Are you prepared for the mobile health tsunami?

71% of millennials want apps to be prescribed and 66% of seniors want technology to access care from home.

Dealing with disruptive physician behavior

Can education and mediation really make a difference?

North/South Doctors’ Golf Tournament a swinging success

88th annual tournament raises over $50,000 for medical student bursaries.
SYMPhONY TOWER

$2.625 Million Penthouse Sale:
Highest In Edmonton MLS® Sales History

Overlooking Legislature Dome & Grounds

Protected River Valley Views

Panoramic Floor To Ceiling Glass Walls

10 Minute Walk To The LRT Station

Condos, Penthouses & Townhomes

Over 79% Sold!

European Inspired Masterpiece

Take A Virtual Tour At:
SymphonyTower.ca/view

9704 - 106 Street (780)701-0058
6 Are you prepared for the mobile health tsunami?
71% of millennials want apps to be prescribed and 66% of seniors want technology to access care from home

8 Dealing with disruptive physician behavior
Can education and mediation really make a difference?

17 North/South Doctors’ Golf Tournament a swinging success
88th annual tournament raises over $50,000 for medical student bursaries
I was taking out an inflamed appendix some time ago. The staff at the OR desk found an assistant for me, a third-year medical student that I’ll call Josh.

The appendix came into view readily enough, a long, angry looking organ, thick and reddened, and covered with pus. It would have burst before long.

Josh peered at it with interest. “What do you make of it?” I asked.

He looked at me over his mask. “It’s the worst one I’ve ever seen?”

I couldn’t resist. “How many have you seen?”

“Umm, this is the first one,” said Josh.

Ha-ha! It was an old gag, I thought, but still impressive given the tentative responses I was used to.

When we were done, Josh followed me to the lounge and we wrote post-op orders.

“I would do it all over again?” Josh asked, referring to my career.

I didn’t answer but asked if he was planning on going into surgery. He allowed he was.

Josh had time to think about things. When I considered my own convoluted journey I couldn’t help but remember Robbie Burns’ line: “The best laid schemes o’ mice an’ men gang aft agley.”

Decades ago I’d started out in a surgical rotation. The curriculum encouraged research exposure after two years of clinical work. I thought I’d miss the “Sturm and Drang” of the hospital, but I didn’t. The dog lab was busy trying to perfect the surgical techniques involved in canine lung transplantation. I became fascinated at the problem of organ rejection and the mystery of immunological tolerance as described extensively by British Nobelist, Peter Medawar.

So I was lost to surgical training for four years. After a year in the dog lab, I moved to a basic science laboratory involved with tissue culture and mouse models of rejection. It was thrilling when things worked, when we found something replicable and new, and when we saw our work published in one of the “big” journals. The downside, of course, was that things often didn’t work, that research funds were hard to come by and the pay was puny. Then too, research supervisors were a spotty bunch and ranged from Attila the Hun to Alfred the Absent.

Maybe it would be a grand idea to do more administrative work: there would be no call.

After my research, I resumed surgical training with a degree of reluctance, but harbored ambition to do a further research fellowship once I was done, in the laboratory of eminent surgical scientist Dr. Joseph Murray. But it was not to be. At the end of my year as chief resident, two of my four staff surgeons became ill, one with metastatic adenocarcinoma of lung, the other with heart disease. Jumping ship seemed a poor choice and I settled into full-time practice.

A busy surgical practice is a spinning wheel that never stops and a decade passed before I caught my breath and paused to look around. Resuming research was unlikely at this remove, though I resolved to try to change the hurly burly of my life. With family in tow (as Zorba the Greek would term it, “the full catastrophe”), I moved to work in a new community hospital. Another busy
decade passed when, nearing 20 years post-graduation, I thought I had figured out an appropriate final path to my zig-zag career. I was tired of call and tired of getting out of bed at night. Maybe it would be a grand idea to do more administrative work: there would be no call.

It happened. As a new medical director, I was soon embroiled in the maelstrom of health care reform in the province in the 90s. A torch job had been done on health care and health care budgets. In the ensuing rejigging of hospital programs, every attempt to crank up the wheel of efficiency had repercussions which were negative for patients, personnel and me.

An old saw reminds us that we learn more from our failures than our successes and this was true for me.

I soon found that my job as medical director was to make people do things they didn’t really want to do. I found I had no appetite for this and left medical administration in one of the spasms of organizational tumult that was characteristic of the time, but not before a brief stint working for the health ministry itself. The frenzy of the hospital was left behind here, but little attention was paid to clinical issues. Work proceeded at a glacial pace, reviewing policy and practice protocols that made little sense. Though relevance was hard to find, there was no call.

It was not enough. I was glad, glad, glad to return to practice for my swan-song years. To be sure in the interim, efficiency zealots had made clinical practice ever more onerous with this or that nutty rule or fiat, but they’d been unable to remove the satisfactions of clinical service. There was to be “call” again, the uphill battle for OR and clinic time, and the wariness of colleagues for a one-time bureaucrat. The surgical milieu had changed too, with minimally invasive surgical techniques at the fore, and with greater involvement of the university and its appetite for clinical funds and publications.

I was a homecoming of sorts and we can leave the story of my digressions there.

Back to Josh. If he wants to go into one of the surgical disciplines, he’ll need to consider the various issues of autonomy, money, job satisfaction, the demands of either academic practice or community practice and the physical rigors of the job.

He should spend as much time as possible with the surgical “tribe” so he can flesh out the pros and cons of surgical practice, whatever subspecialty. Manual dexterity, so commonly regarded by lay folk as essential, is pretty well a non-issue. The only folk I’ve known that probably shouldn’t be surgeons on this account were people who were too pokey, too disorganized and too distrusting of an anastomosis or a suture-line to ever know when things had best be left alone.

But I couldn’t answer Josh’s question about whether I’d do it all over again. On the one hand there are many things I’d appreciate a second time around, but given my trajectory thus far, and given a world of possibilities, I can’t say I’d do anything again.

An old saw reminds us that we learn more from our failures than our successes and this was true for me.
Are you prepared for the mobile health tsunami?

71% of millennials want apps to be prescribed and 66% of seniors want technology to access care from home

Kendall Ho, MD FRCPC | DIRECTOR, EHEALTH STRATEGY OFFICE, PROFESSOR, DEPARTMENT OF EMERGENCY MEDICINE, FACULTY OF MEDICINE, UNIVERSITY OF BRITISH COLUMBIA

It was a sunny morning in March and Dr. Kendall Ho, Director, eHealth Strategy Office at the Faculty of Medicine of the University of British Columbia stood before a room of Alberta Medical Association Representative Forum (RF) delegates. The audience listened avidly as the emergency medicine physician spoke vividly about the ways that technology - specifically the mobile phone and mobile technology - have revolutionized health and disease management.

Dr. Ho explained how mHealth (as he calls it) can increase patient engagement and yield better results for care. Alberta Doctors’ Digest invited him to reprise his key points in an article for the magazine. Read on to learn what he had to say.

mHealth is becoming popular for patients and public

How do you feel about patients downloading and using health apps on their mobile phones to improve their health and disease management? Like it or not, this is highly popular with patients of all ages. Two recent surveys speak to this important health trend. A 2015 survey of millennials suggests that 71% would like their health professionals to prescribe apps to them.¹ Another recent American survey of seniors over 65-years-old indicated that two in three people would want technology to access care from home, and self-care tools and wearables are two of the top five desires.²

Why is using mobile phones for health - or mHealth - so popular with patients and the general public? Much of this is because patients feel engaged and empowered to take control of their own health in unprecedented ways by:

- Being able to find scientific and reliable information about their own medical conditions through portals like MedlinePlus from the National Library of Medicine.³
- Having a community of patients with similar health conditions sharing tips to live healthier lives through websites such as PatientsLikeMe.⁴
- Having health apps to measure their own physiologic states such as free heart or sleep monitors or caloric counters.
- Having access to health professionals through videoconferencing from home or drug stores such as Walgreens in the United States of America.⁵

Mobile technologies and access to information passes the locus of control of health into patients’ hands so they not only discover ways themselves to improve their health conditions, but also become equal partners with health professionals...

mHealth: advantages and challenges

Mobile technologies and access to information passes the locus of control of health into patients’ hands so they not only discover ways themselves to improve their health conditions, but also become equal partners with health professionals, in line with the philosophy of “nothing about me without me.” In fact, in a Forbes article in 2012, engagement was declared as “the wonder drug of the century” as activated patients involved in their own health may receive health outcome improvement that frequently surpasses benefits of proven medications.

To be sure, there are potential and real downsides to patients using mHealth for their healthy pursuit and illness management. Legitimate issues include: are patients able to know and distinguish accurate...
information from rumors or promotional messages without proven evidence? Would patients decide to self-diagnose using these electronic resources to avoid seeking medical help? Would patients believe in the information they found online so strongly that they would not consider health professionals’ advice or suggestions that might be different from what they have found? Would seeking help online lead to patients shopping for answers from different groups and health professionals, thereby compromising the relationships they have with their own primary care physicians?

**Why is using mobile phones for health – or mHealth – so popular with patients and the general public?** Much of this is because patients feel engaged and empowered to take control of their own health in unprecedented ways.

**How should physicians participate in mHealth?**

When searching for online information or apps, our patients have three key concerns: are the information or apps that I find reliable? Appropriate for me? Safe for me? Physicians can play a pivotal role to partner with patients by answering these three questions in partnership with them. This way, we positively recognize their efforts to want to be actively engaged in their own health and disease management, and provide them with expertise that we can uniquely offer to them. Specifically, physicians can offer the DEPTH to support our patients on mHealth:

- **Discern** the information for trustworthiness, appropriateness and safety.
- **Experience** to assist our patients to apply the information for self-management.
- **Partner** with our patients to ensure appropriate usage.
- **Trial/experiment** with our patients to monitor their progress and safety.
- **Humility** to learn from our patients what they have uncovered and how we may use these electronic tools to help them and others.

With so much electronic information and so many health apps available, how can physicians keep up, in addition to learning from their patients? It would be ideal if physicians ourselves form a community of practice and share with each other what electronic tools we find useful and helpful for our patients.

At the University of British Columbia Faculty of Medicine eHealth Strategy Office, we have started a portal called “Health-e-Apps” (www.eHealth.med.ubc.ca), the intent of which is to share health apps for patients. Short YouTube videos of each health app are featured to explain how they can be used to support patient care, and comments and feedback are welcome from viewers to share their own thoughts and approaches. This is one example of how physicians can share and support each other to learn and grow in using e-resources to help our patients manage their own health and wellness.

**Patient – health professional partnership**

mHealth is a very promising approach to help our patients and support them in positive behaviors and disease management. Physicians can play a vital role in partnership with our patients to harness the power of electronic tools to support health and wellness. It would be both timely and exciting for physicians and patients to build upon our strong therapeutic relationships to attain the best of health through the realization of the full potential of this electronic medium.

References available upon request.

---

MedSleep is seeking part-time associate Respirologists, Internists, Psychiatrists, Neurologists or Family Physicians to join our growing medical team as we expand our services nationally. We currently have positions available in Edmonton, Vancouver, Nanaimo and Prince George.

