AMA releases allocation how-to-guide
The beat goes on

The claims that health care is economically “unsustainable” would seem to relate to a propaganda campaign to soften a beleaguered citizenry into further off-loading of costs and more private sector intrusions.

The beat, as they say, goes on. The trouble with this brave new world, for grizzled veterans of past wars, is that this is actually a very old brave new world. We’ve been bludgeoned into thinking our health care is “unsustainable.”

This tired epithet was the buzzword of the mid-1990s and the excuse for cuts in health care funding in excess of 20%, 1994-96, the last time our world turned this topsy-turvy.

The problem, of course, is that this is all unnecessary. To be sure, health care spending is up. The provincial budget for health grew to $12.9 billion in this year’s budget, from $8 billion five years ago.

Over the last 10 years, however, public spending for health care in Alberta has risen at a rate of roughly 5% per annum. But much of this relates to needed repairs after the axe cuts of the prior decade and the services needed for a population that has doubled in the last 35 years.

It behooves us to remember that Alberta is the richest province in Canada. Consider Alberta’s GDP² – the value of all goods and services – and you’ll find that it had grown to some $260 billion in 2007 from $53.4 billion in 1981.

Put another way, provincial GDP on a per capita basis has grown to $63,000 per person in 2007 from $43,000 per person in 1997, about a 4% annual increase.

Look at government health care spending in the province over the same interval and you’ll find it represents a slim 4% of provincial GDP and it has remained remarkably stable.

There’s no doubt – none at all – that health care represents the largest single government expenditure at about a third of all government expenditures, but this is true of most constituencies.

When one looks at the size of government expenditures in total over the so-called “Klein years,” governmental spending as a fraction of the economy fell to 12% of GDP, from 22%, as public sector spending was slashed.³

So although health care expenditures have been growing, these expenditures relate to increased citizenry and robust economic activity. And when expenditures are examined against overall economic activity, they have remained stable.

The claims that health care is economically “unsustainable” would seem to relate to a propaganda campaign to soften a beleaguered citizenry into further off-loading of costs and more private sector intrusions.

The public is fed at least three more canards:³

• An aging population will increase costs hugely.
• Technology costs will soar.
• Waiting lists or queues will become unreasonable.

Though the future is unknown, none of these are part of a necessary future. The aging of our population is at least partly offset by savings in costs elsewhere, say education, and may reasonably relate to no more than 1% of increased costs per year.

New technologies are not inherently more expensive since...
brother’s keeper has served us well. Indeed, to the extent that new drugs represent new technologies, much drug funding has already been off-loaded to private pocketbooks.

Waiting lists don’t necessarily swell either, as amply demonstrated by the success of managed orthopedic care across the province.

In short, there’s no good reason to invoke rationing by ability to pay, as exists in the US. As former Princeton health care economist Uwe Reinhardt has suggested, cutting Medicare is a moral issue. Constraining public health care, while giving free rein to private expenditures, boils down to maintaining that our previous health care expenditures, boils down to caring expenditures have been wrong.

I’m not naive enough to believe we must provide an unexamined array of services to everyone, but the general notion that we are in fact our brother’s keeper has served us well.

As Bob Evans, the doyen of Canadian health care economists, has said, “There is a wolf at the door of the Canadian Medicare system. But it is a political wolf dressed in phony economic clothing to deceive the sheep.”

Do we need more evidence? I recently heard on the radio that governmental coffers are absent about a billion dollars a year since they gave up collecting health care premiums. What’s the trumpeted AHS/governmental budget shortfall? About a billion dollars. Ho-hum.

Still, I reckon there’s more bad news to come. Batten down the hatches.

For the foreseeable future “deskilling” is the name of the game. If one can save 10 or 20 bucks an hour replacing RNs with LPNs across the system, it amounts to real money.

Deskilling, of course, is a camp-follower of the corporatization of health care that started in the 1960s. Just as the search for profit is the idée fixe of profit-minded capitalism, the endless search for cheap, cheaper, cheapest is the reflex, year-after-year-after-year response of health care bureaucrats and their minions.

Quality and patient safety aren’t much mentioned in the move to replace RNs with LPNs and there would appear to be no real basis for this in research – quite the opposite, in fact.

The initiative may prove one that imperils patients. If this works on any basis, look for more downsizing in years to come. As physicians, we are not immune.

The whole system can be ratcheted down, methinks, to the fabled public health nurse – er, excuse me, LPN – attempting to solve health care needs in sub-Saharan Africa with a bucket of disinfectant and a trek to the nearest watering hole.

Exuberant plans to move to activity-based funding likely represents another threat. Activity-based funding is essentially a form of fee-for-service by which, for example, a hospital may be paid a dollar amount for an episode of care, as in a cholecystectomy or a normal delivery.

If no consideration is given to the quality of the undertaking, but only to throughput, patients can be discharged “sicker and quicker.”

Patients represent a diverse group. If remuneration is on the basis of “best practises” – read cheapest! – and does not account for age and socioeconomic circumstances, patients will bear the brunt of things.

Indifference to anything other than cost may be no more evident than in the disregard for staff morale. In a world where Walmart greeters are called associates, cutting administrative positions may mean just about anything.

“We’ve been persuaded that admin types are fat cats toting around clipboards and Starbucks cards, but I don’t see many of these folk around.

There’s a certain disconnect, a dissonance here, and the glad-tiding corporate missives that chirrup how good things are don’t correspond with layoffs, firings and a pervasive bunker mentality. When did you last hear mention of employee satisfaction surveys?

It’s all depressingly familiar. As I’ve written before, it’s all so much more drama and heartache than we deserve. It’s like watching Days of Our Lives forever.

Days of our lives, indeed.

References


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### AMA MISSION STATEMENT

The AMA stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.
Allocation 101: Navigate the allocation maze

Understanding the allocation process can be daunting at best, and downright confusing at worst, for those intrepid newcomers to the process who take on the role of fees representative for their sections.

Even physicians who perform intricate surgeries, solve puzzling medical presentations and counsel patients with complicated psychological issues may, as section representatives involved in an allocation, feel like they are in an uncharted maze.

To assist section representatives, in particular, and interested physicians, in general, the Physician Compensation Strategy Board Steering Committee (PCSBSC) directed that a comprehensive manual be developed to provide information and increase transparency about the:

- Allocation process – with the two major steps involved (macro- and micro-allocation)
- Current policy and policy under development
- Steps involved through both the macro- and micro-allocation
- Individuals and committees that participate in the process
- Timelines for allocation

The result is Allocation 101 – a complete how-to guide about allocation, which includes an all-inclusive handbook for section representatives and a streamlined version for individual physicians.

The allocation process

In a fiscal agreement, funds are generally negotiated for the Physician Services Budget to reimburse physicians for the medical services they provide to Albertans. The trilateral allocation process apportions these funds to sections. The sections then apply their funds to the health service codes in the Schedule of Medical Benefits (SOMB) for which they are responsible.

Macro-allocation is the trilateral process by which the newly negotiated funds for physician services are divided among the sections. Funds are apportioned to three major elements:

- Overhead – An adjustment is calculated for each section to acknowledge business costs.
- Priority funding – Sometimes funds are targeted for specific fee items or sections.
- Full-time-equivalent (FTE) payments – Provides a set amount of funds per-FTE physician in each section.

When macro-allocation is complete and the amount of funding is determined for each section, micro-allocation begins. It is the process whereby sections apportion their new funds to the health service codes they own or share within the SOMB.

Policy

Allocation 101 is one of nine PCSBSC strategic activities currently underway to address the Physician Compensation Strategy objectives of equity, access and productivity. Among the other eight activities, and also related to policy for allocation, are the Physician Business Costs Study and the review of the definition of FTE physicians.

The purposes of the Physician Business Costs Study are to:

- Review physician business costs (overhead) throughout Alberta to better understand the various
Allocation is not completed overnight.

Allocation timelines and players

Allocation is not completed overnight. It is a 15-month process that involves individual physicians, sections, the Representative Forum, Board of Directors and internal AMA committees (PCSBSC, the Fees Advisory Committee, AMA representatives to the Schedule of Medical Benefits Subcommittee [SOMBS]).

