriguez and found that the current prohibition was unlawful for certain categories of patients. It is anticipated that after the Supreme Court hears the appeal in October 2014, it will take several months for the Court to render a verdict.

Legislation in Canada: Bill 52 in Quebec

In late May 2014, the Quebec government re-introduced Bill 52, Quebec's legislation on medical aid in dying and palliative care. The Bill passed by a vote of 94 to 22 on June 5, 2014 in the Quebec National Assembly under a free vote. It is expected to come into force within 18 months after it comes into force. The components of Bill 52 are set out in Schedule A. The bill gained all party support prior to the call of the Quebec election in February 2014 and has been endorsed by several medical organizations in Quebec, including the Collège des médecins du Québec, the federations of general practitioners and specialists, the Quebec Medical Association as well as the Quebec Bar. Some physicians, particularly in the palliative care field in that jurisdiction, have spoken out against the law. It is anticipated that it will be subject to constitutional challenge by the federal government and others as unconstitutional on the grounds that the subject matter of the bill is within the federal Criminal Code. A motion to quash Bill 52 was filed with the Quebec Superior Court in early June 2014 by a physician and a patient residing in Quebec.

Private members’ bills in federal Parliament

Federal MP Stephen Fletcher introduced two private members’ bills on physician-assisted death in spring 2014. Mr. Fletcher’s bills appear to be inspired by the legislative regime in Oregon which has permitted physician-assisted death since 1997. The bills establish criteria for patient eligibility to seek physician-assisted death, the assessment process and the creation of a commission to provide oversight.

Internationally

Several American jurisdictions have established either by statute or case law physician-assisted death. In Europe, the Netherlands, Belgium, Switzerland and Luxembourg have established various regimes to set out who is eligible to receive physician-assisted death and euthanasia and how (see Schedule A).

Strategic questions

Delegates are asked to consider the following strategic questions for discussion and debate:

1. Do your patients have access to adequate palliative care services?
2. If not, what needs to be done to facilitate this access?
3. Should the CMA revise its current policy on euthanasia and assisted suicide?
4. If the law is changed in Canada to make euthanasia or assisted suicide legal how should the medical profession respond?
5. If access to palliative care services was universal, would it eliminate the need for euthanasia and assisted suicide?
**SCHEDULE A: LEGAL STATUS OF PHYSICIAN-ASSISTED DEATH (PAD) IN JURISDICTIONS WITH LEGISLATION**

### A) Patient eligibility for PAD at time of request

#### UNITED-STATES
- Washington
- Vermont
- Oregon

**PATIENT MUST BE:**
- An adult
- Competent/capable of making an informed decision and self-administering medication
- Resident of the state in which PAD will be performed
- Terminally ill (expected death within 6 months)
- Requesting PAD voluntarily

#### EUROPE
- Belgium
- Luxembourg
- Netherlands

**PATIENT MUST BE:**
- Adult, emancipated minor\(^4\) or minor\(^5\)
- Competent/Capable of making an informed decision and conscious\(^6\)
- Suffering from constant and unbearable physical or mental pain
- Terminally ill
- Requesting PAD voluntarily

#### LEGISLATIVE DEVELOPMENTS IN CANADA
- Quebec

**PATIENT MUST BE:**
- Of full age
- Capable
- In end-of-life\(^8\)
- Suffering from a serious and incurable illness
- Suffering from an advanced state of irreversible decline in capability
- Experiencing constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable
- Insured in the province of Quebec
- Requesting medical aid in dying (MAD) voluntarily

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**Key Points:**

The following analysis was framed in the context of the Carter case which challenges the legal status of PAD. These European jurisdictions recognize a patient’s right to both euthanasia and PAD. Quebec’s Bill 52 (An Act respecting end-of-life care) refers to medical aid in dying (MAD), which must be administered personally by a physician.

The term “terminally ill” is defined differently depending on the jurisdiction. In the US, the term refers to having a prognosis of 6 months or less, whereas in Europe, no specific timeline is required. Bill 52 follows the European model.

Bill 52 and the European jurisdictions recognize a patient’s psychological suffering as a factor whereas US jurisdictions are limited to recognizing physical suffering.

