Nap interrupted

I wondered at the call – wouldn’t an email or letter do? – and considered possibilities. Might I at long last – better late than never – have been recognized as one of The Worthies? Would I be made Officer of the Order of the Garter? I could imagine an investiture with pomp and purple robes. A second but darker possibility loomed: Was I guilty, guilty of something I couldn’t put my finger on, a transgression lost in the mists of time and memory?

I couldn’t think of anything more sinister than planning a nap on a sunny afternoon.

But it wasn’t Grand Pooh-Bah on the line at all. And I wasn’t being offered a medal or the chance to open a new pavilion. On the other hand, past but forgotten sins and misdemeanors hadn’t surfaced either. I was momentarily relieved.

A sunny voice on the line announced that it was Trudy (not real name), executive assistant to Pooh-Bah. I’d never met her. We exchanged pleasantries, after a fashion – Trudy was much more genial than I – but these were soon exhausted and the purpose of the call was out. I was being targeted to donate money. Annoyed but still decorous, I blurted a peremptory “Not at this time, thank you” and retreated to my bed.

The mood though was broken and I was left twisting in the wind at an interruption that was untimely, probably unnecessary and that I felt I’d handled poorly.

I arranged pillows and comforter, just so, and felt the luxury of approaching sleep. But it wasn’t to be. A voice from downstairs beckoned, commanding, “It’s the Office of the Grand Pooh-Bah. They want to talk to you.”

I’ll interject here that I know many Grand Pooh-Bahs, and I’ve traveled a fair bit, so if you think you can nail Pooh-Bah’s identity, you’re probably wrong.

Giving, charity, altruism – you get the idea – is something that has been around as long as we have. I can readily visualize an ancestral tribesman – the resemblance is unmistakable – tossing an uneaten haunch of something to a dispossessed confrere in a remote savannah. Experts in evolutionary behavior reckon altruism is a good idea – a win-win situation once everything’s considered.

The Bible promises rewards in heaven and the Koran’s on-message too. For sure we have significant examples in our time. If Mother Teresa isn’t enough, consider that Mitt Romney – who will or will not be president by the time you read this – gave millions away last year. Bill and Melinda Gates have teamed up with legendary investor Warren Buffett to give oodles away. It is really a matter of ethics,

Giving, charity, altruism – you get the idea – is something that has been around as long as we have. I can readily visualize an ancestral tribesman – the resemblance is unmistakable – tossing an uneaten haunch of something to a dispossessed confrere in a remote savannah.
we’re told, and Princeton ethicist Peter Singer – the same fellow who enjoins us not to eat meat – is specific when it comes to giving: Give 1% of net income away, and give it to fight world hunger.

Peter Singer is probably right about world hunger, if not the steak. Who doesn’t want to end world hunger? Whatever my budget for charity, maybe it should all go to fight world hunger. On the other hand, maybe I should hold some back for exigencies, perhaps to mollify callers who interrupt naps.

The more I chew things over, the more convinced I am that this is a huge, thorny subject and one I’d rather not get into. Most charitable donations, I realize, are jet-fuelled by tax write-offs, a custom that started after World War 1. I wonder at this. There’s a lack of clarity here, a lack of purity, and I wonder whether true charity should be sullied by this sort of jerry-rigging.

Perhaps I’d be better off with a schema – what might be called a heuristic or an algorithm by scientists – that would help, that would serve in case of interruptions that would leave me less frazzled. Pace Peter Singer I might award five stars to requests likely to help world hunger/homelessness, possibly four stars for global warming, three stars for important research, and so on. Remembering my plucky medical student from last night, I’m prepared to award a star or two to medical education. My inchoate schema has negative values too: Subtract at least one star for interruptions, two stars for being interrupted from a nap.

I’m in full tussle now with these mental contortions and they’ve trumped my need for sleep. My night of call, the piquant truth of my fortune cookie and my clumsy phone call have all conspired to make me feel like a piker, living an altogether small and cramped existence. I can think about it all forever but I’m tilting at windmills of my own making, intellectualizing, no more.

I call Pooh-Bah’s executive assistant back. I’ve decided I’m capable of larger, more generous stuff and I reverse course. Before I can think more about it I’ve signed on, promising enough money to outfit a room – bed, drawers, etc. – on a new pediatric ward. Trudy is equable and personable throughout at this unexpected turn of events.

I am surprised though at how much better I feel after this second call. It’s my way of contesting things, I reckon, of putting up a struggle against my weariness, my ragged edges and the limited truth of a fortune cookie. Giving as an antidote of sorts?

Sleep will come now. I have a new foothold on my composure and will sleep the Sleep of the Just.

Charity’s not easy, I think, nodding off.

Still, I’d prefer another fortune cookie, next time.

A different one.

Who doesn’t want to end world hunger? Whatever my budget for charity, maybe it should all go to fight world hunger. On the other hand, maybe I should hold some back for exigencies, perhaps to mollify callers who interrupt naps.

The easy way to get online

We’re using QR codes in a few articles in this issue. Scan these codes using your smart phone or tablet device to view online content.

Scanning the code below will take you to the Alberta Doctors’ Digest page on the AMA website.

If you don’t have a QR code reader app on your phone, download one for free from www.scanlife.com.
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VISIT BuildwithBrookfield.com FOR HOME AND COMMUNITY DETAILS
Highlights follow from the Alberta Medical Association’s (AMA’s) Representative Forum (RF) and annual general meeting (AGM) in Edmonton, September 21-22.

Fall RF/AGM

DOCTORS AND PATIENTS:
THE “ESSENCE OF CARE”

Providing the “essence of care”

Dr. R. Michael Giuffre was installed as president September 22. Excerpts of his installation speech follow.

Thank you very much for this opportunity to address you as the 102nd president of the Alberta Medical Association (AMA).

I would like to acknowledge Dr. Linda Slocombe who is now, for the first time, addressed as the immediate past president of the AMA.

Dr. Slocombe has represented the AMA and Alberta’s physicians so well during a year of political change. This past year was a political whirlwind. Dr. Slocombe championed us through a provincial election that was characterized by strong party leaders and an AMA campaign that brought health care to the forefront.

On behalf of all the AMA and all the doctors in Alberta, as well as AMA staff, we thank you Dr. Slocombe.

Essence of care

My specialty is pediatric cardiology. My colleagues in this field in Alberta have grown in number from a half a dozen or so when I started over 22 years ago, to now closer to 20.

My colleagues and I care for infants, children and adolescents with either congenital or acquired heart disease. Many of these infants and children are my patients for years, transferred to others for care when they turn 19.

Over the course of caring for these patients, through the good times and bad, in their clinical or surgical care, deep bonds and relationships develop.

I believe we most commonly refer to these bonds as the cherished “doctor-patient relationship.” Often these relationships extend to the patient’s family or guardians, as they too become our patients and fellow caregivers.

This bonding and this doctor-patient relationship form the part of physician care that I can only describe as the “essence of care.” It is what we do as physicians.

This “essence” describes what we physicians may have to hold on to each and every day, particularly the days where things have not gone well. This is the “essence” that defines the service we provide, how we give of ourselves and how we care.

It is my desire, as a physician, to take the time required, to always provide the best care in the safest way possible and in a timely fashion. I can say with honesty that each day I do my best. My colleagues do the same, across all the disciplines of medicine, each and every day.

My colleagues are also nurses, nurse practitioners, pharmacists, therapists, technologists and other health care professionals. They too want to be able to routinely deliver the best care – quality care – in the safest way possible and in a timely fashion. They also do their best. We all do – and often in a team effort.

You would think this to be noble, reasonable and laudable. But, for this to occur, each and every one of us in the team of health care delivery needs a dependable system of health care. We need a system of care that finally allows us to work really well together, in team environments.
Extending an olive branch to government

Physicians, nurses and others in medical care delivery have been caught in the multitude of change that has enveloped and characterized Alberta’s health care system since the 1990s – 17 regions, then nine, then one large one.

We all know patient care has been affected, suboptimal and often with dignity compromised – with morale and resentment reflected accordingly.

• We simply wanted our surgeons to have adequate facilities that got them back in the operating rooms more than once a week.

• We simply wanted our waiting lists to be gone so patients got the access they deserve.

• We simply wanted world-class clinical diagnostics and health care facilities that made sense.

• We simply wanted to be part of decisions on health care policy and delivery that were evidence-based and that add true Value for Patients.

Is it time for us to stop challenging the leaders that profess health care changes without evidence of a value-add to patients? No, not really.

Is it time for us to look within ourselves and stop the overt criticism of health care delivery and the re-runs of past decision-making since the 1990s that were less than ideal? Well, yes maybe it is time.

Is it perhaps time to change our outlook and attitude? I feel that we must challenge ourselves as a physician profession with these questions.

Finally, is it time to push the re-start button, to move forward and to work with new leadership, side-by-side?

Is it time to say the past is the past and we need to move forward?

I think so.

We as AMA and physicians must now extend an olive branch and become willing partners to sit side-by-side with the government, the health minister and Alberta Health Services (AHS). We need to be perceived as a facilitator and not an obstruction to health care policy.

Collectively and individually we must accept and contribute positively toward the implementation of a directional shift in government health care policy, health care management and health care delivery. Our role is important to make these shifts have a positive outcome for patients.

The AMA and physicians are ready to be invited back to the table, to give guidance toward the planning of health care with government, before decisions are made and before policies are in place.

Primary care

The AMA and Alberta’s physicians have maintained that primary care is the cornerstone of the ultimate success of any health care delivery system.

Primary care, as we know it, largely occurs in the community, delivered often in a team setting by our urban and rural family physicians. Primary care networks (PCNs) are currently the team-based community care delivery model. The 40 PCNs in the province now provide care to 2.8 million Albertans and involve 85% of all family physicians.

The auditor general of Alberta, in his last report, cited a number of PCN accomplishments and stated, “It’s about the physicians and other health professionals who work within them... and it’s all about the quality of care they deliver.”

Our premier has proposed to change the primary care delivery model and has introduced another delivery model called family care clinics (FCCs). We as physicians should certainly be okay with the concept of increased funding in primary care. We also should be okay with the concept of improving access for non-fragmented primary care, and we certainly want to work with the government on this concept.

This willingness to work with government on this endeavor is evidenced by the recent AMA discussion paper on primary care, and how FCCs and PCNs can improve access. This discussion paper, A Vision for Family Care Clinics, can be found on the AMA website.

I think we need to make one thing very clear: Alberta does need to get primary care right or the whole system will never work to anyone’s satisfaction. And let’s face it, Albertans deserve and need cost-effective, safe, timely and quality-driven primary care.

Other levels of care

What about the complex patient needing health care beyond primary care?

Who will provide the navigational map through our complex system of health care?

This scenario of the complex patient getting access and navigating through our health care system remains a big problem. AHS is working on an innovative solution with physicians and the health care team.

AHS is developing what it calls Strategic Clinical Networks (SCNs). They may just turn out to be very effective for complex patients requiring a multitude of services.
These networks promote coordinated or facilitated “specialty care” in a team-based, often institutional setting.

AHS has recently sought the input from physicians and the AMA for this model of care to work.

Let me give you a statistic that effectively underscores the importance of these clinical networks:

- Over 30% of the health care arises from just 1% of the population. It is clear that improving the coordination of complex care will have a lot to do with the eventual sustainability of the health care system.

**Final thoughts**

The major stakeholders in health care – government, the health minister, AHS, the AMA, the nurses, all other members of the delivery team – are all clamoring for the same thing: we all want a dependable system of health care!

Who do we really want this for? We all want this for our patients. So let us once again be reminded of their basic and simple expectations.

It is time for all the stakeholders to get together on the same page, and use a set of objectives that comes from the patient’s perspective:

- Let us create a health care system that responds promptly at all times.
- Let us provide a health care system that supplies world-class care.
- Let us ensure a health care system that fulfills universal access, successfully and safely delivering care to everyone that needs it in a timely fashion.
- Let us provide a continuum of care with excellence in both primary care, in our communities, and specialty care, in our institutes and hospitals.

Similarly, in simple language, let us again be clear in our negotiations with government on principles that allow great comfort to all and allow negotiations to move forward:

- Physicians, health policy makers and health operations will need to work together to make effective decisions about health care.
- Meaningful change and reform will take time.
- An agreement on principles will often lead to significant progress and the achievement of desired outcomes.

In conclusion, as your president over the next year, I will work with the health minister and his team, together with my fellow physicians, the AMA, Representative Forum, board and staff, to deliver a new negotiated contract.

As many of you have come to realize, this new contract is not about money, as we have asked for reasonable increases as contemplated within the Agreement in Principle that government had on the table this past June.

In proper health care delivery, physicians, nurses and other dedicated health care professionals work side-by-side to deliver safe, quality and timely care to Albertans. These are the people that should be responsible for deciding what a patient needs and requires.

It is the physicians that will need to make the correct diagnosis and that will then, most often, determine the decisions for care delivery in all its forms. It is the physicians that take the ultimate responsibility for the care for their patients.

Let’s work together with government, AHS, Alberta Health and the College of Physicians & Surgeons of Alberta. Let us create a well-coordinated team-based care system that makes sense and delivers consistent world-class care that we can afford.

Thank you.

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Promoting a strong vision for the future of health care in Alberta

Excerpts follow from the valedictory address by Dr. Linda M. Slocombe, 2011-12 president.

This year, we witnessed an historic election in the province and the politics of health care have never been more apparent. This has most certainly impacted our ability to negotiate without mistrust on both sides. Uncertainty for our future and fear of the unknown continue to fuel negativity and cynicism.

Yet I remain cautiously optimistic about the fate of our negotiations. I am not naïve and I believe we may be in for a long period of instability. I know, though, that the AMA will continue to be open to honest, frank discussions with the minister and his negotiating team.

I remain cautiously optimistic about the fate of our negotiations.

The media and the opposition parties would love to use the AMA to attack the government, but we must not allow ourselves to become pawns in a political chess game. The timing of what we do and the messages we convey will be critical to our success or failure in the future.

