September/October 2010

THE ALBERTA DOCTORS' DIGEST

AMA reaches milestone:
More than 10,000 members

Patients First®

ALBERTA MEDICAL ASSOCIATION

Volume 35, Number 5

Of perfect systems

Dennis W. Jirsch, MD, PhD
EDITOR

". . . dreaming of systems so perfect that no one will need to be good."

T.S. Eliot, *The Rock*

A recent *Edmonton Journal* headline surprised me: "More power, bonuses proposed for Alberta GPs."[1]

Alberta Health Services (AHS) wants to expand the role of family doctors and the province's 33 primary care networks in an effort to improve primary care.

GPs would be put in charge of more services, including mental health, public health services and home care. If docs keep costs down, they'll be eligible for bonus pay.

The model of primary care in the UK, according to the newspaper article, is said to be "particularly appealing." That's the National Health Service pay-for-performance (P4P) initiative, which began in 2004.[2]

In the Quality and Outcomes Framework that was developed, GPs agreed to income rewards for performance with respect to 146 quality indicators covering various aspects of care. The average general practice scores 95% of the bonus-triggering points available, and nearly all exceed 90%.

Other health jurisdictions have jumped on the bandwagon in parts of the US and Australia.[3] Despite the superficial allure of "incenting" behavior, however, few P4P programs to date have been rigorously evaluated prospectively or even retrospectively.

From varied and uneven literature, it would seem that two things remain true. The relationship between resources and quality in health care remains uncertain, and much of what we call care lacks evidence for both clinical and cost-effectiveness.

Quality can be hard to measure and too many of the P4P initiatives I've read about smack of cost-containment and little else.

Quality can be hard to measure and too many of the P4P initiatives I've read about smack of cost-containment and little else.

As well, too many of the performance yardsticks are "process" goals that measure whether, say, Pap tests or periodic radiographs or other tests are being done. They aren't true "outcome" goals.

It would seem all too easy to fall victim to what has been termed "quantophrenia" or "the psychological compulsion to quantify everything no matter how dubious the basis for doing so or how questionable the provenance of the numbers obtained."[4]

That which is quantifiable too easily drives out that which is important.

On another front – pretending for a moment that quality can be measured – just who is to be rewarded?

We continue to emphasize teamwork and collaboration in health care and, in this complex and interdependent system, how is one to reward group and individual effort?

Indeed, how about rewarding the patient? After all, it is generally the patient who has to change, adopting healthier behavior. Even selecting the care we'd like to gauge presents a problem as it can divert attention from other, less-easily measured issues.

If picking up performance points becomes the nature of the task for docs, it would seem to invite "gaming" by cherry picking easier and more ▸

- compliant patients at the expense of needier, less-tractable ones.

Writing this, I recall a telephone conversation with my son some years ago when he was a medical resident in an easterly province. As our call approached midnight, Number-One-Son interjected that he had to ring off before the hour.

Why? Because of an on-going census of patients waiting in hospital ERs at midnight. In this particular P4P maneuver (a stick, and not a carrot), hospitals were to be penalized for large waiting lists in the ER.

A bureaucrat had opined, perhaps reasonably enough, that one measure of quality or dysquality could be the number of patients domiciled in an ER at midnight.

The unintended consequence was that medical residents were charged with temporarily "cleaning house." Patients were summarily whisked off to a ward setting so they weren't in the ER at the time of census.

It was temporary and illusory in terms of quality, of course, and patients were repatriated to the ER and their care queues once the census was completed.

Physicians have long held to a professional ethos and Hippocratic ideals and it would seem obvious that money and scruples at times conflict. Money – hallelujah! – doesn't always work.

Consider the example described in the recent best seller *Sway*.[5] The Swiss government found a small town that seemed ideal for a nuclear waste depot.

When officials presented the plan to the town's citizenry, half said they would approve the plan and about half said not in my backyard.

Government officials responded with a plan to give all residents 5,000 francs if the dump was built in their town. With the promise of funds, the percentage of Swiss citizens who would approve the plan fell to 24.6% from 50.8%, quite the opposite of expectations. Raising compensation further didn't help.

P4P has come to us, it must be remembered, from industry. After six or more decades of experience with P4P in industrial, for-profit industries, the evidence is mixed. Even in this more straightforward milieu, there is no ringing endorsement for P4P.

Indeed, a review of P4P across a variety of industries finds that P4P systems are less likely to be effective in technologically complex situations and those characterized by ambiguous tasks, marked workplace diversity and interdependent behavior.[6]

Sounds pretty much like health care to me.

And so I'm left expecting little from P4P in health care. This isn't to suggest I begrudge practitioners access to extra funds, but I maintain little will come of it. Our early efforts to "incent" our health care executives to date haven't reassured me either, and successes remain obscure.

Too much, and too little, may have been learned from the industrial bigwigs we've heard so much about through recent economic turmoil. They certainly knew how to tag on performance points.

For my money, health care consultant Steven Lewis says it best. "Show me a P4P system that rewards first-class care of the frail elderly, life-enhancing management of multiple chronic conditions, reduced need for surgery 15 years from now or ending one's career with sunny disposition and compassion intact, and I'm all ears.

"But in my preferred world, the first dollar and the last pay for excellence across the board, an ethos of care, devotion to the public good and the perpetual search for knowledge.

"Settle the money issues swiftly so all can focus on what the money is supposed to achieve. Do this well and we'll have pay-for-performance – not as cause-and-effect but as a harmonious feature of a thriving culture."

"Pay individuals well and fund organizations fairly. Settle the money issues swiftly so all can focus on what the money is supposed to achieve. Do this well and we'll have pay-for-performance – not as cause-and-effect but as a harmonious feature of a thriving culture."[7]

Now that would be worth something.

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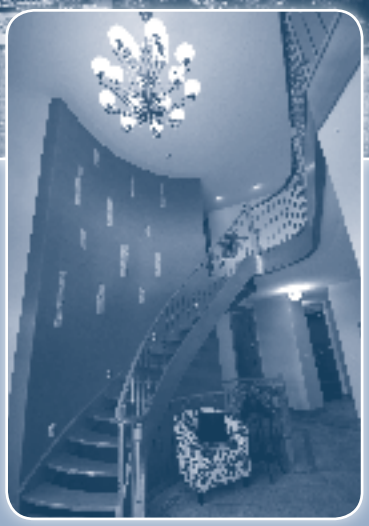

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The Alberta Doctors' Digest is published six times annually by the Alberta Medical Association for its members.

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November/December issue deadline: October 8

Design by Sarah Tiemstra at Backstreet Communications

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TABLE OF CONTENTS

DEPARTMENTS

FEATURES

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.

AMA reaches a milestone: More than 10,000 members

As of April, the Alberta Medical Association (AMA) reached a significant milestone. The association exceeds 10,000 members, including 96% of the physicians practising in Alberta.

This landmark shows a dramatic increase since 2005, when the AMA celebrated 100 years of organized medicine in Alberta. At that time, there were just over 7,500 members.

Today, AMA membership is comprised of:

- Practising physicians – 6,859
- Active practising physicians – 251
- Non-practising physicians – 167
- Administrative physicians – 44
- Supervised physicians – 5
- Residents in post-graduate training – 982
- Medical students – 1,191
- Retired physicians – 237
- Non-resident physicians who live outside of Alberta – 524

History

For 105 years, the AMA has served the physicians of Alberta.

When Alberta was formed in 1905, physicians within the provincial boundaries transitioned from the Northwest Territories Medical Society to form the Alberta Medical Association and the College of Physicians & Surgeons of Alberta in 1906.

These groups began to serve the 300 physicians who were practising in the newly minted province.

The AMA also has actively participated in policy discussions to support the health care system's ability to meet the needs of individual patients and patient populations.

Since its inception, the AMA has advocated for its physician members, providing leadership and support for their role in the provision of quality health care.

The AMA also has actively participated in policy discussions to support the health care system's ability to meet the needs of individual patients and patient populations.

▸ Here are some examples of what the AMA has done over the years:

- 1920s – A grant for Dr. J.B. Collip's studies helps lead to the discovery of insulin by Dr. Frederick Banting and Dr. Charles Best.
- 1930s – AMA supports prepaid medical care and health insurance in a brief to the Hoadley Commission.
- 1940s – Extensive development by the profession is followed by government-created Medical Services (Alberta) Incorporated, providing more than 90% of Albertans with prepaid medical care, until replaced by compulsory federal Medicare in 1969.
- 1950s – The AMA's Committee on Reproductive Care begins a 50-year legacy of improving health care for newborns and their mothers.
- 1960s – AMA representatives, at the provincial government's request, meet with representatives from the government and the Saskatchewan and Manitoba medical associations to study reduction of medical care costs by using health personnel more effectively.
- 1970s – AMA develops and publishes a relative value guide.
- 1980s – Seatbelt legislation becomes law in Alberta in July 1987 largely from AMA advocacy efforts and the petition campaign "Your Name Can Save A Life."
- 1990s – A Patients First® public awareness campaign draws feedback from more than 50,000 Albertans who respond to the call to "Tell Us Where It Hurts."

