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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.
On time

I received a book in the mail some months ago written by New Brunswick family physician John Mary Meagher. Medicine, Mistakes and the Reptilian Brain argues that medical mistakes can be attributed to the oldest parts of our brain developmentally and, in particular, our propensity for haste, fatigue and egotism.

Certainly fatigue and arrogance can get in the way of good medical judgment, but our predilection for haste deserves special consideration. Most physicians are rushed, says Meagher, who counsels practitioners to ignore time, quoting Goethe, “Things which matter most must never be at the mercy of things which matter least.”

Dr. Meagher pretty well leaves it at that, but I’m left wondering about our impatience and our hurry. Our digital world is replete with people rushing around, and the glut of free time promised us 40 or 50 years ago has never come to pass.

I’d argue that our sense of hurry may be related to our conceptions of time. As historian Lewis Mumford has argued, the clock changed everything, and we are forever catching up. Our calendar, for instance, comes to us from the Romans and before them the Egyptians, and is a lunar calendar that has had to have extra days inserted from time to time. It was the remarkable Julius Caesar who adopted the notion of a leap year, adding an extra day every four years. Though a helpful achievement, this left us with an average year of 365.25 days that was still off by 11 minutes a year.

Eleven minutes here, 11 minutes there: it all adds up.

Certainly fatigue and arrogance can get in the way of good medical judgment, but our predilection for haste deserves special consideration.

Things which matter most must never be at the mercy of things which matter least.

Pope Gregory XIII convened a 16th century commission to study problems with the calendar and physician Aloysius Lilius suggested a modification that held promise. Lilius’ suggestion was that century years that were divisible by four, e.g., 1600, would be leap years, while others, e.g., 1500, would have but 365 days. It seemed like a good idea, as the prior calendar was “slipping” about three days every 400 years. To get things back on track Gregory’s papal bull ordered 10 days removed from the calendar. October 4, 1582 was accordingly followed by October 15, 1582 in most countries. As could be expected, there was a terrible ruckus over “lost time” and we’ve been looking for it ever since.

Meanwhile, our clocks have become ever more sophisticated. Mechanical clocks invented by Benedictine monks in the 13th century were rendered obsolete in the late 1920s, once it was found that certain crystals vibrate regularly in response to an electrical charge and could power a display. Short decades later, we have clocks of unthinkable precision: strontium oscillates at a frequency of 429 trillion cycles per second and defines a clock that is accurate to one second every three billion years.
It was a mere 400 years ago that Irish Bishop James Ussher toted up things from the scriptures and announced that the world began at 6 p.m. Saturday, October 22, 4004 BC. Now, at the same time that the second has been divided into attoseconds (one attosecond defined as the time it takes light to travel the length of three hydrogen atoms, or one quintillionth of a second), physicists remind us that the universe is 13.7 billion years old, the sun is 4.5 billion years old, and that it’s good for maybe another four or five billion years before it burns out as a red giant.

For docs, of course, special circumstances may or may not pertain. Unexpected things happen. Patients clamor, bring relatives, are voluble or mute, speak Urdu, Mandarin or Cree. Chronic, complicated disease is booming. Community and other resources can vanish in a breath and the health system still largely rewards episodic, piecemeal care.

There’s the lure, the happy vision of finishing a clinic early, or, perhaps more modestly, of being on time for once. But it would need incautious speed. Care with a wink and a nod, a hope and a prayer? On to the next, and see the secretary on the way out?

I’m reminded of Ulysses on his fabled voyage, hearing the bewitching call of the Sirens. He knows that succumbing to the Sirens will wreck his ship and prevent him returning home – his larger aim – so he has himself lashed to the mast of his vessel.

I like the tale and think our lives are like this. Sometimes one has to lash – or be lashed – to the mast, as it were. What do they say about tough stuff? The only way around is through.

Let me return to Dr. Meagher. I’m grateful to him for his thoughts on the capricious, irrational nature of most medical mistakes and I’m particularly attracted to his Goethe quote. Once again: The things that matter most must not fall prey to things that matter least.

How to make this distinction and how, given the hurly-burly of our lives, to act on it would seem to be the hard part.

It’s a matter of time.

References

To top things off, according to Albert Einstein, time has become, of all things, relative. There is no universal now. Time stops at the speed of light. Clocks close to the planet surface are slower than those on mountain tops.

That’s time in a nutshell. We’re fuzzy about time, wary. Throw in our time-demanding technologies and our thoughtless drive in the developed world to do things ever more cheaply and our recipe is done – we’re in a perfect state of hurry.

In a world where we were once accosted by ravenous lions and other immediate threats to our survival, we had to make quick choices. In a world of nagging, incessant demands our agitation is maladaptive.

In a world where we were once accosted by ravenous lions and other immediate threats to our survival, we had to make quick choices. In a world of nagging, incessant demands our agitation is maladaptive.

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• After you sign in, you’re right in the President’s Letter commenting section and ready to post your first comment.

Take a look at our commenting policy for some common-sense advice on keeping the conversation productive. And, of course, you will still be able to contact the president directly by email.
Embracing change to benefit our patients and our profession

I was reflecting on those changes recently, and I realized that change has been a constant since I started in medicine. To borrow one of Dr. Edward Papp’s favorite lines, it is abundantly clear that change is a process, not an event.

There have been enormous changes in all aspects of medicine for decades, and it will certainly be a prominent feature of the next year for the AMA.

Examples of change

There are many examples of the huge changes that have engulfed society in the last half century.

I was taught to write with a straight pen and an inkwell. I now use a word processor. The first photocopiers came out as I entered university. The first hand-held calculators were available when I started graduate school. Personal computers came into wide use 35 years ago. I can now send an image of anything from my kitchen table to the other side of the world. That seemingly simple act uses more computing power than existed on any university campus 40 years ago.

When I started medical school, H. pylori was a new idea. Most general surgeons were very familiar with ulcer surgery. I have been involved in one such surgery in the last 20 years. I write a lot of prescriptions for H2 blockers and PPIs, drugs that were unknown shortly before I started medical school.

In the mid-80s, the victim of an MI was still put in bed with best wishes from the attending. By 1991, as a medical student, I was giving thrombolytics. Getting consent then was a long and involved process.

The cardiac surgeons did most of the invasive procedures, an honor that seems to be shifting to the stent wizards.

In 1987, we had not yet identified Hepatitis C and AIDS was a death sentence. The gastroenterologists tell me we may well cure Hepatitis C without interferon in the next couple of years. AIDS is known as a chronic condition.

When I started rural practice, the model was the doctor with one or two staff to help with all aspects of providing care. Ten years ago we started rolling out teams in primary care, through the new structure called primary care networks (PCNs). The great majority of primary care physicians now belong to a PCN.
The AMA is now working to take team-based primary care to the next level through PCN evolution.

Last winter, we thought the government was going to rewrite our fee schedule unilaterally. Last spring we negotiated an agreement where the government and AMA will jointly modernize the fee schedule. It is a change that will be uncomfortable for many physicians, but it needs to be done.

Change is a constant in our profession. We cannot deny it, nor can we prevent it. We must embrace it and use it to benefit our patients and our profession.

Talking with patients

At various times through this RF you have heard references to changing how we talk with our patients. All physicians are aware that there is a huge difference between talking to a patient and talking with a patient.

Until recently, it was not possible for the AMA to actually talk with patients. We could talk to them through our publications and advertising campaigns. But, we could not get quick or abundant feedback from our patients or the general public. The communication was essentially a one-way process.

With the rapid changes in communication technology, it is now possible for the AMA to interact with patients in a meaningful and immediate manner. We can now talk with our patients on a grand scale, and we intend to do that. We will put information out to patients and get their responses quickly.

Our communication program will evolve over the next year and beyond. We will offer our physicians ways to use the “big data” that it will generate to improve how an individual physician communicates with individual patients. I believe it will strengthen that all-important doctor-patient relationship.

We will keep you informed as it develops.

Challenges for the year ahead

The year ahead offers many challenges. Thankfully that no longer involves negotiating a framework on how we interact with the government. But, it does mean that we need to take the new framework and implement the change that it embodies. When we are done, the physicians of Alberta will be delivering better care to more patients more quickly.

Remember, change is a constant in our profession. We cannot deny it, nor can we prevent it. We must embrace it and use it to benefit our patients and our profession.

As your president, I will work to ensure that the change which is coming will be a positive for the profession and, most importantly, for our patients.

We must remember the words of Paul Robeson, who said, “My future depends mostly on myself.” For the AMA, our future depends mostly on ourselves.

I am confident that the physicians of Alberta will join the AMA in driving the change that we need.

Here at RF, you have heard some parts of the change that will happen over the next year and beyond. I will provide more details in President’s Letters over the coming year. Where appropriate, more complex issues will get more detailed descriptions through a variety of communication tools.

Thank you for the opportunity to serve the patients and physicians of Alberta, and to lead the change that our patients deserve.
A challenging year, but a promising future 

Excerpts follow from the valedictory address by Dr. R. Michael Giuffre, 2012-13 president.

Colleagues, special guests and delegates: 2012-13 was clearly not the year I expected. It was more challenging - for all of us - than we could have anticipated. The year has both highlighted the weaknesses of the health care system and charted a path forward toward a new sense of strength.

I take great pride in standing before you, for almost the last time, as the AMA president. When I first signed up for this privilege, the AMA had signed a three-year memorandum of understanding with government and the spring 2012 provincial election had been called.

Well, so much for expecting a straightforward year of implementing an agreement rather than negotiating one. The year overall has turned out to be what I can only describe as amazing: not only for its challenges and enormous workload, but also for our profession's exposure to public scrutiny and judgment - and the show of incredible solidarity by our AMA membership during the troubled times.

As doctors and members of the AMA, your diligence and unity paid great dividends this year. We have a seven-year, $25 billion agreement for physicians and government - and with this, we have created some stability within our health care system, even in the midst of recent tumultuous change.

When we are united, focused and determined that we will not be pushed around, physicians - and the patients we care for - are really strong.

The rate of change and the massive scope of change have swept away so much that we have known. For 20 years, health care in Alberta has endured upheaval - and it has been change after change without any significant change management. As many have said, in business schools across Canada, the Province of Alberta has been a case study in showing the world the wrong way to re-organize health care!