Our clinics provide clinical assessment and diagnostic sleep studies (portable and in-house polysomnography) for the full spectrum of sleep disorders. Previous sleep medicine experience preferred, however, on-site training in sleep medicine can be provided. Low overhead with opportunity for both fee-for-service and additional third-party income.

Submit your CV to jobs@medsleep.com
Visit our website at www.medsleep.com
**Disruptive physician behavior** has been linked to decreased patient safety, increased malpractice liability and increased costs to the health care system.

**Dealing with disruptive physician behavior**

Can education and mediation really make a difference?

Joanne M. Todesco, MD FRCPC | UNIVERSITY OF CALGARY (RETIRED)
Elaine Seifert, QC, C. Med | UNIVERSITY OF CALGARY (ADJUNCT)

Disruptive physician behavior (DPB) was defined by the College of Physicians & Surgeons of Ontario (CPSO) in 2008 as follows:

“Disruptive behavior occurs when the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behavior interferes with, or is likely to interfere with, quality health care delivery.”

Other jurisdictions have adopted similar definitions, often expanding on the CPSO’s in that to be considered DPB, the behavior must be repetitive. It is useful to note that the problem is defined as a behavior, rather than a personal characteristic, and as such may be remediable. The CPSO was also careful to indicate that the behavior cannot simply be annoying or odd. Rather, it must interfere with the functioning of the health care team or the delivery of quality patient care, alluding to the workplace conflict that commonly coexists with DPB. Conflict is also subject to remediation.

DPB has been a topic of interest, particularly over the past decade, as complaints to various jurisdictions have increased, accompanied by a growing awareness of DPB’s impact. For example, DPB has been linked to decreased patient safety, increased malpractice liability and increased costs to the health care system. Our experience points to numerous other consequences including modelling of dysfunctional behavior by junior colleagues, poor morale and career disruption for the physician and co-workers. At the same time, although DPB is a serious problem with widespread impact, the percentage of physicians involved is relatively small. For example, an American study estimated that approximately 5% of American physicians exhibit DPB.

Currently DPB is managed through various complaints procedures overseen by faculties of medicine, health authorities and/or licensing bodies, depending upon where the complaint has been lodged. These institutions use stepped approaches characterized by increasing formality and consequences to the physician. At the extreme, a physician may lose their teaching privileges, faculty appointment and/or their license to practice medicine. A variety of affiliated resources are available to augment this policy-driven approach, mainly by providing assistance with the psychological, psychiatric and substance abuse problems that are not uncommonly found in this physician population. Management of DPB and measures of success have seen progress in some jurisdictions over the past decade, but there remains a level of dissatisfaction with our ability to offer definitive support to the complainants, teams and physicians exhibiting DPB, and repeated complaints about the same physician are not uncommon.

Based on the assumption that disruptive behavior and the resulting conflicts can be managed, principles of communication and conflict resolution may provide some new approaches. These principles suggest that after ensuring patient safety and any physician wellness issues are being addressed, the next step should be to address dysfunctional communication. While the physician exhibiting DPB will often be the focus, in many circumstances other individuals in the workplace should also be included. Successful educational techniques for communication skills include interactive didactic sessions, videotaping, role-play, teaching of scripts and/or team workshops, depending on context and specific details. However, experts are now telling us that dysfunctional communication cannot be addressed with information and workshops alone. The use of role-play and one-on-one shadowing and coaching in the workplace by another physician are new and critical components of education that may increase our success rates.

Education is a powerful tool for physicians due to requirements for ongoing professional education to maintain licensure. For Canadian physicians, these requirements are based on the CanMEDS framework, which places a high value on acquisition and maintenance of not >
Based on the assumption that disruptive behavior and the resulting conflicts can be managed, principles of communication and conflict resolution may provide some new approaches.

Personality type can be central to some DPB conflicts, particularly in the absence of self-awareness and when discordant or in competition with the personality type of a coworker. Therefore, in some cases, it is helpful to have the physician formally undergo Myers-Briggs personality testing and counselling separate from any group educational activities. Similarly, testing and counselling of the physician and others with regard to their preferred conflict handling style is often useful for building skills and awareness. Attention to nonverbal communication is also critical, particularly with respect to facial expression, kinesics and paralanguage, as it is often not the actual words spoken that result in a DPB complaint, but how those words are spoken.

“Face maintenance” is a major challenge for the physician who is the subject of a complaint, as physicians tend to maintain a self-impression of competence, leadership, caring, professionalism and prestige in accordance with their training and special status in society. Being the subject of a complaint is threatening to this face. It is therefore also important to address constructive face-maintenance and respect for face in others.

Why include mediation? As noted earlier, the definition of DPB implies conflict. Conflict can be defined as “a perceived divergence of interest, a belief that the parties’ current aspirations are incompatible.” In the case of DPB, the complainant(s) and the physician perceive that their interests cannot co-exist simultaneously. Both parties may believe that the other does not care about something that should be a shared aspiration, such as quality care, patient safety, efficiency, evidence-based medicine or cost-effectiveness. The current approach to DPB tends to focus on the physician, rather than the context and other parties, and seeks to bring about peace and behavioral change without any structured education and without any recognized form of dispute resolution, barring those few cases that end up in a court of law.

A combined educational/mediation approach cannot only settle current complaints but also provide the physician and others with new knowledge and skills to prevent and resolve conflicts in the long term. Other benefits of this approach include confidentiality, relative speed, flexibility and the ability of the parties to craft their own solutions and build a better relationship during the process.

Editor's note: The authors currently provide education and mediation services.

References available upon request.
Refusal of medical treatment
Does no mean no?

Patients who refuse medical treatment or leave a clinic or the hospital against medical advice can present a frustrating and confounding dilemma for physicians in all areas of practice. This issue becomes more complex when the patient has known mental health disorders or there are other questions regarding the capacity of the patient to make decisions about his or her medical care. In order to best serve these patients, it is important to be aware of and understand the delicate balance between preserving a patient’s autonomy and protecting a patient’s physical health.

Aside from the obvious potentially serious medical consequences for a patient who refuses medical care, there are also some significant legal concerns for physicians encountering these scenarios. Withholding medical treatment from a patient who is legally incapable of refusing medical care can lead to potential liability in negligence. Conversely, treating a patient who has not consented can result in the physician being liable in battery. Neither scenario is appealing, so what should a physician do to protect not only the patient’s best interests, but also to protect against possible legal action? Although there is no ironclad method to ascertain whether or not a patient has the capacity to refuse medical treatment, there are legally established steps which can assist medical practitioners in making the best decision possible for all parties involved.

In essence, the same procedures that are in place for obtaining an informed consent should be employed for obtaining an informed refusal. In order for a consent to be considered legally valid, it must be voluntary, given by a patient who has capacity, encompass both the treatment and the practitioner who will administer the treatment, and be given by a patient who is informed.1

Of these, one of the more complex elements is that of capacity. In general, the capacity to make decisions about treatment revolves around the patient’s ability to fully appreciate the realities and repercussions of their decision.2 Patients who refuse medically necessary treatment cannot be determined to lack capacity based on this reason alone. In fact, Canadian courts have repeatedly upheld a patient’s right to refuse medical treatment, even when it is apparent that the treatment is necessary or beneficial to the patient.3

Aside from the obvious potentially serious medical consequences for a patient who refuses medical care, there are also some significant legal concerns for physicians encountering these scenarios.

A key factor to keep in mind when assessing a patient’s capacity is to understand that this test is a functional one that focuses on whether or not a patient understands the particular treatment that is being proposed at the time.4 In some cases, the episode of incapacity can be transient in nature, and therefore may need to be re-evaluated on an ongoing basis. In order to ensure that a patient’s capacity is being assessed appropriately, it may be prudent to request a second opinion of a colleague, legal counsel or that of a clinical ethicist. As in most areas of medical practice, documentation should be thorough and concise. A physician should ensure that he or she has documented which capacity tests have been performed, any second opinions obtained and any other factors a physician believes are important to determining the patient’s capacity.5
Withholding medical treatment from a patient who is legally incapable of refusing medical care can lead to potential liability in negligence. Conversely, treating a patient who has not consented can result in the physician being liable in battery.

Another complicating factor can be the age of the patient. In situations where the patient is deemed to be too young to be making decisions regarding withholding of care, the physician must turn to the guardian, usually a parent. However, there are many documented cases of the guardian’s decision being questioned as not being in the best interests of the child which, unfortunately, typically places the matter in the hands of the courts.

Dealing with patients who refuse medical care or leave hospitals against medical advice can leave practitioners feeling as though they have failed their patients. Although there is no miracle cure for resolving these scenarios, there can perhaps be some comfort taken in the words of Justice Robins in *Malette v. Shulman*:

“people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others.”

References available upon request.

Your voice matters. Visit [albertapatients.ca](http://albertapatients.ca) To share your thoughts about health care through an online community forum

CUMMING SCHOOL OF MEDICINE
Office of Continuing Medical Education and Professional Development

Explore our professional development courses and conferences

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCTOBER 19, 2015</td>
<td>Chronic Pain Management for the Family Physician – A Mainpro-C Course</td>
</tr>
<tr>
<td>OCTOBER 23, 2015</td>
<td>Current Obstetrical Management Seminars</td>
</tr>
<tr>
<td>NOVEMBER 2, 2015</td>
<td>Friday at the Medical School: Allergy</td>
</tr>
<tr>
<td>NOVEMBER 6, 2015</td>
<td>JANUARY 15, 2016 Advanced Communication Skills in Medicine</td>
</tr>
<tr>
<td>NOVEMBER 16-19, 2015</td>
<td>40th Annual Pearls for Practice – Family Practice Update and Review Course</td>
</tr>
<tr>
<td>NOVEMBER 20, 2015</td>
<td>Exercise Prescription in Clinical Practice (Family Practice Review and Update Post Course) – A Mainpro-C &amp; MOC Section 3 Course</td>
</tr>
<tr>
<td>DECEMBER 11, 2015</td>
<td>Friday at the Medical School: Choosing Wisely</td>
</tr>
</tbody>
</table>

To Register [cumming.ucalgary.ca/cme](http://cumming.ucalgary.ca/cme)

All inquiries please contact

Elaine Chow-Baker
Acting Director
Continuing Medical Education & Professional Development
Cumming School of Medicine
University of Calgary
eachow@ucalgary.ca
403.220.4251
Ensuring the confidentiality of patient information in your medical practice is your responsibility as defined by the Alberta Health Information Act (HIA). Despite the media sensation about computer hacking, the most frequent source of disclosure of personal information comes from errors made by people working in your medical practice and it is your responsibility to protect against such disclosures.

What are the top three administrative safeguards that my clinic should have in place to ensure that my employees are able to maintain confidentiality?

Below are three tools to help you strengthen your current efforts to protect the privacy of your patients. If you already have some of these tools in place, it might be a good time to update or refresh. The Practice Management Program (PMP) can offer support and/or advice. For a comprehensive approach to privacy, confidentiality and data security you should consult the guide book from the Office of the Information and Privacy Commissioner of Alberta (A Practical Guide to the Health Information Act).

http://www.oipc.ab.ca/Content_Files/Files/Publications/HIA_Guide_August_2010.pdf

Training and education sessions for staff

Plan and hold regular lunch and learn sessions with staff and physicians on privacy and security and use topics such as those in the training scenarios that are available from PMP. An example of a training scenario is listed below and is meant to be used in an open discussion with all staff, physicians and other members of your team.

