

2019 CMA Annual Report

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Rules of Order

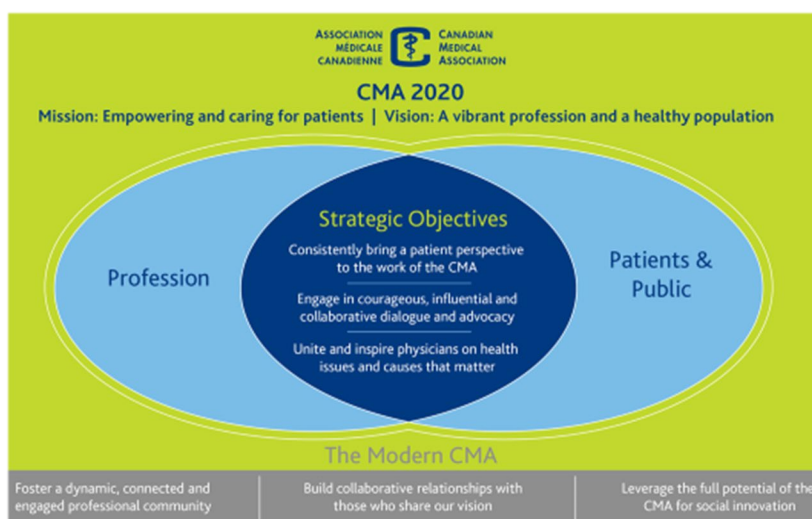
As set out in the CMA Bylaws, the basis for orders and rules of procedure is to be taken in accordance with the current edition of Robert's Rules of Order Newly Revised. Business should be transacted in an orderly manner to enable members to express opinions within limits of decorum. At all times, participants will support a respectful and collaborative environment. Members may raise questions during the Annual General Meeting.

Turning aspirations into actions

The CMA unites physicians to take action on health issues that matter to the profession and Canadians. We focus our efforts on issues where we can have a significant impact through health advocacy, informed policy, impactful programs and powerful partnerships. We look to our members for their bold ideas and engage with them to identify priorities. Our purpose is to drive meaningful change. We achieve this by launching courageous conversation with members, stakeholders and the public, addressing the most pressing and complex health challenges. Through a strong collective voice, we will shape the future of health and health care.

CMA 2020

Physicians empower and care for patients. It is their calling and their passion. We embrace this in our mission as we strive to build a vibrant medical profession and a healthy population.



We are well positioned to deliver on our 2020 vision. Last fall the CMA Board adopted four guiding principles — accountability, transparency, engagement and impact — to frame decision-making and actions, given the evolving and complex landscape in which we operate. Through engagement and dialogue, we continue to prioritize issues that matter most to physicians. We will execute initiatives based on our planning process which includes short, medium and long-term horizons. This will ensure we optimize our efforts in support of new priorities while also sustaining momentum on enduring issues. For 2019 and into 2020 (short-term horizon), our focus will be on:

- proactive policy and advocacy in key areas: physician health and wellness (including gender equity and cultural diversity), health human resources (including virtual care and national licensure) and seniors' care
- advancing current activities: cannabis, opioids, medical aid in dying, and youth mental health and substance use, and
- responding to issues as they relate to global health, climate change, pharmacare and other emerging issues.

At the enterprise level we will execute on the Health Summit, 2019 federal election strategy, affinity agreement with Scotiabank, develop new ways of partnering with provincial and territorial medical associations (PTMAs) and affiliates, and advance an effective enterprise governance.

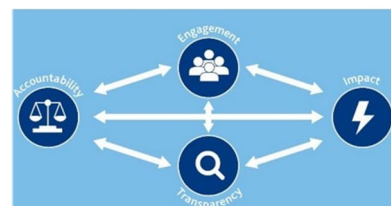
As we approach 2020, the Board will engage in strategic discussions to articulate the future role of the CMA and how the CMA enterprise will deliver bold initiatives that stand up to our vision of a vibrant profession and a healthy population. Working with those that share this vision, we will successfully drive meaningful and impactful change.

Key highlights

In 2018-2019, the CMA achieved significant milestones toward fulfilling the vision for its strategic plan — CMA 2020:

- Held the [inaugural Health Summit](#) in Winnipeg sparking a national conversation about innovation and its potential to help build a future of better health
- Co-hosted the International Conference on [Physician Health](#) in Toronto, engaging participants on the critical issue of physician wellness
- Launched new [platforms](#) to strengthen our connections with members and stakeholders
- Reached a milestone of 70,000 [Demand a Plan](#) supporters for seniors' care
- Established our first-ever [patient advisory group](#)
- Appointed our first non-physician member on the CMA Board of Directors

Guiding principles



Corporate objectives

- Implement key governance initiatives and enterprise framework
- Identify and execute on select issues and define the CMA's role in social innovation and thought leadership
- Select initiatives for execution under the affinity agreement with Scotiabank
- Strengthen CMA engagement with members and stakeholders on issues that matter to the profession and the public

Supporting physicians and a vibrant profession

Physician health and wellness – The CMA recognizes the range of challenges physicians face and is advocating for a shared responsibility approach — targeting individual, cultural and systemic factors that negatively affect physician health — as the pathway to meaningful and sustained improvement. We have surveyed physicians, developed policies and statements and the work continues with a focus on resiliency, safe work environments, decreasing stigma and improving access to services and support for all Canadian physicians and learners. This includes understanding the physician health and wellness landscape to inform the creation of a strategic plan and framework, continuing work on current initiatives (i.e., conferences, member and stakeholder engagement, building collaborative relationships, etc.) and exploring opportunities that could be supported through the [CMA-Scotiabank affinity agreement](#), such as undertaking [a national review on physician wellness](#). A first of its kind in Canada, this comprehensive, national analysis on the state of physician wellness supports and structures across the country will serve as the foundation upon which our future work on physician wellness will be built.

In addition, thanks to the affinity agreement, the [Well Doc Alberta](#) initiative, led by Dr. Jane Lemaire and supported by the Alberta Medical Association, is receiving \$1.6 million over three years to enhance physician wellness. The scalability of the Well Doc Alberta initiative is of national importance, as it can also serve as a model for other provinces and territories. Affinity contributions have also been made to national specialty societies to fund physician health and wellness initiatives.

The 2018 International Conference on Physician Health attracted over 500 participants. The CMA Foundation provided grants to support CMA’s sponsorship of 25 students to attend as CMA Wellness Ambassadors; the CMA also sponsored an additional 25 CMA members’ attendance at this event. [Join us in St. John’s this fall for the 2019 Canadian Conference of Physician Health](#).

As the work continues, stay informed by visiting cma.ca/physician-health-and-wellness.

Tools and Resources

[CMA Statement on Physician Health and Wellness](#) outlines a set of principles and commitments to help you promote healthy training and practice environments.

[CMA Policy on Physician Health](#) provides a series of recommendations to help guide stakeholders to promote a healthy, vibrant, and engaged profession.

[Background to CMA Policy on Physician Health](#) provides recent data and research, including factors which may be impacting physician health and wellness, and the links to patient care.

[CMA National Physician Health Survey: A National Snapshot](#) provides baseline data on a range of wellness indicators for physicians and residents.

Women in medicine – The President has been very active in sharing CMA’s message to increase diversity and inclusion in medicine and to remove biases and take down barriers to improve patient care. Some related initiatives include:

- Releasing a joint CMA-Federation of Medical Women of Canada discussion paper for consultation: Gender equity and diversity in Canadian medicine
- Releasing a joint statement on gender equity and diversity in medicine on International Women’s Day
- Making connections with a CMA-supported physician-led community of interest about creating an inclusive medical community

Physician health

- is a shared responsibility, that involves individual, cultural and environmental/organizational dimensions
- is important all along the physician career phases
- supporting physician health can also improve patient care



To highlight the impact of stigma, at each regional member forum we polled the audience with the following question: *How comfortable would you feel if a colleague opened up to you about their mental health issue?* Most respondents (79%) were either comfortable or very comfortable in listening to their colleagues. But when asking: *How comfortable would you be in opening up to a colleague if you were experiencing a mental health issue?* Only 22% of respondents felt comfortable or very comfortable in opening up to a colleague.

Source: 2019 Regional Member Forums

Financial well-being

Some members have suggested that financial peace of mind is a critical component for wellness and have asked the CMA to explore “pension-like” retirement options for physicians. A third-party expert has been retained to review the current state of legislation for retirement savings, and the options that could be developed in the future. We will provide an update to members on this very complex issue in August.

National Physicians’ Day

The CMA, along with many PTMAs celebrated National Physicians’ Day on May 1. The CMA seized this opportunity to publicly express our sincere appreciation to members. On that occasion, the CMA announced its 2019 awards recipients – read their stories on cma.ca. The CMA and Doctors of BC also marked the occasion by hosting a fireside chat on physician health and wellness in Vancouver.

Engagement and collaboration to drive meaningful change

To create improvements in health and health care delivery, the CMA continues to engage members and stakeholders when developing policies and programs, not only at scheduled events but also year-round through ongoing reflection and dialogue.

Regional Member Forums 2019 – This past winter, the CMA engaged with members in Edmonton, Ottawa, Montreal and Halifax to discuss what matters most to them. Key messages included:

- Support for physician health and wellness as key priority
- The need to add a complementary national perspective on physician resource planning (e.g., licensure, balancing supply and demand across jurisdictions, CaRMS match)
- The need for increased control and flexibility in training and practice to decrease burnout and facilitate career transitions
- Technology/virtual care adoption is stymied by payment, process and policy more so than by technology itself
- The need for more supports to foster diversity and inclusion in the profession (e.g., gender, cultural, generational, etc.)
- Perceived “under-valuing” of family/general practitioners and other generalists may have an impact on supply, for example, in rural medicine

Communities of Interest – The CMA is making it easier for members to connect with people engaged in a specific health topic, and to share their feedback and ideas with the CMA via its [community engagement platform](#). Certain areas of the platform are open to non-members. In addition to regularly scheduled health topic discussions, the platform also hosts communities of interest. Members can also use the site to start their own conversations and connect with other participants with shared interests. By joining the platform and sharing your expertise, you can help ensure our policies are accurate and comprehensive, and that we are taking action on the health issues you care about.

Member proposals – This new process provides more opportunities for member input into policy development with a year-round intake and consultation process. On the corporate side, it also provides the opportunity to suggest enhancements to CMA governance and bylaws.

Policy proposals are reviewed by a physician review group; the Board may then refer proposals to a committee or working group for further consideration or consult with members, PTMAs, affiliates, etc., or approve a proposal without consultation if it is non-controversial, supports a policy gap or requires little/no resources to implement. **Corporate proposals** are reviewed by the Governance Committee and follow a similar process as outlined above. No corporate proposals of a bylaws’ nature were received by the deadline for discussion at this year’s AGM. To date, CMA has received policy proposals on such topics as gun control, digital health and breast screening. Some have been sent out for consultation, while others have been referred to a speciality affiliate society. Click [here](#) for more information and submission forms.