The AMA exceeds 10,000 members, including physicians, medical residents and medical students. Its vision of Patients First® will continue to guide the association.

The campaign was pivotal in the government's decision to stop further funding cuts.

- 2000s – AMA drafts reports about and/or critiques of major health care commissions, including the Mazankowski Report, the Third Way and the Horne Report in Alberta, as well as federal reports by Senator Michael Kirby and Roy Romanow.

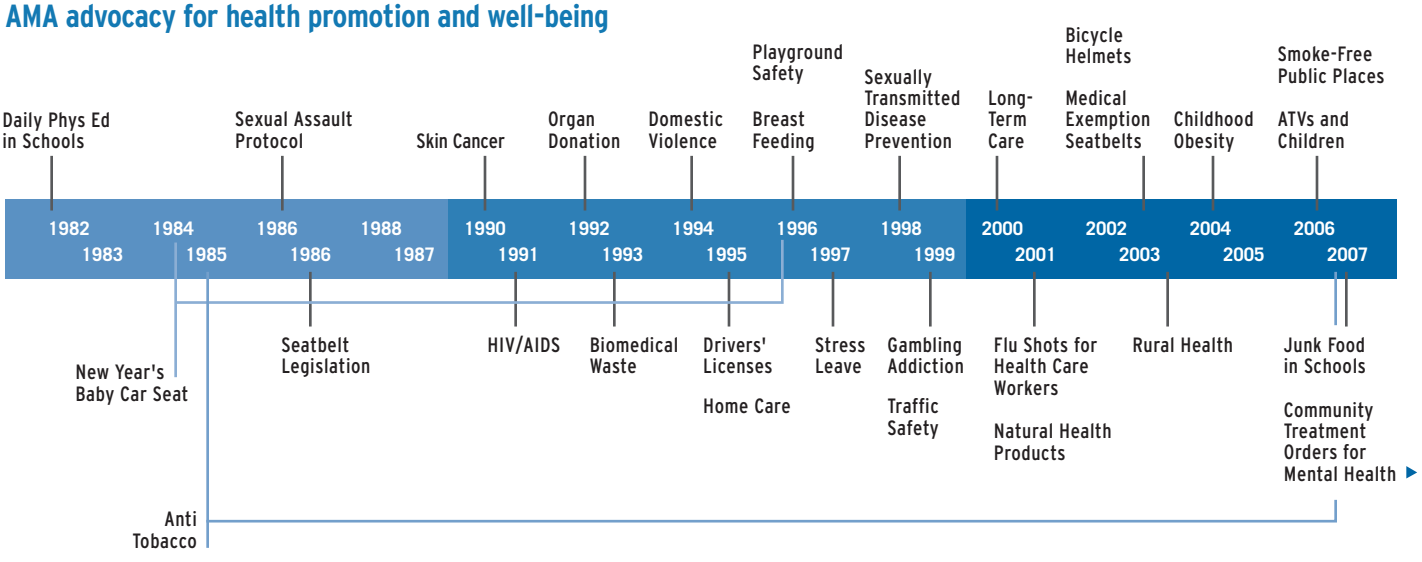
Advocacy today

As Alberta's health care landscape continues to change, the AMA's mission and vision have never been so important.

- **Mission:** The AMA stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.
- **Vision:** Patients First®. It compels the AMA to advocate "value for patients." Value for Patients™ expresses a 365-days-a-year commitment to pursue and support ideas and initiatives that provide real value for patients.

The AMA exceeds 10,000 members, including physicians, medical residents and medical students. Its vision of Patients First® will continue to guide the association.

AMA advocacy for health promotion and well-being



AMA PROGRAMS AND SERVICES

AMA members enjoy a number of programs negotiated over the years to attract and retain physicians; some are proxies for overhead expenses instead of using the overhead component of the fee schedule.

Financial support

- Medical liability reimbursement of CMPA dues
- Continuing medical education allotments ($2,500 per year)
- Retention Benefit payments (reward physicians for their years of service in Alberta)
- Business Costs Program supports community-based office practices
- Rural, Remote, Northern Program supports rural and remote practices
- Parental Leave Program
- Physician Office System Program helps incorporate electronic medical records
- On-call programs, rural and specialist

Practice support

- AMA Physician Locum Services®
- AMA Practice Management Program
- Billing advice and seminars, insured and uninsured services
- Toward Optimized Practice Program guidelines and initiatives
- Canadian Medical Association (CMA) Practice Solutions

AMA and CMA personal support

- AMA Physician and Family Support Program
- CMA Centre for Physician Health and Well-being

Other

- AMA's ADIUM Insurance Services Inc.
- MD Physician Services (formerly MD Financial)
- Preferred car and home insurance through TD Insurance Meloche Monnex

More information about these benefits and programs is available on the AMA website (www.albertadoctors.org) and in the AMA/CMA's *@ your service membership guide*, which members received in September.

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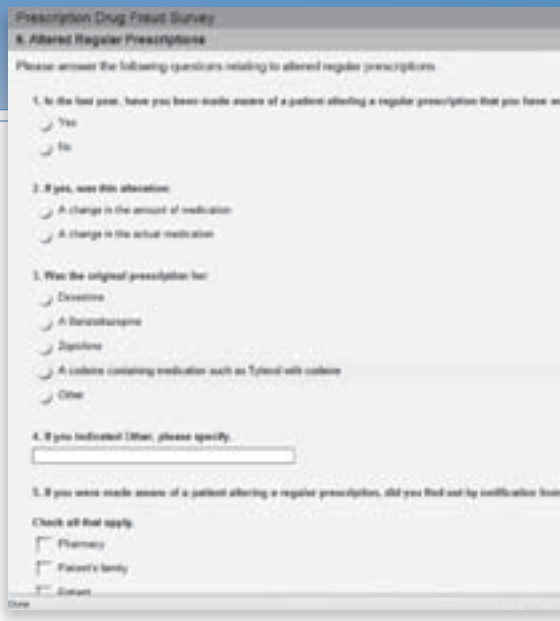
FEATURE

Physicians' experiences with prescription fraud in Alberta:

Survey results released



Prescription drug misuse and abuse is a serious problem in Alberta.

To quantify physicians' experiences with prescription fraud, the Alberta Medical Association, in conjunction with the College of Physicians & Surgeons of Alberta (CPSA), invited Alberta's practising physicians to participate in a survey.

The survey was completed this spring by 677 physicians. A summary of the results follows.

Triplicate prescriptions

Survey results showed only 2% (15) of respondents had a triplicate prescription pad stolen in the past year and, of these, 88% indicated the theft occurred once. According to the CPSA, about 400,000 triplicate prescriptions are logged each year.

Many participants indicated individual prescriptions, rather than whole pads, were often stolen and out of sequence so the thefts weren't discovered until later.

A few physicians indicated they don't keep triplicate prescriptions pads for security and other reasons.

Respondents provided useful tips to help avoid prescription thefts, such as:

- Keep the prescription pad on their person
- Keep the pads in a locked drawer
- Keep them where patients cannot easily access them

Almost 5% of respondents were made aware of a patient altering a triplicate prescription by changing the dose, frequency or total number of pills issued.

Many of those surveyed (81%) said the original triplicate prescription was for an opioid. Other common prescription alterations included Percocet, OxyContin and oxycodone. All physicians who had a triplicate prescription altered were informed by the pharmacy.

Half of respondents discovered a patient was seeing more than one physician to obtain triplicate prescriptions in the past year. Most physicians were informed by the triplicate program (66%) and/or a pharmacist (46%).

In the past year, 36% of physicians had the impression a patient was trying to fraudulently obtain a triplicate prescription.

Often physicians were able to make this determination because the patients: claimed their medications were misplaced, lost or stolen; had a history of drug abuse; asked for a specific medication; exhibited suspicious behavior; had a vagueness of symptoms; or the symptoms did not sound correct.

Regular prescriptions

In the last year, 4% (15) of respondents had a regular prescription pad stolen and, of these, 85% indicated the theft occurred once.