Sample scenario 1: Responding to family requests for information

Setting: A teenager’s mother has called in, concerned that her daughter is pregnant. She asks Jillian, the station attendant, for information about her daughter’s condition over the phone.

Mother: Hello, I am Coco Smith’s mother. She and I have been having some problems lately, and I am concerned that she is pregnant, but she won’t talk to me. I know that she has been in to see Dr. Jones recently, and I want you to tell me what the appointment was about and whether she is pregnant.

Jillian: Hello Mrs. Smith. While I understand that you are concerned about your daughter’s wellbeing, unfortunately privacy laws do not allow me to release information about your daughter to you without her written consent. I understand that this is not the answer you were hoping for and that you would want me to protect your health information if someone were to call with a similar request.

Discussion points may include, but are not limited to:

- Parents don’t have an automatic right to children’s information unless the child is too young to understand the nature of the rights and powers created by the act.
- Disclosure in general terms is allowed to family members but only if the patient has not expressly requested that it not be made.

Signing an oath of confidentiality

All new employees should sign a statement of confidentiality that acknowledges their commitment and understanding of your expectations for privacy of patient information. Signed statements of confidentiality should also be obtained for any staff, volunteers, contractors and/or students, and this also includes staff from your own primary care network (PCN). PCN staff may have signed an Oath of Confidentiality at the PCN, however, that is not sufficient for your private clinic. These signed statements or “oaths of confidentiality” are a strong tool for reinforcing your expectations. A copy of the signed statement should be given to the employee and a copy kept in the employee-specific file in your office to be refreshed and signed annually. To request a template of “Confidentiality Oath for Physician Office Employees,” please contact PMP staff.
Also see the College of Physicians & Surgeons of Alberta website for their Ethics 101 topic: “Maintain confidentiality in a small community” for suggestions on how to run a session about a breach in confidentiality. http://www cpsa.ab.ca/resources/ethics_101/Ethics_101_Archives.aspx

Clear and concise written policies about privacy and security

Your expectations of staff for ensuring confidentiality should be written down in a policy manual and those policies should apply to all clinic physicians and staff including contractors, students and volunteers providing services on behalf of the clinic. It should be relevant to all information regardless of format, and include all facilities and equipment required to collect, manipulate, transport, transmit or maintain the information.

Your clinic privacy and security manual must include the following key principles:

1. Protecting against unauthorized use, disclosure, modification or access to information.
2. Patients have a right to access information about themselves.
3. Patients who believe there is an error or omission in their health information have a right to request to correct or amend the information.
4. Patients must be informed of the purpose and authority for the collecting information.
5. The least amount of health information necessary is collected, used and disclosed.
6. Information is collected, used and disclosed at the highest level of anonymity.
7. Patients have the right to request that the Alberta Information and Privacy Commissioner review access or privacy and correct decisions made respecting their information.
8. Failure to comply with these policies may result in disciplinary action and termination of employment.
9. Individuals may be subject to prosecution for the contravention of any law; and physicians of the practice must adhere to the Canadian Medical Association Code of Ethics, including their fundamental responsibility to protect patient privacy.

For a template manual that was created in Alberta for you to customize for your clinic, please contact PMP staff.

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 780.733.3632.
Last issue I provided the results of our recent insurance survey which showed very high member satisfaction with our insurance products and services. We also heard from a number of members about the limited prescription drug and dental coverage under our Alberta Medical Association Health Benefits Trust Fund (AMA HBTF) “Core Plan” through Alberta Blue Cross. This is a message we have consistently received since the inception of AMA HBTF in 2000. With this issue of Insurance Insights, I am pleased to provide an explanation.

It is important first to highlight the fact that AMA HBTF is funded solely through the contributions of the member participants and the plan is voluntary. Conversely, in employer-sponsored plans (e.g., Alberta Health Services, university academic plans) the employer pays at least 50% of the premium and participation is mandatory (unless the employee has other coverage). This combination of employer funding and a spread of risk among all employees allows these plans to have much more generous plan designs.

The AMA has had a long history of providing voluntary extended health care and dental programs for our members. When I started with the AMA 23 years ago, we had a very rich Alberta Blue Cross program that had to be wound-down due to high premiums and low enrolment. We went back to the drawing board and developed a program with Aetna Canada (later Maritime Life) that offered both basic and enhanced health care and dental coverage that members could choose from. The basic coverage offered up to $15,000 per year of extended health care coverage (including prescription drugs) and the comprehensive plan offered up to $50,000 per year (including prescription drugs).

Both the basic and comprehensive plans still commanded premiums that were considered too high for many members, particularly those that did not have the need for this coverage. After offering the plan for several years, we were still only able to achieve an enrolment of approximately 450 members. This plan design also was not going to be feasible over the long term.

In 2000, following changes to the Income Tax Act that allowed sole proprietors to deduct the cost of health insurance plans as a business expense; we went back to the drawing board again and launched the AMA HBTF.

The AMA HBTF Core Plan provides very basic coverage but premiums low enough to be attractive to a larger number of members (i.e., spread of risk), along with an optional Cost-Plus Plan that allows the incorporated or sole proprietor member to claim excess medical expenses (above what the Core Plan covers) as a business expense. If you are in the top marginal tax rate in Alberta, you save approximately $600 in income tax for every $1,000 of medical expenses. And because it’s self-insured, the Cost-Plus Plan has no premiums, only a small $25 administration fee (AMA administered) which is extraordinarily competitive compared to other Cost-Plus plans in the marketplace. The Core Plan premiums are also an eligible medical expense and can be claimed on their own or on a Cost-Plus Plan claim.

In the fall of 2000, 940 members enrolled in the new plan, more than doubling the enrolment of the previous plan. Today we have over 3,100 participants on AMA HBTF, 2,800 of which are members with the balance being clinic staff.

Beginning with our September 1, 2015 renewal, we have increased our Core Plan prescription drug and dental maximums to $750 per year per person (from $600). We have also added CPAP machines to the coverage ($1,500 over a five-year period). This is in addition to our existing extended health care coverage that includes hospital, paramedical providers, ambulance, etc., plus our Out of Province Emergency Travel coverage that provides...
$5,000,000 of coverage per person, for any trip up to 60 days out of the member’s home province.

Members that require prescription drug coverage in excess of what is offered under the AMA H8TF Core Plan may consider the Alberta Government’s Non-Group Coverage, which is available to all Albertans at a reasonable cost. A bonus is that the premiums for this plan are eligible as a medical expense under the Cost-Plus Plan.

We thank all of our members for their continued participation and support of AMA H8TF.

If you are not currently enrolled and are looking for a competitive benefit plan for you (and your employees, if applicable) please contact our office or visit our website. Our annual open enrolment is now open until October 31.

Congratulations Sun Life Financial!

AMA congratulates Sun Life Financial on its 150th anniversary. We’re proud to call this long-standing Canadian company a partner for over 20 years.

We look forward to continuing our partnership with a company that understands the unique insurance needs of physicians.

Ann Dawrant

“Please call me to experience the dedicated, knowledgeable, and caring service that I provide to all my clients.”

RE/MAX Real Estate Centre
780-438-7000 - office
780-940-6485 - cell

- Consistently in top 5% of Edmonton realtors
- Prestigious RE/MAX Platinum Club
- 29 years as a successful residential realtor in west and southwest Edmonton
- Born and raised in Buenos Aires and has lived in Edmonton since 1967
- Bilingual in English and Spanish

Ann Dawrant

Website
www.anndawrant.com
E-mail
anndawrant@shaw.ca

• Consistently in top 5% of Edmonton realtors
• Prestigious RE/MAX Platinum Club
• 29 years as a successful residential realtor in west and southwest Edmonton
• Born and raised in Buenos Aires and has lived in Edmonton since 1967
• Bilingual in English and Spanish

EFW Radiology
Specialists In Diagnostic Imaging
RADIOLOGY AND NUCLEAR MEDICINE PHYSICIAN EMPLOYMENT OPPORTUNITY CALGARY, ALBERTA

Are you a Radiologist and Nuclear Medicine Physician who is committed to excellence in patient care, dedicated to practicing evidence-based medicine, and passionate about providing education to future care givers? A career with EFW Radiology may be for you.

EFW Radiology is a large growing practice currently seeking a full-time dual certified Radiology and Nuclear Medicine physician to join our team. Eligible candidates must be a Certified Fellow of the Royal College of Physicians and Surgeons of Canada in both Diagnostic Radiology and Nuclear Medicine, and should have training and experience in the supervision and interpretation of PET/CT exams. Candidates must be eligible for registration with the College of Physicians and Surgeons of Alberta and be legally entitled to work in Canada.

EFW Radiology is a Calgary, Alberta group of over 60 physicians which consists of radiologists, perinatologists, and physiatrists; providing services to the Foothills Medical Centre, Tom Baker Cancer Centre, South Health Campus, and Calgary and Airdrie communities. We perform over 600,000 examinations annually with a balance between community and hospital work. We pride ourselves on providing compassionate care, working to earn the trust of referring clinicians and patients, and offering meaningful career opportunities.

The successful candidate will join seven other dual certified physicians practicing all areas of Nuclear Medicine including PET/CT. This is a partnership track position offering long term job security potential to the right candidate.

Compensation is competitive and commensurate with training and experience.

If you are interested in exploring career opportunities available with EFW Radiology please submit a letter of intent and curriculum vitae to:

Helen Lemieux
Director of Human Resources
Email: physicianrecruitment@efwrad.com
www.efwrad.com
Physicians and health care leaders from across the province teed off on July 6 at the Red Deer Golf & Country Club to support Alberta’s next generation of physicians.

The 88th Annual North/South Doctors’ Golf Tournament, co-hosted by the College of Physicians & Surgeons of Alberta (CPSA), Alberta Medical Association (AMA) and the Canadian Medical Foundation raised over $50,000 for medical student bursaries – the largest amount raised in the tournament’s history.

Participants enjoyed a sunny day of golf, buffet breakfast, BBQ lunch and great prize draws. Medical students and residents also attended and teamed up with CPSA and AMA staff to network and connect with their colleagues.

Thank you to all participants and sponsors for making this year’s tournament a success. See you on the links in 2016!
I wanted to be a doctor for as long as I can remember. The challenge of constantly learning new things, the thrill of making a critical and timely diagnosis, the satisfaction of resolving a difficult situation, the adrenaline rushes and the privilege of being invited into someone's personal life were expectations that have been and continue to be fulfilled. The life of medicine continues to be, for me, a rewarding and fulfilling experience. I did not, however, imagine the difficulty and frustration involved in the business side of medicine, in particular, billing.

The billing process, while seemingly mundane and sometimes complex, is an essential and necessary part of practicing medicine. I learned early in my practice that a good billing clerk was worth several times the salary offered. I also learned that in order to be adequately compensated for the long hours I was spending away from my family, I needed to have some knowledge of billing codes, since only I knew exactly what I had done along with how, when and where it happened.

Until recently, the tools to learn how to accurately and honestly bill for time spent included the following:

1. Alberta Health’s Schedule of Medical Benefits (SOMB) (http://www.health.alberta.ca/professionals/SOMB.html): This resource contains five (yes, five!) different documents including the Medical Benefits Price List, the Medical Benefits Procedure List, Medical Governing Rules, Explanatory Codes and Fee Modifier Definitions. Some of these resources are hundreds of pages in length and refer to the other documents, with no direct links. Searching, while greatly improved with the searchable PDF format, is hampered by some non-intuitive and repetitive procedure descriptions. This resource changes at least once a year as fees are added, changed and modified.