A year as president is long enough to:

• Get a sense of the government we are dealing with.
• Feel the yearning for a long vacation.

Yet it is not long enough to:

• Feel I have been able to give everyone the time they deserve.
• Accomplish the goals I set for myself.
• Not to feel real sadness that it is coming to an end.

I have learned many valuable lessons. I learned that no matter where our members practice, no matter what their specialties, they care deeply about our profession and their patients.

I have learned many valuable lessons. I learned that no matter where our members practice, no matter what their specialties, they care deeply about our profession and their patients.

Many have said to me: “You must be glad that your term as Alberta Medical Association (AMA) president is almost over.” I have to admit that it has been a year of challenges, with definite highs and lows.

There is still much unfinished business, and let me start with the topic that’s probably the most top of mind: finalizing an agreement for our members with the government. Your executive director, your negotiating team, your board members and I tried our best to get an agreement.

I am tremendously disappointed that I am standing here without a completed agreement in hand.

But, I firmly believe that no agreement is better than one that could:

• Diminish our organization bit-by-bit.
• Threaten our dignity.
• Question our passion about caring for our patients every day across the province.

We are part of a proud professional organization that has been around for 107 years, and we will still be here when the government as we know it is gone.
How else does one explain the doctors in Slave Lake who continued to work despite having their homes burned to the ground? Or what about the doctors demonstrating in the streets for the refugee patients they treat for free? Or what about every single one of you getting out of bed every morning to do the hard things and the right things for your patients day after day?

We have a strong vision for the future of health care in Alberta and it includes the AMA and every one of our members!

A year ago I stood here and said my priorities were negotiations, the relationship with the government and support for all our members.

I have talked already about the negotiations and government and politics. I want to reinforce that we still have an opportunity to maintain the high road and fight for what we all believe in – an adequately funded, well-run health system that:

- Allows for local, independent decision-making.
- Engages physicians at all levels.
- Puts Patients First®.

In terms of supporting our members, I believe equity issues continue to be critically important.

As we have recently seen with our colleagues in Ontario, equity issues are being used by the government there to justify arbitrary fee cuts to physicians in order to deal with government budgetary woes. These actions are being watched keenly by the other premiers within the Council of the Federation as they contemplate changes to health care at a national level.

Physicians are easy targets and fee equity has been a longstanding issue. We must not let those who know nothing of the practice of medicine decide its future. We must stand united and demand a fair, independent process to be part of any solution to the fee equity issue.

In addition to equity, though, there have been many other hot-button issues for the AMA to pursue under our mission of leadership and support. You can take your pick:

- Physician intimidation.
- Queue jumping, or the newly named preferential access inquiry.
- Our much-publicized ad campaign before, during and after the election.
- New pharmacist prescribing regulations and increased scopes of practice.
- The announcement of 140 family care clinics (FCCs) during an election campaign, which does not appear to be just a “crazy election gimmick.”

Most importantly, our traditional role as the team leader in health care is being challenged. Health care teams and scopes of practice make benign sound-bites. Yet in practice they are being developed and encouraged in a way that belies a true spirit of coordination and cooperation. It is not what our fellow health professionals do that is the problem – it is how they do those things and the effect it has on coordinated, integrated and efficient care.

Physicians are being accused of not being team players, yet all around us our teams we functioned well in have been split apart.

- We used to be on a team with our hospital boards.
- We used to be on a team with Alberta Health Service (AHS) in our agreement.

Today, our family physicians are willing to work in teams within primary care networks or FCCs. Our specialists are willing to work in teams within the Strategic Clinical Networks or in the hospitals or medical schools.

And let’s remember something very important that we heard at the Canadian Medical Association annual general meeting in Yellowknife. Teams cannot be mandated. They evolve and are living things with a soul. At least, they must be if they are going to be truly effective.

Looking back at so many issues this year, it comes as no surprise that my term has set a record for communications with 33 President’s Letters. I hope that your new president, Dr. Michael Giuffre, does not feel the need to challenge it! But no matter how many letters there are, I know he will be as impressed as I have been by the number of members who take the time to read the letters and send thoughtful and passionate letters back in response. This input is so important.

As for your hardworking Board of Directors, I also set a record with 27 meetings and teleconferences over the year. I thank the board members for their time, commitment and sense of duty to the organization.
My final thoughts for you and the year ahead are these:

We are facing an uphill battle in terms of building a better relationship with government. They believe they have found our Achilles heel that we are all out for ourselves and not for our organization, our colleagues or our patients.

They are wrong.

We must stand united as an organization and not be arbitrarily splintered into groups or we will have no real voice in the future.

Organized medicine is not a bad word, it is our lifeline!

The ace up our sleeve is the physician/patient relationship. Anything we can do as a profession to strengthen this bond will benefit the system and physicians in the future by placing the patient at the center of all things.

I also must thank my husband Jack for his loving support throughout this year. He found it most challenging to try and plan dinner around Air Canada’s delays and cancellations!

To that end I would like to suggest a day a year – or an activity a year – where the doctors of Alberta give back to our patients. Not through the government or through AHS but through our own organization which, as I have said, has stood the test of time.

My last job as president, therefore, is to solicit suggestions from the Representative Forum and our members-at-large for what that day should look like in the future. Whether it be a set donation to a medical cause or the beginnings of a new charity. I will ask the board to look at all ideas and choose one. I hope this will be another sign to the Government of Alberta that physicians are independent health care professionals.

In closing, I must note that without the support of the superb staff at the AMA, the work that I have done this year would have been an impossible job. Please join me in thanking Mike Gormley and his staff at the AMA for their outstanding work behind the scenes.

I know that you will be in excellent hands next year with Dr. Michael Giuffre as president. He is a specialist who understands the generalist well – and whose MBA background can help our profession navigate the murky world of business in health care.

What would any speech writing session be without a peek at Sir Winston Churchill? Here’s a line that works:

“Success is not final, failure is not fatal: it is the courage to continue that counts.”

Or, in the wise words of one member this year: “Just don’t let ’em get you down!”

Thank you and it has been a great honor!
Dr. R. Michael Giuffre  **AMA PRESIDENT, 2012-13**

Dr. R. Michael Giuffre officially assumed the role of Alberta Medical Association (AMA) president September 22, during the Fall 2012 annual general meeting (AGM) and Representative Forum (RF).

Dr. Giuffre, a pediatric cardiologist, practices at the Providence Pediatric Clinic in Calgary and is a clinical professor of cardiac sciences and pediatrics at the University of Calgary (U of C).

He has received Gold Star Teacher Awards from the Faculty of Medicine at the U of C, was selected as Physician of the Year by the Calgary Medical Society, and was named a Distinguished Fellow by the American Academy of Cardiology.

Dr. Giuffre has been actively involved with the AMA for many years. He has been an RF delegate since 2003 and is presently a member of the Board of Directors and various committees. He has published extensively, volunteers his time and expertise to local, national and international organizations, and is a member of both private and public boards of directors including UNICEF Canada.

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Dr. Allan S. Garbutt  **AMA PRESIDENT-ELECT, 2012-13**

At the fall 2012 Representative Forum and annual general meeting on September 22, Dr. Allan S. Garbutt, a family physician from Crowsnest Pass, began his term as the Alberta Medical Association’s (AMA’s) 2012-13 president-elect.

Dr. Garbutt has dedicated considerable time to the AMA for much of the past two decades. He has been a Representative Forum delegate since 1997 and has been extensively involved with the Section of Rural Medicine, including as fees representative, and currently as president of the section. As well, he is a member of the Section of General Practice Executive, the Primary Care Network Physician Leads Executive, the Physician Advocacy Group, and the Primary Care Alliance. He has also chaired the General Practitioners’ Forum. For his contributions, Dr. Garbutt was recognized in 2010 with the AMA’s Long-Service Award, and in 2011 with the distinction of AMA Member Emeritus.

Dr. Garbutt received his medical degree from the University of Western Ontario and completed a rural family medicine residency at the University of British Columbia in 1993. That year, he moved to Crowsnest Pass, where he remains today, helping to care for the town’s 6,000 residents as well as the many tourists who travel to the area each year.

Dr. Garbutt has been a clinical instructor in the Department of Family Medicine, Faculty of Medicine, at the University of Calgary since 1994. He is also a long-time member of the Society of Rural Physicians of Canada.
Physicians awarded for significant achievements

CMA Honorary Membership Awards

The CMA honored the following members who, at age 65, have been active association members for 10 years. They were nominated by the AMA’s Nominating Committee and unanimously approved by the AMA and CMA boards. Held in high regard by their colleagues, these physicians are humanitarians who have put into practice the aims and ideals of the profession and exemplify integrity and compassion.

Dr. June S. Bergman

An ardent advocate for primary care medicine, Calgary family physician Dr. June Bergman received her medical degree from the University of Toronto in 1970 and completed a family practice residency at Toronto’s Sunnybrook Medical Centre. After working as a family physician in a northern Ontario community she moved to Calgary, joining a family practice with a special interest in obstetrics. Dr. Bergman is a founding member of the family medicine referral Maternity Clinic at the Peter Lougheed Centre of the Calgary General Hospital. She played an integral role in the 2003 negotiations that crafted the primary care networks and is today the physician lead of the Calgary Foothills Primary Care Network.

Dr. Bergman has been an AMA member since 1990 and has volunteered her time significantly to various roles on committees including: chair, Toward Optimized Practice (TOP) Evaluation Advisory Committee, Clinical Practice Guidelines (CPG) Steering Committee; co-chair, Cervical Cancer Screening Working Group, TOP Review Committee; member, CPG Executive Committee; and AMA representative on the Primary Care Initiative Evaluation Advisory Committee. Presently, she is a member of the IM/IT Coordinating Committee and the Primary Care Network Physician Leads Executive. For her contributions, Dr. Bergman was awarded AMA Member Emeritus distinction in 2011.

Today, Dr. Bergman works part time at the Crowfoot Primary Care Clinic and, since 1990, has taught in the Department of Family Medicine at the University of Calgary (U of C) where she is currently associate professor emeritus.

Dr. Robert M. Hollinshead

Calgary orthopedic surgeon Dr. Robert Hollinshead received his medical degree from the University of Manitoba in 1971 and completed residencies in general surgery at Dalhousie University and orthopedics at the University of Alberta (U of A). He is currently on active staff at the Peter Lougheed Centre and is a clinical professor in the Department of Surgery, Faculty of Medicine, and an adjunct clinical professor in the Faculty of Kinesiology at the U of C.

Dr. Hollinshead has dedicated many years of service to various roles with the AMA including as president in 2001-02, a member of the Board of Directors and Representative Forum delegate, and as president and treasurer of the Section of Orthopedics. As well, he served on the Nominating Committee, Executive Committee, Government Affairs Committee and the Committee on Constitution and Bylaws. Dr. Hollinshead was recognized with the AMA Long-Service Award in 2003 and with AMA Member Emeritus status in 2011.

During his distinguished career, Dr. Hollinshead has published numerous peer reviewed articles and abstracts and has lectured and presented around the world. He is past president of the Canadian Orthopedic Association, past president of the medical staff at the Calgary General Hospital, past chief of surgery at the Peter Lougheed Centre, past clinical chief of orthopedics for the Calgary Health Region and he is presently a physician member of the Canadian Medical Association Holdings Board.

Dr. Edward W. Papp

Dr. Edward Papp, an Edmonton family physician, received his medical degree from the U of A in 1971. In 1973 he joined the medical staff at Edmonton General Hospital, St. Joseph’s Auxiliary Hospital and Glenrose Rehabilitation Hospital. That same year, he began teaching as a clinical lecturer in the Department of Family Medicine, Faculty of Medicine, at the U of A.

Dr. Papp has devoted countless hours to the AMA over the past 36 years. His involvement with the Section of
General Practice began in 1980 and he served as president of the section in 1994-96. Dr. Papp has been a Representative Forum (RF) delegate since 1996 (with designated honorary microphone status!), an MD-MLA contact since 1982, and a director of AMA Holdings Inc. since 1989. Presently, he is chair of the Committee on Constitution and Bylaws (since 2005) and a member of the Physician Advocacy Group. In 1992, Dr. Papp was recognized with the AMA Long-Service Award and, in 2010, with AMA Member Emeritus distinction.

Throughout his career, Dr. Papp has remained extensively involved in various roles on numerous hospital committees, in other organizations and in community activities. Today, Dr. Papp owns and operates a family practice in Edmonton, and is an associate clinical professor in the Department of Family Medicine, Faculty of Medicine, and a clinical instructor in the Faculty of Pharmacy and Pharmaceutical Sciences at the U of A.

**AMA Long-Service Awards**

The following physicians have been honored with the AMA Long-Service Award for unselfish contributions of knowledge, skill and time to the advancement of the profession. Their work, whether on the Board of Directors or its committees, supports and encourages the association’s development.

**Dr. Daniel J. Barer**

Dr. Daniel Barer has served in a variety of roles with the AMA. He is currently finishing his second three-year term on the Board of Directors and has been an RF delegate since 2002. As well, Dr. Barer is secretary of the Section of Emergency Medicine and member of the Nominating Committee and Physician Compensation Committee. Dr. Barer was president of the Section of Emergency Medicine and served on the RF Planning Group and the Job Action Group. On several occasions he has represented the AMA at the Canadian Medical Association General Council. Dr. Barer received his medical degree from the U of A in 1978 and then completed a rotating internship at Victoria Hospital in London, Ontario. In 1980, he joined the staff of the Charles Camfield Hospital in Edmonton where he would later serve as president of medical staff and vice-president medical. Since 1993, Dr. Barer has practiced emergency medicine at the Royal Alexandra Hospital and the North East Community Health Centre.