Health Summit – The CMA hosted its first-ever Health Summit in Winnipeg last year to spark a national conversation about innovation and its potential to help build a future of better health. The summit was attended by more than 700 physicians, providers, patients, innovators and stakeholders who exchanged ideas and questions about innovation as a key driver to a future of better health. Building on this success, the second [CMA Health Summit](#), will look at the full potential of our health system through our connections with each other as physicians, patients, providers and leaders and by driving better connections between data, innovation and technology. Join us in Toronto Aug. 12-13 to learn from experiences, leverage best practices and actively engage on the policy issues that will lead to a better ecosystem of care.

CMA Patient Voice – This new patient-liaison group provides insight on the emerging issues that matter most to patients and the public. Members of this group bring their unique perspectives about navigating medical systems — from coping with their own illness, to providing care and support to family members or running community programs. Learn [more](#).

Click [here](#) to learn more about what we heard at the **Regional Member Forums**

- Open dialogue generated forward thinking on topical issues (physician workforce and health and wellness)
- High interest in more engagement and dialogue opportunities in future
- High expectations of the CMA as unifier of the profession and for leadership at the national level, with positive support for CMA 2020

Learn more about the communities sponsored through our 2018 [communities of interest grant program](#)

- Indigenous health
- Equity in medicine
- Substance use
- Medical assistance in dying
- Medical care for vulnerable populations

Our stakeholders

Memorandums of understanding between the CMA and PTMAs and affiliates are being developed. This will support future collaboration which align member-engagement activities and joint initiatives that will advance shared priorities. The CMA is also exploring how to strengthen collaboration with the Quebec medical community to unite physicians in Quebec with their colleagues across Canada on issues of concern to the profession including the health of Canada’s population.

Unmatched medical graduates

The CMA is exploring ways to assist medical students in the residency matching process (including gradually moving the interview process to a virtual platform) and reducing the number of unmatched Canadian graduates. We continue to partner with Resident Doctors of Canada, the Canadian Federation of Medical Students, the Association of Faculties of Medicine of Canada and the Canadian Resident Matching Service to address these issues.

Advocating on behalf of Canadians and the medical profession

In pursuing our policy and advocacy agenda to address issues facing the medical profession and to improve the health of Canadians, the CMA met regularly with government officials and stakeholders to develop recommendations and solutions for Canada's pressing health issues.

2019 Federal election strategy – The CMA is focused on having health on the 2019 federal election campaign agenda as well as the need to talk about innovative solutions to address the challenges we face within our health care system. This is a great opportunity to mobilize the profession and the public to amplify our advocacy voice and to encourage Canada's political leaders to take notice as they develop election platforms.

As part of the first phase, we hosted a listening tour in March (St. John's, Montreal, Toronto, Winnipeg and Victoria) and carried out public opinion research to hear first-hand what matters most to members and Canadians about their health and the health care system. We also hosted an Election Readiness Day in Ottawa with members of the Board, the [Patient Voice](#), the [Ambassador Program](#) and the [Very Involved Physicians](#) program to get feedback on some of the key advocacy issues we've identified and determine how best to raise awareness on the national stage.

As part of the second phase, CMA will continue to connect with members and the public through a variety of platforms and events to build momentum and engage federal political parties. The findings from our research will also be delivered as part of briefings during intergovernmental meetings (health ministers, seniors' ministers and premiers) to advance health priorities. The last phase will include hosting community roundtables with candidates and members, a president's tour, social media campaigns, engaging grassroots members in target ridings and holding a session at the 2019 Health Summit ([Politically Connected: Getting Health Back on the Agenda](#)). Click [here](#) to get involved.

National seniors' strategy – The CMA continues to advocate for a national plan to address all aspects of seniors' care, including long-term, palliative and home care. Last September, the President appeared before the House of Commons Standing Committee on Finance to share the [CMA's recommendations](#) as part of [pre-budget consultations](#). Included in our recommendations was the need to top up the Canada Health Transfer, providing additional financial support to provinces and territories with higher numbers of seniors.

The CMA continues to be active in the media and in public forums on this issue and encouraged all Canadians to celebrate National Seniors' Day on Oct. 1. We've also reached a milestone of 70,000 [Demand a Plan](#) supporters. And CMA's [2018 Healthy Canadians Grants](#) supported community-based programs focused on seniors' wellness, thanks to the support of the CMA Foundation providing grants totaling \$150,000.

While our advocacy has led to significant achievements, including the creation of the federal cabinet position of Minister of Seniors in July 2018, there's still more to be done. We encourage all physicians to [join the conversation](#).

National pharmacare – The CMA has advocated for more affordable prescription medications for more than 30 years. Recent studies and consultations by the federal government have put the idea of a national pharmacare program back on the country's agenda. The [Advisory Council on the Implementation of National Pharmacare](#) was struck in February 2018. We have suggested to the council that it explore the feasibility of a universal federally-funded "essential medicines" prescription drug plan and will continue to call for Canadians to have access to medically necessary prescription drugs regardless of their ability to pay. The [CMA's brief](#) informed by the results of a member e-panel survey and submitted to Health Canada last November. We will comment on the council's final report when it is tabled.

CMA objective

- Influence political leaders to engage on health care by talking about innovative solutions

Listening to Canadians

53% of Canadians say health care is their greatest worry with 9 in 10 specifically worried about:

- a shortage of health professionals
- long wait times and crowded hospitals
- that governments may need to cut health care to balance budgets
- the cost impact of an ageing population
- that patients will have to pay for health services in the future

6 in 10 Canadians plan to vote for the Party that has the best plan for the future of the health system

Source: Ipsos poll of 3,352 Canadians



Out-of-pocket medical expenses faced by seniors and their caregivers are rising.

[Measures to Better Support Seniors and Their Caregivers](#), a Conference Board report created for the CMA, presents two options for how the federal government could better support lower/middle income seniors and their caregivers.



- \$12,000 is the annual cost of health care for the average senior vs. \$2,700/person for the rest of the population
- \$93 billion is expected in additional health care costs over the next 10 years due to aging

Source: 2018 CMA / Conference Board of Canada report



- 7 in 10 physicians frequently ask patients about drug coverage, indicating lack of coverage is a barrier for many people
- 46% of physicians say patients without drug coverage do not fill prescriptions

Source: 2018 CMA member survey

Advocating on behalf of Canadians and the medical profession

Opioids – The CMA is concerned with the rise in overdose deaths and has recommended a comprehensive, multi-pronged strategy to address the opioid crisis. This includes addressing drug safety, monitoring and optimal prescribing, access to pain management and addiction services and education. We have also participated in many initiatives, including Health Canada’s regulatory changes to address barriers to appropriate care, supporting take-back programs (to encourage appropriate disposal of leftover medications) and opioid prescribing guidelines. The CMA is a partner of the Pan-Canadian Collaborative on Education for Improved [Opioid Prescribing](#), which aims to give health care professionals the evidence and information they need for optimal decision-making about opioids in practice.

Tools and Resources

[Guideline for management of opioid use disorder](#) details optimal strategies for treating opioid addiction (*Canadian Research Initiative in Substance Misuse*).

[Addressing stigma](#) includes seven things you can do to help reduce stigma, an online tutorial with facts about mental illness and practical strategies for combating stigma, and more (*Centre for Addiction and Mental Health*).

[Opioid tapering tool](#) helps you evaluate therapies and reduce patients’ dosages safely and effectively (*Centre for Effective Practice*).

[Opioid prescription manager](#) – helps you manage prescriptions for patients experiencing chronic, non-cancer pain.

Cannabis – To coincide with the legalization of cannabis last October, the CMA launched a [public health campaign on the health risks of cannabis use](#), targeting young Canadians. The ads focused on facts about using cannabis and the potential negative side effects for young users including a [video](#) describing the risks (which was viewed over 500,000 times). We have also recommended to Health Canada that governments and health professionals determine the design and messages on cannabis packaging so people won’t be enticed to use the drug; the government supported this position in its regulations, stating that cannabis packaging must be plain and carry mandatory health warnings. We continue to advocate for a public health approach to cannabis with three primary aims: prevent problematic drug use; make assessment, counselling and treatment services more available; and improve safety through harm reduction programs and awareness.

Tools and Resources

[CMA policy on medical marijuana](#) – Marijuana can offer patients relief when conventional therapies do not, but a lack of evidence of the risks and benefits of its use makes it difficult for physicians to properly advise patients. See our recommendations for addressing this issue and others in our policy.

[Guidelines for lower-risk cannabis use](#) offers 10 science-based recommendations to help individuals lower the health risks of cannabis use (*Centre for Addiction and Mental Health*).

Display the lower-risk cannabis use [poster](#) or [postcard](#) in your office so patients can view or take away reliable information about cannabis use.



- 8,000+ apparent opioid-related deaths occurred in Canada between January 2016 and March 2018
- 81% of accidental apparent opioid-related deaths involved fentanyl or fentanyl analogues in the first few months of 2018
Source: 2018 Government of Canada
- 10.1% decline in the quantity of opioids dispensed in Canada between 2016 and 2017 — more than twice the decline between 2015 and 2016
Source: 2018 CIHI report



The CMA supports a [public health approach to substance use issues](#), and a comprehensive national strategy to address the harms associated with psychoactive drugs. (Dec 2018)

[CMA signs an open letter](#) reinforcing the need to provide greater and more equitable access to supervised consumption sites in Ontario. (Aug 2018)

Code of Ethics and Professionalism

CMA’s new [Code of Ethics and Professionalism](#), which addresses new realities and affirms the core commitments to which the medical profession aspires, is now available. The Code is a key resource, along with the [Charter of Shared Values](#) which outlines physicians’ commitments to each other. More than 6,000 comments helped inform the update, gathered through interviews, surveys, online discussions and in-person events.

CMA Ambassadors

[Several opportunities](#) exist for the medical profession’s next generation to provide input into the future of how care will be delivered to patients, how physicians will work with other health care professionals to improve our system, and how we can strive to keep Canada at the forefront of best in class health care. [Get involved](#).

Advocating on behalf of Canadians and the medical profession

Climate change and health – The CMA joined the Canadian Public Health Association in [calling for the implementation of the Canada-specific recommendations](#) presented in the [Lancet Countdown on Health and Climate Change](#). The CMA echoed the report’s findings that Canada must continue to show leadership in addressing climate change issues and also pushed for action during a media event with the Canadian Association of Physicians for the Environment. The Board also endorsed the Global Climate and Health Alliance’s [Call to Action on Climate and Health](#), which speaks to phasing out coal and includes a transition away from oil and natural gas to renewable energy.

International/global health – The CMA continues its affiliation with several international medical associations and in representing Canadian physicians internationally. Here are some highlights:

- The CMA was chosen as the only NGO to be a member of Canada’s delegation to the [World Health Assembly](#) in Geneva.
- While on her annual medical mission to Uganda in January, President Dr. Gigi Osler connected with several health advocacy organizations, such as the Ugandan Medical Association and local health care providers.
- Dr. Osler met with the British Medical Association to discuss global health, physician health and wellness, and equity and diversity.
- Dr. Osler also participated in a United Nations meeting of the Commission on the Status of Women.
- President-Elect Dr. Sandy Buchman met with key stakeholders in London and Scotland to share what we have learned from the legalization of medical assistance in dying in Canada; he also met with colleagues in Australia to share key learnings from our work on end-of-life care.
- Past president Dr. Chris Simpson represented the CMA as part of the United Nations Working Group on Aging, sharing our work on seniors’ care.
- The Board also met with representatives from [Médecins Sans Frontières \(MSF\)/Doctors Without Borders](#) to learn more about their initiatives for delivering high quality medical expertise all over the world.

