A Balanced Blueprint For The Future
“I think the CMA is the lead organization in Canada to protect the health care rights of all Canadians. The CMA needs to continue in its leadership role to enhance the quality of health care in Canada and improve the timely delivery of this quality health care to all Canadians. The CMA is the main voice of reason in health care reform, which brings balance and understanding of the needs of patients and physicians in ensuring the timely access to quality health at an affordable cost.”

(Consultation Respondent)
# Governance Review Report and Recommendations

*Canadian Medical Association Board of Directors* | Developed following the work of the Governance Review Task Force

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EXECUTIVE SUMMARY

The Need

There are two fundamental reasons for the CMA to consider changes to its governance structures and processes:

- **CMA’s existing governance falls short of accepted exemplary governance practices and this will increasingly impede the organization’s ability to perform effectively and to meet members’ expectations.** Areas of particular concern raised by directors, stakeholders and members, include:
  - uncertainty about roles, responsibilities and authorities among various governance bodies (e.g., General Council and the CMA Board of Directors);
  - complexity of the existing governance structure and the negative impact this may have on members’ perceptions of their ability to participate; and
  - constraints on CMA’s ability to respond quickly and effectively to environmental challenges.

- **The CMA needs to achieve greater connection, engagement and relevance for members.** Many members want a stronger connection to CMA, and, in fact, some view CMA as a closed organization in which participation is difficult and where there is insufficient transparency and accountability.

The Approach

The CMA Board of Directors struck the 12-member Governance Review Task Force (GRTF), headed by Dr. Dan O’Brien, PhD, an individual external to organized medicine who brought objectivity and many years of senior governance experience to the challenge, to consider CMA’s governance processes and structures and to provide advice on recommendations for improvement. Over its 15 months of deliberation, the Task Force applied a consultative, rigorous and open-minded approach to governance review. The Task Force benefited from extensive physician consultation, the expertise of external governance specialists, and a benchmarking study of governance best practices. As it moved forward, the Task Force returned to consult with members continually with options. The Task Force then refined those options to respond to the concerns, questions and suggestions received.

The development of this report involved:

- a national online consultation open to all physicians and physicians in training, that attracted feedback from over 2,500 members;
- best practices research performed by the Institute on Governance nationally and internationally;
- extensive face-to-face consultation with provincial and territorial medical associations, specialty societies, CMA core councils and committees, focused-interest medical associations and in effect, any physician body that had an interest in the subject matter and wanted to be heard;
- distribution of draft options by mail and on the CMA’s Web site, and ongoing collection and synthesis of feedback; and
- many hours of deliberation, revision and critical thinking.
“In my 50 years as a physician, I believe the CMA has moved a long way in the past few years in the right direction for better governance. Even this survey seems to me to be an excellent improvement.”

(Consultation Respondent)

Solutions

This report represents the consensus recommendations of the CMA Board, informed by the iterative approach of the GRTF to the development of its thinking and advice to the CMA Board. The Task Force issued a number of reports for consultation with each version evolving as the Task Force found innovative ways to respond to the needs and aspirations expressed by the CMA membership.

While it is impossible for a governance system to be all things to all people, these recommendations demonstrate that the CMA has listened to members when they said they wanted a national association that stressed both agility and representativeness. It was a tall order, but the solutions contained herein represent a step forward in both regards, and a blueprint that is respectful and responsive to all the different views expressed openly and constructively by stakeholders during the consultation process.

Task Force consultations suggest there is strong support from stakeholders and members to pursue governance change. This support was not for “revolutionary” structural changes, but rather for an “evolutionary” process whereby the organization may move incrementally toward a presumed “ideal” approach. The recommendations herein will achieve real and meaningful improvement to CMA’s governance processes and structures and should be supported by CMA’s stakeholders at this time.

There is support to maintain the primarily federated structure of CMA’s governance systems (i.e., representatives are primarily selected through provincial and territorial medical associations); however, there is a need for a greater member focus within the CMA’s primarily federated governance system. This report and recommendations reflect this fundamental effort.
To address the concerns identified, these recommendations focus on specific areas such as General Council, the Board of Directors, the CMA advisory structures, as well as member communication and engagement.

- **The function of General Council as the legislative authority,\(^1\)** and its role in providing high-level policy guidance and direction for the CMA, should be clarified, reaffirmed and strengthened. General Council should continue to be a representative body composed largely of delegates selected on a jurisdictional basis and responsible for the election of the CMA Board and various legislative functions such as setting fees, appointing the auditor and approving changes to the CMA Bylaws.

- **The CMA Board of Directors should be the principal executive authority\(^2\)** for CMA governance, and the number of Board members should be reduced. In addition, structural changes - such as eliminating the use of alternates – and a focus on orientation, training and functionality will help mitigate conflicts of interests and constraints on the ability of directors to fulfill their fiduciary duties.

- **The CMA Board of Directors should restructure its existing core councils and committees to enhance their efficiency, responsiveness, grassroots involvement and accountability to the CMA Board, in addition to continuing to use focused, time-limited and policy-specific task forces to do the work necessary to achieve the strategic plan objectives.**

- **Specific measures should be undertaken to enhance the transparency of CMA governance to members and to facilitate participation.** These measures must focus on improved two-way communication and engagement, and nurture opportunities for potential new leaders.

A summary of specific recommendations related to these fundamental changes is attached as Appendix A.

CMA has accomplished much over its 140 year history, and it continues to make progress towards its dual vision - *A healthy population and a vibrant medical profession*. However, in an increasingly complex and fast-paced environment, particularly for the patients and members CMA seeks to serve, it will continue to be more important that governance structures and processes facilitate this vision rather than impede it. These recommendations serve this goal and will serve CMA well going forward. They are recommended to General Council for adoption in their entirety.

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\(^1\) **Executive Legislative Authority**: the body that enacts the laws/policies within an organization or entity

\(^2\) **Executive Authority**: the body that puts laws/policies into execution and administers them
1.0 INTRODUCTION

The GRTF was established by the CMA Board in February 2007 to examine CMA’s governance processes and structures – including General Council and the Board of Directors – and to bring forward recommendations for improvement to the Board for presentation to General Council. The Task Force was directed to consult widely with interested constituencies. Appendix B contains the terms of reference and membership of the GRTF.

The Task Force took its consultative role very seriously. Appendix C provides a detailed summary of the consultations it undertook. This included:

- electronic survey of approximately 130 members of CMA’s e-panel in July 2007;
- information and consultation session at the CMA annual meeting in August 2007;
- online member consultation workbook accessed by more than 2,500 members in October-November 2007;
- two separate written consultations with provincial and territorial medical associations, affiliate societies, core councils and committees, General Council delegates, and past officers; and
- numerous face-to-face and teleconference presentations to the CMA Board of Directors, provincial and territorial medical associations, CMA councils and committees, and past officers.

The Task Force commissioned research, and received a report by the Institute on Governance about exemplary governance practices and benchmarking against like organizations. It has also considered extensive work done by previous task forces on governance and other CMA committees. The Task Force was well informed by the list of issues referred to it through the CMA Board of Directors.

As noted in Appendix C, the Task Force released in January 2008 a consultation document entitled Proposed Direction and Areas for Change for CMA’s Governance Structures and Processes. In March 2008, the Task Force released a further Draft Report and Recommendations for consultations. It then considered further input and feedback prior to providing final comments to the CMA Board of Directors in late May. The CMA Board has utilized the information provided by the Task Force throughout the process in developing this report and recommendations.
2.0 RATIONALE FOR CHANGE

There are two main reasons for the CMA to consider changes to its governance structures and processes:

- **CMA’s existing governance falls short of accepted exemplary governance practices and this will increasingly impede the organization’s ability to perform effectively and to meet members’ expectations.** Review of exemplary practice, as well as benchmarking against comparable organizations, demonstrates that CMA’s performance and effectiveness may be limited by its current governance processes and structures. Areas of concern raised by directors, stakeholders and members include:
  - uncertainty about roles, responsibilities and authorities among various governance bodies (e.g., General Council and the CMA Board of Directors);
  - complexity of the existing governance structure and the negative impact this may have on members’ perceptions of their ability to participate; and
  - constraints on CMA’s ability to respond quickly and effectively to environmental challenges.

As evident in consultations with General Council delegates and members, the CMA does not perform as well as it should against the governance principles (see box) identified by the Task Force and it is likely to become more difficult to maintain peak effectiveness without a more appropriate governance structure.

- **CMA needs to achieve greater connection, engagement and relevance for members.** Research conducted by the Task Force, as well as other CMA research, shows that many members are seeking a stronger connection. In fact, some view CMA as a closed organization in which participation is difficult and where there is insufficient transparency and accountability. Many respondents to the online member consultation said they found it hard to become engaged and they did not feel informed about the rationale for significant decisions made by the CMA. CMA’s governance processes and structures need to address these concerns and support the organization’s efforts to become more member-focused.

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**Seven Principles for Sound Governance**

1. Legitimacy and voice
2. Performance
3. Direction
4. Participation
5. Accountability and transparency
6. Coherence and practicality
7. Respect and fairness
3.0 PROSPECTS FOR CHANGE

While the points above illustrate the rationale for change, there is strong support from stakeholders and members for pursuing significant change. At General Council, almost 90% of delegates and observers attending the Governance Review Information/Consultation Session spoke in favour of “significant” or “fundamental” change to CMA’s governance. There was also strong support from respondents to the online member consultation for a re-examination of governance that would take into greater account members’ needs and wishes.