**Dr. D. Glenn Comm**

Throughout his career Dr. Glenn Comm has devoted considerable time and energy to the AMA. He has served as a member of the AMA Board of Directors and as an RF delegate. He was a member of the Negotiating Committee, Nominating Committee, Physician Services Committee, Alternate Relationship Plan Committee and the Job Action Group. In recognition of his efforts, Dr. Comm received AMA Member Emeritus distinction in 2010. Dr. Comm graduated from Loma Linda University in California in 1979. He practiced and taught at the U of A Hospital and then at the Peter Lougheed Centre in Calgary. Dr. Comm held several academic and administrative positions including assistant director of the Division of Anesthesia at the Peter Lougheed Centre, and president of the Calgary and Area Physicians Association (now known as the Calgary and Area Medical Staff Society). He was an associate clinical professor in the Department of Anesthesia, Faculty of Medicine, at the U of C until his retirement in 2010.

**Dr. Christopher J. (Chip) Doig**

Dr. Chip Doig’s contributions to the AMA are many. He was president (2010-11), member of the Board of Directors and RF and president of the Section of Intensive Care. He served terms on the Committee on Constitution and Bylaws, Executive Committee, Government Affairs Committee, Nominating Committee, RF Planning Group and the Joint AMA/College of Physicians & Surgeons of Alberta Executive. Dr. Doig is presently co-chair of the Advisory Committee on Academic Medicine and a Canadian Medical Association board member. Dr. Doig received his medical degree from the University of Saskatchewan in 1988. He is a highly respected expert on the care of the critically ill. Dr. Doig serves on a number of external committees and councils and provides his expertise at invited presentations across Canada and around the world. Since 1995, Dr. Doig has taught at the U of C and is presently professor and head of the Department of Community Health Sciences and professor in the Department of Critical Care Medicine. And, as an avid soccer player in his family, he currently ranks fourth in scoring, but is hoping to do better!

**Dr. Ronald T. Garnett**

Lethbridge family physician Dr. Ronald Garnett has had long-time involvement with the AMA Section of General Practice (SGP). He has been fees representative, president-elect and president of SGP. He also served terms on the SGP Restructuring Working Group and the General Practice Liaison Executive and, since 2001, has been a member of the SGP Executive and RF. Dr. Garnett received his medical degree in 1982 from the U of A and completed a family practice residency.
at the University of Saskatchewan. For 25 years Dr. Garnett practiced at Bigelow Fowler Clinic in Lethbridge and maintained a private practice including family medicine, sport medicine and performing arts medicine. He also took on part-time emergency physician duties at Lethbridge Regional Hospital and was team physician to the Lethbridge Hurricanes WHL hockey team. Presently, Dr. Garnett is assistant professor and clinical medical director in the Department of Family Medicine at the U of C.

Dr. David B. Hogan
NO PHOTO AVAILABLE

Dr. David Hogan, a geriatric specialist, has been a member of the Board of Directors of the Alberta Medical Foundation since 1998 and served as its president for two years. He was a member of the Toward Optimized Practice Cognitive Impairment Working Group and was on the editorial board for the Drug Use in the Elderly Quarterly (DUE Q) publication. Dr. Hogan was instrumental in developing the algorithm for the assessment and prevention of falls, part of the Finding Balance campaign created by the AMA, the Alberta Centre for Injury Control and Research and the U of A’s School of Public Health. Dr. Hogan received his medical degree from Dalhousie University in 1977 and completed his internship at the U of A Hospital. He is a professor in the departments of Medicine, Clinical Neurosciences and Community and Health Sciences in the Faculty of Medicine at the U of C and Brenda Strafford Foundation Chair in Geriatric Medicine.

Dr. Darryl D. LaBuick

President, board member and RF delegate are just a few of the roles Dr. Darryl LaBuick has assumed with the AMA. He currently chairs the Council of Zonal Leaders and is a member of the Negotiating Committee. His prior service includes terms on various committees such as the Committee on Constitution and Bylaws, Executive Committee, Nominating Committee, Government Affairs Committee and RF Planning Group. Dr. LaBuick served three years on the Canadian Medical Association (CMA) Board of Directors and has been, on many occasions, an AMA representative at CMA General Council. Dr. LaBuick received his medical degree from the U of C in 1993 and in 1995 completed his family medicine residency at the University of Alberta and the Misericordia Hospital. Presently, Dr. LaBuick is president and chair of the St. Albert and Sturgeon Primary Care Network and medical director of the Youville Nursing Home in St. Albert. He also teaches as an assistant clinical professor in the Department of Family Medicine at the U of A.

Dr. M. Daniel McGowan
NO PHOTO AVAILABLE

Dr. Daniel McGowan, a physical medicine and rehabilitation specialist, volunteered his time for a number of years to the AMA Section of Physical Medicine and Rehabilitation. He represented the section at RF, became president-elect in 2002-03, president in 2003-05 and assumed the role of past president in 2005-07. Dr. McGowan was also involved with the Relative Value Guide process with the section. He is presently the AMA representative on the AMA/Workers’ Compensation Board Advisory Committee. Dr. McGowan received his medical degree in 1985 from the Memorial University of Newfoundland. He then completed a family practice residency at Memorial followed by a residency in physical medicine and rehabilitation at the U of A. Dr. McGowan now resides in Calgary and practices at the Foothills Medical Centre. He is a clinical associate professor at the U of C in the physical medicine and rehabilitation residency training program and at the medical school in the neurosciences course.

Dr. Daniel J. O’connor

Dr. Daniel O’Connor began his service with the AMA in 2002 as a member of the Committee on Quality Audit, the Quality Assurance Task Force and the Practice Management Program Task Force. Dr. O’Connor is currently president-elect of the Section of Emergency Medicine, an RF delegate, and director of AMA Holdings Inc. After receiving his medical degree from Queen’s University in 1990, Dr. O’Connor completed family medicine training at the U of A and emergency medicine training at the U of C. Thereafter, Dr. O’Connor practiced emergency medicine at St. Paul’s Hospital in Saskatoon, Saskatchewan, and now practices in Calgary. Since 1995, he has been an examiner for the emergency medicine exam with the Canadian College of Family Physicians. In 1997, Dr. O’Connor earned an MBA from the University of Saskatchewan.

Dr. A. James D. Pope

Grande Prairie family physician Dr. James Pope has been a member of the AMA since 1976. He has been an RF delegate since 2002 and has been involved with the Section of General Practice (SGP) since 2003, currently as a member of the SGP Executive. He is an active member of the AMA’s MD-MLA contact program. Dr. Pope also served as a member of the Ad Hoc Committee to Review AMA’s Regional Structure and as an AMA representative to Canadian
Medical Association General Council. After receiving his medical degree from the U of A in 1973, Dr. Pope went on to complete additional training at the Royal Alexandra Hospital in Edmonton. He began practicing as a family physician in Grande Prairie in 1976 and has spent the past 36 years caring for the people of the region. Today, he is chief of staff and facility medical director for the Queen Elizabeth II Hospital in Grande Prairie.

Dr. Roger C. Rampling

Dr. Roger Rampling began his involvement with the AMA as an RF delegate representing the Section of General Psychiatry, a role he continues in today. Since 1994, Dr. Rampling has been fees representative of the Section of General Psychiatry. His prior service includes seven years on the Fees Advisory Committee and two terms on the Nominating Committee. He was also involved for several years with the Relative Value Guide Project. Dr. Rampling received his medical degree from the U of A in 1975. He joined the staff of the Royal Alexandra Hospital in 1980, later serving as acting chief of the Department of Psychiatry. Dr. Rampling also provided consultation services to Fort McMurray Regional Hospital, where he was the first psychiatrist resident from 1984, and was chief of psychiatry until 1987. Thereafter, he was consultant psychiatrist at St. Michael’s Hospital and chief of psychiatry at Lethbridge Regional Hospital until 1992. Since retiring from the hospital in 2005, Dr. Rampling has maintained an active community practice in Lethbridge.

AMA Members Emeritus

The following physicians have been awarded the distinction of Member Emeritus, which recognizes their significant contributions to the medical profession, seniority and long-term membership, based on criteria determined by the AMA Board of Directors. Nominations are made by the Nominating Committee or by a full member of the association. The nominees are approved by a unanimous vote of the board.

Members Emeritus enjoy all the rights and privileges of a full member, but are not required to pay annual dues.

Dr. Robert A. Burns

As AMA Executive Director from 1988-2001, Dr. Robert Burns was instrumental in the organizational restructuring of the AMA to better meet the needs of the association’s then 6,000 members. Dr. Burns attended Board of Directors’ meetings, RF and CMA General Council meetings. He assumed roles on various external and internal committees including: co-chair, Administrative Council with Alberta Health; member/chair, Medical Advisory Wellnet Initiative; chair, Committee on Medical Aspects of Transport Accidents; and member, Committee on Constitution and Bylaws and Physician Resources Planning Committee. Dr. Burns received his medical degree from the U of A in 1972 and, after completing a rotating internship at St. Paul’s Hospital in Vancouver, served as a medical officer in the Canadian Armed Forces. In 1977, he joined the staff of the Charles Camsell Hospital and later the Royal Alexandra Hospital, where he provided full-time emergency services and taught medical students, interns and residents. During this time, he participated in the Mayor’s Task Force on Ambulance Service for the City of Edmonton and chaired the Emergency Medical Technician-Paramedic Training Program Advisory Committee at NAIT. Today Dr. Burns is an executive medical director for the Vancouver Island Health Authority, with shared responsibility for population and community health for all of Vancouver Island. He is also on the faculty of the Physician Management Institute of the CMA.

Dr. Ken Chow

NO PHOTO AVAILABLE

St. Albert family physician Dr. Ken Chow has been a member of the AMA since 1975. He served terms as a member of the Negotiating Committee, the Finance Committee, the Medical Services Delivery Innovation Fund and the Subcommittee on Alternate Payment Plans. Dr. Chow was also the AMA representative on the Canadian Medical Association’s Council on Health Policy and Economics and the Sustainability Task Force. For his contributions, Dr. Chow was
recognition in 1996 with the AMA Long-Service Award. Dr. Chow received his medical degree with distinction in 1973 from the U of A. He then completed a rotating internship at the Misericordia Hospital and a one-year internal medicine residency at the U of A. Since 1975, Dr. Chow has practiced family medicine at the Grandin Medical Clinic in St. Albert. He has admitting privileges at the Sturgeon Community Hospital as well as at the Youville and Citadel nursing homes. He has served on various hospital committees and on the St. Albert Primary Care Network board, finance committee and information technology committee. Dr. Chow finds time to teach as a clinical lecturer in the Department of Family Practice at the U of A. When not practicing or teaching, you will find Dr. Chow carrying out his admitted addiction – golfing!

Dr. Christine P. Kyriakides

Edmonton pediatrician

Dr. Christine Kyriakides has volunteered her time to various roles with the AMA. She has been an RF delegate since 2003 and has served as a member of the Nominating Committee and the Government Affairs Committee. The work of the Committee on Reproductive Care, of which Dr. Kyriakides was a member, was instrumental in improving the health and care of mothers and babies in Alberta and across Canada. Dr. Kyriakides completed a PhD in physiology at the University of Sheffield, United Kingdom (UK), in 1973 and from 1973-75 was a post-doctoral research fellow at the University of Reading, UK. She received her medical degree from the U of A in 1991 and went on to complete her residency in the Department of Pediatrics at the U of A. In 1996 she established her own private pediatric practice and since then has been preceptor in pediatrics to undergraduates and postgraduates at the U of A. Since 2000, Dr. Kyriakides has been the medical director of the Stollery Children’s Hospital and sits on many hospital committees as a member, co-chair or chair. She is a council member of the Edmonton Zone Medical Staff Association and is past president and former board member of Edmonton’s Youth Emergency Shelter Society.

Dr. Wayne M. MacNicol

Dr. Wayne MacNicol, an obstetrician and gynecologist in Whitehorse, was president of the AMA in 1992-93. He sat as a member of the Board of Directors, the Nominating Committee, the Committee on Constitution and Bylaws, the Committee on Hospitals, the Ad Hoc Committee to Review Ambulatory Care Service Delivery and the Ad Hoc Committee on HIV Testing and Compensation Issues. He served terms as a member of the Canadian Medical Association (CMA) Board of Directors and the CMA Council on Health Policy and Economics. After receiving his medical degree from the U of A in 1977, Dr. MacNicol completed further study in obstetrics and gynecology. In 1981 he joined the staff of Medicine Hat Regional Hospital and, in 1993, was appointed chair of the hospital’s Department of Obstetrics and Gynecology. Since 1994 Dr. MacNicol has practiced at Whitehorse General Hospital. Dr. MacNicol was president of the Yukon Medical Association (YMA) from 2001-05 and currently serves on YMA’s Board of Directors, Executive Committee, Nominating Committee and Joint Management Committee. He has been director of the Yukon Hospital Foundation since 2003 and a long-time member of the Society of Obstetricians and Gynecologists of Canada and the Pacific Northwest Obstetrical and Gynecological Association.

Dr. Dennis L. Modry

Cardiovascular and thoracic surgeon

Dr. Dennis Modry has been an AMA member since 1985. He has been president of the Section of Cardiovascular and Thoracic Surgery since 1994 and, since 2000, an RF delegate. From 1988-92 he served as a member of the Committee to Review the Relative Value Guide. For his contributions, Dr. Modry was recognized with the AMA’s Long-Service Award in 2008. Dr. Modry received his medical degree from the U of A in 1973 and went on to complete advanced training in cardiovascular and thoracic surgery at McGill University. After further study in transplantation immunology, heart and lung transplantation and cardiovascular surgery at Stanford University Medical Centre, he joined the medical staff at the U of A Hospital. It was here that Dr. Modry implemented Western Canada’s first heart and lung transplantation program. He performed the province’s first heart transplant in 1985 and the first combined transplant of the heart and both lungs in 1986. Dr. Modry was director of the Heart and Heart/Lung Transplantation Program from 1986-2007 and the Cardiovascular Intensive Care Unit from 1984-2007. Today, Dr. Modry is the surgical director of the Pulmonary Thromboendarterectomy Program at the U of A Hospital and a consultant in the Division of Thoracic Surgery at the Royal Alexandra Hospital.