2. Alberta Medical Association’s (AMA) Mini-Fee Schedule: This print resource, available to order by all physicians, is a condensed version of the SOMB highlighting the most common billing codes.


The AMA Fee Navigator (https://www.albertadoctors.org/fee-navigator), a tool to consolidate all of these resources, was developed.

The AMA Fee Navigator allows the user to “quickly find all associated governing rules, prices and fee modifiers combined with expert advice developed by the AMA.” This mobile-friendly website allows 24/7 open access using any device connected to the Internet. The search capability is consolidated into a single entry which provides a quick preview, allowing accurate results despite the naming idiosyncrasies of the SOMB. For example, if one types in ‘counselling’ spelled with two ‘l’’s, billing code 08.19G will not be displayed as an option as it is spelled with one ‘l’.

The live search bar preview suggestions will include
08.19G as one enters in each character, resolving this issue. The preview suggestions also contain enough characters to differentiate billing codes, allowing for quick selection of the appropriate procedure.

Once a procedure is selected, the user is presented with the SOMB, taxonomy and description as well as AMA billing tips, fee modifiers and governing rules, if any, pertaining to that fee code. Definitions of important terms are provided in a convenient, non-intrusive fashion. I found this format very useful in selecting the correct billing code for common procedures as well as other important information. For example, I found that the best code for billing an excisional biopsy of the skin would be 98.12A (rather than 98.12M) as it is in category M+, allowing the addition of an office visit code for the same diagnosis, increasing the amount I should be billing significantly. Billing tips can also be particularly helpful for making informed, quick decisions.

I learned early in my practice that a good billing clerk was worth several times the salary offered.

The website is optimized to work well on smartphones and tablets, and my experience on these devices was very positive. I have added bookmarks on my desktop on both devices to allow for rapid access to this tool. Internet access is required for this functionality, limiting some of the tool’s usefulness. Overall the Fee Navigator is a significant improvement over previous offerings that I’m sure will improve the billing practices of most physicians and their staff.

App spotlight:

The Family Practice Notebook app (www.fpnotebook.com) is a scaled-down version of the Family Practice Notebook website, authored by Minnesota family physician Dr. Scott Moses, available on your mobile device for free. A small subscription will insure you have the latest data, but those on a budget will find the free version very useful. It contains over 600 topics within more than 700 chapters and 31 subspecialty books, providing referenced approaches to many different medical problems which will be particularly helpful to learners or those new to medical practice. An Internet connection gives access to images, sounds, worksheets, patient education materials and links to other sites. 

“MCI takes care of everything so I can take care of my patients.”

- No financial investment
- Flexible hours and 29 locations
- Trained, professional staff
- Family practice or walk-in
- EMR

With close to 30 years of experience, MCI manages 29 family medicine clinics in the Toronto and Calgary areas and we care for 1,000,000 patients a year.

JOIN OUR TEAM
1.866.624.8222 ext. 133
practice@mcimed.com
www.mcithedoctorsoffice.com

MCI Medical Clinics Inc.
Toronto – Calgary
A division of Altima Healthcare

Flu prevention
services
CO-OP
Pharmacy
From the summits of medical school acceptance, graduation, and the handshakes of gratitude from patients and their families, to the valleys of despair from rejected applications, discussing terminal diagnoses, disclosing medical errors and reaching the limit of medical care, the physician experience is a long, always eventful, and sometimes serpentine journey.

Some challenges are universal – there will always be more patients to see than appointments available in the workday, more papers to read than hours of downtime and more pro-active, preventative advice to discuss than minutes in a consultation.

There are details, however, that from a distance are easy to overlook unless one is conducting the journey. Like the parallel lines of a railway, one would expect any train to be able to universally travel along them. This is not the case as the gauge (distance between rails) varies in different regions of the world. Much like railway routes, the path to licensure and practice includes economic gorges to bridge, unfamiliar geography to cover and bureaucratic morasses to wade through. Nevertheless, according to the College of Physicians & Surgeons of Alberta (CPSA) more than 30% of the physicians currently licensed in Alberta are international medical graduates (IMGs). In the last quarter of 2014, the CPSA recorded 9,254 licensed physicians. Of these, 78 had graduated in the United States of America (USA) and 2,988 were non-USA, non-Canadian graduates. IMGs form a substantial cohort in the Albertan workforce.

I am part of the South African medical diaspora currently practicing in Canada. I am fortunate that, unlike some IMGs, my prior training was recognized and was able to pursue independent practice soon after landing in Canada.

The uncertainties and anxieties of independent practice are universal regardless of whether one is trained locally or not. Certain elements though, are magnified if one is unfamiliar and there are issues that particularly affect IMGs.

Multiple domains overlap

The newly entrusted responsibility, clinical duties, juggling with work-life balance and financial obligations can be onerous for all new physicians entering independent practices. However, there may be local, social, professional and personal norms that can easily be overlooked for those who have grown up in Canada, but whose ignorance or denial can result in incremental distress for newcomers to the workplace.

I am part of the South African medical diaspora currently practicing in Canada. I am fortunate that, unlike some IMGs, my prior training was recognized and was able to pursue independent practice soon after landing in Canada.
Council of Canada evaluating exam prior to being eligible for the restricted CPSA register. Applicants are then able to apply to job vacancies.

Potential job offers may literally have to be assessed on the other side of the globe as it may not be practical to physically visit the various sites. It may not be possible to assess important variables like ergonomic work spaces, compatible assistant staff and intercollegial harmony.

Having jumped those hurdles and potentially accepted a position unseen, a pre-practice, unpaid assessment for three months or more needs to be satisfactorily completed. Steps need to be completed in sequence, with lag processing times between them. All of these steps impose a financial and logistic burden.

Having successfully obtained CPSA licensure, as with local graduates, IMGs need to quickly grasp the local scope of practice, standards of care and referral patterns. However, ingrained practices like outpatient intravenous antibiotics and commonplace resources like home-care may be totally unfamiliar. Practice basics like differing drug trade names, different pharmacologic agents and new antibiotic sensitivity spectra all need to be brought on board. One quickly learns that paracetamol is indeed available in Canada … but it’s not called that!

Personal domain

Complicating this learning cliff of academic and professional administration are the residency demands of Immigration Canada. Between immigration medicals, labor market opinions, resolving outstanding “exit” country tax, legal and medical obligations, repeated consular visits, exclusive and non-exclusive federal and provincial programs, it is no surprise that some IMGs turn to physician recruitment agencies to assist in their transition.

Recruitment agencies are intended to be the bridge that links physicians with communities in need of the physician’s services. At its most fundamental, the agency receives remuneration for successful recruitment at a given community. In return it assists a physician in navigating the professional and immigration requirements. However, if the agency is remunerated only on successful recruitment and not on prolonged and successful retention, there is a potential conflict of interest between finding a good fit for the physician and the desire for the agency to have them sign on. It is much easier to disproportionately inflate the good and underplay the bad when a potential recruit is 10,000 kilometers away, is unfamiliar with prevailing employment patterns and has no opportunity to personally assess the situation.

While professional fulfillment is important, just as important is extra-professional contentment. This can be particularly challenging for IMG physicians and their families. Having immigrated, they will have physically severed ties with long-term friends and family. In addition, family may literally be on the other side of the world and something as simple as a phone call becomes complicated by differing time zones. Even if family are in North America, practice demands may make physical visits less frequent than desired.

While all this is happening, there is the reality of an uprooted spouse and family. They too will have sacrificed old physical, emotional and social ties for the new life. Having given up many long-term social ties, family support may be literally thousands of miles away – and unable to babysit!
Amongst all this upheaval, the IMG and his or her family have to go about the business of trying to live in the new environment.

Accessing funds and opening a bank account can be difficult without a fixed address. Driving road tests may need to be redone. Health insurance, easily overlooked by locals, needs to be actively acquired. Successful navigation of the new environment will be aided by integration into the local community. However, without prior links, IMGs have this bridge to cross as well.

Resources are available

There are numerous resources that can assist in these many and interrelated fields. Professional colleagues and regular clinically related debriefings are invaluable in dealing with the daily professional grind. Compatriots who have immigrated earlier are very useful in providing assistance from the perspective of a non-Canadian. Professional help can be accessed both in rural and urban settings. The Alberta Medical Association Physician and Family Support Program (PFSP) and the Alberta Health Services (AHS) Employee and Family Assistance Program both have varied and overlapping mandates to assist doctors in Alberta and their families.

IMGs form a large proportion of the Alberta physician workforce. Despite many of the described challenges, many have settled in and continue to happily live and work here. The challenges are multidimensional, interlinked and concurrent. Failure to successfully navigate some of the many potential stumbling blocks has the potential to derail the physician, his or her patients, other professionals and the immediate social circle of the physician. Nevertheless, much like the endeavor to establish the Canadian Pacific Railway, despite the many metaphorical canyons and ravines, A Mari Usque Ad Mare, the richness yielded makes me delighted to stake my social, cultural and professional future in Canada.

Take home messages

1. The three domains (medical, community and personal) all interact to mitigate and exacerbate the challenges of a new IMG to Canadian practice.
2. Both the IMG and the incumbent, established physicians in the community may be unaware of or under-appreciate some of the challenges faced by the new recruit.
3. Neglected noxious challenges, like adapting to a new “home” and dealing with reams of professional and immigration administration, can have negative impacts not only on the physician but also on his or her social eco-system.
4. PFSP and AHS have resources to assist. There is no shame in asking for help.

References available upon request.

International medical graduates sacrifice old physical, emotional and social ties for a new life, often in rural Alberta. (provided by Dr. Vincent M. Hanlon)
DESIGNED TO UNCOMPROMISING STANDARDS.

We’d like to welcome Homes by Avi and Augusta Fine Homes to our curated collection of award-winning builders. Each reflects the same commitment to craftsmanship and design that is fundamental at Artesia — where the real luxury is the way in which you’ll live.

Monday – Thursday: Noon – 6pm
Fridays, Weekends & Holidays: Noon – 5pm

liveatartesia.com
Mental illness is becoming an increasingly important issue in low and middle income countries. Historically, health funding has been focused on treating communicable diseases due to their extensive morbidity and mortality. However, with advancements in communicable disease treatment and improved standards of living over the last several decades, non-communicable diseases – including mental illness – are gaining in importance.

According to the 2004 Revised World Health Report, mental health disorders accounted for 13% of the disability-associated life years globally. The financial loss attributed to mental health disorders is estimated to reach $16.3 million USA in the years between 2011 and 2030. The available research attests to the fact that not only does the individual benefit from appropriate mental health care, so do the local and global populations.

A new initiative from the University of Calgary (U of C) Global Health Office aims to address this issue. The Global Mental Health Project is a partnership between the U of C’s Department of Psychiatry and the Catholic University of Health and Allied Sciences (CUHAS) in Mwanza, Tanzania. There are many challenges in addressing the growing concern of mental illness in Tanzania, including limited investment in mental health capacity and fragmented care, with fewer than 20 psychiatrists and few dedicated mental health nurses serving a population of 51 million. Although the challenges are great, the need to address this growing burden of disease is undeniable.