During its consultation, the Task Force heard that the CMA needs to resolve whether it is a “federation” or a “member-based” organization. This appeared to be based on a perception that there is an inherent tension between these two apparently polarized options, and the suggestion that CMA must choose one approach at the exclusion of the other.

CMA’s governance structures are predominantly federated in their current form, i.e., representatives are primarily selected through provincial and territorial medical associations. The Task Force heard support to maintain this system, and the Board of Directors believes the CMA should maintain its current approach. However, there is a need for greater member focus within the CMA’s primarily federated governance system. The recommendations which follow reflect this fundamental recommendation.

1 Of those polled, 87% indicated that the CMA should undertake either fundamental reform (25%) or significant review (62%)
4.0 EVOLUTIONARY CHANGE AND THE NEED FOR EVALUATION

In studying the issues and developing recommendations, the Task Force studied what external research and governance theory might suggest as exemplary practice. However, it was also just as important to focus on the particular realities of CMA’s history, political environment and corporate culture. Consultations did not suggest a ground swell of support for “revolutionary” structural changes, but rather for an “evolutionary” process whereby the organization may move incrementally toward a presumed “ideal” approach. The recommendations herein will achieve real and meaningful improvement to CMA’s governance processes and structures and should be supported by CMA’s stakeholders at this time.

A healthy organization will evaluate its governance processes and structures regularly to ensure that they are serving the needs of the organization and not hindering the achievement of its vision, mission and strategic plan. This should involve both ongoing evaluative processes, and more formal review processes on an intermittent basis. Given the evolutionary nature of some of the changes recommended by the Task Force, it is even more important for the CMA to engage in both ongoing review and a systematic evaluation in the future. This will allow an evaluation and identification of areas where CMA is ready to move “closer” to a perceived ideal for its processes and structures, as well as an identification of those changes which have not succeeded or are hindering CMA.

In addition to ongoing review of the impact of the changes to CMA’s governance processes and structures, the CMA Board of Directors should ensure that a formal review of the impact of the changes is conducted within five years of their implementation.
5.0 CMA GOVERNANCE: INTERCONNECTED STRUCTURES AND PROCESSES

A review of CMA’s existing governance systems, as well as examination of the structures of similar organizations, illustrates that the individual components to the recommendation for change are strongly interconnected. They should not be considered in isolation from each other. Changes to governance structures can significantly impact processes, and changes to roles and functions will often necessitate changes to structures. Similarly, the role and structure of the primary governance body (e.g., the Board of Directors) will have an impact on the role and structure of its advisory bodies.

Function (roles and responsibilities) should ideally be determined before form and structure are addressed. This report addresses the issues identified, and then articulates the appropriate function for each of the key areas and the recommended structure. The proposed functions and structure for each area – General Council, the CMA Board of Directors, advisory structures, members and staff – should be considered in context with all changes recommended. Each area may affect several others, and a particular recommendation may be best understood when viewed along with all other suggested recommendations.

5.1 GENERAL COUNCIL

Issues
One fundamental concern for those involved with the governance of the CMA has been confusion and an apparent lack of clarity regarding the authority and responsibility of General Council relative to that of the CMA Board of Directors. Concerns were expressed about the ability of General Council, composed of approximately 300 physicians, meeting once per year, to provide meaningful guidance and direction to the CMA Board of Directors. Conversely, concerns were also expressed about General Council attempting to provide direction to the CMA Board of Directors on matters for which it was not equipped, or on particular detailed management or implementation issues that were inconsistent with its broad, policy-making role.

Roles, responsibilities and authorities
While Task Force consultations suggested some confusion about the authority and responsibilities of General Council relative to that of the CMA Board of Directors, there was remarkable consensus on what the roles, responsibilities and authorities should be. All felt that General Council should provide high-level policy guidance and direction to the Board, and the Board should in turn be accountable to General Council for how it acted on that direction between meetings of General Council. One of the key mechanisms for this is General Council’s role in electing the Board of Directors, in addition to the other positions it elects. Similarly, there was consensus that General Council should retain its legislative authority\(^4\) and should approve membership fees, auditors and changes to CMA Bylaws. It is recommended that CMA Bylaws be amended, if necessary, to provide clarity to this authority, roles and primary functions.

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\(^4\) Legislative authority: the body that enacts the laws/policies within an organization or entity.
Structure
Consultations, as well as benchmarking against similar organizations, indicate that it is vitally important that a large national organization like the CMA provide a mechanism for broad representation, often based primarily upon the provinces and territories and their relative size. General Council currently serves this role as the representative body, with the majority of delegates representing provincial and territorial medical associations as per the CMA’s primarily federated governance model. This is supplemented by representatives of affiliated societies and delegates appointed by virtue of the office they hold (e.g., Board of Directors) or formerly held (i.e., past officers). This representational mandate for General Council must be continued and should be highlighted.

“Leadership that is deeply respectful of its entire membership, takes a long-term view and constantly tries to make little improvements for its membership every day — these attributes will get members behind the organization, keep interest high and go far to achieving the goals sought out by the CMA.”

(Consultation Respondent)

Recommendation 2
The function of General Council as the legislative authority, and its roles in providing high-level policy guidance and direction for CMA, should be clarified, reaffirmed and strengthened.

Recommendation 3
General Council’s primary functions, which in some cases should be strengthened, should continue to be:
• providing high-level policy guidance and direction to the organization in general and the Board of Directors in particular;
• electing the Board of Directors;
• approving membership fees and the appointment of auditors; and
• approving changes to the CMA Bylaws for subsequent confirmation at the annual meeting.

Recommendation 4
General Council should continue to be a representative body composed largely of delegates selected on a provincial and territorial basis according to relative size.
One issue that did emerge during the consideration of the structure of General Council was the potential influence of the growth in the number of affiliate societies on the relative balance of voting, since each society receives a voting delegate to General Council. Affiliate societies can generally be divided into two types:

- those representing specialties as recognized by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC), known as specialty societies; and
- those not representing specialties, but rather representing a group of at least 100 physicians (and potentially non-physicians) who have come together on the basis of a common interest, referred to by the Task Force as focused-interest medical associations (FIMAs).  

In both cases, to be granted affiliate status a majority of members of the organization must be physicians and CMA members. Under CMA Bylaws, organizations wishing to be granted affiliate status apply to the CMA Board, which forwards recommendations to General Council for approval.

While there is a relative limit on the number of specialty societies that might apply for recognition as affiliate societies by the CMA (based on RCPSC and CFPC classification), concerns have been expressed about the potential growth in the number of FIMAs seeking affiliate status. This also brings the concern that participation of FIMAs in particular can result in unbalanced access to General Council for members such that one member might have their vote represented at the provincial/territorial level and through one affiliate (e.g., their specialty society), while another might have their vote represented at the provincial/territorial level and their specialty society and through many different FIMAs to which they belong.

In considering this matter, attention should be paid to the benefits of affiliate status for these FIMAs. These include a voting delegate to General Council, representation on the Committee of National Medical Organizations, and access to certain staff benefits for their employees. Most importantly, affiliation brings with it a perception of a special bond between the affiliate and the CMA that allows the organizations to work together. As such, it is important to maintain a mechanism for FIMAs to access staff benefits for their employees and for the organizations to forge a special working relationship with the CMA. However, for the reasons outlined above, these organizations should not continue to have a vote at General Council.

The unique contributions that the Canadian Federation of Medical Students and the Canadian Association of Internes and Residents have made as CMA Affiliate Societies must be recognized. This has been perceived as an ideal mechanism to enhance the ability of CMA to connect with these very critical segments of its membership. As such, CFMS and CAIR should continue to enjoy Affiliate Society status as an exception to this recommendation.

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5 A listing of CMA affiliate societies, according to whether they are specialty societies or FIMAs, is attached as Appendix D.

**Recommendation 5**

Status as an affiliated society of the CMA should be limited to specialty societies including family medicine/general practice as recognized by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Canadian Federation of Medical Students and the Canadian Association of Internes and Residents should continue to enjoy status as affiliated societies as special exemptions.
FIMAs have provided important perspectives to General Council, on the basis of the special focus and knowledge that they inherently bring. For example, the Canadian Medical Protective Association (CMPA) and the Federation of Medical Regulatory Authorities of Canada are just two organizations that can bring vital information and perspectives to the debates at General Council. This perspective — rather than a vote — is critical to General Council and should be maintained. The collaboration and cooperation between these organizations and the CMA must also be maintained, and in fact, enhanced. Through the creation of an Associate Society status within CMA Bylaws, a mechanism can be provided to facilitate FIMAs providing vital perspectives to General Council (i.e., with their representative automatically invited and able to speak to General Council), as well as providing sustained access to CMA employee benefits to the FIMA employees. Similarly, collaborative and cooperative relationships between the CMA and these organizations can be maintained and enhanced through other bilateral (e.g., Memorandums of Understanding) and multilateral mechanisms (e.g., the CMA has recommended that the CMPA be added to the voting membership of the Canadian Medical Forum).

