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Now is the time to eliminate the health inequities of Indigenous peoples

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From the Editor-in-Chief

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To request article references, contact:
daphne.andrychuk@albertadoctors.org
While all living things communicate with their environments, Homo sapiens’ history is one of burgeoning accomplishment. Speech, for example, is thought to have originated half a million years ago and probably relates to our enlarging brains’ ability to manipulate objects and activities. We began to draw pictures. Cave paintings date from 30,000 years ago, with petroglyphs or rock carvings appearing two hundred centuries later, or 10,000 years ago.

As we became capable of symbolic thought, we first used pictures to tell a story and later used symbols to represent an idea. A circle could, accordingly, represent the sun; the figure of an eye holding a tear could represent sadness. Once vowels and consonants could be represented symbolically, we had an alphabet of sorts, and our writing systems were launched.

Our more recent communication abilities have depended on our technologic development. The printing press, really a reworked wine press, provided us with the means for mass communication, but it was slow, requiring transport by land and sea, until the invention of the telegram in the 1830s. Telephones came along decades after, but they required wire linkages as well. With radio and video transmission, the internet and digitization as more recent accomplishments, we can now instantly relay information wherever and whenever. We’re left with abundant communications possibilities – phone calls, emails, video links, etc., but there are winners and losers. Email, for example, may be on the wane for personal use compared with the current darlings: text messaging and social media.

Letter writing, apart from business use, has perished, and many schools have given up teaching cursive script. This means, of course, that handwritten letters – Napoleon’s letters to Josephine, say, or Martin Luther King’s letter from Birmingham Jail – along with our diaries and prized notes from yesteryear will all soon be equally anachronistic.

We’ve generally taken to change like ducklings to water, though how much our ceaseless chatter is worth is open to debate. Nevertheless we’re addicted, whether capturing perfect digital copies of mountains or flowers that we’ll never see again, selfies that show us to advantage or thumbing our way through one or two of the 20 billion messages we send each other daily.

Good communication may still at times appear elusive, even mysterious.

Who’s to say that “U r the one 4 me. XOXO” has more or less to it than a handwritten note on good vellum? Personally, my hand is up for the vellum, but I’m both a codger and a Luddite, so I may be developmentally delayed.

Whatever modality we use, however, we’re hard-wired to respond.

Years ago I wandered into a park to get some air after a long lecture at a nearby resort. I’d been traveling and my gut microbiota was no longer in sync with the rest of me, if I can put it delicately. With some urgency, I looked for a washroom, found one in disrepair, but could only gain entrance on the women’s side. Relief was sweet but temporary. The door opened and an old lady in walking shoes and a blue hat looked at me, horrified, but quickly turned and ran away across the park. With little thought – reflexively, really – I wriggled out of the WC and ran after her, obsessed with the need to catch her and explain. A dozen steps into our footrace, the matter appeared bizarre, too funny for words, and I slowed to let her get away. A humorous story for sure, but it illustrates our need to relate to others, to explain things as they really are.
Some explanations may be difficult or impossible, for sure, but we’re often very bad at all of them. How often do we ask for directions, for example, to find that the proffered advice is ambiguous at best, or even wrong or unhelpful? Perhaps we’re at our worst explaining plans to patients. Our polysyllabic jargon stands out (“resectable,” “therapeutic response,” “untoward sequelae”) as we try to push our explanations through a small window of time. We conclude commonly with a list of pros and cons that infers, “we’re all done; now you decide.” We tend to behave badly, falling back to old habits.

Good communication, we know, takes patience, common words and repetition. It also takes practice. Recall the old chestnut. How do you get to Carnegie Hall? Answer: practice. But practice can be hard to come by, so physicians-in-training are enjoined to hook up with someone more senior to learn, apprentice-fashion. This is a grand idea, I know, but the nature of clinical care is such that much comes unexpectedly, from the crucible of complex decisions.

As house officer on a public ward – that long ago! – it fell to the most junior doc to inform kin of a death in the family. This was an overwhelming responsibility for a newbie, and my first forays were nightmarish. I attempted to blunt my bitter news of someone’s passing with middle-of-the-night digressions that touched on the weather (“nice day,” “lots of snow”) or even sports events (“whaddya think about those Habs?”) that side-stepped candor and sympathy and only made things worse.

Perhaps my memory is stuck on times remote, but my so-called green or salad days provide another story.

House officers were once obliged to ride along with the ambulance. Most often this was to declare someone dead. On a wintry Montreal evening, our ambulance was called to a tenement in Point St. Claire. A buffalo-coated constable was already there. A TV blared loudly. An oldster sat contorted in a stuffed chair. Bent in several places, he looked dead, but his spouse or partner seemed unaffected and attended to the television. I took out my stethoscope and listened everywhere – precordium, neck, abdomen – and even, as I’d seen others do, listened to his eyeballs. But all was silent, and I announced at length, that he was gone, dead. The dead man’s partner shrugged it off, allowing, “He gets like this sometimes.” Unnerved, I went back to listening, could hear the television, competing noise from other apartments, but my man’s life was done. Again I announced this to the room, but this time the news held and the room erupted. The man’s spouse, as they’d say today, went postal.

I’ve been reading Warren Buffett lately and think that what the Sage of Omaha has to say about investing money may relate to communications too: “It’s simple, but it’s not easy.”

Communication, done well, may look easy. It likely isn’t.

Reference available upon request.
I recently attended an Indigenous Awareness session in Edmonton and I’m now ashamed to admit that I had no idea of the cultural extermination that was going on right here in my beloved country. I realize it was not the organizer’s intention to make the attendees feel ashamed, but I have no other word for my feeling. Canada’s legacy of colonization and residential schools has had terrible consequences for Canada’s First Nations, Metis and Inuit peoples ... and these consequences have extended into health care.

Now we know. Now there is no excuse. Now is the time to embrace the Truth and Reconciliation Commission Report, as well as the United Nations Declaration on the Rights of Indigenous Peoples. I encourage you to read and understand our cover story about the AMA’s Indigenous Health Policy and consider the poignant introduction by Dr. Cara Bablitz. As well, we have some important thoughts in our regular columns: Health Law Update and PFSP Perspectives. Our theme is extended into our feature story about Indigenous Health at work in the AMA Youth Run Club.

Of course, I also want to bring you up-to-date on our progress toward launching the all-digital version of Alberta Doctors’ Digest. We’re on track for the March-April issue, so if all goes well, this will probably be the final printed magazine version of ADD.

As I’ve mentioned before, with digital distribution we’ll be able to enhance eADD beyond the printed word. We are exploring rich media such as video, audio and greater use of photography. We will have more tools at our disposal to bring you great stories about the business, politics and economics of practicing medicine in Alberta. In fact, if you or someone you know would like to volunteer as a local photographer, that’s a resource we could definitely use. Some of you have already stepped forward, so thanks for that!

Depending on when you’re reading this, there may still be time for you to assist with the development of eADD by participating in small focus groups by phone, video or email. We want your feedback to ensure we get this right. So if you’re interested, please contact Daphne Andrychuk at daphne.andrychuk@albertadoctors.org.

Marvin Polis
Editor-in-Chief
Alberta Doctors’ Digest
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Now is the time to eliminate the health inequities of Indigenous peoples

Cara A. Bablitz, MD

The Indigenous Health policy paper demonstrates the Alberta Medical Association’s commitment to improving health outcomes of First Nations, Metis and Inuit patients. It is not acceptable that Indigenous peoples have poorer health outcomes than other Canadians. We hope the steps outlined in this paper will bring meaningful change. During the writing of this policy paper, we were guided by the Truth and Reconciliation Commission Report, as well as the United Nations Declaration on the Rights of Indigenous Peoples.

The history of colonization, including residential schools, targeted the culture of Indigenous peoples and changed the course of our health. Residential schools were created to eliminate all that was Indigenous, and the effects are multi-generational. It is important for physicians in Alberta to realize that the history of residential schools still directly impacts all Indigenous patients.

Most health care providers have had minimal education on the history of Indigenous peoples and residential schools. This knowledge is critical for all medical students, residents and physicians to better understand Indigenous community perspectives and experiences.

Alberta had 25 residential schools, the most of any Canadian province, and the last of these closed recently – in 1996. The atrocities that happened in residential schools can be read about in detail in the Truth and Reconciliation Report. Those who did not attend residential schools were also affected as they were taught to be ashamed of their culture and faced systemic racism. Most health care providers have had minimal education on the history of Indigenous peoples and residential schools. This knowledge is critical for all medical students, residents and physicians to better understand Indigenous community perspectives and experiences.

The ultimate hope for the future is that we can remove barriers and health inequities to improve the health of Indigenous peoples.

The following story demonstrates the challenges Indigenous peoples face in the health care system. An elderly female Indigenous patient was admitted for symptom control related to advanced metastatic breast cancer. She left the hospital many times against medical advice and was deemed to be a “difficult patient.” When the physician sat down with her for a consult, they took a robust social history and learned that being in an institutional setting reminded her of her days in residential school. This brought up memories of the abuse she suffered. For example, every morning memories were brought up because of the porridge that was served. This was the same food she got daily at residential school and was forced to eat even if she vomited. With an understanding of this, the team was able to better understand her perspective and offered wrap-around support including regular visits from a cultural helper. With these changes, the patient agreed to stay in hospital and received much-needed treatment. This is just one story of many demonstrating the struggle I have seen our people face in a health care setting.
> Past experiences cause Indigenous peoples to be distrustful of the health care system. Relationships with patients and communities should be valued and fostered over time. The AMA must continue outreach to prove it is committed to improving the inequities faced by our people.

Most Indigenous peoples do not have adequate access to primary care. When there is a small town in Alberta that doesn’t have a physician, it is a crisis. However, when a reserve or settlement doesn’t, it is accepted as normal. Many Indigenous patients seek care in the emergency department because equitable access to primary care is not provided and this creates bias. There are also complex jurisdictional challenges that Indigenous peoples face, and I encourage you to review Jordan’s Principle as an example.

The AMA has recognized that you cannot have true reconciliation unless you have an Indigenous voice at every table where health decisions are being made for Indigenous peoples. That is why it was so important to have Indigenous community members and Indigenous physicians as part of our Indigenous Health Working Group and now the Indigenous Health Committee.

Our committee will continue to advocate for equitable Indigenous Health and use the AMA policy paper as our guiding principles. The ultimate hope for the future is that we can remove barriers and health inequities to improve the health of Indigenous peoples.
Articles within the United Nations Declaration on the Rights of Indigenous Peoples speak to the fundamental importance of accessing culture, traditions and reaffirming cultural identity as the foundation for a people's autonomy and equity. The declaration also speaks to an Indigenous right to health in social justice terms through the need for equitable access to social resources and by elimination of any systemic barriers. These concepts are essential for improving health outcomes. They are also essential for the health care system as a whole to become a force for reconciliation.

For example, the declaration states:

- **Article 7(1)** “Indigenous individuals have the rights to life, physical and mental integrity, liberty and the security of person.”
- **Article 8(1)** “Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.”
- **Article 20(1)** “Indigenous peoples have the right to maintain and develop their political, economic and social systems or institutions …”
- **Article 21(1)** “Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.”
- **Article 24(2)** “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health ....”

The Truth and Reconciliation Commission of Canada report provides Calls to Action for redressing the tragic effects of residential school systems in Indigenous communities and peoples. The Alberta Medical Association endorses this AMA Policy Statement which sets out our organization’s support and commitment to respond to the Truth and Reconciliation report’s Calls to Action relating to health matters. It also reflects our determination to provide leadership in improving access to and quality of care provided to Indigenous communities in Alberta.

The AMA adopts the following principles as the basis for this policy:

1. The AMA is committed to addressing health care inequity. The AMA recognizes that Indigenous peoples in Alberta experience barriers to health care due to resource and quality issues arising from inequity. The AMA recognizes health care inequity arises systemically from structural barriers and racism.

2. Health care should be delivered in a way that is appropriate and respectful of all people taking into consideration individual needs and context. Health care should be developed and delivered in concordance with the distinct and diverse social and economic needs and cultural realities of Indigenous peoples in Alberta.

3. We acknowledge that social determinants of health influence the health of Indigenous peoples. Colonization, both historic and ongoing, is the key determinant that influences the more proximal health determinants that cause the current disparity of Indigenous Health. Due to the forces of colonization, Indigenous social determinants are often disparate from mainstream determinants. Approaches to Indigenous Health must comprehend this context. These same forces of colonization adversely influence health service. The AMA is committed to improving the health of Indigenous peoples by advocating for equity of social resources.