The trilateral partners to the master agreement are also actively involved in allocation. Both Alberta Health and Wellness and Alberta Health Services contribute proposals for allocation. The trilateral SOMBS reviews proposals from all three parties and makes recommendations to the trilateral Physician Services Committee for final decisions.

Allocation is a fascinating topic that is relevant for all physicians who are compensated through the Physician Services Budget for the medical services they provide.

As PCSBSC Co-chair Dr. Carolyn A. Lane says, “Allocation is fundamental to physician remuneration, so it benefits them to understand the allocation process. We trust that the physician version of the Allocation 101 document will provide them with the basics they need to comprehend what goes on in an allocation. As well, the section version should provide section representatives with a mini-tutorial to lead them through this complicated process and bring them out the other side . . . having successfully navigated the allocation maze.”

Section reps and other physicians may access versions of Allocation 101 on the AMA’s Allocation web page (log on to www.albertadoctors.org/FeesNegotiations/Allocation), as well as their short surveys to provide feedback about the document they read.

**Member feedback about Allocation 101 requested online.**

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- components and variations in costs associated with maintaining a medical practice.
- Develop a set of indices and a process for periodically reviewing and updating the data.

The results of the study will provide more complete information on which to base macro-allocation decisions about adjustments for overhead. Results are expected this year.

**Review the definition of FTE physician**

This issue has been raised by sections as one that needs to be addressed for fairness in calculating allocation of per-FTE amounts.

The definition is being updated with a look at refining the way FTE is calculated. A new definition is expected this year.

In addition to the current policy under development, the Alberta Medical Association (AMA) Board of Directors has established policies to guide the process and outcomes for allocation.

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Perspectives on Professional Corporations Statutes Amendment Act

See below the legal and financial perspectives on proposed amendments to four acts through the Professional Corporations Statutes Amendment Act, 2009 or Bill 53, as well as excerpts from second reading of the bill.

Bill 53 from the legal perspective

Many physicians are licensed and carry on their practices through professional corporations.

Until recent proposed amendments to the Medical Profession Act, the only shareholder of a professional corporation could be a registered practitioner – that is, a physician.

Similar amendments will be made to the Health Professions Act that will impact physicians once Schedule 21 to the act is proclaimed, expected to be early 2010.

However, recent proposed amendments to the Medical Profession Act will now allow non-voting shares of the professional corporation to be owned by:

1. The spouse or common-law partner of a physician
2. A child of the physician
3. A trust, all of the beneficiaries of which are the physician’s children

Allowing spouses and children to own shares of the professional corporation not only permits family members to participate in the growth and the value of the professional corporation, but also creates an opportunity for splitting income by paying dividends to the physician’s spouse and children.

However, there are significant business and income tax matters to consider if a physician wishes to add family members as shareholders in the professional corporation.

From a business perspective, family members will become shareholders of the professional corporation and become entitled to all the rights of shareholders pursuant to the Business Corporations Act. Those rights can be far-reaching, even in the case of a non-voting shareholder.

However, there are significant business and income tax matters to consider... .

As well, while the legislation as currently drafted permits a trust to hold shares on behalf of children, the recent amendments further stipulate that once the child reaches the age of 18 years, the trust must transfer shares held by the trust within 90 days to that individual.

Accordingly, young adults will become shareholders of the professional corporation. This will expose the shares to creditors of the young adults and also the shares could be matrimonial property in the event of marital breakdown.

From an income tax perspective, care must be taken when issuing the shares so as not to create a taxable benefit to an individual being issued shares.

If the professional corporation shares currently have value, which will likely be the case, then it is not possible to simply issue non-voting shares to family members without creating a tax issue.

It will be necessary to reorganize the issued shares of the professional corporation in order to avoid that from occurring. This is a matter physicians should have their professional advisors carefully review.

While these amendments do create opportunities for physicians using professional corporations, care should be undertaken and thought given to any restructuring involving introducing family members as shareholders.

Before proceeding with any of these transactions, physicians should consult their accounting and legal advisors...
Bill 53 allows the ownership of Alberta professional corporations to expand. No longer must a professional own all the shares. The new rules will permit a spouse and children to own non-voting shares.

Furthermore, where the children are minors, their shares can be held within a trust (to be transferred to the child within 90 days of the child turning 18 years of age).

For physicians, this is very similar to the rules in Ontario. But it does stop short of what is permitted for physician neighbors in Saskatchewan and British Columbia.

The key potential benefit is straightforward – splitting income. The reality of a tax system where higher tax rates apply to higher levels of income is that dividing income often results in less tax than if one person was taxed on all the income.

Put simply, if adding a shareholder allows “income” to be transferred to another individual in a lower tax bracket by way of corporate dividends, there will generally be a tax savings.

Unfortunately, whether to incorporate or restructure an existing corporation is a bit trickier. Let’s work through some examples.

For those who have not already incorporated, some context is important. Splitting income should not be the only consideration. Most practising physicians in Alberta have incorporated to increase their capacity to save for retirement and other goals.

Other factors beyond splitting income do exist and include such wide-ranging considerations as a more effective means to pay health expenses or business-related debt, enhanced benefits from life insurance or even creating one’s own pension plan.

A physician’s financial advisor should help identify which factors are relevant to the physician’s circumstances (where the physician is now and his or her future goals) and conduct at least a preliminary analysis of the potential benefits.

This equips the physician to meet with his or her tax and legal advisors for further analysis and a recommendation on both his or her corporate structure and compensation plan. All of the above will have roles to play if or when the physician chooses to incorporate.

If both the physician and spouse are in the top tax bracket, transferring income does not generate tax savings. Perhaps less obvious, but quite prevalent, are scenarios where the spouse works for the medical practice. Generally speaking, converting salary to dividends is another scenario that has an uphill battle to proving worthwhile.

The new rules are most likely to be of benefit to those who already have corporations where amounts distributed from the corporation are being paid to a physician in the top tax bracket and could instead be paid to someone in a lower tax bracket.

Let’s assume a physician’s yearly lifestyle requirements necessitate a salary of $120,000 and non-eligible dividends of $130,000. Redirecting $100,000 of the dividends to his or her spouse (assuming the spouse has no other income) would reduce income tax by approximately $10,000 per year.

While that may sound compelling, what follows are some examples of important considerations to keep in mind.

1. $100,000 (before-tax) is being transferred from the physician to his or her spouse. Will it be spent the same way?

   In this particular example, roughly half of the tax savings occurs in the first $30,000 of dividends earned by the spouse.

2. Generally speaking, “kiddie tax” rules prevent these tax savings...
if the recipient of the dividend is a minor.

3. There are legal risks to adding shareholders and there are tax considerations, such as corporate attribution rules, that require professional advice.

The above examples are intended as information only – to provide a sense of context for what the new rules might mean for a physician.

I encourage physicians to seek out professional advisors who can dig deeper into their realities and help ensure they get the most from their professional corporation under the new rules.

The information provided in this document is current as of December 1, 2009. It does not replace the tax/legal advice given by a professional advisor.

Clients are strongly encouraged to seek their own professional guidance prior to incorporation and when implementing changes to their existing medical professional corporations.

Second reading of Bill 53, Professional Corporations Statutes Amendment Act, 2009


Mr. Greg Weadick (Progressive Conservative, MLA for Lethbridge-West): Mr. Speaker, I am pleased to rise and move second reading of Bill 53, the Professional Corporations Statutes Amendment Act, 2009.

Before us today we have proposed legislative revisions to four acts involving three ministries. If passed, these changes will extend non-voting share ownership of professional corporations to immediate family members. These professions include doctors, dentists, chiropractors, optometrists under the Health Professions Act and the Medical Profession Act; lawyers under the Legal Profession Act; chartered accountants, certified management accountants and certified general accountants under the Regulated Accounting Profession Act.

The proposed legislation deals with the extension of share ownership and does not change the professional corporation structure. Professionals will continue to maintain full responsibility for the services of their corporation, and of course they will continue to be held personally liable for the professional services they provide.

