2012-13 Reports to the Annual General Meeting

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We are the AMA
2012-13 Reports to the Annual General Meeting

The annual general meeting of the Alberta Medical Association will be held at 10 a.m. on Saturday, September 28, 2013, at The Westin Edmonton (Manitoba/Saskatchewan rooms), 10135 100 ST NW, Edmonton AB.

The easy way to get online
Throughout this report you will find several QR codes. Scan these codes using your smartphone or tablet device to be taken to relevant content online.

If you don’t have a QR code reader app on your phone, download one for free from www.scanlife.com.
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Dr. John T. Huang, Calgary

L to R: Dawn Wyver (Administrative Assistant) and Erika Serek (Project Coordinator, Practice Management Program), Southern Alberta Office

Dr. Susan J. Hutchison, Edmonton
Agenda

O Canada

Call to Order

In Memoriam
Michael A. Gormley

President’s Valedictory
Dr. R. Michael Giuffre

Minutes, 2012 Annual General Meeting

Nominating Committee Report
Dr. Linda M. Slocombe

Report from RF
Dr. Allan S. Garbutt
- Report from the Board of Directors

Executive Director’s Report

Constitution and Bylaws Report
Dr. Edward W. Papp

Committee on Financial Audit Report/Financial Statements
Dr. T. Britt Simmons

Canadian Medical Foundation Presentation by Lee Gould, President and CEO

Other Business

Adjournment
Mission & Vision

Alberta’s physicians and the Alberta Medical Association (AMA) are committed to Patients First®.

Mission: Leadership and Support
The Alberta Medical Association stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.

Vision: Patients First®
Alberta’s physicians are committed to a health care system that facilitates wellness and delivers patient- and family-centered care:

• The provincial health care system is built around patients and families and defined by quality: acceptability; accessibility; appropriateness; effectiveness; efficiency; safety.

• Patients and families enjoy optimal health through access to:
  • Healthy lifestyle choices.
  • Healthy environments and communities.
  • Health service access based primarily on need, not ability to pay.

• The health care system has the resources to deliver patient- and family-centered care, with best evidence used to allocate resources to what is most effective and efficient in meeting health care needs.

• The relationship between physician and patient remains a cornerstone of the health care system, founded on mutual respect, dignity, compassion and trust. Care is delivered with, not to, the patient, including:
  • Patient choice of a physician.
  • Physicians as agents of patients acting always in the patient’s best interests.

Patients First®
Patients First® is a registered trademark of the Alberta Medical Association.

• Clinical and professional autonomy of physicians.

• Providers and patients are partners with funders and managers, sharing the goal of a patient- and family-centered health care system with defined roles and responsibilities and clearly specified appropriate accountability.

Scan to learn more about Patients First®, or visit: www.albertadoctors.org/advocating/patients-first

www.albertadoctors.org/advocating/patients-first
## In Memoriam

Members deceased since the last annual meeting are:

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
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<tbody>
<tr>
<td>ALLEN, Peter B.</td>
<td>Edmonton</td>
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<tr>
<td>ANAND, Harminder S.</td>
<td>Edmonton</td>
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<td>ANSELMO, John E.</td>
<td>Edmonton</td>
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<td>BEAMISH, William E.</td>
<td>Edmonton</td>
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<td>BEARDSWORTH, John H.</td>
<td>Innisfail</td>
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<td>BENNETT, Ian</td>
<td>Lethbridge</td>
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<td>BEREZOWSKY, Walter H.</td>
<td>Edmonton</td>
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<td>BLEVISS, Morley</td>
<td>Edmonton</td>
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<td>BONHAM, Gerald H.</td>
<td>Delta BC</td>
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<td>BOWERS, Leslie S.</td>
<td>Victoria BC</td>
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<td>CALDER, Kimberley C.</td>
<td>Calgary</td>
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<td>COLTER, Donald R.</td>
<td>Edmonton</td>
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<tr>
<td>COOKSON, Francis B.</td>
<td>Qualicum Beach BC</td>
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<td>DELIYANNIDES, Charlie</td>
<td>Calgary</td>
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<td>DIAMOND, Edgar G.</td>
<td>Calgary</td>
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<td>FARVOLDEN, Cynthia G.</td>
<td>Calgary</td>
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<td>FORWARD, James D.G.</td>
<td>Oyama BC</td>
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<td>GANATRA, Bipin H.</td>
<td>Calgary</td>
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<td>GRINSTEIN, Maxwell</td>
<td>Calgary</td>
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<td>HINTON-DRY, J. Margaret</td>
<td>Ottawa ON</td>
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<td>JOHNSTON, Lloyd W.</td>
<td>Lethbridge</td>
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<td>JOWSEY, John W.</td>
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<td>KOCH, Eduard A.</td>
<td>Edmonton</td>
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<td>KOWALEWSKI, Konstanty</td>
<td>Edmonton</td>
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<td>LAWSON, Alan K.</td>
<td>Edmonton</td>
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<td>LEWIS, David J.</td>
<td>Salt Spring Island BC</td>
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<td>LEWIS, Ronald D.M.</td>
<td>Calgary</td>
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<td>LIPPOLT, Gordon B.</td>
<td>Lac La Biche</td>
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<td>MCCCRACKEN, Peter N.</td>
<td>Edmonton</td>
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<td>MCEWEN, Howard</td>
<td>Calgary</td>
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<td>MCLEAN, Spencer R.</td>
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<td>MCPHAIL, Bryan E.</td>
<td>Edmonton</td>
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<td>MERCER, Dennis F.</td>
<td>High River</td>
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<td>MORRISH, Hugh F.</td>
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<td>MORTIMER, Shane</td>
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<td>NATTESS, John R.</td>
<td>Lloydminster</td>
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<td>O’NEIL, Agnes J.</td>
<td>Cochrane</td>
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<td>PIDDE, William J.</td>
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<td>POMAHAC, Anthony</td>
<td>Lethbridge</td>
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<td>RAY, Mihirendra N.</td>
<td>Edmonton</td>
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<td>ROSSALL, Richard E.</td>
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<td>SECTER, Barbara A.</td>
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<td>SHUTT, H. Ken</td>
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<td>SMULSKI, John</td>
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<td>STERNS, Laurence P.</td>
<td>Edmonton</td>
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<td>SUIDAN, Ramzi M.</td>
<td>Medicine Hat</td>
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<td>VISSER, Pieter</td>
<td>Wainwright</td>
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September 22, 2012

1. The 107th Annual General Meeting (AGM) of the Alberta Medical Association (CMA Alberta Division) was held on September 22, 2012, in the Manitoba/Saskatchewan Rooms, Westin Hotel, 10135 100 Street NW, Edmonton, Alberta.

2. O Canada was sung.

3. Call to Order
   Dr. Ernst P. Schuster presided as speaker and declared the 107th Annual General Meeting in session and duly constituted at 10 a.m.

4. Resolutions Committee
   The Resolutions Committee appointed for the Representative Forum (RF) served as the Resolutions Committee for the AGM. Appointees were Dr. Daniel R. Ryan, Deputy Speaker, as chair, and RF Planning Group members Dr. Dianne E. Brox, Dr. Carl W. Nohr and Dr. Maeve O’Beirne.

5. Rules of Conduct
   The speaker noted that business meetings of the association are conducted in accordance with *Procedures for Meetings and Organizations* (3rd edition) by Kerr & King.