Several physicians use their electronic medical records (EMRs) to generate prescriptions to reduce use of prescription pads in their offices. Although these measures have reduced some prescription theft, patients have photocopied prescriptions or created similar-looking documents in Microsoft Word, making them difficult to detect.

In the last year, 16% of respondents were made aware of a patient altering a prescription. If there was an alteration, 88.3% indicated it was a change in the amount of medication and 12% indicated it was a change to the actual medication. ▸

> In the past year, 52% of respondents indicated they found out that a patient was seeing more than one physician to obtain prescriptions.

Of participants who had a prescription altered, 63.2% indicated it was for a codeine-containing medication. Almost all physicians (98%) were informed of the alteration by a pharmacy.

In the past year, 52% of respondents indicated they found out that a patient was seeing more than one physician to obtain prescriptions. The most common ways by which physicians are informed include pharmacists, colleagues/other physicians, the CPSA, the triplicate program, EMR, Netcare or the patient's behavior/history.

In the past year, 39% of participants indicated they had the impression a patient was fraudulently trying to obtain a prescription.

Often physicians were able to make this determination because:

- The patient lost the prescription or requested repeat prescriptions more frequently than expected
- Of the patient's history through EMR, PIN or Netcare
- The patient's behavior was suspicious; they were warned by family member(s)
- The patient requested a specific medication

As part of the survey, physicians also suggested ways to help deal with both regular or triplicate prescription fraud, which included:

- Getting more timely or real-time access to information 24/7 or full PIN access
- Being informed when a pharmacist has doubts about the validity of the prescription or having open communication with pharmacists
- Having a regular list of past offenders or patients who are known to engage in prescription fraud
- Having guidelines indicating the legal obligations and the physician's rights and responsibilities
- Faxing or electronically sending prescriptions directly to the pharmacy
- Having guidelines on appropriate procedure(s) from the CPSA
- Having easier access to triplicate history or patient prescription profiles
- Having a verification code or bar code on prescriptions ■

Tips for avoiding prescription alterations

To help deter patients from altering prescriptions:

- Write the quantity of the prescription numerically and spell it out alphabetically.
- Fax a copy of the prescription directly to a pharmacy of the patient's choice to fill the prescription. Remember to mark the original prescription VOID after it has been faxed to avoid duplicate prescription use.
- Avoid writing prescriptions using time intervals (i.e., one month) as the notation is subject to interpretation.
- Ensure the prescription has the complete and accurate patient information, including the Personal Health Number.

To read a more comprehensive survey result summary, visit the AMA's website (go to www.albertadoctors.org/MDScope/PrescriptionFraudResults).

For more information about the Triplicate Prescription Program, please contact Dr. Susan Ulan, Senior Medical Advisor, Physician Prescribing Practices Department, CPSA, at 780.969.4930 or 1.800.561.3899 (in Alberta).

Watch for the fall issue of CPSA's *The Messenger* for more information about prescription fraud (visit www.cpsa.ab.ca/Resources/Messenger.aspx).

What to do if a triplicate prescription pad is lost or stolen

Physicians should contact the police, notify the CPSA immediately and provide the following information:

- Date of loss or theft
- Serial number(s) of the missing pad(s)
- Name of the last patient prescribed a triplicate prescription
- Police file number and investigation constable's name and phone number

Health information: Privacy and security within your office

ALBERTA MEDICAL ASSOCIATION Practice Management Program

PMP Staff

The attention to ensure patient confidentiality has escalated with amendments to the *Health Information Act* (HIA) becoming law September 1, increased requests to share patient information with other custodians and the theme of interoperable health systems at local, provincial and national information system tables.

Confidentiality is an ethical principle of the medical profession. In order for confidentiality to be realized, privacy and security measures must be in place.

Security measures are in place to:

- Ensure only authorized users have access to the information
- Prevent tampering
- Ensure information is available when needed

Even when security measures are implemented, there is still the risk privacy can be compromised by the misuse of information by authorized users.

Employee errors, more than malicious activities (internal or external), accounted for 62% of data breaches, according to the *Data Breach Investigations Report*[1] by Verizon Business Task Team. This report is a compilation of breach investigations across all industries, including health care.

Privacy policies and guidelines are in place to:

- Identify roles and responsibilities
- Outline the collection, use and disclosure of information
- Protect the "rights of an individual"

Confidentiality is an ethical principle of the medical profession. In order for confidentiality to be realized, privacy and security measures must be in place.

A little less than half of the physicians in Alberta still use paper charts to collect their patient information. Just like their automated counterparts, they must look at safeguards to protect their patient information.

A little less than half of the physicians in Alberta still use paper charts to collect their patient information. Just like their automated counterparts, they must look at safeguards to protect their patient information.

What can you do in your office?

1. Administrative safeguards include:
   a. Developing a privacy and security manual
   b. Orienting and training staff regularly on privacy and security
   c. Having staff, contractors, volunteers and students sign a confidentiality oath
   d. Assigning a member of the clinic to be the privacy officer
   e. Having all custodians familiar with the HIA and their clinic's privacy and security manuals ▸

f. Posting your clinic's privacy policy in a public place that explains what information is being collected and for what purposes

2. Physical safeguards include:

   a. Secure access to facilities, chart rooms and computer equipment

   b. Supervision of monitors, fax machines, scanners, printers, paper charts when in use and in a restricted area when not being used

   c. A destroy/shred medium for patient information that is no longer required

3. Technical safeguards include:

   a. Computer system protection by firewall and uninterrupted power supply

   b. Current anti-virus and anti-spyware software

   c. Confirmation by a security professional of security of wireless and portable devices

   d. Unique username and password per user that are at least eight alpha-numeric cases long and regularly changed

   e. Regular electronic data backup

The above safeguard-suggestion list is not exhaustive. There are many resources you can access to ensure you have a complete privacy and security-compliant office.

These resources include:

- Alberta Medical Association Practice Management Program: 780.733.3632
- Canadian Medical Association: http://www.cma.ca/privacywizard.htm
- Office of Information and Privacy Commissioner (OIPC): http://www.oipc.ab.ca

All custodians must have written policies to help them comply with the HIA, which includes access and correction requests, privacy and security.

At the end of the day, patient confidentiality is the crux of the patient-physician trust relationship.

It is imperative your office can provide your patients with the comfort that their health information is well protected.

All custodians must have written policies to help them comply with the HIA, which includes access and correction requests, privacy and security.

Reference

1. Verizon Business RISK Team. "2008 Data Breach Investigations Report." 2008; page 14 (http://www.verizonbusiness.com/resources/security/databreachreport.pdf).

Alberta Medical Association Practice Management Program (PMP) staff Susan M. Black, Stephanie A. Crichton, Cindy C. Michetti and Sean T. Smith in Calgary, as well as Robert L. Brick, Lucy L. Grenke, Glenda M. Nash and C. Grant Sorochan in Edmonton, contribute articles to the Digest. PMP provides high-quality business consulting services to Alberta physicians as they develop and implement primary care networks. Contact PMP at pmp@albertadoctors.org, 780.733.3632 or toll-free 1.800.272.9680. ■

Saluting our future physicians

ALBERTA MEDICAL ASSOCIATION

AMA congratulates Class of 2010 medical school graduates

On behalf of the Alberta Medical Association (AMA), I congratulate medical school graduates from the universities of Alberta and Calgary.

Welcome to the medical profession. May you achieve your goals in residency and join us in advocating for a health care system that puts Patients First®.

A division of the Canadian Medical Association, the AMA is the official voice of the medical profession in Alberta. We're pleased to be "at your service" at every stage of your medical career. Contact us (www.albertadoctors.org and www.cma.ca) at any time for assistance.