As just one example, look at the approach toward regionalization. We started with 19 regions where physicians and other front-line providers had to learn to work within the organizations and establish relationships with local boards and administrators.

Then, we suddenly shrank to nine regions - with little or no consultation with doctors or patients - and thus we had to re-learn how these new regions worked, and we had to establish a whole new set of relationships.

Then, on a single day in 2008, the nine regions were collapsed into one entity known as Alberta Health Services (AHS) and it ushered in the so-called "super board" to administer the whole system.

Once again, it was dramatic change with little or no consultation - and certainly no change management.

Since then, physicians and other front-line health providers have spent...
> a tremendous amount of time and effort trying to re-learn the way yet another organization works. Only this time the organization was a colossus, with 100,000 employees and 180 vice-presidents and a super board. It left doctors fumbling, just trying to learn who all the players were. All the time and effort we spent trying to make sense from the disorder could have been spent with our patients and focusing on the delivery of care.

Finally, after yet another shakeup in leadership – just as we were getting to our feet and getting to know another new system, a new AHS chairman and board with its new processes – in one swoop the entire board was fired. Now that was a surprise to all and a shock to many.

Physicians collectively seemed to throw up their hands and say: “Here we go again!”

No system can be expected to fully deliver on its “core business” – in our case, “patient care” – with this kind of upheaval.

Whatever the initial hopes for AHS, what is certain is that it has not delivered better care, or made for uncrowded emergency departments, or met wait list targets or even reasonable waits for procedures and surgeries and has not delivered adequate support for our frail or elderly populations.

I do not believe that the problem is lack of funding. In the last six years the AHS budget has compounded 6% each year to a current annual budget of over $13 billion. Yet wait times for procedures and surgeries have not gone down, even as we have spent more money.

The problem is that we have been spun around by one change after another in this massively complex health care system, and there has been no overall guiding direction. Physicians and other front-line professionals – who should be helping to determine the shape of the system – have not been getting that opportunity.

For every physician working in this hospital system that we have been forced to adopt, the arrival of AHS in 2008 severed, overnight, the relationships and processes that we had been re-building through regionalization. Through years of experience, doctors had learned how to work and navigate the system; they knew how to raise issues of concern, and they knew how to work to find solutions. In May 2008 that network of knowledge disappeared.

And today, I’m further troubled that our AMA members tell me there is still a top-down approach by AHS and Alberta Health of “telling the docs what is best for them.” It’s a bureaucratic mindset that has wrongly defined physician engagement to this day, and it remains a problem. There has also been an alleged culture of intimidation when physicians and other health care professionals have spoken up, or have tried to advocate for patient care. That problem hasn’t spontaneously gone away; but it was put on hold in favor of a public inquiry on queue jumping.

Become re-involved in the system of care, make it better and include your patients in your efforts.

I want to emphasize that lack of engagement and other challenges were not a slight to AHS executives who have had an impossible task in recent years. In fact, we would be so much worse off if it was not for heroic efforts of many AHS staff who have held things together to the best of their abilities. Many of these people are our colleagues, fellow physicians who have tried very hard.

But let me describe how I see the environment we find ourselves in. Let’s pretend that the Alberta health care system itself is our “patient.” What does this patient need and what is the prognosis?

Because of all the factors I’ve mentioned, as we assess the “Patient Alberta Health Care System,” we see that things are not good. We can see that the patient has been through some significant trauma and now is unstable with vital signs wavering. The past history of our patient is also not good; as we uncover more we see that the patient has had a 20-year lifestyle that was clearly unhealthy. In fact there are some significant underlying chronic conditions in need of comprehensive care or our patient will not get better.

There is no escaping the facts: Constant and sometimes inexplicable change has taken a toll on the health of our health care system.

So my outlook for the patient is guarded. There are many challenges and unanswered questions ahead. We know that just pointing out problems is not really the way to solve them. But looking at things as they stand today, one wonders where to begin. Is there really any hope for our patient? Is there really any chance of a good prognosis for our “Patient Alberta Health Care System?”

There are indeed a few things worth mentioning in this regard, and they can make us all quite hopeful.

Let me try to elaborate on a new course of treatment for making the patient better. Namely, the new AMA Agreement between physicians and the provincial government that will be the cornerstone of treatment – something we had to work tremendously hard for, in fact, to fight for.

In doing so, I think the AMA learned a valuable lesson for the future: When we are united, focused and determined that we will not be pushed around, physicians – and the patients we care for – are really strong and a true force.

I could spend more time talking about just how we got an agreement, but I’d rather focus on exactly what this agreement can provide going forward and the strength of the profession that is behind it. In general, one can say with confidence that we have
made significant progress on key issues that affect physicians in their daily practice - and in addition, we have made progress on broader issues of physician involvement in health care decision making. We have an agreement structure that carries us forward and does not end when the timeframe of the agreement ends. Briefly, here are five significant examples of what we have achieved within the agreement:

1. We now have a way to tackle technical issues such as modernizing the physician fee schedule so it reflects how care is delivered today, so that compensation aligns with health care policy and reflects the improved technology that’s available.

2. We have a commitment to build a provincial electronic medical record and information strategy with Alberta Health.

3. We will continue to evolve primary care itself toward the medical home.

4. Government has agreed that they will consult with, and seek the AMA’s advice for, any health care issues that “touch and concern” physicians.

5. The AMA will be recognized in legislation as the sole negotiation body for physicians in Alberta.

Perhaps most importantly, this agreement means the years and years of unplanned reorganization should come to an end! Sweeping organizational changes do indeed affect our ability to provide world-class patient care and therefore we must be consulted in the future on the design and delivery of health care in Alberta. The health care system is dynamic and never sits still. We know as physicians that we can always expect change and contribute to change, but that this should be “managed change.”

Going forward, physicians will have the opportunity, lacking in our past, to provide advice and know that the advice will be incorporated into decision making and incorporated as decisions are developed, instead of being told by administrators after a decision is made that “we know best and that this is best for you.”

We now have this agreement and go-forward plan with Alberta Health and now we need to do the same with AHS. A closer working relationship between AMA and AHS is really essential. We need to seek common objectives, and we should view our different perspectives as a strength rather than something that has to be controlled. Perhaps then we can actually say that we have the fundamentals of truly working together and adding value to the health care dollars spent.

My closing advice to the RF, our incoming president and the AMA board is simple: be vigilant. Hold the government to account on the commitments they have made. Become re-involved in the system of care, make it better and include your patients in your efforts.

I am hopeful that we can make some real inroads in some of the challenges we face – in a measurable way and in a reasonable period of time. It will not be easy at all, but then complex things never are.
Dr. Allan S. Garbutt

**AMA PRESIDENT 2013-14**

At the Fall 2013 Representative Forum and annual general meeting, Dr. Allan S. Garbutt was officially installed as the Alberta Medical Association’s (AMA’s) president for 2013-14.

Dr. Garbutt has dedicated considerable time to the AMA over the past two decades. He has been extensively involved with the Section of Rural Medicine, having served as president and currently in the role of past president. He is a director of the Rural Physician Action Plan and serves on the AMA Board of Directors, the Primary Care Alliance Forum, General Practice Representation Working Group, Executive Committee, Committee on Constitution and Bylaws, and the Joint AMA/College of Physicians & Surgeons of Alberta Executive. He has been a Representative Forum delegate since 1997. For his contributions to the profession, Dr. Garbutt was recognized in 2010 with the AMA Long-Service Award and in 2011 with AMA Member Emeritus status.

Dr. Garbutt received his medical degree from the University of Western Ontario and completed a rural family medicine residency at the University of British Columbia in 1993. His passion and advocacy for rural medicine led him to Crowsnest Pass where he remains today, helping to care for the town’s residents as well as the many tourists who visit each year.

Since 1994, Dr. Garbutt has been a clinical lecturer in the Department of Family Medicine in the Faculty of Medicine at the University of Calgary. He holds the same position with the University of Alberta.

Dr. Garbutt also devotes time to the community of Crowsnest Pass. For the past two years he has organized, with the help of his colleagues and Back Country Butchering, the donation of enough ground beef to supply the local food bank for several months.

Dr. Richard G. Johnston

**AMA PRESIDENT-ELECT 2013-14**

At the adjournment of the Fall 2013 Representative Forum and annual general meeting, Dr. Richard G. Johnston, an Edmonton-based intensivist, officially assumed the role of Alberta Medical Association’s (AMA’s) president-elect for 2013-14.

An active AMA member, Dr. Johnston has served for 19 years on the Negotiating Committee, the last 16 as chair. He also provided his expertise as a member and co-chair of the Secretariat Committee, chair of the Finance Committee, member of the Board of Directors, Subcommittee on Finance, and Specialist On-Call Advisory Committee. In 2004, for his contributions to the association and the profession, Dr. Johnston was recognized with the AMA’s Long-Service Award.

In his role as president-elect, Dr. Johnston will serve on various internal committees including the Committee on Constitution and Bylaws, the Government Affairs Committee, as well as the Board of Directors and Representative Forum.

Dr. Johnston obtained his medical degree, with distinction, from the University of Alberta in 1977. In 2002, he received an MBA from the Ivey Business School at the University of Western Ontario. Currently, he is on the attending staff of Adult Intensive Care at the Royal Alexandra Hospital. He was chief of critical care at the hospital for 21 years. Dr. Johnston teaches as a clinical professor in the Department of Anesthesiology and Division of Critical Care in the Faculty of Medicine and Dentistry at the University of Alberta.

Dr. Johnston has contributed to many publications and abstracts and has been principal investigator of research studies and clinical trials. His awards include the Mewburn Memorial Gold Medal in Surgery, Allan Coates Rankin Prize in Bacteriology, and the Sam Fefferman Memorial Gold Medal in Honours Physics.
Physicians bestowed awards for their achievements

AMA Achievement Awards

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

Medal for Distinguished Service

The AMA Medal for Distinguished Service is given to physicians who have demonstrated an unwavering commitment to their communities and passion for their work. This year, three recipients have made outstanding contributions to the medical profession and to the people of Alberta and, in the process, have raised the standards of medical practice for our province.