Advocacy is a very important component of residency, and projects such as the Global Mental Health Project help residents incorporate advocacy into their training.

In April, as first and second year psychiatry residents, we accompanied psychiatrist Dr. Kathy A. Fitch to Mwanza to begin our collaborative project with CUHAS. Our Tanzania partners, identifying gaps in both their Undergraduate Medical Education (UME) programs and Masters of Public Health (MPH) training within the field of mental health, asked the U of C to help address this gap by developing content and strategies for integrating into their current curriculums. During our two-week trip, we completed a needs assessment of the current education within their MPH and UME programs; met with key stakeholders, medical students and graduate students to collect both qualitative and quantitative data about their mental illness education; and delivered a three-day trial curriculum to the MPH students. We found that there was a large education need identified by both learners and stakeholders alike. Understanding mental illness and the stigma around it were identified as areas deserving significant attention.

The quality improvement project found that mental illness in Tanzania is described as a “sickness of the brain,” which impairs an individual’s ability to behave, think and function normally within society. It is viewed as a “great misfortune or a curse” to both the patient and their family. Both the individual and the family are stigmatized. As Tanzanians don’t see those people as normal people contributing to society, it is apparent that advocacy needs to be an important part of any curriculum being developed to help reduce the stigma surrounding mental illness.
These findings will be used as a basis for a collaborative project to improve the current medical school curriculum around psychiatry.

> (a)s health advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health.

Advocacy is a very important component of residency, and projects such as the Global Mental Health Project help residents incorporate advocacy into their training. The Royal College notes that “(a)s health advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when needed, and support the mobilization of resources to effect change.”

This project allowed us to not only improve our own advocacy skills, but also help to expand advocacy and mental illness education with our partners in Tanzania.

The U of C’s Department of Psychiatry has been extremely generous in financially supporting the Global Mental Health Project. We hope that this project will extend into the future, as both the MPH and UME programs grow and as opportunities for further enrichment of Calgary resident training expand. We also recognize the importance of supporting future local leaders in psychiatry at CUHAS and have initiated scholarship funding for local students specializing in psychiatry who are committed to coming back and practicing at CUHAS. Funds provided to these organizations stretch surprisingly far in supporting the growth of medical practitioners, psychiatrists and MPH graduates better trained in meeting their population’s mental health needs.

If you are interested in donating to the Global Mental Health Project, please visit: https://netcommunity.ucalgary.ca/globalmentalhealthproject.

References available upon request.

---

**INTERNATIONAL MOTOR CARS**

Are you looking to lease or purchase a new or pre-owned vehicle?

- No hassles.
- Finance and lease plans available.
- All makes offered.
- We will take your existing vehicle in trade.
- No shopping dealership to dealership.
- Delivery available to your hometown.

“Let my 43 years of Auto Experience and Fleet Connections work for you. I will save you time and provide a no pressure quote on any vehicle.”

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 hassle free.

Call: 1.888.311.3832 or 403.262.2222
Email: mdbaker@shaw.ca
Visit: www.imncars.ca
MANY REFERENCES AVAILABLE
Moins de risque d’erreur.
Meilleure compréhension.
Plus grande satisfaction soignant – patient.

Pour en savoir plus :
soignerenfrancais.ca

Fewer medical errors.
Better understanding all-around.
Greater satisfaction for patient – practitioner.

Learn more:
languagematterstoo.ca

My interest had been piqued by the “dead on arrival” verdict of the gloomy, Tory-hating Jeffrey Simpson, an armchair health care critic and columnist in the Globe and Mail; and the humorless André Picard, another Globe and Mail columnist and armchair expert who wrote: “it is loaded with stinging truths ... (such as) Medicare is aging badly and a major renovation is overdue.”

“Canadian health care is headed for a slow decline in performance relative to peers.” This opinion is re-worded and repeated like a doomsday bell. There is a wringing of hands in the report as a result of dodgy international comparisons where Canada has dropped in the league tables in things like seeing your general practitioner within 24 hours.

Are things that bad? No, but this report should be read by all who plan to practice medicine for the next 10 years in Canada. Well-written, though repetitive, it reviews health care in Canada with 59 recommendations, many of which are already in place here in Alberta.

The Federal Health Minister, Rona Ambrose, in commissioning it, had stipulated that the panel should come through with five priority areas for innovation/improvement – preferably revenue neutral. Well, she got more than she bargained for and the report has been mothballed until after the October 19 federal election – but it shines an uncomfortable light on a hard road ahead. Whoever forms the next government will likely take this comprehensive report as a guide. Be prepared to agree with some of the conclusions, treat others with skepticism, and be uncomfortable at others which could affect your life and practice.

Mind you, we had another “Unleashing Innovation” report in 2005, an Alberta-led effort, where most of the unleashers were a good bit more than arm’s length from the bedside. All the same topics as in the Naylor Report were there: putting patients first, looking at the best systems globally, safety, funding, more technology, etc. This led to Ralph’s “third way” which fell by the third way-side.

There is a wringing of hands in the report as a result of dodgy international comparisons where Canada has dropped in the league tables in things like seeing your general practitioner within 24 hours.

So, who wrote this one? Well, we all knew and respected the late Dr. Cy Frank, a teacher and innovator who was never too far from the bedside. The others were the Chair, Dr. David Naylor, an internist and administrator who is now some years away from the bedside; Francine Girard, Dean of the Faculty of Nursing, University of Montreal (a former director of nursing in the old Calgary Health Region); Neil Fraser, a businessman and president of Medtronic; Ms Toby Jenkins, a health policy theorist and multiple board member; Christine Power, a scientist and expert in drug discovery and processing (and with a name like Power she must be from the east coast); and finally, University of Calgary economist and director of Imperial Oil, Jack (“8,000 jobs lost for every 1% rise in Corporate Tax”) Mintz.

Sadly, nowhere mentioned in this report is the mother of all innovations: improving efficiency and patient care through competition. Is this now taboo?
And let me (as your resident skeptic) also confess some personal, deeply held prejudices:

First, there will never be a complete “seamless system” as the La-Z-Boy experts would like to think. The “system” is a diverse group of human beings, teams and practices with differing training, skills and background, all trying their best to deal with endless challenges. This doesn’t mean that incentives cannot be modified to align with objectives.

Second, it doesn’t matter how efficient, effective, safe and patient-centered any “system” is, there will always be bitter complaints coming in about something or other. Medical practice is bottomless; there will never be enough time or resources to satisfy everyone. In Canada, those demanding more time steal time from the less-demanding patients.

Third, passively doing everything patients and their families want is not good medical care and doing that may work against the Alberta Medical Association’s (AMA’s) Choosing Wisely campaign.

Fourth, hello, presidents, vice-presidents, CEO’s and CFO’s – health care in Canada is not a “business” – unlike the United States of America (USA). There is no sustainable “business model” where services are given out “free.” You are “health service administrators.” The clever patient, doctor, nurse, administrator or whoever learns quickly how to work the “system.”

Fifth, attempts at international comparisons of health care statistics are mischievous and misleading since the definitions, incentives and ground rules differ.

So how do you successfully innovate? For me, a good example was the conversion from film to online X-ray images. Hanging around the radiology department for a hassled assistant to find the films for viewing used to eat big time into one’s clinic. Online viewing was taken up like a box of Tim Hortons doughnuts in the clinic. It was the ideal innovation: financially good and medically satisfying for clinic staff, better care for patients.

For a new drug, the path is clear but complex: innovative lab work and big financing, then through a maze of regulatory approvals and clinical trials, then to cajoling clinicians to prescribe it and provincial payers to stump up for it. You can then retire to the West Indies after being bought out by big pharma before your drug is found to be more toxic and less effective than you thought.

But if you have an administrative idea, the path is less complex but harder. Most of the recommendations in the Naylor Report are administrative, for example, increasing the scope of practice for non-physician professionals.

Take that perennial chestnut: that nurse practitioners can do 70% of the work of a family doctor or specialist without any deleterious outcomes. I can do 70% of the work of a family doctor – and a family doctor could do 70% of what I do – but which 70%? Nurse practitioners are already working in Alberta within primary care networks (PCNs) and the cancer and other programs (at varying levels of complexity but at comparable pay levels to doctors doing the same work) without any noticeable reduction in my workload. In medicine, “work expands to meet the time available.”

And what’s the incentive to make waves? There is this internal paradox: I know where costs can be saved but why should I make waves pointing out these areas? In a highly unionized setting such as Canadian health care, there is nothing but grief for rocking the boat. So armchair experts shout from the side and committees make reports such as the Naylor Report – and nothing much changes. Let’s look at the report in more detail:

There are five thematic recommendations, most political/administrative, none cost-neutral!

1. Patient “engagement” and “empowerment”

These buzzwords tend to produce a rolling of the eyes but hide some decent suggestions – although the traditional role of the general practitioner as a gatekeeper might be breached in keeping a proportion of the patient population happy (i.e., those who are articulate, educated and want in on decision making).

“Canada’s physicians have made huge contributions to health care, but the current mode of organizing and funding health care is holding them back from a larger leadership role.”

The feds are to support large projects of “patient-centered” financing. This will likely entail alternative payment plans. This works fairly well for team-based care with clear objectives (e.g., the cancer programs). An easily-accessed patient portal for “My Chart” documenting history, meds etc., and “co-owned” by the patient is perhaps a good idea. More social media, emailing and twittering interaction may be okay for some, but patients booking their own appointments would not work for me and in a family practice, side-lining the triaging of an experienced receptionist would be a mistake. The cost: Substantial. The benefit: Some patients will be happier … for a while … perhaps.
2. Health systems integration with workforce modernization

Here the old clothing chestnut creeps in with the word “seamless.” Kaiser Permanente (KP) in the USA is lionized as the “system” to emulate. What? A private, free-of-government-meddling, insurance-financed system (operating budget $56.4 billion for 10.1 million members) complete with the for-profit competition that drives USA medicine?

“... much of Kaiser’s success is due to integration through partnerships between physicians and the administration. Related factors were system control and accountability across all components of the health care system, efficient management of hospital use, greater investment in information technology, and the motivation for continuous improvement provided by competition.”

Ah, yes, competition – there is a degree of competition between medical practices in Canada but none between hospitals. In the KP system there are tasty bonuses for innovations that improve patient satisfaction and the bottom line. Physicians lead in this system but they do not bill fee-for-service – they earn much more ...

“... Canadians have suboptimal access to ambulatory care – including family doctors, specialists, nurse practitioners, nurses, non-physician psychotherapists, and physiotherapists. Access to basic primary care compares poorly to other nations. For example, a 2012 study of 10 nations by the US-based Commonwealth Fund found that only 22 percent of Canadian doctors say their patients can get an appointment the same or next day (compared to 38 percent in Australia and 55 percent in the UK).”

A summary slide on page 15 (Fig 2.6) is stunning in its bare-faced trickery. It compares 11 countries numerically on “scores of health system performance” with bogus accuracy like attempting to rate the justice system. “Effectiveness,” “safe care,” “co-ordinated care” and “patient-centered care.” There are “access” parameters of “efficiency,” “equity” and “healthy lives.” For all these “measurements” the United Kingdom (UK) is number one and Canada is number 10, ahead only of the USA.