With the CMA’s departure from the World Medical Association, ideas on championing health issues at a global level are being explored with a focus on mirroring successful initiatives such as the International Conference on Physician Health (in collaboration with the American and British medical associations). We are excited about the opportunities that lie ahead including those geared to improving health care through innovation.

Virtual care and removal of barriers to cross-border services – At the Health Summit last August, attendees identified virtual care as a “significant innovation” for improving access to primary and specialty care. Similar themes emerged at the CMA’s Regional Member Forums this winter, with participants calling for more technology, training and payment models to support the adoption of virtual care in their practices.

With the potential to improve access to care, decrease wait times and make physicians’ practices more efficient, virtual care could help relieve many of the pressures facing the health care system today. But Canada is lagging many other countries in its adoption. To look at what’s standing in the way, the CMA has joined forces with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada as part of a new [task force](#). The group’s mandate is to identify the regulatory and administrative changes needed to support virtual care in Canada, and to allow physicians to deliver care to patients within and across provincial/territorial boundaries.

Choosing Wisely Canada

The CMA continues to financially support CWC plans to lead large-scale implementation projects, over the next four years, to reduce overuse, measure related impacts and build capacity across the system so that reducing overuse becomes an increasingly common feature of good health care delivery.

New policies | reports endorsed

- Antimicrobial Resistance and Stewardship Policy
- Head Injury and Concussion Policy
- Future of Medical Education in Canada – Continuing Professional Development Final Report
- College of Family Physicians of Canada’s A New Vision for Canada Family Practice -The Patient’s Medical Home
- Violence Evidence Guidance Action Project: Family Violence Education Resources
- Call to Action on Climate and Health



The CMA launched an advocacy campaign opposing the reinstatement of sick notes for short leaves in Ontario and submitted [a brief](#) stating our concerns with the move owing to the potential impact nationwide.



When asked about support for various national practice licence frameworks:

- 93% of respondents were supportive of creating a national licence permitting them to practise across Canada
- 92% of respondents supported their provincial/territorial licences being recognized across jurisdictions without additional requirements
- 29% of respondents favoured each province/territory having their own license application requirements

Source: e-Panel, fall 2018

Technology and innovation – Advancing health into the future

Medical practice and health care are continually evolving. How and where people are cared for is different today than it was a few decades ago. Technology is transforming health care. Mobile health apps and devices are creating new opportunities for patient monitoring and health promotion. Virtual care innovations are helping physicians reach patients in remote communities and across the globe. Big data and analytics are yielding deep insights into population health, contributing factors to diseases, clinical effectiveness and more. Around the corner, robotics, 3D printing, nanotechnology, the Internet of Things and virtual and augmented reality are creating new possibilities.

Though the evolution of medicine has often been difficult, the medical profession has learned from the past and looks to the future. There are always new challenges to overcome, solutions to be found and innovations to be embraced. With all this potential, there are also important questions to answer about equitable access, safety, privacy, security, funding and responsibility. The CMA is committed to driving the conversation about technology's role in Canadian health care and providing resources for physicians to support their use of technology in practice.

The CMA is working to advance programs and create a culture to support the leadership, innovation and training needed within health care. Our findings have set the stage for ongoing Health Summit conversations as we explore how to scale up innovation and break down the barriers to better health care delivery. [Let's continue the conversation this August](#) and leapfrog into the next quadrant of innovative health care. Let's pave the way for a brighter future for our patients and for the medical profession.

Governance within a modern CMA

Stemming from last year's AGM bylaw discussions, there was support for modernizing CMA's structure in an incremental approach and maintaining General Council to oversee elections and as a policy vehicle. The AGM approved a smaller board (19 by August 2020) with a new non-physician director. [Ms. Janet Ecker](#) was appointed by the Board in May to take this seat effective August 2019. We also welcome [Dr. Suzanne Strasberg](#), appointed by the Board in March, as the next Chair of the CMA Board of Directors. We thank Dr. Brian Brodie for his leadership and as an advocate for the profession and Canadians.

Plans for 2019 and 2020 include holding the Annual General Meeting (including the Awards Gala) and General Council (elections and policy session) in conjunction with the Health Summit to facilitate attendance at all three events. The 2019 [AGM and General Council elections](#) are being held on Aug. 11 in Toronto. The 2020 AGM, General Council and Health Summit are planned for August in Halifax. We welcome all members to participate.

The Nominations Committee continues to highlight more diversity and inclusion for elected positions. It has worked diligently with PTMAs and affiliates to seek and encourage nominations, where vacancies exist, that reflect the diversity and demography of the physician population. Click [here](#) to learn more about CMA elections.

Proposed bylaw changes for 2019 are mainly housekeeping in nature. Please refer to Appendix A at the end of this report.



- 411,778 telehealth sessions in 2014
Source: 2015 Canadian Telehealth Report
- 82% of physicians enter or retrieve clinical patient notes electronically
Source: 2017 Physician Workforce Survey
- 75% of Canadians believe new technologies could solve existing issues in our health care system
Source: 2018 Ipsos survey



The [Future of Technology in Health and Health Care: A Primer](#) explores the potential of virtual care, big health data and technological developments to revolutionize the delivery of medicine and health care in Canada

[Shaping the Future of Health and Medicine](#) – the CMA commissioned Ipsos to examine the state of public opinion in Canada as it relates to these issues

As one of CMA's subsidiaries, [Joule](#) supports physician-led innovation, knowledge products and innovative technologies:

- [Joule Innovation grant program](#)
- [Physician Leadership Institute](#)
- DynaMed Plus®, ClinicalKey®, CPS Online and CPS on RxTx Mobile app
- POEMs
- Ask a Librarian
- CPG Infobase™
- Quantum Clinical Search™
- [CMAJ](#)
- Journals, textbooks, publications and more

CMA members also receive special pricing on several new Canadian physician-led health care innovations including:

- The Cloud DX Connected Health Kit
- The Ocean Platform for Patient Engagement
- The Reacts integrated, secure virtual collaboration platform

Learn [more](#).

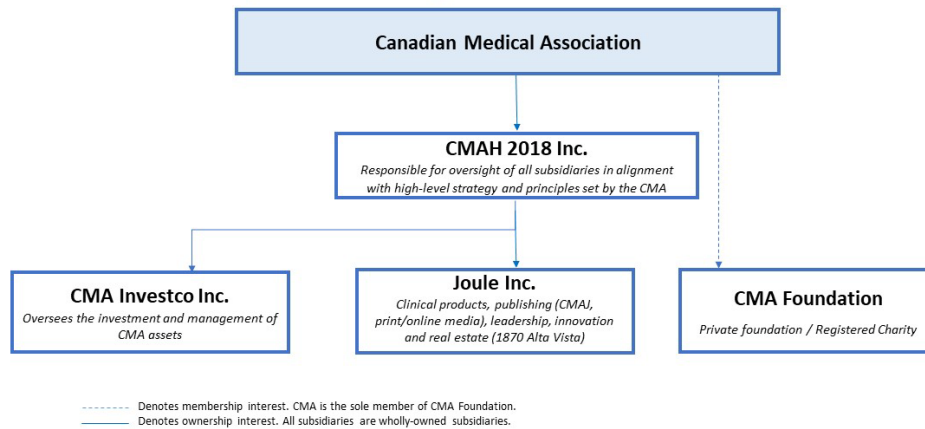
CMA's new enterprise structure

With the sale of MD Financial Management (MD) to Scotiabank in 2018, the CMA has restructured its enterprise to ensure it meets best governance practices. All activities generating (or intended to generate) revenues are carried out by the appropriate taxable CMA subsidiary. Through a subsidiary governance framework, the CMA Board ensures appropriate oversight of its subsidiaries through CMA Holdings (CMAH) 2018 Inc. Four guiding principles will assist with this oversight: accountability, transparency, efficiency and excellence.

The CMA also retains oversight over its subsidiaries through various policies:

- approving the mandates and composition of each subsidiary board
- electing subsidiary directors and approving subsidiary bylaws
- articulating and approving a clear subsidiary governance framework which guides and directs the enterprise and the relationship between the CMA and its subsidiaries
- setting high level policies and guidelines to guide and direct the subsidiaries

CMA Group of Companies



The CMA has established a new subsidiary, CMA Investco Inc., to oversee the investment and management of the assets from the sale of MD. CMA Investco is governed by a board of directors made up of people with extensive investment expertise. The CMA has and will continue to solicit feedback from its members on how the proceeds from the sale can be used to build initiatives that support our vision.

The CMA Board is also helping to identify focus areas for the CMA Foundation so that it can positively impact Canadians and their health through health equity. The insights provided will be leveraged to inform the Foundation's refreshed strategy.

With the restructuring of the enterprise, a review of Joule's mandate is underway to strengthen alignment and promote efficiencies within the enterprise while continuing to deliver value-based products and services to members.

CMA-Scotiabank affinity agreement

In tandem with the sale of MD, Scotiabank and the CMA entered into a 10-year collaboration to support physicians and the communities they serve. This will see Scotiabank invest \$115 million over 10 years on priority areas, including physician wellness. In March, Scotiabank and MD announced the launch of the Scotiabank [Healthcare+ Physician Banking Program](#), which provides more innovative banking choices for physicians. The launch of this new banking offer is the result of Scotiabank and MD collaborating to expand the financial products and services available to Canada's physician community. Scotiabank maintains MD's unique physician model, brand and remuneration for financial advisors. The CMA endorses [MD Financial Management](#) as a preferred financial provider for physicians and their families.

CMA Enterprise

CMA Board is responsible for delivering on CMA's mandate, which includes overseeing for-profit subsidiaries, strategic planning and risk management.

CMAH 2018 oversees the CMA subsidiaries and promotes alignment with the strategy set forth by the CMA Board of Directors.

Joule helps physicians be their best by supporting physician-led innovation, providing learning opportunities for physicians, and by offering access to leading evidence-based clinical products and research.

CMA Foundation provides impactful, charitable giving to registered Canadian charities to further excellence in health care.

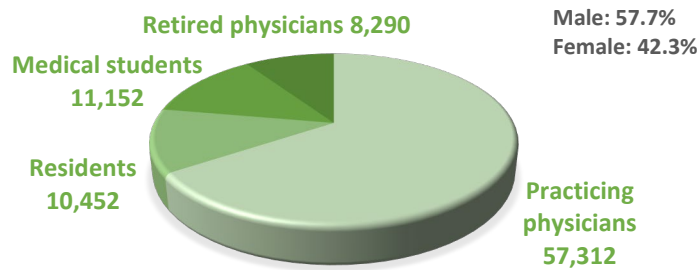
CMA Investco is responsible for monitoring and managing the CMA's assets.