6. In Memoriam
   Thirty-nine members passed away since the last Annual General Meeting, and Executive Director Michael A. Gormley read their names into the record:

   ARMITAGE, John 
   BAKER, Donald B. 
   BHARADWAJ, Baikunth B. 
   BOUTIN, Laurier G. 
   BROWN, ROBERT H. 
   CHOI, M. Vincent 
   CHONKO, Michael E. 
   CLARKSON, James G. 
   DAFOE, Charlotte S. 
   DOWNSBROUGH, Frank K. 
   DUNN, Douglas A. 
   GJOSUND, Walter K. 
   GOMES, Sydney J. 
   HODGINS, Kenneth W. 
   HOWELL, James M. 
   HUTFIELD, David C. 
   JAMIESON, William S. 
   KERESZTURI, Joseph J. 
   KLOPPER, Juri 
   KUZYK, Nicholas J. 
   MAHON, John D. 
   MARSHALL, George 
   MCPHEDRAN, Norman T. 
   MELGRAVE, Anthony 
   MERCER, John E.H. 
   MILNE, John D. 
   MOSSEY, Joseph F. 
   PAWLUK, William 
   PLEWS, Anthony 
   RAPP, Edna F. 
   RIDGWAY, Clayton R. 
   SETTLE, John R. 
   SIMS, Harry V. 
   SINGH, Santokh 
   TAYLOR, Ronald M. 
   VAN NETTEN, Francis M. 
   VERNICK, John P. 
   WARD, Bryan D. 
   WILLIAMS, Robert G.

   The meeting stood to observe one minute’s silence in their memory.
7. President’s Valedictory
   The outgoing president, Dr. Linda M. Slocombe, reflected on her term as president and on its challenges and accomplishments. She thanked the directorate for its support during her term.

8. Minutes, Meeting of September 24, 2011
   By formal motion, minutes of the Annual General Meeting of September 24, 2011, were accepted for information.

9. Reports from the Nominating Committee
   2013 CMA General Council
   Dr. Patrick J. (P.J.) White, Chair, Nominating Committee, presented the report and the list of nominees.
   
   MOTION: Moved by Dr. Patrick J. (P.J.) White, seconded by Dr. Daniel J. Barer:
   
   THAT the following Nominating Committee nominees for representatives to CMA General Council 2013 be approved (AMA President attends by virtue of position):
   
   • President-elect, AMA.
   • Immediate past president, AMA.
   • Speaker or deputy speaker.
   • Nine representatives named by the board.
   • Eight representatives named by the Nominating Committee.
   • Two physician appointees of the college (at least one of whom must be an elected member of the council).
   • One dean or designate from his office.
   • One student representative.
   • One PARA representative.
   
   “CARRIED”

   Nominating Committee Members Elected by the Annual General Meeting
   By due process the following were elected as members of the Nominating Committee for 2012-13:
   
   • Dr. Kathryn L. Andrusky
   • Dr. Daniel J. Barer
   • Dr. Peter C. Jamieson
   • Dr. Gerry D. Prince

10. Election of Speaker and Deputy Speaker
    The meeting was informed that there were five nominees for the speaker and deputy speaker election:
    
    • Dr. Susan J. Hutchison
    • Dr. Darryl D. LaBuick
    • Dr. Carl W. Nohr
    • Dr. Fredykka D. Rinaldi
    • Dr. Daniel R. Ryan

    Each candidate presented a two-minute platform to the meeting.
By due process Dr. Carl W. Nohr was elected as AMA Speaker for 2012-13; Dr. Darryl D. LaBuick was elected as AMA Deputy Speaker for 2012-13.

11. Report from the Representative Forum

President-Elect Dr. R. Michael Giuffre highlighted the issues addressed in the written report circulated to members.

MOTION: Moved by Dr. R. Michael Giuffre, seconded by Dr. Allan S. Garbutt:

THAT the report from the RF be accepted.

“CARRIED”

President-Elect

Dr. Allan S. Garbutt was introduced as president-elect 2012-13; he expressed his appreciation for being elected as president-elect.

12. Report from the Committee on Constitution and Bylaws

Dr. Edward W. Papp, Chair, Committee on Constitution and Bylaws, presented the report from the committee.

MOTION: Moved by Dr. Edward W. Papp, seconded by Dr. Daniel R. Ryan:

THAT proposed non-substantive amendments to the Constitution and Bylaws outlined in the 2011-12 Annual Reports be authorized and approved.

“CARRIED”

MOTION: Moved by Dr. Edward W. Papp, seconded by Dr. Daniel J. Barer:

THAT the existing bylaws of the association be rescinded in their entirety and the bylaws as amended by resolution passed at this Annual General Meeting held on September 22, 2012, be adopted.

“CARRIED”

13. Report from the Committee on Financial Audit

Dr. T. Britt Simmons, Chair, Committee on Financial Audit, presented the report from the committee.

MOTION: Moved by Dr. T. Britt Simmons, seconded by Dr. R. Michael Giuffre:

THAT the Auditor’s Report and the audited financial statements for the Alberta Medical Association for the year ended September 30, 2011, be received for information.

“CARRIED”

MOTION: Moved by Dr. T. Britt Simmons, seconded by Dr. Daniel J. O’Connor:

THAT the firm of PricewaterhouseCoopers be reappointed as auditors for the Alberta Medical Association for the 2012-13 fiscal year.

“CARRIED”
14. Installation of Officers
Dr. R. Michael Giuffre was installed as AMA president for 2012-13 by CMA President Dr. Anna Reid at the CMA President’s Luncheon.

15. Acknowledgments
MOTION: Moved by Dr. R. Michael Giuffre, seconded by Dr. Allan S. Garbutt:
THAT the profession express its sincere appreciation to Dr. Linda M. Slocombe and her husband Jack for their service, sacrifice, and dedication to the profession over the past year.

“CARRIED”

MOTION: Moved by Dr. Allan S. Garbutt, seconded by Dr. Patrick J. (P.J.) White:
THAT the Annual General Meeting express its sincere appreciation to the Senior Management Team and staff for their dedication to the pursuit of the goals of the association.

“CARRIED”

MOTION: Moved by Dr. Allan S. Garbutt, seconded by Dr. Patrick J. (P.J.) White:
THAT the association express its sincere appreciation to Dr. Ernst P. Schuster and Dr. Daniel R. Ryan for their conduct of this meeting.

“CARRIED”

16. Other Business
MOTION: Moved by Dr. Kevin M. Hay, seconded by Dr. Edward J. Aasman:
THAT the list of nominees to various positions be presented in random rather than alphabetical order.

“CARRIED”

17. Adjournment
There being no other business, the speaker adjourned the formal business session of the 107th Annual General Meeting at 10:30 a.m.

Following the annual meeting, delegates participated in the Margaret Hutton Lecture Series (Alberta Medical Foundation History of Medicine presentations).

Alberta Medical Foundation – Margaret F. Hutton Lecture Series
Dr. Dawna M. Gilchrist, President, Alberta Medical Foundation, introduced the presentations on the following topics:

- Survey of Descriptive Terms Referring to Congenital Cognitive Impairment Over the Past Century – Caroline Lee
- Albert Ross Tilley: The Legacy of a Canadian Plastic Surgeon – Kevin Mowbrey
Many priorities, many challenges but one vision

1. A year that began in great uncertainty finished with a new foundation for the future. Throughout this challenging year, the Alberta Medical Association vision Patients First® and our mission to provide leadership and support were the anchors for our decision making and for the results that were achieved in 2012-13. This report outlines the many activities aimed at turning mission and vision into action.

2012-13 Business Plan and Budget

2. The AMA’s business plan establishes the long-term goals for the organization and the plans for moving toward these goals during a particular year. It describes the ends for the association as established by the Board of Directors, ensures that management’s plans are aligned with the goals and ends established by the board and Representative Forum (RF), and is the basis for assessing the annual performance of the CEO (and used by the CEO in discussing performance with senior staff).

3. Although vision and mission have remained unchanged, the way in which they are operationalized evolves from year to year. Since 2007-08, the AMA has planned on a foundation of four key result areas in response to pressures in the environment:
   - Financial health: Improve the financial health of physicians and their practices.
   - Innovation and support: Provide opportunities to physicians to improve productivity.
   - Quality: Assistance to physicians in providing the best care possible.
   - Advocacy: The public, government, Alberta Health Services (AHS) and other health care stakeholders are aware of the interests and concerns of physicians.