Let me inform you (and the Naylor committee) that the UK is also the global champion in the gamesmanship of dodgy statistics. And, general practitioners receive extra money for seeing patients within a day, but if the practitioner can’t see you that day, dude, you might be asked to phone the day before you can make it.
In the dismal history of health care policy data, rarely have I seen such a density of manure matched only by the ranking of the world’s top 10 hottest women golfers in Golf City Newsletter. Using the Principle of Ockham’s Razor, the simplest explanation for this data is that it is so biased and inaccurate that anyone seriously using it deserves extraordinary rendition to Singapore for a flogging.

“Non-physician scopes of practice are evolving and expanding in Canada, but wide variation exists across the country. Canada should emulate jurisdictions like Australia and the Netherlands that have promoted greater role flexibility on a national level and thereby enabled the emergence of stronger multi-professional teams.”

OK, but there are now so many more commis-chefs in the kitchen that people shouldn’t wonder why health care costs are going up and communication is becoming harder. And by the way, both of the countries mentioned have thriving private health care.

“As one example of poor integration, physicians and hospitals are funded through separate budgets in Canadian healthcare systems. This makes little sense for the majority of specialists, given the substantial influence they have over hospital expenditures. Under the current fee-for-service payment system, most of these superbly-trained professionals have no specific financial rewards for quality of care or stewardship of scarce health care resources.” (Chapter 1 page 4).

Agreed. How thrusting a colonoscope up a butt and collaring a few polyps ($84.49/polyp) is valued more than a full multi-system consultation and management plan baffles me – perhaps it’s seen as danger money. Mandate a sessional fee for colonoscopies and watch the number of scopes plunge. Canadian health care is all about volume. Justice Emmett Hall, when asked years ago how to reward quality, replied that he didn’t know. The days of fee-for-service outside real private practice may be numbered. The “capitation” system for general practices may gradually be brought in with specific incentive payments.

An arm’s length from government “Kaiser Permanente system” could be introduced for the First Nations/Inuit programs which remain a complete mess. It was a mess 30 years ago when I first consulted in Inuvik and outlying nursing stations. I enjoyed The Mad Trapper Lounge and Bar and the harangues between the surgeon (splutteringly furious when he couldn’t access the instruments he needed) and the administrator (a po-faced pharmacist who rigidly followed his budget). This forlorn saga continues with patients being sent by air to Yellowknife for weekly thoracenteses due to the unavailability of appropriate bottles. If it wasn’t so bloody sad we could all have a laugh at this Parkinsonian stupidity. My sympathy here is with the First Nations/Inuit patients. I have conversed with an assistant deputy minister of what used to be called at the time “Indian Affairs” and a smugger, more arrogant, ignorant individual … but enough. This fiscal craziness can and must be sorted out fast.

3. **Technological transformation via digital health and precision medicine**

One of the cardinal rules forgotten by the panel is the old axiom that Canada is usually two to three years behind the USA – and that allows us to keep ahead of the game.

This chapter makes interesting reading but some cause for eye-rolling. Take “precision medicine” (mentioned by USA President Barack Obama in a state of the union address). This buzz term is being pushed by the Asperger blokes in Silicon Valley, many of whom have failed to become billionaires after as much as five years of toil.

As I take a break from this column and go down to see a poor soul with malignant ascites, I can’t see how precision medicine will ever help me. But one shouldn’t be negative. So, what is it? Well, no one’s quite sure other than it is big data, coming with a big price. I fully understand the link with pharmacogenomics and epigenetics to individualize drug dosing with genetic metabolic make-up, but this will require the usual, careful clinical trial and observation – and we’re doing this already, but combining global data might be helpful. And using an algorithm for the initial starting dose of warfarin is good but I don’t want big data for that. I want good data. Big data could well be the opposite of precision medicine (i.e., “imprecision medicine”).

Stand by for big promises needing big bucks. Cost: astronomical.

4. **Better value from procurement, reimbursement and regulation**

Not particularly a gobsmacker this, but I didn’t realize that the dozy federal bureaucracy does not join the pan-Canadian Pharmaceutical Alliance for their purchase of drugs and devices from industry. It’s not difficult economics.

“The pan-Canadian Pharmaceutical Alliance (pCPA) has already emerged as one of the key outputs. pCPA is undertaking joint provincial/territorial negotiations for brand name drugs in Canada, and getting better value for provincial and territorial drug plans.”

Big bargaining should mean better deals. The feds should get in on this pronto.
> 5. Industry as an economic driver and innovation catalyst

What? Can’t you communicate immediately with your 2,500 patients and get their blood sugar, ECG or heart rate in real time, dude? Shame on you. Get your digit out and get it into digital.

The formula for future health care transfers has been set at the annual rate of gross domestic product increase or 3% whichever is higher. So this year it will be 3%. That’s not much to do all the reforms suggested by the panel. And so:

“The Panel proposes a major new mechanism to accelerate the evaluation and scaling-up of innovative ideas ... the Panel had no trouble concluding that the goals to be accomplished through creation of a Healthcare Innovation Fund are not remotely achievable within any existing research agency’s mandates, machinery or relevant budgets.”

The report suggests yet another pan-Canadian agency be set up, “The Canadian Healthcare Innovation Agency,” with an annual budget of a billion dollars. Now Nelson Bunker Hunt and I both know a billion ain’t what it used t’be, but in Canada it still buys a lot.

This billion bucks would not support the provision of insured health services or pilot projects, but would support programs set up (after “rigorous adjudication”) against “transparent specifications and goals” as set by the panel’s report. Proposals should have successful demonstrations, meet milestones and no doubt have positive patient reported outcomes. How all this is measured is vague but an annual report would be written.

Real advances and clever innovations that improve patient care get around fast and everyone wants in on it. They are “scaled up” quickly (using the terminology of the report). For example, Herceptin in breast cancer was an obvious advance with minimal toxicity. It was two years before the Cancer Board agreed to cover it. We couldn’t wait for that so we brought it in using research funds. Clinics were quickly modified and expanded with no complaints from anyone and algorithms set up without any egging on from an Ottawa-based Agency for Innovation. Everyone knew it had to be done.

To satisfy Ms Ambrose for change at no extra cost, she should have realized that the panel needed a few thrifty, experienced clinicians working “at the clinical coalface” – as the report calls us – bringing them down to earth. Unfortunately, the “coalface” metaphor is inappropriate. Innovations in the coal mining industry came from educated, clever engineers, not the poor souls at the >
coalface. And that’s where the best ideas come from – you and I – and the Naylor Report clearly understands that. What the feds really wanted were cheaper ways to achieve the same results.

Here are some modifications of the Naylor Report recommendations for the next government to consider:

- Please, not yet another Ottawa-based “pan-Canadian” agency. Re-name the Canadian Foundation for Healthcare Improvement (CFHI) by adding two words to its title: “and Innovation” (CFHII) and budget for a division, perhaps $100 million/annum to start. Over time, fold in the “Canadian Partnership against Cancer” and the “Canadian Patient Safety Institute.” The “Canadian Health Infoway” should be subject to instructions and mandates from CFHII.

- Support a national “patient portal” so patients have access to their chart – to be handed to you when you see them – rather like an expanded Alberta Netcare without wasting five minutes trying to access it yourself. I’d find this useful. Support the AMA’s Choosing Wisely campaign with funds to do an outcomes review.

- Insist on the technique of “competitive dialogue” whereby “The Division for Innovation” in the CFHII does not hand over chunks of money to be frittered away but makes aliquot awards during the life-span of a project after critical cross-examination, including unexpected on-site visits. The Canadian Council on Health Services Accreditation should do the same instead of having administrative staff waste a ridiculous amount of time preparing a huge sandbagger’s document showing everything is fine.

- Leave “precision medicine” to the universities and cancer agencies. If it helps, they will come.

- Take First Nations/Inuit health care and the $2.6 billion budget out of the hands of Health Canada’s “First Nations and Inuit Health Branch” and create an arm’s length “Kaiser Permanente-style” agency run by professionals with incentives for innovations along the lines of the cancer programs.

There are some amusing quotes in the report: this from one of those perpetually outraged people with a conflict of interest not hard to figure out – you can feel the thumping on the gubernatorial roundtable:

“Outlaw the fax machine in doctors’ offices ... It is absolutely unacceptable that fax machines still exist in medicine, it is absolutely unacceptable that e-mail is not accepted in doctors’ offices. These things must change and must change tomorrow as a national standard.”
- Participant at Industry/Government Roundtable

And this (from a member of the public) was to me the most cogent among all the whinging and self-promoting comments published in the report:

“We may not need more doctors or more testing. We may need better communication between professionals and better communications with patients.”

Now that doesn’t cost much – but it’s hard work.
**Political shenanigans**

As we head toward a federal election, perhaps we should consider the shenanigans which have happened at higher echelons of power. According to the *Urban Dictionary*, “Shenanigans” can be defined as: “… remarks intended to deceive: Tomfoolery: A mischiefous act: An underhanded act: … Nefarious activities.”

**Remarks intended to deceive**

Richard Nixon denied involvement in Watergate saying: “I am not a crook…” and most remember Bill Clinton saying under oath: “I did not have sexual relations with that woman.” (Shame about the... “evidence” on a certain blue dress!) Canadian politicians may not intend to deceive quite so blatantly, but check their election promises.

**Tomfoolery and mischievous acts**

Since the “Munsinger Affair” in the late 1950s, Canada has had few steamy sex scandals.

Gerda Munsinger was allegedly a Soviet spy who slept with some cabinet ministers, including the associate minister of national defence. He even signed her application for Canadian citizenship … sweet! She was deported to Germany in 1961, though a judicial inquiry concluded there was no security leak.

In the late 1970s a solicitor general in Pierre Elliott Trudeau’s cabinet resigned after forging a signature while arranging an abortion for the married woman with whom he was having an affair.

Brian Mulroney’s government “lost” an average of one cabinet minister each year during his reign (1984-93):

- Defence minister: visited a strip club in Germany.
- Minister of fisheries and oceans: “tainted tuna” affair.
- Minister of regional industrial expansion: conflict of interest allegations over a loan.
- Minister of state for transport: alleged land speculation.
- Minister of public works and supply and services portfolios: charged with demanding and taking bribes (charges dropped).
- Supply and services minister: conflict of interest allegations over a loan.
- Minister of consumer and corporate affairs: impaired driving.
- Minister for fitness and amateur sport and youth portfolios: trying to talk to a judge about an ongoing case.
- Housing minister: joking about having a gun while boarding a flight.

Mulroney spent about $500,000 on his first leadership race and did not provide full financial disclosure of campaign expenses. Then, before leaving office, he took an international “farewell” tour mostly at taxpayers’ expense, without transacting any official business.

**Underhanded act**

The best example of a federal “Hail Mary” nomination was Kim Campbell who was unfairly (underhandedly?) given the Conservative Party leadership after Brian Mulroney with only 2.5 months remaining in their five-year mandate. Kim Campbell was the first and only female prime minister of Canada for a few months in 1993. She had served as Minister of State for Indian Affairs and Northern Development, Justice and Attorney General of Canada, National Defence and Veterans Affairs.