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1 The terminology used in this document is reflective of the definitions used by CMA in end-of-life discussions. See Appendix 2: Care at the end of life.
2 Montana and New-Mexico have recognized the right to PAD through court-rulings, see Statutory exception (Switzerland) and case-mandated (USA) PAD legal status (see p.8).
3 Switzerland provides physicians with a defense against prosecution for PAD, see Statutory exception (Switzerland) and case-mandated (USA) PAD legal status (see p.8).
4 Emancipated minors can qualify as eligible patients in Belgium; minors that receive consent from legal guardians are eligible in the Netherlands.
5 In the Netherlands, patients aged 16-18 who are deemed competent can receive PAD after parental/guardian consultation. Patients aged 12-16 who are deemed competent can receive PAD with parental/guardian consent. In Belgium, if the patient is a non-emancipated minor, a consultation with a pediatric psychiatrist or psychologist is necessary.
6 Patient consciousness is not required in the Netherlands.
7 Two Private Member’s Bills have also been introduced in Canadian parliament by MP Steven Fletcher, Bill C-581 and Bill C-582.
8 Term is undefined in Bill 52.
### B) Procedure to follow when a patient requests physician-assisted death

#### UNITED STATES
- **Washington**
- **Vermont**
- **Oregon**

**A PHYSICIAN MUST:**
- Receive an oral and written request (signed by two witnesses) from the patient
- Receive a second oral request from the patient 15 days later
- Confirm patient eligibility criteria (as stated above)
- Refer patient for second opinion by a consulting physician
- Counsel patient on conditions for taking the medication and offer an opportunity to rescind the request
- Fulfill documentation requirements
- Prescribe medication after a 48 hour waiting period

#### EUROPE
- **Belgium**
- **Luxembourg**
- **Netherlands**

**A PHYSICIAN MUST:**
- Receive a request from the patient
- Communicate with patient over a “reasonable period of time” to ensure patient eligibility (as stated above) and consent
- Inform patient of health condition, life expectancy and discuss palliative care options
- Believe that there is no other reasonable alternative other than PAD and that the request is voluntary
- Refer patient for second opinion by an independent physician
- Verify whether or not advance care directives have been registered

#### LEGISLATIVE DEVELOPMENTS IN CANADA
- **Quebec**

**A PHYSICIAN MUST:**
- Receive a signed form (Minister’s form) from the patient (or other, if patient is physically unable to sign)
- Confirm patient eligibility criteria (as stated above)
- Inform patient of prognosis and other therapeutic possibilities
- Communicate with patient at reasonable intervals to confirm MAD wish and persistence of suffering
- Refer patient for second opinion by an independent physician
- Take care of and stay with the patient until death ensues

### Key Points:
- All jurisdictions require a second opinion.
- The American jurisdictions require following a particular sequence of steps when a request is made.
- All jurisdictions require the consent to be considered and/or sustained over a period of time.

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9 In Vermont, the physician is also required to inform the patient of palliative care options. Patients in all states can be referred for psychological consultations to evaluate their capacity to make an informed decision.

10 In Belgium and Luxembourg the request must be in written form. If the patient is unable to sign the document, it can be done by a person designated by the patient.

11 Legislation in the Netherlands does not require the physician to discuss palliative care options with the patient.

12 In Belgium, if the patient is a non-emancipated minor, a consultation with a pediatric psychiatrist or psychologist is necessary.

13 Requirement to verify is applicable in Luxembourg through the National Commission for Control and Assessment. Also applicable in the Netherlands.
## C) Physician obligations and legal implications