Christopher J. (Chip) Doig, MD, MSc, FRCPC
President

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Awarded the degree of Doctor of Medicine at the June convocation:

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Alford, Tyler
Armstrong, Glen Lawrence
Armstrong, Ian George
Aspler, Anne Lynn
Bach, Phil Vu
Ball, Brandon Jonah
Barnett, Carly Alanna
Barry, Chantal Avrielle
Barry, Keith Ryan
Bazzarelli, Amy Kathleen
Benard, Magali Anna
Benoit, Luc Andre
Benoit, Marc Anatole
Bentz, Christine McKenzie
Bergh, Nikoletta
Bhanji, Rahima Amirali
Blackburn, Paul Edward
Blackmore, Christopher
Bolshin, Carly Sara
Bond, Christopher Matthew
Borrelli, Sergio
Breton, Jessica Mary
Buchanan, Brian Malcolm
Budd, Emily Lauren
Carpenter, Thirza Lianne
Cheng, Florence Jeanie
Chiu, Darren
Chmiel, Konrad
Chow, Amy Shirley
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Davies, Laura Michelle
Denby, Amelia Katherine
Dietrich, Jaclyn Nicole
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Elliott, Cameron Alistair
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Emamaullee, Juliet Ann
Emery, William Thomas
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Tackaberry, Kelly Megan Joy
Taylor, Mark Robert
Thompson, Erin Elizabeth
Tram, Janna
Van Mulligen, Tyler Kent
VanderPluym, Juliana Hendrika
Varghese, Jayant Cherian
Wang, Zhan Tao
Wat, Stephen Wun-Lok
Wensel, Andrea Kay
Wong, Janet Pui Yee
Wong, Joyce Wendy
Wood, Laura Jane
Xing, Jerry Guangyu
Xu, Caroline Chong
Yorke, Ekua

UNIVERSITY OF CALGARY
MEDICINE

Afra, Kevin
Aguanno, Alaina
Ainsworth, Erin Alexandra Ellen
Aiton, Kara Melanie
Andruski, Benjamin Paul
Archer, Lori Anne
Baker, Ava Catherine
Bassili, Adam David Michael
Bevilacqua, Micheli Umberto
Black, Colleen
Boe, Corene Danielle
Bolton, Johan
Bouchard, Karen Rae
Bouchard, Thomas Paul
Box, Adrian Harold
Brandman, David Michael
Brown, Jessica Lynne
Brown, Jevon James Yardley
Campbell, Stacy Marie
Chan, Yong Wern
Chopra, Puja
Corie, Mark William
Countess, Robert
Cowan, Hamish Jonathan
Creba, Aran Skye
Cunningham, Diana Marie
DeBruyne, Elizabeth Anne
Dehaeck, Ulrike Cornelia
Dobrowolski, Peter Anthony
Doulla, Manpreet
Dressler, Jason David Thomas
du Prey, Beatrice Alicia
Duke, Linnea Diane
Duncalf, Karen Anne
Eardley, William
Eng, Evelyn Marion
Evaniew, Nathan
Fair, Justine
Flynn, Andrew Norman
Fox, Danya
Gabel, Jesse Daniel
Germain, Carlie
Gillis, Judith Lynne
Goad, Andrew Jamieson
Goodarzi, Zahra Shirin
Grimbly, Chelsey Suk Kun
Grintuch, Benjamin Shaun
Hall, Stacey
Hermanutz, Katie Elizabeth
Hj Zulkifli, Hjh Nurul Atiqah
Hyder, Stephanie
Jablonski, Eric Vincent
Kachra, Rahim
Kahlon, Bhavneet Kaur
Kalf, Daniel James
Kerr, Brendan Gordan
Khosravani, Houman
Kisilevsky, Alexandra Elizabeth
Klein, Max Friedrich
Knox, Matthew Kenny
Krauss, Emily Marie
Kwan, Michael
Lamb, Jeffery Chalres
Lau-Sawyer, Suzanne Kit-Yan
Lenz, Ryan Charles
Liddle, Jessica

- Liu, Wei-Qiao
- Livingstone, Margaret Jean
- Lockwood, Joel
- Ma, Jeffrey Curtis
- Marois, Judith Michelle
- Maser, Rachel
- McBain, Adina May
- McIntyre, Katherine Victoria
- Mitchell, Katherine Ann
- Morrison, Ellen
- Moulton, Kyle
- Moylan, Beverly Amanda
- Muzychuk, Adam Kiel
- Myers, Kenneth Alexis
- Ngu, Janet Mee Chin
- Pau, Stephanie
- Paw, Jadine Hua Zhi
- Pengiran Haji Ismail, Dayangku Maizatul Aiman
- Peters, Steven Ray
- Peti, Carmen DeEtta
- Pin, Sophia Elizabeth
- Plester, Jennifer Catherine
- Pocock, David
- Poliakov, Ilia
- Poon, Tiffany
- Potok, Olivia Victoria
- Premji, Shafeena
- Procyshen, Jennifer Rae
- Raguz, Nikolett
- Ramos, Timothy Jesse
- Rodgers, Christopher
- Rosborough, Amy
- Salim, Ahmad Munawwar Helmi
- Sandercock, Linda Eileen
- Saude, Erik
- Schaan, Richard James
- Sharma, Vishal Kumar
- Shehata, Nadia
- Sheppard, Matthew Gordon
- Skeith, Leslie Anne
- Skelton, Geoffrey George
- Skolnik, Kate
- Somayaji, Ranjani
- Stewart, Nicole Astrid
- Sudbury, Ian
- Sun, Julia
- Sy, Eric
- Szewchuk, Andrea
- Talavlikar, Rachel Katherine
- Tan, Vi Ean
- Thoo, Vanessa Li-Jien
- Thurston, Jackie Lee
- Tien, Julia Irene
- Turner, Christian
- Urness, Philip
- Walzak, Alison
- Wang, Jessica Castillo
- Warkentin, James
- Wheat Hozack, Margaret Joan
- Wilson, Brett
- Witt, Samantha Bernice
- Wong, Ken Koon
- Wong, Sarah Louise Heather
- Wray, Heather Erin
- Yu, Horace
- Yusuf, Omer
- Zhou, Jian ■

Edmonton teens trade vacation for week of med school

Tara R. McGrath
MEDICAL STUDENT, CLASS OF 2013, UNIVERSITY OF ALBERTA

Students of a different sort flocked to the University of Alberta (U of A) July 5-9.

Twenty-eight local high school students attended the Asclepius: Medical Camp for Youth, at the Katz Group Centre for Pharmacy and Health Research lecture theatre. The camp was designed to give 15-17 year-olds a sense of what it feels like to be a medical student.

In addition to hands-on clinical activities such as suturing, casting and interviewing patients, they participated in group discussions, medical lectures and a range of med school-themed games (e.g., a race to dress in protective clothing).

Asclepius: Medical Camp for Youth was an initiative spearheaded by a committee of U of A medical students, the MD Ambassadors – Social Outreach Committee. The mission is to increase diversity in medical school by exposing young people from under-represented demographics to the field of medicine.

The idea was based on findings from a UK study that showed exposing high school students from non-traditional backgrounds to the field of medicine positively influenced attendance at post-secondary institutions, generally, and medical school specifically.[1]

Asclepius participants were nominated by their high school teachers based on a number of criteria, including aptitude for learning, empathy, integrity, maturity, positive attitude and ability to work in a team.

The mission is to increase diversity in medical school by exposing young people from under-represented demographics to the field of medicine.

Teachers were also asked to nominate students of lower socio-economic status. The participants came from three Edmonton high schools, based on the demographics of their communities.

Generous sponsorship from ATCO Gas, the U of A Faculty of Medicine & Dentistry, U of A Hospital Emergency Physicians, the Alberta Medical Association, and the College of Physicians & Surgeons of Alberta made it possible for the camp to be offered free-of-charge. Five local restaurants donated lunch.

The camp was planned and facilitated by a team of first- and second-year U of A medical student volunteers. Three physicians offered lectures on subjects such as HIV, heart conditions and orthopedic injuries.

Emergency medicine residents taught the students how to cast, showed them X-rays and demonstrated the use of an ultrasound machine.

Medical students ran sessions on a number of topics such as taking patient histories, suturing, assessing reflexes, ethical issues and mental health.

A highlight of the week was an afternoon of shadowing, where nine physicians from various specialties ▸

- brought in patients who were willing to be interviewed by students.

The students rotated in small groups through the stations and practised their history-taking skills. In addition to gaining exposure to a variety of specialties in medicine, they gained a real appreciation of the doctor-patient relationship.

The camp closed Friday with "Grand Rounds." Parents and volunteers gathered in the lecture theatre to hear groups of students present the medical cases they had been working on throughout the week.

With positive feedback from lecturers, shadow physicians, volunteers and, especially, the campers, the medical student camp coordinators are looking forward to a larger, improved and even more exciting program next summer.

The coordinating team is also planning to use data collected in pre- and post-camp surveys to study the effects of the Asclepius experience on students' confidence, medical knowledge, and future education and career decisions.

Reference available upon request.

Photos supplied ■

FEATURE

Renew your AMA/CMA membership today

It is time to renew your Alberta Medical Association (AMA)/ Canadian Medical Association (CMA) membership. The membership year begins October 1.

Renew now to continue to receive AMA/CMA benefits and services, plus information about provincial medical staff bylaws, Negotiations 2011 and other issues important to physicians.