**Recommendation no. 6**

An associate society status should be created within CMA Bylaws for organizations that do not meet the amended criteria for CMA affiliate society status, and such status should include observer status at General Council such that General Council may continue to benefit from the particular perspective brought by these organizations.

“I think that the answer to this question will flow from the answer to the question: what exactly is the CMA for? Who does it serve - it cannot serve everyone as each group has its own vested interests. Perhaps this answer already exists and I am just not aware of it.”

(Consultation Respondent)
To begin to address the goal of increased connection between CMA members and the governance structure (particularly suggested by the online member consultation), it is important to ensure that members are aware of the mechanisms by which they can participate in General Council as delegates. To this end, efforts should be made to encourage and publicize any opportunities for grassroots members to be elected or selected to be General Council delegates by provincial and territorial medical associations. Such delegates might be chosen from an actual election at the provincial/territorial medical association (e.g., during annual election processes or at the annual meeting), or they might be selected from a call to the general membership in that constituency. The mechanism should be left to the discretion of each jurisdiction.

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"The people involved in governance should reflect the membership – i.e., MDs. There should be a wide variety of MDs to represent different regional and socio-ethnic backgrounds as well as the different branches of medicine"

(Consultation Respondent)

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**RECOMMENDATION 7**

Provincial and territorial medical associations should be encouraged to consider allocating an increased percentage of their General Council delegation for members-at-large elected or selected directly from the general membership of that jurisdiction.
Past CMA officers (presidents, chairs of the Board, speakers of General Council, secretaries general and CEOs) are currently ex-officio voting delegates to General Council for life. This practice is highly unusual and does not reflect current theory on exemplary governance practices, which suggests that individuals may lose touch with the issues of the day after a certain period without active involvement. Past CMA officers often provide very valuable perspective and information for the benefit of General Council, particularly in relation to past experience. As well, for the initial period following the conclusion of the term as a sitting officer, past officers maintain some currency in relation to the unique information and experience they have accumulated. However, this does not necessitate or justify an ongoing and permanent vote or franchise at General Council.

As such, past officers should be entitled to voting delegate status at General Council for five years following the termination of their term of office. After five years, they would be eligible to attend General Council as observers with the right to address General Council. As well, past officers are always eligible to be selected/elected as a General Council delegate by their provincial/territorial medical association. As well, the CMA should continue its current practice of financially supporting the attendance of past officers at General Council, irrespective of their voting status. Finally, this should be implemented immediately with all current past officers continuing to vote at General Council for the five years following implementation. This change will require amendments to the CMA Bylaws.

**no.8 RECOMMENDATION**

Past officers should be entitled to be voting delegates at General Council for five years following the completion of their terms of office. Subsequently, they should continue to be invited to General Council as non-voting observers. Existing past officers at the time of implementation of this recommendation should be entitled to voting delegate status at General Council for five years following the date of implementation.
Process and implementation

In considering mechanisms by which to strengthen General Council as the CMA’s primary representative body and its role in providing high-level policy guidance and direction to the Board of Directors, the Task Force consulted with stakeholders and members on the possibility of conducting two meetings of General Council per annum. While there was some support for this option as a mechanism to allow General Council to better inform and to hold the Board of Directors accountable for its stewardship, the more commonly expressed view was that efforts should be focused in the first instance on improving the existing meeting of General Council.

Mechanisms to accomplish this include enhanced and improved education and orientation for new and existing delegates, focused efforts by General Council itself, through the speaker and deputy speaker, examining how to improve General Council, and better use of advisory structures within the organization in facilitating the General Council agenda and supporting materials.

To improve the quality and effectiveness of General Council:

- education and orientation efforts should be focused on ensuring new and existing delegates to General Council have clarity and certainty as to the role of General Council and their responsibility as a delegate;
- the speaker and deputy speaker should be asked to consider how to best make meetings of General Council more effective, efficient and meaningful for delegates; and
- efforts should be made to utilize CMA’s advisory structures in advance of General Council to facilitate meaningful debate.
“ The current structure is too complex. The executive and Board of Directors should have the agility and information to deal with most issues quickly. This agility should come from the supporting structures (committees, General Council, affiliates etc.) having identified areas of consensus and controversy well in advance of any required action.”

(Consultation Respondent)

5.2 BOARD OF DIRECTORS

Issues
In the course of consultations, there were many expressions of concern that the division of roles, responsibilities and authorities between General Council and the CMA Board of Directors requires clarification. As well, stakeholders expressed concerns about the size of the Board and suggested that this limited the ability to have meaningful debate. Finally, there have been concerns within the Board with respect to the understanding of Board members’ fiduciary responsibilities. The Task Force’s review of exemplary practices also highlighted the difficulties associated with a large Board and the importance of ensuring that fiduciary responsibilities are well understood, particularly where directors may be viewed by some as “representing” a particular constituency.

Roles, responsibilities and authorities
The review of exemplary practices, benchmarking and input from stakeholders and members suggests that the CMA Board of Directors should be the principal executive authority for CMA governance. In fulfilling this role, the members of the Board act as fiduciaries, which means in law that they have a duty to act primarily for the benefit of the CMA and its members. There are legal responsibilities and specific accountabilities as a Board Director, such as the duty of good faith. These liabilities pertain to the Board Director as an individual and as a collective Board. Thus, the Board must have full authority to act for the CMA, but be accountable to General Council for those actions. In practice, this means that General Council will elect the Board of Directors and provide it with policy direction and guidance. However, when acting on this direction, the Board of Directors must consider all information at its disposal, including information that may not have been available to General Council. General Council is then able to hold the Board accountable for its actions at the next meeting, when the Board reports back.

RECOMMENDATION 10
The CMA Board of Directors should be the principal executive authority for CMA governance.

Executive Authority: the body that puts laws/policies into execution and administers them.
Structure

A common theme in stakeholder consultations has been the suggestion that the CMA Board of Directors, which now has 34 members, is too large. Many think the current size makes effective and efficient deliberations very difficult. This conclusion is supported by the review of exemplary practices and benchmarking against similar organizations. In fact, exemplary practice points to a Board size of somewhere between 10-12 directors.

In the course of consultations, questions were raised about why directors needed to be assigned on the basis of jurisdictions, particularly given the role of General Council as a representative body. While the ideal nature of a Board selected only on the basis of the characteristics of the individual director is understood, it must also be recognized that the traditionally federated nature of CMA’s governance model has served the organization well and should be preserved. Similarly, while there is some merit to an approach in which there would be only one director per jurisdiction, there is greater merit at this time to recognizing the need for more directors to adequately bring forward the perspective of more populous provinces.

In clarifying the CMA’s executive authority and strengthening General Council’s role as the representative legislative authority, it should be possible to reduce somewhat the emphasis on jurisdictional representation at the CMA Board of Directors. For example, it is not necessary to continue to appoint an additional Board member every time the total number of CMA members in a specific province or territory exceeds the thresholds of 2,000 and each additional 5,000 members respectively. Rather, a threshold of an additional director for every 6,000 members still provides an appropriate voice and perspective from more populous jurisdictions.

In its consultations the Task Force put forward the option that the president, past president and president-elect be considered and counted as directors from their home jurisdiction. This was put forward on the premise that CMA presidents could adequately bring forward the perspective of physicians from their home jurisdiction. Further, this reflected the belief that directors are not expected to represent a particular jurisdiction, and the fiduciary duty to put the interests of CMA first is identical for both directors and those occupying presidential positions. However, many noted that it is unreasonable and perhaps impractical to ask an individual focusing on the role of president-elect, president or past president to also take on the task of bringing forward the perspective of physicians from his or her home jurisdiction.

It is also recommended that the chair of the Board of Directors be chosen by the Board of Directors. This reflects exemplary practice, as the primary role of the chair is to facilitate Board meetings and the Board is in the best position to identify the most skilled individual for this responsibility. However, as the Board chair is not generally entitled to speak to discussions at the Board table, if the chair comes from within the Board itself the director position vacated upon the election of the Board chair should be filled so as to ensure that the voice and perspective of physicians from that particular jurisdiction is not lost. The Board should be empowered to choose someone not on the Board to act as chair if the Board believes this will best allow it to complete its business.

As well, the honorary treasurer should be chosen by the Board of Directors from among the members of the Board. In this case, the honorary treasurer does not lose his or her ability to speak to issues and provide the voice and perspective of the jurisdiction from which he or she came, and therefore there is no need to elect an additional director.
Finally, the affiliate director position should be eliminated. The other director positions provide a mechanism to ensure that the perspectives of all CMA members, including medical students and residents, can come forward to the CMA Board. An affiliate director position seems to suggest a need for organizations to be represented at the CMA Board. Although such an approach may have served the CMA in a particular time and situation, it is no longer appropriate. Through bilateral and multilateral interactions, the CMA can ensure that it understands the needs and perspectives of these organizations.

Given the above factors, it is recommended that the CMA Board of Directors be reduced, such that membership at this time will result in 25 members. This change will require amendments to the CMA Bylaws.