If passed, family members eligible to own non-voting shares will include spouses, children and common-law partners. Same-sex couples are also covered in this legislation. The proposed changes do not extend share ownership quite as broadly as in British Columbia; however, they will allow professionals to pay dividends to immediate family members, which will improve the professionals’ ability to income-split with their families.

Restricting share ownership to immediate family members limits Alberta’s exposure to aggressive tax planning, which increases as more individuals become eligible to hold non-voting shares.

Mr. Speaker, the revisions before us will bring the share ownership of these professions more in line with professional corporations in other western provinces. Let us not kid ourselves. Every profession looks at their counterparts in other jurisdictions and asks: what about us? This isn’t just about levelling the playing field among provinces; it’s also about levelling the playing field right here in our own backyard.

These revisions will also bring doctors, lawyers, accountants, dentists, optometrists and chiropractors more in line with other Alberta corporations. Family members can already own shares in other corporations, including engineers, architects and veterinarians. This change will simply allow professionals and their families to enjoy the same benefits.

You know, when I read over any proposed legislation, whether I’m sponsoring a bill or even before my time as an MLA, I always ask myself: who would be against this, and who would have a beef with what’s being proposed?

Mr. Speaker, I suppose some Albertans could be concerned with Bill 53 since they might think this is a case of the rich getting richer at a time when government revenues are down. I have no reservation in tackling the argument head-on.

Government has determined that the benefits associated with extending share ownership to non-professional family
members outweighs the estimated $1 million in reduced personal income tax revenues.

These changes will better align Alberta’s professional corporations with neighboring provinces and with other corporations operating within Alberta. This will improve the attractiveness of Alberta and help encourage professionals to practise and do business in our province.

Mr. Speaker, these proposed legislative revisions are about being fair. They’re about levelling the playing field among other corporations within Alberta, and they’re about levelling the playing field between Alberta professional corporations and their counterparts throughout western Canada.

Mr. Hugh MacDonald (Alberta Liberal, MLA for Edmonton-Gold Bar): When we are considering through this legislation allowing income-sharing with their spouse and children by members who have a registered professional corporation, we have to have a good look at this and at what exactly it means for the bottom line of the province.

But before we do that, Mr. Speaker, if we look at a doctor, for example, who has registered as a professional corporation, that individual can transfer shares, if this bill becomes law, to a spouse or child and, as I understand it, reduce the income tax that is required to be paid.

The amendments also clarify that non-voting shareholders – for example, a spouse or a child of a registered member of the professional corporation that has had shares transferred to them – have no liability in the business of the corporation.

The registered member of the professional corporation still has full liability and must carry liability insurance for his or her business. That’s noteworthy, and that is important.

If we look at the general corporate income tax rate for Alberta, it’s 10 per cent. If we look at Ontario’s, it’s significantly higher, at 14 per cent. Again, if we compare it to BC’s, our rate is slightly less than BC’s. BC’s is 11 per cent. So I think we’re competitive already – that is my point – with or without this legislation at this time.

Mr. Jonathan Denis (Progressive Conservative, MLA for Calgary-Egmont): Now, going back a little way here, professional corporations, or PCs as people have mentioned them, not referring to the political party, Mr. Speaker, were created in the late 1970s to allow some professional groups to take advantage of tax benefits.

Now, in turn, these tax benefits made Alberta a more attractive choice for needed professional groups, most notably chartered accountants, certified management accountants, certified general accountants, doctors, dentists, chiropractors, optometrists and, yes, even lawyers.

Bill 53 would further enhance Alberta’s business climate for these professionals and could possibly prompt more professionals to establish themselves in Alberta. This could mean more doctors helping to deliver patient care and reduce wait times. This could also mean more accountants, ensuring that Alberta corporations remain competitive on the world stage, and again all three accounting designations apply. This could also mean more lawyers supporting the legal process and providing counsel to Albertans.

After all, Mr. Speaker, this would mean that a professional could rest assured knowing that their family could benefit from investment in this particular professional corporation, as is the case with any other corporation, as I mentioned.

To be clear, family in this bill refers to spouses, children, common-law partners, and does include same-sex partners, as the Member for Lethbridge-West noted.

In addition to matching more closely with other provinces’ legislation, Bill 53 also brings professional corporations closer in line with other private corporations, as I mentioned earlier. To give you an example, the family of an individual working in a corporation like an investing firm or an oil company are certainly allowed to own shares in that corporation. Why should it be any different with a professional corporation?

Bill 53 would extend this allowance to professional corporations on a fair and a competitive basis. It’s true that changes made by Bill 53 will result in a decrease of tax revenue by about $1 million. I’d argue for the aforementioned reasons that this is arguably money well forgone.

Ms Bridget A. Pastoor (Alberta Liberal, MLA for Lethbridge-East): I think that this is a bill that certainly should go forward if for no other reason than it keeps us competitive with the other provinces in this country. I would suspect that as we go forward with this, many of the other provinces will try to catch up, which then levels the entire country, and then TILMA, of course, would be irrelevant in that conversation.

The sectional analysis on this bill is that it really is the same for every profession that has been mentioned, which is the health profession, the legal profession, the medical profession and the regulated accounting profession. Even within these professions some others have been mentioned that would fall under these.
Clearly, this is a bill to enhance the tax advantage in this province. One of the areas that I think we have to work on in this province is to attract and keep our physicians. This bill may come forward, particularly in that area.

Mr. Hector Goudreau (PC, MLA for Dunvegan-Central Peace, Minister of Employment and Immigration): I agree as well with the Member for Lethbridge-West that it is important to provide a level playing field for professional corporations and that the playing field is consistent across professional corporations.

I’m confident that these proposed legislative revisions accomplish this. These revisions extend non-voting share ownership to immediate family members.

This will allow professionals to pay dividends to family members, which will improve the professionals’ ability to split income with their families.

Bill 53 comes, no doubt, with a price tag. There are tax revenue implications associated with the implementation of Bill 53, and those are estimated to be around $1 million per year.

Mr. Speaker, I believe this is a price worth paying as it creates the level playing field along with tax-planning benefits that many others can currently access.

Mr. Darshan Kang (Alberta Liberal, Member for Calgary-McCall): This is a good bill. The amendments will allow Alberta to remain competitive with British Columbia, particularly in light of TILMA, and with Ontario.

Without this first step in allowing more flexibility of tax planning for professional corporations, these corporations could move their business to other provinces to take advantage of these tax perks allowed there.

So this will benefit lots of corporations, and they will probably stay in Alberta because we are creating an environment where they don’t have to move.

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AMA seeks nominations to recognize outstanding achievements in health care

The Alberta Medical Association (AMA) is calling for Achievement Awards nominations for individuals who have contributed to the improvement of the quality of health care in Alberta. Nominations must be submitted by April 30. The awards will be presented at the AMA annual general meeting, September 24, in Edmonton.

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

In 2009, three physicians were recognized with Medals for Distinguished Service.

Dr. Peter B. Allen is a neurosurgical pioneer, educator and mentor, considered by many physicians to be the father of modern neurosurgery in Alberta. During his 40-year career, he maintained a busy surgical practice while training dozens of neurosurgeons, becoming the longest-serving chief of neurosurgery in the history of the University of Alberta. Retired since 2001, Dr. Allen continues to share his expertise as a professor emeritus and a mentor to both staff and students in the Department of Medicine.

Dr. Martin H. Atkinson is a highly respected rheumatologist and educator, who has devoted himself equally to patients and students throughout his career. He has taught at the University of Calgary (U of C) since 1971, and was instrumental in establishing the rheumatic disease unit at the U of C. For 30 years he supervised internal medicine trainees on their rotations through the rheumatic disease unit, and has received numerous awards for his teaching excellence. As a clinician, he has worked tirelessly to improve outcomes for people living with arthritis and related conditions.

Dr. Allan L. Bailey is a Spruce Grove family physician who was instrumental in establishing one of Alberta’s first primary care networks. A long-time advocate for interdisciplinary patient-centred care, in 2005 he led a local group of physicians to establish the WestView Primary Care Network. Dr. Bailey is also an associate clinical professor at the University of Alberta and passionate community supporter who has spearheaded several community health promotion projects.

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

The 2009 Medal of Honor recipients follow.