CEO CMA Group of Companies –

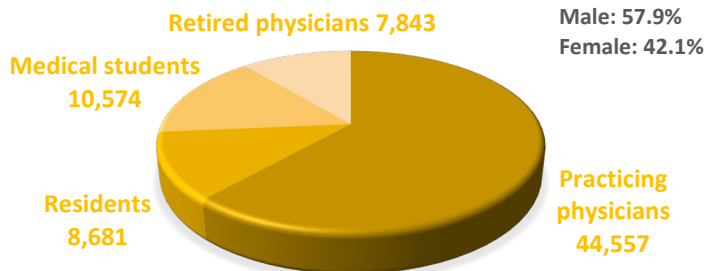
The CMA Board has expanded the CMA CEO's role to CEO for the CMA Group of Companies. This sees the CMA's current CEO, Tim Smith, assume CEO responsibilities for CMAH 2018 and CMA Investco Inc. Mr. Smith will also provide strategic oversight for Joule, working with its CEO and Board members.

Our members

2018 Membership (as at Dec. 31): 87,206



2019 Membership (as at June 10): 71,655



The CMA is actively communicating with physicians to renew their membership for 2019 by promoting its value proposition via a membership awareness campaign. This year's campaign emphasizes the CMA's role in supporting physicians and uniting them on [health issues that matter](#). CMA's 2019 membership has exceeded our projections of 68,000.

Health Summit, Annual General Meeting and General Council

[Join us in Toronto this August](#) as the CMA hosts its second Health Summit in Toronto, Aug. 12-13, with a theme centered around 'Connected in Care'. On Aug. 11, we will be holding our [AGM, General Council elections](#) and [Awards Gala](#). A General Council policy session on virtual care will be integrated into the Summit. Click [here](#) for more information.

Appointment of auditors – The Board will be recommending to members that PricewaterhouseCoopers be retained as CMA's auditor for 2020.

Bylaw amendments – As previously noted, proposed bylaw amendments of a housekeeping nature were reviewed by the Board in May for consideration at the 2019 AGM. This includes confirming the ratification role of General Council in the electoral process. The proposed amendments become effective when adopted by a two-thirds majority vote of members present and voting at the AGM. There were changes also made to the Operating Rules and Procedures in the past year. The current version, recently adopted by the Board of Directors, is available [here](#).

Members Q&A – Members are encouraged to attend and participate in this year's AGM. Members will have an opportunity to ask questions of the CMA leadership during the AGM on Aug. 11 in Toronto.

Nominations and Elections – The Nominations Committee report is available [here](#). Bios for each nominee as well as the nominations and elections processes are included in the committee's report. Elections will take place on Aug. 11 in Toronto.



Several factors have contributed to the anticipated change in membership in 2019:

- declining membership renewal/retention experienced by all member-based organizations
- changed value proposition with access to MD available irrespective of CMA membership
- change in the collection of membership fees in Manitoba and Ontario (a first for CMA)
- discontinuing conjoint membership in Alberta and BC (nominally)
- usual yearly lapses in membership renewals



In 2018, as the CMA focused its efforts on launching a new online engagement platform, it surpassed its engagement target of 10,000 by almost 4,000 touch points. So far in 2019, over 7,500 members engaged with the CMA on various issues.

Looking ahead

In delivering on CMA 2020, an exciting new path awaits us. As we move forward, innovative thinking will be the cornerstone of success in strengthening the new, modern CMA.

In addition to implementing the CMA 2020 and looking beyond, we will continue to work on priority activities that are relevant to the profession and Canadians and where we are able to make a difference. As such, please note that the priorities listed at the beginning of this report are subject to change to allow flexibility in addressing those issues that matter most to members.

Stay in touch on [cma.ca](#) and through [Board meeting summaries](#) published quarterly.

THE ACT OF INCORPORATION AND BYLAWS

Appendix A

AS AMENDED, AUGUST 2019~~2018~~



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© Canadian Medical Association

An Act to Incorporate the Canadian Medical Association

S.C. 1909, c. 62, as am. by S.C. 1959, c.73 and S.C. 1993, c.48

Whereas Adam T. Shillington, Robert Wynyard Powell, Frederick Montizambert, Henry Beaumont Small and John D. Courtenay, all of the City of Ottawa, in the province of Ontario, physicians, have by their petition on behalf of the unincorporated society known as the "Canadian Medical Association," prayed that it be enacted as hereinafter set forth and it is expedient to grant the prayer of the said petition: Therefore His Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

1. The said Adam T. Shillington, Robert Wynyard Powell, Frederick Montizambert, Henry Beaumont Small and John D. Courtenay, and all other members of the said present unincorporated society, together with such other persons as become members of the corporation, are hereby constituted a corporation under the name of the "Canadian Medical Association" hereinafter called the "Association."
2. The objects of the Association shall be
 - (a) to promote the medical and related arts and sciences and to maintain the honour and the interests of the medical profession;
 - (b) to aid in the furtherance of measures designed to improve the public health and to prevent disease and disability;
 - (c) to promote the improvement of medical services however rendered;
 - (d) to publish the Canadian Medical Association Journal and such other periodic journals as may be authorized, together with such transactions, reports, books, brochures or other papers as may promote the objects of the Association;
 - (e) to assist in the promotion of measures designed to improve standards of hospital and medical services;
 - (f) to promote the interests of the members of the Association and to act on their behalf in the promotion thereof;
 - (g) to grant sums of money out of the funds of the Association for the furtherance of these objects; and
 - (h) to do such other lawful things as are incidental or conducive to the attainment of the above objects.
3. The Association may make such by-laws and rules, not contrary to law or to the provisions of this Act, as it may deem necessary for the government and management of its business and affairs, and especially with respect to the qualification, classification, admission and expulsion of members, the fees and dues which it may deem advisable to impose, and the number, constitution, powers and duties of its executive council, or other governing or managing committee, and of its officers, and may from time to time alter or repeal all or any of such by-laws and rules as it may see fit.
4. Until altered or repealed in accordance with the provisions thereof, the existing constitution, by-laws and rules of the said unincorporated society, in so far as they are not contrary to law or to the provisions of this Act, shall be the constitution, by-laws and rules of the Association.
5. The present executive council and other officers of the said unincorporated society shall continue to be the executive council and officers of the Association until replaced by others in accordance with the constitution, by-laws and regulations aforesaid.
6. No member of the Association shall, merely by reason of such membership, be or become personally liable for any of its debts and obligations.
7. The Association may receive, acquire, accept and hold real and personal property by gift, purchase, legacy, lease or otherwise, for the purpose of the Association, and may sell, lease, invest or otherwise dispose thereof in such manner as it may deem advisable for such purposes.

Bylaws

Chapter 1. General

1.1 This Association shall be known as the “Canadian Medical Association” or “Association médicale canadienne.”

1.2 Language

French and English may be used in the conduct of the business of the Association.

1.3 Definitions

Affiliate Society means a Canadian medical organization approved for affiliation by the Board of Directors according to these bylaws.

Annual General Meeting or **AGM** means the Annual General Meeting of Members.

Associate Society means a Canadian Medical organization that is approved for associate status by the Board of Directors according to these bylaws.

Association means Canadian Medical Association or Association médicale canadienne.

Bylaws means this bylaw and all other bylaws of the Association as amended and that are, from time to time, in force and effect.

Delegate to General Council means a person appointed pursuant to section 10.2 of these bylaws to attend General Council and includes a delegate appointed by virtue of his/her position.

Divisional Entitlement means the formula used for determining the number of nominations for honorary membership a division may make, and the number of delegates to General Council a division may elect or appoint, pursuant to these bylaws; that number depends on the number of members who are honorary or fee-paying in the division who are members of the Association as of December 31.

Membership Year means the membership year of the Association that runs from January 1 through December 31.

Operating Rules and Procedures means the rules prescribed by the Board of Directors pursuant to Chapter 20 of these bylaws.

Recognized Medical School is one that has been recognized by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada.

Transition

1.4 ~~Subject to section 4.5, the~~ The bylaw amendments adopted during the ~~Annual Meeting~~ AGM in 2018 ~~2019~~ take effect immediately following the close of ~~General Council in 2018~~ Health Summit, ~~which will be held immediately following the close of the 2018 Annual Meeting.~~ These amendments shall not affect the previous operation of any bylaw or affect the validity of any act done pursuant to any former bylaw.

1.5 ~~Notwithstanding subsection 11.2.1(b)(i), there shall be 3 directors from the province of Ontario until the close of the Health Summit in 2020. The composition of the Board of Directors shall remain as follows until the close of the Health Summit in 2019:~~

(a) ~~The President, President-Elect, Immediate Past President, and Chair of the Board of Directors elected or appointed pursuant to these bylaws; and~~

(b) ~~the following elected directors:~~

i) ~~provincial/territorial directors as follows:~~

Commented [PC1]: Housekeeping: All of the amendments adopted during the 2019 AGM take effect at the close of the 2019 Health Summit, including removal of the 2018 transition provisions.

Commented [PC2]: Housekeeping: the new board composition approved in 2018 will be achieved through attrition when current directors' terms expire

Province/Territory	Number of Directors
Alberta	2
British Columbia	3
Manitoba	4
New Brunswick	4
Newfoundland & Labrador	4
NWT	4
Nova Scotia	4
Ontario	5
Prince Edward Island	4
Quebec	2
Saskatchewan	4
Yukon	4

ii) ~~a student director; and~~

iii) ~~a resident director.~~

Chapter 2. The Seal

2.1 The Seal of the Canadian Medical Association shall be in the custody of the Chief Executive Officer and shall be affixed by the Chief Executive Officer or delegate or by a person selected by an ordinary resolution of the Board of Directors to all documents that require to be sealed.

Chapter 3. Divisions

3.1 Subject to the approval of General Council, the provincial/territorial medical association representing organized medicine in a province or in a territory may become a division and enjoy all the rights and privileges of a division in the following manner:

- (a) by intimating to the Association in writing that it desires to become a division;
- (b) by agreeing to amend, where necessary, its constitution and bylaws to place them in harmony with the constitution and bylaws of this Association; and
- (c) by agreeing to collect from those of its members who desire to be members of the Association such annual fee as may from time to time be set for membership and remit same to this Association, unless otherwise requested by the division.

3.2 An affiliation formed under this Chapter shall mean that a friendly relationship exists between CMA and the division. There shall be no obligation on the part of either party to sponsor policies or programs initiated by or on behalf of the other.