Renew via **one** of the following methods:

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

Membership information packages, mailed in September, vary depending upon member category. Your package could include the following:

1. Letter from the AMA president
2. *@ your service membership guide*
3. Membership form
4. Medical Liability Reimbursement Administration Policy
5. Continuing Medical Education Administration Policy
6. Retention Benefit Administration Policy
7. AMA Privacy Commitment Statement
8. CMA Corporate Privacy Policy
9. Postage-paid return envelope

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

NOTE ON YOUR MEMBERSHIP FORM:

- **STEP 3** – Designate your section for Representative Forum purposes.
- **STEP 5** – Join a section.
- **STEP 6** – New. Support the Alberta Medical Foundation (AMF) with a donation, if you wish. The AMA's charitable organization is dedicated to promoting the research, study and appreciation of Alberta's history of medicine.
- **STEP 9** – Payment options. AMA no longer retains year-to-year credit card information. This means:
  - Credit-card payments may be made for one membership year only.
  - Ongoing pre-authorized payments may only be made by bank withdrawal. ■

The journey toward medical practice in Canada: An IMG's perspective

Dr. Florence N. Obianyor
SECOND-YEAR RESIDENT, FAMILY MEDICINE, UNIVERSITY OF CALGARY
VICE PRESIDENT; INTERNAL AFFAIRS, PARA

The experience of international medical graduates (IMGs) no longer makes news for good reason. Now more than ever, there are opportunities for IMGs to become fully licensed physicians in Canada. In fact, I am training to become one myself.

In recent years, the Alberta Government has significantly increased investment into utilizing the skills of IMGs living in this province, and rightly so. There are many individuals living and working in Alberta who have the potential to serve as competent and productive health care providers.

This investment is good news and it means we are heading in the right direction. But there is still more work to be done!

Some of this work includes achieving a better understanding of the IMG perspective. When people come to learn that I am an IMG, I am often asked: Why do IMGs leave an established medical career for the elusive chance of one in Canada? Why would they risk the known for the unknown?

IMGs immigrate for the same reason anyone else does – to seek a better life for themselves and for their families; and the desire to experience a different way of life, a way of life that allows access to an excellent social infrastructure and better educational opportunities for their children. These reasons are a few of many cited by IMGs.

During my own journey through residency, I have often discovered that many people are misinformed about what an IMG must accomplish in order to practise medicine.

For example, I have often heard people comment on how an IMG spends six years learning what a Canadian medical graduate learns in three or four years. This understanding is a misconception.

To clarify, an IMG will often spend the first three years of a six-year program studying pre-clinical sciences, with the last three years being spent studying clinical sciences.

> IMGs are Canadian and they see themselves that way. When I go back to visit the country of my birth I am now the foreigner. . . .

These three years are not dissimilar to what Canadian medical graduates study in their pre-medical years.

I was educated under a six-year medical degree model. Not having a non-medical degree upon entering the Canadian workforce proved to be a challenge.

I quickly discovered that an international medical degree was not as competitive as a Canadian research degree. This reality became clear as I was often overlooked in favor of other Canadian-trained candidates for research-oriented jobs.

Regardless, this tough luck was for the best as it enabled me to realign with my initial goal, which was getting accepted into a Canadian residency program and to practise medicine in Canada.

Another challenging question in response to concerns about IMGs unable to obtain a Canadian residency spot is: Why don't they go back and work at home? They don't because they are home.

IMGs are Canadian and they see themselves that way. When I go back to visit the country of my birth I am now the foreigner, and I must take all the precautions most other foreigners must take.

From both the cultural and biological perspectives, I have become a visitor to my birth country. I have even lost ▸

> Canada is an amazing place to call home; however, the country faces cultural and organizational handicaps that make it challenging for bright, talented, internationally trained professionals to succeed.

my immunity to malaria! For better or for worse, Canada is my home.

Last spring, I visited Nigeria and marvelled at the advancing careers of my old friends and classmates. Many were already staff physicians enjoying the benefits of well-established careers.

Nevertheless, I am not envious. I'd rather be where I am, in Canada! It's a dream I am living today, and I am most grateful to the system that has allowed me to get this far. I am one of the lucky ones and I know it.

Canada is an amazing place to call home; however, the country faces cultural and organizational handicaps that make it challenging for bright, talented, internationally trained professionals to succeed.

These barriers can be as simple as the cultural meanings associated with body language.

No one ever thinks to teach body language, and it can come as a nasty shock when colleagues and mentors interpret that language in an unintended way.

IMGs are not just facing the rigors of residency and their postgraduate medical education. Often, they are also training in this "new" language, a different social and medical culture, with new, often unspoken expectations.

It is a challenging experience. Many effective international businesses and organizations recognize their employees can be more productive with training in this "cultural language."

This type of training could be successfully applied to IMGs preparing for residency.

Such a proactive initiative would make for a better experience and learning for us, our peers and our mentors.

This country's triumph was built by the international citizens who chose to call Canada home. Thus, I encourage my fellow resident physicians, be they born here or abroad, to get involved in the system in which they work.

Being involved can mean many different things. A good starting place for resident physicians is the Professional Association of Residents of Alberta (PARA), where issues influencing residency and the Alberta health system are discussed in-depth.

It is an opportunity that has eased my integration into the Canadian system.

I feel fortunate to be involved in PARA, last year, through my role as a board member and, this year, as a member of the executive.

For me, being active in my community is not just a means of learning, it is an opportunity for me to give back and have a say in shaping the system of which I am a part.

> For me, being active in my community is not just a means of learning, it is an opportunity for me to give back and have a say in shaping the system of which I am a part. ■

Work-life balance:
Lessons to be learned from the legal profession

Jonathan P. Rossall, QC, LLM
PARTNER, McLENNAN ROSS LLP, BARRISTERS AND SOLICITORS

Medicine, like many science-based professions, has evolved at a frenetic pace over the last century.

It is probably safe to say there have been more advances on the technology, pharmaceutical and information management fronts in the last decade than in the previous 90 years, and likely there will be more in the next year than in the last decade. The developments are breathtaking.

Alberta, and likely the rest of Canada, cries out for more physicians and the universities cannot seem to graduate sufficient numbers of doctors to meet the demand.

I admire professionals who are able to sustain the balance necessary to dedicate meaningful time to family and hobbies, yet maintain their skills and practices.

The climate seems ripe for physicians to work hard and reap the rewards. But what if they don't want to?

The practice of medicine, much like the legal profession, appears to be addressing a different crisis that goes beyond the ability to adapt to new technology, keep up with evolving techniques or practices, or deal with changes in modes of practice.

The fact is, many of the current generation of graduating physicians are looking for more than just a full and fulfilling practice and (hopefully) a positive bank balance.

Many of today's young doctors, like today's young lawyers, are looking and expecting to find some balance in their busy lives.

I was raised in a medical family and saw first-hand the traditional demands on physicians. Many, if not most physicians to whom I was exposed, worked very long days and usually weekends, as well.

When not actually seeing patients, doing rounds or teaching, they were on-call.

While physicians then were not equipped with BlackBerries or cell phones, the telephone or the pager was never far away. It would not be unusual for family events, travel plans, holidays or other recreational events to suffer as a result.

I was luckier than some. My father made a commitment to spend time with his family and honored that. But many families were not that fortunate.

The legal profession was no different. There was a saying, "The law is a jealous mistress" and it rang true in the '50s, '60s and '70s. Lawyers were expected to work long hours, weekends and holidays. Not just expected. Many embraced the practice and spent more time with that jealous mistress than with their own spouses, sometimes to the detriment of their marriages.

Today, things are changing. In law, and I expect in medicine, we see many young professionals graduating with an expectation that work demands will not unduly impact on family and other non-legal pursuits.

The legal profession has not become a 9-to-5 proposition, but there are certainly increasing opportunities for lawyers seeking a work-life balance in the public sector or in-house to modify or adapt to their lifestyles.

None of this is intended to be critical of this trend. Indeed, I admire professionals who are able to sustain the balance necessary to dedicate meaningful time to family and hobbies, yet maintain their skills and practices. ▸

The question is, at what cost to themselves and their profession? Because the economics simply don't work.

The volume of work to be undertaken in the health care industry is enormous and does not appear to be abating.

The numbers of physicians graduating or moving to Alberta is relatively static or, if increasing, not at the pace necessary to address the increasing workload.

In addition, some graduating doctors are choosing to move into areas of practice that place less severe constraints on their private lives, with the result that more labor- and time-intensive areas are becoming underserviced.