Dr. Robert R. Moriartey

Dr. Robert Moriartey, an Edmonton pediatrician, educator, and advocate for children, has been an AMA member since 1980 and is currently serving in the role of past president of the Section.
Dr. David P. O’Neil

**Cochrane family physician** Dr. David O’Neil’s involvement with the AMA began in the 1990s. Since then he has held various roles including president of the Section of Rural Medicine, RF delegate, member of the Nominating Committee, Rural Locum Program Steering Committee, Rural Physician Action Plan Coordinating Committee, and co-chair of the Physician On-Call Programs Committee. Dr. O’Neil received his medical degree from the U of A in 1972 and completed his internship at Sacramento Medical Centre at the University of California, Davis. He returned to Alberta in 1973 to a family practice residency at Calgary General Hospital. In 1974 he began practicing at Elnora General Hospital and thereafter at St. Mary’s Health Care Centre in Trochu and Three Hills Health Care Centre, where he remained until 2010. During those intervening years, he also worked as a medical examiner for Elnora, Trochu and Three Hills, and was the medical director for the Trochu Fire Department EMT service. Dr. O’Neil has volunteered his time to various external organizations such as the Society of Rural Physicians of Canada, of which he was president, and the organizing committee of the World Conference on Rural Medicine. Today, Dr. O’Neil is Alberta Health Services Provincial Medical Director (south) for Community and Rural Health service planning, and continues to advocate for the importance of rural medicine.

Dr. Terry D. Sosnowski

**NO PHOTO AVAILABLE**

Dr. Terry Sosnowski, an emergency medicine physician, has assumed various roles with the AMA including president of the Section of Emergency Medicine and member of the Committee on Medical Aspects of Transport Accidents and the Committee on Hospitals. He has served as a member, then chair, for the past six years on the Canadian Medical Association Committee on Education and Professional Development. Dr. Sosnowski was recognized in 1992 with the AMA’s Long-Service Award and in 1996 with the AMA’s Medal for Distinguished Service. After receiving his medical degree from the U of A in 1972, Dr. Sosnowski became a staff emergency physician at the Holy Cross and Rockyview hospitals in Calgary. In 1980, he came back to Edmonton to join the staff of the Charles Camsell Hospital as chief of the Department of Emergency Medicine. Since 1993 he has been staff emergency physician and director of medical education at the Royal Alexandra Hospital. Dr. Sosnowski has taught at the U of A since 1995, presently as a clinical professor in the Department of Emergency Medicine, Faculty of Medicine and Dentistry. He is coordinator of the PGY1 Program in the faculty. As well, Dr. Sosnowski is a reviewer of the *Canadian Journal of Emergency Medicine* and the *Canadian Medical Association Journal*.

Dr. Brian D. Willis

Dr. Brian Willis, a family physician in Edson, has been an AMA member since 1979. He served as president of the Section of Medical Examiners (1999-2005) and as an RF delegate representing that section (2001-05). In the 1990s he was president of the Westview Regional Medical Organization, RMO representative on the Ad Hoc Committee to Review AMA’s Regional Structure, and AMA representative to the Physician Liaison Council for Region 8. Dr. Willis received the AMA’s Medal for Distinguished Service in 2000. In 1972 Dr. Willis received his medical degree from Queen’s University in Belfast, Northern Ireland, and went on to complete a rotating internship in general surgery, orthopedic surgery, cardiology and pediatrics. He arrived in Canada in 1977 and joined a general practice in Edson, where he has cared for the people of that community for 35 years. He is also on active staff of the Edson and District Healthcare Centre. Dr. Willis has been medical examiner for Edson since 1987. He is an executive member of the McLeod River Primary Care Network. Since 2007 he has been a clinical lecturer in the Department of Family Medicine and a preceptor for third-year medical students in the Integrated Community Clerkship program at the U of A.
### Double Award Winners

The following physicians were awarded both CMA Honorary Membership and AMA Member Emeritus distinctions.

#### Dr. Saibal Nandy

Medical Hat psychiatrist Dr. Saibal Nandy received his medical degree from the University of Calcutta in 1974 and went on to complete advanced training in psychiatry at the University of Nottingham. He completed his residency in psychiatry at Memorial University of Newfoundland and Labrador in 1980 and soon after became the staff psychiatrist at Waterford Hospital in St. John’s, Newfoundland. In 1982 Dr. Nandy became chief of psychiatry at Medicine Hat Regional Hospital and established his own private practice. Dr. Nandy is also a clinical associate professor at the U of A.

Dr. Nandy has taken on various roles with the AMA. He served terms as an RF delegate, a member and chair of the Advisory Committee on Membership Benefits, and a member of the Nominating Committee, Committee on Financial Audit and Committee on Quality Audit. Currently, he is chair of the AMA Health Benefits Trust Fund and director of AMA Holdings Inc. Dr. Nandy was recognized in 2006 with the AMA Long-Service Award and, this year, he will receive AMA Member Emeritus status and CMA Honorary Membership.

Dr. Nandy has worked throughout his career to improve the mental health and well-being of his patients. He has been principal investigator on numerous clinical trials and has made various presentations to physicians on affective disorders, eating disorders and psychoses, as well as financial management.

### AMA Achievement Awards

The AMA Achievement Awards were created to honor physicians and non-physicians for their contributions to quality health care in Alberta. The Medal for Distinguished Service and the Medal of Honor are the highest awards presented by the association.

#### MEDAL FOR DISTINGUISHED SERVICE

Calgary obstetrician and gynecologist Dr. Ian R. Lange has proven ongoing leadership and advocacy for the health and care of women and families in Alberta. Dr. Lange was instrumental in introducing to Calgary, and Alberta, the Society of Obstetricians and Gynecologists of Canada’s “Managing Obstetrical Risk Efficiently (MOREOB) Program.” MOREOB is a comprehensive improvement program that creates a culture of patient safety in obstetrical units.

In 1972, Dr. Lange received his medical degree from the University of Otago, New Zealand. In 1991, he relocated from Winnipeg to Calgary, where he joined the Foothills Hospital as program director of perinatal services until 1997 and division chief of obstetrics from 1993-98. Dr. Lange is currently a professor in the Department of Obstetrics and Gynecology and residency program director at the U of C. He is a devoted teacher to undergraduates, postgraduates, and CME learners locally, nationally and internationally.

Dr. Lange has been recognized for various awards, including two International Federation of Gynecology and Obstetrics Awards. Dr. Lange has published extensively and has made numerous presentations. His devotion to research, spanning from 1981 until 2010, has resulted in over 50 publications. He has been a regular presenter in the Annual Calgary Therapeutics Course.

#### Dr. J. Paul Ryan

Throughout his career, Dr. J. Paul Ryan has been committed to improving the lives of patients with rheumatoid arthritis.

He received his medical degree in 1973 from the University of C in what was the university’s first graduating medical class. He then completed residencies in rheumatology at McGill University in Montreal. In 1978, Dr. Ryan joined the staff of the Foothills and Rockyview hospitals where he continues to practice today. His professional activities include serving as associate medical advisor for both the Bank of Montreal and the Royal Bank of Canada, and as a member of boards and societies such as the Alberta Arthritis Society, the Alberta Lupus Society and the Western American College of Rheumatology.

Dr. Ryan has had long-time involvement with the AMA as president of the Section of Rheumatology as well as an RF delegate representing the section. He also served as a member of the Specialist On-Call Advisory Committee and on a number of working committees relating to the Relative Value Guide and Overhead. For his contributions, Dr. Ryan received the AMA Long-Service Award in 2011 and, this year, he will receive AMA Member Emeritus distinction and CMA Honorary Membership.

For the past 30 years Dr. Ryan has taught undergraduate and postgraduate students in the Department of Medicine, Faculty of Medicine, at the U of C, currently as a clinical associate professor.
Most recently, Dr. Lange is developing a “Point of Care” Ultrasound Course. The course is structured around first year residents in obstetrics and gynecology to improve the ability of timely and accurate assessment of the fetal status with labor and delivery triage questions.

Calgary cardiologist Dr. Eldon R. Smith has brought excellence to the medical and academic community. Dr. Smith singlehandedly built and recruited the clinical and research leadership for cardiac science in Calgary, making Calgary one of the strongest cardiology centers in Canada.

In 1967, Dr. Smith received his medical degree from Dalhousie University in Halifax and was the gold medalist of his class. After working at Dalhousie as a staff cardiologist and associate professor until 1980, he moved to Calgary and became a professor of medicine and head of the Division of Cardiology at the U of C, and chief of the Division of Cardiology at Foothills Hospital. Dr. Smith was the fourth dean of the Faculty of Medicine at the U of C (1992-97), where he spearheaded the Partners in Health Campaign, raising more than $50 million for the faculty.

Over the past 40 years, Dr. Smith maintained a variety of critical leadership positions. In 1981, he developed a core cardiology training program, which quickly became one of the most popular training programs in Canada, and remains so to this day. Dr. Smith was nationally recognized for his role on the examination board in cardiology for the Royal College of Physicians (1976-79 and 1985-89). For more than two decades Dr. Smith has been involved with the Heart and Stroke Foundation. He has been president of the Canadian Cardiovascular Society, trustee of the Alberta Heritage Foundation for Medical Research, editor-in-chief of the Canadian Journal of Cardiology, chaired the Canadian Heart Health Strategy and is currently a director of Alberta Health Services and board chair of the Libin Cardiovascular Institute of Alberta.

Dr. Smith is an Officer of the Order of Canada. He remains a devoted supporter of the community, particularly through his work with the Libin Institute and numerous boards of foundations, societies and other organizations.

Dr. D.H. Ross Truscott received his medical degree from the U of A in 1955 and proceeded to his rotating internship at Regina General Hospital. He then started supervised pediatrics with Dr. Barrie Duncan followed by residency training in Vancouver and the Hospital for Sick Children in Toronto, then a year in pediatric pathology at Columbia-Presbyterian Medical Center in New York.

After two years in Regina he returned to Alberta in 1962 on active staff at Alberta Children’s Hospital, Holy Cross Hospital and Calgary General Hospital. In 1967 Dr. Truscott was acting director of the Department of Pediatrics at Foothills Hospital and subsequently deputy director until 1969. In 1970 he was appointed pediatric consultant to the Calgary Cancer Clinic and in 1973 he was president of the medical staff at Alberta Children’s Hospital.

During much of his busy professional life, Dr. Truscott was active in the medical community including president of the Alberta Pediatric Society from 1968-70 and member-at-large for the Calgary Medical Society. He also served on the AMA Fees Committee and was chair of the Audit Subcommittee on Childhood Cancer in 1975-76. Dr. Truscott served on the board of the Canadian Pediatric Society from 1970-73 and 1981-86 and as pediatric consultant to the Southern Alberta Pediatric Oncology Program since its inception in 1970.

Until this year he maintained his position as director of the Long-Term Survivors Follow-up Clinic at the Oncology Program at Alberta Children’s Hospital. After decades of utter devotion to caring for children with various cancers, Dr. Truscott retired at the end of last year.

**MEDAL OF HONOR**

The AMA Medal of Honor is presented to a non-physician who has made outstanding personal contributions to the people of Alberta and who is recognized for his or her contributions to the advancement of medical research, medical education, health care organization, health education and/or health promotion in efforts to raise the standards of health care in Alberta.

Vivian Mushahwar, PhD, is a strong advocate for improving the lives of individuals, Albertans in particular, who suffer from the destructive effects of spinal cord injuries. Her research is primarily focused in the areas of restoring standing and walking after spinal cord injuries and preventing the formation of pressure ulcers in people with reduced mobility and sensation. With this, Dr. Mushahwar and her colleagues developed Smart-e Pants, an intelligent electrical stimulation-based system for preventing ulcers. Dr. Mushahwar and her group of colleagues have trained nearly 200 Alberta nurses, and physical and occupational therapists in interventions such as Smart-e Pants.
After achieving her PhD in Bioengineering in 1996, she held many professional and academic positions, including associate professor in physical medicine and rehabilitation, and adjunct professor in the Centre for Neuroscience at the U of A, secretary of the International Functional Electrical Stimulation Society, chair of the CIHR Biomedical Engineering peer-review committee, and leader of the pan-Alberta Interdisciplinary Team in Smart Neural Prostheses.

Her devotion to spinal cord injuries has significantly impacted people with neurological pathologies. For example, Dr. Mushahwar published a study that demonstrated, for the first time, empirical evidence of the importance of both central pattern generators and sensory-driven reflex modulations to the production of over ground walking. These findings led to the design of control paradigms for any neural interface system designed to restore walking.

Dr. Mushahwar regularly gives seminars and keynote talks at national and international conferences and symposia. She has received many awards and honors, including the Distinguished Women in Neural Engineering Award presented by the University of Wisconsin in Madison.

Shirley van de Wetering has demonstrated ongoing leadership in her various initiatives to offer solutions, resources and outlets to children and families with asthma. With an MBA and an interest in marketing and new venture development, Ms van de Wetering spent three years on a Health Innovation Fund project near to her heart. As such, in 2001 she assumed the leadership, design and implementation of the Child Asthma Network (iCAN). iCAN provided clinical resource tools to Calgary and High River community physicians and their patients and families, including one-hour personalized asthma education in their own physicians’ offices. The combined efforts of Ms van de Wetering, her team and others, have contributed to a significant reduction in emergency visits and hospitals days reported in the Calgary Zone. Her keen leadership skills continue to lead to strong results. She developed the iCAN website, targeting children and families with asthma, which is recognized locally, nationally and internationally and currently leads the Community Pediatric Asthma Service.

Ms van de Wetering continues to introduce various major projects, including quality improvement initiatives to streamline pediatric asthma patient referrals and discharges linking ER and physician offices. Not only are her contributions exemplary, she continues to benefit many teams and committees, including the Provincial Pediatric Asthma Pathway Community Pharmacists & Coaches Sub-committee. Ms van de Wetering is an exceptional local and provincial asthma leader in clinical service and health care organizational process and flow design. Whether she is working with patients and families, staff and physicians, or members of the community, she has a knack for recognizing the needs of her customers and effectively engaging them toward a higher standard of quality services and outcomes.