A former councillor and reeve for the Town of Fairview, Walter Doll worked tirelessly to ensure the citizens of Fairview have access to quality health care. For 23 years he dedicated countless hours to attracting and retaining medical staff and improving hospital facilities, equipment and services within the community. Mr. Doll was instrumental in securing funding and support for building the Fairview Health Complex, and lobbied vigorously for funds required for its expansion. Sadly, this award was presented posthumously. Mr. Doll passed away July 9, 2009, at the age of 74.

Respiratory therapist Rick Linton has spent his entire career caring for the people of the Chinook Health Region. Recently, Chinook Health engaged in the Alberta Cardiac Access Collaborative, a provincial project that improves access to adult cardiac services, and he has been instrumental in supporting the project. Through his work in assessing patients, referring them to the appropriate heart failure services and advocating on their behalf, Mr. Linton has helped improve outcomes and the quality of life for these patients. He is also a passionate educator, who has helped colleagues better understand the assessment and management of chronic respiratory conditions.

To request a nomination form, please contact Pat Shinkewski, Coordinator, Public Affairs, AMA: pat.shinkewski@albertadoctors.org, 780.482.0315, toll-free 1.800.272.9680, ext. 315 or visit the AMA website (www.albertadoctors.org/Awards Scholarships/AchievementAwards).
AMA celebrates
60 years of insurance services

J. Glenn McAthey,
CFP,CLU, RHU
DIRECTOR / SENIOR
INSURANCE ADVISOR,
ADIUM INSURANCE
SERVICES INC.

January 1 marked the 60th anniversary of the Alberta Medical Association’s (AMA) group insurance plans, administered by ADIUM Insurance Services Inc.

The plans have evolved throughout the years, continuously upgraded to ensure competitiveness for our members. The premise of the plans today is no different than when they were launched in 1950 – to provide value-added group insurance programs for members, with no added commissions or fees.

Check below what members have been offered since 1950.

1950 to 1992 – The plans were underwritten by North American Life and Casualty Company, of Minneapolis, Minnesota.

January 1993 – The Disability, Office Overhead Expense and Term Life Insurance plans were transferred to Prudential Group Assurance Company of England (Canada), and major plan design and premium restructuring took place.

Most notably, the AMA moved away from “premium refunds” and started to price the plans at “market price.” The result was substantially lower premiums for members, coupled with numerous improvements in plan design (e.g., higher plan maximums, optional riders, improved contract provisions).

For the past five years, members have been able to take advantage of the 15% discounts on our already competitive published rates due to favorable financial experience.

January 1995 – Sun Life Assurance Company of Canada (a member of the Sun Life Financial group of companies) became underwriter of our Disability, Office Overhead Expense and Term Life Insurance plans after its acquisition of Prudential Group Assurance Company of England (Canada).

January 1999 – Voluntary coverage under AMA’s Disability Insurance plan replaced the Alberta Physician Disability Insurance plan (APDIP). APDIP was a disability plan funded through the AMA’s agreement with Alberta Health and Wellness.

Replacement coverage was offered to all members at that time because ADIP did not offer all of the bells and whistles that the AMA’s voluntary Disability Insurance plan could.

In exchange, the Continuing Medical Education (CME) benefit was increased by $500 for all eligible members. More than 2,500 members elected to purchase the replacement disability coverage.

June 2000 – The AMA Health Benefits Trust Fund (HBTF) was launched and it replaced our Extended Health Care and Dental Insurance plan. Within the first year, the number of participants grew to 870 from 400, and grew again to more than 2,000 participants by October 2009. The AMA HBTF “Core Plan” is underwritten by Alberta Blue Cross.

February 2002 – The AMA group Critical Illness Insurance plan was offered for the first time. Underwritten by Sun Life Financial, this plan had grown to 483 participants. In the fall of 2009 we launched a revised plan, for which more than 400 additional members have signed up.

January 2003 – Industrial Alliance Pacific assumed the underwriting of our Accidental Death and Dismemberment Insurance plan.

January 2010 – More than 5,700 members carried at least one AMA group insurance product.

– The AMA Premium Discount on our Disability, Office Overhead Expense and Term Life Insurance plans increased to 20% for 2010. The discount applies to currently insured members, spouses as well as new members and spouses who take out coverage during the year.

For more information about AMA’s group insurance products, contact: adium@albertadoctors.org, 780.482.0692, 1.800.272.9680, ext. 692 or visit www.albertadoctors.org/AdiumInsurance.

ADIUM Insurance Services Inc. is a wholly owned subsidiary of the Alberta Medical Association. ADIUM administers the group Disability, Office Overhead Expense, Term Life, Critical Illness, Accidental Death & Dismemberment, AMA Health Benefits Trust Fund, Student Disability Insurance and PARA Disability and Life Insurance plans.
Congratulations to the Alberta Medical Association on 60 years of providing insurance services to your members.

Sun Life Financial is proud to be the underwriter of AMA Disability, Office Overhead Expense, Term Life and Critical Illness Insurance plans - aligning with ADIUM Insurance Services to make life brighter for AMA members.

LIFE’S BRIGHTER under the sun

Group Insurance is underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.
A recent decision of the Alberta courts* has again highlighted the difficulties inherent in medical/legal actions involving children whose births allegedly should have been prevented.

The actions either arise as a result of damage to the child born with birth defects (the birth, but not necessarily the birth defects, were alleged to have been caused by negligence) or from the fact that the child is not wanted.

The cases usually arise as a result of allegations of negligence against physicians who are said to have failed to give proper or thorough information, or failed to perform surgical procedures properly.

Canadian courts have struggled in defining the characteristics of the various causes of action advanced in this context. The cases essentially fall into the following categories:

a. The “wrongful birth” action where the parents seek the costs of raising a child born with birth defects, claiming the loss of the opportunity to make an informed choice post-conception to terminate the pregnancy, or preconception to avoid the pregnancy altogether

b. The “wrongful conception or pregnancy” cases where the parents advance a claim for damages relating to the pregnancy and birth of an unwanted but healthy child

c. The “wrongful life” claim, advanced by or for the damaged child for losses associated with his or her disability on the basis that the defendant physician negligently failed to prevent the child’s conception or birth

It is largely settled, both in Canada and many other jurisdictions, that the latter claim for damages for wrongful life is not sustainable.

The basis for this is the rejection by the courts of the proposition that a compromised existence is worse than none at all.

In addition, such claims necessitate the impossible comparison between life with disability and no life at all.

The first category, “wrongful birth,” is well-accepted and the damages are capable of definition (and, needless to say, can be significant).

It is the second category, the “wrongful pregnancy,” that continues to trouble the courts and it is this category that gave rise to this recent decision.

In this case, the plaintiff alleged that the defendant physician failed to adequately advise her of the risk of failure associated with tubal ligation and that, had she been properly informed, she would have taken additional precautions following surgery, thus avoiding conception.

Following the tubal ligation procedure performed by the defendant physician, the plaintiff became pregnant and gave birth to a healthy girl.

The plaintiff did not contend that the surgery itself was negligently performed, only that the lack of information essentially caused an unwanted pregnancy.
evidence that the failure rate associated with tubal ligation was “common knowledge.”

He also determined that, in any event, the plaintiff had failed to establish that she had been informed, she would have taken additional steps to avoid pregnancy and, therefore, there was no causal link between the defendant’s alleged misinformation and the pregnancy.

He, therefore, dismissed the plaintiff’s claim but he went on to discuss the assessment of damages in case an appeal of his decision was successful.

This is perhaps the most interesting part of the case. The trial judge accepted that if the pregnancy was caused by the acts of the physician, then certain losses were or would be suffered by the plaintiff.

He accepted that the plaintiff had suffered pain and discomfort associated with the pregnancy and the delivery and would have given a modest monetary award for that.

It is in the area of assessing whether any award should be made for the costs of the child’s upbringing that was most troubling for the court.

He noted comments made by the English House of Lords, in an earlier decision, where such a claim was rejected.

The comments in that case ranged from a recognition that it was, “... not fair, just or reasonable to impose on a physician the consequential responsibilities imposed on or accepted by the parents to bring up a child” to a comment that, “... the birth of a healthy child is not a harm and, therefore, not a matter for compensation.”