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<tr>
<th>UNITED STATES</th>
<th>PHYSICIANS</th>
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<tbody>
<tr>
<td>Washington</td>
<td>- Do not have an obligation to participate in PAD</td>
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<tr>
<td>Vermont</td>
<td>- Cannot be professionally disciplined</td>
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<tr>
<td>Oregon</td>
<td>- Are protected from criminal and civil liability</td>
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<td></td>
<td>- Have no duty to intervene when a patient has self-administered lethal medication, no duty to prevent the administration</td>
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<td></td>
<td>- Who do not wish to participate in PAD have a duty to transfer patient care to another physician who can fulfill the request</td>
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<td></td>
<td>- Have a duty to report to the Department of Health or Department of Human Services</td>
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<td></td>
<td>- Cannot perform PAD in health care facilities that have policies against PAD</td>
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<tr>
<th>EUROPE</th>
<th>PHYSICIANS</th>
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<tbody>
<tr>
<td>Belgium</td>
<td>- Do not have an obligation to participate in PAD</td>
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<tr>
<td>Luxembourg</td>
<td>- Are not criminally liable for participating in PAD</td>
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<tr>
<td>Netherlands</td>
<td>- Who do not wish to participate in PAD have a duty to transfer patient care to another physician who can fulfill the request¹⁴</td>
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<td></td>
<td>- Have a duty to report all PAD to a commission</td>
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<td></td>
<td>- Can perform euthanasia following written advance care directives if all patient eligibility criteria are met and the patient is no longer conscious¹⁵</td>
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<tr>
<th>LEGISLATIVE DEVELOPMENTS IN CANADA</th>
<th>PHYSICIANS</th>
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<tbody>
<tr>
<td>Quebec</td>
<td>- Do not have an obligation to participate in MAD</td>
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<td></td>
<td>- Are not civilly liable for participating in MAD¹⁶</td>
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<tr>
<td></td>
<td>- Who do not wish to participate in MAD have a duty to notify the director of professional services who will ensure patient care transfer</td>
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<tr>
<td></td>
<td>- Have a duty to report all MAD to a commission</td>
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<tr>
<td></td>
<td>- Cannot perform MAD in palliative care hospices that have not included MAD in their policy</td>
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</table>

### Key Points:

In all jurisdictions there is no requirement to participate in PAD/MAD. Each jurisdiction has a process to transfer eligible patients if the attending physician declines to participate (not explicit in the Netherlands). All jurisdictions require mandatory reporting of all PADs/MADs to ensure compliance.

In the US jurisdictions and Bill S2, health facilities have the authority to exclude PAD/MAD from services offered on-site.

PAD/MAD cannot be included in advance care directives in American jurisdictions or in Quebec.

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¹⁴ No mention of this duty in legislation in the Netherlands.
¹⁵ Patients in the Netherlands must be 16 years of age or older to have an advance care directive that includes PAD.
¹⁶ Not expressly stated in the bill. The bill amends the following legislation: the Civil Code of Quebec, the Code of Civil Procedure, the Medical Act, the Pharmacy Act and the Act respecting health services and social services.
STATUTORY EXCEPTION (SWITZERLAND) AND CASE-MANDATED (USA) PAD LEGAL STATUS

SWITZERLAND

Switzerland has revised its Criminal Code to include a provision (Article 115) regarding physician-assisted death but does not have any legislation in place. Assisted dying organisations such as Dignitas and Exit Deutsche Schweiz have established patient requirements and physician guidelines to follow. The Swiss Academy of Medical Sciences, an independent foundation, has put forth medical-ethical guidelines and recommendations for the Swiss Medical Association members to follow when performing physician-assisted death. Other governmental legislative acts such as the Federal Narcotic and Psychotropic Substances Act (1951), could indirectly encompass requirements for physicians to follow when performing PAD. There are no residency requirements to be met by the patient, which explains the large influx of foreign patients receiving physician-assisted deaths in Switzerland.

MONTANA

Baxter v Montana; This 2009 Montana Supreme Court decision recognized a patient’s constitutional right to receive lethal medication from their physician. The patient must be competent and terminally ill to be eligible. This ruling creates a defense for physicians who are prosecuted and charged for assisting a patient in dying.

NEW MEXICO

Morris v New Mexico; This 2014 trial court decision in the state of New Mexico (judicial district surrounding Albuquerque only) recognized a patient’s fundamental right to receive their physician’s assistance in death. The patient must be mentally competent and terminally ill. This decision has been appealed.

ARTICLE 115

*Inciting and assisting suicide*

“Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.”

Reference List

UNITED STATES

http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245


EUROPE


BILL 52


Information current as of June 11, 2014.
Governance of the MD Group of Companies

CMA is the only medical association in the world to offer comprehensive financial services to members through a wholly owned financial services subsidiary. The MD Group of Companies is governed by the CMA Holdings (2009) Inc. Board, composed of independent physician and business directors and chaired by Dr. John Rapin. The Board meets quarterly to engage in oversight and strategic planning discussions, as well as partake in committees. The strong governance culture at MD is further strengthened by an Executive Leadership Team that promotes the adoption of industry-leading business practices.