Chapter 4. Ethics

4.1 The Code of Ethics ~~and Professionalism~~ of the Association shall be the members' guide to professional conduct.

Commented [PC3]: Housekeeping: title has been updated

Chapter 5. Membership

- 5.1 All members, as a condition of membership, shall agree to accept, uphold and be governed by the CMA Code of Ethics and to be governed by the bylaws. The provisions set forth in the Operating Rules and Procedures shall apply to all applicants for membership.
- 5.2 The membership categories of the Association shall be: full, student, resident, retired, at-large, associate and honorary, designated as follows.
- 5.3 Full Members
- 5.3.1 Every member in good standing of a division shall be a full member of the Association on payment of the applicable Association annual fee.
- 5.4 Student Members
- 5.4.1 Any medical student enrolled in a Canadian medical school who is a member of a division may be a student member of the Association on payment of the applicable Association annual fee.
- 5.5 Resident Members
- 5.5.1 Any medical practitioner enrolled in a postgraduate program at a Canadian medical school who is a member of a division may be a resident member of the Association on payment of the applicable Association annual fee.
- 5.6 Retired Members
- 5.6.1 Any individual who has retired from the practice of medicine, who is no longer engaged in professional activities and who is a member of a division may be a retired member of the Association on payment of the applicable Association annual fee.
- 5.7 Members-at-Large
- 5.7.1 Applicants from within Canada
- The following residents of Canada are eligible to become members-at-large of the Association upon the payment of the applicable Association annual fee:
- (a) Physicians who:
 - i) have graduated from a recognized medical school;
 - ii) demonstrate that they are members in good standing of a Canadian or foreign licensing authority, or were members in good standing immediately prior to their retirement; and
 - iii) are ineligible for division membership.
 - (b) Physicians who are members of the Canadian Armed Forces.
- 5.7.2 Applicants from Outside of Canada
- The following non-residents are eligible to become members-at-large of the Association upon the payment of the applicable Association annual fee:
- (a) Physicians who:
 - i) have graduated from a recognized medical school; and
 - ii) demonstrate that they are members in good standing of the licensing authority of the jurisdiction in which they practise medicine or were members in good standing immediately prior to their retirement.
 - (b) Canadians who:
 - i) are medical students enrolled in a recognized medical school; or
 - ii) are medical residents enrolled in a postgraduate program at a recognized medical school.
- 5.8 Associate Members

- 5.8.1 Members of a division who are in special circumstances, as defined by the Board of Directors, and who require a reduction in the full membership fee, may become associate members upon application, approval and payment of the applicable Association annual fee.
- 5.9 Honorary Members
- 5.9.1 Persons who have distinguished themselves by their attainments in medicine, science, the humanities or who have rendered significant services to the Association may be appointed as honorary members with the unanimous approval of the Board. Honorary members shall enjoy all the rights and privileges of the Association but shall not be required to pay any Association fee. The Board may approve the following as Honorary Members:
- (a) Members of the Association in good standing who have attained the age of 65 years and have been members for 10 years may be nominated for honorary membership by a member of the Association. Such nominations require the approval of the executive body of the division in which the nominees practiced, are practicing medicine or reside.
 - (b) Each division, in accordance with the following divisional entitlement, is entitled to nominate 1 honorary member each year for up to 1000 of its members and 1 additional honorary member for each further 1000 or fraction thereof. A division acting as host of the Annual General Meeting may nominate 1 additional honorary member that year.
 - (c) Persons who may or may not be members of the medical profession, who have attained eminence in science or the humanities, or who have rendered significant services to the Association may be nominated by a member or division for honorary membership. The number of these memberships shall not exceed 1 per 1000 members.

Chapter 6. Fees

- 6.1 Subject to section 5.9.1, the Board of Directors shall establish the applicable Association annual fee for all membership categories, and shall report the annual fee to the AGM.
- 6.2 When changes are proposed, the Board of Directors shall send a notice of intent to the divisions and the members no later than 30 days before the AGM. The fee changes shall be effective at the start of the Association's next membership year.

Chapter 7. Rights and Privileges of Members

- 7.1 All members are entitled to attend and vote at the AGM as full participants.
- 7.2 All members are entitled to attend open meetings of General Council as observers.
- 7.3 Members are eligible for services and benefits of the Association under terms and conditions established from time to time by the Board of Directors.
- 7.4 The Board of Directors shall call a Special Meeting of members on its own volition or within 100 days from receipt by the Chief Executive Officer of a request signed by not fewer than 500 Association members. Such a request shall state the object of the proposed meeting. Any Special Meeting shall consider only such business as shall be specified in the notice calling the meeting. For all such meetings, 30 days' notice must be given to the members.

Chapter 8. Termination of Membership, Removal or Suspension of Rights and Privileges

- 8.1 If a member ceases to meet the conditions for membership described in Chapter 5, membership in the Association may be terminated or suspended by the Board of Directors in accordance with the Operating Rules and Procedures.
- 8.2 A division shall notify the Association immediately of any suspension or termination of a member of that division, at which time membership in the Association shall automatically be suspended or terminated accordingly. In that event, any membership fees that have been paid to the Association by the member shall be automatically forfeited. The division shall notify the Association of any reinstatement or readmission of the member, in which case, provided the member meets the qualifications for membership in the Association, the Association shall reinstate or readmit the member, as the case may be.
- 8.3 Membership in the Association shall automatically terminate if a member has not paid the applicable Association annual fee in accordance with the requirements set out in the Operating Rules and Procedures.
- 8.4 By accepting membership in the Association under the terms of the bylaws, each member agrees to such right of termination of membership as aforesaid and thereby specifically waives any right or claim to damages in the event of membership being so terminated.
- 8.5 Resignation of membership may be effected by giving notice directly to the Chief Executive Officer.

Chapter 9. Annual General Meeting

- 9.1 There shall be an AGM at a time and place to be decided by the Board of Directors. The time and place shall be announced to the membership in an Association publication with distribution to all members as early as possible and at least 30 days prior to the meeting.
- 9.2 Planning and other matters relating to the AGM are set forth in the Operating Rules and Procedures of the Association. Business conducted at the AGM shall include:
 - (a) receiving the reports of the Board of Directors and Committee on Ethics, and allowing members to ask questions of the Board of Directors;
 - (b) enactment, amendment or repeal of bylaws; and
 - (c) appointment of an auditor.
- 9.3 A quorum for the AGM shall be 50 members present in person.

Chapter 10. General Council

- 10.1 Duties and Powers
 - 10.1.1 General Council shall provide policy guidance and direction to the Association and the Board of Directors and more specifically, shall as far as possible deal with
 - (a) the report of the Committee on Nominations and
 - (b) any matter relating to the general health and welfare of the public or the profession.

10.1.2 Subject to ~~15-215.1~~ and the provisions in these bylaws concerning filling vacancies, General Council has sole authority for, and may not delegate, the election of the President-Elect, the directors, the Speaker and the Deputy Speaker of General Council, the Chair of the Committee on Ethics, members of the committees on Ethics and Nominations, and elected members of the Governance, Audit and Finance, and Appointments committees, in accordance with the nominations process outlined in the Operating Rules and Procedures.

Commented [PC4]: Housekeeping: numbering of section 15.2 changed to 15.1 in 2018

10.2 Composition of General Council

10.2.1 Delegates to General Council shall be as follows:

- (a) Delegates by virtue of their position:
 - i) the Chair of the Board and the Board of Directors;
 - ii) the Speaker and Deputy Speaker;
 - iii) the President of each division;
 - iv) the chairs of the Committee on Ethics, the Governance Committee and the Committee on Awards;
 - v) a delegate from the Royal Canadian Medical Service, at the direction of the Surgeon General; and
 - vi) past Presidents, past Speakers, past Chairs of the Board of Directors, and past Chief Executive Officers are entitled to be voting delegates at meetings of General Council for 5 years following completion of their term of office.
- (b) Division and Affiliate Society delegates elected or appointed subject to paragraph 10.2.2.
 - i) delegates from the divisions; and
 - ii) the affiliate society delegates.

10.2.2 Divisional and Affiliate Entitlement for Delegates to General Council

- (a) Delegates shall be appointed by divisions to General Council in accordance with the following divisional entitlement: each division is entitled to appoint 4 delegates for up to 100 of its members; 1 additional for 101 to 250; 1 additional for 251 to 500 and 1 additional for each further 500 or fraction thereof. For greater certainty, student members may be appointed by their divisions as divisional delegates to General Council. Notwithstanding the divisional entitlement, the Ontario Medical Association is entitled to appoint one additional delegate to represent the Territory of Nunavut, until such time as a medical association in the Territory of Nunavut is established as a division of the Association. The individual appointed to represent the Territory of Nunavut must be currently residing and practising medicine in the Territory of Nunavut and shall be appointed in accordance with the Operating Rules and Procedures.
- (b) Affiliated societies shall each be entitled to 1 delegate.
- (c) Delegates must be Association members.

10.2.3 The names and addresses of delegates appointed pursuant to paragraph 10.2.2 shall be submitted by divisions and affiliates to the Chief Executive Officer at least ~~90-30~~ days before the first day of General Council. A delegate may be replaced by an alternate on notification in writing to the Chief Executive Officer by the constituency represented.

Commented [PC5]: Elections: to allow more flexibility in 2020 if GC elections occur in spring prior to the AGM.

10.3 Meetings

10.3.1 General Council shall meet at least once in each year.

10.3.2 Special Meetings of General Council

- (a) For the purposes of special meetings, the membership of General Council, unless new delegates have been appointed, shall be as at the previous meeting.
- (b) The Board of Directors shall call a Special Meeting of General Council on its own volition or within 100 days from receipt by the Chief Executive Officer of a request signed by:
 - i) not fewer than 500 Association members, or
 - ii) 50 delegates from at least 3 divisions, provided that not more than 50% are from any 1 division.

Such a request shall state the object of the proposed meeting. Any Special Meeting shall consider only such business as shall be specified in the notice calling the meeting. For all such meetings, 30 days' notice must be given to the delegates.

10.3.3 A quorum shall be 50 delegates present in person. All delegates except the Speaker and Deputy Speaker shall be eligible to vote.

10.3.4 Observers may attend open meetings of General Council in accordance with these bylaws and the Operating Rules and Procedures.

10.4 Speaker and Deputy Speaker of General Council

10.4.1 Speaker

The Speaker:

- (a) shall preside at all meetings of General Council and enforce due observance of the bylaws and the rules of order according to Chapter 18;
- ~~(b) shall, in consultation with the Chair of the Board of Directors, decide upon the relative order of all business to be presented to General Council;~~
- ~~(c) shall have the authority to establish a Resolutions Committee;~~
- (b) ~~(d)~~ shall remain in office for a 3-year term, and may hold office for a maximum of 2 consecutive terms, until the conclusion of General Council or until such time as his or her successor is appointed; and
- (c) ~~(e)~~ if the office of the Speaker should become vacant, the Deputy Speaker shall assume the position.

Commented [PC6]: Housekeeping: the agenda for General Council is focused on elections and a policy session. Business such as appointing auditors and approving bylaws were migrated to the AGM in 2016.

Commented [PC7]: Housekeeping: following trend towards removal of most committees from the bylaws; in this case additional rationale is that because of integration of GC with Health Summit, we do not expect to debate motions, making the Resolutions Committee redundant.

10.4.2 Deputy Speaker

The Deputy Speaker:

- (a) shall, when requested or when the Speaker is absent, deputize for the Speaker and assume all rights, duties and responsibilities of the Speaker;
- (b) shall remain in office for a 3-year term, and may hold office for a maximum of 2 consecutive terms, until the conclusion of General Council or until such time as his or her successor is appointed; and
- (c) if the office of the Deputy Speaker should become vacant, the Board of Directors shall appoint any member of the Association to the position until a replacement is elected at the next meeting of General Council.