It is this latter point that caught the trial judge’s attention. He focused on evidence from the plaintiff mother that, in almost every way, her life was better than it was before her daughter was born. The father agreed.

The plaintiff attempted to advance the argument that a “no-recovery” approach disregards the real costs of raising a child and essentially “let the physician off the hook.”

The trial judge’s response was that the purpose of compensatory damages was not to punish the alleged wrongdoer but to compensate the plaintiff for loss or injury.

He concluded by agreeing with the House of Lords that, “... it is inappropriate to characterize the cost of raising a healthy child, born to a family who loves her, as an injury or loss.”

This case illustrates the requirement in law that, in order for negligence to be proven in law, there must be damages suffered as a consequence of the wrongdoer’s actions.

The role of the courts is not to punish a wrongdoer but to compensate the victim.

Even where a practitioner’s conduct falls short of the requisite standard of care, where the victim’s life is actually enhanced by the result, there are no long-term losses suffered (although arguably there may still be damages for the pain and suffering of the mother during the actual pregnancy and childbirth).

References
T.G. v. Dr. B., 2009 ABQB 651 (November 13, 2009).
History of medicine contributions

History of medicine articles, especially those focused on the achievements of physicians, health care workers and institutions in Alberta, have long been included in the Alberta Doctors’ Digest.

Following the success of the Dr. Margaret Hutton Lectures at the Alberta Medical Association’s (AMA’s) Fall 09 annual general meeting, the Digest will share continuing history of medicine contributions by three medical student presenters.

These historical perspective articles are an opportunity to reflect on Western Canadian contributions and their place in the wider history of medicine. (Dr. Frank W. Stahnisch, Alberta Medical Foundation/Hannah Professorship in the History of Medicine & Health Care, University of Calgary.)

Canadian freeze: Application of hypothermia and other advances in blood oxygenation in cardiac surgery during the 1950s

Kate E. Elzinga
MD CANDIDATE, UNIVERSITY OF CALGARY

In the historiography of cardiac surgery, it is claimed that the first heart operation was performed in 1801 by Francisco Romero (ca. 1770-1815).1 His pericardiostomy involved making a thoracic incision,2 then opening and draining the pericardium.3

“Blood oxygenation” did not restrict this type of minor surgery but proved to be a significant barrier limiting cardiac surgery for the next 150 years. Open-heart surgery only became possible with the creation of the cardiopulmonary bypass machine and the use of hypothermia.

Experimentalists since François Magendie (1783-1855) and William Beaumont (1785-1853) had worked with animals and registered physiological reactions following changes in body temperature.4

Yet by the beginning of the 20th century, the application of hypothermia in surgery was still limited.

One of the first surgeons to develop ideas for overcoming this age-long problem of maintaining blood oxygenation was a Canadian. . . .

Canadian contributions

One of the first surgeons to develop ideas for overcoming this age-long problem of maintaining blood oxygenation was a Canadian – Dr. Wilfred Bigelow (1913-2005), from Brandon, Manitoba.5

Intrigued by the phenomenon of hibernation, he investigated the use of medical hypothermia in dogs, which have a comparable body temperature of 37.8-39.2 C.6

Bigelow discovered that if dogs were cooled to 25-30 C, they could be brought back to consciousness in warm water. These were encouraging results as heart operations would be safer if a patient’s oxygen demands were decreased during surgery.

Debut of hypothermia

On September 2, 1952, at the University of Minnesota, a cardiac surgeon, Dr. John Lewis (1916-93), lowered his patient’s body temperature to 28 C using an ice-packed tank.

Once the heart rate had decreased to half of its normal rate, Lewis opened the patient’s chest, exposed the heart and repaired an atrioseptal defect.

After thoracic closure, normal body temperature was restored through the use of a tub of warm water (as shown in the photo, top of page 19).

This occasion marked the first use of hypothermia in open-heart surgery.7 One of the challenges of this procedure was that a patient could only be maintained at a lower temperature for a limited amount of time.8

An alternate way of allowing heart surgery was to stop blood circulation using a cardiopulmonary bypass machine, which Dr. Clarence Dennis (1909-2005) had learned from Dr. John H. Gibbon, Jr. (1903-73) in Philadelphia.

Using Gibbon’s blueprints, Dennis returned to the University of Minnesota and, over a period of five years, assembled a machine with the help of the university’s machinists.

The apparatus consisted of pumps, switches, motors, a flow metre, a solenoid, a reservoir and a series of rotating steel disks.9
Tip of the iceberg

On December 3, 1967, Dr. Christiaan Barnard (1922-2001), a South African cardiac surgeon, performed the first human heart transplantation using a cardiopulmonary bypass machine.

This feat, the ultimate achievement in cardiac surgery, was made possible by earlier advancements in blood oxygenation made both in Canada and beyond.

Acknowledgements: I wish to thank my preceptor, Dr. Frank W. Stahnisch, for his guidance in writing this article.

References available upon request

Students lobby MLAs for clerkship program

Scott A. McLeod
SECOND YEAR MEDICAL STUDENT, UNIVERSITY OF ALBERTA

During the second annual Pan-Alberta Political Action Day at the Alberta Legislature, more than 50 medical students from the universities of Alberta (U of A) and Calgary (U of C) met with 45 MLAs to encourage support for the Rural Integrated Community Clerkship Program.

The optional third-year clerkship program provides students nine months of core rotations in a rural setting.

Prior to the October 26, 2009 event, students learned important lobbying skills from the following Alberta Medical Association (AMA) members and staff: Dr. Patrick J. White, President-Elect; Dr. John T. Huang, Chair, Government Affairs Committee; Ronald A. Kustra, Assistant Executive Director (Public Affairs) and Shannon E. Rupnarain, Director, Public Affairs.

For the sake of their education and their future patients, the medical students look forward to the third annual Political Action Day in 2010 and AMA’s continued advocacy mentoring.
To most physicians MDS, RAI-2.0, RAI HC, CAPs, QIs, CPS, RUGs are unfamiliar terms, yet these terms represent a movement that has the potential to transform care standards and quality in Alberta.

These terms come from the Resident Assessment Instrument (RAI), which was developed by a collaborative network of international researchers from more than 30 countries (interRAI) in a commitment to improving health care.

The goal is to promote evidence-based clinical practice and policy decisions through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

RAI is being introduced across Canada to measure and track health indicators in residents of long-term care, supportive living and home care. Alberta has mandated provincial rollout of RAI in these settings.

Data is collected on admission to home care or a facility and routinely thereafter (annually in home care, quarterly for long-term care), and includes information on multiple clinical and functional domains and medication use.

RAI instruments share a common language and common measures, which enable clinicians to monitor clients across settings. Assessment data guides clinicians in developing client specific care plans and supports analysis of resident risks and outcomes over time to improve continuity of care.

At the management and policy-making levels, the outputs of the RAI assessment are used to support planning, quality improvement, funding and accountability.

Alberta Health and Wellness (AHW) is developing a repository to collect all community client assessment data and will, in turn, share this information with the Canadian Institute for Health Information (CIHI).

**How is RAI data used?**

RAI data is used in numerous ways, as follows:

- Care planning
- Early identification of patient problems needing further assessment (e.g., delirium, nutritional status, falls and pressure ulcers)
- Reporting individual patient outcome measures such as cognitive and functional status, pain and depression
- Facility performance (using quality indicators) and funding
- Establishing provincial benchmarks using data from CIHI repository
- Research and education

Outputs of the RAI instruments provide a framework for interdisciplinary care planning of which the physician is an integral team member.

Familiarity with the assessment and an understanding of the different outcome measures available will
- enhance communication and provide physicians with “real-time” data to enhance clinical decision-making.

Individual patient outcome measures can be reported to physicians on a routine basis and at times of change in health status. Consistent measurement and reporting of quality indicators will allow medical directors to track care in their facility and use this information to focus education and quality initiatives.

Physicians have so far had limited input and involvement with the RAI movement in Alberta. This is changing.

RAI data is a powerful tool to aid clinicians and medical leaders to monitor and evaluate the care given to patients, and to look at improvements in care based on quality initiatives and best practices.