4. The AMA will use a collaborative approach in achieving improvements to access and quality of Indigenous Health. The AMA as a health systems advocate will collaborate with existing health service stakeholders - which includes funders, policy makers as well as all levels of health service (local, provincial, federal) operational leads, Indigenous leadership and community leaders - to facilitate dialogue and relationship building towards leverage for change.

5. The AMA is committed to reconciliation, collaboration, meaningful empowered community engagement and knowledge exchange with Indigenous peoples. Reconciliation in the area of health service means advocacy to achieve not only quality but also equity rooted in the social and cultural contexts of Indigenous peoples.
Alberta Medical Association Commitments to the TRC Calls to Action

1. The AMA will promote, in conjunction with Alberta Health Services, Alberta Health, Primary Care Networks (PCNs), the College of Physicians & Surgeons of Alberta, universities and other stakeholders, that every physician, medical student and resident in Alberta complete professional development related to Indigenous Health through the various levels of learning. This professional development will be grounded in community perspectives and experiences, provide a critical spectrum of knowledge and skills and generate a community of practice. We will also support development of a course structure which incorporates a cross-cultural applicability to other vulnerable cultural communities. Proposed strategies could include:

   - The AMA will dedicate a section of its website to professional development related to Indigenous Health and to Indigenous Health issues.
   - The AMA will seek to establish a focused strategy for communication on Indigenous Health, such as a regular column in Alberta Doctors’ Digest on Indigenous Health issues.
   - The AMA will advocate for innovative approaches to cultural education, such as a fellowship or chair on Indigenous Health.

2. The AMA will take positive steps towards relationship building with the Indigenous community – i.e., First Nations & Inuit Health, Alberta Region, Health Co-Management Committee – and will advocate for safe learning environments.

   - For AMA committees with mandates that directly affect Indigenous Health, we will ensure that there is Indigenous representation and engage community representation where appropriate.
   - The AMA will facilitate community experiences in Indigenous communities for learners.
   - The AMA will advocate for more and better safe clinical environments to learn about Indigenous peoples throughout the medical training continuum. This will allow learners to gain experience in the provision of safe care to Indigenous populations.
   - The AMA will collaborate with other groups and with Indigenous leadership to build a pool of Indigenous applicants at various levels of training to gain interest and the skills needed to be successful in medical education.
   - The AMA will advocate for the creation of safe learning environments in medical training for Indigenous students.

3. The AMA will continue to support measures to identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities.

   - The AMA will advocate for integration of data on Indigenous Health quality and access; we will seek consultation with Indigenous communities and research bodies such as the Health Quality Council of Alberta (HQCA), the Population Public and Indigenous Health Strategic Clinical Network (SCN), Health Canada, the Alberta First Nations Information Governance Centre, etc.

   - The AMA will discuss with the HQCA mechanisms for identifying and measuring gaps in health care access and quality between Indigenous and non-Indigenous communities. We will support and facilitate the role of Alberta physicians in assisting with this function.
   - The AMA will advocate for increased capacity in Alberta to carry out impactful research measuring Indigenous Health services outcomes.

4. The AMA will advocate with all levels of government, health care authorities and Indigenous leadership to meaningfully address current jurisdictional issues. The parallel levels of funding unique to Indigenous peoples often present barriers to care. Examples of this type of advocacy include:

   - The AMA will work with Alberta Health, Health Canada and Indigenous leadership to ensure that Jordan’s Principle is implemented and monitored effectively.
   - The AMA will support broadening of Jordan’s Principle to other jurisdictional issues and age groups.

5. The AMA will facilitate innovative health service models to meet the needs specific to Indigenous populations within their local area.

   - The AMA supports every Albertan, including all Indigenous peoples, to have access to care within the framework of the medical home.
   - The AMA will advocate for PCNs to develop an Indigenous service delivery component. We will build upon successful PCN projects and work to scale success to all PCNs. We will work with Alberta Health and AHS to ensure sufficient funding and resources for PCN Indigenous community support.
   - The AMA will advocate for Indigenous leadership and perspectives within the PCN governance framework.
   - The AMA will facilitate the creation of a space for discussion and collaboration devoted to Indigenous Health primary care innovation.
   - The Practice Management Program (PMP) will incorporate Indigenous Health training and support.
   - The AMA will continue to support primary preventative programs, such as AMA Youth Run Clubs in Indigenous communities.
   - The AMA will encourage Indigenous projects in its Emerging Leaders in Health Promotion program.
6. The AMA recognizes the value of traditional Indigenous healing practices in addressing the effects of racism and cultural oppression and will work to support its incorporation with Western medical practices when requested by Indigenous patients.

- The AMA recognizes the contributions that Elders, knowledge keepers and cultural supports bring to relationship building to ensure a more sustainable approach to addressing Indigenous Health.

7. The AMA will work with AHS, Alberta Health, Health Canada and Indigenous leaders and communities to increase access and outreach for safe health care provision by physicians including those members of the Indigenous specific Alternative Relationship Plans (ARPs) (Siksika ARP and Indigenous Wellness Program ARP).

- Enter into discussions with AHS to increase support for physicians serving under-resourced Indigenous communities.
- Advocate for the provision of social workers and mental health/addiction support in Indigenous communities through both ARP and other primary care delivery models.
- Advocate for resources and professional development within Indigenous communities to address ongoing health priorities including addictions.
- Seek means to include community members as workers in clinics.

In the words of Justice Murray Sinclair: “Achieving reconciliation is like climbing a mountain - we must proceed a step at a time. It will not always be easy. There will be storms, there will be obstacles, but we cannot allow ourselves to be daunted by the task because our goal is Just and it is also necessary.”

This policy statement confirms the AMA’s determination to be leaders in addressing past and current injustices to Alberta’s Indigenous communities.

Appendix A To AMA Policy Statement on Indigenous Health

Extract

Truth And Reconciliation Commission Report (TRC)

Calls to action that have impacts on health

- TRC #18 We call upon the federal, provincial, territorial and Indigenous governments to acknowledge that the current state of Indigenous Health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health care rights of Indigenous peoples as identified in international law, constitutional law and under the Treaties.

- TRC #19 We call upon the federal government, in consultation with Indigenous peoples, to establish measurable goals to identify and close the gaps in health outcomes between Indigenous and non-Indigenous communities, to publish annual reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

- TRC #20 In order to address the jurisdictional disputes concerning Indigenous peoples who do not reside on reserves, we call on the federal government to recognize, respect and address the distinct health needs of Metis, Inuit and off-reserve Indigenous peoples.

- TRC #21 We call on the federal government to provide sustainable funding for existing and new Indigenous healing centers to address the physical, mental, emotional and spiritual harms caused by residential schools.

- TRC #22 We call on those who can affect change within the Canadian health care system to recognize the value of Indigenous healing practices and use them in the treatment of Indigenous patients in collaboration with Indigenous healers and Elders where requested by Indigenous patients.

- TRC #23 We call on all levels of government to: (i) Increase the number of Indigenous professionals working in the health care field. (ii) Ensure the retention of Indigenous Health care providers in Indigenous communities. (iii) Provide cultural competency training for all health care professionals.

- TRC #24 We call on medical and nursing schools in Canada to require all students to take a course dealing with Indigenous Health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Indigenous rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights and anti-racism.

- TRC # 55 We call on all levels of government to provide annual reports or any current data requested by the National Center for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include but not be limited to: ....(iv) Progress on closing the gaps between Indigenous and non-Indigenous communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

References available upon request.
FEATURE

Alberta Medical Association
Board of Directors 2017-18

Front row, left to right: Dr. Kimberley Kelly; Dr. Wendy Tink; Dr. Shelley Duggan; Dr. Robin Cox.

Middle row, left to right: Dr. Lloyd Maybaum; Dr. Padraic Carr, Immediate Past President; Dr. Neil Cooper, President; Dr. Alison Clarke, President-Elect; Dr. Derek Townsend.

Back row, left to right: Dr. Paul Boucher; Dr. Jordan Stosky, PARA Observer; Dr. Tobias Gelber; Dr. Jennifer Williams.

Missing: Dr. Paul Parks; Stephanie Smith, MSA observer; Michael Gormley, Executive Director.
In keeping with the theme of this edition of Alberta Doctors’ Digest, we’ve chosen to explore issues relating to differential provision of health care between federally funded and provincially funded health care systems, most notably, involving First Nations children.

Most Canadians are fortunate to have access to publicly funded health care that enables them to receive timely and effective treatment. First Nations children, especially those on reserves and in isolated communities, may not have the same access, in part as a consequence of the federal government’s responsibility for their funding. Although numerous efforts have been made to erase or at least bridge some of these barriers to health care access for First Nations children, the death of a young boy at age five, resonated with the Norway House Cree Nation community in Manitoba and has likely assisted in pushing for real solutions to the barriers these children face in accessing meaningful health care.

Jordan’s Principle

Jordan River Anderson was a Norway House Cree Nation child born in 1999. He was diagnosed with a rare disorder and was hospitalized under provincial care due to a lack of available health care services on the reserve. Health care providers made the decision he could be moved into a medical foster home to be closer to his family and his community. However, the Manitoba government and federal government disputed who would cover the cost of Jordan’s care. As a result, Jordan was denied the opportunity to leave the hospital and spend his remaining years in close proximity to his family; instead he died at age five, having lived his entire life in the hospital.

Jordan’s case highlighted the serious barriers many First Nations children face in accessing health care due to jurisdictional tensions. On October 31, 2007, Ms Jean Crowder, Member of Parliament, brought forward a private member’s motion (M-296) to resolve jurisdiction disputes and end the bureaucratic tug-of-war between provincial and federal governments in determining who would pay for health care. The motion was unanimously passed in the House of Commons on December 12, 2007. The principle was a simple child-first strategy, where

Most Canadians are fortunate to have access to publicly funded health care that enables them to receive timely and effective treatment.

The decision

Approximately 10 years after the passage of Jordan’s Principle, the First Nations’ Child and Family Caring Society of Canada and the Assembly of First Nations brought a complaint to the Canadian Human Rights Tribunal alleging discrimination in the provision of child and family services to First Nations on reserves and in the Yukon on the part of Aboriginal Affairs and Northern Development Canada (AANDC). On January 26, 2016, the Canadian Human Rights Tribunal found that First Nations children were adversely affected by government involvement and bureaucratic red tape in receiving health care.
This decision provided a comprehensive overview of the discrimination First Nations individuals have faced generally and, more specifically, the challenges evident in obtaining equal access to health care. The decision conclusively determined that systemic discrimination against First Nations children on reserves existed. Specifically, the tribunal considered that Jordan’s Principle not only applies to disputes between Canada and a province/territory, but also between departments within the government. It determined that the crux of Jordan’s Principle was to “prevent First Nations children from being denied essential public services or experiencing delays in receiving them.”

The decision reviewed circumstances where there was a lack of communication between government departments and found issues with funding and lack of authority being used to deny requests for specialized medical aids to assist First Nations children. These issues created gaps in service to First Nations children and their families on reserves.

These issues were further compounded by findings that there did not seem to be a clear process on how to obtain non-insured health benefits. In an effort to clarify the purpose of Jordan’s Principle, the tribunal noted that “it is Health Canada’s and AANDC’s narrow interpretation of Jordan’s Principle that results in there being no cases meeting the criteria for Jordan’s Principle ... such an approach defeats the purpose of Jordan’s Principle and results in service gaps, delays and denials for First Nations children on reserve.” The tribunal found AANDC was to stop its discriminatory application of the Jordan’s Principle by narrowing the definition and apply Jordan’s Principle broadly as was intended. The tribunal made its finding clear – Jordan’s Principle was to apply to all First Nations children.

Moving forward

While the decision pushed Jordan’s Principle forward in an effort to reduce barriers to health care, the responding action has been slow. Despite two additional decisions by the tribunal finding how Canada was to apply the broad definition in Jordan’s Principle, Canada continued to narrow its interpretation.

On May 26, 2017, the Canadian Human Rights Tribunal again had to determine whether Canada was meeting its obligations to broadly interpret Jordan’s Principle as intended in the decision. Complainants brought forward allegations that Canada continued to define Jordan’s Principle narrowly, failed to adopt the orders in the decision and built further delays and gaps into cases after the decision. In the result, the tribunal made the following findings:

- Jordan’s Principle is a ‘child-first’ principle and is to be applied equally to all First Nations children regardless of reserve status. The principle is not to be limited to those with disabilities or critical needs.
- Gaps in government services are not to prevent meeting the health care needs of First Nations children.
- The government department of “first contact” will pay for the services without the necessity of policy reviews or other administrative procedures. Reimbursement is of secondary concern after ensuring the child obtains the services they require.
- Substantive equality, taking into consideration culturally appropriate services and best interest of the child, is to be paramount when a government service may be beyond the normative standard of care or not available to all other children.
- Disputes between or within governments is not a requirement to apply Jordan’s Principle. Lack of dispute should not be a shield for failure to provide adequate care.