Dr. Werner J. Becker is a neurologist renowned locally, nationally and internationally for his pioneering work in relation to headaches and migraines and for his significant contributions to medical education and research. He delivers lectures and presentations around the world and has received many awards and distinctions including the John R. Graham Clinician’s Award.

Dr. Suna A. Smith is now retired and enjoying a more relaxed schedule. She has been recognized with honors including the Canadian Mental Health Association Dedication Award.

Dr. Cyril B. Frank’s distinguished career as an orthopedic surgeon, teacher, researcher and advocate for his patients has had a profound impact worldwide. He recently received the Queen Elizabeth II Diamond Jubilee Medal and the Order of the University of Calgary.

Medal of Honor

The AMA Medal of Honor is presented to non-physicians who have made significant personal contributions to ensuring quality health care for the people of Alberta.

Health champion and Edmonton coordinator for ‘NSTEP (Nutrition, Students, Teachers, Exercising with Parents) Eat Walk Live program, which focuses on preventing and improving health issues in children and youth, is just one of Darlene R. Schindel’s many accomplishments in her successful career. She was also the first nursing coordinator in Edmonton.

AMA Long-Service Awards

The AMA Long-Service Award honors physicians who unselfishly contribute their knowledge, skill and time to the advancement of the profession. Their work, whether on the Board of Directors, or its committees, supports and encourages the association’s development. >
Pathologist Dr. Pauline Alakija recently finished her second term on the AMA Board of Directors and participates on other committees. She has received many excellence in teaching awards and offers her expertise at lectures and presentations locally, nationally and internationally.

Dr. Allan L. Bailey was honored with the AMA’s Medal for Distinguished Service in 2009 and continues to contribute by serving on many AMA committees. He is an associate clinical professor at the University of Alberta and is principal investigator and owner of BioQuest Research.

Although she was a student representative on the AMA Board of Directors many years ago, Dr. Sarah L. Bates is currently serving her first term on the board and participates on various committees. She is a clinical assistant professor in the Department of Family Medicine at the University of Calgary.

Psychiatrist Dr. Padraic E. Carr sits on the AMA Board of Directors, Representative Forum and other committees. He mentors and instructs medical students and residents and is a sought-after speaker. He is a Distinguished Fellow of the American Psychiatric Association.

A tenured professor of anesthesia at the University of Calgary, a professional mentor with the AMA’s Physician and Family Support Program, and a frequent invited guest speaker worldwide are just a few of the ways Dr. Robin G. Cox has contributed his knowledge, skill and time to the profession.

Dr. Brent T. Friesen is a public health and preventive medicine specialist who’s involvement on AMA committees began in 2003. He is medical officer of health for the tobacco reduction program with Alberta Health Services and has taught at the University of Calgary for 27 years. (No photo available)

Orthopedic surgeon Dr. James A. Harder provided his expertise to the AMA Committee on Financial Audit for 10 years. He contributes to publications, speaks at national and international events, and has volunteered on many medical missions in the Caribbean Islands, Palestine and South America.

For 32 years Dr. Michael P. Poitras has practiced family medicine in Edmonton. He has served on various AMA committees and is a clinical lecturer in the Department of Family Medicine, Faculty of Medicine and Dentistry, at the University of Alberta. (No photo available)

A well-known surgeon and leader in the medical community, Dr. Harold Prokopishyn cared for the people of Lethbridge for over four decades. He has been a member of the AMA since 1977 and served on various committees and, most recently, on the Representative Forum as a regional delegate.

Dr. Ann R. Vaidya is currently president of the AMA Section of General Practice. In 2010 she was recognized by the Canadian Medical Association with the Award for Young Leaders in the Early Career Physician category, an award that “celebrates the efforts of young physician leaders of tomorrow for their efforts today.”

AMA Member Emeritus Awards

The AMA Member Emeritus award recognizes physicians who have made significant contributions to the medical profession, seniority and long-term membership based on criteria determined by the AMA Board of Directors.

Dr. Robert W. Broad, a neurosurgeon, served for 10 years on the Committee on Financial Audit and has been a member, and now chair, of the Canadian Medical Association’s Audit Committee for four years. He continues his involvement on various committees and is an assistant clinical professor in the Division of Neurosurgery at the University of Alberta.

A previous recipient of the AMA’s Long-Service Award, Dr. Eugene J. (Sean) Cahill has remained active with the association. While interning at University Hospital Galway, Ireland, and in Great Yarmouth, Norfolk, England, Dr. Cahill experienced Alberta winters doing locums in Hardisty and in “ominously named Killam!” (No photo available)
Dr. William S. Hnydyk is the AMA’s assistant executive director of professional affairs, providing input, advice and guidance on services that support members in their professional roles and responsibilities. Prior to his staff appointment, he cared for the people in the community of Vegreville and served five years as chief of staff at St. Joseph’s General Hospital.

AMA’s Senior Medical Advisor, Dr. Lyle B. Mittelsteadt, practiced family medicine in Lethbridge and then in Fort Saskatchewan, where he served terms as site lead and chief of staff at Fort Saskatchewan Hospital. As part of the AMA’s senior management team, he is responsible for issues relating to pharmacy and therapeutics, as well as patient safety.

Dr. Sandy J. Murray was president of the AMA and served on both the AMA and CMA Board of Directors and many other committees. He has had privileges at Red Deer Regional Hospital for 25 years. Dr. Murray maintains an occupational medicine practice and is medical consultant to a variety of industries and businesses.

Dr. A. James D. Pope has cared for the people of that region for 37 years. He continues today in his role as a Representative Forum delegate and offers his expertise to other committees as well as the AMA’s MD-MLA contact program. He is a recipient of the AMA’s Long-Service Award in recognition of his contributions.

Grande Prairie family physician Dr. Tzu-kuang (T.K.) Lee, an internal medicine specialist, was president of the AMA in 2005-06 and served on many committees. He is a dedicated and passionate teacher and has received many provincial and national teaching awards. Dr. Lee’s expertise is sought-after at scientific presentations, invited talks, lectures and workshops worldwide.

The work of the Committee on Reproductive Care, of which Dr. Christine P. Kyriakides was a member, was instrumental in improving the health and care of mothers and babies in Alberta and across Canada. Dr. Kyriakides operates her own pediatric practice and is preceptor in pediatrics to undergraduate and postgraduate students at the University of Alberta.

Dr. Sandy J. Murray was president of the AMA and served on both the AMA and CMA Board of Directors and many other committees, councils and forums. He has had privileges at Red Deer Regional Hospital for 25 years. Dr. Murray maintains an occupational medicine practice and is medical consultant to a variety of industries and businesses.

For 39 years Dr. Harvey P. Woytiuk has practiced in St. Paul. He also teaches as an associate clinical professor in the Department of Family Medicine at the University of Alberta. He is a long-time member of the AMA and has offered his expertise on many committees and councils. Dr. Woytiuk is a recipient of the Alberta Family Physician of the Year award.

Dr. David P. O’Neil’s rural practice began 36 years ago in Elnora, Three Hills and Trochu. Today, he continues to advocate for the importance of rural medicine in his role as provincial medical director (south) for community and rural health service planning with Alberta Health Services. He is an AMA Member Emeritus and held various roles on a number of committees.

CMA Honorary Membership

Canadian Medical Association (CMA) honorary members “have distinguished themselves by their attainments in medicine, science, the humanities or who have rendered significant services to the Association.” They are “members of the Association in good standing who have attained the age of 65 years...." This year, there are eight recipients.

Dr. Harvey P. Woytiuk has practiced in St. Paul. He also teaches as an associate clinical professor in the Department of Family Medicine at the University of Alberta. He is a long-time member of the AMA and has offered his expertise on many committees and councils. Dr. Woytiuk is a recipient of the Alberta Family Physician of the Year award.
A respected medical leader with more than 20 years of organizational leadership experience, Dr. Douglas C. Perry has played a pivotal role in guiding several provincial, national and international health initiatives. Dr. Perry was president of the AMA, speaker for the AMA and the Canadian Medical Association, and served on many internal and external committees.

Throughout his distinguished career, emergency medicine physician Dr. Terry D. Sosnowski has been recognized with many awards, including the AMA’s Medal for Distinguished Service and the Dr. Garnet E. Cummings Lifetime Achievement Award. He is a reviewer of the Canadian Journal of Emergency Medicine and the Canadian Medical Association Journal.

For more than 35 years Dr. Clayne A. Steed has provided medical care to the people of Raymond. His passion for rural medicine is evident through his 17 years as an AMA representative on the Rural Physician Action Plan Committee. He was president of the AMA in 2000-01 and served on many committees. This year, Dr. Steed received the Queen Elizabeth II Diamond Jubilee Medal.

Now retired, Dr. Luxie C.E. Trachsel practiced physical medicine and rehabilitation in Edmonton up until 1999 when she became the AMA’s assistant executive director of professional affairs. She served on many internal and external committees. For 20 years, Dr. Trachsel taught in the Division of Physical Medicine and Rehabilitation at the University of Alberta.

Dr. Brian D. Willis was medical examiner in Alberta for 27 years and has cared for the people of Edson for 36 years. He is a recipient of the AMA’s Medal for Distinguished Service, the Alberta Rural Physician Award of Distinction, and the University of Alberta (U of A) Preceptor Excellence (Year 3) Award. He is a clinical lecturer in the Department of Family Medicine at the U of A.

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MANY REFERENCES AVAILABLE
In a two to one decision, British Columbia’s highest court recently upheld the federal ban on physician-assisted suicide. The ruling overturned the June 2012 British Columbia Supreme Court decision in *Taylor and Carter et al. v. A.G. of Canada* which struck down s. 241(b) of the Criminal Code prohibiting assisting another person to commit suicide.

To summarize the lower court’s decision, the plaintiffs, both of whom suffered from intractable and progressive diseases, brought a civil claim challenging the constitutionality of a series of Criminal Code provisions dealing with assisted suicide and euthanasia. This was in spite of the fact that in 1993 the Supreme Court of Canada had ruled five to four to uphold s. 241(b) in *R. v. Rodriguez*. The trial judge in the *Taylor* case was of the view that a change in the applicable legal principles had occurred since 1993 and, therefore, she was no longer bound by the *Rodriguez* decision. In addition, much of the plaintiff’s case was based on arguments surrounding the s. 15 equality rights provisions of the Charter of Rights and Freedoms, which were not canvassed to any extent in the *Rodriguez* decision. Finally, she was also prepared to find that the s. 7 right to life was engaged, because the prohibition had the effect of causing some people to end their lives sooner than they otherwise would if physician-assisted dying were available.