- CMA Holdings (2009) Inc.’s Consolidated Financial Statements, as at Dec. 31, 2013, were reviewed by the CMA Holdings (CMAH) Board and are included under separate cover as Schedule B to the 2014 Audit Committee’s Report to General Council.
- 2013 Corporate performance highlights include:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net New Members</td>
<td>2458</td>
<td>2941</td>
</tr>
<tr>
<td>Assets Under Management (AUM)</td>
<td>$30.6B</td>
<td>$35.6B</td>
</tr>
<tr>
<td>Net New Dollars</td>
<td>$748M</td>
<td>$1278M</td>
</tr>
<tr>
<td>Private Investment Counsel AUM</td>
<td>$12.0B</td>
<td>$15.4B</td>
</tr>
<tr>
<td>Money transferred out of MD</td>
<td>$718M</td>
<td>$573M</td>
</tr>
<tr>
<td>Overall Employee Engagement Score</td>
<td>75%</td>
<td>83%</td>
</tr>
</tbody>
</table>

- Directors George Davie and Patricia Croft (see biographies on mdm.ca/about-md/who-we-are/leadership/board-of-directors) who add significant business acumen and governance expertise.

Strategy execution

At the end of 2012, the CMAH Board approved the 5-year Strategic Plan for MD Financial Management. The organization’s success in 2013, the first year of strategy execution, is characterized by the following highlights:
1. Organize MD around a clear and powerful purpose

- MD’s 2013 key operating priorities and annual operating plan were cascaded down through departmental goals and into individual employee goals. Disciplined business monitoring took place at an executive quarterly business review.

- MD CEO Brian Peters joined the CMA President and CMA CEO on their provincial/territorial medical association (PTMA) tour. This joint activity worked to align objectives and drive understanding of common challenges. MD is clear on its role in this triumvirate, as reflected in its mission, “to support the CMA and enhance the CMA/PTMA membership experience by assisting members throughout their lifetime to achieve financial well-being.”

- With the sale of its Electronic Medical Records business in early 2013, MD returned to focus fully on its core; financial services and total wealth management. To operate in the intensely competitive financial services market, against a backdrop of increasing regulation, MD has directed all of its internal energy and resources to providing fully differentiated financial advice and services to members, its primary contribution to the CMA value proposition.

- MD also partnered with CMA on the PTMA engagement strategy, and has been working on the CMA Strategy Refresh as part of the steering committee and working group, and acting as a full partner in the One Member strategy and resulting tactics.

2. Experience growth in all segments

- Prior to 2013, MD had been experiencing a multi-year gradual increase in the number of physicians leaving MD, while simultaneously suffering from lower than historical client acquisition. A strategic imperative for MD has been to reverse this trend through a “growth” agenda, focusing on attracting new physician clients across all segments, while increasing the number of physician clients who consider MD their primary financial services firm. In 2013, MD attracted 1,556 new physician clients to the firm, almost double the 2012 acquisition result of 920.

- Students and residents remain an important focus for future growth. MD has added 11 positions to serve this segment, working with universities to educate on the collective CMA/PTMA/MD value proposition. This value proposition was articulated through a tri-branded (CMA, MD, PTMA) welcome letter that was included in all medical school orientation packages. In addition, the welcome tradition of handing out backpacks to all first year medical students was continued. (photo: Students pick up CMA/OMA/MD-branded backpacks at the University of Toronto)
• To retain and attract practising and retiring physicians, MD showcased the unique delivery of personalized advice and best-in-class financial solutions with the 2013 launch of MD ExO™ – MD’s Expert Office of financial advisors and specialists. MD ExO™ is a branded reflection of what MD already does for clients every day. With a collaborative approach to total wealth management, MD advisors have the greatest ability to put the interests of their clients first by bringing the right specialists to the table at the right time. Helping MD client’s address their full range of financial goals is core to the MD service model and in MD’s experience, having a complete and unbiased view across multiple disciplines can deliver better outcomes.

• Also designed to serve practising and retiring physicians, MD Private Investment Counsel (MDPIC), the discretionary management arm of MD Financial Management, remained the largest independent private investment counsel firm in Canada (as ranked by Investor Economics in March 2013). MDPIC outpaced its competitors with growth of $1.28 billion over six months (ending June 30, 2013) the largest increase among all private investment counsel firms in Canada.

3. Bring increased value to physicians by way of new and exciting offerings

• MD’s new Alternative Investments had an outstanding debut for our Private Investment Counsel clients. The MDPIM Strategic Yield Pool and the MDPIM Strategic Opportunities Pool launched in 2013 have surpassed $1 billion in assets under management as of February 2014.