CONSIDER CRITICAL CARE MEDICINE in Calgary, Alberta

The Department of Critical Care Medicine is currently recruiting Clinical Associates for the Intensive Care Units at all adult sites within the Calgary Zone.

We require clinical associates to provide service from 1700 to 0800 hours, seven days a week in the 4 multisystem ICUs of the Region and day shifts (0800-1700) in one of these ICUs. Physicians will be integrated into the current physician healthcare team, including bedside physicians, residents and attending intensivists.

As part of a specialized multidisciplinary team, the clinical associates’ role, in addition to patient care responsibilities in the unit, will be to provide tier one responses for all ICU Outreach Team calls within the institution. These teams were created as a patient safety initiative to advance the “ICU without walls” concept. Activation of the outreach team can occur by any concerned staff member on any unit of an acute care facility. The team is expected to rapidly assess and stabilize the patient, assist with communication, educate and support staff who have activated the team and assist with transferring the patient to the ICU when necessary (25 – 30% cases).

INCENTIVES:
• ~13 shifts per month for 1.0 FTE (FTE of 0.25 to 1.0 available)
• CME opportunities are encouraged and supported
• Partnership training with the Society of Critical Care Medicine (Fundamentals of Critical Care Support Course)
• Crisis Resource Management training provided via high fidelity simulation (on-site)
• Additional support always available through function in the ICU team environment

QUALIFICATIONS:
Physicians must be eligible for a Practice Permit from College of Physicians and Surgeons of Alberta, CHR Medical Staff Privileges, appropriate Canadian Medical Protective Association coverage, and ACLS certification.

Interested physicians should forward their CV with references and address all inquiries to:

Jeannie Shrout, DEPARTMENT MANAGER
Critical Care Medicine
Alberta Health Services
Room 0452 – McCaig Tower, 1403-29 St. N.W.
Calgary, AB T2N 2T9
jeannie.shrout@albertahealthservices.ca
Fall RF/AGM

Alberta Medical Association
Board of Directors 2012-13

(Standing L to R) Dr. Alison Clarke; Dr. Joanna Lazier, PARA observer; Dr. Paul Boucher; Dr. Paul Parks; Braden Teitge, MSA observer; Dr. Pauline Alakija; Michael Gormley, Executive Director; Dr. Sandra Corbett; Dr. Neil Cooper; Dr. Padraic Carr; Dr. Sarah Bates; Dr. Christine Molnar; Dr. Kathryn Andrusky.

(Seated L to R) Christine Fleck, Manager, Executive Office; Dr. Allan Garbutt, President-Elect; Dr. Michael Giuffre, President; Dr. Linda Slocombe, Immediate Past President.

(by Fred Katz Fine Art Photography.)

SHOWHOMES NOW OPEN.
IMAGINE THE POSSIBILITIES.

OUR DETAILS
MONDAY TO THURSDAY: 2PM—8PM
WEEKENDS & HOLIDAYS: 12PM—5PM
FRIDAY: CLOSED
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OUR BUILDERS
Employee recruitment is a primary challenge in operating any type of business. The cost of employee turnover is high and the cost of hiring the wrong person is even higher. On the other hand, finding the right employee pays back through a positive work environment, increased employee engagement and greater productivity. The time and energy that you will spend to recruit the right person for your team will give a huge return on investment.

The following is a road map to help guide you through the challenge of finding the best employee for your team.

1. **Slow down.** Many problem employees have been hired for the wrong reasons because “we needed someone yesterday” or by hiring “someone who is available.” The short-term gain by filling a vacancy without following a complete hiring process will be greatly outweighed by hiring an employee who is the wrong fit for your office. Do it right the first time. Look at your options before you rush into a hiring decision. Can you find temporary help? Can some tasks wait? Can the additional duties be shared by other staff temporarily?

2. **Know what you are looking for.** Review the position profile. Do you have a current position profile that clearly states what is needed to do the job? Has the job changed or do you want to use this time as an opportunity to make some changes? What qualifications are needed? Are there specific education or experience requirements? Is it critical that the candidate is able to perform all duties immediately?

Who is your ideal candidate? If there is someone successfully filling the job currently, what traits and qualities does he or she bring to the job? Is the position independent or part of a team? What qualities and characteristics are needed to fit with your culture?

What is the going rate of pay? You may need to update your pay grid to match the market rate for similar positions.

A clearly defined job description allows you to evaluate all candidates against a constant standard. New employees are more satisfied when their expectations about the job are aligned with information learned during the interview process.

3. **Look for candidates.** Prepare the job ad using the key requirements from the profile. Decide where to advertise. Options include local newspapers, educational institutes, internet job sites and professional association websites or publications. Don’t forget word of mouth. Tell people that you are hiring and be clear about what you are looking for.

4. **Screen the candidates.** Only interview candidates who have enough of the skills you are looking for. Cover letters matter. If accuracy is an important aspect of the position, consider how many grammatical errors are found in the cover letter. Further screening can be done by a short telephone interview. Save time; determine over the phone that the candidate is not qualified.

5. **Plan the interview.** Decide where you will hold the interview. Where possible, arrange the seating in an informal way such as a meeting room table or around a coffee table rather than from behind a desk. If you are using an office, clear your desk or find a place that isn’t cluttered. This shows that you are prepared and organized. Block the time and don’t allow interruptions for that time. Don’t forget that you are also making an impression on the candidates.

Prepare a list of questions so you have the same information for each candidate and won’t forget to ask the questions. Use behavioral-based interview questions. These questions are based on the logic how people behaved in the past will predict how they will behave in the future. Prepare questions based on the position profile that will allow the candidates to demonstrate that they have the skills, ability, and strengths to do the job. Consider how the answer to each question will help you evaluate the candidate in terms of skills, ability, motivation or fit. Usually eight to 12 questions are sufficient for the initial interview.
Determine who will interview the candidates. You can build employee engagement by involving co-workers and having them contribute to the decision. Having a second, or even third, person involved in the interview allows for different viewpoints and interpretations of the same answers. Assign the questions amongst the panel so there is consistency in how the questions are asked.

6. Hold the interviews. Bring on the candidates. Interviews generally take one hour and can be structured as follows:

First 10 to 15 minutes:

- Start by putting the candidate at ease. The candidate will show you more about herself/himself when not stressed. Give an overview of the interview process and spend a short time on the organization and the position. Remember to keep it short. The initial interview is for you to evaluate the candidate and not for you to spend valuable interview time by talking too much.

- Ask the candidate to “tell us about yourself.” The goal is to find out about the candidate’s career background and skills he/she believes is important to do the job. How does this job fit into his/her career plans? How much does the candidate know about the position and your organization? Has the candidate done anything to find out more about the position? What is his/her motivation for applying for the job?

Next 30 minutes:

- Ask the prepared questions. Probe the resume and ask for more if the question wasn’t answered or if you want to know more about a particular situation. Ask “How” and “What” questions to get more examples and get to the real motives and feelings. The candidate may not have direct experience but could provide an example from a similar situation that still indicates how successful he/she would be in this position.

- Listen, Listen, Listen. Your goal is to assess and rank each candidate throughout the interview. Could this person be a member of your team?

Final 10 minutes:

- Let candidates ask questions. Pay attention to the questions that they ask. Good candidates use this opportunity to add more information about how they can add value. They also are interested in exploring more about whether or not this position is a good fit for them.

7. Rank candidates and confirm your choice. Debrief with the interview panel. Rank the candidates according to the following criteria:

Can the candidate do the job?

Does the candidate have the skills and ability to perform the technical requirements of the job? What are his/her strengths? How much support and training will be needed?

Will the candidate do the job?

Were you able to determine what motivates the candidate? Does he/she genuinely want this job, or become bored in a short time and leave when something better comes along? Will the position be an exciting opportunity? People can be motivated by many different things.

Will the candidate fit with your team?

Did he/she talk too much during the interview? This may be due to nervousness or this could be a normal part of his/her personality that may not fit your team. Did your questions get answered? This may indicate lack of experience or demonstrate poor listening skills or inability to take direction. How did the candidate present? If you are hiring for the receptionist position in your office, is this the first impression that your patients have of your clinic?

Determine which candidates, if any, should be invited for a second interview. Have them meet other members of the team and get feedback. Follow up on anything you forgot to ask or was not covered in the first interview. Continue to assess the candidates using the same criteria.

8. Check references. You are looking for more information on past performance that will help determine ability, motivation and fit for the team. Consider who has been provided as a reference. Can you contact the current employer? Develop a list of questions to ask. Would your candidate be rehired? Reference checking is useful to clarify your assessment or may provide information that could lead to an additional interview with the candidate.

9. Make the offer. Or start over. If the candidate isn’t a perfect fit, make sure you are clear about the compromise that you are accepting. If skills are lacking, how will the gap be addressed? People can be trained, but compromising on a personality fit is never a good idea.

If none of the candidates are suitable, don’t assume that you
need to hire anyone. Start again.

Were there any potential candidates that were missed in the initial screening? Can you expand your advertising? Would extending the closing date make a difference? Are your expectations for a job too high? Is the pay scale according to market?

Ultimately, spending the time and effort in finding the right person will contribute greatly to the success of your business.

The Practice Management Program is available to assist in a number of areas related to the effective management of your practice. For assistance, please contact Linda Ertman at linda.ertman@albertadoctors.org or phone 780.733.3632.

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This past summer, three medical students from the University of Alberta (U of A) came together to create an educational initiative called Birthing Babies Together. Bailey Adams, Danielle Lewis and Katie Stringer have produced a documentary about what it means to provide woman-centered maternity care in a system that offers choice for birthing families.

The film takes a unique perspective as Ms Lewis and Ms Stringer are mothers and current learners. It was their contrasting maternity care experiences, Lewis with midwifery care and Stringer with a family physician, that spurred their desire to create this documentary. Initially, the project explored the roles of physicians and allied health care professionals providing maternity care with a focus on collaboration. However, as filming began it became clear that the scope of the initiative was expanding both in nature and audience. With support and encouragement from the maternal health community, the team traveled to British Columbia and throughout Alberta to learn from the leaders in the field. Interviewees included obstetricians, family doctors, midwives, doulas, registered nurses, neonatologists, maternity health researchers and families. They had the opportunity to take a detailed look into the world of normal childbirth and the many facets of maternal health and neonatal care.

As the practice of medicine and innovative research are continually evolving, this film is a creative opportunity to provide supplemental learning to medical students.

With the continued support of the Undergraduate Medical Education Department at the U of A, the team is working to have the film incorporated into the curriculum. They would like to see the film distributed to medical schools across Canada so that it can be seen by future health care innovators. Ms Lewis, Ms Stringer and Ms Adams hope the film will inspire future physicians to believe in supporting women’s choices as well as to inform their patients using quality, current maternity research. The medical students impart the view that, “birth in most cases is more than a physiological event and should be a celebrated milestone in a woman’s life.”

You can learn more about the Birthing Babies Together project and the women behind the scenes at www.birthingbabies.ca.

To donate on indiegogo go to http://www.indiegogo.com/birthing-babies-together.

If you’d like to receive a charitable tax receipt, go to http://birthingbabies.together.eventbrite.com/.


Follow us on Twitter http://twitter.com/Birthingbabies.
The Alberta Medical Association’s (AMA’s) Section of Rural Medicine recently awarded the Tarrant Scholarship to two third-year medical students. The scholarship covers one year’s tuition and differential costs. It is one of Alberta’s largest unrestricted medical school undergraduate awards.

The 2012 recipients are:
- Clark P. Svrcek (University of Alberta)
- Stephen Annand (University of Calgary)

Scholarship recipients must demonstrate an interest in rural medicine in their undergraduate work with the intention of pursuing a career in rural medicine in Alberta.

Dr. Allan S. Garbutt, President, Section of Rural Medicine, presented the awards on September 19 at the University of Alberta’s Faculty Club in Edmonton.

“Again this year we have had many good candidates for the award,” said Dr. Garbutt. “We are confident that this year’s winners will, like those ahead of them, strengthen the group of physicians serving rural Alberta.”

The scholarship is named in honor of the late Dr. Michael Tarrant, a Calgary family physician, who championed rural medical undergraduate education.

Applications for the 2013 scholarship will be available on the AMA website (www.albertadoctors.org) next spring.

ABOUT THE RECIPIENTS

University of Alberta

Clark P. Svrcek grew up in Wetaskiwin, Alberta, experiencing the benefits of a small town atmosphere and a close-knit community.

Upon completing high school, Mr. Svrcek moved to Edmonton and completed a degree and a masters in engineering. After meeting his wife at the University of Alberta, they resided in Edmonton before recently relocating to Hinton to participate in the Integrated Community Clerkship program for his third year of medical school.

As a Red Cross First Aid Instructor for the past four years, Mr. Svrcek realized the benefits of being a practical generalist and is particularly interested in wilderness medicine and global health. His interests stem from his recreational pursuits, including his days as a water treatment engineer and a world traveler. Mr. Svrcek hopes to combine his previous training in engineering with his current interests in rural and remote medicine.

Mr. Svrcek and his wife have a two-year-old daughter and are looking forward to welcoming their second child this fall.

University of Calgary

Stephen Annand grew up in Okotoks, Alberta. With Calgary only a short commute away, Mr. Annand was exposed to both rural and urban environments.

Mr. Annand attended the University of Western Ontario, with the goal of achieving a double degree in engineering and business. After completing his first year of post-secondary studies, Mr. Annand decided to pursue medicine.

After working with the Tim Horton Children’s Foundation in a program facilitation and development role, Mr. Annand achieved his masters in Public Health at the University of Alberta. He pursued his practicum in Emergency Preparedness during the H1N1 outbreak. This gave Mr. Annand the opportunity to work with physicians directly involved in the frontline management of the outbreak.

Upon completing his masters, Mr. Annand entered medical school. Initially, he found it difficult to focus on one particular specialization.