The *Taylor* trial judge ultimately granted two declaratory orders (one pursuant to s. 15, and one pursuant to s. 7) declaring that the impugned provisions of the Criminal Code infringed on the Charter and were of no force and effect to the extent that they prohibited physician-assisted suicide:

“...by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully informed, non-ambivalent competent adult patient” who was otherwise free from coercion or undue influence, was not depressed, and suffered from “…a serious illness, disease or disability … is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy … and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.”

The declarations were then suspended for one year (to allow for legislative change) but an exemption from the suspension was granted to Ms Taylor.

The British Columbia Court of Appeal chose to retreat behind the rubric of precedent and binding higher court decisions and not enter the arena of physician-assisted suicide.

Prior to the release of the British Columbia Court of Appeal’s decision, the debate regarding physician-assisted suicide was further sparked by a video featuring Dr. Donald Low, a well-known Ontario physician, containing an impassioned plea to allow physician-assisted suicide for people who were in severe pain and terminally ill. In addition, the Province of Quebec has joined the debate by threatening to pass legislation specifically allowing physicians to provide assistance as part of the medical treatment provided in accordance with the provincial medical plan.

So, what did the British Columbia Court of Appeal have to add to the debate? Well, two members of the Court of Appeal’s three-judge panel based their decision to overrule the trial judge’s ruling on the fact that, while the law had seen some evolution since the 1993 decision in *Rodriguez*, it had not changed sufficiently to justify diverting from the precedent set in that case: “...no change sufficient to undermine *Rodriguez* as a...”
All of this is intriguing for legal scholars but, for the person on the street, what does this mean? It does not bode well for those interested in the passionate and human side of the right to physician-assisted suicide debate. Where the trial justice based her decision on facts, and evidence given by two individuals intensely and directly impacted by the restrictions imposed by s. 241(b) of the Criminal Code, the British Columbia Court of Appeal chose to retreat behind the rubric of precedent and binding higher court decisions and not enter the arena.

The next step in the process will be (and likely already is) an application by the plaintiffs for leave to appeal this newest decision of the British Columbia Court of Appeal to the Supreme Court of Canada. It will be fascinating to see if the Supreme Court accepts the challenge. It does have the ability to review its own decisions and current thought is there is a distinct possibility that the Supreme Court will, indeed, agree to revisit Rodriguez. In passing, it is worthy of note that the current Chief Justice of our Supreme Court was one of four judges who dissented in 1993 when the issue was last decided and is the only member of the current court who heard argument and participated in that decision.

It will be fascinating to see if the Supreme Court accepts the challenge (to rule on the issue).

While any decision ultimately made will be too late for either Gloria Taylor or Lee Carter, there are many, many similarly affected Canadians who will be anxiously hoping for, and awaiting, the re-visitation.

References
1. The argument was essentially that the ban on assisted suicide discriminated against individuals with severe medical conditions that prevented them from taking their own lives.
2. Gloria Taylor subsequently passed away from an unrelated medical problem before the case was argued in the Court of Appeal. Lee Carter subsequently travelled to Switzerland and took her own life with the assistance of a physician, as sanctioned under Swiss law. However, given the importance of the issues, the Courts have allowed the matter to proceed on behalf of the estates or personal representatives of the two former plaintiffs as well as other named plaintiffs, including the British Columbia Civil Liberties Association.
3. S. 7 of the Charter guarantees “...the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the provisions of fundamental justice.”

The Province of Quebec has joined the debate on physician-assisted suicide by threatening to pass legislation specifically allowing physicians to provide assistance.

The dissenting judge would have dismissed the appeal relating to the s. 7 (right to life) challenge. Reviewing the principles of fundamental justice, as they apply to a s. 7 analysis, the Chief Justice of the Court wrote that the Supreme Court, in Rodriguez, did not give full weight to the two principles of overbreadth and gross disproportionality, and therefore it was open to the trial judge to consider these in her decision. (These principles essentially say that a law which is on its face contrary to the right to life might be acceptable if it is a proportional and reasonable response to a perceived social issue.)

For those seeking change, there was a glimmer of hope in the Chief Justice’s dissenting opinion. He commented on how, in Rodriguez, the Supreme Court focused more on the s. 7 rights to liberty and security of the person, rather than on the right to life. He wrote:

“The value a person ascribes to his or her life may include physical, intellectual, emotional, cultural and spiritual experiences, the engagement of one’s senses, intellect and feelings, meeting challenges, enjoying successes, and accepting or overcoming defeats, forming friendships and other relationships, cooperating, helping others, being part of a team, enjoying a moment, and anticipating the future and remembering the past. Life’s meaning, and by extension the life interest in s. 7, is intimately connected to the way a person values his or her lived experience. The point at which the meaning of life is lost, when life’s positive attributes are so diminished as to render life valueless, when suffering overwhelms all else, is an intensely personal decision which everyone has the right to make for himself or herself.”

The majority did say, however, that in the event that the Supreme Court ultimately chose to review Rodriguez and provide a fresh analysis, it would favor the remedy of “constitutional exemption” rather than a declaratory order. This exemption is essentially a “special dispensation” given in favor of persons on whom an otherwise sound law has an extraordinary or extreme effect.

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FEATURE

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Due to the retirement of distinguished writer, Dr. J. Barrie McCombs, Alberta Doctors’ Digest is recruiting for a technology writer. Our regular column, Web-footed MD, will become Dr. Gadget, reflecting the many broad aspects of how technology can be useful in medicine. From web resources, to mobile apps and new devices for the examination room – you’ll get to write about it all. Alberta’s doctors want to hear your opinions, conclusions and recommendations.

This is an opportunity that doesn’t come along every nanosecond. So if you’re interested in being considered by the selection committee, here’s what we need. Just write a 500 word article covering a medical-technology topic of your choosing. Look up the email address of the editor-in-chief of Alberta Doctors’ Digest (it’s at the end of this article). Press send by December 31.

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Sharing and disclosing information responsibly
Here’s what you need to know

In an era when information is so instantly accessible, it’s no surprise that physicians are increasingly being asked to share patient information for various purposes. At the same time, multiple health care providers often need access to patient records in order to deliver needed care. No matter what the circumstances, whenever physicians are asked to share or disclose patient information they need to make sure they’re compliant with the Health Information Act (HIA) and following the College of Physicians & Surgeons of Alberta (CPSA) Standards of Practice.

“We hear from a lot of members that they are being asked more frequently to share or disclose information with groups or organizations,” explains Stephanie Crichton, a senior information management/information technology consultant with the Alberta Medical Association (AMA). She notes that with more than 80% of community physicians now utilizing electronic medical records (EMRs), organizations such as primary care networks, Alberta Health Services and the Health Quality Council of Alberta want access to patient and health care provider information in order to assist with population health data, planning and budget forecasting. Although those requests for information are valid, physicians still have a responsibility to be good custodians of patient data and to abide by HIA requirements.

“We wanted to help physicians understand how to share or disclose information while fulfilling their professional, ethical and HIA obligations,” notes Crichton.

In order to develop the necessary tools, the AMA created a working group that included several AMA physician members and staff, as well as AMA legal counsel and representatives from other organizations.

The group developed two different template tools:

- An information sharing agreement that can be used when custodians share patient records (e.g., an EMR within a clinic).
- A disclosure agreement that can be used when a custodian is asked to disclose information to a third party.
- Both templates set the parameters for what recipients can and can’t do with the information they receive and are available on the AMA website at http://bit.ly/1avQwOl.

“We created the tools as templates rather than forms, which means physicians can customize them to suit their specific needs,” says Crichton. “And since they have already been vetted through legal counsel, physicians can be confident that these templates will help them protect patient information and fulfil their obligations as responsible custodians.”

Although most physicians will recognize the importance of agreements for sharing or disclosing information in response to outside requests, Crichton stresses that it’s also important to know how to share information with the people you work with every day. “When physicians work together, you know that at some point it will end. Whether one of you retires, or you simply move on, if you share information within your practice you need to know how you’ll handle it and what you’ll do with those records when you no longer work together. It’s inevitable and something that should be part of your planning.”

In determining which template to use, it’s helpful to understand the distinction between information sharing and information disclosure, says Jon Rossall, a lawyer with Edmonton’s McLennan Ross law firm and legal counsel for the AMA. “Information sharing involves giving other custodians access to patient information in order to provide care,” explains Rossall. “Information disclosure involves disclosing patient data to third-party organizations or entities who need it for specific purposes, such as tracking health trends or evaluating the effectiveness of screening or interventions.”

If in doubt about the nature of the request and which template is best, physicians are encouraged to contact stephanie.crichton@albertadoctors.org for guidance. She also invites physicians to share any suggestions they might have about how to improve or refine the templates once they see them. “We always appreciate feedback,” notes Crichton. “This is a process and just like community practices, the templates can adapt and evolve.”
Financial reports are included on the meeting agenda. Or perhaps they appear with your monthly invoice for overhead. Do you cringe, plan to check phone messages during that part of the meeting or file the reports away without looking at them?

Wait. This is important to you and your practice.

One objective of regularly reviewing financial reports is to reduce surprises. They are an important diagnostic tool for operating your business. When you understand areas where costs are increasing and proactively take action to reduce costs – or increase revenue – you may be able to improve your net results.

Financial information is most commonly provided in two formats – the balance sheet, or statement of financial position, and the profit and loss or income statement.

Balance sheet

This report provides you with a snapshot of your assets, liabilities and equity. Assets are things that a company owns that have value. Liabilities are what you owe to others. Equity, or net assets, is the money that would be left if your company sold all of its assets and paid off all of its liabilities. When you owe more than you own, there is a net deficit. The value of things continue to change but, at that date, this is the status of what you own, what you owe and everything you have accumulated to that point in time.

