What you say matters!
AMA bulks up resources to capture member input

Literacy and health
Health literacy and its impact on our health care system

Get the 411 on "Lobbying 101"
Medical students getting involved and making a difference

AMA seeks 2013 nominations for our highest awards
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The Alberta Doctors’ Digest is published six times annually by the Alberta Medical Association for its members.

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EASY WAYS TO GET ALBERTA DOCTORS’ DIGEST
We’re using QR codes to enhance your experience. Scanning this code will take you to the Alberta Doctors’ Digest page on the AMA website. There are also QR codes embedded in a few articles in this magazine issue. Scan the codes using your smart phone or tablet device to go to the alternate content. If you don’t have a QR code reader app on your phone or tablet, download one for free from www.scanlife.com.
Globe and Mail columnist Jeffrey Simpson has recently published an analysis of the Canadian health care system: *Chronic Condition: Why Canada’s Health Care System Needs to be Dragged into the 21st Century.*

In spite of the enduring appeal our health care system holds for its citizens, Mr. Simpson finds that the Canadian enterprise provides, at best, middling value for money. It is “characterized by above-average overall costs, average health care outcomes, less high-tech equipment and fewer acute care beds, fewer doctors and medical students per capita, less choice among providers and patients, less regulation on prices for anything outside the basic medicare services and a weak setting of priorities by payers, namely governments.”

Mr. Simpson looks abroad for answers. Sweden, for example, has a single-payer system that has been burdened with mounting costs and lengthening wait times. Recent reforms have established targets for wait times, and have developed internal competition within a single-payer model by rewarding good performance.

Australia, which spends less on a gross domestic product (GDP) basis for health care than Canada, encourages a parallel private system for delivery of essential health services in hospitals. As well, it has a national pharmacare system and, on a budgetary basis, has financial models in which money follows the patient.

Britain’s National Health Services has also undergone reform. Initial “terror and targets” reforms introduced performance goals, including reduced wait times with system audits. Under Prime Minister Tony Blair, further decentralization occurred with funds shifted from hospitals to community care and with increasing involvement of private health care.

Mr. Simpson’s view is a lofty one – 50,000 ft. or so – and the potpourri of fixes he’s found doesn’t acknowledge the rolling, usually ill-considered changes of successive provincial ministries inflicted across the country over several decades. In particular, Mr. Simpson neither acknowledges the pervasive morale issues among health care workers buffeted by unending regime change across the country, nor notes the persistent and widespread failure to decentralize care. And he doesn’t mention the unique demands of providing health care in a country as enormous and as sparsely populated as ours. Most importantly, there’s little mention of reforming the system so that it is more accessible and responsive to patients, who now find themselves trapped in a hodge-podge of solitudes or “silos” of care that are never patient-friendly.

Following his survey of Australia, Britain and Sweden, Mr. Simpson appears to think there is much to be said for increased private involvement in a revamped system, but he avoids the larger economic...
January - February 2013

I would argue that the real issue in health care reform is one of failed decentralization.

Context is important and size matters. Mr. Hardin’s tragedy of the commons becomes a reality only when group size becomes large and unworkable and when individuals become cogs in the machine – when “group size exceeds our capacity for keeping track of one another.”

There’s even a number I propose that has been harvested from our long evolutionary history of supple cooperation and altruism: It’s called Dunbar’s number.

Oxford anthropologist Mr. Robin Dunbar looked at grooming behavior in primates and plotted group size versus brain size/development. He was able to predict that humans start losing track of who’s doing what to whom – that old cog-in-the-machine anonymity – once group size hits about 150 individuals. New Yorker author Malcolm Gladwell agrees, popularizing the notion of 150 being a limit to functioning groups. Marvin Harris, another anthropologist, has provided the rationale: “With ... 150 per village, everybody knew everybody else intimately so that the bonding of reciprocal exchange could hold people together. People gave with the expectation of taking and took with the expectation of giving.”

Fair and just control of resources – not only who gets what, but when, and under what conditions – can happen most reliably and expeditiously in communities that are small enough to act and observant enough to be just in their use of resources. This is the cardinal issue facing health care.

Mr. Rousseau may have said it best. “If I had to choose my place of birth I would have chosen a state in which everyone knew everybody else so that neither the obscure tactics of vice nor the modesty of virtue could have escaped public scrutiny and judgment.”

To sum up, Chronic Condition is a good enough read, but it’s only a start. I can agree that change is needed to respond to the travails of patients, who presently are often ill-served by the system. Bravery and fortitude will indeed be required to change health care, but I hope our understanding of complex issues comes first.

