BCMA leads country with 16 resolutions at CMA

Each year the BCMA, like the other provincial and territorial divisions of the Canadian Medical Association, sends a delegation to the CMA's General Council (GC). The CMA's annual meeting this year was 22–25 August in Niagara Falls.

The BCMA Caucus met 16 July, under the able chairing of Dr Shelley Ross. As chair of General Assembly, she is responsible for the planning and coordination of the BCMA's input to GC. BC has a history of leading the way in health promotional initiatives. We had sufficient resolutions (16) going forward this year to involve all of the caucus members in moving or seconding a resolution—great experience for the new delegates. The following is a brief roundup of the resolution topics.

We endorsed collaboration with Health Canada and the Public Health Agency of Canada to investigate the deleterious effects on ecosystems from the nonveterinary use of antibiotics in agricultural operations, including the role they play in the emergence of antibiotic-resistant organisms in humans.

We encouraged addiction prevention measures for youth by proposing that energy drinks be included under the Food and Drug Regulations of Canada so that the amount of caffeine they contain could be regulated. Another resolution proposed that liquor distribution boards follow Health Canada regulations and not sell premixed alcoholic energy drinks.

The BCMA caucus had a lively debate before advocating for a ban on mixed martial arts fighting in Canada. Less controversial, taking into account the large and well-conducted international studies of the last decade, was a motion to perform a comprehensive review of the net benefit/risks of male infant circumcision as a prophylactic public health measure.

Bringing back a resolution opposed by Ontario last year, we supported the installation of automatic external defibrillators (AEDs) in public facilities (e.g., sport venues) and high-traffic areas, where it is feasible. The last phrase was added so as not to make it a requirement that every medical office install an AED.

In conjunction with our recently released policy paper, *Partners in Prevention*, the BCMA endorsed the development and implementation of a lifetime prevention plan for patients. The plan would be coordinated by a GP.

We asked government to ensure that patient-focused funding initiatives be developed collaboratively, with meaningful consultation from physicians who are representative of, and accountable to, the medical profession; the initiatives should also be evidence-based and quality-of-care enhancing.

We want multidisciplinary care initiatives that incorporate long-term, sustainable funding and resources that will remove the financial barriers to involving diverse allied health professionals (e.g., nurses, physician assistants, nurse practitioners) within physician offices.

Finally, your caucus supported the recognition of a sixth principle of sustainability in the Canada Health Act that meets reasonable and defined standards of health human resources, infrastructure, clinical outcomes, and fiscal capacity.

New funds for emergency medicine

Moving away from resolutions and on to the topic of emergency medicine, an understanding was reached with government that now provides $6 million of new funds identified for emergency departments—thanks to the leadership of Dr David Haughton, president of the Section of Emergency Medicine, and the efforts of Mr Geoff Holter and Mr Tod MacPherson (BCMA Negotiations Department). Half of this funding will be used to increase the number of emergency physicians in the service-contracted emergency departments, with the other half dependent upon increases in the number of services provided at the various sites.

The increase in resources will clearly benefit patients at these sites, yet I have received some strong complaints from a few physicians who provide emergency services in rural and urban areas, each perceiving themselves to be less fairly treated than their colleagues. In my opinion, we have made good progress in addressing the issue of funding for emergency services and will have some continuing work to fine tune the new workload model and to ensure that it addresses the factors affecting each site with a service contract in place. It is not always possible to arrive at an envy-free solution, but I have no doubt that the compromises that were made were done with best efforts to be fair and objective to all.

—Ian Gillespie, MD
BCMA President