These are some items to look for when reviewing this report:

- Are there changes in the accounts from last year that need further explanations?
- How much cash is in the bank? Compare the amount to last year or last month. Is your bank balance relatively stable or is it changing significantly? Do you know why changes are happening?
- How much money is owing to your organization? Do you know who owes the money and when you expect to be paid? Can you do anything to speed up how soon the money is collected?
- How much do you owe to suppliers? Is there sufficient money to pay all the bills owing? Is there a problem with cash flow that will need to be addressed?
- Is vacation payable for your staff recorded in your financial statements? This is the amount you owe the staff for unused vacation at this point in time. This may indicate that there is an unrecorded amount owing if it is not shown.

Profit and loss/income statement

This statement is usually the most interesting. This report shows what has happened during the year (or month) from a financial perspective. These reports often include columns that represent the current period of time, the prior period of time, the prior year-to-date or the budget. The additional columns are provided for comparison purposes. Variances are sometimes included to show the differences and highlight items to be discussed further.

Details in the report should be at a level to provide transparency of how money has been spent to operate the clinic. If the level of detail is too high or too low, you will be unable to understand the information or ask meaningful questions. Consider having the categories of expenses revised for your own operation if they are not clearly described. For example, “cost of space” may include both rent and utilities. It may be useful to record rent and utility expenses in separate accounts so variations are more apparent. Variance from prior periods may not be relevant when expense categories are changed.

Revenue will provide information on how much you earned for that period. When clinic financial reports are used only to record expenses for cost allocation purposes, the revenue section of the report will include recoveries that reduce expenses for overhead calculations rather than a true reflection of income earned.
Expenses are amounts paid out as a cost of operating the organization. Expenses can be considered to be either fixed or variable costs. Fixed costs are not significantly impacted by the activity of the organization while variable costs increase or decrease as clinic activity increases or decreases.

By reviewing these expenses, you may identify opportunities to reduce your costs or to increase your net income. Here are some ideas:

• Compare what you have spent for this month to last month; for this month to the same month in the prior year; for this year-to-date to last year for the same period of time. Do you understand why any changes have occurred? Are changes to your practice reflected in the monthly expenses?

• Fixed costs, such as insurance, rent and utilities should be predictable and provide no surprises. An annual review of these expenses is normally sufficient. If these costs seem high, consider the following:
  - Get another quote on insurance when it is up for renewal.
  - Are utility costs higher than for the same time last year? Are there variances that are not explained by increases in rates? Higher costs may indicate wastage such as an unidentified leak in your water system.
  - Is your rent expense the same every month? If you have a lease, the amount should be constant.

• Variable costs will change depending on the level of activity that you are incurring. Comparing these amounts to prior periods and to a planned budget can highlight expenses that are not expected.
  - Lower than normal expenses may indicate that there are unrecorded expenses or variations in the purchasing cycle. Perhaps medical supplies are only ordered occasionally. Buying in bulk for items that you will use may lower costs and increase net income but will cause variances in your monthly expenses.
  - Is an expense higher than expected? Investigate methods to reduce your costs. Do you understand why this amount is more or less than last year? Ask more questions until the explanation is clear.
  - Are repair and maintenance costs increasing? If so, it may be advisable to replace outdated equipment.
  - Have computer support costs increased from the prior year? Think about reviewing the contract for services. You may be able to negotiate a lower rate if you agree to a monthly support contract.

• In service organizations, such as physician offices, staff costs are usually the highest cost item. Variations in these expenses may not be evident through the detail provided on a profit and loss/income statement.
  - Ask for a detailed report of employee earnings that includes a breakdown of administrative staff cost versus clinical staff cost, staff overtime and benefits.

• How much is being spent on administrative salaries and how much on clinic staff? Is this changing? Administrative salaries are often fixed while clinic staff costs change according to the amount of activity in your clinic.

• Lower costs are not always best. Review the percentage of your overhead expenses to total revenue. Sometimes you need to spend money to make money. Adding staff may improve your efficiency so you can see more patients. Providing staff benefits may reduce your staff turnover. Increasing your training costs may improve efficiencies and improve patient care in your practice.

Annual budget

Budget is not a bad word. A budget is a plan based on what you think might happen. It does not require you to spend exactly as planned if circumstances change. However, a budget gives you another benchmark for comparison to actual spending. It provides information to anticipate the impact of adding another physician or what happens if someone leaves the practice. It provides an opportunity for many people to have input to plan for activities that will improve your operation for the next year. Physician monthly contributions are commonly based on the annual budget for expenses.

A budget can be created easily:

• Start with what you actually spent last year.
• Identify increases or decreases that you know about. Adjust costs for insurance premium rates, adjustments for inflation and equipment purchases.
• Plan for changes in staff costs such as number of positions or increases in hourly rates.
• Discuss changes with people who are in a position to influence the future. There may be ideas on how to reduce costs without reducing your services or patient care. Set targets to reduce expenses based on input from others.
• Adjust revenue and expenses for various scenarios such as adding a staff member or revise the amount of activity in your clinic – either increase or decrease. Your budget can be very useful to predict how much you will spend in the current year.

Reviewing your actual expenses on a regular basis, having a budget in place, asking questions about the financial reports and taking action can lead to predictable results, less stress about your finances and greater success in your practices.
It has been another busy year for ADIUM Insurance Services Inc. (ADIUM). The purpose of this article is to update members on our activities during 2013 and to communicate improvements we’ve made to our plans for 2014.

Revised Disability Insurance plan for students, residents and physicians

We worked with Sun Life Financial on an improved Alberta Medical Association (AMA) Disability Insurance plan that is now available to members. Below are highlights of the revised plan.

For medical students we now offer:

- An 80% AMA Premium Credit off our already competitive rates.
- $4,000/month coverage to final-year students (up from $2,500).
- All optional riders without proof of good health. The Cost-of-Living Adjustment and Guaranteed Insurability Benefit riders are automatic and the Own Occupation and Retirement Protection riders are optional following completion of medical school.

For postgraduate residents we now offer:

- Up to $4,000/month coverage, and for those residents training in Alberta, this coverage is paid in addition to the coverage provided under the AMA-administered Professional Association of Resident Physicians of Alberta Group Disability Insurance plan.
- Upon completion of residency, the Guaranteed Insurability Benefit which may be exercised up to our first-year physician limits. They are not restricted to the base option amount.

For physicians we now offer:

- Up to $25,000/month coverage (up from $20,000), which is sufficient to cover a physician’s net income to $980,000.
- Our Guaranteed Insurability Benefit rider option amount has increased without proof of good health to $2,500/month and applies to all ages up to 55.
- An increase to two years (from one year) on disability benefit periods for members over age 63.

Due to low enrolment, the Lifetime Accident Total Disability rider has been discontinued. All members who have this rider will be grandfathered for as long as they maintain their coverage.

Getting better for you: AMA Health Benefits Trust Fund “Cost-Plus Plan”

The increasing popularity of our AMA Health Benefits Trust Fund (AMA HBTF) has necessitated a more efficient Cost-Plus Plan claims process. During our peak claim period (November–January annually) we were not able to process claims in a timely manner and improvements had to be made. To address this problem, we were very pleased to introduce on September 13 two major changes to our Cost-Plus Plan claims process:

1. Introduction of electronic funds transfer from a member’s business bank account to fund the claim, replaced the need to submit a cheque. The problem with cheques is that after adjudication of the claim the amount was often incorrect. That required us to go back to the member for a new cheque or to issue a reimbursement cheque for the amount of an ineligible expense.

2. Original receipts and Explanation of Benefit statements are no longer required to be submitted with the claim. An audit process is in place that will randomly select a small number of claims, which will require original receipts to be submitted to verify the medical expense.
These changes will save members and ADIUM a significant amount of effort and improve our turn-around time during our peak claims season.

**AMA premium credit for 2014**

The refund accounting methodology used on the AMA Term Life, Disability and Office Overhead Expense Insurance plans has allowed us to provide premium credits to participating members over the past 10 years. We are pleased to announce the following premium credits that will be applied to our insurance plans in 2014:

- Disability – 20%
- Office Overhead Expense – 20%
- Term Life – 20%

These credits demonstrate the value of the non-profit nature of our group insurance plans that are not available through individual policies purchased in the retail insurance environment. We’ve provided value-added group insurance products to AMA members since 1950.

**New staff members at ADIUM**

Due to our continued growth, we were pleased to add an administrative position to help with the processing of new application forms on our group insurance plans (i.e., term life, disability, critical illness and accident policies). Carmelita Flores joined our team on May 1. Mrs. Flores brings to the AMA many years of experience in life insurance underwriting.

On August 26, we were pleased to welcome Crystal Cowell to our team as our new AMA HBTF Benefits Administrator. Ms Cowell joined us from a major health benefits provider where she had extensive experience in its claims department.

If you have questions about any of the above-mentioned changes, we’d be happy to speak with you! Please contact me (glenn.mcathey@albertadoctors.org or 780.482.0307) or one of our salaried insurance advisors:

**Edmonton and Northern Alberta**
- Kelly Guest, EPC
  - T 780.482.0306
  - kelly.guest@albertadoctors.org

**Calgary and Southern Alberta**
- Mona Yam, BA, BComm, CLU, CFP
  - T 403.205.2088
  - mona.yam@albertadoctors.org

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The Leduc Beaumont Devon Primary Care Network (LBD PCN) is a joint venture between participating local family physicians and Alberta Health Services. Our mandate is to sustain and enhance the quality, coordination and integration of health care services in Leduc and area and to improve the quality of life for the community of patients and physicians.

The LBD PCN is looking for long term locums to help support our group of 50 family physicians. Locums would be asked to sign a contract (negotiable but ideally 3-12 months), and to be available to provide locum coverage preferentially to our LBD PCN physicians. We are seeking physicians wanting to practice full-scope family medicine, including inpatient care, ER, and long term care with the added support of our multi-disciplinary team.

We provide favourable compensation with an additional $500 per week available to help defray overhead costs. CME benefits of $2500 per year would be provided to locums working for our group more than 42 weeks per year. Start dates are flexible.

Get involved with primary care reform, in communities offering the challenge and diversity of rural care, but right in your back yard.