References available upon request.
Think of your email inbox. If you had to, could you produce a report to overview the emails living there, e.g., what they are about, who sent them, what issues they relate to in your work environment, whether they’ve been followed up, etc.? Recently, this was a challenge faced by the Alberta Medical Association (AMA) – and the solution will help us serve members even better.

YOU WROTE TO US, WE PAID ATTENTION

As the voice of Alberta physicians, it’s critically important that the AMA is aware of the needs, wishes and concerns of physicians. We invest heavily in doing so, from regular surveys to significant efforts day-to-day to respond to member queries and comments.

As AMA President Dr. R. Michael Giuffre has mentioned in several issues of the President’s Letter, the November 16, 2012 imposition of a settlement on physicians by government unleashed an unprecedented influx of member emails. Dr. Giuffre received over 2,000 in the month following the imposition. He read every single message – and replied to as many as he could directly. (In the run-up to the holiday break, he also enlisted AMA senior staff to reply on his behalf to those he had not yet reached.)

“These emails,” Dr. Giuffre says, “were not quick-dash, two-or-three-line notes. These were long, well-thought-out, passionate, articulate and compelling letters. They were overflowing with powerful sentiments, persuasive information and creative ideas for moving ahead.”

To ensure that all of this energy and input was captured, he directed AMA staff to develop a system for analyzing and categorizing the emails and making various parameters searchable for future use.

worked diligently toward the end goal of a precise summation of the correspondence to inform AMA leadership in time for the special meeting of the Representative Forum on December 15, 2012. Senior staff retained oversight to ensure items requiring escalation or other special response received what was needed.

TURNING INFORMATION INTO KNOWLEDGE

“Like most associations,” Dr. Giuffre said, “the AMA has a lot of information about members. The challenge is compiling that information so that we can learn from it in order to serve members better.”

This initial database exercise has been highly successful and is being incorporated into ongoing management of member input and correspondence. We expect to improve upon it so that the tool can be expanded beyond the scope of negotiations and into something that can be used throughout the business year and across the many complex issues facing the medical profession.

ANATOMY OF AN INFORMATION MANAGEMENT TEAM

A small group of AMA information systems group professionals came together to develop a database to help organize member input within the emails so it could be reviewed for different issues or search parameters. The task was complete in about five working days. Then with the database live, six AMA employees collaborated to read and sort the emails, one-by-one. The group

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WHO WROTE TO US AND WHERE DO THEY COME FROM?

WHAT DID THEY WRITE ABOUT?

<table>
<thead>
<tr>
<th>Email Mentions of Categories</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive statement regarding Dr. Giuffre's/AMA's approach.</td>
<td>49%</td>
<td>1,234</td>
</tr>
<tr>
<td>Supported non-clinical actions of some sort and offered suggestions, e.g., public awareness, education materials, advertising, etc.</td>
<td>22%</td>
<td>558</td>
</tr>
<tr>
<td>Describing potential &quot;impact on my practice&quot; of the imposition.</td>
<td>8%</td>
<td>200</td>
</tr>
<tr>
<td>Questions for Dr. Giuffre, requesting points of clarification.</td>
<td>6%</td>
<td>163</td>
</tr>
<tr>
<td>Supported job action but had no specific recommendations.</td>
<td>6%</td>
<td>155</td>
</tr>
<tr>
<td>Offering general suggestions.</td>
<td>5%</td>
<td>130</td>
</tr>
<tr>
<td>Offered suggestion for clinical job action.</td>
<td>3%</td>
<td>71</td>
</tr>
<tr>
<td>Non-supportive (overall negative response to AMA approach).</td>
<td>&lt;1%</td>
<td>11</td>
</tr>
<tr>
<td>Said they did not support action of any kind.</td>
<td>&lt;1%</td>
<td>9</td>
</tr>
</tbody>
</table>

In total we received 1,449 emails. Common themes were identified to be used as categories. Then each email was reviewed again and tagged according to those categories. Each message was tagged as many times as necessary to capture its content.

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Your November/December 2012 Alberta Doctors’ Digest discussed the project targeting children with the history of early childhood trauma. I would like to bring the attention to the key team members who made this project successful.

It is vital to emphasize the collaboration between various groups who worked hard to create the idea and transform it into a practical tool that produced a strong change in mental and potentially physical wellbeing of our future generations. Henry Ford once said: “Coming together is a beginning, staying together is progress and working together is success.” This was truly reflective of the roles and partnership between our project leaders.