The tribunal went on to set numerous deadlines between May and November of 2017 for Canada to rectify its discriminatory practices, including reviewing cases it had denied previously and developing systems to prevent gaps and delays in care.

First Nations children, especially those on reserves and in isolated communities, may not have the same access, in part as a consequence of the federal government’s responsibility for their funding.

In Alberta

A group in Alberta has now been established to specifically address health care access for all First Nations children in the province. The First Nations Health Consortium (FNHC) is made up of 11 First Nations in three treaty areas that will act as advocates for First Nations children in obtaining health care without bureaucratic barriers. Jane Philpott, Federal Health Minister at the time, pledged $5 million to the FNHC over three years to assist First Nations children in obtaining access to health care.

While these important issues facing First Nations children have yet to be settled, the FNHC is a step in the right direction that appears to have the backing of the federal government in moving forward with its mandate.
Hello Dr. Jirsch:

I read your recent “From the Editor: When breath becomes air” with great interest as I have also recently reviewed this book among four books in my article in the BC Medical Journal (http://www.bcmj.org/premise/how-would-you-die).

As we physicians wrestle with this age-old question of “How would you like to die?” I’d like to offer this review as a self-reflection as well as a segue into serious illness conversations with patients and families including our own.

With greetings from across the Rockies!

E.M. Wong, MD, CCFP-EM, FCFP
U of A grad and former Alberta physician
Vancouver BC

Dear Dr. Jirsch:

I liked your special issue about information management. May I add a couple of extra thoughts?

Information management began before computerization with the Problem List. Our general practice clinic found it so very useful. Our standing rule was that whenever a page of clinical notes was filled to the bottom, after billing, our secretary would return the chart to the physician for review of the Problem List. What a lot of trouble (and maybe some mistakes of diagnosis) that prevented. We were working smarter instead of harder. When computers came in, it was easy to incorporate this simple procedure into our clinical program. Why doesn’t everyone do it?

We also devised a prototype computer diagnosis program. Saved us a few red faces. “Uncommon presentations of common disorders are commoner than common presentations of uncommon disorders.” That useful maxim fits so well onto computers. Our program was made on First Choice. That’s no longer supported, but a bigger and better program, “Isabel,” is now available. Computers will do a lot more than billing when you give them a chance.

I’m retired now, to Newfoundland, and no longer an active member of the AMA. But do let me know if you’re interested to read any of the (short) pieces I wrote back then about computer diagnosis. I believe they’re still quite relevant.

Keep up your good work.

With best regards,

David Playfair
Colliers River Head, Newfoundland and Labrador

P.S. I’m the David A. Playfair who worked in Calgary and Didsbury (and not the David R. Playfair who worked at Strathmore).

P.P.S. I agree with you about the death penalty, though for a more mundane reason. Unscrupulous or ambitious police have been known to manipulate evidence to convict. The Christie and Evans case back in 1950s England is a classic example. Evans was an unpleasant bully, but it turned out that his landlord, a respectable special police constable, was the actual killer of Mrs. Evans (plus quite a few more). But by the time this was discovered, Evans was already hanged.
AMA seeks 2018 nominations for our highest awards

The Alberta Medical Association is calling for Achievement Award nominations for individuals who have contributed to the improvement of the quality of health care in Alberta.

The Medal for Distinguished Service is given to a physician(s) who has made an outstanding personal contribution to medicine and to the people of Alberta, and in the process has contributed to the art and science of medicine while raising the standards of medical practice.

The Medal of Honor is awarded to a non-physician(s) who has raised the standards of health care and contributed to the advancement of medical research, medical education, health care organization, health education and/or health promotion to the public.

Nominations must be submitted by April 30. The awards will be presented at the AMA’s fall 2018 annual general meeting in Calgary.

To request a nomination form for these awards, please contact Janice Meredith, Administrator, Public Affairs, AMA, janice.meredith@albertadoctors.org, 780.482.2626, ext. 3119, toll-free at 1.800.272.9680, ext. 3119 or visit the AMA website at www.albertadoctors.org.

In 2017, three physicians were recognized with Medals for Distinguished Service:
- Dr. Gary A.J. Gelfand, Calgary
- Dr. David S. (Shaun) Gray, Edmonton
- Dr. Nairne W. Scott-Douglas, Calgary

In 2017, one individual was recognized with the Medal of Honor:
- Sangita (Gita) Sharma, PhD, Edmonton

To read more about the 2017 honorees, visit the AMA website at www.albertadoctors.org.

FEATURE

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INSURANCE INSIGHTS

Accidental death & dismemberment insurance
Why do you need it?

There is a misconception that AD&D insurance is life insurance – it is not. It is a form of casualty insurance that pays out indemnity benefits when the insured suffers a defined loss or dies as a result of an accident.

AD&D insurance acts as a supplement to term or permanent life and disability insurance coverage. As there is no proof of good health required to enroll in the plan, it is a viable option for those individuals who may not be able to obtain insurance due to health or lifestyle reasons.

There are two components to the plan – coverage for premature death by accident (accidental death) and a physical loss (dismemberment) – up to the anniversary date of the plan following the 75th birthday of the insured. You are insured 24-hours-a-day, anywhere in the world.

If an insured passed away as a result of an accident and not an illness, the full face value of the policy would pay out to the beneficiaries. If the insured had additional life insurance under a separate policy, those proceeds would also be paid – or a double indemnity payment consisting of the life and accidental death benefits would be paid to the beneficiaries designated in the policies.

As with any type of insurance, there are exclusions attached to the coverage. Typical exclusions include suicide or any attempt, and intentionally self-inflicted injuries. Full-time deployable military personnel and crew members on any aircraft are also not eligible for the coverage.

If an insured suffers a permanent physical loss or total loss of use of limbs, hearing, eyesight, or paralysis, as examples, within 12 months after the date of an accident, a portion of the face value of the policy would pay out to the insured. This is the dismemberment element of the plan. Physicians are particularly interested in this benefit due to the protection it provides should they suffer a physical loss which could potentially end their career in medicine such as hand(s) or eyesight.

Several years ago, an AMA member received a dismemberment payout of $2 million after suffering paralysis due to an accident in his home. In addition to the dismemberment benefit, he also received monthly disability payments as the paralysis rendered him totally disabled.

Spousal and dependent child benefits are also available under the family AD&D plan. A percentage of the face value would be paid to the primary insured in the event of death – or they as the insureds would be paid a portion of the value of the policy if they suffered a physical loss.

Additional coverage may also be included for rehabilitation, repatriation, family transportation, spousal occupational training, home and vehicle modification, day care costs, bereavement benefit, critical disease and funeral expenses.

Again, AD&D insurance should only be purchased as a supplement to life and disability insurance – but for uninsurable individuals, it may be one of your limited choices.

Example:
$1 million in member AMA AD&D coverage
Member only is $25/month
Member/family is $35/month

Kelly Guest | INSURANCE ADVISOR, ADIUM INSURANCE SERVICES INC.
List of AD&D losses and sums payable under the AMA plan at $1 million in benefit.

<table>
<thead>
<tr>
<th>Loss Description</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$1 million</td>
</tr>
<tr>
<td>Both hands</td>
<td>$1 million</td>
</tr>
<tr>
<td>Both feet</td>
<td>$1 million</td>
</tr>
<tr>
<td>Entire sight in both eyes</td>
<td>$1 million</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$1 million</td>
</tr>
<tr>
<td>One hand and entire sight of one eye</td>
<td>$1 million</td>
</tr>
<tr>
<td>One foot and entire sight of one eye</td>
<td>$1 million</td>
</tr>
<tr>
<td>Speech and hearing</td>
<td>$1 million</td>
</tr>
<tr>
<td>One arm or one leg</td>
<td>$750,000</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>$666,666</td>
</tr>
<tr>
<td>Entire sight of one eye</td>
<td>$666,666</td>
</tr>
<tr>
<td>Either speech or hearing</td>
<td>$666,666</td>
</tr>
<tr>
<td>Four fingers of either hand</td>
<td>$333,333</td>
</tr>
<tr>
<td>Thumb and index finger of either hand</td>
<td>$333,333</td>
</tr>
<tr>
<td>Hearing in one ear</td>
<td>$333,333</td>
</tr>
<tr>
<td>All toes of one foot</td>
<td>$250,000</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>$2 million</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>$2 million</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>$2 million</td>
</tr>
</tbody>
</table>

For more information on the AMA AD&D plan, visit www.albertadoctors.org/services/insurance or contact the following:

**Kelly Guest, EPC, CHS**  
Insurance Advisor, Red Deer and north  
ADIUM Insurance Services Inc.  
T 780.482.0306  
kelly.guest@albertadoctors.org

**Mona Yam, CFP, CLU, CHS, BComm, BA**  
Insurance Advisor, Southern Alberta  
ADIUM Insurance Services Inc.  
T 403.205.2088  
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*ADIUM Insurance Services Inc. is a wholly owned subsidiary of the Alberta Medical Association and has been providing competitive insurance services since 1950.
Recently, I learned that my favorite dermatology app, VisualDx, introduced an add-on feature called DermExpert which allowed the user to take a photograph of the skin lesion “utilizing Apple’s Core ML Technology to get personalized skin answers in seconds.” This app and website is one of the perks of a faculty appointment at the University of Calgary and access to the U of C library; it is otherwise available for purchase for around US$400 per year. The DermExpert add-on is another US$100 per year.

In November 2017, Apple, in partnership with Stanford Medicine, launched a first-of-its-kind research study using the heart rate sensor contained in the Apple Watch to look specifically at atrial fibrillation.

For this kind of money, I was expecting the add-on to somehow match the photo I take to the large database of dermatologic lesions on file to help me more quickly arrive at a diagnosis with the patient. Unfortunately, I was disappointed when the app would only guess at the morphology (and not so accurately to start) and didn’t seem to even attempt to access the aforementioned database. I expressed my concerns and disappointment to the company; they were very gracious, open to feedback, and readily refunded the money invested. At the same time, I was advised that the tool would improve over time and was also given an instructional tour of the website which made me appreciate even more its potential as a point-of-care diagnostic tool.

This experience prompted further questions on exactly what artificial intelligence (AI) and machine learning (ML) are, how they are related, and in particular, what their applications are in medicine. Briefly, AI is the broader concept of machines being able to carry out tasks in a way that we would consider “smart” and ML is a current application of AI based around the idea that we should be able to give machines access to data and let them learn for themselves. In other words, ML is a subset of AI, using a pioneering technology called the neural network, which mimics (to a very rudimentary level) the pattern recognition abilities of the human brain by processing thousands or even millions of data points. Pattern recognition is pivotal in terms of intelligence. AI encompasses other areas apart from ML, including knowledge representation, natural language processing/understanding, planning and robotics.

AI and ML are currently used in several applications in medicine that extend beyond simply identifying dermatologic morphology. For example, in the spring of 2017, a study conducted by the University of California, San Francisco (UCSF) suggested that the Apple Watch could detect an abnormal heart rhythm with 97% accuracy when paired with an AI-based algorithm called DeepHeart. There was also some suggestion in the same study that the sensors present in the watch could also accurately detect sleep apnea and hypertension.

In November 2017, the US Food and Drug Administration (FDA) approved the AliveCor Kardiaband ECG reader as the first ever medical device accessory for the Apple Watch in the US. This US$200 accessory, available in Europe for quite some time, clicks into a slot on the watch band and can be used to detect abnormal heart rhythms including atrial fibrillation. Users can obtain a monitor reading continuously and discretely by simply touching this sensor.

While these advancements are exciting, they do not come without some disappointment and some risk. While the Kardiaband or a similar device may be helpful in an identified well-informed high-risk individual, there may be significant harm in releasing such a tool to the masses.
Some concerns include:

- How accurate will this technology be “in the wild?”
- Even if it is accurate, how will this affect “the worried well” when they get information about “funny” heartbeats?
- How does one react in a coherent way to deal with and act on this data?
- Will reported normal heart rhythms falsely reassure individuals causing them to delay or avoid an appropriate visit to their physician, such as normal rhythms with anginal chest pain?

This Stanford/Apple approach seems to answer many of my concerns and illuminates some of the great potential for the use of artificial intelligence and particularly machine learning specifically in cardiology, but also in many areas of medicine.