Please forward a letter of interest and resume by January 31, 2014 to:

Len Frank, Executive Director
#301, 4710-50 Street Leduc, AB T9E 6W2
Phone: 780-980-8800  Fax: 780-986-6634
Email: len.frank@lbdpcn.com

Only candidates selected for an interview will be contacted.
Law vs. Licensure: Which shall rule?

*Lafferty vs. Lincoln* test case an intriguing snapshot in history

J. Robert Lampard, MD

The provinces of Alberta and Saskatchewan were created by an Act of the Parliament of Canada on July 20, 1905. It was a Canadian precedent. There had never been a “territory” that then became a “province” under the *British North America Act* of 1867. Nor has there been one since.

A key legal question was whether the Northwest Territories (NWT) institutions, corporations, societies and associations would continue in the two new provinces.

The controversy arose because of Section 16.3 of the 1905 *Alberta Act*, which states that societies and associations incorporated by the Legislature of the NWT “shall continue to be dissolved and abolished by order of the [federal] Governor in Council [cabinet].”

On May 18, 1906, Dr. William A. Lincoln registered to practice under the NWT Medical Ordinance. He did not reapply to be grandfathered under the Alberta *Medical Profession Act* passed by the Alberta Legislature on May 9, 1906, nine days before. His position was that the *Medical Profession Act* was invalid.

As Dr. Lincoln had not registered under the Alberta *Medical Profession Act*, Dr. Lafferty initiated legal action against him for practicing without a license. In Calgary on December 20, 1906, the case was heard by police magistrate Crispin E. Smith. At the hearing, Dr. Lincoln agreed that he had been in practice “for gain” on December 13. He also admitted he wasn’t registered under the Alberta Act, but he was under chapter 53 of the Consolidated Ordinances of the NWT of 1898.

On October 18, 1906, after the newly elected Medical Council of Alberta met on October 3, it appointed Dr. James D. Lafferty as the registrar. He had been the NWT registrar since 1901 and had drafted the Alberta and Saskatchewan medical acts.

The police magistrate found Dr. Lincoln guilty and ordered him to pay a penalty of $1, and $2 for the costs.

Dr. Lincoln appealed, alleging the Alberta *Medical Profession Act* was not in force and never had been. He said it was outside the jurisdiction of the Alberta Legislature to pass such an Act. He alleged the Act could not come into force until the NWT Medical Ordinance was abolished by the federal government. The province, he said, had no authority to dissolve the NWT Medical Ordinance.

In January 1907, the Supreme Court of the Northwest Territories agreed with Lincoln, citing the *Dobie vs. The Temporalities Board* case as its precedent, and the “shall continue” clause in the 1905 Alberta Act as its authority. This reversed the police magistrate’s decision. It meant the Alberta *Medical Profession Act* was neither in force nor legally valid, throwing the whole registration process into legal uncertainty. It also left the NWT Medical Council...
intact as the examining authority for registration purposes. The NWT court’s decision was not unanimous as Judges Harvey and Stuart disagreed with it. The Medical Council immediately met with the Deputy Attorney General B.B. Wood who agreed to join in the appeal to the Supreme Court of Canada. The appeal was led by Drs. Brett, Braithwaite, Simpson, Lafferty and Olson. As the issue remained sub judice, Saskatchewan physicians continued to act in accordance with and under the authority of the NWT Medical Council, which would have left Dr. Lafferty as its registrar.

The appeal was accepted by the Supreme Court of Canada on February 19, 1907, and heard on April 3, 1907. The decision was handed down on May 7, 1907. It unanimously held that the Alberta Medical Profession Act was valid, and the Legislative Assembly of Alberta had the jurisdiction and authority to pass and implement such an Act. The rationale was that the “shall continue” clause only allowed the NWT Medical Council time to wind up its affairs. Further, the federal government was not going to interfere by rescinding the NWT Medical Ordinance or interfere with the Legislative purview of the province. The only other jurisdiction that might intercede itself was the English Parliament, which they agreed could, but had not. They interpreted the Temporalities Act as not comparable and therefore not applicable.

The success of the appeal meant that any incorporated societies or associations established under the NWT ordinances could continue. Lawyers, pharmacists, physicians, veterinarians, architects and dentists all benefitted from the decision and the work of the NWT Medical Council, as did the medical profession of Saskatchewan, who had waited for it. The Honorable C.W. Cross, the Attorney General, was delighted, as he had taken a leading role in having the Act passed.

Dr. Lincoln began his longstanding association with the Alberta Medical Association by becoming a member. He was appointed the secretary-treasurer in 1908. At that convention he gave a paper on “nervousness.” How appropriate.

While council’s registration authority was clarified, the possibility of a dual process for registration remained.

On May 9, 1906, a Dr. Steele applied to the Alberta Medical Council to be registered. Dr. Lafferty didn’t accept the application because he wasn’t in the office, as the Alberta Act was being passed in the Legislature. Further, there was a question whether the Lieutenant Governor brought the Act into force at noon or at 3 p.m. that day - by “nodding his head in approval.”

Regardless, Dr. Steele was not registered under either Act and chose not to complete another registration application. Instead, he went to his MLA John R. Boyle and applied to have a private members bill passed in the Legislature, entitling him to practice in the province. Steele was a graduate of the University of Pennsylvania and had suitable testimonials to attest to his competence, including working on the Canadian National railway. Boyle’s private members bill was sent to a committee of the Legislature on or about February 11, 1909.

With Medical Council support, Dr. Lafferty said he was willing to withdraw council’s objections to the bill, providing this was a singular case and neither the committee nor the Legislature would in future override the rulings of the Medical Council. The committee agreed. The bill was passed and Dr. Steele was registered without an examination. It was the first and last such case.


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We had a very nice bump in the number of visitors to the Alberta Medical Association (AMA) website this year, hitting over 100,000 for the first time (an increase of 48% over the previous year).

One other significant trend was the number of visits to our website from Facebook accounts - up by a staggering 5,157% (from 266 in 2011-12 to 13,984 in 2012-13).

This interest from Facebook is one of the main reasons that the AMA started its own Facebook account a few months ago (http://on.fb.me/XPQ9yM).

Don’t mention it!

Mention is a news tracking service that picks up keywords in online media stories. We’re using Mention to help you follow recent media articles on the AMA or health care in Alberta.

Go to the news box in the media area of our website (http://bit.ly/187UmgP) to see the latest stories.

Brush up for the Many Hands™/AMA Youth Run Club web pages

We’ve recently given the Many Hands™ part of our website a brush and polish to better include the AMA Youth Run Club – the AMA’s own flagship Many Hands™ project.

Try out several new features on this part of the website.

• Find out about the many ways we can support you getting involved in one of the AMA Youth Run Clubs across Alberta (http://bit.ly/15WITju).
• Visit the “Current Opportunities” box to check out new volunteering opportunities (http://bit.ly/ZRetuc).
• Follow news from featured charities and other volunteer organizations via the Twitter box on a new “Get involved” web page at http://bit.ly/1akJ7Vo.

We’re always looking for new stories about physicians who are volunteering.

Whether you’re volunteering with large or small projects here or abroad or helping out with the many run clubs across the province, we’d love to hear from you. Send an email to Alexis Caddy (alexis.caddy@albertadoctors.org), and we’ll get in touch.

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"I like to feel that all my best photographs had strong personal visions and that a photograph that doesn’t have a personal vision or doesn’t communicate emotion fails.”
- Galen Rowell

On November 15-16 in Calgary, the Alberta Medical Association (AMA) hosted the 2013 Canadian Conference on Physician Health (CCPH). As part of its activities, there was a juried display of physician photography entitled “How Doctors See the World.” This article is in response to an invitation to comment on this initiative and, more broadly, on the relationship of art to physician well-being.

Art has had a long and storied dance with medicine throughout the ages. It has been used as a vehicle for therapy,1 artists of all forms have themselves been impacted by illness2 and the arts have been used as a vehicle to examine medicine itself.3 Many have come to see the arts as synonymous with self-expression. Certainly the display of physician photography gives each participant the opportunity to share their unique vision of the world. But I see it as much more than that. For me, as a working artist for the last 25 years (mixed media and large-format photography), it is much more about connection and communication on a level distinct from that of normal daily interaction.

For a number of years, I hosted a large installation in our local hospital on one of the medical floors. This was usually timed with the onset of winter and the often forbidding landscape outside the bank of windows there. I began to include other artists as well so that after a time it became simply titled “With a little help from my friends.” That experience gave us (as artists) much more than a chance to show our particular vision to others. It gave us a chance to see the impact the images had on other people, and how the images spoke to them as individuals.

This would often lead to long conversations with the patients and relatives in the hall that was the display area, as well as lively exchanges between the artists on their works. I will remain forever indebted to those who made that experience possible – the staff of the Volunteer Services of Grey Nuns Community Hospital (in particular Paula Marusyk) and all the artists involved. In addition to teaching me that art is less about expression and more about communication, that experience reinforced for me in a very real sense that what you get out of professional life is what you put into it. And also how some of the most rewarding things about a career in medicine remain largely intangible.

Intangible yes, but always within reach.

One simply has to extend – to connect.

On the following page are my images selected by the jury for inclusion in the 2013 CCPH Physician Photography Exhibition. I hope they connect with you in some way.

Technical note
For the photographers out there, these images were taken hand-held, using the Canon Mark V D11 camera body with an ISO of 1600-3200, underexposed 1/3 ¬ 2 f stops to keep a shutter speed < 1/40- 1/60 sec. Shadow detail was reconstituted in Photoshop CS5.

References

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Viaggio (Journey). This image was taken in an abandoned castle in a small rural village in Piedmont, Italy. Our family had traveled there to see what some consider the eighth Wonder of the World. For a while we were the only inhabitants of the guesthouse attached to this castle. Once inside the castle, I was struck by this long hallway and series of doors, each opening into a completely different, highly ornate room. Each one was left behind, in turn, and at the final end of the hall there was simply a wall. It struck me as a metaphor for the journey we take through life, passing through stages in sequence, leaving each one behind in the growth process, until at the very end the realization is evident that the journey itself was what life was all about. For more information: The Temples of Humankind, Federated Society of Damanhur (www.thetemples.org).