Our team is lucky to have Ms Yanina Vihovska as a lead-teacher who has been one of the first teachers in Elk Island Public School Board creating and implementing lessons with a use of iPods in grades five and six. Ms Vihovska has an extensive knowledge and experience working with technology and multimedia tools. Her commitment and passion towards the children has been truly inspiring. Dr. Edna Wakene, a psychologist at the Family Centre in Edmonton, has also generously contributed her knowledge and expertise in the design of the delivery and assessment process, to whom we are grateful for. The leadership of the project was strongly supported by Dr. Rowan Scott, a staff psychiatrist who has kindly provided his advice during the crucial stages of our community initiative.

Finally, the project would not have been possible without the support received from the Alberta Medical Association (AMA). The team could not fully express the gratitude for the sponsorship of this preventive intervention. We strongly believe that the AMA has enabled our community, particularly the socially and emotionally deprived pediatric population, a strong start to develop and continue effective prevention strategies that would help reduce the incidence and impact of mental disorders in adulthood.

Yours sincerely,
Maryana Duchcherer MD, MSc
Edmonton AB

The Alberta Medical Association welcomes comments about Digest articles and suggestions for future topics. Please contact Daphne C. Andrychuk, Communications Assistant, daphne.andrychuk@albertadoctors.org, or write her c/o Public Affairs, Alberta Medical Association, 12230 106 Ave NW, Edmonton AB T5N 3Z1. The association reserves the right to edit all letters.
Please allow me the indulgence of writing about my father.

Richard Edward Rossall, MB, ChB, MRCP (London), MD (Leeds) (By Thesis), FRCP, FRCP (London) was, by all accounts, an outstanding physician, teacher and administrator. He joined the faculty of the University of Alberta in 1957 (having just emigrated from England) and quickly developed a superb reputation as a consulting cardiologist. From 1969 to 1988 he served as director of the division of cardiology and also as assistant, and later associate, dean of medicine. He pioneered the development of the postgraduate teaching program at the University of Alberta and for many years served as its director. He retired from the university in 1991 but continued to practice for many years after.

In my work with various medical organizations, I have come across countless physicians who have benefited from his knowledge, compassion and teachings. His reputation and the respect he garnered has served as an introduction and a reference for me in my professional life for more than 30 years.

One of his former students recently wrote to me,

“Every so often you run across a physician who brings to their trade tremendous inter-personal skills, wisdom, and the ability to nurture and mentor others, all in a gentlemanly manner. Your father displayed all of these characteristics.”

Every one of his former students that I have met spoke with some reverence of his clinical skills, his bedside manner and his ability as a hands-on physician.

But what’s so special about a “hands-on” physician? Aren’t all physicians “hands-on?” Perhaps not, or not as much as they could be.

There is no doubt that the technology of medicine has evolved at a breathtaking pace. It’s not that long ago that the ability to hear chest and heart sounds with a stethoscope was a breakthrough, to say nothing of the advent of X-ray technology, ultrasound and other valuable diagnostic tools. But arguably every piece of equipment used moves the diagnosing physician another step back from the bedside. My father, and many of his contemporaries, could diagnose an illness by something as simple as looking at a patient, or talking to the patient or just putting their hands on the patient.

This is not to say that there is no place in the world of medicine for state-of-the-art technology. Clearly today’s scanners, MRI imaging and cardiac catheterizations allow physicians to look inside the patient and see clear, digital imagery or witness blockages or bulges which simply cannot be detected from the outside. Dr. Rossall would simply say: Don’t let the use of this technology dull your own skills, your own instincts and your own clinical judgment.

Ironically for a physician so renowned for his hands-on skills, he developed the first computer-assisted instruction course for undergraduates in cardiology as far back as 1969, a program which is still in use in locations around the world.

The other thing my father did was treat others with respect and courtesy, whether they were contemporaries, juniors, hospital staff or the janitor sweeping the floors. Another physician who learned from my father wrote:

“Most importantly, he was one of the true gentleman physicians. There seemed to be many in our parents’ generation and seem to be too few today.”

The practice of medicine is busy, hectic, complicated and at times risky. If he was teaching today, he would still be telling his students to treat others as they would like to be treated.

My father passed away on November 28, 2012. He will be missed by the thousands of medical students, residents and colleagues whose lives he touched, but he left a tremendous legacy and example for those who follow.
An Edmonton-area group is continuing the discussion about health literacy and its impact on our health care system.

The conversation began this way on a recent morning. “If you’ve ever been a patient seeking health care, I would like you to stand.”

With that, everyone in the meeting room at downtown Edmonton’s Stanley Milner Library stood up. This was the kick-off for a second health literacy workshop hosted by the Northeast Edmonton Literacy Network – a group that has brought together various local organizations with a deep interest in raising awareness and addressing literacy challenges. Both Alberta Health Services (AHS) and the Alberta Medical Association (AMA) participated.