The CMA Board of Directors should comprise the following membership:

<table>
<thead>
<tr>
<th>Position</th>
<th>Number of Directors - based on threshold of 1 director per 6,000 CMA members in that jurisdiction and current membership data.</th>
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<tbody>
<tr>
<td>President</td>
<td>1</td>
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<tr>
<td>President-Elect</td>
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<td>Past President</td>
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<tr>
<td>Chair of the Board</td>
<td>1 (Chosen by the Board, with an additional director appointed if chosen from the Board)</td>
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<tr>
<td>Honorary Treasurer</td>
<td>Chosen from within the Board</td>
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<td>Alberta</td>
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<td>British Columbia</td>
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<td>New Brunswick</td>
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<td>Newfoundland and Labrador</td>
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<td>NWT/Nunavut</td>
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<td>Nova Scotia</td>
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<td>Prince Edward Island</td>
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<tr>
<td>Resident</td>
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“In other organizations what seems to be working is that a group of dedicated, approachable, selfless individuals work together to achieve the objectives of the organization. These representatives have a clear understanding and experience in the system and are open to ideas and problems on a one-to-one basis with the doctors they represent.”

(Consultation Respondent)

Along with the consideration of the size of the Board of Directors, the issue of the length of term for directors also merited review. The CMA Bylaws currently provide for three-year terms for provincial/territorial directors, renewable once, and one-year terms for student and resident directors and officers. While the complexity of the role of a CMA director may suggest the need for longer terms to allow directors to become well educated about their role and the CMA, this is balanced against the desire to ensure that the CMA Board is not viewed by the membership at large as a “closed club” with very little turnover. Given these two considerations, there is not sufficient justification for adjusting the term of office from the existing policy.

CMA Bylaws currently provide for an Executive Committee composed of five officers (president, president-elect, past president, chair of the Board and honorary treasurer) and a member-at-large elected by the Board of Directors. Traditionally, the CMA Executive Committee has executed the Board’s will between the five Board meetings held each year. However, concerns have been expressed around whether there has been clarity in the role of the Executive Committee and its accountability to the Board of Directors. These concerns played some part in the Board’s decision in 2007 to appoint an additional member of the Board as an observer to the Executive Committee. Such concerns are not unique to CMA, and exist in many organizations with executive committees.

Some organizations with small boards that meet frequently do not require the assistance of an Executive Committee. With the reduction in the size of the Board of Directors as recommended above, the CMA Board may decide in the future that it does not require the services of an Executive Committee. Similarly, if it does wish to continue to retain an Executive Committee, the changes made to the processes of electing the board chair and honorary treasurer may lead the Board to conclude that a five-member committee composed of the officers is sufficient. Given this, CMA Bylaws should permit the Board to appoint an Executive Committee according to a structure and size deemed appropriate by it. This reflects the clear philosophy that an Executive Committee is meant to be a mechanism by which the Board of Directors chooses to facilitate the conduct of its business.

**Recommendation 12**

CMA Bylaws should permit the CMA Board of Directors to establish an Executive Committee with roles, responsibilities, authorities and structure as deemed appropriate by the Board.
Currently, the CMA Executive Committee also comprises the CMA Staffing Committee, which reports to the Board of Directors on matters with respect to personnel and staffing policies, particularly in relation to the secretary general and CEO. While the matter of the Staffing Committee can be considered in a similar manner as the CMA Executive Committee with respect to composition and mandate, exemplary practices suggest that the CMA Board should have a separate Staffing Committee. As such, it is recommended that the Board be required to appoint a Staffing Committee (or some equivalent such as a Human Resources and Compensation Committee) according to a structure and size deemed appropriate by the Board of Directors. This change will require amendments to the CMA Bylaws.

In 2007, a working group of the CMA Board of Directors recommended that the Staffing Committee be comprised of a combination of members of the Executive Committee and the Board of Directors. There is evidence of effectiveness of both the models. As such, the choice of the appropriate structural model is best determined by the CMA Board itself.

**RECOMMENDATION 13**

CMA Bylaws should require the CMA Board of Directors to establish a Staffing Committee with roles, responsibilities, authorities and structure as deemed appropriate by the Board.

In addition to the recommendations with respect to size listed above, there is compelling evidence regarding Board alternates. Exemplary practice does not support the use of Board alternates: it is considered too difficult for alternates to remain current on Board issues and fulfill fiduciary obligations without attending most meetings. Therefore, the practice of appointing Board alternates should be discontinued. Mechanisms can be found to ensure that the participation, perspective and opinions of members can be captured and taken into account in the very unusual circumstances when a member is unable to participate in person. This should include the use of electronic means (e.g., teleconference or videoconference) to allow a director to participate in discussion and debate, as well as permitting the attendance of a non-voting observer from the relative jurisdiction. This observer would be identified by the particular provincial or territorial medical association and would be entitled to full participation in discussions, but he or she would not be entitled to vote. This change will require amendments to the CMA Bylaws.

**RECOMMENDATION 14**

The practice of appointing alternate directors should be discontinued. In those extraordinary circumstances where directors are unable to attend meetings in person, efforts should be made to facilitate participation through alternative means such as teleconferencing or videoconferencing. Where this is not possible or appropriate, a non-voting observer from the affected jurisdiction should be entitled to attend and participate in Board discussions so as to ensure that the perspective of that jurisdiction is brought forward.
Consultations brought out particular concern on the matter of alternate student and resident directors. It was suggested that these individuals may experience greater difficulty in attending CMA Board of Directors meetings, and other activities on behalf of organized medicine, because of the constraints of their training programs. This is a very significant and serious problem which should be addressed so such that there are no constraints on the ability of medical students and residents to engage in participating in leadership activities of the medical profession. As such, the CMA should engage in active advocacy of those involved in such decisions to ensure that students and residents are not constrained in their ability to participate.

“As a busy resident with a young family starting on a second career, I find it difficult to spend much time being involved in the CMA or its governance. The structures that have led to the development of resident support services (e.g., MD Management to name one) have been great at seeing a need and fulfilling it even when I have been too busy to dedicate my own time to informing the organization of my needs independently.”

(Consultation Respondent)

RECOMMENDATION 15

The CMA should actively advocate on behalf of students and residents to ensure that they are fully supported in their efforts to engage in professional leadership, particularly as members of the CMA Board of Directors.
Finally, the number of observers attending CMA Board of Directors meetings should be limited such that non-directors (such as chairs of committees and task forces) only attend to provide reports, and that this attendance be restricted to the specific agenda item(s) in question. This will reinforce the respective roles and responsibilities of the Board and advisory bodies. The attendance of observers must be at the discretion of the CMA Board of Directors, as it may wish to have some key non-directors attend entire meetings (e.g., the CMA Holdings Inc. Board Chair).

**Recommendation 16**

The number of observers attending CMA Board of Directors meetings should be limited, at the discretion of the Board, such that non-directors only attend to provide reports, and that this attendance be restricted to the specific agenda item(s) in question.

**Process and implementation**

Research and consultations emphasize the importance of having clear criteria for the election of Board members, as well as for other elected positions. These criteria should reflect the competencies required, and should be communicated by the Committee on Nominations to those nominating as well as to General Council delegates responsible for such election. Special effort should be made to ensure that the Board reflects the diversity of the profession and the face of medicine. This may help to address perceptions of the general membership that the CMA Board does not adequately reflect the demographic characteristics (e.g., age and gender diversity) of the medical profession.

**Recommendation 17**

The CMA Committee on Nominations should communicate the job description, key characteristics and role of CMA Directors. The job description and key characteristics should be reviewed by the CMA Board of Directors each year and revised as necessary.
Much of the feedback received by the Task Force in the course of its deliberations focused on the importance of a functional Board. With the changes recommended above, such as a clearer mandate and improved structure, functionality should improve. However, this also depends on how the Board conducts itself. A code of conduct and conflict-of-interest policy should be introduced by the Board, and training and orientation improved for both Board members and the Board chair.

“Public companies with boards of governors must answer to a code of conduct and to their shareholders. This model should work well for the CMA — a Board that holds the management accountable and improves my shareholder value.”

(Consultation Respondent)
5.3 ADVISORY STRUCTURES

Issues
An important input in considering the matter of the key advisory structures which assist the CMA Board and General Council was the work of the CMA Appointments and Review Committee (ARC) which conducted a Strategic Review of CMA Core Councils and Committees from May 2004 to May 2007. The CMA Board of Directors referred the ARC report to the Task Force for its deliberations.

In delivering its final report to the Board, ARC noted a need for better connectivity and communication between the CMA Board of Directors and the advisory structure. ARC also concluded that there was confusion about roles and responsibilities of councils and committees and that the existing structure was cumbersome, inflexible and limited the ability of the organization to “get the work done” in a timely manner.

Roles, responsibilities and authorities
In assessing the role of advisory structures, which ARC referred to as the Board substructure, it concluded that there were five main purposes with respect to ‘what the substructure should be’ and ‘what the substructure should do’:

1. Representative (made up of representatives of CMA constituencies)
2. Aligned with the CMA Strategic Plan
3. Serve as early-warning and issue-identification mechanisms
4. Serve as a mechanism to “get the work done”
5. Allow and facilitate better connectivity (input and output) and communication between the Board and its substructure, with provincial and territorial medical associations, affiliates and (to the extent possible) grassroots members

This is an appropriate description of the roles of CMA’s advisory bodies, and recommendations for structural change are made on this basis. It should be noted that the structural changes recommended continue the evolution already underway within CMA’s practices toward the use of ad hoc task forces and Board working groups.

“[There should be a] small core group of decision-makers with many small standing committees to advise the CMA.”