Priere (Prayer). I was wandering inside the splendor of the Basilica of Notre Dame in Old Montreal, when I happened upon a man praying in the Sacristy. There was an almost Norman Rockwell appearance to the scene. I was (and still am) quite drawn to wondering as to the nature of the prayer and what brought him there. Illness in a loved one? Remembrance of one lost? Thankfulness for some blessing he’d felt he received? Or perhaps just the desire to commune spiritually as part of a regular meditative endeavor? I was also very taken by the everyday appearance to his figure bowed in prayer and how it spoke to an active spiritual component being a huge piece of humanity. ■

The Marks Board. A photograph taken during the 40th reunion of our high school class. During that weekend, we were able to tour our junior high school and reunite with some of our teachers from that period - now so many years ago. In one of the classrooms, I discovered the Marks Board. I was suddenly aware of how much had gone on behind the scenes in that school (and how much hard work by the parents and the teachers at that time) to give me the skills needed to realize my dreams. And how profoundly grateful I should be for that. There are many other artifacts that have remained in the school for all those intervening years, including the original intercom system that announced the assassination of JFK to us all, soon after we had taken our seats for the day.

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Rural medicine rocks!

Tarrant Scholarship inspires medical students to practice rural medicine

The Alberta Medical Association’s (AMA’s) Section of Rural Medicine awarded the Tarrant Scholarship to three third-year medical students.

The 2013 recipients are:

University of Calgary (U of C)
- Michael Beach
- Edward Schaffer

University of Alberta (U of A)
- Jarritt Seeman

The recipients were selected because they demonstrated an interest in rural medicine in their undergraduate work and intend to pursue a career in rural medicine in Alberta. The scholarship provided a full year’s tuition for Mr. Seeman and a full year’s tuition was divided between Mr. Beach and Mr. Schaffer.

Dr. Tobias N.M. Gelber, President, Section of Rural Medicine, presented the awards on October 23 at Toscana Italian Grill in Calgary.

“We had several good candidates this year and I’m delighted that rural medicine is appealing to many medical students,” said Dr. Gelber. “I know this year’s recipients will be a great asset to the rural communities in which they may choose to practice medicine.”

The scholarship is named in honor of the late Dr. Michael Tarrant, a Calgary family physician, who championed rural medical undergraduate education. It is one of Alberta’s largest unrestricted medical school undergraduate awards.

Since its inception in 2004, the Tarrant Scholarship has been awarded to 27 medical students and provided over $250,000 to its recipients. Applications for the 2014 scholarship will be available on the AMA website (www.albertadoctors.org) next spring.

About the recipients

University of Alberta

Jarritt Seeman was raised in Claresholm, Alberta. From a young age, he was very involved with community sports including hockey, baseball and swimming. He attended Willow Creek Composite High School in Claresholm, where he played high school football and baseball (as well as continuing with minor hockey).

Following high school, Mr. Seeman attended the U of A and completed a BSc in kinesiology. Throughout his undergraduate degree, he was very involved in the agriculture club and the FarmHouse Fraternity, which he joined because of their association with small towns and rural life.
When Mr. Seeman started medical school, he was drawn to family medicine almost immediately because of the relationships and continuity of care family medicine fosters. In his second year, Mr. Seeman represented his Medical Students’ Association on the Alberta College of Family Physicians Board of Directors. Mr. Seeman is currently enrolled in the Integrated Community Clerkship program in Edson. He strongly believes that the best care occurs in a patient’s home community where they are comfortable, and he really hopes to be able to provide that for a community one day.

University of Calgary

Michael Beach grew up in Waterloo, Ontario. He headed to the west coast for his undergraduate education, completing his BSc at Trinity Western University followed by his MSc at the University of British Columbia.

Mr. Beach’s wife, Stephanie, was raised on a ranch in Pollockville, Alberta, and quickly saw to his “rural education.” Be it calving, branding or harvest time, they both enjoy contributing to and being a part of the farm life that was so instrumental in his wife’s upbringing.

Through his medical education, Mr. Beach has been an active leader and advocate for family medicine by serving as an executive for the Family Medicine Interest Group, and taking on roles on several College of Family Physicians of Canada councils as a medical student representative. In the future, Mr. Beach plans to stay in Alberta in a rural-based practice and is also interested in pursuing advanced skills training in either anesthesia or emergency medicine.

Edward Schaffer was born and raised in Bassano, Alberta. He spent his childhood enjoying all the benefits of growing up in a small town.

After high school, Mr. Schaffer completed the Lakeland College fire fighter training program and received his credentials as a fire fighter and Emergency Medical Technician (EMT-A). He worked as a fire fighter and EMT in the oil and gas industry throughout Western Canada.

During a volunteer medical trip to Guatemala in 2008, Mr. Schaffer was inspired by the physicians he worked alongside, and he decided to apply to medical school following his completion of a three-year human nutrition program at U of A.

Mr. Schaffer has always been drawn to the scope of practice of rural family physicians, and has tried to experience rural medicine throughout Alberta during his training. His intention is to take additional training after his family medicine residency in order to provide surgical obstetrics and minor surgical procedures, in addition to his responsibilities as a family physician.

---

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The Guidelines to Billing Uninsured Services rates have been updated for 2013. However, hard copies of the guide will not be distributed to members at this time.

The Alberta Medical Association (AMA) is not distributing hard copies as several key portions of the content are set to change within the next few months. One of the sections includes the College of Physicians & Surgeons of Alberta Standards of Practice around uninsured services, which are currently under revision.

In the meantime, a PDF copy of the guide will be available for members to download or print from the AMA website.

Scan for more information about the Guidelines to Billing Uninsured Services (log in required) or visit http://bit.ly/169p7Gm (log in required).
November - December 2013

In all my years of practice I have never observed any patient who needs to be seen urgently being jumped by one who does not require to be seen urgently.

“ignis fatuus: also called friar’s lantern, will-o’-the-wisp. A flitting phosphorescent light seen at night, chiefly over marshy ground, and believed to be due to spontaneous combustion of gas from decomposed organic matter.

One of the biggest stories this year, we’ll all agree, was the horrifying revelations from the $10 million, two-year inquiry into preferential access commissioned by the Not Your Father’s Party (NYFP). Originally this was to have been an inquiry into physician intimidation but because this would have uncovered embarrassing stuff, the NYFP (at the Red Queen’s behest) wisely diverted that outcome to the more promising end-point of queue jumping. This was apparently common practice – at least according to a late lamented economist.

Which of us has not been outraged at having been outwitted while standing in a line and seeing a “capitalist roader”1 “swanning”2 to the head of the line?

Why, this happened just yesterday to me at Safeway. I was standing in the queue with my loaf of bread (a 60% grain with sesame-seeded crust) in the 15 items or less line and was still four bodies from the cash till (and also a young woman in front of me who had at least 26 items in her basket) when another cashier appeared on the other side of the paying counter.

“I can help you here!” she shouted.

There was a rush of left and right wing queue jumpers from behind me toward the newly opened cash till. I couldn’t get round the display of bananas and Nestle’s Chunky Kit Kats in time and found myself back where I was with four bodies still in front of me but now at the back of the line. The outrage, injustice and loathing of my fellow creatures took a while to dissipate. I behaved with dignity and controlled the urge to shoulder charge the smarmy guy who was now paying his bill having been five places behind me.

It’s important to give further examples of this societal scourge before discussing medical queue jumping.

There was, for example, the time at the car wash when I was at the head of a line of cars waiting for the yellow light to come on at one of the four bays indicating that the previous car had been washed and had left. A woman knocked on my window.

“Which line are you in?” she said.

“What? I’m waiting for a bay to open up,” I said.

“Y’have to choose a bay and wait outside it,” she said.

“No you don’t,” I said. “You go to the first one that opens up.”

There was more of this banter which I won’t go into. She got into her car, drove past me and parked in front of one of the four bays. She had chosen cleverly because the yellow light came on, the automatic door slid open and in she went. I thought of accelerating my car into the back of her car but the frontal lobes kicked in just in time. I was left shaking with rage and thinking dark thoughts – black affrontit and steamin’ as they say in Scotland.

And there’s a cultural element to queuing. If you have skied in Austria or Germany you already know that German skiers don’t like to queue to get on a chairlift. It’s survival of the fittest with elbows and shoulder pushes used openly. When you shout “Oi, you, Fritz, what’s going on?” they look at you with surprise and pity. The

>
> more civilized sly, surreptitious edging of the tips of the skis in front of the skis of the guy beside you is a better approach to preferential chairlift access.

So proper queuing is the mark of a civilized society but the unhappy fact is that “preferential access” goes on – and will continue since it’s a feature of market supply and demand in this sad life. Anyone who has had to catch the attention of the clerk in the midst of a third world rammie at the check-in desk of an Indian Airlines counter knows that a system of triage is preferable.

Governments know this and can create angst and outrage at will, then rush to the rescue even when the problem is minimal. And that of course was the reason for the change of primary end-point of the Health Services Preferential Access Inquiry. The fact that there is minimal queue jumping going on is beside the point. The NYFP will get to the bottom of it and in the process divert attention from much bigger and less easily solvable issues.

I had a sleepless night when the Honorable John Z. Vertes, a lawyer and commissioner of the preferential access inquiry (and author of the paper “Should Judges be on Facebook”) revealed that not only had the Calgary Flames received the H1N1 vaccine before the Edmonton Oilers but some donors to the coffers of the University of Calgary and other charities had been rewarded with an immediate colonoscopy. Most people I know felt their anal sphincters contracting in outrage.

And there will be a comprehensive response. A committee has been established to implement the recommendations from Mr. Vertes. My predictions?

1. An Alberta Health Services (AHS) department will be established with a bagman ombudsman appointed by the NYFP who will report jointly and directly to the AHS administrator, the executive director and the minister (a “reverse triad”).

2. Universal triage will be taken over from our nice, experienced nurse and given to an anonymous and vast administrative staff. Operating room lists will be approved by the operating room porter who will be issued a whistle. Not so strange. It happened in the United Kingdom in 1975.

3. Any gaming of referral letters from family doctors exaggerating symptoms (currently around 7% according to a friend) will be a college disciplinary concern.