In November 2017, Apple, in partnership with Stanford Medicine, launched a first-of-its-kind research study using the heart rate sensor contained in the Apple Watch to look specifically at atrial fibrillation. The Apple Heart Study, available to US residents, uses an app which passively monitors heart rate and notifies the user if an irregular heart rhythm is observed. This notification is followed by a free video consultation on the iPhone with the study’s medical professionals for further analysis after which additional testing may be recommended. User privacy is protected as heart rate sensor data will be collected and analyzed by Stanford Medicine with no individual access by Apple. The results of this analysis will be used to further understand and improve the complex algorithms required for this type of individualized machine learning as well as advance our knowledge of this medical condition.

This Stanford/Apple approach seems to answer many of my concerns and illuminates some of the great potential for the use of AI and particularly ML specifically in cardiology, but also in many areas of medicine. For example, will we be able to predict and prevent falls based on identified gait abnormalities or is the development of a truly effective artificial pancreas for diabetics becoming a reality?

While these advances have great potential, the real benefit, as illustrated by the Stanford approach, will only happen after personal contact with a trusted professional – you!
The ELiHP grant program

The Emerging Leaders in Health Promotion (ELiHP) grant program provides funding to help medical students and resident physicians conceive and implement health promotion projects in support of the development of their CanMEDS/FM core competencies, particularly health advocacy.

Jointly sponsored by the Alberta Medical Association and the Canadian Medical Association and its subsidiaries – MD Financial Management and Joule™ – ELiHP projects facilitate the growth of physician leadership and advocacy skills in a mentored environment while enhancing the wellbeing of the general Alberta population through education, advocacy or community service.

With the goal of supporting families and alleviating the parental anxiety, post-traumatic stress disorder and depression that are common risk factors with pre-term births, then-medical students Alanna Chomyn and her Emerging Leaders in Health Promotion project co-lead, Supraja Rengan, designed a parent-support program comprised primarily of family playgroup sessions and peer support.

“Parents with infants admitted to the neonatal intensive care unit (NICU) frequently report feelings of stress, helplessness and alienation,” explains Alanna. “These adverse parental experiences can have long-term implications for the child and family, potentially interfering with parent-infant bonding, which can lead to attachment issues, and even result in impaired cognitive and behavioral development in the child.”

Throughout winter 2015-16 and through the following spring, summer and fall, Alanna and Supraja developed the NICU Graduate Family Support Program, learning to focus on the elements of the program that were most successful in engaging their target group: families transitioning home after admission into one of Edmonton’s NICUs.

Parents with infants admitted to the neonatal intensive care unit (NICU) frequently report feelings of stress, helplessness and alienation.

“Initially, our program plan included four components: playgroups, peer counselling, peer support buddy matches and a telephone support service providing access to peer support volunteers,” Alanna explains.

As the project got underway, Alanna and Supraja realized that the initial project plan, which included a complementary buddy program and telephone support program, had been “a bit ambitious” for the first year of the project, particularly given their reliance on a small group of volunteers, and that success would best be achieved by focusing on the popular playgroup sessions and the peer support program in the first year, and striving to incorporate buddy matches and telephone support in the second year.

“We made changes as we executed the project,” says Supraja. “These changes were made partly due to feasibility, given the small group of individuals working on this program.”
Along with me and Supraja, the rest of our project group volunteers – a small group of medical students – also benefitted from this experience, as we planned, organized, promoted and facilitated playgroups and designed the program to meet the needs of our target population.

These adverse parental experiences can have long-term implications for the child and family ...

In addition to their team of medical students, Alanna acknowledges the valuable guidance and support of the involved parents and pediatricians, including Katharina Staub (Canadian Premature Babies Foundation), Jen Hanrahan and Caitlin Nicholson (moms), and ELiHP project mentor Dr. Jennifer Toye (Edmonton-based neonatologist).

Dr. Toye’s strong interest, experience and training in public health and social determinants of health proved incredibly helpful, along with her extensive work with families directly in the NICU and during follow-up. Her experience and position “gave us a foothold with NICUs across the city, introducing us to important contacts and generally helping keep us on track,” Alanna comments. “She’s collaborative and has a wealth of knowledge that we relied on, including other programs internationally that we could model our project after.”

In her final report on her project, Alanna concluded, “I’m excited and optimistic about what our project will achieve for Alberta families, and I believe that the leadership opportunities and skills, and the opportunity to practice health advocacy, will have a long-lasting impact on the young learners and physicians involved with this project.”

The NICU Graduate Family Support Program is still active in Edmonton and hosts regular playgroups throughout the year. More information about upcoming sessions can be found at facebook.com/NICUPlaygroup.

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FEATURE
Dr. William A. Cochrane, March 18, 1926 - October 6, 2017

J. Robert Lampard, MD

Dr. W.A. Cochrane was the last surviving dean from the four medical schools recommended by the Hall Royal Commission in 1964. His passing on October 6, 2017 ended an era in Canadian academic medicine not to be repeated. MD enrollment doubled from 1966-70 to 1,600 per year, increasing MDs particularly from Calgary and Hamilton.

The federal governments of the time are to be credited for bringing Canada temporarily closer to MD self-sufficiency. It recognized a national response was needed to meet the post WWII baby boom, a marked increase in immigration, the pending universal medicare program and the gradual doubling of the doctor-patient ratio of 1:500.

Two of the new deans (Dr. W.A. Cochrane and Dr. J. Evans) realized it was an opportunity to implement a unique curriculum. Both chose to design a three-year, continuously-taught, body-system based program that included a full clinical clerkship year. Their successors have sustained that approach. Since then all medical schools have developed much more clinically orientated curricula. Despite this trend, these two precedent-setting programs remain the only three-year ones in North America – an approach much favored by the programs’ own graduates.

Dr. Cochrane’s own career was a Canadian dream. The son of a Bernardo orphan who came to Canada in 1908, Dr. Cochrane was inspired by his family physician, so in 1944 he chose medicine over the navy. A natural athlete, he received the “athletic stick” award in his last year for exceptional athletic and academic performance.

Dr. Cochrane chose pediatrics because he loved working with families and their sick kids. His research focus was on non-diabetic hypoglycemia. He discovered that the protein leucine caused one form of it. His Cochrane test diagnosed it.

At 31, and already a widely published clinical researcher, Dr. Cochrane accepted a pediatric GFT1 post at Dalhousie. He would later rise to become the Children's Hospital pediatrician in chief and the professor and head of pediatrics.

Foreseeing the need to expand pediatric services in Halifax, Dr. Cochrane proposed building an entirely new referral hospital. The central figure in funding became Dorothy Killam, the widow of Nova Scotia magnate Izaak Walton Killam. Dr. Cochrane persuaded her to pledge $1 million toward the proposed hospital. It became $3 million after a site visit. When she died shortly afterwards, her estate donated $8 million of the $24 million cost.

Four months before the release of the Hall Report in June 1964, Dr. Cochrane joined the faculty’s medical curriculum review committee. It would be a career-changing decision.

The committee visited the original system-based curriculum at Cleveland’s Western Reserve medical school. They studied several schools that had accelerated three-year programs for exceptional students. Dr. Cochrane convinced the committee to recommend conversion of the Dalhousie program to a system-based one. Before being released in 1966, the proposal was critiqued by Drs. John Evans and Alan Gilbert and the curriculum evaluation guru, Dr. George Miller.

Not accepted, Dr. Cochrane began looking elsewhere to implement it – to the University of Toronto, University of Manitoba, and the US. The only Canadian opportunity left was at the University of Calgary. The founding deanship came open in the fall of 1966. He was approached to apply for it.
Simultaneously, Dr. Cochrane began planning his unique curriculum, carefully selecting a new faculty to implement it, designing the medical school around it, and belatedly securing funding to operate it. The school was completed $5 million under budget and two years early, using an innovative project management approach. The surplus covered the renovation of the warehoused research space. Development of the whole Foothills site totaled $56 million.

Convocation of the first class coincided with the opening ceremonies in June 1973. The faculty was ecstatic when the first class earned above average marks on their LMCCs. It confirmed that a curriculum based on didactic presentations – small group teaching – and self-learning could be successful. The McMaster problem-based learning approach was only partially followed. The curriculum remained essentially unaltered until 1992, when it was modified to focus more on the 122 most common diagnoses. As research groups formed, they too were organized by body system, an approach that was well ahead of its time.

Dr. Cochrane resigned as dean after the convocation, when Premier Peter Lougheed offered him the deputy minister of health position. He wanted to learn how governments made decisions.

The next year he was asked to advise the U of C president selection committee. They offered him the position. With the premier’s agreement, Dr. Cochrane accepted it and became one of eight Canadian medical doctors who went on to become the president of a university. As president, he weathered the last of the government’s fiscal curtailment and began the innovative faculties of law and humanities.

Dr. William A. Cochrane was named one of Alberta’s 100 doctors of the century and became the second Calgary physician to be inducted into the Canadian Medical Hall of Fame.

With the Heritage Trust Fund approved in 1976, followed by early discussions on the formation of the Alberta Heritage Foundation for Medical Research, Dr. Cochrane anticipated research dollars would flow to the two medical faculties in unprecedented amounts. They would after 1980.

Connaught Laboratories began courting Dr. Cochrane to accept their CEO position. He did in 1978. It was risky because the vaccine maker was losing money. His strategy was to sell its patent for making insulin, concentrate on genetic engineering, focus on producing high volume vaccines for flu and polio, and expand into the US. Connaught was sold for almost $1 billion in 1989.

Returning to Calgary, he incorporated W.A. Cochrane and Associates as a business and health care consulting firm. Joining many boards, he chaired several including the Banff Centre. He spoke articulately of the need for Canada to invest in biotechnology as a path into the future.

In retirement, Dr. Cochrane continued to support community projects and made many trips to China to foster pediatric programs there.

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FEATURE

History of medicine: It’s all in how you frame the question

A colleague and I recently presented a workshop at the 2017 International Conference on Residency Education. The title of the workshop was History of Medicine can Contribute to Physician Competency.

In the almost two decades I have been involved in history of medicine activities, my major interest has been educational: the many ways that history of medicine can inform the practice of medicine for medical students, residents and practicing physicians in early, middle or late careers.

The major question I have heard is: “How can history of medicine possibly be relevant? It’s in the past.” My response: “It’s all in how you frame the question.”

Grade 11 history
1. Who is Galen?
2. What did Lister recommend?
3. When was the great flu epidemic?
Names, dates – boring stuff, indeed!

Undergraduate history course
1. How did Galen influence medicine in ancient Rome?
2. How did asepsis change surgery in Lister’s time?
3. How did the great flu affect the post WWI world?

More interesting questions, but all in the past.

Medical student or resident research projects
1. Analyze why Galen’s influence on medicine lasted for over a millennium. Do some of the factors involved in adopting new medical information still exist today?
2. Discuss how evolving theories of sepsis and asepsis have altered the practice of modern surgery.
3. Compare and contrast the effects of the great flu and Ebola on the public’s perception of epidemics.

These are the types of questions that really make one think and require significant research and reflection. Further, the resulting analysis and interpretations can contribute to physician competencies.

So when someone says to me that history of medicine is “old stuff” and that memorizing names and dates is a waste of time, I say: “Let me change your perspective by changing the questions you ask.”

Dawna M. Gilchrist, MD, FRCPC, FCCMG, DHMSA | PROFESSOR EMERITA, FACULTY OF MEDICINE AND DENTISTRY, UNIVERSITY OF ALBERTA ON BEHALF OF THE ALBERTA MEDICAL FOUNDATION
While preparing to write this piece about Richard Wagamese’s 2016 book, *Embers: One Ojibway’s Meditations*, I received an Alberta Health Services memo about the new Ceremony Room at the Chinook Regional Hospital (CRH) in Lethbridge. This dedicated space at the CHR, opposite the fourth floor roof terrace, was included in the recent renovation and expansion of the hospital. It is part of an Alberta Health Services collaborative Indigenous Health Program that aims to provide “accessible, culturally appropriate health services for First Nations, Métis and Inuit people in Alberta.”

Sylvia Ann Fox, Blackfoot traditional wellness counsellor at CRH, greeted me when I entered the Ceremony Room. The table in front of Sylvia was covered with a multi-colored blanket. On the blanket was an eagle feather, a small box of matches and a half shell. In the shell was a small clump of sage and sweet grass from which a fine ribbon of aromatic smoke rose.