Information can be generated locally (i.e., in the facility) and used locally to report to physicians and other team members on changes in health status of their patients, as well as to professional advisory committees monitoring quality in the facility. RAI also has a powerful research potential.

Areas that may be of particular interest include nutritional status, client’s functional independence and mobility, wound care and medications.

**How and what RAI data is generated?**

The Minimum Data Set (MDS) is the core RAI screening assessment instrument. Trained staff complete the instrument electronically.

Four types of outputs are automatically generated:

- Outcome measures
- Quality indicators (QIs) (e.g., incidence of new fractures, infections, antibiotic use, skin ulcers, falls and fractures, use of nine or more medications)
- Resident or client assessment protocols (RAPs or CAPs)
- Resource utilization groups (RUG)

Medical directors may use QI information to determine how a unit or facility is performing today compared to another peer organization, and proactively identify areas for quality improvement. Quality indicators may lead to quality improvement initiatives at the unit, care centre, organization, zone and provincial levels.

Embedded within the MDS are several outcome measurement scales that can be utilized to monitor change in a client’s status over time and guide clinical decision-making.

Examples of these include:

- Cognitive performance scale (CPS)
- Depression rating scale (DRS)
- Chronic health and end-stage signs and symptoms (CHESS)

### RAI data is a powerful tool to aid clinicians and medical leaders to monitor and evaluate the care given to patients, and to look at improvements in care based on quality initiatives and best practices.

Many of these scales have been validated against existing familiar tools. For instance, the CPS provides a functional view of cognitive performance and is automatically derived upon completion of the MDS.

CPS scores correspond closely with scores generated by the Mini-Mental State Examination (MMSE)\(^1\) and the Test for Severe Impairment.\(^2\) The CPS classifies all clients into seven categorical levels of cognitive performance, ranging from intact (score of “O”) to very severe impairment (score of “6”).

Certain data elements in the RAI combine to trigger RAPs or CAPs. These are problem-oriented frameworks designed to organize MDS information and highlight clinically relevant information about a client.

RAPs and CAPs indicate an actual or potential problem area for which further in-depth assessment and client-centred care planning is warranted. Examples of RAPs include delirium, nutritional status, pressure ulcers and falls.
In the coming months a common set of CAPs for use with the RAI 2.0 and RAI HC will be implemented.

RAI is not a tool for monitoring physician performance or practice patterns.

RUG is a grouping tool applied to MDS assessment data to assist in determining the approximate resource use of a client. Each client is assigned to a RUG score based on clinical characteristics drawn from the MDS.

Each RUG has an associated case-mix index value that represents the relative cost of caring for an average continuing-care resident within a group compared to the average resident in the population. Activity-based funding for all long-term care centres utilizing RUGs is to be phased in beginning April 2010.

Confidentiality of physician information with RAI

The RAI instruments can provide a physician with a comprehensive picture of the current and ongoing health status of individual patients, or groups of patients under their care, through custom report requests at the location where care is provided.

However, identifiable physician information is not attached to RAI data being aggregated and forwarded by the facility to AHW and CIHI. Thus, RAI is not a tool for monitoring physician performance or practice patterns.

RAI is a powerful tool for use in clinical care and quality improvement across settings.

Physicians need to continue to be engaged in the RAI process and review of RAI data to enhance the provision of quality health care to Albertans.

References
The part-time stigma

From a 30-something female resident physician’s perspective

Consider the following true scenario. A medical student on her anesthesia rotation strikes up a conversation with the surgeon across the drape. When she tells him that she is interested in obstetrics and gynecology, he disparagingly replies: “Well, that will make a nice part-time job for you, won’t it?”

She is speechless. What can she say? Ironically, in this particular circumstance, the surgeon was talking to a woman who had always planned to work a traditional full-time schedule.

Nevertheless, in that moment she found herself subject to a criticism faced by a growing number of physicians – part-time choices show lack of commitment and contribute to the doctor shortage.

Hearing this anecdote prompted me to investigate some of the debates about part-time work, female physicians and the doctor shortage.

My quick Google search turned up a number of recent articles, academic and non-academic, regarding the work-hours’ issue. One can always count on the Internet for sensationalism.

I certainly discovered plenty of hostile message boards with blatantly sexist “get back in the kitchen” comments but these were far from the mainstream sentiment.

The most widely quoted article revealed in my search was written by Dr. Brian McKinstry in the April 2008 British Medical Journal.

McKinstry argued that society needs to ensure an equal number of men and women enter medical schools to meet future health care demands because women simply work fewer hours over the course of their careers.\(^1\)

In the same issue, Dr. Jane Dacre argued the counterpoint. If women are the most capable candidates for medical school entrance, they should be admitted and no limitations should be implemented based on gender.\(^2\) Instead, she argued that more should be done to encourage women to take on leadership roles given there are still few women in these positions.

All of this research made me sit back and think about whether I am doing something detrimental to my profession or my society by choosing to work part-time hours.

Following much reflection on my priorities, I took the unusual step this year of requesting a part-time residency arrangement. I will be working sequences of two blocks in training followed by one block free of duties until I complete my program, about six months later than I would have otherwise.

Will I continue to work part-time after I complete my residency? Most likely. Is this choice wrong? I don’t think so.

In all this discourse, there exists the implied assertion, shared by a number of my colleagues, that I should not have entered the medical profession unless I was willing to put the rest of my life’s aspirations aside.

True, I will serve fewer patients in my career. But I believe I will serve them better and I will serve them longer.

This perspective saddens me because I have much to offer the profession, even working only a portion of the “full-time” hours resident physicians often work – an average of 75 hours per week (before studying).

True, I will serve fewer patients in my career. But I believe I will serve them better and I will serve them longer.
I know I am fallible and I have limits. The responsible solution for me is to pace myself throughout my career. If I decide to have a family, I accept that my net contribution to society working part-time as a physician serving patients and part-time within the home will equal or exceed even the hardest-working physician.

My role in society will be different, not reduced. I do not argue this is the path for everyone.

Whether we approve or not, the trend in medicine is toward alternative ways of practising. Collectively, the profession will need to find ways to allow for part-time employment.

It will do us no good to disparage colleagues who make different choices or to lament the “good old days.” It is time to reshape our ideas about medical practice.

In the end, I agree with both Dr. Dacre and Dr. McKinstry. Dr. Dacre is right that we need to be more flexible in the way we practise medicine.

On-site child care, easily accessible part-time training and practice options would go a long way in this respect.

We must also ensure equal numbers of men and women in the profession, as Dr. McKinstry argues.

However, the reason for this is not only to ensure adequate human resources but also to ensure diverse perspectives that reflect the population we serve. A completely feminized version of medicine would have its own limitations.

Overall, this discussion does not need be one of “either, or.”

With a bit of out-of-the-box thinking, we should be able to provide career flexibility for those who seek it, all the while valuing the many physicians who want nothing more than to dedicate the entirety of their lives to their jobs.

There is room for us all in medicine.

References

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Scene one: The drama

Mrs. N.: “I’m looking for a new doctor. My last doctor has ‘cut me off’ and has given me one month to find a new one. I didn’t like that doctor anyway, and I’ve been on pain medications for years for my chronic back pain. I need weekly prescriptions for 90 Percocet.”

MD: “Groan.”

Emotional responses to patients are real

Emotional reactions to patients are real and have consequences for physicians and patients. These reactions can sabotage or enrich health care.

Best practice requires that the physician has awareness, acceptance and an action plan for emotional responses to the patient.

Emotional responses provide valuable information about what we think and feel is important to us. Best practice requires that the physician has awareness, acceptance and an action plan for emotional responses to the patient.

What is going on between this physician and patient?

“If everything looks black, we’ve probably got our eyes shut.” (Melody Beattie)

The doctor and the patient are “tied together” in an emotional drama. The patient is angry, demanding and controlling. The doctor responds, feeling controlled and helpless.

It can be one example of a codependent emotional transaction. The behavior of one person determines the behavior of the other.

Stephen Karpman, a teacher of transactional analysis, has called this the Drama Triangle. He has named three roles on the triangle: Persecutor, Rescuer and Victim. The Victim role is at the top of the triangle, as this is usually the start position.