Chapter 11. Board of Directors

11.1 Duties and Powers

- 11.1.1 The Board of Directors shall be responsible for the management of the affairs of the Association, including risk management. In particular, the Board of Directors:
- (a) shall appoint a Chair of the Board, who may but need not be an elected director, but must be a physician and an Association member;
 - (b) shall appoint the Chair of the Audit and Finance Committee from its members;
 - (c) shall appoint a non-physician Director;
 - (d) shall appoint the Chief Executive Officer and designate the duties of the office;
 - (e) shall approve the budget and establish membership fees for the ensuing calendar year after considering the recommendation of the Audit and Finance Committee;
 - (f) unless otherwise stated in these bylaws, shall establish committees and task forces as necessary to carry out the work of the Association, set their terms of reference, appoint the members of such bodies, and receive their reports;
 - (g) shall name the signing officers of the Association and indicate limits to their authority;
 - (h) may authorize the payment of honoraria and travel and maintenance expenses to directors, officers, officials, chairs and members of committees and others engaged in Association business;
 - (i) may appoint representatives of the Association to outside bodies;
 - (j) shall elect a vice-chair from its members, who will chair meetings of the Board in the absence or at the direction of the Chair; and
 - (k) shall create and amend the Operating Rules and Procedures of the Association and have authority for enactment, amendment or repeal of the bylaws for referral to the members at the AGM.

11.1.2 The Board of Directors is hereby authorized:

- (a) to borrow money upon the credit of the Association in such amounts and on such terms as may be deemed expedient by obtaining loans or advances or by way of overdraft or otherwise;
- (b) to mortgage, hypothecate, charge, pledge, or give security in any manner whatever upon, all or any of the property, real and personal, immoveable and moveable, undertakings and rights of the Association, present and future; and
- (c) to delegate to such appointed officials, officers or directors as they may designate, all or any of the foregoing powers to such extent and in such manner as they may determine.

11.2 Composition

11.2.1 The Board of Directors shall be comprised of:

- (a) The President, President-Elect, Immediate Past President elected or appointed pursuant to these bylaws, and Chair of the Board of Directors appointed pursuant to these bylaws; and
- (b) the following elected directors:
 - i) 1 director (includes the Chair of the Board if he or she is appointed from amongst the sitting directors) from each province or territory which has a minimum number of 50 members,
 - ii) a student director;
 - iii) a resident director; and
 - iv) a non-physician director.

11.3 Term

11.3.1 The term of office of the directors commences immediately following the AGM, General Council and Health Summit and shall be as follows:

- (a) Officers shall hold office in accordance with the terms set out in section 13.1.
- (b) Subject to section 11.3.3, student directors and resident directors shall hold office for a term of 1 year or until such time as their successors are appointed.
- (c) Subject to section 11.3.3, directors from a province or territory as defined herein and non-physician directors shall hold office for a term of 3 years, or until such time as their successors are appointed.

11.3.2 Subject to section 11.3.3, student and resident directors may hold office for a maximum of 3 consecutive terms and provincial/territorial directors and non-physician directors may hold office for a maximum of 2 consecutive terms.

11.3.3 If an incumbent becomes a provincial/territorial director, student, or resident director as a result of filling a vacancy under Section 11.5.3, the time spent filling the vacancy shall not count toward the length or number of terms that the incumbent is entitled to under these bylaws.

11.4 Removal of Directors, Officers, Electees and Appointees

11.4.1 The Board of Directors may by extraordinary resolution requiring two-thirds majority vote, remove any director, officer, electee or appointee from office before the expiration of such person's term if their conduct has been found likely to bring the Association or the profession into disrepute, if malfeasance has been found, if there has been a gross violation of the Code of Ethics and Professionalism, or for any other reason that the Board of Directors in its discretion may determine to be valid. The Board may appoint a qualified individual to fill the resulting vacancy for the remainder of the term of the director, officer, electee or appointee so removed. Any such removal shall be carried out in accordance with the requirements set out in the Operating Rules and Procedures. Notwithstanding this section, the members of a meeting may remove the chair of the meeting by following the procedures set out in the Rules of Order designated in these bylaws.

11.5 Vacancies

11.5.1 An office, a seat on the Board of Directors or on a committee shall be declared vacant:

- (a) if the incumbent resigns in writing to the Chief Executive Officer;
- (b) if the incumbent is found by a court to be of unsound mind;
- (c) except in the case of the non-physician director, if the incumbent ceases to be a member of the Association;
- (d) if the incumbent is removed by the Board of Directors in accordance with section 11.4;
- (e) if no candidate is elected by General Council;
- (f) on the death of the incumbent.

11.5.2 Unless otherwise stated in the bylaws, vacancies are filled by the Board of Directors.

11.5.3 A vacancy on the Board of Directors shall be filled by the Board of Directors, as follows:

- (a) A vacancy among the student and resident directors shall be filled by the Board with a nominee from the constituency concerned for the remainder of the incumbent's term.
- (b) A vacancy among the provincial/territorial directors shall be filled by the Board with a nominee from the constituency concerned, until the next AGM.

Commented [PC8]: Housekeeping: to allow for changes in the order of AGM, General Council and Health Summit sessions; allows elections to proceed under the pre-existing bylaws.

Commented [PC9]: Housekeeping: reflect change in title

- (c) A vacancy among the officers shall be filled in accordance with the requirements in Chapter 13.1
- (d) A vacancy in the position of the non-physician director shall be filled by the Board of Directors, and such an appointment begins the first of two consecutive 3-year terms of office a non-physician director is eligible to serve.

11.6 Meetings of the Board of Directors.

11.6.1 Notice of the time and place of each meeting shall be given to each director not less than 48 hours before the meeting is to be held. A director may waive notice of or otherwise consent to a meeting.

11.6.2 The Board of Directors shall meet at the call of the Chair.

11.6.3 On the request in writing by 6 directors representing at least 2 provinces/territories, the Chair of the Board shall call a special meeting of the Board.

11.6.4 In the absence of the Chair of the Board, the chair shall be the Vice-Chair and in the absence of both the Chair of the Board and the Vice-Chair, the President shall chair the meeting.

11.6.5 The quorum shall be 50% of the directors plus 1.

Chapter 12. Nominations

12.1 Committee on Nominations

12.1.1 General Council shall annually elect the members of the Committee on Nominations, which shall be comprised of 1 member from each province/territory, 1 member representing the affiliate societies, 1 resident member, 1 student member and the Immediate Past President of the Association who shall chair the Committee on Nominations. The process and rules for making nominations for election to the Committee on Nominations shall be contained in the Association's Operating Rules and Procedures. The Committee on Nominations shall meet at the request of the Board of Directors. ~~A quorum at any meeting of the committee shall be 10.~~

Commented [PC10]: Housekeeping: this is in the committee's Terms of Reference

12.2 Eligibility for Nomination

12.2.1 Except for the position of non-physician director, only members of the Association who are members of the medical profession shall be eligible for nomination. All nominees are subject to the Conflict of Interest Guidelines as set out in the Operating Rules and Procedures. All nominees must be residents of Canada.

12.2.2 Only members of the Association who have been members for 5 consecutive years preceding their nomination shall be eligible for nomination to the positions of President-Elect, Speaker and Deputy Speaker. Nominees for President-Elect are subject to the Conflict of Interest Guidelines as set out in the Operating Rules and Procedures.

12.3 Nominations Rules and Process

12.3.1 Any division or 50 members of the Association may submit nominations for the offices of Speaker and Deputy Speaker of General Council, Chair of the Committee on Ethics, members of the committees on Ethics and Nominations, and elected members of the Audit and Finance, Governance and Appointments committees.

12.3.2 Nominations for the student member and resident member of the Committee on Ethics shall be carried out in accordance with the Association's Operating Rules and Procedures.

12.3.3 Nominations for the Board of Directors will be made to the Committee on Nominations in accordance with the following:

- (a) Nominations for provincial/territorial directors shall be submitted by each division or by the required number of Association members of the division. Ten Association members from a division with 99 or fewer Association members, 25 Association members from a division with 100 to 499 Association members, 40 Association members from a division with 500 to 999 Association members, or 50 Association members from a division with 1000 or more Association members, may submit nominations for provincial/territorial directors.
- (b) Nominations for the student director may be submitted by any affiliate society representing medical students, or by 50 Association members of any affiliate society representing medical students. Only student members shall be eligible to be nominated.
- (c) Nominations for the resident director may be submitted by any affiliate society representing residents, or by 50 Association members of any affiliate society representing residents. Only resident members shall be eligible to be nominated.

12.3.4 The following may submit a nomination for the Office of President-Elect, in accordance with the Association's Operating Rules and Procedures:

- (a) any division;
- (b) any 50 members of the Association; ~~and~~
- ~~(c) any 5 delegates provided that such nomination is presented to General Council in session on the first day of General Council.~~

12.3.5 The general process applying to nominations shall be set forth in the Association's Operating Rules and Procedures.

12.4 Responsibilities of the Committee on Nominations

12.4.1 The primary task of the Committee on Nominations shall be to recruit and secure strong balanced leadership for the Association. In particular, the duties of the Committee on Nominations shall be as follows:

- (a) to issue a call to all members, divisions and affiliate societies, not less than 9 months prior to the next AGM, for nominations for the following elected positions in the Association: President-Elect, Speaker and Deputy Speaker of General Council, directors, the Chair of the Committee on Ethics and all members of the committees on Ethics and Nominations. The call for nominations shall also include, subject to vacancies arising; up to 2 members of the Governance Committee, up to 2 members of the Audit and Finance Committee and 1 member of the Appointments Committee. Only nominations received at least 5 months prior to the AGM, or made by the Committee on Nominations as in 12.4.1(e), shall be eligible for presentation to General Council by the Committee on Nominations;
- (b) to interact with divisions and affiliates to seek and encourage nominations that reflect the diversity and demography of the physician population, specifically with a sensitivity to age, gender, and cultural and regional balance, and the requirements of the Association regarding the specific vacancies to be filled;
- (c) to establish and maintain a process to enable nominees to indicate their eligibility and commitment;
- (d) to establish a process to ensure that all nominees for the position of director understand and agree to commit to the responsibilities of the office;
- (e) to select nominations only from those placed before it through the process referred to in these bylaws or in the Association's Operating Rules and Procedures. In the event that no eligible

Commented [PC11]: Elections: removing provision for 5 delegates to nominate a President-elect candidate to enable potential implementation for online elections.

nominations for any position are placed before it, the committee may select a nominee of its choice;

- (f) to submit, at its discretion more than 1 nomination for any position to General Council; and
- (g) in carrying out the above duties to ensure that the Association's requirements concerning eligibility for nomination set forth in Section 12.2 and the rules and procedures for nomination contained in the Association's Operating Rules and Procedures are followed.

12.4.2 The report of the Committee on Nominations shall be provided to each delegate to General Council at least 15 days before the meeting of General Council and shall be presented to General Council. Any additional nominations received by the Committee in accordance with these bylaws and the Operating Rules and Procedures shall then be presented to General Council.

~~12.4.3 When the report of the Committee on Nominations has been received by the General Council in session, except in the case of nominations under 12.3.4, other nominations may be proposed from the floor.~~

Commented [PC12]: Elections: removing nominations from the floor in preparation to enable potential implementation of online elections in the future.