4. Within these key result areas, the board establishes measurable goals and objectives for framing success, intended to achieve substantive strategies identified by the board.
5. In the spring and summer of 2012 when the 2012-13 business plan was written, the environment was more unstable than it had been for many years. Negotiations for a new master agreement were still underway, an agreement in principle had been reached and then abandoned by government following the provincial election, and many other factors outlined in this report meant that planning for the future was fraught with uncertainty. Accordingly, the Board of Directors undertook a scenario-based approach to business planning in which a number of alternative futures were sketched out. Then, the board identified those strategies and activities it believed would be appropriate across the broadest range of the possible scenarios. The intent was to improve our ability for nimble and effective response when circumstances – many outside our control – unfolded in the year ahead.

6. The 2012-13 business plan is available on the AMA website. (Visit www.albertadoctors.org. Enter “business plan” in the top-right search box and log in with your member number and password when prompted.)

7. A report card about progress on the business plan is prepared at the end of each planning cycle. The 2012-13 update will be presented to the 2012 annual general meeting and is also available on the website.

Negotiations 2012

8. As the business year began, an agreement was still in abeyance. In that absence Alberta Health (AH) had extended all physician programs and benefits to June 30, 2013. October saw several meetings between the minister of health and AMA President Dr. Michael Giuffre from which came a statement of the government’s so-called “best offer.” In the weeks that followed the AMA attempted to gain clarity on what was essentially a set of government preconditions to reaching a full agreement. On November 16, the minister announced that he was imposing an agreement.

9. The AMA rejected this imposition and called for the minister to return to the bargaining table. The president was active in media about the need for a fair and transparent dispute resolution process to work through the current impasse. The AMA also ran ads in major daily papers, focusing on the need for fairness.

10. Members expressed overwhelming support for this position in thousands of emails sent to the president. Public opinion polling undertaken in December showed that the public also supported fair dealings with doctors by government. The public also believed that doctors should be a partner with strong input into decisions about the health care system.

11. A special meeting of the Representative Forum (RF) on December 15 reviewed full aspects of the AMA’s negotiating situation at the time and endorsed the AMA’s position with respect to expected renewal of discussions. Key outcomes were incorporated in AMA positions. A number of resolutions were passed. Chief among these were support for a joint process, with an independent chair, to address the value of fee codes and a commitment that in
any actions the AMA pursued to advance negotiations, patient care would not be directly affected.

12. In late December, the parties agreed to a facilitated process to develop a negotiated physician agreement. Phase One of the process identified issues for discussion and a timeline and process for working through those issues. Phase Two involved detailed discussions. Professional facilitation was provided throughout.

13. Discussions continued through February, but were stymied by government’s unwillingness to table a financial position. The minister said that this could not occur until the provincial budget had been tabled on March 7.

14. When the budget was released, the AMA initial analysis pointed to fee reductions, loss of benefit program dollars and inadequate coverage for overhead costs, population increases and primary care networks (PCNs). The AMA did not accept the budget as a financial position from government and called on the minister to properly table a full position that would articulate his stance on financial matters. We reiterated the need for fair process and called once again for a dispute resolution process.

15. This approach was endorsed by the facilitators who recommended that, if the parties could not reach agreement on the financial elements of the contract, that they submit to final offer, interest-based arbitration.

16. In the weeks following, the AMA received a letter from the minister requiring that, by March 22, the AMA would provide him with a proposal for $275 million in cuts to fees and services – an impact that no other profession was being asked to absorb in the provincial budget or various negotiations.

17. The AMA rejected the government’s ultimatum and continued to hold firm for a negotiated agreement or the use of arbitration if differences simply could not be resolved. The spring meeting of the RF provided resounding support and advice on strategies for the time ahead.

18. On April 15, a memorandum of understanding (MOU) was announced by the parties, to be finalized as a formal agreement by April 22. This MOU addressed what physicians had been seeking in negotiations while recognizing government’s financial situation. A special meeting of the RF was convened May 4 to review the subsequent agreement and its comprehensive elements. A negotiations tour with seven meetings across the province and availability by videoconference was also held. On May 30, the agreement was ratified by 93.5% of voting members.

19. The AMA Agreement contains the following provisions, aligned with the organization’s success factors for negotiations.

• A fair and equitable settlement that recognizes the economic challenges of government and physicians.
  • The fact that there are no rate adjustments for April 1 of 2011, 2012 and 2013 is recognized as a significant challenge for physicians and a major contribution to the needs of the province.
- Mitigating factors:
  - Government has accepted responsibility for all service growth from population and other factors.
  - All services and programs see price and volume increases commencing April 1, 2014.
  - Threat to Retention Benefit, Business Costs Program and other programs is gone.
- A place at the table: Physicians have the knowledge and skill to provide advice and have a say on major issues.
- AMA Agreement has a general clause requiring consultation on all matters affecting physicians.
- AMA Agreement provides physicians with significant input on key services and programs:
  - Recognition.
  - Grant agreements.
  - Physician Compensation Committee.
- Companion Consultation Agreements provide for input on key issues:
  - EMRs.
  - Primary care and PCNs.
  - System-wide efficiencies and savings.
  - A more stable process with clear roles and responsibilities that is longstanding: recognition; continuance; dispute resolution.
- Simplified, clear governance structure for clinical service payments and programs.
- AMA recognition and binding arbitration of rates survive the initial financial term through the evergreen provisions. These apply to:
  - Insured services paid by Alberta Health.
  - Physician Support Programs: Continuing Medical Education; Medical Liability Insurance; Physician and Family Support; Parental Leave; Physician Locums; Practice Management; and Compassionate Expense.
- ALL physicians providing insured services, regardless of payer, are eligible for physician benefits.

20. Media coverage and editorial commentary have emphasized what the AMA stated throughout: These negotiations were about far more than money. The extraordinary unity of the profession (thousands of emails of support, 450-plus letters to and meetings with MLAs in the final critical weeks of discussions, grassroot physicians speaking out in open letters, meetings with editorial boards, talking to media, purchasing advertising and more) showed that the dispute was about having a voice in making decisions that affect patient care. It was about creating a stable environment in which health care reform can move forward, without tumbling over a cliff each time an agreement expires.

21. In 2011, AMA members contributed $500 each to a special levy fund to support “activities and efforts required” to conclude negotiations. As with past special levies, the intent was to return any funds not used to the
membership. Under the stewardship of the board, by the time the AMA Agreement was reached, just over 25% of the $3.5 million collected was expended. The remaining $2.6 million (74% of each member's contribution) was in the process of being returned to physicians at time of writing.

Early agreement implementation

22. The AMA Agreement has a term of April 1, 2011, to March 31, 2018. There were no fee adjustments for 2011-12, 2012-13 and 2013-14, but a one-time payment of $68 million was applied, to be paid to physicians within 90 days of agreement ratification. Subsequent fee increases will be: 2.5% in each of 2014-15 and 2015-16 and cost of living adjustments for each of 2016-17 and 2017-18.

23. Work to issue the $68 million one-time payment was underway at time of writing. Of these funds, $5 million will be directed to cover physician costs associated with participation in various aspects of the AMA Agreement. Predominantly this will provide compensation for physicians involved with committees, working groups and tasks, e.g., activities of the Physician Compensation Committee, the System-Wide Efficiencies, Electronic Medical Record and Primary Care consultation agreements and all working groups thereof. These funds may only be used for these purposes and the expenditures will be audited. (If the funds are not required for these purposes, we will pay unexpended funds to members using the same mechanism that will apply for the $63 million.)

24. To distribute the $63 million, the board looked to guidance provided by the Representative Forum at our special May 4 meeting and also during Negotiations Tour meetings by members. The board considered a number of options for paying out the funds, which were somewhat limited by extremely short timelines.

25. In the end, the board chose a payment mechanism that closely mimics the Retention Benefit program as the best way to distribute the funds. We expected that the average physician will receive a payment in the range of $7,500 to $8,000 by the end of August.