Occasionally, physicians will assume the start position as Rescuer. Our emotional experiences often determine where we feel most comfortable to start – using shame, blame or guilt.

Regardless of the start position, the energy of the triangle is generated by rotating through the variety of roles, often in a matter of seconds.

For example, the physician can assume the roles of Persecutor, Victim and Rescuer, respectively, feeling irritation/anger at the nature of the patient’s drug problem, feeling victimized by the patient’s attempt to control medical prescribing and feeling guilty because of the inclination to just dismiss the patient.

The patient, of course, assumes the reciprocal roles and the emotional drama begins.

Do you have a visceral response to a patient? Perhaps you are being invited to play a role on a Drama Triangle.

Emotional nexus

Humans are emotional beings and emotional wellness is essential to our health. Emotions are complex responses to an external stimulus or person and/or a response to one’s inner workings – perceptions, expectations, judgments, experiences, etc.

Regardless of origin, emotions are tell-tale and require your attention. Emotions give us valuable information about what seems important to us. For example, what is this feeling telling me – about me, the other, our transaction?

In the Drama Triangle transaction, the emotional responses are attempts to control the other person’s behavior.

Inherently, the solution to getting off the triangle and this emotional
enmeshment is to disengage, that is, to not try to control the other person. Rather, the emotional goal is to respect each other’s integrity and autonomy. That requires clear personal and professional boundaries.

Be aware to care: Getting off the triangle

“The real voyage of discovery consists not in seeking new landscapes but in having new eyes.” (Marcel Proust)

Unexamined emotional responses can sabotage your best professional intentions. Scenarios follow.

- You take on all the drama roles: judging, criticizing, cajoling your patients; giving up, taking a passive and helpless role; assuming total responsibility for your patient (Rescuer providing any number of excuses).
- You feel intellectually and emotionally exhausted without an equal measure of professional satisfaction.

Ask yourself, am I on the triangle? How can I understand these emotions and advocate for the patient? Accept and be aware of emotional responses. Make a conscious decision to assume positive professional roles.

Each role on the triangle has a positive alternative as leader and educator, compassionate caregiver and collaborator in finding creative solutions to the patient’s problems.

These roles are based on respect for each other’s integrity, ability and capacity to make good decisions for each other. The roles establish clear boundaries of who is responsible for what and, accordingly, disengages emotionally one from the other.

Each person is responsible for what he or she thinks, feels and does, independent of the other. This allows for a separation of emotional responses and allows for clarification of your professional response.

How do you get your emotions to work for you? Self-care is important in emotional management.

Clearly, emotional wellness is connected with physical wellness (rested and well-fed), social wellness (interpersonal connections) and a grounded sense of our worth and meaning, ever reminding us to take care of our whole selves as we take care of others.

The deliberate doctor or back to basics

“In the depth of winter, I discovered that within me there lay an invincible summer.” (Albert Camus)

Back to basics: Choose to be the physician you want to be. Clarify your values and professional goals.

Do no harm (get off the triangle) and, second, do a kindness – to the patient and to yourself.

The deliberate doctor is mindful of the covenant of care and the duty to provide a relationship founded on mutual respect and trust. First, do no harm (get off the triangle) and, second, do a kindness – to the patient and to yourself.

One approach for the patient follows:

- Establish boundaries. Determine shared goals and create a deliberate plan for recovery. Is there an investigative alliance to determine the nature of the problem? Is there a therapeutic alliance for a solution to the problem?
- Respect the patient, acknowledging his or her capacity to determine his or her own choices and capacity to change.
- Always be compassionate to the patient but ruthless to the disease. Explore creative solutions and give “best practice” advice. Accept the patient’s choices but if you do not agree, explain why.
- Recognize your limitations of specialty/strength, expertise and experience. Work with other health providers to provide a holistic plan to wellness, considering the physical, emotional, spiritual and social needs of the patient.
- Get ahead of “conflicts” with co-workers. Communicate and establish clear boundaries regarding staff interactions (zero tolerance of abuse), appointment scheduling and unreasonable or harmful requests concerning prescription drugs.
- Know where you are on the plan and have contracts for care where necessary.
- Be supportive, acknowledging that the patient is responsible for his or her choices and that making changes can be hard work.

Good intentions may not carry the day. The patient may not be ready for change. However, your professional intentions will be clear and emotionally sound, always leaving access to care open to the patient.
Scene two: Willingness to change

On the second visit, Mrs. N. was tearful and she stated that her two daughters (and five grandchildren) were very concerned about her health and prescription use. They were encouraging her to “get off the drugs,” reminding her that she had “beaten alcoholism” in the past.

At this point the physician has had time to reflect and detach from the drama and consider how to involve the patient in her own recovery.

The patient was willing to obtain her medical records, start a program of opiate reduction, attend weekly appointments for mental health/addiction counselling and consider a residential treatment program.

The final act: Off the triangle, on the Medicine Wheel (Holism)

The Medicine Wheel (see above) is one Aboriginal approach to wellness. It recognizes the inter-relationship of the physical, emotional, social and spiritual aspects of health in each of us.

Patients and physicians share the same wheel and each is responsible for personal growth or change in each of the directions.

Life is full of emotional dramas. It is what gives depth and meaning to our lives. But life, like your patient, is best approached “on its own terms.” You are not in control. Attempts to control or manage either can have disastrous consequences.

The physician’s covenant of care is to teach the patient about best health practices. The physician needs to stay informed, which includes intelligent reflection on emotional responses – his or her own and the patient’s.

There are as many analyses as emotional responses but, in the scenario given, the physician was aware of an emotional reaction.

Be aware to care. Caring is best practice. Emotions can inform rational care and aid in the physician’s primary goal of providing health care and recovery. Emotions connect us to each other and aid us in mutual understanding.

The result is more compassionate care for the patient and for the physician. We are all the richer for the discovery.

References


Mental Health America (formerly the National Mental Health Association). Factsheet: Co-Dependency. (www.mentalhealthamerica.net/go/codependency).

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The Internet Explorer Eight (IE8) web browser is part of the latest version of Microsoft Windows. It is also available as a free download for older versions of Windows (visit www.microsoft.com). A quick tour of some of the new and old features of IE follows.

**Address bar**

When the user types in the Address bar, IE8 displays suggestions based on his or her browsing history or favorite websites. Single words typed into the Address bar will be matched to simple domain names, making web surfing more efficient.

**Menu bar**

The classic Menu bar containing the File, Edit, Favorites, Tools and Help menus is not displayed when IE8 is first installed. This will appear by pressing the Alt key.

**Favorites bar**

The Favorites bar can display links to sites the user visits frequently. A website can be added to the Favorites bar by typing its address in the Address bar, then clicking the Favorites tab in the main Menu bar.

There is an option to add the site to the main Favorites list or to the Favorites bar itself. Titles of tabs on the Favorites bar can be shortened by right-clicking on the tab and selecting the Rename option.

**Tab bar**

IE8 allows multiple pages to be opened in the same window. Navigating between them occurs by clicking on their tabs at the top of the main window. This makes it easy to compare two different pages or even different versions of the same page.

At the left end of the Tab bar are links to the Quick Tabs and Tab List functions, which are useful if a large number of tabs are open at once. An individual tab may be closed by pressing Control-W or clicking on the “X” on the current tab.

**Open a new tab**

Clicking on the small blank tab, displayed to the right of the Tab List, or pressing the Control-8 key combination allows the new tab to automatically display the user’s list of most-frequently visited sites. A duplicate of the current tab may be created by pressing Control-K.

**Command bar**

The new Command bar appears to the right of the Tab bar, just above the main window. It is the new home of the Home, Print, Safety, Tools and Help icons.

**Home icon**

Clicking the House icon returns a user to his or her personal home page, which is displayed when IE opens. A home page can be changed by clicking the down arrow beside the icon or by selecting Internet Options from the Tools menu.

**Print icon**

By clicking on the Printer icon, the user will print his or her current page. Clicking the down arrow beside the icon will display the Print, Print Preview or Page Setup menus. The Print menu (Control-P) allows a user to select a range of pages to print and to print multiple copies.