**Nefarious activities**

They say the “airbus affair” started after Brian Mulroney left office, then after successfully suing the Government of Canada for libel, he later confirmed that he had accepted cash “payments” – in brown paper bags – from businessman Karlheinz Schreiber, totalling either $225,000 or $300,000. Mulroney later alleged the cash was for “lobbying foreign leaders” to buy armored vehicles from Thyssen Industries, and not for Airbus lobbying in Canada.

Mulroney is a lawyer, yet he claims that he had no written contract with Schreiber, made no written reports, issued no receipts for the cash payments and destroyed all records. Then he did not pay tax on these “payments” until well after all was public knowledge from Schreiber’s testimony … really?

In the works of Aesop: “We hang the petty thieves and appoint the great ones to public office.” Be careful whom you vote for on October 19.

**Dr. Kevin M. Hay**

Wainwright AB
PHYSICIAN WANTED

CALGARY AB

Med+Stop Medical Clinics Ltd. has immediate openings for permanent full-time physicians to provide primary health care to patients at our four Calgary locations. Requirements are MD degree and must be eligible to be licensed by the College of Physicians & Surgeons of Alberta. Experience is an asset but not required. Our family practice medical centers offer pleasant working conditions in well-equipped modern facilities, high income based on fee-for-service, TELUS Health Solutions electronic medical records, low overhead, no investment, no administrative burdens and a quality of lifestyle not available in most medical practices. We also have some part-time positions available at two of our clinics.

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

PHYSICIAN(S) REQUIRED FT/PT

MILLWOODS EDMONTON

Also locums required

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

CALGARY AND EDMONTON AB

Imagine Health Centres in Calgary and Edmonton have an immediate opening for a psychiatrist certified with the College of Physicians & Surgeons of Alberta (CPSA).

Imagine Health Centres are dynamic multidisciplinary clinics with a large array of services including family physicians, specialists and many other allied health professionals such as pharmacists, physiotherapists, psychologists and more. Imagine Health Centres are dedicated to promoting the health of patients utilizing the most up-to-date preventative and screening strategies.

The successful candidate will work closely with our multidisciplinary team to optimize management of our patients with mental health issues. Collaborate with our large network of family physicians and their referrals to maximize outcomes for your patients.

Opportunities for group therapy and corporate health are available. There are also opportunities to help develop leading programs for mental health at all levels of primary care within our multiple sites located throughout Calgary and Edmonton.

An attractive compensation package will be offered to the successful candidate.

ALL-WELL PRIMARY CARE CENTRES

MILLWOODS EDMONTON

Phone: Clinic Manager (780) 953-6733
Dr. Paul Arnold (780) 970-2070

Contact: Dr. Neville Reddy, MB ChB, FRCPC (Anesthesia)
C 403.689.4259 or 403.240.4259
nreddy@telusplanet.net
innovationshealth.ca
All candidates must be immediately eligible for licensure or already licensed with the CPSA and provide proof of malpractice insurance from the Canadian Medical Protective Association. Compensation is fee-for-service.

All inquiries will be kept strictly confidential and only qualified candidates will be contacted.

Submit your CV to: Dr. Jon Chan
physicians@imaginehealthcentres.ca

EDMONTON AB
Two positions are immediately available at the West End Medical Clinic/M. Gaas Professional Corporation at unit M7, 9509 156 Street, Edmonton AB. T5P 4J5. We are also looking for specialists: internist, pediatrician, gynecologist and orthopedic surgeon to join our busy clinic. Full-time family physician/general practitioner positions are available. The physician who will join us at this busy clinic will provide family practice care to a large population of patients in the west end and provide care to patients of different age groups including pediatric, geriatric, antenatal and prenatal care.

Physician income will be based on fee-for-service payment and the overhead fees are negotiable. The physician must be licensed and eligible to apply for licensure with the College of Physicians & Surgeons of Alberta (CPSA), their qualifications and experience must comply with the CPSA licensure requirements and guidelines. We offer flexible work schedules, so the physician can adopt his/her work schedule. We also will pay up to $5,000 to the physician for moving and relocation costs.

Contact: Dr. Gaas
T 780.756.3300
C 780.893.5181
westendmedicalclinic@gmail.com

EDMONTON AB
Parsons Medical Centre (PMC) and Millbourne Mall Medical Centre (MMMC) want you. To meet the growing needs, we have a practice opportunity for family physicians at PMC and MMMC. Both clinics are in south Edmonton. PMC and MMMC are high-patient volume clinics with friendly reliable staff for billing, referrals, etc., as well as an on-site manager. Enjoy working in a modern environment with full electronic medical records. PMC and MMMC serve a large community and wide spectrum age group (birth to geriatric). Both clinics have on-site pharmacy, ECG machine, lung function testing and offer a large array of specialist services including: ENT, endocrinologist, general surgeon, internist, orthopedic surgeon, pediatrician and respirologist.

PMC and MMMC are members of the Edmonton Southside Primary Care Network which allow patients to have access to an on-site dietitian and mental health/psychology/psychiatry health services. Overhead is negotiable, flexible working hours and both clinics are open seven-days-a-week.

Contact: Harjit Toor
T 587.754.5600
F 587.754.8822
manager@parsonsmedicalcentre.ca

EDMONTON AB
Family medical clinic in west Edmonton is seeking part- and/or full-time family physicians. We offer flexible hours, low overhead (negotiable), fully computerized clinic using Mediplan electronic medical records. The clinic is associated with Edmonton West Primary Care Network.

Contact: Dr. Patocka
T 780.487.7532
foodprex@telus.net

EDMONTON AB
Dx Medical Centres is a new, spacious and modern clinic in Mill Woods with high-visibility exposure in a busy residential area. We are looking for general practitioners for the growing practice to join our team working collaboratively with multiple disciplines of the health care field.

Our clinic offers a pleasant working environment in a contemporary facility. The clinic is paperless with excellent support staff. We would like to offer you the opportunity to work in an enhanced practice environment that fits your lifestyle, needs and availability without investment or administrative time commitments. We provide competitive split to our valued physicians on a fee-for-service schedule.

Candidates must be licensed or eligible to apply for licensure with the College of Physicians & Surgeons of Alberta.

Contact: Christina
T 780.705.8400
info@dxmedical.ca
also on weekends, allowing physicians to have flexible work hours and flexible work arrangements.

Job duties: The physician will be providing primary care to patients of the Beverly Towne Medical Clinic, including diagnosing and treating medical disorders, interpreting medical tests, prescribing medications, and making referrals to specialist physicians as appropriate.

Education and experience: Medical degree with specialist training in family medicine. Preference will be given to candidates with family practice experience and candidates must be eligible for registration with the College of Physicians & Surgeons of Alberta. Preference will be given to candidates that are College of Family Physicians of Canada certified and preference will be given to Canadian citizens and permanent residents.

Skills required: Specialist training in family medicine; ability to work effectively, independently and in a multidisciplinary team; effective written and verbal communication skills.

Contact: Dr. A. Elfourtia or Dr. Z. Ramadan
T 780.756.7700 or C 780.224.7972
Beverly Towne Medical Clinic
11730 34 St
Edmonton AB

EDMONTON AND FORT MCMURRAY AB

MD Group, Lessard Medical Clinic, West Oliver Medical Centre and Manning Clinic each have 10 examination rooms and Alafia Clinic with four examination rooms are looking for six full-time family physicians. A neurologist, psychiatrist, internist and pediatrician are required at all four clinics.

Two positions are available at the West Oliver Medical Centre in a great downtown area, 101-10538 124 Street and one position at the Lessard Medical Clinic in the west end, 6633 177 Street, Edmonton.

Two positions at Manning Clinic in northwest Edmonton, 220 Manning Crossing and one position at Alafia Clinic, 613-8600 Franklin Avenue in Fort McMurray.

The physician must be licensed or eligible to apply for licensure by the College of Physicians & Surgeons of Alberta (CPSA). For the eligible physicians, their qualifications and experience must comply with the CPSA licensure requirements and guidelines.

The physician income will be based on fee-for-service with an average annual income of $300,000 to $450,000 with competitive overhead for long term commitments; 70/30% split. Essential medical support and specialists are employed within the company and are managed by an excellent team of professional physicians and supportive staff. We use Healthquest electronic medical records (paper free) and member of a primary care network.

Full-time chronic disease management nurse to care for chronic disease patients at Lessard, billing support and attached pharmacy are available at the Lessard and West Oliver locations.

Work with a nice and dedicated staff, nurse available for doctor’s assistance and referrals. Also provide on-site dietician and mental health/psychology services. Clinic hours are Monday to Friday 8:30 a.m. to 8:30 p.m., Saturday and Sunday 10:30 a.m. to 5 p.m.

Contact: Management Office
T 780.757.7999 or T 780.756.3090
F 780.757.7991
mdgroupclinic@gmail.com
lessardclinic@gmail.com

WETASKIWIN AB

Associate Clinic is looking for two family physicians/general practitioners to join a group of eight physicians. Close to Edmonton (40 minutes), enjoy a full-service rural practice with hospital and clinic work. The clinic is fully equipped with electronic medical records and all physicians are members of the Wetaskiwin Primary Care Network.

Contact: Wendy Taje
Manager
T 780.352.7157

PHYSICIAN AND/OR LOCUM WANTED

CALGARY AND EDMONTON AB

You require balance ... you demand the best. Join the fastest growing medical group in Alberta to practice medicine the way it was meant to be.

Imagine Health Centres (IHC) is currently looking for family physicians and specialists to join our dynamic team in either Calgary or Edmonton. Physicians will enjoy extremely efficient workflows allowing for very attractive remuneration, no hospital on-call, paperless electronic medical records, friendly staff and industry-leading fee splits.

Imagine Health Centres are multidisciplinary family medicine clinics with a focus on health prevention and wellness. Come and be a part of our team which includes physicians, physiotherapists, massage therapists, psychologists, nutritionists and pharmacists.

Imagine Health Centres prides itself in providing the very best support for family physicians and their families in and out of the clinic. Health benefit plans and full financial/tax/accounting advisory services are available to all IHC physicians. There is also an optional and limited time opportunity to participate in ownership of our innovative clinics.

Compensation is fee-for-service. Current positions available are locum, part- or full-time.

We currently have three Edmonton clinics with a fourth opening this fall in Windermere (southwest Edmonton). The current clinics are near South Edmonton Common, Old Strathcona and west Edmonton.

We currently have one clinic in southeast Calgary with a second clinic that opened downtown in April.

All inquiries will be kept strictly confidential and only qualified candidates will be contacted.

Submit your CV to: Dr. Jon Chan
physicians@imaginehealthcentres.ca

Contact: Wendy Taje
Manager
T 780.352.7157

Contact: Dr. A. Elfourtia or Dr. Z. Ramadan
T 780.756.7700 or C 780.224.7972
Beverly Towne Medical Clinic
11730 34 St
Edmonton AB

Imagine Health Centres prides itself in providing the very best support for family physicians and their families in and out of the clinic. Health benefit plans and full financial/tax/accounting advisory services are available to all IHC physicians. There is also an optional and limited time opportunity to participate in ownership of our innovative clinics.

Compensation is fee-for-service. Current positions available are locum, part- or full-time.

We currently have three Edmonton clinics with a fourth opening this fall in Windermere (southwest Edmonton). The current clinics are near South Edmonton Common, Old Strathcona and west Edmonton.

We currently have one clinic in southeast Calgary with a second clinic that opened downtown in April.