Mr. Annand’s inspiration to pursue rural medicine comes from his involvement with the Rural Integrated Community Clerkship in the Crowsnest Pass.
A patient with a terminal, debilitating and disabling disease is faced with a horrible dilemma: by the time one’s quality of life has deteriorated to the point when one would choose to end one’s life, the ability to do so without assistance may be gone. Until recently, section 241 of the Criminal Code of Canada formed an impediment to seeking such assistance:

\[241\] Every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding 14 years.

It seems strange that, while the act of suicide is not in and of itself a crime in Canada, counseling or aiding or abetting the act is. Of this, Justice Beverly McLachlin (now Chief Justice) wrote as follows in the famous 1993 Supreme Court decision in Rodriguez v. A.G. Canada and A.G. British Columbia:

“Parliament has put into force a legislative scheme which does not bar suicide but criminalizes the act of assisting suicide. The effect of this is to deny to some people the choice of ending their lives solely because they are physically unable to do so.”

Justice McLachlin was writing for the minority of the court, the majority having denied the request to declare s. 241(b) constitutionally invalid. A year after her failed attempt, Sue Rodriguez ended her decade long battle with amyotrophic lateral sclerosis (ALS, also referred to as Lou Gehrig’s disease) with the “unlawful” assistance of an unknown accomplice, reputed to be a physician.

The reality is – simply because the criminal sanction is removed does not necessarily mean that a physician may morally or ethically participate in the event.

Dr. J. Donald Boudreau recently wrote in the Globe and Mail:

“The Hippocratic Oath includes a stern injunction: ‘I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.’ This constraint has guided medical doctors for more than 2,400 years. For example, it provides the inspiration and motivation for the steadfast refusal of the vast majority of physicians from participating in capital punishment. We do not administer the lethal injections that kill convicted criminals. Neither should we accept to administer it under scenarios envisaged by Judge Smith.”

Fast forward to 2012, where another British Columbian, Gloria Taylor (also inflicted with ALS) is now fighting the same fight, but with considerably more success. This August, Ms Taylor succeeded in convincing BC Supreme Court Justice Lynn Smith that the effect of s. 241(b) is more “burdensome” on persons with physical disabilities than on able-bodied persons, and therefore the section creates a distinction based on physical disability, and thus a discrimination. Justice Smith found that the Criminal Code section offened s. 15 of the Charter of Rights and Freedoms (Equality Rights), which discrimination was not demonstrably justifiable in a free and democratic society. She went on to declare the offending section invalid, but suspended the invalidity for a period of one year (to allow Parliament an opportunity to revise or re-draft the section). However, she exempted Ms Taylor from the suspension, thus opening the door for her to seek assistance in ending her life and allowing her to approach the intersection of law and medicine.
Yet, many physicians have no trouble with the ethics of withdrawing care to terminally ill patients. As Dr. Boudreau himself wrote,

“... we are able to have conversations about halting futile life-supporting interventions; we are able to ‘unplug’ ventilators and be a compassionate witness to death; we are able to relieve physical and emotional suffering with an increasingly sophisticated array of medications, up to and including progressive terminal sedation.”

It is difficult, from a legal perspective, to see the distinction between withdrawing care, knowing that death is the inevitable result, as opposed to providing a means to allow the patient to essentially perform the same act. If a physician turns off a ventilator, knowing the result will be the death of the patient, this is “halting futile life-supporting intervention.” If the same physician places the switch under the patient’s finger, however, this is arguably assisted suicide. The distinction (at least until the Taylor case) is that one is a crime, and the other is not.

It is impossible for a non-physician to comment definitively on a physician’s duty when faced with these difficult situations. However, it seems logical that the decision of a physician to participate, or not, in any interventions which are intended to end a patient’s suffering should be a personal choice and not one guided by the prospect of a 14-year jail term.

References
1. Dr. Boudreau is Arnold P. Gold Foundation Associate Professor of Medicine at McGill University.

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David Baker spouse of Dr. Karen Bailey knows first hand that a physician’s time is valuable. He has helped many physicians in Alberta obtain their vehicle of choice without any hassle.
U of A staff receive national well-being, education and service awards

Four University of Alberta (U of A) staff members were recognized by the Canadian Association of Internes and Residents (CAIR) with the following awards, presented on November 3:

- **Drs. Kathryn Dong and Erica Dance** of the Emergency Medicine Department of the University of Alberta are the staff recipients of the 2012 Dr. Derek Puddester-CAIR Award for Resident Well-Being.

- **Dr. Keith Goulden**, neurodevelopment pediatrician and outgoing program director for the Development Pediatrics Subspecialty Residency Training Program at the University of Alberta, is the staff recipient of the 2012 Dr. Joseph Mikhail-CAIR Award for Medical Education.

- **Ms Brenda Meier**, a program administrator with the University of Alberta’s Psychiatry Residency Program, is the recipient of the 2012 Lois Ross-CAIR Service to Residents Award.

Drs. Dong and Dance together developed and currently maintain a resident physician wellness program for the Emergency Medicine program at the University of Alberta. Dr. Goulden has been a leader in the establishment of developmental pediatrics as a subspecialty. It was his work with the Royal College that led to the accreditation of the University of Alberta program, the first in Canada. Ms Meier coordinates a number of events including resident well-being day and a job fair for psychiatry residents. She has worked with hundreds of residents over the years, always with kindness and patience.

CAIR is the national representative body of over 8,000 resident physicians in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, the Maritime Provinces, and Newfoundland and Labrador.
In your professional life alone, how many people rely on you in some way? The tally is probably well into the hundreds, when you consider patients, staff and any partners in your practice. Those made of lesser stuff might crack under the strain of such a heavy responsibility. Not you! As a doctor, duty is your middle name.

But what happens if you’re unable to fulfill that duty because of circumstances beyond your control, like an injury or illness? If caught unprepared, losing patients, damaging professional relationships and draining your savings to pay salaries, rent and other business-related costs are just some of the few possible outcomes.

Office Overhead Expense Insurance (OOEI) is a smart, affordable way to meet your obligations, maintain valued relationships and protect your financial assets while you take time to recover.

Similar, but different, protection

OOEI is not the same as Disability Insurance (DI). Both provide a financial benefit when you can’t work due to a disability. However, DI is used to help replace lost income, while OOEI is designed to reimburse the costs of running your practice (see sidebar).

Financial assistance, even if you return to work

The coverage provided by the Alberta Medical Association (AMA) features a valuable “partial disability benefit.” This means that if you can return to work – whether to your practice in a reduced capacity or in another type of employment altogether – your OOEI policy will pay a benefit based on the percentage loss of your pre- and post-disability income, until your benefit maximum has been reached.

Cash back in your pocket

Because the AMA is a not-for-profit organization, OOEI premiums that we do not pay out in claims will be refunded back to the AMA and used toward the AMA Premium Discount.\(^1\) As an added plus, your premiums are also tax deductible.

Valuable automatic and optional benefits

Included in the OOEI plan is a Parental Benefit, which provides benefits to new parents during parental leave. Also included is a Return to Work Benefit which provides up to 50% of your benefit the first month you return to work from a disability. You also have the option to add a Guaranteed Insurability Benefit Rider. This gives you the opportunity to bump-up your OOEI coverage at pre-specified points in time without having to provide medical evidence (proof of good health).

Eliminating the ouch factor

OOEI provides vital financial assistance that helps keep your practice running and your patients and partners happy while you take time to get back on your feet. And if you won’t be able to return at all, it buys time for you to transition your practice to a new physician or clinic.

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- Professional dues

Talk to an AMA Insurance Advisor to get full details on covered expenses.

To learn more about the advantages of Office Overhead Expense Insurance and other insurance solutions available to AMA members, please contact your non-commissioned and licensed Insurance Advisors at AMA’s ADIUM Insurance Services:

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1. The AMA Premium Discount is not guaranteed.
Expecting more from end-of-life care
What physicians can deliver, what Canadians deserve

When Manitoba physician Dr. Harvey Max Chochinov accepted the Canadian Medical Association’s (CMA’s) Frederic Newton Gisborne Starr Award, he spoke of that remarkable moment in his life as one that will fade – while the dialogue surrounding palliative care, a highly misunderstood practice, must continue.

Palliative care comes with a large set of challenges and rewards. It is necessary to introduce more dialogue and address the questions surrounding the widely disputed subject. Palliative care measures are often viewed in terms of physical pain control. However, in addition to competent pain management, the purpose of palliative care is to treat the whole person using a holistic and comprehensive approach.

Dr. Chochinov has aptly used the idea of flying in an aircraft as a metaphor for life. “Medicine has focused its attention, so to speak, on seeing to it that we fly longer, perhaps faster and higher, certainly with a minimum of turbulence,” he told the CMA General Council. Continuing with that construct, he encourages physicians to imagine the dismay of passengers who learn over the announcement system that the pilot has exited the cockpit and has given up flying the plane. “This would be unconscionable,” he says. “When we tell our patients ‘there is nothing more we can do for them,’ we have exited the cockpit. We have forgotten that the nature of life is that it must end. We have forgotten that when cure is beyond reach, providing patient comfort and care is almost always within our grasp.”

According to Dr. Chochinov, there are still instances when dying patients and their families are left to “watch the clock” in anticipation of their next round of pain killers. Not providing adequate pain control leads to preventable suffering, which all too often taints the memories of grieving families. Dying patients face many challenges, which are ideally addressed by professionals working together to control their patients’ physical, mental, emotional and spiritual suffering using a holistic approach.

Many resources are available to deliver quality palliative care. Various specialists, including but not limited to social workers, nurses, registered massage therapists, psychologists, pastoral care workers and physicians, collaborate to offer patients the best quality of health care possible.

A united and strong team of palliative care providers can help assure a comfortable death. Ensuring that each patient dies comfortably with strong peace of mind is one of the main goals for palliative care providers. Another goal is to optimize function so that, within the limitations of a person’s illness, life can be lived as fully as possible as the time of death approaches. In recent years, physicians have refined their roles in palliative care. This form of health care heavily depends on available resources. If there is a lack of access to equitable resources, an inequity persists.

We have forgotten that the nature of life is that it must end.
We have forgotten that when cure is beyond reach, providing patient comfort and care is almost always within our grasp.

Dr. Wasylenko’s views align with those of Dr. Chochinov’s. He demonstrates the comfortable living and care that patients receive in palliative care centers and hospices. He and his colleagues have high expectations of delivering optimal service and comfort to their patients.

The goal of palliative and end-of-life care, in Dr. Wasylenko’s words, is to “… prepare [patients] for death but also have their symptoms relieved so they can accomplish the things that are important to them during this living time before their death.” He indicates that a holistic approach produces superior care. He promotes the fact that good palliative end-of-life care can also occur within other settings such as home care, in hospitals and in long-term care.

Dr. Chochinov and Dr. Wasylenko both state that death is more than a physical loss. Rather, it is important to many people in their final days to reflect on all areas of their lives and relationships. This provides a means to bring an important measure of peace as people near the end of their lives. Time speeds up as much as it slows down when patients approach death. Creating a meaningful and comfortable experience should be at the top of each physician’s mind in providing care.

As health care providers work with their patients, they remain focused on each individual’s life story. As such, some patients engage in mending existing relationships with friends and family, while others find comfort in the legacy they will leave behind.

Death comes with uncertainty, and sometimes with fear and anxiety. Palliative care offers enveloping care, medical expertise and compassion. Dr. Chochinov may have said it best during the conclusion of his acceptance speech. He said, “I would like to be able to tell Canadians that they should expect more from end of life care; that they deserve more.”

Do you have thoughts or comments about Alberta’s or Canada’s approach to palliative care? Email us at doctorsdigest@albertadoctors.org.

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  > Advance humanitarian or cultural life of his/her community.

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Ban the tech. Pass the tech.

AMA’s Emerging Leaders grant supports two projects with opposing views of technology

Medical students and resident physicians are realizing that technology can have both a positive and negative impact on the health of Albertans. In continuation of our series covering the recipients of the Alberta Medical Association’s (AMA’s) Emerging Leaders in Health Promotion grant, we look at two projects that have opposing views on the use of technology. One is using handheld technology as a way to interact with children exposed to domestic violence. The other wants to ban all forms of mobile technology while driving. The projects’ leaders give us an update on how things are progressing and how they foresee positive changes in health promotion as a result of their work.

Students for Cellphone-Free Driving — Calgary Chapter

Distracted driving legislation has been in effect in Alberta for over a year, but University of Calgary (U of C) medical student Peter Iglinski doesn’t see much of a difference on the roads today.

“People are aware of the legislation but continue to use their phone while driving,” said Iglinski. “Now they just try to conceal it more – which is probably more dangerous.”

Iglinski doesn’t believe the legislation goes far enough. He is a member of a province-wide coalition that wants to eliminate all cell phone use – including hands-free – while driving. Students for Cellphone-Free Driving (SCFD) was established in 2009 by University of Alberta (U of A) medical students to raise awareness about the issue amongst peers and high school students. Iglinski has taken the lead on establishing a chapter at the U of C.

“The U of A has quite a well-established program,” said Iglinski. “I thought there was a real need in Calgary; our message would have a meaningful impact on local youth.”

Creating the new chapter has been a seamless experience, especially with the support of the Edmonton chapter which has already developed curriculum and interactive presentations targeting high school students. The challenge for Iglinski and his fellow students has been to market the Calgary chapter and reach out to Calgary area schools willing to participate in the initiative. At the time of writing, the Calgary chapter had presented to six schools.

“The students really like our presentations,” added Iglinski. “The graphic images we use are different than the public safety announcements on safe driving. We show them that the consequences of careless driving are often very gruesome.”

Both Edmonton and Calgary chapters are partners with the Coalition for Cellphone-Free Driving, a group of companies and organizations who are committed to reducing cell phone use while driving. The coalition is led by Dr. Louis Hugo Francescutti, an Edmonton-area emergency physician and the president-elect of the Canadian Medical Association. For Iglinski, Dr. Francescutti is setting a wonderful example of physician advocacy and leadership.