26. Financial aspects of the AMA Agreement are overseen by a Management Committee (MC) consisting of the deputy minister of health and AMA executive director or their designates. The MC ensures the scope and purposes of the AMA Agreement are followed and implemented. It also provides general direction to a Physician Compensation Committee (PCC), which itself has specific and focused duties regarding physician compensation matters. The PCC will be comprised of up to three members each (each group with one collective vote) from AMA and AH. An independent chair will be selected jointly by the minister and AMA president.
27. The Board of Directors has considered many candidates and made two selections for physician representatives to the PCC: one from family medicine and one from secondary/tertiary care. We will be well served by these outstanding individuals, both past presidents of the AMA and well versed in matters of physician payment and incentives. Dr. Linda M. Slocombe is a family physician within a primary care network specializing in obstetrics and Dr. Gerry N. Kiefer is a pediatric orthopedic surgeon. The third AMA seat will be filled by AMA Assistant Executive Director, Health Economics, Jim Huston.

28. As for the chair position, the parties have agreed upon a search company to develop a shortlist. Conroy Ross, a well-respected business advisory and executive search firm with offices in Calgary, Edmonton and Regina, has been awarded the task. The fall 2013 Representative Forum will receive an update on these and other activities for early implementation of the AMA Agreement.

Electronic medical records

29. The AMA Agreement contains a Provincial Electronic Medical Record (EMR) Strategy Consultation Agreement. It explains that, in 2010 before the end of the previous agreement, the parties agreed to an EMR acceleration plan for which AH committed funding through March 31, 2014. As such, physician support for the implementation of EMRs, currently provided through the Physician Office System Program (POSP), will end on March 31, 2014.

30. The Provincial Electronic Medical Records Strategy Consultation Agreement commits the parties to develop a provincial EMR strategy that will define the future approach to EMR use in Alberta. While not a signatory to this Consultation Agreement, AHS will play a role in the strategy development, participating in a working group for the EMR strategy that will develop a report by February 15, 2014. The report will be presented to the provincial Health Information Executive Committee, for recommendation to the minister of health prior to March 31, 2014.

31. Since 2001, POSP has supported physicians to implement EMRs in their offices. As of March 31, 2014, EMR support and transition services as per the original program will end.
- VCUR 2008 funding support and services will continue for eligible enrollees up to the maximum funding amount of $35,000 or to March 31, 2019.
- VCUR 2006 funding support ends March 31, 2014; invoice deadlines apply.

32. AH and the AMA have reached an agreement that provides for continued but limited new VCUR 2008 EMR deployments in fiscal year 2013-14. The arrangement extends the province’s commitment to support VCUR 2008 EMR use up to March 31, 2019, which allows eligible physicians access to their $35,000 maximum funding. More information including deadlines and timelines can be found at www.posp.ca.

Innovation in the delivery of primary care

33. Throughout negotiations, the Primary Care Alliance (Section of General Practice, Section of Rural Medicine, and PCN Physician Leads
Executive) led the AMA’s activities around primary care under the Primary Care Action Plan within the 2012-13 business plan. Specific activities included:

- **PCN 2.0:** In January 2013 the PCA Board was asked by the minister of health to develop a blueprint and action plan for the evolution of primary care networks (PCNs) in Alberta. A draft charter was developed to look at structure, governance, funding and the basket of services being provided with recommendations for enhancements for all areas. In May, the minister requested the PCN 2.0 Steering Committee present a paper, *Evolving Primary Care Networks in Alberta*. The paper provided a brief history of the vision and principles of what enhanced PCNs could look like as well as identifying ways to achieve that vision. This work will continue, incorporated under the Primary Medical Care/PCNs Consultation Agreement under the seven-year AMA Agreement.

- The PCA Board has continued to explore various key concepts contained in the Primary Care Action Plan. These include accreditation of primary care clinics and facilities and formal attachment of patients.

34. The AMA’s plans for primary care this year required research into Albertans’ perspectives regarding primary care and the role of physicians. To undertake this, two primary care summits were held with patients and physicians.

35. The first, in Edmonton February 2, was well-attended with 28 patients, 40 physicians, physician leaders from AHS Strategic Clinical Networks (SCNs) and other observers. Media also attended part of the day. The morning session included an interactive discussion on the needs of primary care with the patients and physicians. The second session in Calgary June 1 further explored concepts such as formal attachment and the relationship between physicians and patients. In addition to serving as valuable information for the AMA board, results of both events will be the foundation of further research including public opinion polling.

**Innovation in the delivery of specialist care**

36. Work with and support for secondary and tertiary care proceeds in a number of areas:

- **Strategic clinical networks:** Meetings were held with SCN medical leads to discuss how the AMA could assist with specialty care delivery strategies. Further discussions will lead into implementation of AMA Agreement activities including the System-Wide Efficiencies and Savings Consultation Agreement. The RF will receive an update.
• **Academic medicine and the Provincial Academic Alternative Relationship Plan (PAARP):** The AMA has interfaced regularly with the universities through our Advisory Committee on Academic Medicine and has hosted the deans and associate deans at a board strategic session dinner. The development of the PAARP has been a focus of faculty activity for many months. While the AMA has been involved provincially in the development of the PAARP framework, we are also looking at ways to support individual physicians more directly as they contemplate involvement with the PAARP. This could include providing analysis and advice to academic physicians on particular elements of the PAARP that may be of specific interest or concern to individual members. Progress on the PAARP implementation has been slowed as a result of funding discussions between government and the faculties on the conditional grant funding portion of the academic alternative relationship plans (AARPs). The AMA’s new mandate arising from the AMA Agreement may present new opportunities to assist members in these arrangements.

**Family care clinics**

37. Staff continue to assist the physicians who are under contract with the three family care clinic (FCC) pilot projects in Slave Lake, Northeast Edmonton and East Calgary. Work includes guidance around enhancing the legal agreements while ensuring the physicians are well informed on their rights and responsibilities under their contracts.

38. The AMA initiated a process to solicit interest from physician clinics and PCNs that may want to pursue joining an FCC. The 40-plus physician groups across the province who submitted expressions of interest in pursuing an FCC were invited to the February 2 Primary Care Summit Series meeting where FCCs were discussed. Depending on direction of Alberta Health pertaining to FCCs, the intention if requested is to appoint AMA resources to serve as consultant to clinics still interested in moving forward.

39. The AMA responded formally to AH’s Family Care Clinic Application Kit Wave 1. President Dr. R. Michael Giuffre and Section of General Practice President Dr. Ann R. Vaidya co-signed a letter that was sent mid-February, noting some positive inclusions in the document but also highlighting numerous significant issues with the document and approach. The letter to the minister was shared with AMA members.

40. In June government announced that 24 new FCCs would be established across the province. The AMA began supporting members on the myriad of business and practice decisions associated with those who may wish to become involved in these ventures (either as new ventures or evolving from an existing PCN). Plans for FCCs will form another element of discussion under the Primary Medical Care/Primary Care Networks Consultation Agreement.

41. In tandem with supporting FCCs, the AMA continued discussions with both AH and AHS on the evolution of primary
care and primary care networks. Physician representation was provided to the government as part of their development of a primary care strategy. This strategy will guide the further expansion of FCCs and the role of PCNs and their continued evolution. Concepts such as attachment, accreditation and access improvements are key to strategy and continued evolution of primary care. Physicians have played a leadership role within these areas and will continue to work with the trilateral partners in further developing models to implement in the coming year.

42. Discussions on a provincial FCC payment rate for physicians have begun.

Preferential Access Inquiry

43. This year, the AMA sought and was granted full intervener status in the public inquiry into preferential access to health services. The AMA attended on behalf of the profession and as a demonstration of support for a system in which access to care is based on medical need. The Canadian Medical Association (CMA) agreed to provide financial support for the AMA’s participation. Hearings were held in December, January and February and continued through April. The AMA filed a formal submission with Commissioner John Vertes.

44. For the AMA, the underpinning of the inquiry was the ability to provide appropriate and timely access for patients, based on their needs. Canada’s health care system and Medicare are predicated on this philosophy. There are three components to delivering access based on need. These are:

- The patient-physician relationship.
- The advocacy role and function.
- Clinical autonomy.