Sylvia coordinates smudging ceremonies for interested First Nations patients and their families on Tuesdays and Thursdays. Serious illness, according to Sylvia, is a time when some patients seek to reconnect with their spiritual traditions and practices. The day I spoke with her she was expecting three patients to arrive for a smudging ceremony.

In the introduction to Wagamese’s book, he describes the early morning smudging ceremony with which he began each day, sitting at his living room table. He lists “…the four sacred medicines of my people – sage, sweet grass, tobacco and cedar. I put small pinches of each in the smudging bowl, which I set upon the table. I close my eyes and breathe for a few moments. Then I light the medicines, using a wooden match, and waft the smoke around and over my head and heart and body with the eagle wing fan. When I am finished, I set the fan on the table, too.”

Wagamese likens the smoking embers in his smudging bowl to the stories he has written, the words he will write today, and the words of other writers. “The words in this book are embers from the tribal fires that used to burn in our villages. They are embers from the spiritual fires burning in the hearts, minds and souls of great writers on healing and love. They are embers from every story I have ever heard. They are embers from all the relationships that have sustained and defined me. They are heart songs.”

His purposeful intentions for the new day intermingle with the rising smoke. “For you today, my friends, I raise sacred smoke. For you who are troubled, confused, doubtful, lonely, afraid, addicted, unwell, bothered or alone, I raise sacred smoke. For those of you in sorrow, grief or pain, I raise sacred smoke. For those who work for people, for change, for spiritual evolution, for the upward and outward growth of our common humanity and the well-being of our planet, I raise sacred smoke. For those of you in joy, in the glow of small or great triumphs, who live in love, faith, courage and respect, I raise sacred smoke. And, in the act of all of this, I raise it also for myself.”

Take one step into the wonder of nature each day.
In his daybreak ritual, Wagamese turns for guidance to the words of writers he respects as his teachers. “There are certain spiritually oriented books I read from each morning. I lift the books from the couch beside me and read from them in turn. Then I place the books on the table as well. I close my eyes and consider what the readings have to tell me that day. When I’m ready, I settle deeper into the burgeoning pool of quietude, and when I feel calm and centred and at peace, I say a prayer of gratitude for all the blessings that are present in my life. I ask to be guided through the day with the memory of this sacred time, this prayer, the smell of these medicines in the air, and the peace and calm in my heart. I pick up the role Creator has asked me to play in this reality.”

Embers is the central metaphor that informs this work; another is the living room table. If embers are living words, the table is the writer’s life. “Everything I have come to know and rely upon as centring, spiritual, real and valid has its place on that table in my living room. The table is like my life: dented, scarred, battered and worn, but rich and full nonetheless, and singing its histories. In that way, mornings themselves have become my table. Enveloped in Ojibway ceremony, protocol and ritual, ringed by strong words on faith, love, resilience, mindfulness and calm, I reclaim myself each morning.”

Nurture your connections to the living world.

I am not created or re-created by the noise and clatter of my life, by the rush and scurry, the relentless chase or the presumption that more gets more.

Wagamese's distinguished career as a journalist and writer ended unexpectedly in the spring of 2017 when he died in his sleep at the age of 61. Later in 2017, Embers: One Ojibway’s Meditations was awarded the Bill Duthie Booksellers’ Choice Award.

The writer’s thoughtful and lyrical prose in this book is, unfortunately, hijacked to a degree by contemporary approaches to book publishing and marketing. A surfeit of stock photographs, words, fonts and font sizes threaten to reduce the wisdom of his meditations to an overly long series of colourful greeting cards. Stock images beget stock thoughts. The meditations might be better served by a simpler Zen format. Fortunately Wagamese’s distinctive voice, although muted in places by the publisher’s production values, is not silenced.

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No, I am created and re-created by moments of stillness and quiet. I am struck richer by a pure solitude that allows me to feel the world around me and lean into my place in it.

My vicarious participation in Wagamese’s smudging ritual brings to mind four observations or questions pertinent to our ongoing conversations about physician health.

1. What are the objects of most significance on our living room tables?
2. Make friends with silence. Continue to explore the salutary presence of silence in your life. According to Wagamese: “I am not created or re-created by the noise and clatter of my life, by the rush and scurry, the relentless chase or the presumption that more gets more. No, I am created and re-created by moments of stillness and quiet. I am struck richer by a pure solitude that allows me to feel the world around me and lean into my place in it.”
3. Who are our wisdom figures and spiritual guides in 2018?
4. Take one step into the wonder of nature each day.

Recall those nature deficit studies of children in first world countries and the negative effects experienced by kids who spend less and less time outdoors. Wagamese encourages others to nurture their connections to the living world: “Wake and watch the universe shrug itself into wakefulness, as night surrenders slowly to day and shadow relinquishes itself to light. I watch this display and realize that the moon lives in the lining of my skin, the sun rises with my consciousness, and the earth thrums in the bottoms of my feet. Everywhere I go, I take that sense of wonder and mystery with me.”
As a recurring motif in the book, Wagamese records brief encounters with Old Man or Old Woman. To one or the other of these wisdom figures he brings his hardest questions:

Me: What if we’re wrong?
Old Woman: Wrong about what?
Me: All this ceremony, prayer, meditation. What if, at the end of it, all there is is nothing?
Old Woman: Then we still come out better people.
Me: How?
Old woman: Can you think of a better way to live than in gratitude? Can you think of a better way to be than to be kind, loving, compassionate, respectful, courageous, truthful and forgiving? Even if we’re wrong, can you think of a better way to breathe than through all that?

Wagamese concedes: “I couldn’t. I can’t. I continue ...”

When I’m ready, I settle deeper into the burgeoning pool of quietude.

When I feel calm and centred and at peace, I say a prayer of gratitude for all the blessings that are present in my life.
As a physician representative on the Central Patient Attachment Registry (CPAR) Working Group, I’ve been providing direction on its development. The Chinook Primary Care Network (PCN), of which I am a member, created a similar tool several years ago. I’m sharing the experiences and lessons learned to avoid reinventing the wheel with CPAR. So what is it?

CPAR is a centralized database that captures the attachment of primary care physicians and nurse practitioners and their paneled patients. CPAR is a key technical enabler for better continuity of care for Albertans by facilitating improved relational and informational continuity and data for health care planning. There is significant evidence that continuity improves preventative care, decreases utilization and hospitalization, reduces mortality, improves patient health, reduces health care costs, improves overall care quality, increases patient satisfaction and improves patient adherence to care. Continuity of care is essential to improve patient care and achieve health care system transformation.

You’ve probably heard a lot about CPAR through various AMA communications over the last few months. Physicians and other stakeholders are asking lots of questions about CPAR. I want to provide some answers to the most common questions I’ve heard.

Why was CPAR created?

The development of CPAR was a part of the Amending Agreement with Alberta Health signed in October 2016. There was a commitment by both parties to develop this tool for primary care. It is a joint initiative of Alberta Health, Alberta Health Services and Alberta Medical Association. The Section of General Practice (SGP) is leading this work on behalf of the AMA. The SGP and AMA staff have representation on both the CPAR working group and steering committee to keep up with aggressive timelines for the project.

Close to 70% of family physicians in PCNs across Alberta are in an active phase of developing or completing their panel processes with their practices. CPAR is also the logical next step for providers and teams that are actively engaged in proactive panel-based care; it is one more step in this panel process that will consolidate continuity and ultimately improve patient care.

What gap is CPAR filling?

Currently, there is no centralized way for determining to which primary provider patients are attached. When we started the project in Chinook PCN, 27% of patients were paneled to more than one family physician. There was extensive potential for duplication of care and potential confusion when patients receive discordant advice from their primary providers. With CPAR, we are now down to below 4%.

CPAR is a centralized database that captures the attachment of primary care physicians and nurse practitioners and their paneled patients.

Does CPAR address some of the gaps identified in the auditor general’s report about health care in Alberta?

Yes, CPAR will address some of the gaps. It was noted in the auditor general’s report that there is “a lack of sharing and use of clinical information.” CPAR will help facilitate improved informational continuity. Information continuity is the transfer of relevant patient information between multiple care providers and locations. It includes accumulated knowledge about the patient’s preferences, values and context. These are the benefits of information continuity:

- Better handoffs between providers
- Better communication
- Less duplication
- Increased patient and provider satisfaction
- A patient-centered approach to care
> Does a central registry exist in other jurisdictions? Has this approach been successful elsewhere?

CPAR is not a new concept; two PCNs have successful initiatives with functionality and capabilities like CPAR. The Chinook PCN and South Calgary PCN created tools like CPAR. Both PCNs have found it extremely valuable. With both tools, providers receive conflict reports (like CPAR will do) that identify patients on their panel who are confirmed on another providers’ panel.

For example, a conflict report showed a conflict for a patient on my panel who was receiving anti-coagulation therapy. While this patient had been on my panel in Pincher Creek, we knew he lived in another town. This patient had been managed by the INR nurse but had not been optimally controlled for a while. When we saw this patient’s name on the conflict report, a member of the team called him to discuss the situation. The patient explained that he liked the way that we did things at our clinic, but it was more convenient to go to his hometown practice. The team member discussed with the patient the benefits of having a single family physician manage his care, especially his anti-coagulation therapy. He agreed that going to one clinic was the best for his health, so he decided to remain a patient with the family physician in his home town clinic. As a result, we removed this patient from my panel and knew he was receiving ongoing care.

What’s the biggest value that CPAR will have for patient care?

The biggest value that CPAR has for patient care is that it is a technical enabler to improve continuity of care. Evidence is clear that when patients have a longitudinal relationship with a single family physician, results are better quality of care and a reduced overall health care system utilization and costs. Overall, CPAR is the next step in improving care for patients. Importantly, CPAR sets the stage for future improvements in transitions in care; once a patient shows in the registry as attached to one primary provider, the information will be on that patient’s Netcare record. This will allow users across the system to identify the patient’s primary provider.

What do physicians need to have in place to be able to participate in CPAR?

Physicians and their clinic teams who are actively engaged in paneling their patients will be able to participate in CPAR. Foundational is the ability to produce a list of each provider’s paneled patients. There is a readiness assessment that can be accessed on the Toward Optimized Practice website www.topalbertadoctors.org/cpar.

What are the physician benefits of participating in CPAR?

Physicians will have the ability to confirm who is on their panel and identify duplication of patients on multiple panels. This can potentially reduce physician work by clarifying with patients who their family physician is. For practices engaged in panel management, this is a logical next step to ensure proactive care is offered to patients that are verified on a physician’s panel.

Once streamlined, CPAR has the potential to improve integration and transfer of care from acute care facilities. There is also the potential to financially encourage continuity by using the registry and practicing comprehensive care.

Why should physicians participate in CPAR?

If you are among the 70% of family physicians already working on panel processes, this is the next step to strengthen panels/patient registries as a clinical tool. The only catch is encouraging family physicians and clinics to continue to work on panel and registry participation.

Communication is also key to the success of CPAR to physicians and to our patients. SGP has made it clear to Alberta Health that informing patients and the public is a shared effort that cannot be left solely to physicians and our clinics. An Alberta Health public campaign is forthcoming.

What support will be available to implement CPAR?

AMA, Alberta Health and Alberta Health Services are working together to create tools to help physicians, clinic teams and PCNs implement CPAR. For example, step-by-step instructions and videos are currently under development.

What are the timelines for CPAR implementation?

Here are the general timelines for CPAR.

- In December 2017, the registry technical solution was ready for roster management by alternate compensation programs for January use.
- In spring 2018, CPAR will be ready for registry registration.
- In April 2018, CPAR will be ready for panel uploads. Limited production roll-out will occur before broader roll-out.

For more information about CPAR, please visit: www.topalbertadoctors.org/cpar.

Reference available upon request.
With the start of its 2017-18 season last October, the AMA YRC expanded its scope by undertaking a new program aimed at encouraging girls to participate in physical activity and to decrease the significant gap that exists in the athletic participation rates of girls and boys, one that starts at an early age and continues through high school.*

Girls only

The new program is called GO! Run Club (GO! = Girls Only). It is currently in 18 schools, mostly elementary but some junior high and high schools, in Calgary, Cold Lake, Edmonton, Fort McMurray, High River, Lac La Biche, Lethbridge, Red Deer and Siksika.*

Schools that host GO! Run Clubs most often also host regular AMA Youth Run Clubs and are setting up the GO! Run Clubs specifically to increase the involvement of girls. As Dao Haddad, assistant principal at Edmonton’s Delton Elementary School commented in an article in the Edmonton Examiner (October 10, 2017), when describing the school’s Youth Run Club: “The girls that were in it were generally the fast ones and the ones who already viewed themselves as athletic.” Haddad, along with Grade 2 teachers and GO! Run Club leaders Anne Bradley and Kayla Hannan, hope that their school’s GO! Run Club will appeal to a diverse group of girls and be a source of comradery and inclusion.