People are aware of the legislation but continue to use their phone while driving. Now they just try to conceal it more – which is probably more dangerous.
“We always think about the work of physicians as simply treating diseases or conditions,” added Iglinski. “I think it is equally important for physicians to be advocates and share with government and other organizations some of the key problems we see in our society – many of which can be prevented with proper education and increased awareness.”

The chapter is planning to expand its reach to more Calgary-area schools with a brand-new group of medical student volunteers for the new semester.

**Early intervention strategies for children exposed to domestic violence**

U of A resident physician Dr. Maryana Duchcherer believes in the value of preventive care, even in the field of psychiatry.

“Many psychiatric patients have had traumatic experiences in their childhood,” said Dr. Duchcherer. “From what I have observed, this trauma doesn’t go away without having some significant impact on their later lives.”

In fact, according to Dr. Duchcherer, traumatized toddlers and preschool children have a tendency to express their stress by adopting various patterns of attachment and expressing distinct emotions. She believes it is possible to prevent further development of behavioral, cognitive or psychiatric issues by identifying these patterns and intervening in formative childhood years.

This is where her project fits in. Its main objective is to help affected children gain confidence in expressing their thoughts and feelings. It also promotes the value of sharing and engaging in positive interactions with other peers with the use of technology.

“Technology affords us a set of new tools that we can use to create positive outcomes in any form of intervention,” Dr. Duchcherer explained. “Personally, as I do rounds in child psychology, I have noticed that technology makes a huge difference when trying to connect with kids.”

Equipped with a set of Apple iPods, Dr. Duchcherer and her team are working at an Edmonton-area shelter for victims of domestic violence. To date, she has worked with more than 12 children at the residence, guiding them through different projects using various software applications.

“The functionality of the iPod, with a variety of educational applications, makes it easy for children to learn and adapt,” said Dr. Duchcherer. “The children can feel comfortable and positive after using the device because they have communicated in an easy way – and in a way that works for them.”

“More importantly, the device facilitates what I call a translation of their inner self, through drawing or listening to music.”

Dr. Duchcherer is already seeing results with her work. She recalls her observation of a four-year-old girl who was at the shelter.

“The child had a significant speech delay as a result of her trauma,” recalled Dr. Duchcherer. “When she started using a talking application on the iPod, we noticed incredible improvement when communicating with her teachers or her mother.”

“The whole community in the shelter was excited to witness this huge impact.”

Examples like this will be used as part of a final assessment of the children who participated in the project. In addition, Dr. Duchcherer plans to survey the mothers of the children and ask them to share their observations about the impact of technology on their children.

“We will use the data collected to determine whether we should expand to other shelters,” she added. “Hopefully we will see that, without using a lot of resources, we have been able to create positive outcomes.”
In the Canadian Medical Association Journal (CMAJ), I saw a recent advertisement for a free new software application (app). It allows Canadian Medical Association (CMA) members to access the full text of articles in the CMAJ using Apple iPhone, iPad, or iPod Touch mobile devices. I downloaded and tested the app on my iPad and decided to write an article that might save other physicians some time and effort.

This page provides information about the app and how to register for access to the CMAJ articles. This page is also linked in a pop-up advertisement that appears on the CMA website (cma.ca).

HARDWARE AND SOFTWARE

The app is 3.7 megabytes in size and is currently only available for Apple iPad, iPhone and iPod Touch devices using the iOS 4.2 (or later) operating system. It is not yet available for BlackBerry or Android devices.

CMAJ registration

www.cmaj.ca/cgi/activate/basic

You must be a CMA member to access the articles. If you are a CMA member and do not have a cmaj.ca login, you can create one by following these steps:

1. Go to http://www.cmaj.ca/cgi/activate/basic.
2. Enter your CMA membership number and click “Submit.”
3. Fill out the Subscriber Information and choose a username and password. The phone number and fax number are required fields but you can enter a “/” or “0” instead.
4. Click Send Form. An email will be sent to you, confirming the activation.

ELDER ABUSE AND ZERO RESPONSIBILITY?

I’m a senior citizen (gimme my @#$% discount) and my old CMA membership number has only five digits. The registration process would not recognize my number, so I called CMA Membership Services and learned that I now have to insert a zero at the start of it. (Expletive Deleted!)

DOWNLOADING THE APP

There were “App Store” icons on the CMAJ web page that I expected to help me download the app, but they were not active links. I was able to download the app using the existing iTunes software on my desktop computer and searching for “CMAJ.”

ITUNES

Apple mobile device users must download this software program to their desktop or laptop computer when they first purchase the device. The program manages the connection between their main computer and the mobile device. It provides access to the iTunes Store where users can download a variety of apps (many are free) or music and video files.

INSTALLATION

I have an existing account with the iTunes Store and had no difficulty downloading the app to my desktop computer and then transferring (“syncing”) it to my iPad. However, the first time I downloaded a free app from the store, I had to provide a credit card number, even though there was no charge.

INTERNET CONNECTION

You need an active Internet connection for the mobile device to access the CMAJ. I had no problem connecting using my home wireless network.

INITIAL LOGIN

The app is accessed from a “CMAJ” icon on your device’s main menu. When you first use the app, you are shown a pop-up window asking for the user name and password that you set up during registration (as above). Press the “Submit” button after entering the information. This pop-up window is part of the “Settings” tool in the app and must be closed manually using the “Back,” “Settings” and “Done” buttons to close all the windows. The app remembers your information and immediately connects to the CMAJ on future visits.

GETTING HELP

You can obtain help with the registration or download by calling CMA Member Services toll-free 1.888.855.2555 or by sending an email.
Your comments and suggestions are welcome.
Please contact me:
bmcombs@ucalgary.ca
T 403.289.4227

FEATUrE

Renew your AMA/CMA membership and continue to receive important benefits

As an Alberta Medical Association/Canadian Medical Association (AMA/CMA) member, receive AMA/CMA benefits and services, plus information about Negotiations 2012 and other issues important to physicians.

Renew via one of the following methods:

• Online (log on to www.albertadoctors.org).
• Mail your completed membership form to the AMA.
• Fax both pages of the form to 780.482.5445.

Membership forms and information packages were mailed in September. They will vary depending upon member category and may include the following:

• Letter from the AMA president.
• @ your service membership guide.
• Membership form.
• Medical Liability Reimbursement Administration Policy.
• Continuing Medical Education Administration Policy.
• Postage-paid return envelope.

Membership questions? Contact AMA Membership and Benefits Team Leader Kirsten M. Sieben at 780.482.0323, toll-free 1.800.272.9680, ext. 323 or email kirsten.sieben@albertadoctors.org.

Scan to find out how you can join or renew your membership, or visit www.albertadoctors.org/membership.
“Jolibee” restaurants are big in the Southern Philippines. They remind me of Dickens’ Mrs. Jellyby, the character in Bleak House who was oblivious to the squalor and poverty in Victorian London but devoted to bettering the lot of the Borrioboola-Gha tribe by re-locating the London under-class:

“You find me, my dears,” said Mrs. Jellyby, “as usual, very busy; but that you will excuse. The African project at present employs my whole time. It involves me in correspondence with public bodies, and with private individuals anxious for the welfare of their species all over the country. I am happy to say it is advancing. We hope by this time next year to have 200 healthy families cultivating coffee and educating the natives of Borrioboola-Gha, on the left bank of the Niger.”

In Global Health projects, I like to ask: “Is this a Jellyby Project?” For nearly 20 years, the University of Calgary Medical School has been involved in the Philippines island of Mindanao with the Ateneo de Zamboanga Medical School. Initiated by Clarence Guenter with faculty going to teach the medical students and give advice on a curriculum emphasising local diseases and local social problems, the aim has been to train students to make a difference locally rather than training them to work in Canada and the USA. It is not a Jellyby Project.

On my last visit in September, I met Vicente Barrios. Last year he had a husky voice with a weak cough, and after a laryngoscopy and biopsy, he was diagnosed with an early stage carcinoma of the larynx.

I had also heard that he was known in Zamboanga for an event two years before and I was determined to ask him about this.

As often happens in third-world countries (or “disadvantaged” countries, as some prefer to call them) we arranged to meet, not in a Jolibee restaurant, but in a local hotel, the Lantaka, in the coffee bar. I had already suggested that he be reviewed for radiotherapy (which is curative in the early stage) and he had been to Cebu to see a radiation specialist but had seemingly been put off by the list of side-effects from radiation. He was still equivocating.

In Zamboanga there is a Cobalt-60 machine but the cobalt source is 12 years old. There is no effective radiotherapy on this side of the island of Mindanao, an island of 38 million people.

Vicente was a fit looking man of 62 with a proud, intelligent face. He came in with his son, a local pediatrician.

“I have stopped the smoking, doct-awr, ▶
and I improve my diet with my son’s advice. Do you think that will stop this cancer?”

I shrugged. We sat back in the squared seating booth for four and ordered tea:

“I hear you were kidnapped by the Abu Sayyaf a while ago. Tell me about that.”

He looked around and his son nodded.

“It was perhaps a case of mistaken identity,” said his son. “He looks like the owner of the fish processing plant. But he is only the manager.”

His father was non-committal:

“Who knows? In the afternoon at the dock by the ponds, I was overseeing work when a fast boat came to the dock. Five men jump out and go for me. I carry a rifle at work and the first man to come at me – I hit him on the side of the head with my rifle butt.”

He punched his clenched fist reliving the hit.

“Then I was hit on the head. They blind-fold me and take me in the boat over to Basilan. We go a long way inland by motor bike and walking. When the blind-fold is removed I am in a valley with mountains on each side.”

“How did they treat you?” I asked.

“Well enough. I eat the same food as them. But I lie awake every night and doze during the day. They sleep with their guns beside them. I know how to use a gun. I could have shot them all while they sleep. But what then? I did not know where I was – the whole island is under Abu Sayyaf.”

His son interrupted: “All the time he is there, I negotiate with them for ransom. They want two million pesos (about $48,000). We do not have that. So we bargain for price.”

“After two months I know something is happening because it is soon Ramadan and they say to me: ‘We must be preparing to purify ourselves.’” Mr. Barrios curled his lip with a sardonic smile at the memory.

With upcoming Ramadan, the deal was struck, his son carried the money over, the mayor of Basilan acting as go-between, Vicente was handed over, and on return to Zamboanga, the local politicians, like politicians everywhere, crowded into the photographs, looking as though they had been the cause of the settlement.

“Security has improved over the last 15 years but these kidnappings go on sporadically. It is the main reason we have not recommended medical student or even resident electives – although the learning and experience would be invaluable.

I have mentioned before (Alberta Doctors’ Digest May/June 2010) these students and residents can knock spots off our students on infectious diseases, village sanitation, hygiene and water purification – although they’re not so well versed as ours in mechanisms of action of third generation calcium channel blockers…

So the clinical teaching has gone well, but now we are entering a different phase. The economy of Mindanao is growing, a few more cars are on the roads and it’s time to look at helping with training residents and upgrading the facilities for the treatment of patients in the Zamboanga City Medical Centre.

A 15-year-old girl had earlier that day been presented to me: a miserable muco-cutaneous rash, fever and a painless mass in the neck. A chest X-ray showed a large mediastinal...
mass. A CT scan had even been done and a fine needle biopsy had shown “probably malignant lymphoma, large cell type.” Now the family was running out of money. A biopsy costs 5,000 pesos ($120) – much more than a fine needle aspiration, so there was no biopsy. Single agent chemotherapy had been suggested. One cycle was given with some improvement in the rash and the mass. But money was now low. Her mother was pleading for help.

With some shame I made suggestions, knowing that nothing much would happen, that a routine treatment here in the west with CHOP/rituximab might have sorted her out. She would return to her village to die, probably without morphine.

I was also ashamed because that week (September 17, 2012) I read in the papers the following news accompanied by a medical drama photo: “A nurse comforts Peanut, an orangutan from a private zoo, as a group of medical professionals gather over the table for R-CHOP therapy, a combination of drugs used in chemotherapy to treat her aggressive non-Hodgkin lymphoma in Miami. Human medical specialists are treading new ground in applying a standard chemotherapy regimen to treat cancer in an orangutan.”

New ground indeed – Peanut and our pets get better attention than our fellow humans. That usually raises an embarrassed nod and shrug here but on the rounds in the hospital the Filipino residents had also heard of the obvious and the not-so-obvious.

In the Philippines there are many nuances, things you see and things you don’t see, the obvious and the not-so-obvious.

($5)/person/month but even that is beyond most of the population in the Southern Philippines. It covers bare services – perhaps the cost of a doctor visit. There’s always more to pay. And there’s no way it will cover R-CHOP for curable lymphomas even if there were facilities to handle the pathology, radiology, lab work and toxicity complications.

In the Eureka restaurant that evening, I met Gregorio (or “Gay” as he likes to be called), the owner of the Eureka, a top restaurant in Zamboanga. He wanted to discuss his metastatic prostate cancer in his bones. He was 62 and had had bone metastases for 12 years. Gay was a man who’d been everywhere and tried everything – all the hormones, lots of chemotherapies. He’d had zoleodronate monthly for years and now had jaw osteonecrosis. He’d even been to Texas to see Bruzinski, a mega-millionaire, and spent a few weeks there receiving injections of “anti-neoplastons” (made from your very own urine with the curious side-effect of loss of hip pocket weight).

He was now on one of the latest medications for prostate cancer, cabazitaxel, managed from Manila. I told Gay that he had a biologically indolent bone malignancy and he may have done quite well with symptom remedies only but I didn’t want to discourage him and said the medication looked “promising.” We munch on chicken adobo and bacon garlic rice. Gay had just got off the airplane from Manila after his injection:

“I will not feel well tomorrow but tonight I am fine. This dinner is on me.”

I’d given him the cheapest advice he’d had in his entire illness.