(Consultation Respondent)
“Publicize the work of standing committees and allow physician input from the whole profession regarding their work. Educate physicians on the work of the committees and work at hand so they may understand what issues the profession faces as a whole.”

(Consultation Respondent)

Structure

The CMA Board of Directors should continue the evolving use of focused, time-limited and policy-specific task forces to conduct the work necessary to achieve the objectives of the strategic plan. As noted in the ARC report:

“The use of task forces at CMA has proven a successful way of getting the work done over the past few years. Their success can be mainly attributed to the fact that they are assigned clear direction and resources by the Board; they are smaller more nimble groups with the ability to interact electronically and by teleconference between meetings; and they have a close liaison/reporting relationship with the Board.” (A Strategic Review of CMA Core Councils and Committees and Board Substructure — Issues, Options and Recommendations. CMA Appointments and Review Committee, May 2007)

In 2007, the CMA Bylaws were amended to move reference to the functions and structures of CMA core councils and committees to Operating Rules and Procedures, with the exception of the Committee on Ethics which continues to report to and be elected by General Council. This amendment is consistent with exemplary practice suggesting that bylaws should only contain essential legislative elements and continues the evolution to ensure that core councils and committees are responsive to the needs and direction of the CMA Board, and that the Board is able to alter mandates, roles, responsibilities and membership of these bodies as necessary in a timely manner as circumstances change.

Consistent with these changes, CMA’s existing core councils and committees, with restructuring, can also fulfill roles complementary to task forces. Many have observed that the existing advisory structure has recently become better connected and responsive to direction from the CMA Board of Directors, and more aligned to the CMA strategic plan. This improved performance can be enhanced by making these bodies smaller and more responsive, and increasing the connection between them and the Board, as well as enhancing the adoption of technology and other key tools.
To continue the evolution of CMA’s advisory structures, the councils on Health Care and Promotion, Health Policy and Economics and Medical Education and Workforce, and the Committee on Political Action, should be restructured so as to include five members appointed by the CMA Board of Directors on a regional basis, a member for each of students and residents, and a liaison member appointed from the Board of Directors. These appointments would be on the recommendation of the Appointments and Review Committee and could be on a similar regional basis as employed for the Committee on Ethics. By virtue of being smaller, these bodies should be able to meet more frequently and on shorter notice to address emerging issues and challenges. Although it should continue to report to General Council and be elected by General Council, the Committee on Ethics should have its membership expanded to include a liaison member appointed by the Board of Directors. This specific change will require an amendment to the CMA Bylaws.

In keeping with the philosophy expressed with respect to the chair of the Board of Directors, the chairs of these advisory bodies other than the Committee on Ethics should also be elected by the body itself from within its membership.

With respect to the Committee on Political Action, the special requirement within the CMA for individuals to provide advice on political issues and to participate as necessary in communicating with government officials is recognized. A political action committee composed of members with special political expertise and experience provides strong benefit to the CMA. As such, the CMA should continue to have a committee charged with political action.

In recognition of the role that the existing councils and committees play in facilitating communication between provincial and territorial medical associations, and between the CMA and provincial and territorial medical associations, the Task Force recommends that “corresponding members” to these bodies be permitted for those jurisdictions not directly represented on the particular body. Though not entitled to vote, the corresponding members would receive minutes and documents and would be permitted to attend meetings as observers. This is best facilitated through environmentally responsible and cost-effective mechanisms such as video conferencing and teleconferencing.

It is important that there be strong efforts to ensure that important functions identified in consultations, such as leadership development, connectivity between CMA and provincial/territorial medical associations, and early warning and issue identification be a focus moving forward. These items can be addressed through special attention to the make-up of special task forces and working groups, extensive consultation processes, new leadership development mechanisms and the significant efforts devoted to member engagement as described later in this report.
Finally, there is the matter of the names of CMA’s Councils. There is not a rationale or benefit from the use of the term council, and in fact this terminology creates confusion and perhaps a misperception as to the roles of the councils in acting on the direction of the CMA Board. As such, the existing councils should be renamed as committees. These changes do not require amendments to the CMA Bylaws.

Exemplary practices in governance suggest the need for a limited number of standing committees for a few core purposes. To this end, the committees on Bylaws, Ethics and Nominations should continue as standing committees reporting to General Council, and the Appointments and Review Committee and the Committee on Archives and Awards should continue to report to the CMA Board of Directors. In the case of the Committee on Ethics, this committee should continue to be elected by General Council and report to General Council and the Board of Directors in recognition of the very special role of ethics within the medical profession.

RECOMMENDATION 19
To continue to improve the effectiveness of the CMA’s advisory structures:
- the CMA Board should utilize both standing committees and time-limited, policy-specific task forces to conduct the work necessary to achieve CMA’s strategic plan;
- the existing councils on Health Care and Promotion, Health Policy and Economics and Medical Education and Workforce should be renamed as committees;
- voting membership on the core committees, including the Committee on Political Action, should include five members appointed by the Board on a regional basis, plus one student member and one resident member, plus a liaison member appointed from the Board of Directors, with the chair of the committee elected by the committee from within its membership;
- corresponding members from jurisdictions not included in the voting membership of each of these committees should be permitted, whereby these members are entitled to receive agendas, minutes and documents from these committees and are also permitted to attend meetings as non-voting observers, with the permission of the chair; and
- the CMA Bylaws should be amended to include a liaison member to the Committee on Ethics appointed by the CMA Board of Directors.

RECOMMENDATION 20
The Committees on Bylaws, Ethics and Nominations should continue as standing committees reporting to General Council, and the Appointments and Review Committee and the Committee on Archives and Awards should continue to report to the CMA Board of Directors.
Financial Advisory Structure

The CMA Finance Committee is elected by General Council and reports to both General Council and the Board of Directors. It serves a dual role by ensuring proper audit of the financial governance and financial management of the association, and by providing guidance, advice and oversight to budgeting and financial operations.

The audit role is appropriately served by a committee of General Council that reports to General Council. Conversely, the role of oversight of budgeting and financial operations should be served by a committee reporting to the Board. This recognizes that the Board, as the executive authority, is the appropriate body to be charged with financial planning and the making of financial decisions. General Council, as the legislative authority, will hold the Board accountable through an audit committee independent from the Board and through reporting from the Board. Therefore, an Audit Committee reporting directly to General Council should be established. The Committee on Finance should continue to exist but should be appointed by the CMA Board of Directors and should report directly to it.

The current structure of the CMA Finance Committee — a chair and five members are elected annually by General Council — is also appropriate for the Audit Committee. Individuals on this committee should not hold any other elected office within the CMA, and the Committee on Nominations should seek nominees with special interests and skills in this area. The Audit Committee itself must have authority to invite the honorary treasurer and key CMA staff, as well as external advisers as appropriate, to come to meetings to provide information with respect to CMA’s finances and financial and management practices.

**RECOMMENDATION 21**

An Audit Committee elected by General Council and reporting to General Council should be established. The Committee on Finance should be appointed by the Board of Directors and report to the Board with respect to CMA budgeting and financial operations.

“Modern medicine is so fragmented that I don’t think we have a very up-to-date concept of what our constituencies are or how to represent them. I don’t think that geography works, but I am at loss as to what will. And we continue to ignore the fundamental divide between primary care and specialists.”

(Consultation Respondent)
There is a very significant role and importance of bodies not currently enshrined in the formal governance structure, such as the Presidents’ Forum that comprises provincial/territorial medical association presidents and their CMA counterparts. These quarterly meetings appear to meet a very important need for information sharing and issue identification across the broad spectrum of physician organizations. As such, the existing role and structure of the Presidents’ Forum is appropriate and should be maintained.

Given the proposed changes to the structure of the CMA Board of Directors, the Presidents’ Forum may become an even more important vehicle for the sharing of organizational perspectives between the CMA and provincial and territorial medical associations. As such, the presidents of these associations may wish to discuss whether there is a need for more frequent meetings of the Presidents’ Forum to facilitate this sharing of perspectives. However, it is clear that the Presidents’ Forum is not meant to assume the fiduciary duties and responsibilities of individual boards of directors.

CMA’s present structure includes a Forum on General and Family Practice, which considers issues of importance to general and family medicine and reports to the Council on Health Policy and Economics. In this context, consultations revealed the need to provide a mechanism for other specialty physicians to come together to discuss relevant issues and develop advice for the CMA. Although the CMA Committee on National Medical Organizations is largely composed of specialty societies, it also includes other affiliated societies with different interests (i.e., focused-interest national medical organizations) and its mandate has been to provide a forum for sharing issues of common interest for all affiliates. Such a structure may not have maximized effectiveness for specialty societies, and as such the CMA should have both a Forum on General and Family Practice and a Specialists’ Forum. These will provide a mechanism for practitioners to come together to discuss areas of concern and provide input to the CMA.

The Forum on General and Family Practice currently comprises members from each province and territory. However, such an approach for a Specialists’ Forum might not result in sufficient representation of perspectives across the broad range of specialties. It is recommended that the Specialists’ Forum be constructed in a manner that might include representation from each specialty.

Currently, the Forum on General and Family Practice reports to the Council on Health Policy and Economics, while the Committee on National Medical Organizations reports directly to the CMA Board and its chair has generally served a dual role as the affiliate director on the CMA Board. Each forum should function in a similar manner, and the connection with the CMA Board of Directors should be increased. It is recommended that a Board liaison be appointed to each forum to provide the direct link to the CMA Board. As well, the establishment of the Specialists’ Forum should eliminate the need for the Committee on National Medical Organizations, and it should be sunset.