“Many of these kids come from home lives that are very tough, so to give them something that they can be strong and excel at and be happy; to give them that positive environment and energy is very important,” Haddad added.

Growing the positives

In its fifth year, the AMA YRC has consistently grown and proven to be popular with Alberta schools and teachers. From 233 schools and 17,000 student participants in 2013-14 to last fall’s 450-plus schools and 24,000 participants, word of the good organization, the comprehensive hands-on support and the web-based resources provided by Ever Active Schools (EAS), AMA’s partner in the YRC, has spread among the province’s teachers.

From facilitated Coach’s Workshops to the video library, warm-up poster, Running Log, Coach’s and Runner’s Handbooks and Finisher Prizes, the YRC and GO! Run Club resources are based on current research and need, as communicated to EAS during their engagements with schools and clubs. For some time, EAS has been aware of the Canadian data supporting the discrepancy in male-female youth participation in athletics. According to the Canadian Association for the Advancement of Women: “If a girl does not participate in sports by age 10, there is only a 10% chance she will be physically active at 25.”

The GO! Run Club steps in to fill the physical activity void that too many young girls fall into for many reasons. It’s an exciting program, particularly for the teachers and coaches who’ve observed the predominance of boys in YRCs.

St. Brigid School teacher Maria Verbonac speaks on behalf of herself and her coaching partner, Assistant Principal Marilyn Nasse, about their experience managing their school’s RunHers Club: “We savour every, >
single minute and notice a difference in the girls, already ... (not just) physically but their confidence level ... The girls tell us how they feel like they belong ... like this is their very own, special thing they can do ... without pressure from boys, without pressure from older kids ... We consistently have over 20 girls show up to run club at 8 a.m. twice a week ... The girls love the run club, and we sure get plenty of hugs at the end of the class.”

The positives don’t end there. Maria continues: “To top it off, this has now trickled down to our female staff members as well. We have five to six additional staff members coming to our club, too ... It’s amazing how something so small – such a small vision – has created a healthy environment for the females in the building.”

And from the mouths of RunHers Club participants:

“Thank you for making me feel healthy and happy.” Sanduni

“I wish we had Run Club every day.” Audrey

“I get up all by myself just to make it to Run Club.” Bailey

**AMA member benefits**

Over the past five years of the AMA YRC, a number of AMA member physicians, residents and medical students have been involved with YRC events and/or have visited YRC schools to give School Health Advocacy Talks. Without fail, they too find the experience highly rewarding.

In October 2017, Dr. Dianne Brox, a family physician and “do-it-to-stay-sane” runner, attended the GO! Run Club Fun Run hosted by Delton School. Along with visiting Lauderdale School’s GO! Run Club members, Dr. Brox and Ever Active Schools’ staff joined about 40 girls, who laughed, exercised and celebrated the sisterhood of running together outside.

Commenting on her involvement in Delton and Lauderdale’s official launch event of their GO! Run Clubs, Dr. Brox said, “This generation of children are the most anxious we’ve seen. They can use running to relieve some of the stress in their lives.”

As Dr. Brox spoke to the girls before the run, she invited them to reflect on their feelings. To help them “think about putting words to their stress,” she asked, “Are you ever sad? Worried? Angry?” Then, to a resounding display of exuberance, she advised them: “Go running! For sure, you’ll feel better!”

Judging from the smiles and rosy cheeks all around, the doctor’s activity prescription worked!

* Canadian Tire’s Jumpstart® charity has funded the first 18 GO! Run Clubs and will fund the addition of 18 additional schools in spring, 2018.
MD Financial Management will once again be a sponsor of the Alberta Medical Association Youth Run Club during the 2017-18 season.

The AMA Youth Run Club is making a real difference in Alberta communities – and there are stories about how this is happening in this issue of Alberta Doctors’ Digest. The work of the program is made possible by the combined support of Alberta’s physicians, our partner Ever Active Schools and generous sponsors. The AMA is fortunate to partner with like-minded organizations such as MD Financial Management and Alberta Blue Cross to deliver this important program to schools across the province.

Owned by the Canadian Medical Association, MD Financial Management’s mandate is to advise physicians to help them achieve financial well-being. Supported by more than 45 years of physician-focused experience, MD’s advisors and teams of experts provide physicians with comprehensive financial plans, advice and solutions specific to every life stage. Whether you are interested in incorporating your practice, funding your child’s education, or preparing for retirement, MD Financial Management can help. For further information, please visit https://mdm.ca/ourservices.

MD Financial Management is a strong advocate of supporting and giving back to the medical profession. This second-year YRC sponsorship with the AMA is a perfect example of their commitment to the physician community.

For more information about the AMA Youth Run Club, contact:
Vanda Killeen
Senior Communications Consultant, AMA
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You can also stay up to date on Youth Run Club activities by following @albertadoctors and @AMAYouthRunClub on Twitter.
Over the past five years, the AMA Youth Run Club (YRC) has been running into more and more Alberta schools, in communities large and small, rural and urban.

The AMA YRC is an inclusive, school-based program welcoming and supporting children and youth in schools in every corner and community of the province. The program provides participants with a healthy, fun outlet for physical activity and all the good-for-the-body, soul and mind benefits that go with that.

It’s also long been the desire of the AMA YRC to develop clubs in Indigenous communities, and in the past couple of years we’ve achieved some success. Currently, there are YRCs and/or GO! (Girls Only) Run Clubs located in the following schools in 10 Alberta First Nations School Authorities:

- Aahsaopi Elementary School
- Alexis Elementary Junior Senior High School
- Chief Old Sun Elementary School
- Ermineskin Elementary Junior High School
- Kainai Alternate Academy
- Kainai High School
- Kehewin Community Education Centre
- Kihew Asiniy Education Centre
- Kipohtakaw Education Centre
- Miyo Wahkohtowin Community Education Authority
- Napi’s Playground Elementary School
- Nipisihkopahk Education Authority
- Paul Band First Nation School
- Prince Charles School
- Saipoya Community School
- Sikisika Nation High School
- Sikisika Storefront School
- Tatsikiisaapo’p Middle School
- Tsuut’ina High School
- Tsuut’ina Nation Middle School

Brian Torrance, Director, Ever Active Schools (AMA’s partner in the Youth Run Club) comments: “It’s a positive step to see the AMA YRC embraced in Indigenous school communities. The learning has gone both ways, as the participating communities have shared with us their land-based learnings as well as a true love of physical activity and the sport of running.”

“It’s wonderful to work alongside the communities,” he continues, “but we have so much more to do. Indigenous schools have expressed additional equipment needs, and the youth have requested more coaches in the community.”

Through the AMA YRC program, we’ve been able to provide running shoes, sports bras, socks and some coaching assistance. By working in and with the communities, we’ve identified areas of need and helped to build capacity in the community to address wellness.”
Gold medal winner and YRC Ambassador

Last spring, the AMA YRC proudly introduced its newest YRC Ambassador, 22-year-old Rilee Many Bears, from Siksika Nation. At the 2015 World Indigenous Games in Palmas, Brazil, Rilee joined over 2,000 Indigenous athletes from 30 countries, proudly winning a gold medal for Canada and Indigenous peoples in a challenging, 8.4-kilometer combination of cross-country and road race.

Follow Rilee Many Bears on Twitter @RgoodEagle4.

The participating communities have shared their true love of physical activity and the sport of running.

“The reality is that there are challenges in the community,” says Brian. “But the strong sense of belonging that the AMA YRC provides is bringing youth and the broader community into a positive and healthy place. I’m hopeful of the future in the participating communities, and the power of sport and physical activity to influence overall wellbeing.”
Whether you’re just starting to invest or have been doing so for some time, you probably know the golden rule of investing: don’t put all your eggs in one basket.

In other words, diversify your portfolio.

Diversifying means buying securities from multiple asset classes (e.g., equities, fixed income, cash) and different industry sectors and geographical areas. When you diversify, it helps to reduce risk, but it doesn’t completely eliminate it. Diversifying gives you a smoother ride, which can help you stay focused on your investment objectives when markets are volatile, rather than panic and sell.

What’s great about diversifying your portfolio these days is that anyone has the ability to diversify regardless of how much money you have. Back in the mid-1980s, when I first started in the financial industry, it was much, much harder to diversify. But these days, whether you have $500 or $5 million to invest, you can own a well-diversified portfolio.

For a medical student or resident who’s just beginning to invest, a managed portfolio solution can be ideal. This is a single mutual fund investment that holds a diversified mix of underlying funds that are carefully selected, combined, monitored and rebalanced to fulfill a range of risk and return characteristics to help you meet your financial goals. Where it gets interesting are the possibilities for diversification as physicians build their wealth.

How to diversify if you have significant assets

The basic building block of diversification is asset class: equities, fixed income and cash. For the average investor, it means owning publicly traded stocks and bonds (whether directly or through mutual funds and exchange-traded funds).

As you accumulate more assets, you can start expanding the asset classes you invest in and consider real estate (e.g., rental properties, farmland and timberland) and alternative investments such as hedge funds, derivatives, foreign currency and private equity.

These different asset classes provide additional diversification benefits because they have a lower correlation to traditional asset classes, giving you the chance to generate potentially greater long-term returns. How much you allocate to alternative investments would, of course, depend on your individual situation.

One area that’s becoming more accessible to wealthier investors is private equity investments.

What is private equity?

Private equity strategies invest in shares or holdings in a company that isn’t listed on a stock exchange. Think Facebook before its initial public offering.

Private equity investments can be complex, whether the company is a start-up seeking venture capital, a mature company looking to expand or a company that needs capital to restructure. It takes a special kind of expertise to analyze, evaluate and invest in private companies. Like the public stock market, private equity can generate growth – but because the investment is privately held, investors are looking to improve performance through operational changes or new ideas. It means investors have a lot more say in the future of the company.

For the most part, private equity investments have typically been accessible only to sophisticated institutional investors such as pension funds, since the minimum investment amount is usually $1 million or more. However, these strategies are becoming available to qualified Canadians. In Canada, being an “accredited” investor means having either an income of $200,000+ before taxes ($300,000 if combined with a spouse) or net financial assets of $1 million before taxes or net assets of $5 million (which could include real estate). Besides being accredited, private equity investments are also best suited to long-term investors who are looking for higher returns over time through a patient, long-term approach.
One of the most compelling reasons to invest in private equity comes back to the increased diversification benefits for a portfolio. Although private equity has similar characteristics to public equities, there are additional factors that drive private equity (think long-term investment horizon). These different factors provide lower correlations relative to traditional stocks and bonds, which in turn provide further diversification and a more robust risk-return profile for a portfolio.

When you think of eggs in a basket, private equity is simply another basket you can use.

For more information about private equity investing for physicians, see md.cma.ca/platinum. MD Platinum™ is a new offering with a low initial minimum investment and is exclusively available to MD clients until April 30.

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IN A DIFFERENT VEIN

Automatic reply: Out of office on Global Health project. For emergencies call ...

Alexander H.G. Paterson, MB ChB, MD, FRCP, FACP | CO-EDITOR

In the George W. Bush Star Alliance Lounge, Houston, Texas – an oasis of peace, soft music and that furtive, squirrel-like activity of travellers loading up on free food and drinks – we ran into Dr. Eldon Smith, former dean of the Faculty of Medicine at the University of Calgary, who was going home from a consulting visit in Monterey, Mexico. Eldon was always a great supporter of Global Health projects.

I was returning from a consulting visit to Managua, Nicaragua with two colleagues: cardiologist, Dr. Sonny Belenkie and pediatric cardiac surgeon, Dr. Kishan Narine. The talk got to Global Health and our projects, why we did it and what might be the societal benefit. We all agreed contributing to Global Health was good. Eldon even said: “If every Canadian were to receive a grant of around $2,000 to visit a developing country, Canada would be a better place with more understanding of their problems.”

And there might be fewer complaints of waiting four hours in the ER. Annoying, yes, but try a two-day journey with a broken leg to a small health care outpost in northern Nicaragua on a make-shift hamaca (stretcher).

Eldon may be ahead of his time. The current blarney in Davos economic circles is of doing away with complex welfare schemes for the poor and substituting a “guaranteed income” for all citizens. This is being discussed in Nordic countries and even in the UK with possible fulfilment when Red Jeremy becomes Prime Minister of the People’s Republic of Corbyn. A grant for every UK citizen to visit North Korea or Venezuela may not be far off.