In the Philippines there are many nuances, things you see and things you don’t see, the obvious and the not-so-obvious. The cost of a course of chemotherapy using five-fluorouracil, adriamycin and cyclophosphamide varies. Some surgeons can give this in their private practice and the company delivering the drugs charges $600. The government hospital however pays $1,000 which is the list price. Why no discount for a big buyer? Where does the $400 go?

The Cobalt-60 source needs renewing. This should be done every five years. They are waiting for “approval” for a new source. A Canadian company has agreed to supply the source at cost. The company has been waiting for a year for the contract and price to be approved in the Philippines.

My father spent a year in the Philippines in the early 70s as a mining consultant for the United Nations. In 1963, the UN gave $10 million to the Marcos regime for development of coal mining in the Philippines. My father found a couple of open cast pits on Mindanao but he never got to the root of where the money had gone. He was offered some interesting propositions by cabinet ministers in the Marcos regime including putting Filipino produced gin into Gordon’s Gin bottles.

A member of the Calgary Rotary Club contacted me last week.

“We’ve had a request from Harvard – they want to do a telemedicine project in the Southern Philippines. They think the Filipino doctors will benefit from discussing their cases with Harvard.”

“It’s not like here you know,” I said. “It’s not like a patient in the Northwest Territories being discussed in the University of Alberta by “Telehealth.” They can’t afford much that would be suggested. But it may make the Harvard types feel good.

This one may be a Jellyby Project.

It’s a lovely part of the world – and there are no tourists. A breakfast of coffee, fresh mango, eggs, pork tocino and sinangag rice in the sun on the verandah of the old Lantaka Hotel overlooking the harbor and the Sulu Sea with the Spanish cannon pointing at the mountains of Basilan in the distance makes my rushed toast and coffee here seem absurd. The hotel’s bedrooms have native paintings of Muslim villages and sailboats on the walls; the water pipes clank and the air conditioners rattle.

“How much did you have to pay for the ransom?” I asked Vicente Barrios.

His son smiled: “Because of Ramadan I beat them down to 600,000 pesos.” Mr. Barrios looked pained. He was not wealthy.

“Two months as a prisoner of the Abu Sayyaf and you’re frightened of a few side-effects from radiotherapy?” I said.

He smiled.

“I will think about it,” he said.

But I knew what the problem was. It was not his fear of radiation side-effects; it was that he and his family could not afford the treatment.

It’s important to follow local advice as to any direction taken, but practical people – doctors, nurses and engineers – can help in these parts of the world, mainly with training, education and a few donations. The rest is up to the local population – not the Jellybys of this world.

For more information on “Project Zamboanga” contact Dr. Paterson or Dr. Sonny Belenkie at Tom Baker Cancer Centre, Foothills Medical Centre and University of Calgary.
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Med+Stop Medical Clinics Ltd.
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T 403.240.1752
F 403.249.3120
msmc@telusplanet.net

CALGARY AB
Celebrating more than 30 years of excellence in serving physicians, MCI The Doctor’s Office™ has opportunities in northwest Calgary for both family practice and walk-in shifts. We’ll move your practice or help you build a practice. We offer flexible hours and schedules, no investment, no financial risk, no leases to sign, and no administrative or human resource burdens. MCI Medical Clinics (Alberta) Inc. provides quality practice support in nine locations throughout Calgary.

Contact: Margaret Gillies
TF 1.866.624.8222, ext. 433
practice@mci-med.com

CALGARY AB
Dr. Neville Reddy is recruiting family physicians and specialists to his new medical facility Innovations Health Clinic, within seven minutes of the new South Health Campus.

Innovations Health Clinic is positioned to provide medical service to the Douglasdale and surrounding communities (projected growth of 100,000 people). Competitive expenses offered.

Contact: nreddy@telusplanet.net

DEVON AB
Devon Medical Clinic is looking for a physician to join our busy family practice and help ease the load of physicians who are nearing retirement. We have an on-site X-ray clinic, pharmacy and are across the street from a laboratory and hospital. We use electronic medical records.

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

EDMONTON AB
Corrections Health, Alberta Health Services (AHS), is inviting applications for family physicians to work at various correctional facilities in Edmonton.

Inmates who are remanded or sentenced to less than two years serve their sentence in a provincial correctional service facility. In the Edmonton Zone, there are three facilities:

Edmonton’s new state-of-the-art Remand Centre will open in April 2013. It will house 1,952 inmates in seven pods of living units. With future potential expansion, it will be able to hold up to 2,816 inmates in 10 different pods.

The Fort Saskatchewan Correctional Centre is a multi-purpose 496-bed correctional facility comprised of 10 buildings in an open environment that provides a variety of educational, vocational, recreational and mental health programs.

The Edmonton Young Offenders Centre offers group living, open and secure custody programs, temporary detention and remand facilities, work training programs, psychological services, recreational services, Aboriginal programs, addiction programs and spiritual guidance.

While maintaining an independent practice, the successful applicants will engage in clinical service in these facilities that includes outpatient clinics and on-call service. Specifically, this will entail: one or more half-day clinics per week depending on facility; seeing patients who have been pre-screened by nursing staff; caring for patients with injuries, withdrawal symptoms or who require wound care; chronic disease management; reviewing patient files and results; working with highly independent nursing colleagues and participate...
in the on-call rotation which involves accepting telephone inquiries from nursing staff.

Remuneration is based on a competitive sessional stipend.

The successful applicant must hold an MD and shall have or be eligible for certification in family medicine with the College of Family Physicians of Canada and be eligible for licensure with the College of Physicians & Surgeons of Alberta.

Details about Alberta Health Services and the Department of Correction Services can be found at www.albertahealthservices.ca and https://www.solgps.alberta.ca/programs_and_services/correctional_services/Pages/default.aspx.

All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority.

Alberta Health Services hires on the basis of merit. We are committed to the principle of equity in employment. We welcome diversity and encourage applications from all qualified men and women, including persons with disabilities, members of visible minorities and Aboriginal persons.

To apply, forward a copy of your curriculum vitae and a letter of interest to:

Dan Woods
Director, Corrections North
T 403.309.2846
C 403.340.9027
dan.woods@albertahealthservices.ca

EDMONTON AB

Alberta Health Services in partnership with the University of Alberta, Faculty of Medicine & Dentistry, Department of Family Medicine, is inviting applications from family physicians with expertise in geriatrics to join the Glenrose Rehabilitation Hospital Geriatric Inpatient Rehabilitation Program in the Edmonton Zone.

The Glenrose Rehabilitation Hospital is the largest free-standing tertiary rehabilitation center in Canada, serving patients of all ages who require complex rehabilitation to enable them to participate in life to the fullest. As a leading-edge academic teaching hospital, the Glenrose participates in educational training programs for health sciences professionals and offers an array of research and technology development opportunities.

The successful candidates will join an integrated group of health care professionals. Geriatric patients are the focus of our service; treatment includes an integration of medicine, nursing, rehabilitation, social work and pharmacotherapies. These patients have had acute physical, cognitive and social decline in the past two-to-three months and have reduced independence.

The responsibilities for successful individuals would include clinical rehabilitative care for six in-patients, working collaboratively with the interdisciplinary team, participating in an on-call roster (average one-in-eight second call), completing all administrative data related to cared-for patients, and participating in regular meetings related to patient care and quality improvement.

Remuneration is competitive and based on a sessional Clinical Alternate Relationship Plan.

The successful applicants shall have an MD or be eligible for certification in family medicine with the Royal College of Physicians of Canada or with the College of Family Physicians of Canada and be eligible for licensure with the College of Physicians & Surgeons of Alberta. Training in geriatrics and/or experience in the care of the elderly would be an asset. We offer core geriatrics training to anyone interested. A proven track record of collaboration and mentoring trainees is preferred.

This individual will be encouraged to apply for a clinical academic colleague appointment in the Department of Family Medicine, University of Alberta, which will be considered through a separate process with the Faculty of Medicine & Dentistry.

Edmonton, with a growing population of over one million, is the cosmopolitan capital of Alberta. With an abundance of services, beautiful river valley, community activities and attractive and financially reasonable living accommodations, this energetic city has something for everyone. Edmonton boasts a superior public education system for school-aged children through Edmonton Public Schools. For more information, visit www.edmonton.ca.

Details about the University of Alberta, Faculty of Medicine & Dentistry and the Division of Geriatric Medicine, can be found on the faculty’s website at www.med.ualberta.ca, Alberta Health Services at www.albertahealthservices.ca and the City of Edmonton at www.edmonton.ca.

All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. The University of Alberta and Alberta Health Services hire on the basis of merit. We are committed to the principle of equity in employment. We welcome diversity and encourage applications from all qualified women and men, including persons with disabilities, members of visible minorities and Aboriginal persons.

Interested candidates should submit a curriculum vitae outlining their current clinical and leadership experience, and three reference letters. The competition will remain open until the positions are filled.

Contact: Dr. Hubert Kammerer
hkamm@yahoo.com or
Dr. Elisa Mori-Torres
elisa.mori-torres@albertahealthservices.ca
Co-Facility Chiefs, Geriatrics
Glenrose Rehabilitation Hospital
10230 111 Ave NW
Edmonton AB T5G 0B7
T 780.920.4773 or
T 780.910.2509
F 780.735.8846

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STRATHMORE AB

Excellent practice opportunity in a rural setting only 50 kilometers from Calgary. Invest in yourself and your family. Join five happy physicians in a true family practice and have a life as well. Strathmore is a town of 12,000 people situated on the prairies, but close to all the amenities of the Rocky Mountains and a big city. Our hospital has a 23-bed acute-care ward, long-term care and an exciting ER (more than 30,000 visits per year). Earning potential is limitless. Expenses are only 30% of office billings. We are part of the Calgary Rural South Primary Care Network with an array of enhanced services. Our group provides great mentorship for a young physician who wants to practice full-service medicine.

Contact: Dr. Ward Fanning
T 403.934.4444 (office)
T 403.934.3934 (home)

TABER AB

The Taber Clinic is looking for three full-time family physicians to join our team. We are an 11 physician clinic, providing comprehensive, team-based care in rural southern Alberta, 30 minutes east of Lethbridge. We have X-ray, laboratory and bone mineral densitometry in clinic and provide emergency, surgical, obstetrical and anesthesia services through our local hospital. Competitive remuneration through our Alternate Relationship Plan with paid vacation and benefits package.

Contact: Michael Brand,
Clinic Manager
T 403.223.3525, ext. 320
michael.brand@taberclinic.ca

Physician and/or locum wanted

CALGARY AB

An opportunity for long-term locums and associate positions are available at Crowfoot Village Family Practice (CVFP). CVFP is a progressive and innovative group that uses a patient-based funding model to deliver primary health care in northwest Calgary. We are looking for talented family physicians to join this dynamic team-based practice in both long-term locum positions and associate positions. This is a great opportunity if you are looking for a diverse practice in an urban setting.

CVFP features no mandatory weekend or after-hours service, no mandatory on-call, participation in family medicine training program at a core training site, strong physician leadership, well-established patient base, supportive administrative and medical office staff, strong role for registered nurses, collaborative medical team including on-site dietitian, pharmacist, psychologist, diabetic and respiratory educators, nurse practitioner and health management nurse.

Contact: Shauna Wilkinson
Executive Director
T 403.208.0722, ext. 561
swilkinson@cvfp.com

CALGARY AND EDMONTON AB

Is your practice flexible enough to fit your lifestyle? Medicentres is a no-appointment family practice with clinics throughout Calgary and Edmonton. We are searching for superior physicians with whom to partner on a part-time, full-time and locum basis. No investment and no administrative responsibilities. Pursue the lifestyle you deserve.

Contact: Cecily Hidson
Physician Recruiter
T 780.483.7115
chidson@medicentres.com

SLAVE LAKE AB

Slave Lake Family Medical Clinic is urgently looking for a full-time family physician to work clinic and on-call hospital schedule. Paperless clinic, Netcare available. Urgently need locums to work Monday to Friday, 8:30 a.m. to 4:30 p.m.

Contact: Daniel Payne
T 780.849.2860 (office)
T 780.849.4009 (home)
danielsl@telusplanet.net

Space available

CALGARY AB

Quarry Park is a part of a new commercial development anchored by a Calgary Co-op grocery store with 1.5 million sq. ft. of surrounding office development and a fast-growing residential community in southwest Calgary and has striking French themed architecture. There is excellent access/egress via 18th Street and 24th Street SE with connections to Glenmore and Deerfoot Trails. There is an opportunity for general medical and medical specialties in the main retail area that is comprised of 88,256 sq. ft. of retail space.

Contact: Alistair Corbett
CBRE Ltd.
T 403.294.5709
alistair.corbett@cbre.com

CALGARY AB

Centre 10 is an office building at the southwest corner of 10th Avenue and 4th Street SW in Calgary. This 370,000 sq. ft. building has main-floor street front opportunities for a medical practice located adjacent to the main downtown core. The building is within two blocks of Bankers Hall, Eighth Avenue Place, Watermark Tower and is close to Calgary’s largest high density area. The building will be opening in September 2013 and has exceptional parking.

Contact: Alistair Corbett
CBRE Ltd.
T 403.294.5709
alistair.corbett@cbre.com

CALGARY AB

The District at North Deerfoot is a new mixed use retail/office/light industrial development in a high-profile location with exposure to Deerfoot Trail and Country Hills Boulevard NE. (The main access road servicing the communities of Coventry Hills, Harvest Hills, Country...
Hills Village and Panorama Hills). This site will include a significant retail portion with opportunity for a medical practice.

Contact: Alistair Corbett
CBRE Ltd.
T 403.294.5709
alistair.corbett@cbre.com

CALGARY AB

Shaganappi Urban Centre at 3320 17th Avenue SW is a brand-new two storey “A” class mixed use medical/retail/office development situated along 17th Avenue and 33rd Street SW. Located directly adjacent to the new Westbrook light rail transit station. Main and second floor opportunities. Various sizes available. Fall 2013 possession date.

Contact: Brad Boyce
CBRE Ltd.
T 403.303.3609
brad.boyce@cbre.com

ST. ALBERT AB

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Contact: Dr. Azim Bharmal
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