45. The fundamental question for this inquiry was whether improper preferential access has been occurring in a systemic way, i.e., as a result of “threat, influence or favor.” The AMA submission stated that if the system is running with adequate resources, then it is fairly simple to grant access to health services based on the relative needs of patients who pass through our care. If, however, the system is inadequately resourced, then wait times grow, some services may become scarce and bottlenecks build. This climate may make it more difficult to decide about one patient over another and who gets care first, even without the hypothetical presence of threat, influence or favor.

46. The AMA submitted that the queue of concern for the inquiry should begin at the point where the patient begins to access services through AHS facilities and programs, e.g., surgery in a hospital, pathology or imaging in a diagnostic clinic, or other screening clinic such as a colonoscopy clinic. We note that this philosophy matches the approach of Canadian wait list registries, including the Alberta Provincial Waitlist Registry.

47. We stated in our submission that any processes the patient passes through to get to such access points within the queue should themselves be outside the scope of the inquiry. We wished to resist needless intervention with the practice of “professional courtesy” for physician family members and friends.
Certainly many of these services are publicly funded, but we argued that physicians should remain free to exercise traditional practices, to see patients in their private practices at their discretion and, if necessary, provide patients with access to AHS services.

48. The point was made several times during the inquiry (and not only by the AMA) that any solutions to prevent improper preferential access within the queue should not be counterproductive in terms of slowing time to service or paralyzing clinical autonomy. Certainly this would be the effect of regulatory measures to control pre-queue movement of the patient within the doctor-patient relationship. That is the great point that supports the exclusion of this part of the continuum from the purview of the inquiry as the AMA has argued.

49. What kind of preferential access is “improper?” The AMA believes that all access to publicly funded AHS services is fundamentally “preferential,” if only because of the fact that someone has to get to a service in a facility first! For example, processes to access specialist services that are within the queue vary widely. Family physicians may have stronger working relationships with some consultants than others. In some facilities, streamlined referral-consultation processes might improve efficiency such that patients passing through them enter the queue more quickly. These things have always been and they cannot ever be wholly eliminated.

50. In the AMA’s eyes, the concept of harm is the lynchpin. Physicians regularly extend professional courtesy to other physicians by seeing those physicians’ family members or friends out of office hours without bumping any patients in the existing schedule.

51. We do not believe this is harmful, because these things do not undermine the fundamental integrity of access and movement within the queue based on medical need. The Canada Health Act does not guarantee “equal” or even “equitable” access to health care services, but instead requires physicians to “facilitate reasonable access.” Once the patient arrives in the queue as defined, movement forward is based on medical need. Any movement within the queue based on any other factors would be improper.

52. The commissioner released his report on August 21 with his conclusions and 12 recommendations. He concluded that there was no evidence of widespread improper practices although some instances of improper preferential access were uncovered. The commissioner found no evidence that “anyone had been medically harmed as a result.”

53. With respect to issues raised by the AMA, the commissioner did not find that professional courtesy was in and of itself improper when limited to services provided “by one physician to another physician or to other professional colleagues such as nurses.” He expressed concern, however, about any extension of such courtesies beyond that level and said the AMA, with the regulatory bodies and public representatives, should “closely examine the practice and ethical implications
of professional courtesy with a view to defining its scope and application and providing guidelines to health care professionals." While we see practical difficulties to this recommendation (as does the registrar of the College of Physicians & Surgeons of Alberta), the AMA is willing to participate in such a process.

54. Other key commentary from the inquiry report supported the concept that the best way to eliminate improper preferential access is to eliminate the queue itself. The AMA welcomes the recommendation that AHS “continue its current efforts to improve access to health care overall and to reduce associated wait times. It should also consider implementing a comprehensive wait time measurement system.” We are also pleased that the commissioner recommended expansion of whistleblower protection to include physicians who are not employees of AHS.

Zone Medical Staff Associations

55. In accordance with prior RF direction, the AMA implemented measures to support a strong and integrated partnership between the AMA and the zone medical staff associations (ZMSAs). This has included providing channels of communication, representation and advocacy back and to the AMA through Zonal Advisory Forums (ZAFs). Calgary and Edmonton ZMSAs are fully functioning and hosting ZAF meetings twice yearly. Central ZMSA hosted its first annual general meeting February 13 and is hosting ZAF meetings twice a year. South ZMSA elected a new president and is organizing itself as a society with a first ZAF planned for October. We continue to assist the North ZMSA in efforts to organize; they are at work on constitution and bylaws but no ZAF has yet been scheduled.

56. In August, ZMSA presidents became the first point of contact from the Physician Advocacy Assistance Line (PAAL). This service was originally hosted by AHS, but at the urging of the ZMSAs, AHS has agreed to transfer intake for calls coming to PAAL to a third-party provider Confidence Line. ZMSA presidents will be alerted by the Confidence Line when a physician in the zone calls for help and the ZMSA president will manage responding to the call.

Other issues

Pharmacist prescribing and scopes of practice

57. AMA members continue to express concerns about pharmacist prescribing and increasing scopes of practice by other health professions. Meetings were held this fall with the Alberta Pharmacists Association (RxA) to discuss issues of concern for both sides.

58. Subsequently, a meeting was held with the AMA, CPSA, RxA and Alberta College of Pharmacists to discuss working together
to improve communication and processes around pharmacist prescribing. The intent was to use the first meeting to build consensus for moving forward, but that objective has not yet been reached.

59. The Board of Directors discussed how to address pharmacist prescribing and scope of practice issues in general at the 2013 board retreat in May. Resolutions relating to scope of practice were tabled by Alberta delegates and passed at the Canadian Medical Association General Council meeting August 19-21 in Calgary.

60. The College and Association of Registered Nurses of Alberta has a proposal to expand the scope of practice to allow registered nurses with extra training to prescribe Schedule One drugs, limited to their demonstrated expertise within a certain geographic location. This expanded scope would allow them to diagnose within that scope of practice.

61. We are still awaiting government’s decision on a major proposal from optometry regarding an expansion to scope of practice for that profession. The AMA made a presentation in late 2012 to the Health Professions Advisory Board to express serious concerns about the safety and efficacy of the optometry proposals.

Physician and Family Support Program and Health Law Institute

62. The AMA and the Physician and Family Support Program (PFSP) staff have been involved in lengthy discussions with the College of Physicians & Surgeons of Alberta (CPSA) on how to operationalize recommendations arising from a June 2012 report from the Health Law Institute (HLI). The HLI was retained by the parties to help explore and resolve difference of opinion with respect to standards of practice around duty to report impairment. Members may recall that CPSA had proposed changing the standards to require reporting of suspected vs. demonstrated impairment for oneself or a colleague. While some issues have been resolved, some outstanding issues remain around logistics for a proposed review panel. We appreciate the ongoing dialogue.

Other negotiations

63. Groups of physicians and individuals came to the AMA again this year seeking support in various negotiations and contracts. The association supported ongoing and new discussions for: cancer care physicians; laboratory physicians, physicians billing Workers’ Compensation Board (WCB); Alberta Orthopedic Society and others. AMA staff also continue to assist with requests from individual physicians to review their individual service contracts.

64. New agreements between the Alberta Society of Laboratory Physicians and AHS, and cancer care physicians and AHS, were completed, ratified and are now in place.

Advocacy

Health issues

65. Health Issues Council (HIC) continues to discuss and advance a variety of health advocacy issues. Additionally, HIC implemented the second year of the Emerging
Leaders In Health Promotion initiative. This program provides grants to medical students and residents for health advocacy initiatives. The goals are to: promote development of the physician's role as advocate for healthy populations; provide experience in health promotion as integral to medical practice; and facilitate growth of leadership and advocacy skills in a mentored environment. For 2012-13, seven projects received funding.

66. In a brand new initiative, the AMA partnered with Ever Active Schools to pilot an “AMA Youth Run Club” on a small scale this spring. This project is based on one operated very successfully by Doctors Nova Scotia. The pilot was extremely successful and will lead to more involvement for the AMA in the coming year.