Innovations, such as primary care networks (that encourage multidisciplinary care), are helpful, but the workload is still extraordinary.

Taking physicians out of the workforce, or reducing the time they spend in it, only increases the workload for the others. And the amount of money available to fund these services is not increasing at anywhere near the demand.

The issue then becomes one of compensation. If a physician shoulders more responsibility, spends more time at the office or does more call than another, it would not come as a surprise that there will be an expectation of higher compensation.

The question is, are physicians who are seeking a greater work-life balance prepared to accept the negative financial consequences of that choice?

Again, in the legal business that is not always the case. This is because the model of practice (in the private sector) is still based on high expectations of billable hours and a commitment to meet those targets.

Salaries are based on comparisons with equivalent law firms. Concepts of part-time practice or job-sharing are not new, but there are challenges to their implementation in a profession where the practitioner cannot always dictate his or her hours of work.

So, the young lawyer who fails to meet expectations ultimately leaves (or is asked to leave), placing more pressure on the remaining lawyers to pick up the slack. If enough leave, the model is simply not sustainable.

Physicians, like lawyers, are looking in the mirror and re-assessing the traditional models of practice, recognizing the current and future generations' needs and wants.

It may be that physicians need to re-adjust expectations in terms of compensation or examine newer, innovative models of practice that allow the balance in their lives. . . .

It may be that physicians need to re-adjust expectations in terms of compensation or examine newer, innovative models of practice that allow the balance in their lives that their mothers, fathers or grandparents may not have enjoyed. ■

Challenge yourself: Invest in your health

Sample reliable, easy-to-use resources

Vincent M. Hanlon, MD
PFSP ASSESSMENT PHYSICIAN

Physician health is a legitimate concern. But how can you make your own wellness a priority in your busy life? Or perhaps you already do that but you are looking for new tools.

In either case, consider the variety of easy-to-use resources, as follows, to help invest in your health and well-being.

Some of the PFSP presentations

Part of the Physician and Family Support Program (PFSP) mandate is education.

To help fulfill that mandate, some of the PFSP team members take on teaching assignments.

> Consider these presentations as vital conversations about different aspects of our own health.

- PFSP will do a number of presentations to first- and second-year University of Alberta medical classes in the 2010-11 academic year. We continue to add physician health content to education half-days for resident training programs.
- January through March 2011 is also a busy time for PFSP, bringing the physician health message to a number of mid-winter alpine continuing medical education/continuing professional development events in Banff, Kananaskis and Lake Louise.
- These sessions raise awareness of physician health as a subject of legitimate concern and add structured self-care content to the various streams of medical education and professional development.
- Consider these presentations as vital conversations about different aspects of our own health.
- Topics of conversation vary: managing fatigue or stress, dealing with our addictions, resolving conflict and communicating effectively, building healthier workplaces, or living and teaching work-life harmony.

Online resources

Increasing amounts of information about physician health is now available online. Many of us are refining the way we attend to our ongoing education and professional development.

Some of us have attenuated our reliance on books and periodicals. We choose and use more online resources.

- Access to quality digital information (much of it inexpensive) is relatively straightforward if one knows where to look.

  A good source of information can lead to another, although digital information has unique challenges – finding, storing and retrieving it. For some of us, just staying on task while online requires effort.
- Sometimes, while we acquire the fundamentals of working in a digital world, it helps to direct a question at another more tech-savvy human being.

  Dr. J. Barrie McCombs, Medical Information Service Coordinator, the Alberta Rural Physician Action Plan (RPAP), is such a person.

  He is the author of *Web-footed MD*, a regular column in the Alberta Medical Association's *Alberta Doctors' Digest* and, over the years, has kindly and quickly answered questions I've directed his way (barrie.mccombs@rpap.ab.ca).

To facilitate an efficient online search for physician health information, I have found the following sites valuable. ▸

INFORMATION-BASED SITES

- In November 2009, Calgary sociologist Jean Wallace and physicians Jane B. Lemaire and William A. Ghali published, in *The Lancet,* "Physician wellness: A missing quality indicator."

  In their extensive review of physician health, they propose that the health of physicians is directly related to the quality and performance of the health care system, and vice versa.

  Growing interest and research into physician health is evident in the hundred references provided.

  Get the article free from *The Lancet* online: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61424-0/fulltext.

  Hear a *Lancet* interview with author Jean Wallace by downloading the podcast: http://podcast.thelancet.com/audio/lancet/2009/9702_14november.mp3.

- ePhysicianHealth.com – "A comprehensive, online physician health and wellness resource" came online during autumn 2009 at the Canadian Conference on Physician Health, in Vancouver: http://www.ephysicianhealth.com.

  - Site navigation is straightforward. Program menus vary, such as substance use, disruptive behavior, weight, nutrition and fitness. Units are neatly organized into five sections: The Focus, The Reality, The Strategies, Next Steps and Resources.

  - To acquaint yourself with the site, listen to introductory comments by two physicians: Dr. Derek Puddester (psychiatrist; director, Faculty Wellness Program, University of Ottawa), who had a lead role in creating ePhysicianHealth.com and the unit on depression, burnout and suicide; and Dr. Michael Kaufmann (founding director, Physician Health Program, Ontario Medical Association), who introduces the unit on physician resilience.

  - ePhysicianHealth.com provides relevant information about a number of important topics and many practical strategies to help individuals deal with issues like anxiety, fitness or being a patient.

- The Canadian Conference on Physician Health also promoted the recently published *CanMEDS Physician Health Guide: A Practical Handbook for Physician Health and Well-Being.*

  - Edited by Drs. Puddester, Leslie Flynn and Jordan Cohen, the guide is a comprehensive introduction to the wide spectrum of physician health topics, written by physicians primarily but not exclusively, for residents.

  - Various topics are presented in a succinct two-page format that includes two or three objectives, an introduction and subject elaboration, a "real-life" case and its resolution, and a few key references.

    For example, in the section "Balancing Personal and Professional Life," Dr. Dianne B. Maier, PFSP Program/Clinical Director, presents "Promoting healthy partnerships in medical families."

  - Royal College of Physicians and Surgeons of Canada members have free online access (visit www.rcpsc.medical.org). Paper copy and Kindle editions are available for purchase. It's a useful resource for residents and their teachers.

INTERACTIVE SITES

- The Heart of Medicine (http://theheartofmedicine.org) was developed with the guidance of Dr. Rachel Naomi Remen and the Institute for the Study of Health and Illness.

  For two decades Remen has counselled hundreds of physicians, individually and through weekend workshops, to rediscover the heart of their medical work. She also created curriculum – "The Healer's Art" – taught in US and Canadian medical schools.

They propose that the health of physicians is directly related to the quality and performance of the health care system, and vice versa.

  - The website "encourages self-discovery and personal reflection, promotes self-care, enables an in-depth, multi-faceted exploration of the meaning of medicine and its lineage and offers the opportunity for a genuine connection with other physicians worldwide."

  - Topics with the most comments in the Finding Meaning in Medicine discussion forum are mistakes in medicine, death of a colleague and success stories by those who have found happiness in medicine. Dr. Pamela Pappas, a psychiatrist and homeopath, facilitates the conversations.

  - Venues are provided to upload and share stories, poems or photographs with the intent of "expanding our definition of ▸

what it means to be a physician, [and] strengthening our connection to other physicians."

- The Tarascon Primary Care Pocketbook, a smart phone application, is available for the iPhone and BlackBerry. It's not focused specifically on physician health but one of the tools in this app is the *Adult Health Maintenance Screening Guidelines*.
  - Sources of information are American (e.g., American Academy of Family Physicians and the National Institute of Health).
  - Categories include vaccine schedules, recommended intervals and ages for screening for diseases (e.g., breast, colon and prostate cancers).
  - Guidelines list recommended periodic examinations and potential counselling topics during health maintenance visits.

Health maintenance and disease prevention should be no less important for us than for our patients.

  - Why is it that not many physicians would schedule a health maintenance visit with a family doctor to be screened for cardiovascular disease or skin cancer, let alone depression or alcohol misuse?

    Evidence may vary from good to inconclusive? We are reluctant to see ourselves as patients or we don't have time for prevention?

    This screening guideline is a reminder that health maintenance and disease prevention should be no less important for us than for our patients.
  - The guidelines are a comprehensive, easy-to-use checklist of potential subjects that we could address during visits to our family physicians.

Sites, links, podcasts, apps. From time to time it's liberating to sign off the digital grid and power down our electronic devices.