More attainable might be a grant for medical students and residents in Canada to work and study in a developing country. Seeing patients with rabies, dengue, bacterial endocarditis and malaria, balances the dominant chronic diseases in the west, and students would see the limited medical services in deprived parts of the world and the disparity between their circumstances and ours. The educational advantage to our students is obvious, less so for those receiving the learners. But only a few will take this up. As my friend, Chris, said:

“When I say we’re off to Laos to teach, people say ‘Wow, that’s cool! I’d love to do that.’ But when the time comes, they bail.”

And so our little band of brothers in the Star Alliance Lounge decided we were doing our best, in the way that you do when you know you’re doing the right thing but are conscious that some might spoil the mood by pointing out that you enjoy travel, that you stay in mostly nice places (not Bates’ motels), that you meet interesting people and leave the daily grind of running a practice to others.

As a gloomy Presbyterian Canadian Scot, I’ve been raised to assume a variety of motives for folks cutting out of Canada. A big chunk of the appeal for me is a mix of altruism and fun – getting away from a Canadian winter with the humdrum routine of an Alberta practice and the fun of tax-deductible travel to exotic parts (more likely to survive a CRA review than a CME at sea junket) and staying at a four-star resort and scuba diving after your teaching. And it is grounding and humbling...
Dr. Narine is a pediatric cardiac surgeon. Trained in Guyana and fostered as a potential talent by the ubiquitous Jesuit priests, Kishan has set up a pediatric cardiac surgical unit in Guyana and had come to help set up another at the Military Hospital in Managua. I asked Kishan what drove him to take on this extra work. He thought carefully: “It’s about who I am and how can I live a worthy life. This is a Buddhism concept and you have to be able to answer to yourself when the time comes. Have I lived a worthy life?”

For Dr. Belenkie, cardiologist and Avenging Thor of students and residents who fail to examine the neck veins, it was “about passion to do a better job. And in the case of the developing world, how can I make this work.” Sonny finds the challenge of fighting bureaucratic obstacles thoroughly invigorating. He’s been instrumental in bringing Rotary Club funding for a new medical school in Nicaragua.

The main reasons for doctors not involving themselves in Global Health were difficulties scheduling time away (but no difficulties scheduling vacations), no connections to international partners (but no difficulties organizing connections for vacations in Hawaii) and concerns for personal safety (poor things).

And so, we have an amiable group under the loose auspices of Global Health in the University of Calgary. We meet in a restaurant chosen by Dr. Taj Jadavji, pediatrician and gastronomic bon-viveur, who proffers scoops of basmati rice, trowels of Szechuan beef and large spoons of Thai coconut tilapia fish while pouring cups of green tea, as we chat about residents on attachments, visits forthcoming to foreign parts and vaulting the ever-increasing bureaucratic hurdles. This last has become a big time hassle. Gone are the privileged days of the invitation: “Come on over and we’ll fit you into some clinics ...” While tightening the organization of visiting learners was warranted, it has now become a maze, a Rubik’s Cube, a Sisyphean task of overcoming red tape - you almost finalize an attachment, only to find it scuppered by vagaries of federal visa complexities and college, university, department and clinic rules.

We call ourselves Project Zamboanga and have a budget from members of the group, mainly Sonny, our unofficial chair. There’s Taj (who knows university ropes) and myself as a general spear thrower and hardened traveller, and Dr. Gwen Hollaar, Assistant Dean, Global Health.

Gwen is a general surgeon who follows “effective altruism” (a term from philosopher, Peter Singer, author of A Life You Can Save). Global Surgery is a force in Canada with many surgical teams visiting needy places and performing surgeries unavailable to the local population. She has worked effectively over the last decade in Laos focusing on ”general surgery post-graduate training” and substitute “training generalists (family docs) to work rurally in a variety of capacities.”

The Centre for Global Health (Surgery) at the University of Calgary, advocates for surgical care by building partnerships that promote surgical care in low and middle-income countries and providing a means for faculty, residents or staff to participate.

The number of deaths worldwide due to conditions needing surgical care exceeds the number of deaths from HIV/AIDS, tuberculosis and malaria combined. A major report in 2015 from The Lancet Commission on Global Surgery provides the background and sensible recommendations for these activities. They are directly relevant to all aspects of Global Health.

High-income countries have 14 operating rooms/100,000 people compared to less than two operating rooms/100,000 people in low-income countries. In Nicaragua, one public cobalt-57 unit serves six million people compared to 30 linear accelerators for three million people in Alberta. One example of the sensible recommendations from The Lancet Commission report is that “all donated equipment should be accompanied by long-term maintenance arrangements.”

Calgary student Azalea Lehndorff found in a survey that the main reasons for doctors not involving themselves in Global Health were difficulties scheduling time away (but no difficulties scheduling vacations), no connections to international partners (but no difficulties organizing connections for vacations in Hawaii) and concerns for personal safety (poor things).

The Global Surgical objectives are to build local capacity, teach relevant information and create bi-directional communication. It’s a temptation when visiting a deprived country to don the mantle of Bringer of All Things Good, Teacher of all Things Worth Knowing and Seer of the Road Ahead. And it’s easy to criticize the shortcomings of the local practitioners and the corruption of local administrators, forgetting that their travelled paths are different to yours: the wars, looting, persecutions, exploitations and betrayals that led to their present deprivation; and the lottery of history, the rise and fall of empires – what was it that led Cambodia and Laos, Home of the Angkor Empire, now to have become deprived states?
Gwen’s advice is simple: stay humble and maintain a teachable attitude. And on return to Alberta, ask yourself some questions: “What was I thinking during this experience? What does this teach me? What might I do differently in the future?”

Most of the international contacts at the U of C are through university links following up requests for help. Much of the pioneering work in southern Alberta was done by Clarence Guenther – to Clarence goes the title of patron of Global Health in southern Alberta. There are now nine collaborating U of C partners in low to middle-income countries on the three deprived continents.

When I say we’re off to Laos to teach, people say ‘Wow, that’s cool! I’d love to do that.’ But when the time comes, they bail.

Some personal memories:

In India, the weird contrast of a ward round in the spotless bone marrow transplant unit at the Tata Memorial Hospital in Bombay (now Mumbai) and outside, barely a block away, a woman sweeping dust from the front of her cardboard box set in the middle of a bustee (slum) of cardboard dwellings.

And in Douala, Cameroon, the rammie (a scramble of people trying to get attention) of patients and families in the main hospital in the city contrasting with the empty German-built hospital outside the city that none could afford.

In the Philippines last year, a physical examination teaching session in Zamboanga, a southern Philippines city on the Christian/Muslim fault-line where one is accompanied by armed security to avoid – one hopes – kidnapping by the Abu Sayyaf gang and being ransomed for big bucks – or beheaded. We’re examining the abdomen. I ask one of the male students to volunteer by taking off his shirt and lying on the stretcher. When he peeled off his shirt … giggles from the assembled young students – many females in hijab. I’m demonstrating physical examination of the spleen, percussing Traube’s space when a large, bearded young man approaches the front of the class.

“Doctor. He is Muslim. He is embarrassed by showing his body. I ask that you take a non-Muslim.”

I stared at him and felt a cold annoyance and said: “Examination of the human body is fundamental to the study of medicine … if you don’t understand that, you should study something else.” I suspect that class was memorable.

Global Health Outreach should be fully supported in this imperfect world. It’s an attempt, often imperfect, partial, uneven, but an attempt to give back.
Also in the Philippines, a headline on the photograph in the International Herald Tribune read: “Florida Team rescues lymphoma victim, Peanut, the Orang-Utang.” The photo was of six doctors and nurses around an animal receiving IV chemotherapy for non-Hodgkin lymphoma.

In every country I’ve visited – communist, capitalist, Catholic, Protestant or atheist – it’s the rich who get top-class service and the poor who miss out. As the old Cockney song goes: “It’s the rich wot gets the pleasure; it’s the poor wot gets the blame; it’s the same the ‘ole world over, ain’t it all a bloody shame.”

Most of the medical schools in the Philippines have Western curricula: management of heart attacks and malignant disease. Only a few focus on local health: infectious diseases, diarrhea, trauma, sanitation and public health. Those are the schools that Project Zamboanga focuses on. The Ateneo de Zamboanga trains doctors for the islands off the southern Philippines. There are few deserters to the west.

Global Health Outreach should be fully supported in this imperfect world. As my colleagues in the Houston Star Alliance Lounge agreed: it’s an attempt, often imperfect, partial, uneven, but an attempt to give back.

I asked Gwen what would be the biggest thing to improve her programs – expecting an answer like “more funding.”

“No question: more volunteers giving time and skills coming forward.”

So come on out and volunteer, you empty nesters playing golf with safe travel plans. Do your bit!

“They treat monkeys with that in your country?” asked a resident. We’d been seeing a young woman with non-Hodgkin lymphoma whose family could afford only two cycles of Cyclophosphamide, Doxorubicin, Vincristine and Prednisone. She’d return to her village; the disease would recur; she’d see a local shaman; and she’d die. Treating an Orang-Utan before a fellow human being?

So come on out and volunteer, you empty nesters playing golf with safe travel plans. Do your bit!
PHYSICIAN WANTED

CALGARY AB

Drs. Young & Wouters, Calgary Vein & Laser, has an immediate opening for a part- or full-time physician. Calgary Vein & Laser has been providing venous disease treatment for 25 years. Injectable cosmetics and a variety of laser treatments are also provided by our office. This practice is a patient-centered experience and is a very gratifying practice for the physician. A team of nurses, medical assistants and laser technicians assist in providing excellent patient care.

Training will be provided and experience is an asset. Physician must be licensed with the College of Physicians & Surgeons of Alberta and member of the Canadian Medical Protective Association.

Contact: Debbie McFarlane
Manager
calvein@telus.net
www.veinlase.com

CALGARY AB

Start practicing right away. Westside Medical Clinic, a collaborative family medical centre is seeking general practitioners to join our team.

We’ve been operating for over 10 years but recently moved to a beautiful new clinic at 110, 1923 17 Avenue SW.

This clinic offers an ideal location for physicians wanting to practice family medicine, build a patient panel, or for established doctors that would like an ideal, central location from which to anchor their practice.

With over 45,000 vehicles a day passing by, in a high-density area, we are seeing a lot of interest from the public in the area and have an excellent signage opportunity for promotion of a new doctor. With a highly diverse patient demographic, we offer an excellent opportunity for doctors, and a great service to the community.

Brand new equipment, modern design; our clinic strives to provide both patients and doctors with a terrific environment and experience. Westside Medical provides shared access to PCN collaborative health care professionals, two surgical suites, and ample well-trained staff.

We are one kilometer from Sunalta C-train and the #2 transit stop is right in front of our building. Richmond Diagnostic Centre is two blocks west.

Contact: Rob Filyk
T 403.815.8488
robfilyk@shaw.ca to arrange a visit with our doctors and learn more

CALGARY AB

Med+Stop Medical Clinics Ltd. has immediate openings for part-time physicians in two of our Calgary locations. Our family practice medical centres offer pleasant working conditions in well-equipped modern facilities, high income potential, low overhead, no investment, no administrative burdens and quality of lifestyle that is not available in most medical practices.

Contact: Marion Barrett
Med+Stop Medical Clinics Ltd.
290-5255 Richmond Rd SW
Calgary AB T3E 7C4
T 403.240.1752
F 403.249.3120
msmc@telusplanet.net

CALGARY AB

Pristine Health is looking for family physicians and specialists to join our clinic. We offer Med Access electronic medical records, competitive overhead split (75/25) and opportunity for partnership. We have a branch each in north and south Calgary. We can help with transitioning from another clinic and provide relocation assistance.

Contact: T 403.402.9593
pristinehealthclinic@gmail.com

CALGARY AB

Crescent Medical Centre is a family clinic in southwest Calgary and is accepting applications for a part- or full-time physician who is looking to build a new practice as well as a physician with an existing panel. The clinic is a member of the Calgary West Central Primary Care Network providing high-quality care. The physicians work in collaboration with the PCN including on site practice nurse, behavioral health consultant, geriatric nurse, clinical pharmacist and physiotherapist.

Contact: Nadia
T 587.318.1608
crescentmedcentre@gmail.com
www.crescentmedical.ca

CALGARY AB

Exciting opportunity to join a family practice in northwest Calgary named Family Practice of the Year, 2015 (Department of Family Medicine, Calgary Zone) and recognized by the College of Family Physicians of Canada as a model of the Patient Centred Medical Home in the Province of Alberta. Our practice has used a patient-based funding model (not fee-for-service) since 1999 to deliver comprehensive care to a population of newborn to geriatric patients in an innovative, collaborative and team-based practice. This well-organized practice provides family physicians with a well-supported interdisciplinary team, streamlined processes, competitive compensation and collegial environment.