67. We have continued to support Students for Cell Phone Free Driving for educational sessions in high schools.

Refugee health

68. Recent changes to the federal government’s provision of health care coverage to refugees in Canada have led to the current situation where approximately two-thirds of refugees have no health care coverage except when their medical condition poses a risk to public health or safety (e.g., tuberculosis). The AMA has written to the federal minister responsible asking him to reverse the decision. We have also asked Alberta’s minister of health to extend coverage to these disadvantaged people. Information has been provided to physicians via MD Scope newsletter on billing practices for those refugee claimants who are covered by Medavie Blue Cross.

69. Media reports say a charter challenge by Canadian Doctors for Refugee Care and the Canadian Association of Refugee Lawyers will be brought before the Federal Court. The lawsuit will argue that the cuts to refugee care violate the fundamental human rights of refugees.

Indoor tanning

70. The AMA is also assisting a coalition, “Indoor Tanning is Out,” which is lobbying the provincial government to introduce legislation to ban usage of artificial tanning facilities to those under 18 years. Three other provinces have already introduced similar legislation. The federal minister of health has also released draft regulations, replacing labeling laws for tanning beds.
to one that reads: Tanning equipment can cause cancer. Not recommended for use by those under 18 years of age.

Day of Service proposal

71. In her valedictory address in September 2012, Past President Dr. Linda M. Slocombe proposed that the AMA establish a “day of service” or some initiative through which physicians could collectively give back to the community. The Board of Directors explored the suggestion and a number of options.

72. The outcome was the establishment of the Many Hands™ initiative (www.albertadoctors.org/advocating/many-hands). Through Many Hands™ the AMA compiles and celebrates the amazing volunteer contributions of Alberta physicians at home and abroad. Information is also being included for doctors who would like to volunteer but are seeking good opportunities. Many Hands™ has been well received by honorees and members alike and will be expanded further.

Canadian Medical Association

73. The 2013 General Council (GC) was held August 18-21 at the Calgary TELUS Convention Centre. The GC was last hosted in Alberta in 2005. The 2013 AMA delegation was:

- AMA President.
- President-Elect.
- Immediate Past President.
- Speaker or Deputy Speaker.
- Nine representatives named by the board.
- Nine representatives named by the Nominating Committee.
- Two physician appointees of the college, at least one of whom must be an elected member of the Council.
- One dean or designate from his/her office.
- One student representative.
- One PARA representative.

74. On August 21, Dr. Louis H. Francescutti, an Edmonton-based emergency medicine physician, was installed as the 2013-14 President of the CMA. He became Alberta’s nominee after an election for which there were six candidates.

75. Dr. Ernst P. Schuster, who served as speaker and deputy speaker of the Representative Forum for 14 years, sat on the GC Resolutions Committee.

76. Two outstanding Alberta physicians were honored with CMA Special Awards. The Dr. William Marsden Award in Medical Ethics was presented to Calgary’s Dr. Ian Mitchell (along with Toronto-based physician Dr. David McKnight). Dr. Mitchell was recognized as a leader who enhances ethical and professional behavior in physicians and displays excellence in his own ethics research and teaching initiatives. He is known as a meta-teacher who serves bioethics and the profession with insight, innovation and fearlessness.

77. Board member Dr. Kathryn Andrusky of Edmonton was recognized with the CMA Award for Young Leaders in the early career physician category. Now a clinical lecturer and preceptor for the Department of Family Medicine at the University of Alberta, she has been politically active in medical issues since her undergraduate years, and is a past president of the Professional Association of Resident Physicians of Alberta.
78. The AMA also nominated two additional winners. The CMA Award for Excellence in Health Promotion went to the Boys and Girls Club of Canada. Canadian humanitarian Mr. Nigel Fisher received the CMA’s Medal of Honour for personal contributions to the advancement of medical research and education.

Member communication

79. The AMA launched a new website in May 2012, featuring state of the art design and built around extensive research with members and staff. While it was rather early to measure success at the time of the 2012 annual general meeting, a year later we can say that utilization statistics speak to a high level of satisfaction.

80. The number of people visiting the site has increased 66% for the full year period (measuring from launch date in May). The amount of time visitors spend on the site with each visit has increased by 47%. That’s an average visit of almost four minutes.

81. The mobile friendly design appears to be having an effect: the number of visits by phone or tablet went from 8,000 to 36,000 per year.

82. The AMA has ventured into the realm of social media, engaging in Twitter (media, opinion leaders, industry observers), Facebook (members and public), Linked In and YouTube. We will continue to monitor the effectiveness of these tools, usage of which by website visitors took a massive jump in November 2012 during the period of the imposition.

83. Members received a record 42 President’s Letters in 2012-13. Thousands of members chose to reply and exchange email directly with the president about their thoughts and concerns. This direct input was as valued as it was appreciated by the president.

84. Three membership opinion tracker surveys were conducted this year. The schedule fourth-quarter tracker was cancelled once the new agreement was reached to provide an opportunity to review the survey’s structure. Most questions have remained unchanged since 2003. We expect to launch a new tracker in the new business year.

85. Overall, the surveys continue to show that members overwhelmingly (96% range) support the AMA’s role as their representative in negotiations. Members also indicate they feel well-informed about the health care system (85% range) and the association’s activities (88% range).

86. Special surveys were also conducted regarding the AMA website and student sponsorship initiatives. We conducted two additional member surveys vis a vis negotiations and potential actions to support the profession.

87. MD Scope electronic newsletter was revamped. Typically, about 45% of members open and read articles in the newsletter, up from 29% 18 months ago.

88. Alberta Doctors’ Digest magazine was also redesigned and is now being produced in full color. Increased printing
costs are being offset by the availability of additional full color advertising space. Podcast versions of Digest feature articles are available on the AMA website.

Flood support

Following the devastating fires in Slave Lake two years ago, a disaster recovery plan was established for affected physicians there. We worked with Alberta Health (AH) and Alberta Health Services (AHS) for some interim income support during practice disruption. The AMA also waived its annual membership dues. We have taken similar steps for members most affected by the flooding this summer. Specifically, we are using the boundaries of the provincial state of emergency zone established by the government around the High River community. Physicians in that disaster zone:

- Will be guaranteed 80% of their gross billings (based on fees billed last year), for the first 120 days after the flood and this may be extended further. I thank Premier Redford and Minister Horne for their fast response to this obvious need.
- AMA membership dues for 2013-14 will be waived for these members.

In the first few days of the flood, the AMA also helped to connect physicians who were out of home with temporary accommodations. Over 100 physicians offered up their homes in the first 48 hours – a heartwarming display of collegiality that was so very much appreciated.

TD Insurance Meloche Monnex

89. Our AMA membership has a high enrolment rate for TD Insurance Meloche Monnex (TDIMM) products. In fact, 5,800 members carry TDIMM products, which represents over half of our entire membership. TDIMM is endorsed by the AMA. This arrangement is scheduled for a review because we are at the mid-point in our 10-year exclusive contract. This planned review is underway and was discussed at the board. We have established an advisory group to conduct our portion of the review. Member feedback will be sought, and all recent experiences – positive and negative – will be shared and discussed in detail, including with respect to the flood recovery from the recent flooding in southern Alberta. We have heard directly from over 80 AMA members specifically on this issue. The AMA will be thorough in our deliberations and you will be further informed.

Leadership and AHS

90. The AMA is working with the CPSA and AHS to explore development of leadership and advocacy training for Alberta physicians. The steering committee also includes a ZMSA representative, Dr. Fredrykka Rinaldi. We have hired a consultant to define the advocacy process and produce navigational tools for physicians who are advocating for their patients. In addition, the consultant will hold focus groups with physicians in each of the zones to ascertain what leadership skills physicians would like to see in such a program and how they wish to have the instruction delivered. The consultant’s report is due for presentation in October.