4. An anonymous queue jumping hotline, with the unfortunate name “Report a Jumper,” will be set up.

5. There will be compulsory attendance of a re-education ethics course with annual certification. Any doctor overheard talking to anyone (especially a friend or relative) about things medical will be reported to the Office for the Elimination of Preferential Access (OEPA). Any nurse mentioning that a friend or relative “might be coming to the clinic today” must be reported to the OEPA and his/her College Disciplinary Committee.

6. Anyone looking at a private MRI (or reading the report) must be assessed as to whether this has influenced any subsequent action taken. If action has been taken, see suggested punishments below.

7. Anyone acting on information from a letter coming from any boutique clinic must be reported and the letter destroyed.

8. Anyone with a laptop with rapid access to information allowing them into a queue earlier than someone without a laptop will be sent for ethical re-education.

9. A review committee and appeals panel will be set up to see if there has been a breach of standards of care. If the perpetrator is found guilty, AHS Public Relations must be informed and a sincere-sounding apology issued.

The fact that there is minimal queue jumping going on is beside the point. The government will get to the bottom of it and in the process divert attention from much bigger and less easily solvable issues.

Suggested punishments

1. First offense: Anyone found guilty of committing a queue jumping offense shall be dosed with a laxative, issued with an AHS standard bucket, taken to the nearest Division of Gastroenterology corridor waiting area and after eight hours receive the punishment of colonoscopy.

2. Second offense: The same procedure performed by the most junior resident in general internal medicine.

Strangely, in all my years of practice I have never observed any patient who needs to be seen urgently being jumped by one who does not require to be seen urgently. I have been quizzed by friends and relatives as to what might be the best approach to navigate a complex system – and for this I apologize. I do understand why Edmonton Oiler fans were outraged that the Calgary Flames had preferential access to the H1N1 vaccine. And I do understand that bridges between the Helios and the Colonoscopy suite must be linked-out.

Triaging can be simple or hugely complex (e.g., which is more urgent – a small breast cancer or an onset of irrational behavior?). All departments should have simple, common sense triaging lists that can be flexible if clinically required. Most already do.

There are many ways some patients can and will game the system. These include the “squeaky wheel” and >
the “broken record” technique, symptom exaggeration (“I have pain 10 out of 10 here, and here and here.”), symptom rivalry (“My cough is worse than his cough.”), accessing the emergency room after determining who is on-call for the relevant specialty, consulting a physician known to be willing to make calls to specialists, knowledge of key words (e.g., “tight chest pain”) finding the shortest queue, etc., etc., etc.

There are also many ways physicians can game the system - by exaggerating symptoms, persistence in phoning, instilling guilt in the specialist contacted, inside knowledge of sudden openings in wait lists, deal making, etc., etc., etc.

But we rely on physicians behaving honorably and doing the best for their patients while being aware of the tension between societal justice (in a market shortage) and lobbying for their patients. The difficult problem of occasional gaming by practitioners frustrated by the wait times in some specialties can be dealt with by a personal phone call and chat.

**There are more pressing matters elsewhere**

While I was thinking about these petty issues for this article, other more important matters emerged. Did you know there was a rebellion and hostage taking in a region where the University of Calgary has a development project? This is not ignorance on your part but speaks more to the strange reporting of news occurring since the Internet has usurped professional newspaper hacks. On the other hand, you will have heard of the hostage taking atrocity in Nairobi with 67 deaths and six perpetrators killed.

There was an invasion of Zamboanga, a city of over one million people in the Southern Philippines, by some 500 armed Islamist rebels of the Moro National Liberation Front in the early hours of September 10 this year – resulting in the taking of 195 hostages. This led to battles in the streets, the displacement of thousands of people, the evacuation of the main government hospital and the deaths of over 200 people including the execution of two hostages.

I hear you asking, “Why did I not hear of this?” The reason I’ll put to you is that there were no oil platforms or diamonds involved and no westerners were taken hostage. The lack of interest in the western press brings to mind the old Scottish joke of the headline in the *Dundee Courier* after news of the sinking of the Titanic: “Dundee Man Lost at Sea.”

Never mind. We’ve got more important things to argue about like the will o’ the wisp of queue jumping.

The issue of preferential access has become absurd, Orwellian and, from a political NYFP perspective, potentially dangerous - although I doubt they realize this. We will be watching closely the added costs of policing a system of referral that works, not perfectly, but pretty well.

**References**

1. “Capitalist Roader” was the term Mao Tse-tung and his followers used to describe the West and its population of capitalists.

2. “Swanning” is a verb used to describe a person who moves without effort or concern.
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Contact: nreddy@telusplanet.net

EDMONTON AND STONY PLAIN AB

General practitioner planning to retire in early 2014 has a busy practice near Grey Nuns Community Hospital with laboratory and X-ray close by. In the past, two of us worked in the three-room office and at other times one full time and two part time. Plenty of room for increasing patient load as I have been turning away requests for a long time.

Contact: Dr. J.A. Deane
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Two specialists with a well-established practice in north-central Edmonton (Circle Square Plaza) are seeking one full-time physician or two part-time physicians to take over one vacant office in our large leased space. Office features include spacious shared entry and waiting area, front-desk space for clinic nurse or assistant, ample free parking for patients, handicap access, elevator and secure underground staff parking. ECG facilities are available onsite. Successful tenant will share one-third of all office expenses.

Contact: Catherine
catherinem@live.ca
PHYSICIAN AND/OR LOCUM WANTED

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

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

HIGH RIVER AB
Rural family physicians are invited to join active teaching practices in High River. Opportunities in three different, fully computerized clinics with a collegial group of doctors enjoying a great professional, supportive relationship. Practice opportunities abound at the local hospital with 32 acute-care beds, low-risk obstetrical group, community cancer clinic, active emergency room and two surgical suites, supported by anesthesia, obstetrics/gynecology, visiting surgeons, CT and ultrasound. Live in a picturesque, growing community 30 minutes from Calgary and the Rocky Mountain Foothills with an abundance of recreational opportunities for the active individual. Great opportunities for family as well.

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

FORT MCMURRAY AB
Part- or full-time family physician wanted to join an existing walk-in ready clinic. Wonderful staff, flexible hours and schedules, great northern incentives and offer low overhead percentage.

Contact: Dr. Loretta Roberts
T 780.370.8425
roberts.loretta@yahoo.com

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

Contact: Dr. Ward Fanning
T 403.934.4444 (office)
T 403.934.3934 (home)
Imagine Health Centres are multidisciplinary family medicine clinics with a focus on health prevention and wellness. Come and be a part of our team which includes physicians, physiotherapists, massage therapists, fitness trainers, nutritionists and pharmacists.

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

If you are interested in learning more about our exceptional clinics, contact us. All inquiries will be kept strictly confidential.

Contact: Ray Yue
T 780.995.8188 (direct)
TF 1.855.550.5999
info@imaginehealthcentres.ca

**CANMORE AB**

Looking for a full-time locum to start immediately and if agreeable to join the practice as a partner at Bow River Associate Medical Clinic. Partnership would include hospital privileges as well as other activities if requested but not necessary. No obstetrics as full obstetrics already here but part- or full-time office work with or without hospital privileges. Office overhead is low, clinic has four examination rooms, hours are 9 a.m. to 5 p.m. and no weekend work.

Contact: Dr. Louise Feddema
T 403.609.1118
louise.feddema@yahoo.ca

**EDMONTON AB**

Summerside Medical Clinic and Edge Centre Walk-in Clinic require part-time and full-time physicians. Locums are welcome. The clinics are in the vibrant, rapidly growing communities of Summerside and Mill Woods. Examination rooms are fully equipped with electronic medical records, printers in all examination rooms and separate procedure room.

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

**EXOTIC WESTERN CARIBBEAN**

**February 9-16, 2014**
Focus: Men’s health
Ship: Navigator of the Seas

**TAHITI AND COOK ISLANDS**

**March 1-12, 2014**
Focus: Primary care refresher
CME: With the British Columbia Medical Journal
Ship: Paul Gauguin

**EASTERN CARIBBEAN**

**March 14-24, 2014**
Focus: Pediatrics, women’s health, neurology and physician health
Ship: Celebrity Equinox

**GALAPAGOS ISLAND**

**April 26-May 3, 2014**
Focus: Adventures in medicine
Ship: Silver Galapagos

**CHINA AND TIBET**

**May 10-26, 2014**
Focus: Endocrinology and respirology
17-day tour including Yangtze River cruise

**PHYSICIAN(S) REQUIRED FT/PT**

**MILLWOODS EDMONTON**

Also locums required

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

**ALL-WELL PRIMARY CARE CENTRES**

**MILLWOODS EDMONTON**

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

27TH ANNUAL UPDATE IN EMERGENCY MEDICINE
HILTON WHISTLER RESORT
WHISTLER BC
FEBRUARY 23-26, 2014

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Financial and Management Consultant
Seek Value Inc.
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F 780.439.0909
aamiri.mba1999@ivey.ca
www.seekvalue.ca

MEDITERRANEAN
July 19-26, 2014
Focus: Mental health 2014
Ship: Celebrity Equinox

JAPAN AND CHINA
September 28-October 12, 2014
Focus: Clinical pearls in medicine
Ship: Celebrity Millennium

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F 780.483.5492
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DOCUDavit Solutions
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ssoil@docudavit.com

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cruises@seacourses.com
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BALTIC AND RUSSIA
June 2-14, 2014
Focus: Current concepts in medicine
Ship: Celebrity Constellation

ALASKA GLACIERS
July 4-11, 2014
Focus: Renaissance in primary care
Ship: Celebrity Solstice

August 16-23, 2014
Focus: Second annual McGill CME cruise
Ship: Zuiderdam

BERMUDA
August 3-10, 2014
Focus: Primary care
CME: With the Ontario Medical Association
Ship: Celebrity Summit

DANUBE RIVER
September 11-21, 2014
Focus: Cardiology, nephrology and medical-legal
Ship: A-Rosa Stella (exclusive charter)

JAPAN AND SRI LANKA
November 26-December 9, 2014
Focus: Adventures in medicine
Ship: Azamara Quest

INDIA AND SRI LANKA
November 26-December 9, 2014
Focus: Adventures in medicine
Ship: Azamara Quest

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TO PLACE OR RENEW, CONTACT:

Daphne C. Andrychuk
Communications Assistant, Public Affairs
Alberta Medical Association
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