We currently have a wait list of patients looking to join our model and practice and are seeking a family physician to join our team. Physician must be licensed with the College of Physicians & Surgeons of Alberta and member of the Canadian Medical Protective Association.

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COALEDALE AB

The Campbell Clinic Group is offering an opportunity to take over the patient panel of a retiring family physician. The Coaldale Campbell Clinic has six family physicians, visiting mental health counsellors and attached pharmacy. Coaldale is a rural town of approximately 7,000, 10 minutes east of Lethbridge. The community has an ambulatory care centre with paid on-call coverage. Physicians may also choose to care for their own inpatients at the Chinook Regional Hospital in Lethbridge with an established inpatient call group.

The Coaldale Campbell Clinic is part of the Chinook Primary Care Network and offers support from a multidisciplinary team. Candidates must possess or be immediately eligible for an unrestricted license from the College of Physicians & Surgeons of Alberta – no sponsorship opportunities are available for this position.

Contact us if you are interested in this opportunity.

Contact: Tim Neufeld
Clinic Manager
tneufeld@campbellclinic.ca to send your CV along with other credentials
www.chinookprimarycarenetwork.ab.ca for more information on our clinic and network

DEVON AB

Devon Medical Clinic is a well-established practice consisting of six family physicians that is in need of physicians. We are looking for part- or full-time physicians interested in practice sharing. Clinic has been using Wolf electronic medical records for 11 years, X-ray clinic and pharmacy on site. Devon General Hospital is across the street.

Our friendly team would greatly appreciate help in caring for our growing community.

Contact: Kim Babiy
T 780.987.3315, ext. 227
kbabiya@devonmedical.ca

EDMONTON AB

Edmonton Medical Clinic is located in a prime and vibrant district on 10230 142 Street in Edmonton is seeking two or more full-time family physicians to start a clinic. This is an ideal clinic with a great potential for an abundant steady patient flow and one that will provides physicians with an ideal practice space, flexible schedule and an ideal income.

Physicians will be remunerated at a rate of $200 per hour for the first few months until an adequate number of patients can be regularly booked. Thereafter, a competitive overhead of 80/20 split will be offered for the first year. We warmly invite family physicians to join the team.

Candidates should be certified or eligible for certification by the College of Family Physicians of Canada and eligible for licensure with the College of Physicians & Surgeons of Alberta.

Contact: Guilin Yang
Clinic Manager
C 778.868.5111
ygl6188@hotmail.com

EDMONTON AB

The Links Clinic, centrally located at the MIRA Health Centre, has openings for part- or full-time family physicians who value a quality lifestyle. The clinic is well established with 19 family doctors and two specialists and is open Monday to Friday with no evening or weekend shifts and appointments are by appointment only.

The Links Clinic offers excellent patient volume and minimal after hours on-call. The clinic has been using electronic medical records for over 25 years and is currently using Accuro. The doctors are active members of the Edmonton Oliver Primary Care Network and work collaboratively with different disciplines in a medical home. No capital investment is required.

Please give us a call if you may be interested. We would be happy to answer any questions. Also contact us if you would like a tour.

Contact: Dianne Walker, CA, CPA
Clinic Business Manager
T 780.453.9467
dwalker@thelinksclinic.com

INNISFAIL AB

The Associate Clinic is a well-established busy clinic with Canadian, British and South African trained family physicians. We are seeking two family physicians to replace two retiring physicians. We have full functioning electronic medical records, fully trained support staff and part of the Wolf Creek Primary Care Network. Physicians participate in the on-call rotation at the Innisfail Health Centre and Penhold Medical Walk-in Clinic. The Associate Clinic and Penhold Walk-in Clinic hours are Monday to Friday 9 a.m. to 5 p.m.

Interested applicants must be licensed or eligible to apply for licensure with the College of Physicians & Surgeons of Alberta. Compensation is fee-for-service. Inquiries will be kept strictly confidential.

Contact: Dr. E. Barker
ebarker3@telus.net

LEDUC AB

Griffiths Medical Clinic is looking for a full-time family physician to join our existing group of four physicians. We are an established, community-based family practice in Leduc with a focus on quality, continuity patient focused care. Well run clinic with same day access for patients and utilize TELUS Wolf electronic medical records. Work with friendly and dedicated staff, with an RN available for doctor’s assistance.

We are active members with the Leduc/Beaumont Primary Care Network (PCN) with ability to access a dietician, behavioral health consultant and other PCN support services.

There are opportunities available for OR assisting and possible emergency shifts at the Leduc Community Hospital.

In-patient care at Leduc Community Hospital is required as part of the on-call group. CCFP preferred.

Contact: Elizabeth Smith
Office Manager
T 780.986.6200
griffithsclinic@gmail.com
RED DEER AB
Practice opportunities for part- or full-time family physicians. One physician would like to retire, and we need a motivated physician to take over the panel.
Clinic is supported by four physicians, TELUS Health electronic medical records, primary care network support, also opportunities regarding hospital, hospice, labor and delivery, hospitalist and long-term care work if desired.
Applicants must be eligible for licensure with the College of Physicians & Surgeons of Alberta.
Contact: T 403.346.4206 F 403.346.4207 lora.l@shaw.ca

ST. ALBERT AB
The Associate Medical Clinic is a well-established family practice in the downtown core of St. Albert with a satellite clinic in Morinville.
We are seeking a part- or full-time physician to join our seven family physicians to add to our steadily growing practice. With our supportive group of physicians and hardworking, highly trained staff, we would welcome you.
Clinic details include: Affiliated with the St. Albert & Sturgeon Primary Care Network, with an in-house pharmacist, registered nurse, and behavioral health consultant along with other PCN supports; close proximity to the Sturgeon Community Hospital; obstetric and long-term care options are available; electronic medical records - Mediplan/Telin and attached pharmacy.
With a growing population of 72,000 just minutes north of Edmonton, the City of St. Albert was voted in 2015-16 as one of Canada’s Best Places to raise a family. St. Albert’s reputable low crime rate and strong support for the sports and arts communities provides a friendly and ideal place to live.
Contact: Dr. Gerhard Jacobs zuma1972@live.ca

ALBERTA
Pinnacle Medical Centres, a proud division of Peak Medical Group, is pleased to be expanding our clinics in Alberta.
Our clinics in Calgary, Edmonton, High River, Medicine Hat, Okotoks, Red Deer, Sherwood Park and Strathmore have professional support staff.
Come join a progressive network of family physicians and specialists that offers a favorable compensation plan, energetic and experienced support staff, and a flexible schedule with part-time, full-time or locum tenens spots available. Weekend and evenings clinics can also be made available.
Contact: Erika Berger erika.berger@peakpulmonary.com to send your CV and start the conversation

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Alberta’s Netcare Screening Status Report & Cancer Screening Guidelines: Webinar (FEBRUARY DATE TBA)
Choosing Wisely Alberta Symposium (MARCH 7)
4th Annual MSK Pearls Course (MARCH 9)
Preparation Course for the CCFP Exam (MARCH 17-18)
Stroke Symposium (MARCH 23)
35th Annual Calgary Therapeutics Course (APRIL 19-20)
ASSOCIATED CALGARY THERAPEUTICS PRE-COURSE
Cannabis Update 2018: A Framework for Conversations with Patients (APRIL 18)
Women’s Mental Health Day Conference (APRIL 27)
Calgary Pain Conference (MAY 7)
Calgary Pain Conference Breakfast with Lorimer Mosely (MAY 8)
5th ACH Paediatric Update Conference (MAY 10-11)
5th Annual Women’s Health in Primary Care (JUNE 1)
ECG Interpretation Course (JUNE 8)

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Medical Record Keeping Program
Tapering and Stopping Opioid Therapy

All inquiries please contact
GENERAL
cme@ucalgary.ca
403.220.7240
REGISTRATION
cmer@ucalgary.ca
403.220.7032
To register
cumming.ucalgary.ca/cme
CALGARY AND EDMONTON AB
Imagine Health Centres (IHC) is currently looking for family physicians and specialists to join our dynamic team in part-time, full-time and locum positions in Calgary and Edmonton. We have a unique opportunity for a full-time/locum physician to take over an existing patient panel in Calgary.

Imagine Health Centres are multidisciplinary health clinics with a focus on preventative health and wellness. Come and be part of our team which includes family physicians, specialists, physiotherapists, chiropractors, psychologists, pharmacists and more.

Imagine Health Centres prides itself in providing the best support for family physicians and their families in and out of the clinic. Health benefit plans and full financial/tax/accounting advisory services are available. There is also an optional and limited-time opportunity to participate in equity opportunities in IHC and related medical real estate. Enjoy attractive compensation with our unique model while being able to maintain an excellent work-life balance.

We have two clinics in Calgary and three clinics in Edmonton. All inquiries will be kept strictly confidential.

Contact: Dr. Jonathan Chan to submit your CV in confidence
T 403.910.3990, ext. 213
corporate@imaginehealthcentres.ca
www.imaginehealthcentres.ca

DRAYTON VALLEY AB
Two physicians/locums required immediately to fill positions at the Malone Medical Clinic in Drayton Valley. Drayton Valley is one and one-half hour drive to the Edmonton International Airport and a three-hour drive to the Rocky Mountains.

The 6,000 sq. ft. modern, very busy rural clinic is fully computerized, and the hospital is half a block away. We have on-site laboratory and do pulmonary function testing, hearing testing and minor surgery. We are very flexible as to hours and days of the week to work. On-call is on a rotational basis at the local hospital.


Experience:

• Flexibility – Practice to fit your lifestyle.
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• Travel costs, honoraria, accommodation and income guarantee provided.

CONTACT:

Barry Brayshaw, Director, AMA Physician Locum Services®
barry.brayshaw@albertadoctors.org
T 780.732.3366  TF 1.800.272.9680, ext. 3366
www.albertadoctors.org/pls

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health care and communicating health promotion, disease prevention and performing patient advocacy role. Consult with other medical practitioners.

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Contact: Nanci Stocks  
nanci_anne@hotmail.com or  
Amy Markovitz  
amy.ccmc@hotmail.com  
F 780.444.0476 to attention of Nanci or Amy

SHERWOOD PARK AB
The Sherwood Park Primary Care Network is looking for several physicians to cover a variety of locum periods in a variety of Sherwood Park offices. Practice hours vary widely. Majority of practices run electronic medical records. Fee splits are negotiated with practice owners. Some practices are looking for permanent associates.

Contact: Dave Ludwick  
T 780.410.8001  
davel@sherwoodparkpcn.com

CHILLIWACK BC
A busy well-established, well-appointed, five-physician medical clinic is looking for two family physicians for permanent part-time, full-time or locum positions.

Clinic is close to the hospital, laboratory, X-ray and pharmacy, and free parking for physicians and patients. Option to do hospital work/maternity is available. We use OSCAR electronic medical records. Each physician can enjoy his or her own private office and two examination rooms, shower and change room. We have caring and knowledgeable staff and medical office assistants. Excellent split of 75/25 with many more perks, flexibility, help with transitioning from another clinic and a moving allowance where applicable.

Enjoy all the advantages of living in an established farming community with excellent housing, schools, shopping, golf and other outdoor recreational activities – just over an hour away from Vancouver.

Contact: Nazlin Khamis  
T 604.780.4579  
nazlinkhamis@gmail.com

CALGARY AB
Medical professionals wanted for Westman Village in Mahogany. Jayman Built brings to Calgary 25,000 sq. ft. of high-end main street retail, serviced by more than 250 visitor parking stalls, and surrounded by more than 900 residential units in what will become the premiere community within the community of Mahogany (soon to be Calgary’s largest neighborhood). Units range from 1,500 to 3,500 sq. ft.

Contact: Jeff Robson  
JR Mercantile Real Estate Advisors Inc.  
T 403.770.3071, ext. 200  
jeff@jrmercantile.com

CALGARY AND EDMONTON AB
Medical offices available for lease in Calgary and Edmonton. We own full-service, professionally managed medical office buildings. Competitive lease rates, attractive building amenities and turn-key construction management available.

Contact: NorthWest Healthcare Properties  
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Regional Leasing Manager  
T 403.282.9838, ext. 3301  
lindsay.hills@nwhreit.com  
Michael Lobsinger  
Leasing Manager, Edmonton  
T 1.877.844.9760, ext. 3401  
michael.lobsinger@nwhreit.com
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