For those who might want to curl up with a good book, try *The Medical Marriage: Sustaining Healthy Relationships for Physicians and Their Families*, by W.M. Sotile and M.O. Sotile. ■

AMA celebrates quarter-century relationship with TD Insurance Meloche Monnex

Louis H. Guay, LLB, CIP
VICE-PRESIDENT, AFFINITY MARKET GROUP, WESTERN REGION, TD INSURANCE MELOCHE MONNEX

Members of the Alberta Medical Association (AMA) have benefited from group rates on their home and auto insurance with TD Insurance Meloche Monnex since 1984.

These savings are the reason that more than 5,300 members trust TD Insurance to insure their homes and automobiles. But that's not all.

More than 97% of AMA's clients are retained each year and the program continues to grow.

TD Insurance believes that informing clients about insurance will help them make better choices to protect themselves.

The following simple guide explains how easily you can take advantage of these benefits and save money the next time you renew or shop for a new policy.

Putting clients first

TD Insurance places emphasis on clients. Many resources are dedicated to maintaining responsiveness for our clients and using technology that serves people, not the other way around. More than just please clients, this has also fuelled TD Insurance's success.

The growth that counts the most is among existing clients. The long-standing AMA agreement is a great representation of a quality relationship.

TD Insurance has more than 60 years of experience and is the largest direct-response home and auto insurer in Canada, with over 15% market share in Alberta. Its service model makes it the most cost-efficient insurance provider and the recognized leader in affinity marketing.

With more than 1.1 million clients, the TD Insurance portfolio exceeds 1.8 million policies and $2 billion in written premiums. The company has more than 3,700 personnel across the country and is part of TD Bank Financial Group, one of Canada's largest financial services businesses.

Automobile insurance tips

Did you know the basic automobile policy for Alberta is standard no matter where you purchase it? TD Insurance Meloche Monnex has created packages of endorsements offering unique policy enhancements such as:

- 5-Year Replacement Cost Solution®: Will replace with new model even if it exceeds original purchase price.
- Grand Touring Solution®: Best coverage for loss of use following an accident, damage to rentals included, no deductible for hit-and-run and more.
- Accident Forgiveness Advantage™ and Goodbye Deductible®: Peace of mind from the accidents of life.

Prior to calling or quoting online, be sure to have the following information handy:

- Year, make, model and serial (VIN) number of the vehicle
- Driver's licence number
- Name and address of leasing or financing company
- Banking information (for free monthly payment plan)

Residential insurance tips

Unlike automobile policies, residential policies can vary greatly.

TD Insurance Meloche Monnex is a benchmark and provides the broadest range of coverage options in the industry, including these unique features:

- Coverage packages from Bronze to Platinum Plus. ▸

Saving money as simple as 1-2-3

TD Insurance Meloche Monnex

- 5-Million Dollar Solution®: Blanket coverage for any shortfalls.
- Identity Plus Solution®: Full restoration protection of your good name.
- In-Home Office Solutions™: For your in-home business.
- Plain language that is easy to understand.

Before calling or quoting online, be sure to have the following information handy:

- Address, year built and square feet or metres of the property
- Basic physical details and existing coverages, if applicable
- Name and address of financing or mortgage company
- Banking information (for free monthly payment plan)

Going green puts more green in your pocket

TD is among the greenest companies in the world. It was the first Canadian bank to adopt and reach the goal of being carbon neutral.

Since 1990, the TD Friends of the Environment Foundation has provided more than $50 million in funding to more than 18,400 environment and wildlife projects across Canada.

Opting for hybrid technology means using less fuel, which translates into cost savings for you and a reduction in greenhouse gas emissions.

It also means a reduction in your insurance costs with TD Insurance's *Green Wheel* discount to owners of hybrid vehicles. It's our way of saying thank you for doing your part to help against climate change.

Money-saving tips

Limit your glass. Automobile glass coverage is usually included automatically with physical damage insurance but you may choose to limit this to save some premium.

Higher deductibles. Choosing a higher deductible will lower your premium.

Consider limiting physical damage for older vehicles. If you drive an older vehicle, call to discuss options for reducing your optional coverage.

Loyalty pays. Combining your home and auto insurance or even multiple vehicles with TD Insurance will save you more money.

Safety pays. Smoke detectors, monitored fire or security alarms and anti-theft systems are only some of the discounts available.

Take advantage of these tips and get a quote today! You will be entered to win one of two Honda Insight hybrids plus $3,000 for gas (or $30,000 cash).

Visit www.melochemonnex.com. ■

Compare
cell phones and carriers

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Rapid changes in the cell phone market make it difficult to compare models and service plans from different carriers. I recently discovered a useful Canadian website that allows users to quickly compare cell phones and service plans.

At the end of the article, you'll also find a few cell phone news items.

Cell Phones Etc.

www.cellphones.ca

The main menu contains options to compare cell phones or service plans, read news items, participate in discussion forums or return to the home page.

The two comparison links have drop-down menus that link to other options. The site contains some advertising messages.

Compare Cell Phones

This section allows users to compare the features of two or more models side-by-side.

The categories include power and battery, physical characteristics, display/screen, input/navigation, call management, web/email/messaging, connectivity, camera, audio/video and applications.

Select the phones you would like to compare. Then, at the bottom right, click on Compare Selected Phones.

Compare Cell Phones – Options

The default is to display all available cell phones. You can limit the list by selecting options on the left side of the page.

The options include selecting a country (e.g., Canada only), release date, carrier, manufacturer and design type. More than one option in each category may be selected by using the control-click key combination in Windows or command-click on a Mac.

Check-boxes help narrow the selection for certain important features, such as a video camera, music player or connection to a high-speed 3G network. After selecting your options, click the search button at the bottom left.

Compare Cell Phones – Extras

Cell Phone Reviews and manufacturer information are available in a drop-down menu under Compare Cell Phones.

Also under this menu, the Resources section includes how-to information, answers to frequently asked questions (FAQs) and a glossary of cell-phone terminology.

Compare Cell Plans

This section allows comparisons of the features of two or more service plans side-by-side. The categories include price, length of contract, fees and available minutes of use.

Options for narrowing the search are available in the left-hand menu, including the carrier, plan type and fees. An option at the top of the display allows changes to the province and town where service is desired. This is a very useful feature for rural physicians.

Compare Cell Plans – Extras

Carrier reviews and descriptions are available in a drop-down menu under Compare Cell Plans. These include user ratings.

News

The News menu features news items about Bell, Rogers, TELUS and some of the newer Canadian carriers. This includes a link to older news and some additional how-to articles not listed under Resources.

Forums

The Forums menu provides feedback from users about different carriers and manufacturers. Anyone can read the posted items.

To post an item, register using the Join Free link at the top of any page. ▸

OTHER NEWS

Blackberry Torch 9800

http://www.rim.com

This device uses a new operating system (OS 6) that includes an improved Internet browser program. News reports state the new operating system is available for some older models.

Apple iPhone 4

http://www.apple.com

Apple's newest model is now available from Bell, Rogers and TELUS. The *Consumer Reports* website confirms reports that its signal strength may drop if a finger touches a gap in the external antenna, but also confirms the free case now offered by Apple corrects the problem.

Android Applications

http://www.androidapps.com

A recent report suggests cell phones using the Android operating system have a large number of add-on applications available – more than for the BlackBerry but less than for the Apple iPhone.

As with any of the application downloading websites, it is difficult to distinguish medical applications for physicians from those designed for consumers.

Chatr

http://www.chatrwireless.com

Rogers has introduced a new low-cost cell phone service to complement its original discount brand called Fido.

TELUS already operates the Koodo brand and Bell operates the Virgin and Solo brands.

Your comments and suggestions are welcome.
Please contact me:
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T 403.289.4227 ■

A sorry tale of foolish prognosticating

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

A man hears from his doctor that he has cancer and six months to live. The doctor recommends the man marry an accountant and move to northern Finland. "Will this cure my cancer?" "No," says the doctor, "but the six months will seem much longer."

A year has passed since I watched news clips of Abdelbaset Ali Mohmet al-Megrahi skip down the steps of an aircraft in Tripoli, Libya, to a hero's welcome from a crowd waving Scottish flags.

He had been convicted in the 1988 bombing atrocity of a Pan-Am jumbo jet over Lockerbie, Scotland; 270 people died, many of them college students returning to the US for Christmas.

Sentenced to life imprisonment, al-Megrahi has metastatic prostate cancer and was released from his prison cell in Greenock, Scotland, under a humanitarian provision in Scots Law. He was "a dying man" and had been given a prognosis of "three months to live."