• MD provided timely US Passive Foreign Investment Corporation (PFIC) information to proactively help meet the needs of our US person clients—by creating and distributing comprehensive and authoritative information on the US PFIC rules, including details on how to file qualifying exemptions for MD funds as well as an Information guide to help potentially-affected clients take appropriate action.

• MD understands the needs and challenges facing medical students and residents and worked with National Bank in 2013 to expand the student / resident line of credit limits to keep pace with increased tuition and cost of living. To help offset any increased borrowing, MD worked with students and residents to develop a detailed debt management plan and budget. We continue to put our efforts toward helping them manage their education funding challenges.

4. Provide service excellence to members

• MD continued to excel in customer satisfaction in 2013 — reinforcing its promise to always put Physicians First. MD scored 770 on a 1,000-point scale for overall customer satisfaction in the 2013 Canadian Full Service Investor Satisfaction Study™ by J.D. Power and Associates. MD missed the top spot by only three points and scored well above the industry average of 737.

• MD is the only financial services firm to achieve five out of five Power Circles for four years in a row. This equates to “Among the Best” in the Power Circle Ratings™ on JDPower.com. In the study, MD also scored above the industry average in six out of seven categories: investment advisor; investment performance; account information; account offerings; and website, including the most favourable score in commissions and fees.
• In a 2013 independent survey by the Service Quality Measurement (SQM) Group, 94% of MD clients said they were “very satisfied” with their customer service experience with MD — compared to the wealth management industry average of only 74%. MD was also awarded the SQM First Call Resolution Improvement Award: when calling the MD Service Centre, our clients had their issue resolved on the first call 91% of the time (versus the wealth management industry average of only 73%).

5. **Inspire all stakeholders to believe MD is the best in all it does**

• In 2013, MD continued to deliver strong long-term performance. As of Dec. 31, Morningstar percentile rankings ranked MD number 1 in one-year and ten-year returns compared to bank-owned fund families. Morningstar rankings also indicated that MD had 12 funds with a ranking of three stars or better and 5 funds with a ranking of four stars or better as of Dec. 31, 2013, representing 97% of MD assets under management.

![Fund-weighted average Morningstar percentile ranking](image)

• MD filed an application in Canada and the US to patent its proprietary fund management process and protect associated intellectual property rights. The application is to also safeguard the exclusivity of this unique investment process for MD’s physician clients and their families. MD’s proprietary investment process goes far beyond common industry practice. Deep qualitative and quantitative research and analysis enable us to drive forward with an informed prediction of how each of our funds will likely perform in future, allowing for an enhanced probability of success in achieving performance objectives.

• MD continued to build its profile with financial services standards bodies. In November, MD was the diamond-level sponsor of Financial Planning Standards Council’s “Beyond the Numbers: CFP Professional Symposium,” helping to promote the importance of the financial planning profession. The sponsorship demonstrated MD’s commitment to financial planning expertise and advice, which is foundational to MD’s best-in-class solutions.

• MD grew its reputation for objective economic expertise in the financial services industry. Chief Investment Officer William Horton was a regular quarterly contributor on Canada’s national Business News Network (BNN) to discuss MD’s Tactical Asset Allocation strategies, Alternative Investments and to comment on other timely economic insights. Other appearances included participation at the 2013 Ontario Security Commissions (OSC) Dialogue as a featured panelist to discuss ‘Behavioural Economics and Investor Protection.’

• MD also demonstrated it is a top employer to potential employees by being named one of the National Capital Top Employers for 2013; and recognized as one of Canada’s Most Engaged Workplaces.
(Achievers) in 2013. Attributes such as corporate culture, collaborative environment, open leadership and effective teamwork helped MD earn this recognition.

6. **Strengthen the MD organization through a select set of transformative actions**

- The MD employee engagement survey had a participation rate of 93% (benchmark is 70%) with an 83% overall engagement score; in the top decile. The score for organizational vision was 80, up 10 from last year and 21 above benchmark. The score for “there is a strong feeling of team spirit and cooperation in the organization” was another high mark, landing at 74, 12 above last year and 25 above benchmark. This level of engagement reflects investments in leadership and culture and suggests that people believe in the mission of the company and willingly give discretionary effort—a key business driver.