Chapter 13. Officers

13.1 The officers of the Association shall be the President, the President-Elect, the Immediate Past President, the Chair of the Board of Directors and the Chair of the Audit and Finance Committee. The President, President-Elect and Immediate Past-President shall hold office for a term of 1 year or until such time as their successors are appointed. The Chair of the Board of Directors and Chair of the Audit and Finance Committee shall hold office for a term of up to 3 years and may hold office for a maximum of 2 consecutive terms or until such time as their successors are appointed. The officers of the Association shall be elected or appointed in accordance with these bylaws and the Operating Rules and Procedures. If there is more than 1 nomination for any position, a ballot shall then be taken for that position. Subject to the provisions of this Chapter, vacancies among the officers shall be filled by the Board of Directors.

13.2 The President:

- (a) shall be the senior elected officer of the Association;
- (b) shall perform such duties as custom requires;
- (c) shall be the primary spokesperson of the Association; and
- (d) with the exception of the Committee on Nominations, shall have the right to attend and vote at meetings of all committees of the Association.

13.2.1 In the event that the office of President becomes vacant, the President-Elect shall serve as Acting President.

13.3 The President-Elect:

- (a) shall assist the President in the performance of the presidential duties, and in the President's absence, or at the President's request, preside or perform such other functions as are the duties of the President, unless otherwise provided for in these bylaws;
- (b) shall assume the office of President at the close of the next AGM; and
- (c) shall serve as Acting President in the event that the office of President becomes vacant, and in that capacity shall assume all the powers and duties of the President during the unfinished portion of that presidential term.

13.3.1 In the event that the office of President-Elect becomes vacant at any time prior to 90 days before the Annual Meeting and there is only 1 person nominated for the position from the call for nominations

issued by the Chief Executive Officer in accordance with the Operating Rules and Procedures, the Chair of the Board of Directors shall declare that person duly elected. If there is more than 1 nomination for the position, General Council will fill the vacancy in accordance with the process described in the Operating Rules and Procedures. In the event of a vacancy in the office of President-Elect during the 90-day period before the Annual Meeting, General Council shall fill the vacancy in accordance with the process described in the Operating Rules and Procedures.

13.4 The Immediate Past President

- (a) shall be a member of the Board of Directors;
- (b) shall assist the President and President-Elect with spokesperson duties as delegated
- (c) shall chair the Committee on Nominations; and
- (d) shall preside over the elections at General Council.

13.4.1 In the event that the office of Immediate Past President becomes vacant, the preceding Immediate Past President shall serve as Immediate Past President. A person so appointed shall not assume the title of Immediate Past President.

13.5 Chair of the Board of Directors

- (a) shall chair and be responsible for the calling of meetings of the Board of Directors;
- (b) shall act as chief liaison officer between the Board of Directors and the Chief Executive Officer;
- (c) shall be a nonvoting member of the Board of Directors;
- (d) shall present the report of the Board of Directors to members.

13.6 The Chair of the Audit and Finance Committee

- (a) shall be the custodian of all monies, securities and deeds that are the property of the Association and shall be accountable for the safekeeping of all funds, derived from whatever source, belonging to the Association;
- (b) shall undertake the payment of all bills, monies, etc., as directed by the Board of Directors; and
- (c) shall chair the Audit and Finance Committee.

Chapter 14. The Secretariat

14.1 The Chief Executive Officer:

- (a) shall be appointed by the Board of Directors;
- (b) shall be the chief executive officer of the Association;
- (c) shall be responsible to the Board of Directors through the Chair for the general administrative supervision of the affairs of the Association, and for the organization and management of the Secretariat;
- (d) shall be a nonvoting member of all committees of the Association unless otherwise directed by the Board of Directors;
- (e) shall be an official representative of the Association; and
- (f) shall assume or delegate such duties as may be assigned by the Board of Directors.

14.2 Other appointed officials and employees shall be responsible to the Board of Directors through the Chief Executive Officer for the performance of duties assigned to them.

Chapter 15. Committee on Ethics

15.1 Subject to 12.4.2 and this section, General Council will elect the Chair and members of the Committee on Ethics in accordance with the report of the Committee on Nominations. If there is more than 1 nomination for any position, a ballot shall then be taken for that position in accordance with the Operating Rules and Procedures. The committee shall determine its own procedure including quorum, unless otherwise determined by the Board of Directors. Committee members may serve up to 2 consecutive 3-year terms. The term of office for the Committee on Ethics Chair is three years, renewable once. The term of office for a student or resident member is one year, renewable twice.

- (a) The Committee on Ethics will elaborate on, interpret, and recommend amendments to the Code of **Ethics and Professionalism**, address problems related to ethics referred to the Association, advise the Association on matters pertaining to ethical issues of interest or concern to the medical profession and on ethical issues related to the Association's core strategies and priorities and perform other duties as determined by the Board of Directors.
- (b) The Committee on Ethics shall comprise:
 - i) 5 members selected on a regional basis (BC/Yukon, Prairie provinces/NWT, Ontario, Quebec, Atlantic provinces);
 - ii) 1 resident member;
 - iii) 1 student member;
 - iv) 1 member appointed by and from within the Board of Directors; and
 - v) a chair.

Commented [PC13]: Housekeeping: to reflect new title

Chapter 16. Affiliate Societies and Associate Societies

16.1 Eligibility for affiliation

- (a) Any Canadian medical organization representing a medical specialty that is recognized by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, the majority of whose members are physicians and are members of the Association, may become affiliated with the Association. For the purposes of this section, a medical student enrolled in a Canadian medical school shall be deemed a physician.
- (b) The national organizations representing medical students and residents may become affiliated without meeting the requirements set out in 16.1(a) and shall be entitled to all the rights and privileges thereof.

16.2 Such organization may, on application to, and approval by the Board of Directors be accepted as an affiliate society and shall be entitled to 1 delegate to General Council.

16.3 Any affiliation formed under this Chapter shall mean that a friendly relationship exists between the 2 bodies. There shall be no obligation on the part of either party to sponsor policies or programs initiated by or on behalf of the other.

16.4 Affiliation shall be on a year-to-year basis and shall continue unless either party shall give notice to the other in writing of its intention to withdraw or unless the affiliate society ceases to meet the qualification for affiliation.

16.5 Associate Societies

16.5.1 Any Canadian medical organization that does not represent a medical specialty, other than the national organizations representing medical students and residents, the majority of whose members are

physicians and are members of the Association, may become associated with the Association. The organization representing the medical regulatory authorities may become associated without meeting the requirement above. Such organization may, on application to, and approval by the Board of Directors, be accepted as an associate society. Each associate society shall be entitled to 1 observer at General Council. Any association formed under this Chapter shall mean that a friendly relationship exists between the 2 bodies. There shall be no obligation on the part of either party to sponsor policies or programs initiated by or on behalf of the other. Association shall be on a year-to-year basis and shall continue unless either party shall give notice to the other in writing of its intention to withdraw or unless the associate society ceases to meet the qualifications for association.

Chapter 17. Auditor

- 17.1 An Auditor shall be appointed by the members at the AGM on the recommendation of the Board of Directors.
- 17.2 The Auditor:
- (a) shall examine annually the financial statements of the Association, perform procedures to obtain audit evidence about the amounts and disclosures in the statements, and prepare a report in accordance with the generally accepted auditing standards set out in the Chartered Professional Accountants Canada Handbook – Assurance, as amended from time to time.
 - (b) shall file the Auditor's report with the Chief Executive Officer by no later than May 15 each year (the report shall be submitted by the Chief Executive Officer to the Board of Directors), and be made available to all members of the Association by June 30; and
 - (c) shall examine and report on other financial affairs of the Association at any time during the year upon the request of the Board of Directors.

Chapter 18. Rules of Order and Meetings of the Association

- 18.1 The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Association in all cases to which they are applicable and in which they are not inconsistent with these bylaws, with the Operating Rules and Procedures, and any special rules of order the Association may adopt.
- 18.2 Secret Ballot
- 18.2.1 At meetings of the Association, an election or an issue may be determined by secret ballot if so requested by any one member present and eligible to vote.
- 18.3 Participation at meetings by telephone or electronic means
- (a) Any person entitled to attend a meeting of Members may participate in the meeting using telephonic, electronic or other communications means that permit all participants to communicate adequately with each other during the meeting, if the Association makes available such a communication facility or the person in question has access to such a communication facility. A person participating in the meeting by any such means shall be deemed to have been present at that meeting. A person participating by telephonic, electronic or other communication facility may vote by any such means if the facility, when necessary, can be adapted so that the votes can be gathered in a manner that permits their subsequent verification and permits the tallied votes to be presented to the Association without it being possible for the Association to identify how a particular member or group of members voted.
 - (b) Provided all of the directors or committee members consent, a director or committee member may participate in a meeting of directors or committee members by means of an electronic,

telephonic or other communication facility that permits all participants to communicate adequately with each other during the meeting. A director or committee member participating in the meeting by such means shall be deemed to have been present at that meeting.

18.4 Meetings held by electronic means

- (a) If the Board calls a meeting of Members, the Board may determine that the meeting shall be held entirely by means of a telephonic, an electronic or other communication facility that permits all participants to communicate adequately with each other during the meeting.
- (b) Members of the Board of Directors or committees may participate at meetings by means of such telephone or other communication facilities as permit all persons participating to communicate with and to hear each other.

18.5 Adjournment

The chair of the meeting may, with the consent of the meeting, adjourn the meeting, but no business shall be transacted at the resumption of any such adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place.

18.6 Absentee Voting.

The Board may, by resolution, prescribe one or more of the following methods of voting by Members not in attendance at a meeting of Members:

- (a) By appointing a proxyholder in accordance with the provisions set out in the Operating Rules and Procedures;
- (b) By using a mailed in ballot in the form provided by the Association provided that the Association has a system that enables the votes to be gathered in a manner that permits their subsequent verification and permits the tallied votes to be presented to the Association without it being possible for the Association to identify how each Member voted; or
- (c) By means of a telephonic, electronic or other communication facility, if the Association makes available such a communication facility and the facility enables the votes to be gathered in a manner that permits their subsequent verification and permits the tallied votes to be presented to the Association without it being possible for the Association to identify how each Member voted.

18.7 Remote Ballot for the Board of Directors and committees of the Board

- (a) The chair may take a remote ballot on any urgent matter or any appointment and in addition shall take a remote ballot, in the case of the Board at the request in writing of 6 directors and in the case of committees at the request in writing of 2 committee members.
- (b) In the case of a resolution an affirmative vote by two-thirds of the directors or committee members who are eligible to vote shall have the same force and effect as a resolution duly passed at a regular meeting. In the case of an appointment, a candidate must receive an affirmative vote by a majority of the total directors who are eligible to vote. An appointment made by remote ballot shall have the same force and effect as an appointment at a regular meeting.
- (c) A remote ballot is taken in the following manner: the questions submitted shall be in a form to which an affirmative or negative answer can be given or the appointment proposed shall be in a form by which it can be completed. The ballot shall be sent to all directors or committee members, accompanied by an explanatory note stating the circumstances of the emergency (where the matter is urgent) and giving the last date on which ballots will be received. A remote ballot may be sent to each director or committee member and returned to the Association by each such director and committee member by (i) personal delivery or courier; or (ii) electronic means. A remote ballot sent by electronic means (an "electronic ballot") is considered to have

been provided when it leaves an information system with the control of the originator or another person who provided the document on the originator's behalf. An electronic ballot is considered to have been received when it enters the information system provided by the addressee. No ballot will be counted unless it is received by the Chief Executive Officer not later than the date given. The Chief Executive Officer shall examine the ballots, record and announce the vote.