**Page menu**

This new menu displays options to control the display of the current page. An important one is the Compatibility View option that properly displays older sites designed for earlier versions of IE.

**Safety menu**

The user can use this new menu to display options to control his or her browsing history and privacy. There is also an option to check for program updates.

**Tools menu**

This new menu provides quick access to many of the most common tools available in IE8. More options are available using the Tools menu in the classic Menu bar.
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As an admirer of the Chinese Communist Party and that fine human being Chairman Mao, I find it comforting that central planning has finally come to this neck of the woods.

In days gone by, directors of hospitals, institutions and centres could pick up the phone and talk with a minister and regional board chair – actions fraught with risk for over-hasty decision-making and wide open for lobbying and corruption.

I am delighted to report that with proper centralization of decision-making, these folksy ways are now a thing of the past. I have never seen a wider gulf between practising physicians and government bureaucracy.

Sober second, third, fourth, fifth and more thought is now given in a proper vertical manner, all aspects of potentially risky decisions being weighed, as they make their way up a rickety stovepipe of committees, leaders, vice-presidents, senior vice-presidents, executive vice-presidents, the president, the central committee (known as “The Superboard”) and, finally, to the (hushed voice here) minister himself so that local requests can be stymied, decisions delayed or not taken and, hence, no money wasted.

Professor C. Northcote Parkinson’s Law of Delay, “Delay is the deadliest form of denial,” is verified in its most naked wisdom – in nunga punga, as they would say in India. Decisions should and are now being properly taken by those most knowledgeable, that is, at what is amusingly known as “The Top.”

This makes things like running a vaccination program in Calgary careful, slow and uniform, it being important to have all decisions approved centrally. Waiting six hours for a simple jab in cold weather reminds people of the value of what they are receiving, thanks to The Party.

In another exhilarating example, however, of rapid decision-making and The Party’s ability to act swiftly, the people were reassured, after the shock and horror of the Calgary Flames receiving life-saving vaccinations from the dreaded H1N1 ahead of the peasants, to see the public dismissal of two capitalist roaders responsible for this outrage.

Decadent western organizations might have hailed their action as rather clever and showing initiative. These capitalist roaders are now JOBLESS! Yes!

I have never seen a wider gulf between practising physicians and government bureaucracy.

For too long in the province we have had local bureaucracies with decisions on delivery of things like health care being taken at a regional – or worse – a local level. This is akin to having the rural bumpkins decide how to run their farms!


But the meeting lasted only 45 minutes and, for much of the time, it was like watching the old BBC comedy show The Two Ronnies.

Inexplicably, the darkened auditorium was empty save for three giggling girls who had been given time-off to have an H1N1 vaccination at the station outside the hall and who were clearly extending their leaves of absence. I shall report them.

After an up-lifting review from President Dr. (Econ) Duckett (who reported that everything was apples), the chair introduced a series of numbered reports, which were rapidly proposed, seconded and approved.
These reports included proposals on executive pay and a recommendation that Alberta Health Services (AHS), a government body I had thought, would borrow some $220 million from the Royal Bank of Canada at a favorable interest rate.

I raised my hand and shouted into the void of the auditorium that I wanted to ask a question. But, alas, it was a one-way transmission system and I remained unheard.

Surely there would be animated discussion from our Superboarders. There was none. Nothing. Nada. All motions were unanimously approved without discussion or the revelation of any interesting content.

This thrillingly reminded me of the Chinese Communist Party's National Congress where, every five years, representatives meet in the Great Hall of the People and give unanimous approval to all resolutions proposed by the Central Committee.

But I love the new light-blue logo on note paper, websites, policies, procedures and protocols, as well as the general renaming of things. True, this can cause confusion for a year or two but the ends justify the means.

And the slogans! "Institute Best Practices!" and "One Province, One System!" But come on, we can still learn much from the Chinese Communist Party regarding punchy slogans: "Achieve the Four Modernizations!" "Smash the Gang of Four!" "A Hundred Flowers Bloom, a Hundred Thoughts Contend!"

We have also now instituted a system of approvals for all staff, which require central authorization of such bourgeois decadent occasions as buns and coffee at rounds and lunch-hour meetings. All catering events now require a signature in Edmonton, and you may not receive it!

As for travel out-of-province, the signature of someone called an executive vice-president is required even when no money from the central authority is required. This is because it is important someone in Edmonton, who knows nothing of your activities, actually authorizes your activity, you understand.

And we are much closer to our leaders now than we have ever been. One of our Four Modernizations – “Engagement!” (the others being “Transparency!” “Access!” and “Accountability!”) now allows us to receive personal, comforting contact by means of a BLOG, updated regularly with selected information. This vanquishes the lazy old system of discourse.

But now I must be serious. Here's another exciting example of where we are headed. Take our patient advocate. This wise lady, experienced in dealing with complex complaints and very good at sorting them out, has been reclassified.

She is now a “patient complaints consultant” with a 17-page job description. Although living and working in Calgary, she reports to a “senior patient complaints consultant” in Cold Lake.

She must remove herself from the hospital and move into neutral territory because she is too close to the doctors. She will no longer talk with complainants face-to-face but deal with them on the phone, recording the gory details but not acting on them unless approval is given.

This heralds the triumph of process over substance – blogging with its illusion of contact, listing complaints with its illusion of action, establishing advisory groups with its illusion of influence.

All of this bodes an increasingly centralized and enlarging bureaucracy, inevitable since that is the nature of all centralized bureaucracies ever established. To cope with the likelihood of inappropriate decision-making when there is minimal local input, much help is required, at first a secretary, then an assistant, then a deputy, then an associate and so on.

All motions were unanimously approved without discussion or the revelation of any interesting content. This thrillingly reminded me of the Chinese Communist Party’s National Congress. . . .

Professor Parkinson enunciated a series of laws, all of which are Nobel Prize material. From his first law, “Work expands so as to fill the time available for its completion” (verified within AHS in the re-jigging of policies, procedures and protocols that were already widely available), to his Law of 1000 (“An enterprise employing more than 1,000 people becomes a self-perpetuating empire creating so much internal work that it no longer needs any contact with the outside world.”).

We are well on the way to creating a governmental monster that will delay, subvert or twist any innovation that comes its way.

Barry Cooper, Calgary Herald columnist and member of the dreaded Calgary political/economic group, in
his latest book *It's the Regime, Stupid!: A Report from the Cowboy West on Why Stephen Harper Matters*, writes: “We know that governments do not shrink when a crisis is over and we know why; because they come to govern in their own interests . . . administrative tyranny is the worst of all, because it is the rule of rules, a tyranny without a tyrant, and thus cannot be extinguished. . . .”

Don’t use phony words like “transparency” when your purpose is the opposite. You will be outed.

This “reorganization” at a time of cutbacks has been an unnecessary stress and will require big modifications in the years to come, long after this government has gone the way of the United Farmers.

There are some lessons from all this humbug, bunkum and gallimaufry.

First, in times of recession, we dopes can forgive a lack of funds but not arrogance, hubris and sneering disrespect for our professional experience.

Cut back funding if you have to but do not add a complex, fatuous “reorganization.”

Second, policies, procedures and protocols can be centralized if this is useful for patient care but implementation is always local.

Third, don’t use phony words like “transparency” when your purpose is the opposite. You will be outed.

Fourth, don’t bully. There will be a blow-back.

And, with (for those who are politically ambitious), never expose yourself to the likelihood of a fiasco. We do know who to blame for this massive cock-up.

Never have I witnessed such general derision from mature, thoughtful leaders about the current bureaucratic silliness and the widening gulf between practice and people in boxes with titles such as “Director: Patients as Partners.”

Finally, a call to all covert poets! At my friend’s suggestion and as my personal contribution to the cost-cutting mania pervading the province, I am announcing a Grand Limerick Competition. The best limerick on the theme of cost-cutting will be published in this column and receive a prize at my own expense.

To make it harder, it must contain somewhere, in those five lines, the words “Rockin’ Ron,” “blog” and “Duckett.”

This is my modest contribution to the Great Leap Forward.

References

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