**Recommendation 22**

A Specialists’ Forum should be established in addition to the Forum on General and Family Practice. Each should be charged with bringing practitioners together to discuss areas of concern and to provide input to the CMA Board of Directors, and should include a liaison representative appointed by the Board to provide a direct link to the Board.
“Primary input should come from individual physicians, selected proportionately by geography and specialty, supported by expert advice (staff or consultants).”

(Consultation Respondent)

It is recognized that the creation of a Specialists’ Forum will reduce the usefulness of the Committee on National Medical Organizations as currently structured. Issues of concern to specialty societies will primarily be considered and discussed at that forum, and there will be a mechanism for connection with the CMA Board through the liaison representatives from the Board. However, if the CNMO is eliminated there will be a void created for FIMAs, or Associate Societies as recommended under recommendations #5 and #6, with respect to their connection to the CMA. (A listing of current CMA Affiliated Societies is attached as Appendix D, with an identification of FIMAs and specialty societies.)

Concerns about the potential loss of connection for FIMAs with the CMA do not justify retaining the Committee on National Medical Organizations in its current form, given the recommendation to establish a Specialists’ Forum. As such, it is recommended that the committee be eliminated. However, efforts should be made to ensure that the connection with FIMAs is maintained. The question is how best to do this, given the diversity of structures and interests of the various FIMAs. Currently, CMA has used bilateral mechanisms such as memoranda of understanding with individual FIMAs and multilateral mechanisms such as the Canadian Medical Forum to maintain connections with some of these groups, as well as observer status on appropriate core councils or committees in relation to the areas of interest of the particular FIMA. However, these may not be sufficient or appropriate, and the Board should work closely with the FIMAs to identify appropriate mechanisms to facilitate such connections. This might include another forum specifically for FIMAs.

This recommendation does not require amendments to the CMA Bylaws.

**Recommendation 23**

The Committee on National Medical Organizations should be sunset. In doing so, the CMA Board should work with those associate societies not representing specialist physicians to identify appropriate bilateral and multilateral mechanisms to ensure appropriate connection between these associate societies and the CMA.
“Whenever an important subject is being discussed I would very much like to be kept informed, and I would like to have my say in the form of a vote about whatever subject is being discussed. This could easily be done using the Internet and e-mails.”

(Consultation Respondent)

5.4 MEMBERS

Issues
The deliberations of the Task Force, particularly the online member consultation, provided substantial insight into members’ views and perceptions about their role in CMA governance. Several participants said they did not feel engaged, or found it difficult to become engaged within the existing governance structure. They also did not feel informed of the rationale for significant decisions that have been made, and requested more information on why and how these choices are made.

The challenge for the CMA is to provide opportunities for meaningful participation to those members who are keenly interested in the association, and to remain transparent and accountable to all members, no matter what their level of interest. The research indicated that organizations are increasingly opting for governance processes and structures that offer a high level of transparency and accountability to stakeholders.

“Transparency is a key to receiving feedback. That is not to say that the CMA is not currently transparent, it’s more that access to information is not provided readily to members but instead must be searched out re: selection of representatives, board members, president, direction, etc.”

(Consultation Respondent)
These developments in CMA’s external environment have created heightened expectations with regard to its own transparency, accountability and member engagement. The CMA has taken steps to provide members with convenient and meaningful options for staying informed and making their views known. Plans are in place to build on this foundation in the years ahead, and to continually evaluate whether measures are meeting member expectations. The following measures which have already been substantially adopted by the CMA Board of Directors following the report of the Ad Hoc Working Group on Member Communications:

- **Develop a Member Communications and Outreach Plan with accountability and transparency as key objectives, and incorporate this objective into the performance metrics of the CEO and staff responsible for member communications.** The present focus of member communications efforts is largely advocacy and promotion, not transparency and accountability.

- **Report annually to members via an accountability document that explains what CMA set out to do (strategic plan) and how it performed on these objectives.**

- **Regularly report on the outcomes of Board meetings through member communications vehicles, including cma.ca.**

- **Undertake a member-targeted communications effort** to make members aware of planned General Council activities before and outcomes after General Council.

- **Make all the above actions visible** so that even members who do not monitor CMA developments know that this is an option and CMA is a transparent organization.

**Participation**

To facilitate greater member participation, it is recommended that CMA:

- **Expand, co-ordinate and promote existing participatory opportunities for members** (e.g., as a delegate to General Council, on an advisory body, as a member of the MD-MP Contact Program, though online consultations such as the Member e-Panel).

- **Review opportunities for involvement and build them into a life-cycle model** that would describe ideal pathways from low to high involvement within the CMA and organized medicine (e.g., CMA membership -> Member e-Panel -> participation on provincial/territorial medical association working groups -> MD-MP Contact Program -> CMA committee -> Board working groups and task forces -> Board -> President). There should be multiple pathways that include involvement with CMA, provincial and territorial medical associations, and affiliates at multiple points (i.e., beginning, middle and end).

- **Develop a strategy for guiding members through this model,** including materials that make them aware of different options and levels of involvement, the obligations of each option and easy ways to engage.

- **Build into all high-involvement opportunities a certain number of positions for promising and committed new members** to address the desire for uninitiated members to become involved.

- **Build and promote a talent pool of potential leaders,** a reserve of individuals who could be encouraged to apply for Board ad hoc working groups and other high-involvement roles. Individuals who have taken part effectively in other member-engagement vehicles should be identified and considered for this talent pool, and be matched by qualifications and interests to suitable roles.

- **Continue to build on successful consultation and dialogue initiatives,** such as the Baseline Survey, Member e-Panel, deliberative consultations and member outreach initiative.
“There are certain issues that are of such a magnitude that they require a means to involve the entire membership. However, there are many issues that would be untenable to put to the whole membership as it would bog down the function of the organization. Balance in these two ideas is necessary and is not currently being achieved.”

(Consultation Respondent)

Appendix E provides greater detail on how these measures might be implemented. These changes do not require amendments to the CMA Bylaws.

**Recommendation 24**

Measures to enhance the transparency of the CMA and its governance and to facilitate greater member participation should be adopted as outlined in this report.
5.5 CMA STAFF

Issues
Consultations suggested that the role of staff was made more difficult by the uncertain roles of governing bodies, Board functioning and complex decision-making processes and structures. It appears that staff members are sometimes left without sufficient clarity or direction from governing bodies, and must either act and risk criticism for leading without authority or delay action and risk frustrating expectations.

Roles, Responsibilities and Authorities
These issues are best addressed through the efforts recommended earlier to address role, responsibility and authority clarity for General Council and the CMA Board of Directors, as well as changes to improve the effectiveness and timeliness of advisory structures. The CMA's staffing structure does not need to be altered, but the roles, responsibilities and authorities of the CEO should be clearly defined and communicated to the Board (e.g., through orientation). Similarly, it is very important for the Board to recognize its role in hiring and evaluating the CEO as distinct from his or her role in hiring and evaluating staff.

This recommendation does not require changes to the CMA Bylaws.

RECOMMENDATION 25
The CMA Board of Directors should ensure that the roles, responsibilities and authorities of the CEO are clearly defined and communicated to the Board of Directors on an ongoing basis.

6.0 NEXT STEPS
CMA has accomplished much over its 140 year history, and it continues to make progress towards its dual vision, A healthy population and a vibrant medical profession. However, in an increasingly complex and fast-paced environment, particularly for the patients and members CMA seeks to serve, it will continue to be more important that governance structures and processes facilitate this vision rather than impeding it. These recommendations serve this goal and will serve CMA well going forward. They are recommended to General Council for adoption in their entirety.

“Congratulations on the efforts that you are undertaking, as reflected in this questionnaire, which is also a learning experience. I now know more re: the workings of the CMA”
(Consultation Respondent)
Appendix A

**Summary of Recommendations**

**Recommendation #1**
In addition to ongoing review of the impact of the changes to CMA’s governance processes and structures, the CMA Board of Directors should ensure that a formal review of the impact of the changes is conducted within five years of their implementation.

**Recommendation #2**
The function of General Council as the legislative authority, and its roles in providing high-level policy guidance and direction for CMA, should be clarified, reaffirmed and strengthened.

**Recommendation #3**
General Council’s primary functions, which in some cases should be strengthened, should continue to be:
- providing high-level policy guidance and direction to the organization in general and the Board of Directors in particular;
- electing the Board of Directors;
- approving membership fees and the appointment of auditors; and
- approving changes to the CMA bylaws for subsequent confirmation at the annual meeting.

**Recommendation #4**
General Council should continue to be a representative body composed largely of delegates selected on a provincial and territorial basis according to relative size.

**Recommendation #5**
Status as an affiliated society of the CMA should be limited to specialty societies including family medicine/general practice as recognized by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Canadian Federation of Medical Students and the Canadian Association of Internes and Residents should continue to enjoy status as affiliated societies as special exemptions.