- Over the course of 2013, MD leadership focused on a number of development initiatives targeted at increasing capability within the organization and providing additional value to its business and membership. MD continued its work with advisors and other customer-facing staff to heighten their awareness of physician needs, and how to serve them. For example, the Advisor onboarding curriculum was augmented with the Trusted Advisor program. This program focuses on providing advisors with the skills to strategically uncover needs, advise and build trusted relationships with their valued members and speak to their financial plans in the context of their overall financial objectives.

- Due to a fire, MD Head Office employees worked from their homes for most of 2013. These unusual circumstances drove leaders at all levels to try new forms of technology and to learn to manage outcomes rather than activity. This has led to a new level of agility at MD, and a new appreciation for teaming and collaboration. These skills were tested again in the summer flood in Calgary. In both instances, teams were able to focus on safety and ensured continuity in service to members.

- Head office employees were welcomed back to the 1870 Alta Vista building in early 2014, and greeted by a work environment designed to drive collaboration and results. The refit of the building included environmental benefits such as: sustainable and low environmental-impact materials; 30% reduction in water use; high efficiency appliances, heating and lighting; natural light and improved airflow. (photos: Jan 2013, Feb 2014)

**The road ahead**

2013 was an extraordinary year for MD. Business results were stellar and fueled by engaged employees motivated to provide exceptional member value. Changes made in 2013 will help MD focus on its original mandate: MD was created 45 years ago by CMA to help physicians put aside and grow their hard-earned income so it is available to draw down when they retire. To do this more effectively in 2014:

- MD will refresh its brand with a renewed focus on its core financial management services. The intent of this initiative is to strengthen the firm level relationship with clients, with an emphasis on growing the
number of physicians using MD as their primary investment management provider. To achieve this, MD must have a strong, well-positioned financial services brand. The unique value proposition must be well understood by members, clients, prospects, employees and new employee recruits, empowering clients and employees to assertively communicate the MD brand message. Results will be realized as both clients and employees become advocates for MD.

- MD is researching and testing approaches to delivering the exact client experience members want from their primary financial services firm. By delivering an experience that members can get nowhere else, CMA membership will grow and so will MD’s client base.
  - The first set of initiatives which includes the introduction of Service Standards, a New Client Onboarding Program, a Convenience and Choice Program and a policy around Client Response Times, all focus on driving a consistent, exceptional experience for our clients, offering more flexibility and increasing proactive relevant contact from the advisor and the firm.

- MD recognizes the transition to residency as an important stage in the physician life cycle. MD will provide a legacy gift of a leather (tri-branded) notebook to be handed out to first year residents. MD is developing a program in conjunction with PTMAs and residents to offer training to students on how to prepare for their Canadian Resident Matching Service (CaRMs) interviews.

- MD continues to focus on promoting the MD value proposition to the physician market. MD has developed lead generation programs leveraging multiple channels, including client events. Over 7,200 CMA members and family members attended events hosted by MD Regional Offices in 2013 and similar success is expected from these initiatives going forward.

- MD is designing a series of online offers to complement its face-to-face channel and enhance trusted relationships with clients. This will provide members in all segments additional opportunity to engage and extract value from the firm, where and when they want.

- MD is looking to implement an enhanced banking and lending offer along with a revitalized service model, to ensure MD can provide value to members, across their full balance sheet. This includes the launch of a differentiated MasterCard offer: all physician clients will soon qualify for the CMA/MD World Elite MasterCard.

- MD is working towards launching a new MDPIM Emerging Markets Equity Pool in July 2014. The launch of the new pool will allow clients to see their exposure to emerging markets as well as benefit from the ability to have strategic asset allocation for emerging markets separated from international equity.

- Building on the success of MDPIC, in February 2014, MD introduced the MD Strategic Yield Fund and MD Strategic Opportunities Fund into the MD Precision Portfolios, these two new funds will be available for direct investment in June 2014.
  - The MD Strategic Yield Fund invests in exchange-traded funds (ETFs) that provide investors with access to yield-generating fixed income and equities—including global bonds, emerging-markets debt and preferred equities. The MD Strategic Opportunities Fund invests in ETFs that provide investors with access to real estate investment trusts (REITs), infrastructure, commodities and small cap equities from around the world.

As always, MD is working with the industry’s top investment managers to ensure a defensive, but also participative investment strategy designed to weather whatever ups or downs 2014 might bring. In summary, MD is well equipped to help physician clients and their families continue to build wealth and capitalize on opportunities that ensure they meet their personal and professional goals.