All inquiries will be kept strictly confidential and only qualified candidates will be contacted.

Submit your CV to: Dr. Jon Chan
physicians@imaginehealthcentres.ca

Contact: Wendy Taje
Manager
T 780.352.7157
DEVON AB
Devon Medical Clinic requires physicians or locums to help meet the needs of our growing community. We currently have one physician on maternity leave and a few others are looking to reduce their work load.

The clinic uses TELUS Wolf electronic medical records, a diagnostic imaging clinic and pharmacy are the same building, and the hospital is across the street. Emergency room shifts are optional, we are part of the Leduc Beaumont Devon Primary Care Network and we are closed on weekends.

We enjoy a pleasant working environment with excellent support staff.

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

EDMONTON AB
Summerside Medical Clinic and Edge Centre Walk-in Clinic require part- and full-time family physicians, specialists and locums are welcome. The clinics are in the vibrant, rapidly growing communities of Summerside and Mill Woods. Examination rooms are fully equipped with electronic medical records, printers in all examination rooms and affiliated with the Edmonton Southside Primary Care Network.

The Edge Centre has 5,000 sq. ft. and can accommodate other medical professionals such as dentist, massage therapist, physiotherapist, chiropractor, etc.

Contact: Dr. Nirmala Brar
T 780.249.2727
nimmi@theplaza.ca

SHERWOOD PARK AB
Dr. Patti Farrell & Associates is a new busy modern family practice clinic with electronic medical records and require locum coverage periods throughout 2015. Fee split is negotiable. Current clinic hours are Monday to Friday 8 a.m. to 4 p.m. are negotiable.

Dr. Farrell is a lone practitioner (efficient clinic design built for two doctors) looking for a permanent clinic associate.

Contact:
C 780.499.8388
terrypurich@me.com

SHERWOOD PARK AB
The Sherwood Park Primary Care Network is looking for several physicians to cover a variety of locum periods in a variety of Sherwood Park offices. Practice hours vary widely.

---

EFW Radiology
Specialists In Diagnostic Imaging

RADIOLOGISTS
MULTIPLE OPPORTUNITIES AVAILABLE
CALGARY, ALBERTA

Are you a Radiologist who is committed to excellence in patient care, dedicated to practicing evidence-based medicine, and passionate about providing education to future care givers? A career with EFW Radiology may be for you.

EFW Radiology is a large growing practice with a broad variety of opportunities for Radiologists seeking full-time or part-time careers ranging from exclusive community radiology practice without evening or on-call work, to higher intensity work at a large tertiary level trauma centre with opportunities for teaching and multi-disciplinary collaborations.

Candidates with a preference towards a community practice career must be very knowledgeable and comfortable with interpretation of obstetrical, abdominal, and pelvic ultrasound.

Candidates interested in a career balanced between community radiology and smaller community hospital work must be comfortable with minor image guided procedures and CT cross-sectional imaging studies typical for a community hospital.

Fellowship training is not required, but welcomed. All candidates must be eligible for registration with the College of Physicians and Surgeons of Alberta and be legally entitled to work in Canada.

EFW Radiology is a Calgary, Alberta group of over 60 physicians which consists of radiologists, perinatologists, and physiatrists; providing services to the Foothills Medical Centre, Tom Baker Cancer Centre, South Health Campus, and Calgary and Airdrie communities. We perform over 600,000 examinations annually with a balance between community and hospital work. We pride ourselves on providing compassionate care, working to earn the trust of referring clinicians and patients, and offering meaningful career opportunities.

Compensation is competitive and commensurate with training and experience.

If you are interested in exploring career opportunities available with EFW Radiology please submit a letter of intent and curriculum vitae to:

Helen Lemieux
Director of Human Resources
Email: physicianrecruitment@efwrad.com
www.efwrad.com
Majority of practices run electronic medical records. Fee splits are negotiated with practice owners. Some practices are looking for permanent associates.

Contact: Dave Ludwick  
T 780.410.8001  
davel@sherwoodparkpcn.com

---

SPACE AVAILABLE

CALGARY AB

Fully finished medical office space for lease. New construction, 1,630 sq. ft., bright corner unit, functional and efficient plan including five examination rooms, one corner office, staff room, clean room, nurse's station and reception/waiting area. Located within a busy medical office building and conveniently situated near Rockyview General Hospital.

Contact: Lindsay Hills  
Leasing Manager  
NorthWest Healthcare Properties  
T 403.282.9838, ext. 3301  
lindsay.hills@nwhp.ca

---

COURSES

CME CRUISES WITH SEA COURSES CRUISES

- Accredited for family physicians and specialists
- Unbiased and pharma-free
- Canada's first choice in CMEatSEA® since 1995
- Companion cruises FREE

FIJI, TONGA AND TAHITI
November 10-21
Focus: Endocrinology  
Ship: Paul Gauguin

PANAMA CANAL
November 20-30
Focus: Dermatology, psychology and infectious diseases  
Ship: Zuiderdam

SOUTH AFRICA
November 24-December 9
Focus: Adventures in medicine  
Ship: Regent Seven Seas Mariner

CARIBBEAN NEW YEAR’S
December 27-January 3, 2016
Focus: Dermatology and women’s health  
Ship: Freedom of the Seas

AUSTRALIA AND NEW ZEALAND
January 5-19, 2016
Focus: Caring for an aging patient  
Ship: Celebrity Solstice

TAHITI AND COOK ISLANDS
February 20-March 2, 2016
Focus: Geriatrics and women’s health  
Ship: Paul Gauguin

SOUTH AMERICA
February 28-March 9, 2016
Focus: Hot topics in medicine  
Ship: Celebrity Infinity

CARIBBEAN
March 13-20, 2016
Focus: Primary care review  
Ship: Liberty of the Seas

TASTE OF THE EAST
April 12-May 2, 2016
Singapore, Asia, India and United Arab Emirates  
Focus: Adventures in medicine  
Ship: Regent Seven Seas Voyager

WEST COAST WAYFAKER
June 13-19, 2016
Focus: Internal medicine and infectious diseases  
Ship: Crystal Serenity

BALTIC AND NORTHERN CAPITALS
June 19-July 1, 2016
Focus: Cardiology, neurology and gastroenterology  
Ship: Celebrity Silhouette

GREECE AND TURKEY
July 9-16, 2016
Focus: ER medicine: Novice to expert  
Ship: Celebrity Equinox

ICELAND AND NORWAY
July 16-28, 2016
Focus: Neurology, cardiology and psychiatry  
Ship: Holland America Zuiderdam

MEDITERRANEAN
August 7-21, 2016
Focus: Psychiatry and endocrinology  
Ship: Navigator of the Seas

JAPAN AND KOREA
September 18-29, 2016
Focus: Endocrinology and dermatology  
Ship: Celebrity Millennium

DUBAI AND ARABIA
October 24-November 3, 2016
Focus: Neurology and rehabilitation medicine  
Ship: Azamara Journey

TAHITI AND MARQUESAS
November 19-December 3, 2016
Focus: Endocrinology and dermatology  
Ship: Paul Gauguin

For current promotions and pricing, contact: Sea Courses Cruises  
TF 1.888.647.7327  
cruises@seacourses.com  
www.seacourses.com >
SERVICES

ACCOUNTING AND CONSULTING SERVICES
Independent consultant, specializing in accounting and tax preparation services, including payroll and source deductions, using own computer and software. Pick up and drop off for Edmonton and areas, mail or courier options available for rest of Alberta.

Contact: N. Ali Amiri, MBA
Consultant
Seek Value Inc.
T 780.909.0900
aamiri.mba1999@ivey.ca
aliamiri@telus.net

DOCUdavit MEDICAL SOLUTIONS
Retiring, moving or closing your practice? Physician’s estate? DOCUdavit Medical Solutions provides free, paper or electronic patient record storage with no hidden costs. We also provide great rates for closing specialists.

DOCUdavit Solutions has achieved ISO 9001:2008 and ISO 27001:2013 certification validating our commitment to quality management, customer service and information security management.

Contact: Sid Soil
DOCUdavit Solutions
TF 1.888.781.9083, ext. 105
ssoil@docudavit.com

PHYSICIAN RECRUITMENT SERVICE
Global Medics Canada have been successfully placing physicians in roles across Canada for the last six years and are currently working with many family physicians already pre-approved by the College of Physicians & Surgeons of Alberta, looking for long term roles in Alberta.

Company and service overview plus references are available upon request. We can help you recruit the perfect family physician for your clinic in the most efficient and hassle free way possible. If you’re interested or just keen for further information, please contact us.

Contact: Phil Martin
Business Manager
T 250.307.4352
phil@globalmedics.com

FOR SALE
COLUMBIA VALLEY BC
3.71 acres of privacy in Columbia Valley with spectacular, mountain view. Two-bedroom, two-bathroom home with custom (tile, granite and woodwork) finishing, tucked amongst mature trees. Outdoor hot tub and low maintenance professional landscaping. Less than 30 minutes from Kicking Horse Ski Resort. Asking $469,000.

Contact: MLS # 2397965

DISPLAY OR CLASSIFIED ADS
TO PLACE OR RENEW, CONTACT:
Daphne C. Andrychuk
Communications Assistant,
Public Affairs
Alberta Medical Association
T 780.482.2626, ext. 3116
TF 1.800.272.9680, ext. 3116
F 780.482.5445
daphne.andrychuk@albertadoctors.org

FOR LEASE: PROFESSIONAL OFFICE SPACE
(South Edmonton)
RUNNING CREEK PROFESSIONAL CENTRE 11025 - 9 Ave NW, Edmonton, AB
New Upscale Development located in south Twin Brooks

(SE corner of 111 St and 9th Ave NW)
Medical Clinic is anchor tenant Units from 1000 - 4000 sq ft
Contact SDL at 780.489.6985
“WITH MD, I DON’T HAVE TO WORRY ABOUT MEME REMBERING TO PLAN FOR MY FINANCIAL FUTURE.”

“I believe that MD not only really understands my role as a doctor, but also as a mother and someone with unique challenges. MD’s support and financial advice has helped me make sense of the path I’m on and see exactly where it is I want to go—and how to get there. I stay with MD because I really feel they put physicians first.”

– Dr. Sarah Lesperance, Public Health and Preventative Medicine Resident

EVERY PHYSICIAN HAS A STORY. HEAR MORE FROM YOUR PEERS: MD.CMA.CA/MYSTORY

FOUR TIMES MORE PHYSICIANS TRUST MD.1

1 Fifty-three per cent of Canadian Medical Association members trusted MD Financial Management as their primary financial services firm, four times more than the next closest individual competitor at twelve per cent. Survey respondents (MD clients and non-MD clients) were also asked to identify their primary financial institution (MD or Other), and rate their level of trust associated with that institution. MD received the highest trust rating compared with all other firms rated. Source: MD Financial Management Loyalty Survey, June 2014.

MD Financial Management provides financial products and services, the MD Family of Funds and investment counselling services through the MD Group of Companies. For a detailed list of these companies, visit md.cma.ca. Incorporation guidance limited to asset allocation and integrating corporate entities into financial plans and wealth strategies. Professional legal, tax and accounting advice regarding incorporation should be obtained in respect to an individual’s specific circumstances. Banking products and services are offered by National Bank of Canada through a relationship with MD Management Limited.