Chapter 19. Amendments to Bylaws

- 19.1 Proposals for amendments to the bylaws may be submitted by **H-10** or more members. These proposals must be received by the Chief Executive Officer 90 days before the date of the AGM for consideration by the Board of Directors.
- 19.2 Amendments to the bylaws may be proposed by the Board of Directors. These proposals must be received by the Chief Executive Officer in time for a notice to be published in an Association publication with distribution to all members and on the Association website at least 30 days before the AGM.
- 19.3 Amendments that have been proposed and published or communicated as in Section 19.2, become effective when adopted by a two-thirds vote of the members present and voting at the AGM.

Commented [PC14]: Housekeeping: to align the bylaws with the new corporate proposals process which requires 10 sponsors

Chapter 20. Operating Rules and Procedures

- 20.1 The Board of Directors may prescribe and amend from time to time such operating rules and procedures not inconsistent with the bylaws relating to the management and operation of the Association and other matters provided for in this bylaw as they may deem expedient.

Chapter 21. Execution of Documents

- 21.1 Deeds, transfers, assignments, contracts, obligations and other instruments in writing requiring execution by the Association may be signed by any 2 of its officers. Notwithstanding the foregoing, the Board of Directors may from time to time direct the manner in which the person or persons by whom a particular document or type of document shall be executed. Any person authorized to sign any document may affix the corporate seal thereto.

Chapter 22. Liability and Indemnity

- 22.1 The Association will not hold the members of the Board of Directors, or any member acting on its behalf individually or collectively liable for decisions or actions taken in good faith on behalf of the Association.
- 22.1.1 For the protection of officers, directors, officials and members of the Association, except as otherwise provided by law:
 - (a) No officer, director, official or other member or the Association is liable for any of the following acts or omissions:
 - i) the acts or omissions of any other officer, director, official, member or employee;
 - ii) joining in any act for conformity;
 - iii) any loss, damage or expense happening to the Association
 - (I) through the insufficiency or deficiency of title to any property acquired on behalf of the Association; or
 - (II) for the insufficiency or deficiency of any security upon or in which any of the monies of the Association are placed out or invested;

- iv) any loss or damage arising from the bankruptcy, insolvency or tortious act of any person, firm or corporation with whom or which any monies, securities or assets are lodged or deposited;
- v) any loss, conversion, misapplication or misappropriation of any monies, securities or other assets belonging to the Association;
- vi) any damage resulting from any dealings with any monies, securities or other assets belonging to the Association; or
- vii) any other loss, damage or misfortune which may happen in the execution of or in relation to the duties of the office or trust;

unless the act or omission happens by or through the wrongful and wilful act, neglect or default of the officer, director, official or other member of the Association.

- (b) No officer, director, official or other member of the Association is liable for any contract, act or transaction entered into, done or made for the Association, whether or not completed, if it has been authorized or approved by the Board of Directors;
- (c) If any officer, director, official or other member of the Association
 - i) is employed by or performs services for the Association other than in the individual's role in the Association; or
 - ii) is a member of a firm or a shareholder, director or officer of a company employed by or performing services for the Association;

the fact that the individual is an officer, director, official or other member of the Association shall not alter the individual's entitlement to proper remuneration for the services performed.

22.1.2 Indemnities to Officers, Directors and Others

Every officer, director, official or other member of the Association, or other person who has undertaken or is about to undertake any liability on behalf of the Association or any company controlled by the Association, their heirs, executors, administrators and estates are indemnified out of the funds of the Association, from and against:

- (a) all costs, charges and expenses incurred in the execution of the duties of the office
 - i) in or about any proceedings commenced against the individual;
 - ii) in respect of any other liability; and
- (b) all other costs, charges and expenses incurred in relation to the affairs of the Association;

unless the costs, charges or expenses happen by or through the individual's wrongful and wilful act, neglect or default.

Chapter 23. Winding Up the Association

- 23.1 In the event of the dissolution or winding up of the Association, it is specially provided that all of the assets remaining after the payment and satisfaction of the Association's debts and liabilities shall be distributed to 1 or more organizations in Canada carrying on similar activities or having objects similar to 1 or more of the objects of the Association.
- 23.2 The Association is to carry on its operations without pecuniary gain to the Association's members, and any profits or other accretions to the Association are to be used in promoting its objects.

Appendix A: CMA Divisions and Addresses

Doctors of BC
115–1665 Broadway West
Vancouver BC V6J 5A4
Tel: 604 736-5551
Fax: 604 736-3987

Alberta Medical Association
12230–106 Avenue NW
Edmonton AB T5N 3Z1
Tel: 780 482-2626
Fax: 780 482-5445

Saskatchewan Medical Association
201 – 2174 Airport Drive
Saskatoon, SK S7L 6M6
Tel: 306 244-2196
Fax: 306 653-1631

Doctors Manitoba
20 Desjardins Drive
Winnipeg, MB R3X 0E8
Tel: 204 985-5888
Fax: 204 985-5844

Ontario Medical Association
150 Bloor Street West, Suite 900
Toronto, ON M5S 3C1
Tel: 416 599-2580
Fax: 416 340-2944

Quebec Medical Association
3200-380, rue Saint-Antoine ouest
Montréal QC H2Y 3X7
Tel: 514 866-0660
Fax: 514 866-0670

New Brunswick Medical Society
21 Alison Blvd
Fredericton NB E3C 2N5
Tel: 506 458-8860
Fax: 506 458-9853

Doctors Nova Scotia
25 Spectacle Lake Drive
Dartmouth NS B3B 1X7
Tel: 902 468-1866
Fax: 902 468-6578

Medical Society of Prince Edward Island
2 Myrtle Street
Stratford PE C1B 2W2
Tel: 902 368-7303
Fax: 902 566-3934

Newfoundland and Labrador Medical Association
164 MacDonald Drive
St. John's NL A1A 4B3
Tel: 709 726-7424
Fax: 709 726-7525

Yukon Medical Association
5 Hospital Road
Whitehorse YT Y1A 3H7
Tel: 867 393-8749

Northwest Territories Medical Association
PO Box 1732, Station Main
Yellowknife NT X1A 2P3
Tel: 867 920-4575
Fax: 867 920-4578

Appendix B: CMA Affiliated Societies

Association of Medical Microbiology and Infectious Disease Canada	Canadian Orthopaedic Association
Canadian Academy of Geriatric Psychiatry	Canadian Paediatric Society
Canadian Academy of Sport and Exercise Medicine	Canadian Psychiatric Association
Canadian Anesthesiologists' Society	Canadian Rheumatology Association
Canadian Association of Medical Biochemists	Canadian Society for Vascular Surgery
Canadian Association of Emergency Physicians	Canadian Society of Allergy and Clinical Immunology
Canadian Association of Gastroenterology	Canadian Society of Cardiac Surgeons
Canadian Association of General Surgeons	Canadian Society of Colon and Rectal Surgeons
Canadian Association of Nuclear Medicine	Canadian Society of Endocrinology and Metabolism
Canadian Association of Paediatric Surgeons	Canadian Society of Internal Medicine
Canadian Association of Pathologists	Canadian Society of Otolaryngology — Head and Neck Surgery
Canadian Association of Physical Medicine and Rehabilitation	Canadian Society of Palliative Care Physicians
Canadian Association of Radiation Oncology	Canadian Society of Plastic Surgeons
Canadian Association of Radiologists	Canadian Thoracic Society
Canadian Association of Thoracic Surgeons	Canadian Urological Association
Canadian Cardiovascular Society	National Specialty Society for Community Medicine
Canadian Critical Care Society	Occupational Medicine Specialists of Canada
Canadian Dermatology Association	Public Health Physicians of Canada
Canadian Federation of Medical Students	Resident Doctors of Canada
Canadian Geriatrics Society	Society of Gynecologic Oncologists of Canada
Canadian Neurological Society	Society of Obstetricians and Gynaecologists of Canada
Canadian Neurosurgical Society	Trauma Association of Canada
Canadian Ophthalmological Society	

Appendix C: CMA Associated Societies

Canadian Association of Physicians for the Environment

Canadian Association of Physicians with Disabilities

Canadian Life Insurance Medical Officers Association

Canadian Medical Protective Association

Canadian Society of Addiction Medicine

Canadian Society of Clinical Neurophysiologists

Canadian Society of Physician Executives

Canadian Spine Society

Federation of Medical Regulatory Authorities of Canada

Federation of Medical Women of Canada

Occupational & Environmental Medical Association of Canada

Society of Rural Physicians of Canada

2019 Award Recipients

F.N.G. Starr Award

Danielle Martin, MD

Medal of Service

Ak'ingabe Guyon, MD

Owen Adams Award of Honour

Ed Hobday

May Cohen Award for Women Mentors

Mamta Gautam, MD

Sir Charles Tupper Award for Political Action

Alika Lafontaine, MD

John McCrae Memorial Medal

Lt. Col. Vivian McAlister, MD

Award for Young Leaders (Students)

Philip Edgcumbe, PhD

Charles-Antoine Barbeau-Meunier

Award for Young Leaders (Residents)

Ali Damji, MD

Sheila Wang, MD

Award for Young Leaders (Early career physician)

David-Martin Milot, MD

Terms of reference for each award and biographical information for recipients are available [here](#).

2019 Honorary Members

Northwest Territories

Margaret Anne Woodside, MD

British Columbia

Kenneth Bassett, MD

William Ehman, MD

Karen Gelmon, MD

Alan Hill, MD

Simon Holland, MD

Paul Klimo, MD

Louise Martin, MD

Margaret McGregor, MD

Richard Nuttall, MD

Jack Onrot, MD

Tim Rowe, MD

Andrew Sear, MD

Barry Turchen, MD

Garth Warnock, MD

Keith White, MD

2019 Honorary Members (Cont'd)

Alberta

Douglas B. DuVal, MD

Steven M. Edworthy, MD

Brent T. Friesen, MD

Gordon H. Johnson, MD

Gerhard N. Kiefer, MD

Dale C. Lien, MD

Roger C. Rampling, MD

Fredrykka D. Rinaldi, MD

Peter M. Venner, MD

Saskatchewan

Anne Doig, MD

Milo Fink, MD

George Miller, MD

Louis Poulin, MD

Manitoba

Jagmit Arneja, MD

Allan Becker, MD

Harold Booy, MD

Catherine Cook, MD

James Ross, MD

Ontario

Craig Campbell, MD

Laurence Colman, MD

Garrett Foley, MD

Wendy Graham, MD

Alan Hudak, MD

Michael Kaufmann, MD

Stewart Kennedy, MD

Peter Kuling, MD

Geraint Lewis, MD

Ross Male, MD

David Morgan, MD

Gordon Porter, MD

Quebec

Thomas Connor O'Neill, MD

New Brunswick

Roderick Canning, MD

Thomas Goulding, MD

Réjean Savoie, MD

Nova Scotia

Kim Crawford, MD

Albert Doucet, MD

Sharon Litz, MD

Prince Edward Island

Stephen O'Brien, MD

Newfoundland and Labrador

Donald Andrew Tennent, MD

Randolph Chiu-Lun Tsang, MD