**Recommendation #6**
An associate society status should be created within the CMA Bylaws for organizations that do not meet the amended criteria for CMA affiliate society status, and such status should include observer status at General Council such that General Council may continue to benefit from the particular perspective brought by these organizations.
Recommendation #7
Provincial and territorial medical associations should be encouraged to consider allocating an increased percentage of their General Council delegation for members-at-large elected or selected directly from the general membership of that jurisdiction.

Recommendation #8
Past officers should be entitled to be voting delegates at General Council for five years following the completion of their terms of office. Subsequently they should continue to be invited to General Council as non-voting observers. Existing past officers at the time of implementation of this recommendation should be entitled to voting delegate status at General Council for five years following the date of implementation.

Recommendation #9
To improve the quality and effectiveness of General Council:
• education and orientation efforts should be focused on ensuring new and existing delegates to General Council have clarity and certainty as to the role of General Council and their responsibility as a delegate;
• the speaker and deputy speaker should be asked to consider how to best make meetings of General Council more effective, efficient and meaningful for delegates; and
• efforts should be made to utilize CMA’s advisory structures, in advance of General Council to facilitate meaningful debate.

Recommendation #10
The CMA Board of Directors should be the principal executive authority for CMA governance.
Recommendation #11

The CMA Board of Directors should comprise the following membership:

<table>
<thead>
<tr>
<th>Position</th>
<th>Number of Directors – based on threshold of 1 director per 6,000 CMA members in that jurisdiction and current membership data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>1</td>
</tr>
<tr>
<td>President-Elect</td>
<td>1</td>
</tr>
<tr>
<td>Past President</td>
<td>1</td>
</tr>
<tr>
<td>Chair of the Board</td>
<td>1 (Chosen by the Board, with an additional director appointed if chosen from the Board.)</td>
</tr>
<tr>
<td>Honorary Treasurer</td>
<td>Chosen from within the Board</td>
</tr>
<tr>
<td>Alberta</td>
<td>2</td>
</tr>
<tr>
<td>British Columbia</td>
<td>2</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>1</td>
</tr>
<tr>
<td>NWT/Nunavut</td>
<td>1</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>1</td>
</tr>
<tr>
<td>Ontario</td>
<td>5</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>1</td>
</tr>
<tr>
<td>Québec</td>
<td>2</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1</td>
</tr>
<tr>
<td>Yukon</td>
<td>1</td>
</tr>
<tr>
<td>Student</td>
<td>1 (thresholds will not apply)</td>
</tr>
<tr>
<td>Resident</td>
<td>1 (thresholds will not apply)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Recommendation #12

CMA Bylaws should permit the CMA Board of Directors to establish an Executive Committee with roles, responsibilities, authorities and structure as deemed appropriate by the Board of Directors.

Recommendation #13

CMA Bylaws should require the CMA Board of Directors to establish a Staffing Committee with roles, responsibilities, authorities and structure as deemed appropriate by the Board.
Recommendation #14
The practice of appointing alternate directors should be discontinued. In those extraordinary circumstances where directors are unable to attend meetings in person, efforts should be made to facilitate participation through alternative means such as teleconferencing or videoconferencing. Where this is not possible or appropriate, a non-voting observer from the affected jurisdiction should be entitled to attend and participate in Board discussions so as to ensure that the perspective of that jurisdiction is brought forward.

Recommendation #15
The CMA should actively advocate on behalf of students and residents to ensure that they are fully supported in their efforts to engage in professional leadership, particularly as members of the CMA Board of Directors.

Recommendation #16
The number of observers attending CMA Board of Directors meetings should be limited, at the discretion of the Board, such that non-directors only attend to provide reports, and that this attendance be restricted to the specific agenda item(s) in question.

Recommendation #17
The CMA Committee on Nominations should communicate the job description, key characteristics and role of CMA Directors. The job description and key characteristics should be reviewed by the CMA Board of Directors each year and revised as necessary.

Recommendation #18
To improve the functionality of the CMA Board:
- a code of conduct and conflict-of-interest policy should be introduced by the Board of Directors, and directors should use this code and policy in evaluating their own circumstances;
- training and orientation for Board members and the chair should be improved;
- consideration should be given by the Board to enlisting a Board coach to assist the Board with its functioning; and
- as necessary, the CMA Board should establish in writing any policies it requires to best articulate how it wishes to deal with certain areas of governance and the culture it wishes to maintain for itself.

Recommendation #19
To continue to improve the effectiveness of the CMA's advisory structures:
- the CMA Board should utilize both standing committees and time-limited, policy-specific task forces to conduct the work necessary to achieve CMA's strategic plan;
- the existing councils on Health Care and Promotion, Health Policy and Economics and Medical Education and Workforce should be renamed as committees;
voting membership on the core committees, including the Committee on Political Action, should include five members appointed by the Board on a regional basis, plus one student member and one resident member, plus a liaison member appointed from the Board of Directors, with the chair of the committee elected by the committee from within its membership;

• corresponding members from jurisdictions not included in the voting membership of each of these committees should be permitted, whereby these members are entitled to receive agendas, minutes and documents from these committees and are also permitted to attend meetings as non-voting observers, with the permission of the chair; and

• the CMA Bylaws should be amended to include a liaison member to the Committee on Ethics appointed by the CMA Board of Directors.

Recommendation #20
The committees on Bylaws, Ethics and Nominations should continue as standing committees reporting to General Council, and the Appointments and Review Committee and the Committee on Archives and Awards should continue to report to the CMA Board of Directors.

Recommendation #21
An Audit Committee elected by General Council and reporting to General Council should be established. The Committee on Finance should be appointed by the Board of Directors and report to the Board with respect to CMA budgeting and financial operations.

Recommendation #22
A Specialists’ Forum should be established in addition to the Forum on General and Family Practice. Each should be charged with bringing practitioners together to discuss areas of concern and to provide input to the CMA Board of Directors, and should include a liaison representative appointed by the Board to provide a direct link to the Board.

Recommendation #23
The Committee on National Medical Organizations should be sunset. In doing so, the CMA Board should work with those associate societies not representing specialist physicians to identify appropriate bilateral and multilateral mechanisms to ensure appropriate connection between these associate societies and the CMA.

Recommendation #24
Measures to enhance the transparency of the CMA and its governance and to facilitate greater member participation should be adopted as outlined in this report.

Recommendation #25
The CMA Board of Directors should ensure that the roles, responsibilities and authorities of the CEO are clearly defined and communicated to the Board of Directors on an ongoing basis.
Appendix B

Terms of Reference - Governance Review Task Force

**Purpose**
To examine CMA’s governance processes and structures - including General Council and the Board of Directors - and bring forward recommendations for improvement to the Board of Directors for presentation to General Council.

**Deliverables and Timelines**
An interim report on the work of the Task Force will be provided to the CMA Board in time to be presented to the 2007 General Council.

A final report will be delivered to the CMA Board in sufficient time that any Bylaw changes can be presented to the 2008 General Council.

The Task Force will conduct wide communication and consultation efforts with interested constituencies (e.g., CMA Board, CMA volunteers, staff, provincial/territorial medical associations, affiliates, general membership).

**Membership**
Membership of the Task Force shall be chosen by the CMA Board of Directors following recommendation from the CMA Appointments and Review Committee (ARC) and shall comprise regional representation to include members with previous experience in governance reviews, according to the following breakdown.

2 CMA Board members: ............................................................... Dr. Jack Burak
Dr. Tzu-Kuang Lee

1 CMA Executive member: .......................................................... Dr. John Rapin

1 member of ARC: ...................................................................... Dr. Michael Golbey

2 members chosen from nominees submitted by Divisions: Dr. Ann Collins – NB
Dr. Mark MacLeod – ON

2 members chosen from nominees submitted by Affiliates: Dr. André Bernard
Dr. Blake Woodside

2 members chosen from the general membership: Dr. Garth Campbell
Dr. Daniel Wagner

1 CMA Holdings Board member: ............................................... Dr. Jeffrey Gandz, PhD

Once appointed to the CMA Governance Review Task Force, all members are expected to work in the best interest of the CMA as a whole. The Board will appoint the Chair of the Task Force (Dr. Daniel O’Brien, PhD).
Appendix C
CMA GRTF Consultation Activities