91. In further leadership development activities, the AMA is also assisting the CMA on its leadership development program. The CMA has contracted the services of
Rothman College from the University of Toronto to explore options for a national, CMA-sponsored leadership development program for physicians. They are holding focus groups in various regions of the country to determine the needs of physicians in each region. The AMA participated in the focus group held recently in Vancouver. As a result of those efforts, the CMA will be launching their first national leadership development course in 2014. The AMA will be sending five participants to that course, which will be held annually.

Board of Directors and Executive Committee

92. Members of the 2012-13 Board of Directors:

2012-13 Board members:
• Dr. R. Michael Giuffre – President
• Dr. Allan S. Garbutt – President-Elect
• Dr. Linda M. Slocombe – Immediate Past President
• Dr. Pauline Alakija
• Dr. Kathryn L. Andrusky
• Dr. Sarah L. Bates
• Dr. Paul E. Boucher
• Dr. Padraic E. Carr
• Dr. Alison M. Clarke
• Dr. Neil D.J. Cooper
• Dr. E. Sandra Corbett
• Dr. Christine P. Molnar
• Dr. Paul Parks
• PARA observer: Dr. Joanna S. Lazier (July 1, 2012 – June 30, 2013); Dr. Sylvia G. McCulloch (July 1, 2013 – June 30, 2014)
• MSA observer: Braden Teitge (May 31, 2012 – June 30, 2013); Stefan B. Link (July 1, 2013 – June 30, 2014)

93. In 2012-13, the Board of Directors met:
• September 22 (post-RF meeting)
• October 9 (teleconference)
• October 16 (teleconference)
• October 26
• November 19 (teleconference)
• November 29 (teleconference)
• December 13-14
• February 8
• March 7 (teleconference)
• March 19 (teleconference)
• March 22 (teleconference)
• March 25 (teleconference)
• March 30 (special board meeting)
• April 5 (teleconference)
• April 9 (teleconference)
• April 11-12
• April 24 (special board meeting)
• May 4 (post-special RF board meeting)
• May 23-25 (meeting and retreat)
• July 18-19
• September 25

94. Members of the Executive Committee:
• Dr. R. Michael Giuffre – President
• Dr. Allan S. Garbutt – President-Elect
• Dr. Linda M. Slocombe – Immediate Past President
• Dr. Sarah L. Bates
• Dr. Padraic E. Carr

95. The Executive Committee met:
• October 5
• November 16
• January 18
• March 22
• May 3
• June 28
• September 3
This past year has had its share of tension and surprises, but overall it marked a positive transition point in many of our key relationships and role within the health care system.

The sources of tension and surprise are not difficult to identify. The difficult course of negotiations, the Preferential Access Inquiry, the firing of the Alberta Health Services board and initial go-it-alone approach of government in key initiatives such as family care clinics were hallmarks of a system that at times appears to lack direction and struggles to find a focus. Outside the health system, the flooding in southern Alberta continues to have a major impact on the personal and professional lives of many physicians.

Significant elements of all these events were beyond the control of the AMA. Even in negotiations, the initial steps in moving away from the table and into the public realm were taken by government.

While many events are beyond our control, how we respond is within it. In that regard, I am proud of how the AMA responded to our challenges and worked to influence the health system in a positive way. While many examples of this could be provided, there are three themes that underlie the AMA’s success.

First, the leadership within the profession – embodied in the board, Representative Forum, sections, Primary Care Alliance and elsewhere – kept their focus on what was most important and maintained unity throughout. The new agreement, which focuses on physician engagement and leadership, reflects this leadership.

Second, even in the most trying of times the AMA maintained a positive approach, being critical when necessary, but also offering solutions. Even in the midst of negotiations the AMA maintained its efforts related to primary care and held patient summits to get the views of those who matter most. While the scope of the Preferential Access Inquiry was not as broad as what the AMA thought was needed, we participated fully and advanced important views on the need for expanded whistleblower protection and for reduced waiting times for medical care.

Third, AMA staff remained committed and focused in what has been a difficult two years.

These core elements – strong leadership, a commitment to improving the system for patients and dedicated staff – are what is also needed as we move forward in implementing the new agreement and ensuring the patient and physician voice continue to be heard. The agreement and our improving relationship with government provide significant opportunities. Given the AMA’s track record, I am very confident that we will succeed.
## Proposed Non-substantive Amendments to the Constitution and Bylaws of the Alberta Medical Association

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### NON-SUBSTANTIVE CHANGES

<table>
<thead>
<tr>
<th>Proposed wording</th>
<th>Present wording</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15.15 Add</strong> clarification with regards to voting rights of the Speaker and Deputy Speaker:</td>
<td>Not applicable; addition to provide clarification</td>
</tr>
<tr>
<td>15.15 The Speaker and the Deputy Speaker shall not have the right to vote at meetings of the Forum and shall not be included in the determination of whether quorum exists for a meeting of the Forum.</td>
<td>17.3 Directors shall be elected by and from among the Members of the Forum to hold office for a term of three years, with annual elections for approximately one-third of the Directors provided, however, subject to the provisions of Section 46.4 that no Director serve more than two consecutive three-year terms.</td>
</tr>
<tr>
<td><strong>17.3 Amend</strong> reference to Section 46.4. Should read 45.4, due to the deletion of a section last year, which altered the numbering sequence. To read:</td>
<td></td>
</tr>
<tr>
<td>17.3 Directors shall be elected by and from among the Members of the Forum to hold office for a term of three years, with annual elections for approximately one-third of the Directors provided, however, subject to the provisions of Section 45.4 that no Director serve more than two consecutive three-year terms.</td>
<td></td>
</tr>
</tbody>
</table>
In accordance with the Alberta Medical Association Constitution and Bylaws, the Nominating Committee nominates candidates for office to be elected by the annual general meeting, to be elected by the Representative Forum, and to be appointed by the Board of Directors of the association.

The Nominating Committee submits the following nominations for consideration during the annual general meeting:

1. Representatives to CMA General Council 2014
   
   NOTE: The president attends General Council by virtue of the position and is not included in the number of Alberta representatives (27). The Nominating Committee recommends that the 2014 CMA General Council representatives be:
   
   • President-Elect.
   • Immediate Past President.
   • Speaker or Deputy Speaker.
   • Nine representatives named by the board.
   • Nine representatives named by the Nominating Committee.
   • Two physician appointees of the CPSA, at least one of whom must be an elected member of the Council.
   • One dean or designate from his office.
   • One student representative.
   • One PARA representative.
   • Alberta representative on CMA Resolutions Committee.

2. Speaker and Deputy Speaker 2013-14
   
a. Speaker: Dr. Carl W. Nohr, General Surgery, Medicine Hat
   
b. Deputy Speaker: Dr. Darryl D. LaBuick, General Practice, St. Albert

   In accordance with custom, brief profiles for these candidates follow on page 29.

3. Nominating Committee 2013-14
   
The bylaws require that the annual general meeting elect four (4) members to the Nominating Committee. The current elected incumbents are:
   
   • Dr. Kathryn L. Andrusky, General Practice, Edmonton.
   • Dr. Daniel J. Barer, Emergency Medicine, Edmonton.
   • Dr. Peter C. Jamieson, General Practice, Calgary.
   • Dr. Gerry D. Prince, General Practice, Medicine Hat.