I was in Scotland at the time and, watching these clips, I was stunned no one seemed to question the prognosis by British radiation oncologist, Professor Karol Sikora, an administrative academic gentleman with a bunch of other titles.

It also turns out the professor was paid a "fee" by the Libyan government for this report.

The size of the fee is unknown but might determine whether this qualified as a bona fide fee (perhaps up to $10,000) or as something more sinister.

Scurrilous rumors circulating that the fee was considerably higher (though not in the range of Alberta Health Services bonuses or "pay not taken") are, of course, outrageous and should be treated with the respect they deserve.

Most doctors know that patients with bone metastases from prostate or breast cancer can live for many years (with a median of 2.5 years for breast cancer and up to three years for prostate cancer), especially when their activities and performances status are good.

The Machiavellian machinations behind this release or the guilt of the convicted man are beyond the scope of this article.

There seems to have been considerable commercial pressures on the British government emanating from your favorite oil company, British Petroleum, regarding Libyan off-shore oil contracts.

But I recall the crocodilian sob line of Scottish Justice Secretary Kenny MacAskill eschewing the contrary opinions of several G-U cancer experts, choosing Sikora's opinion and invoking "Scottish values," and intimating with sincerity and a girning whine (particularly irritating and unconvincing when delivered with a Scottish accent) that this release was a humanitarian decision for a dying man.

I was stunned no one seemed to question the prognosis by British radiation oncologist. . . .

And I remember thinking, hello, that man looks like he could live for several years. How is this going to look to the relatives of those who died in the Lockerbie atrocity, when he survives a lot more than three months?

Now that a year has passed and, not surprisingly, Mr. al-Megrahi is functioning just fine at home in ▸

Libya, it's time to call to account the woefully foolish prognosis given by Professor Sikora.

Prostate cancer is one of his areas of apparent expertise, among many others. He made the "wise list" of *Saga Magazine* (a pretentious British glossy) in 2006, being listed as "a trail-blazing oncologist, a sage."

It may be the professor does not see many patients or the excitement of being involved in a front-page case warped his thinking.

But by this foolish prognosis he has diminished his standing as a "sage" and increased public skepticism toward the medical profession.

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Perhaps there was more to it and his prognosis was couched in percentage risks, and the politicians grasped at the three-months-to-live part.

However, if that were the case, there was ample time for him to amplify and couch his prognostications with extreme caution. This was not done, to his shame (or, as he puts it, his "embarrassment").

I hope the General Medical Council, in the UK, takes this further. But I doubt it because prognosticating is the ultimate subjective medical art.

Anyone can get it wrong (though not usually so grossly as in the al-Megrahi case). And yet patients rarely question a prognosis and the consequences of this are far-reaching and mischievous.

Prognosticating requires an intimate knowledge of the natural history of the disease in question, together with a painstaking clinical examination and experience in clinical judgment that must be confirmed by cast-iron laboratory and radiological examinations.

And even then you can get it a bit wrong, so prognosticating should always be accompanied by caveats.

The late Sir Ronald Bodley Scott, clinical hematologist and physician to the Queen, (he failed me on my first attempt at the Fellowship examination on a strangely smiling "short-case" patient when I failed to diagnose syphilitic risus sardonicus), used to say with tongue-in-cheek: "I always make the prognosis a little worse than I actually think it is.

"Then if the patient dies sooner than I really expected, I was correct. And if the patient lives longer than I expected, then it might be due to my treatment."

I never liked that approach, but I can't deny that it seems a successful way to build a reputation.

A common and mischievous outcome of the three-months-to-live pronouncement, and a certain outcome if coupled with a "nothing much can be done, I'm afraid," is that whatever bumble juice a patient may be taking is credited with the benefits of his or her unexpectedly longer life.

Predictably, al-Megrahi's father is crediting the incredible prolongation of his son's life to "a positive outlook and alternative medicines." And who can blame him? Few patients are going to quibble that the doctor was wrong.

Instead, they may get their affairs in order, repair relationships and enjoy life to the full, seeing the extra time as an unexpected gift. And, maybe in some cases, the foolish prognosis has contributed to an enhanced life quality.

But more frequently, mischief arises from an incorrect prognosis. In oncology, we see this frequently.

Someone who has been given a falsely dire prognosis, after overcoming gloom and despair, usually ascribes his or her extended life to some quack nostrum instead of to an ill-considered prognostication.

So survives laetrile, Essiac tea, shark cartilage, antineoplastons, anti-oxidants, Hoxsey therapy, Gerson therapy, magnets and, the latest one I've heard about, "energy healing (the DNA signature destruction method)."

On the other hand, to support Sir Ron's approach of giving a worse prognosis than you actually think, are several medico-legal cases (in California) where overly favorable prognoses led to failures to prepare for imminent death, leaving wills unrevised or absent.

Principles to follow in the art of prognosticating are usually learned on the job and rarely taught in medical school, and yet this is a serious skill requested by patients and relatives.

▸ Some of my mistakes: On the insistence of a relative, I told a perfectly content patient that she might have between six and 12 months to live.

I managed to convert a serene, content lady to an agitated seeker for unattainable cures in Mexico and beyond.

As a junior doctor, I was upbraided by a senior physician for my reply to a patient with a recurrent lymphoma, who asked me what I thought his chances were of living for another year.

"Oh, probably 50-50," I glibly replied.

"Who do you think you are?" said my boss, Professor Gordon Hamilton-Fairley (on hearing this prognosis from the patient). "A bookmaker?"

As Will Rogers said, "Good judgment comes from experience, and a lot of that comes from bad judgment."

I have certainly given some foolish prognoses in my time, although I've never been rewarded to the level of Professor Sikora.

I have, however, also been involved in correcting some egregious foolish prognoses: a chest physician giving a "terminal lung cancer" prognosis to a stunned man based on an X-ray and a spuriously confident cytology report; a GP giving a "terminal cancer" talk to a terrified woman with ascites, secondary to a highly treatable recurrent breast cancer; another "terminal lung cancer" report given to a patient who had the resources to have a second opinion at the Mayo clinic, where pathology review changed the diagnosis to Hodgkin's disease.

You might collect a handsome "fee" from a grateful government but you also may pay for it with your reputation.

One must be very cautious with respect to time left to live.

I will sometimes say things like, this may be your last Christmas (or summer or whatever). I've found this helpful for the patient and family to focus without being too specific about time.

Hydration and antibiotic therapy has made prognosticating in the last few weeks of life difficult.

The old adage of bronchopneumonia being a 24-hour prognosis will be inaccurate if the patient is being hydrated and on antibiotics.

And here is a rather obvious tip. If the patient is fully active, smiling and able to skip down the stairs of an aircraft unaided, then whatever the diagnosis, a prognosis of three months to live is going to be unlikely.

These poorly considered three-months-to-live or terminal prognoses can be so mischievous.

You might collect a handsome "fee" from a grateful government but you also may pay for it with your reputation. ■

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I'm Dr. Andrew Kohler and I own Callingwood Crossing Medical Centre, 6905 172 St in Edmonton. We are a very busy 18-year-old clinic with a very strong and growing clientele. We are next to a pharmacy and chiropractor's office, surrounded by a high-density area of condominiums and apartment buildings. We foster a team environment and are never alone when it comes to diagnosing difficult cases or if we require second opinions, etc.

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Medicentres Canada
T 780.483.7115
edmphys@medicentres.com
Shannon Klassen
Coordinator, Physician Services
T 403.291.5599
calphys@medicentres.com

EDMONTON AB

The Links Clinic, an 18-physician group with family practice, obstetrics/gynecology and pediatrics, has been in business for 56 years. We are currently seeking part- and full-time and/or locum physicians who wish to work in an appointment-based practice. The Vein Clinic, which has been an integral part of the clinic for years, has relocated to its own larger location. The Links Clinic offers excellent patient volume, work hours and has been on electronic medical records for 19 years.

The Links Clinic is part of the Edmonton Oliver Primary Care Network. The doctors and clinic patients have access to a referral coordinator, INR nurse, dietitian, kinesiologist, two chronic disease management nurses, pharmacist, two mental health personnel, psychologist and screening staff. We have specialist linkages with an ENT, orthopedic surgeon, cardiologist and two psychiatrists. All services are offered at the Mira Health Centre, 11910 111 Ave, where the Links Clinic is located.

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Contact: Dianne Walker, CA
Clinic Business Manager
T 780.453.9467
dwalker@thelinksclinic.com or
Dr. Lisa Burchett
T 780.453.9462
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