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2007</td>
<td>Inaugural Meeting of the Governance Review Task Force (GRTF). Consultation with the Canadian Medical Association (CMA) Board of Directors. Institute on Governance was hired to provide a benchmarking and exemplary practices report.</td>
</tr>
<tr>
<td>June 2007</td>
<td>Consultation with provincial/territorial medical association (PTMA) Chief Executive Officers on proposed consultation process. CMA conducted key informant interviews designed to help inform the Governance Review Task Force’s consultation and engagement strategy.</td>
</tr>
<tr>
<td>July 2007</td>
<td>CMA member e-panel consultation was launched to target a random sample seeking to validate the need for the review of CMA’s structure and processes and to measure interest in participating. 93% or 131 respondents indicated that consulting with members on governance is either very important (57%) or important (36%). President’s letter sent to CMA members informing them, among other things, that the CMA has undertaken a review of its governance.</td>
</tr>
<tr>
<td>August 2007</td>
<td>During the Annual Meeting, the CMA conducted an educational session for General Council delegates to familiarize them with the Task Force’s mandate and the work completed to date. It also provided an opportunity for delegates to comment and ask questions on key issues under consideration by the Task Force and to offer input on governance issues to inform and feed the work of the Task Force. A CMA President’s letter was sent to CMA members advising them of the review and to identify opportunities for input and involvement. A post-card mailer was included encouraging individuals to provide their email addresses if they wanted to take part in the governance consultation. Over 1,500 members did so. A short article, featured in the CMA Bulletin, was written advising members of the governance review and informing them of opportunities for input and involvement. The CMA Bulletin, published as an insert in CMAJ, is a newsletter designed to provide news stories of national interest to physicians. The work of the Task Force is featured on CMA’s Web site, cma.ca/governance and updates are continually provided.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sept. 26, 2007</td>
<td>Consultation with the CMA Board of Directors on governance issues identified so as to focus the GRTF’s efforts.</td>
</tr>
</tbody>
</table>
| October & November 2007 | First round of consultations conducted by the Task Force on Issues Identification.  
The document was sent to CMA’s stakeholder organizations (PTMAs, affiliates, councils and committees and past officers) and the CMA contracted the Institute on Governance to conduct 60 consultative interviews to determine priority issues and options visioning.  
An online workbook was made available to members and promoted through e-mail broadcasts, in collaboration with PTMAs and affiliates, and advertising and earned media – a total of 2,508 members provided their feedback on governance topics. |
| Dec. 1, 2007       | Consultation with the CMA Board of Directors on the proposed direction and areas for governance change that would form the basis for the consultation document. |
| January & February 2008 | Second round of consultations on Proposed Direction and Areas for Change with stakeholder organizations.  
The Proposed Direction and Areas for Change document was also uploaded to cma.ca/governance giving CMA members the opportunity to provide feedback and comment. An e-mail broadcast was also sent to all CMA members inviting them to review the document. |
| Feb. 23, 2008      | Consultation with CMA Board on the draft recommendations.                                                                                           |
| March & April 2008 | Third round of consultations on Draft Report and Recommendations with stakeholder organizations including meetings with CMA core councils and committees and the Presidents’ Forum.  
The Draft Report and Recommendations document was also uploaded to cma.ca/governance giving CMA members the opportunity to provide feedback and comment. An e-mail broadcast was sent to members who had expressed an interest on this issue and to 2007 General Council delegates. |
| May 26-27, 2008    | Consultation with the CMA Board to finalize the Board of Directors’ report and recommendations to General Council.                                      |
Appendix D

FOCUSED-INTEREST
MEDICAL ASSOCIATIONS
(FIMA) OF CNMO AS OF
FEBRUARY 2008

Canadian Academy of Sports Medicine
Canadian Association of Internes and Residents
Canadian Association of Physicians for the Environment
Canadian Association of Physicians with Disabilities
Canadian Federation of Medical Students
Canadian Life Insurance Medical Officers Association
Canadian Medical Protective Association
Canadian Society of Physician Executives
Federation of Medical Regulatory Authorities of Canada
Federation of Medical Women of Canada
Society of Rural Physicians of Canada
Occupational & Environmental Medical Association of Canada
The Canadian Spine Society
The Canadian Society of Addiction Medicine
The Canadian Society of Clinical Neurophysiologists

NATIONAL SPECIALTY
SOCIETIES

Association of Medical Microbiology and Infectious Disease Canada
Canadian Anesthesiologists’ Society
Canadian Association of Emergency Physicians
Canadian Association of Gastroenterology
Canadian Association of General Surgeons
Canadian Association Medical Biochemists
Canadian Association of Nuclear Medicine
Canadian Association of Pathologists
Canadian Association of Physical Medicine and Rehabilitation
Canadian Association of Radiation Oncologists
Canadian Association of Radiologists
Canadian Cardiovascular Society
Canadian Critical Care Society
Canadian Dermatology Association
Canadian Geriatric Society
Canadian Neurological Society
Canadian Neurosurgical Society

Canadian Ophthalmological Society
Canadian Orthopaedic Association
Canadian Paediatric Society
Canadian Psychiatric Association
Canadian Rheumatology Association
Canadian Society of Allergy and Clinical Immunology
Canadian Society of Internal Medicine
Canadian Society of Otolaryngology - Head and Neck Surgery
Canadian Society of Plastic Surgeons
Canadian Thoracic Society
Canadian Urological Association
National Specialty Society for Community Medicine
Occupational Medicine Specialists of Canada
Society of Gynecologic Oncologists of Canada
Society of Obstetricians and Gynaecologists of Canada
Appendix E
DEVELOPING A STRONGER MEMBER ORIENTATION

Throughout the consultations, it was clear that members want the opportunity to become engaged in the CMA and to take part in the development of policies and in making major decisions. Even if they choose not to become involved, they still wish to be able to easily have access to the substance of major decisions and to understand how these decisions were made.

The area of member communications and engagement has been a growing priority at CMA for several years, and a number of key steps have been taken to improve transparency and to provide greater opportunity or member engagement.

Among these measures are:
- the introduction of the CMA Members e-Panel, which now has 1,500 members and provides any interested member with the opportunity to have regular input into issues of importance to the profession;
- the introduction of the Member Outreach Initiative, which makes the CMA President available to meet on an informal basis with groups of members across the country and included meetings with some 700 physicians in 20 communities in 2008;
- the introduction of member polling to the General Council planning process;
- a change in CMA’s policy on email communication to members, which has allowed it to interact with members more frequently and cost-effectively than in the past; and
- regular deliberative consultations on key issues, which in the past 18 months have included three national consultations dealing with specialty care, the member outreach initiative and governance, each of which has involved between 2,500 and 5,000 physicians.

To further advance the CMA’s member communications and engagement objectives, the Board of Directors formed an Ad Hoc Working Group on Member Communications in February 2007. It incorporated the Governance Review Task Force’s draft recommendations related to members into its own report, and presented its work to the CMA Board in February 2008.

The Working Group’s recommendations are based on two key strategic thrusts:
- The migration of the traditional one-way approach to communications (CMA speaking to members) to a collaborative, community-based approach to communications (CMA speaking to members, members speaking to CMA and members speaking to members).
- Enhanced cohesiveness and coordination in member communications and engagement across CMA and CMAH to deliver an improved member experience.

The Board endorsed the Working Group’s recommendations at its February meeting and called for the development of an implementation document.

The resulting Member Communications and Engagement Implementation Strategy, endorsed by the Board at its May 2008 meeting, applies specifications, timelines and costs to the recommendations of the Working Group.
The following is a summary of the tactics and strategies being proposed.

**Planning and Collaboration**
- Mechanisms for stronger staff collaboration.
- A pan-corporate Member Communications and Engagement Communications Plan with transparency and participation as central objectives, renewed annually.

**Transparency and participation**
- Create a page on cma.ca that is a “headquarters" for members wanting to observe CMA’s governance activities, become involved in CMA, and provide feedback. Produce an associated brochure on getting involved.
- Promote the above products/opportunities through the Web site, and through earned and unearned media.
- Enable CMA members to subscribe to a notification service to find out whenever the headquarters Web page is updated with new information.
- Produce bulletins following board meetings and General Council that explain decisions reached, and upload these regularly to cma.ca (now underway).
- Create an annual reporting mechanism to members that serves as an accountability document, explaining what CMA set out to do in the year (strategic plan) and how it performed vis-à-vis these objectives.
- Review the different opportunities for involvement in the CMA and build them into a life-cycle model. This model would describe an ideal pathway that a member would follow, from low-involvement to high-involvement with CMA (e.g., CMA membership -> Member e-Panel -> MD-MP Contact Program -> Board working group -> Board membership -> president).
- Develop a strategy for guiding members through this model, including segmenting members between low potential for involvement and high potential for involvement, setting in place standard methods and materials targeting the segments, making members aware of different options and levels of involvement, the obligations of each option, and easy ways to engage.

**Electronic Tools**
- Conduct a review of cma.ca to determine what is required to realize the working group’s vision/recommendations.
- Pilot a social networking tool that will function as a kind of “doctors’ lounge” on the Internet. Using the tool, physicians will be able to interact one-on-one, or in groups, at their convenience, to exchange knowledge and advice on clinical, professional and personal topics.
Face-to-Face Member Outreach
• Continued enhancement of the Member Outreach Initiative.
• Explore new technologies for interacting with members, including a videoconferencing network.
• A speakers’ module for use by Board members, core council and committee chairs and staff physicians to provide greater opportunity for the CMA to meet face to face with members.

Brand Management
• A full review of the CMA brand to ensure that the CMA’s value proposition, personality and messages are on target with today’s physicians.

Segmentation
• Analysis of current advocacy initiatives to identify relevance to specific segments.
• Development of segmented messaging targeting students, residents, practising and retired physicians.
• A pilot project using two segments to develop and test a segmentation strategy for the CMA.

Provincial and Territorial Medical Associations
• Develop a better understanding of current member communications vehicles and programs.
• Foster greater cross-over between communications directors and membership directors.

Specialized Media
• Stronger focus on journals and periodicals targeting physicians, with a special emphasis on CMAJ.

Member Research and Knowledge Products
• Increase the profile of the CMA as a provider of knowledge products by positioning the association as a top-of-mind purveyor of these offerings (branding) and positioning the offerings themselves as a family of products, rather than as stand-alones (marketing).
• Conduct research to identify emerging needs.
• Ensure that the results of CMA research/consultation are communicated to physicians.
• Add appropriate forums to social networking application and advance internal communications work.