   The Nominating Committee is scheduled to meet Friday, November 1. Anyone who is a member of the Nominating Committee cannot be the committee’s nominee for the Board of Directors. This does not, however, preclude a member of the Nominating Committee from being nominated from the floor.
Curriculum Vitae

Dr. Carl W. Nohr

2012-present
RF Speaker
Vice-President, South Zone Medical Staff Association

2010-present
CPSA Councilor

2009-present
Member, Provincial Physician Liaison Forum
RF Planning Group (currently Chair)

2009-12
Member, Council of Zonal Leaders

2009-10
AMA Co-chair, AHS Medical Staff Bylaws Committee

2008-10
Member, Nominating Committee, PFSP Advisory Committee
RF delegate

2007-12
AMA representative to CMA General Council


Dr. Darryl D. LaBuick

2012-present
RF Deputy Speaker
Member, RF Planning Group

2011-present
Chair, Council of Zonal Leaders

2010-present
Member, Negotiating Committee

2010-11
Member, General Practice Representation Working Group
RF delegate

2008-11
CMA Board member

2002-09
AMA Board member

2008-09
Chair, Trilateral Agreement Committee – Co-Chairs
Chair, Nominating Committee

2007-09
Member, Joint AMA/CPSA Executive

2005-09
Member, Executive Committee

2007-08
President

Member, Committee on Constitution and Bylaws, Nominating Committee, RF Planning Group

2006-08
Member, Trilateral Agreement Committee – Co-Chairs
Chair, Pharmacists and Primary Care Networks Advisory Committee

2006-07
President-Elect
Member, Committee on Constitution and Bylaws, Government Affairs Committee, RF Planning Group

2004-06
Member, RxA/AMA Working Group

AMA representative to CMA General Council
Financial Statements

Responsibility for the financial statements

The management of the Alberta Medical Association (the Association) is responsible for the integrity and fair presentation of the financial statements.

The Association has developed prudent financial controls that give management reasonable assurance that the assets are safeguarded and reliable financial records are maintained. These controls, which are reviewed by the Committee on Financial Audit, include written policies and procedures, technology controls and an organizational structure that segregates duties.

The Association’s independent auditors, PricewaterhouseCoopers LLP, Chartered Accountants, have been appointed to express an opinion as to whether these financial statements present fairly the Association’s financial position and operating results in accordance with Canadian generally accepted accounting principles. Their report follows.

The Board of Directors has reviewed and approved these financial statements. To assist the board in meeting its responsibility, it has established the Committee on Financial Audit. The committee meets with management and the independent auditor to review accounting principles and practices, financial controls and audit results.

Michael A. Gormley
Executive Director
Cameron N. Plitt
Chief Financial Officer

Auditors’ report on summarized financial statements

To the Members of Alberta Medical Association (CMA Alberta Division)

The accompanying summary financial statements, which comprise the summary statement of financial position as at September 30, 2012, the summary statements of operations, summary statement of net assets for the year then ended, and related notes, are derived from the audited financial statements of Alberta Medical Association for the year ended September 30, 2012. We expressed an unmodified audit opinion on those financial statements in our report dated February 8, 2013. Those financial statements, and the summary financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The summary financial statements do not contain all the disclosures required by Canadian generally accepted accounting principles. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of Alberta Medical Association.

Management’s responsibility for the summary financial statements

Management is responsible for the preparation of a summary of the audited financial statements in accordance with Canadian Auditing Standard 810, “Engagements to Report on Summary Financial Statements.”
Auditor's responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with the criteria referred to above.

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of Alberta Medical Association for the year ended September 30, 2012, are a fair summary of those financial statements, in accordance with Canadian Auditing Standard 810, “Engagements to Report on Summary Financial Statements."

PricewaterhouseCoopers LLP
Chartered Accountants
Edmonton, Canada

Notes to Summarized Financial Statements
September 30, 2012

1. Basis of presentation

This report represents selected financial information extracted from statements, audited by PricewaterhouseCoopers LLP, Chartered Accountants. Complete financial statements are available upon request.

2. Administered Programs

In addition to its principal activities, the Alberta Medical Association (the AMA or Association) administers certain programs by agreement between the AMA, her Majesty the Queen in Right of Alberta, and the Regional Health Authorities (now operating as Alberta Health Services) (the Parties). These programs are governed by the Master Committee of the Parties, with separate audited financial statements being provided to the Parties annually. As the AMA is the administrator of the programs, the assets, liabilities, revenues, and expenses of these programs are not included in these statements. The administration fees received by the AMA to administer these programs have been included and are segregated for greater clarity.

A summary of the total net assets of the programs administered by the Association for the Parties as at and for the year ended March 31, 2012, which is the most recent fiscal year of the programs, is as follows:

<table>
<thead>
<tr>
<th></th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening restricted program net assets</td>
<td>21,437,598</td>
</tr>
<tr>
<td>Revenue</td>
<td>165,351,861</td>
</tr>
<tr>
<td>Expenses</td>
<td>(166,488,853)</td>
</tr>
<tr>
<td>Reserve adjustment</td>
<td>(400,887)</td>
</tr>
<tr>
<td>Closing restricted program net assets</td>
<td>19,899,719</td>
</tr>
</tbody>
</table>

3. Reconciliation of carrier experience

It is the intention of the Association that insurance products operate on a break-even basis over the long term. Over the short term, the Association participates in experience surpluses and losses out of reserves, calculated as of December 31 of each fiscal year.

An experience gain of $2.5 million (2011 - $4.5 million) was recognized during the year.
## Condensed Statement of Financial Position

**As at September 30, 2012**

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>17,664,154</td>
<td>11,726,732</td>
</tr>
<tr>
<td>Accounts receivable and prepaid expenses</td>
<td>562,306</td>
<td>657,796</td>
</tr>
<tr>
<td>Due from administered programs</td>
<td>2,867,266</td>
<td>2,618,269</td>
</tr>
<tr>
<td>Due from AMA Health Benefits Trust Fund</td>
<td>45,547</td>
<td>50,506</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>21,139,273</td>
<td>15,053,303</td>
</tr>
<tr>
<td><strong>Portfolio investments</strong></td>
<td>17,371,325</td>
<td>16,337,019</td>
</tr>
<tr>
<td><strong>Property, plant and equipment</strong></td>
<td>2,094,510</td>
<td>2,330,043</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>40,605,108</td>
<td>33,720,365</td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>3,839,701</td>
<td>3,872,203</td>
</tr>
<tr>
<td>Payable to Canadian Medical Association</td>
<td>1,225,472</td>
<td>793,616</td>
</tr>
<tr>
<td>Due to Alberta Medical Foundation</td>
<td>2,871</td>
<td>525</td>
</tr>
<tr>
<td>Deferred membership revenue</td>
<td>4,270,390</td>
<td>2,745,864</td>
</tr>
<tr>
<td>Deferred membership revenue - levy</td>
<td>3,508,734</td>
<td>773,000</td>
</tr>
<tr>
<td>Deferred revenue and program grants</td>
<td>76,024</td>
<td>81,503</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>12,923,192</td>
<td>8,266,711</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>27,681,916</td>
<td>25,453,654</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>40,605,108</td>
<td>33,720,365</td>
</tr>
</tbody>
</table>
## Condensed Statement of Operations and Net Assets

For the year ended September 30, 2012

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members dues</td>
<td>12,545,966</td>
<td>12,126,553</td>
</tr>
<tr>
<td>Fees and commissions</td>
<td>1,537,097</td>
<td>1,441,889</td>
</tr>
<tr>
<td>Other</td>
<td>856,451</td>
<td>748,349</td>
</tr>
<tr>
<td>Investment income</td>
<td>609,523</td>
<td>1,068,058</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>15,549,037</td>
<td>15,384,849</td>
</tr>
</tbody>
</table>

| **Expenditures**     |            |            |
| Corporate affairs    | 5,651,379  | 5,833,209  |
| Executive office     | 3,201,093  | 2,907,494  |
| Health policy and economics | 2,673,122 | 2,020,045 |
| Committees           | 1,816,140  | 2,056,855  |
| Public affairs       | 1,767,244  | 1,742,480  |
| Professional affairs | 960,169    | 884,123    |
| Southern Alberta Office | 490,561  | 251,989    |
| **Total Expenditures** | 16,559,708 | 15,696,195 |

| **Realization of insurance experience** (note 3) | 2,549,072 | 4,469,790 |

| **Net revenue for the year** | 1,538,401 | 4,158,444 |

| **Net assets – Beginning of year** | 25,453,654 | 21,825,865 |

| Unrealized gain (loss) for the year on available for sale financial assets | 565,051 | (152,727) |

| Realized loss (gain) impairment loss transferred to investment income | 124,810 | (377,928) |

| **Net assets – End of year** | 27,681,916 | 25,453,654 |