It was November 27, 2012 and over 50 representatives from Edmonton-area non-profits, health care organizations, educational institutions and government agencies were asked to step out of their professional worlds and imagine themselves as patients in the health care system. For over two hours, Nancy Becker, Health Literacy Consultant with AHS, led the attendees through an interactive workshop on health literacy entitled Literacy and Health. What’s the Connection? At the end of the workshop, attendees were asked to reassume their roles and brainstorm ways to address the impact of health literacy on patients and the health care system.

We have an obligation [to our patients] that our communications - verbal or written - are clear and understandable.

“I invite you to listen and participate ... from the perspective of the patient,” said Ms Becker. “As you will see, health literacy touches every aspect of our lives.”

According to Ms Becker, health literacy is critical to managing one’s health. It is defined as the ability to obtain, understand and act on health information and services, and the ability to make appropriate health decisions independently. According to a 2007 study by the Canadian Council on Learning, 60% of Canadian adults and 88% of seniors lack the health literacy skills to do these things.

Contrary to popular belief, health literacy affects more than those with low literacy levels. In fact, the well-educated attendees at the workshop were stumped when presented with different pieces of health information. They provided varying responses to deceivingly simple dosage instructions for prescription medication, and they were unable to determine next steps when shown examples of hospital signage or patient forms.

“We put a lot of demand on people when we ask them to take an active role in managing their health,” said Ms Becker in a telephone interview. “Low literacy levels and health literacy challenges are huge barriers to many people when taking on this kind of responsibility.”

Ms Becker added that these barriers also contribute to the escalating costs of managing chronic illnesses.

Several jurisdictions throughout Canada are stepping up to address this issue. In 2007, the Manitoba Institute for Patient Safety launched an awareness campaign entitled “It’s Safe to Ask” that encourages patients to ask questions, request information and become active participants in managing their health. In Richmond, British
Columbia, the local health authority has partnered with the public library system to develop and promote a variety of health information resources, and train library staff to assist clients who seek this information.

"Every sector has an important role to play," said Ms Becker. "For health care providers, we have an obligation [to our patients] that our communications – verbal or written – are clear and understandable."

"It's not about 'dumbing down' our language - communicating clearly benefits everybody."

At the end of the presentation, a discussion session took place about possible steps, small and large, to address the challenges related to health literacy. Ideas generated from this discussion include:

• There needs to be collaboration across sectors. We need to share and know what each organization is doing to address health literacy.
• Organizations need to develop simple language standards for communication materials. Norquest College, for example, has a readability standard for email communications.

For health care providers, attendees presented the following suggestions:

• Ask for feedback when communicating with patients. For example, physicians can ask their patients to repeat the health information they’ve received in their own words.
• If appropriate, provide patients with the option to bring a friend or family member to appointments.
• Remember that health news may cause stress or distress – this can impair health literacy skills for anyone.

For Ms Becker, the workshop is the start of a longer process to tackle the issue of health literacy.

"My hope would be that we continue to find ways that we can get together, talk about how each of us can continue raising awareness and work on initiatives to support literacy and health literacy."

For more information on the Northeast Edmonton Literacy Network, visit http://literacyfriendly.wordpress.com. Or contact Ms Becker, Health Literacy Consultant, AHS, by email: nancy.becker@albertahealthservices.ca.
Starting or transitioning into an independent practice may feel like a daunting challenge, especially when you begin to consider the numerous financial, legal and business decisions required. However, if you invest the time up front to develop a business strategy, you will be better able to make informed decisions.

Whether you are new to practicing medicine or are contemplating a move into independent practice, the following checklist may help you make the first steps toward an exciting new journey.

**THE BASICS**

- **Recognize that your practice is a business and that you are a business person.** Pay attention to details especially when you are making fundamental decisions such as owning or renting, partnering with other physicians, legal agreements for software, and more.

- **Establish your strategies and values for your practice.** This will guide your decision-making process. These strategies and values will also be important during professional negotiations and the development of your practice.

- **Know when to get professional help – and know when to ask the right questions.** The two key professionals you will require are an accountant and a lawyer. Find those who have had experience working with health care professionals, or ask colleagues for recommendations.

- **Complete a Privacy Impact Assessment.** If you are making any changes in the way health information is collected, used or disclosed in your practice, this will help you identify, analyze and address potential privacy risks.

- **Have your staff sign confidentiality agreements.**

- **Pay attention to release-of-information standards as well as patient consent processes.**

**WHEN BUILDING A GROUP PRACTICE**

- **A comprehensive practice agreement is essential for success.** This is a legal agreement between two or more physicians who wish to practice together. View this as another form of insurance that will ensure that you and your colleagues offer the most optimal patient care. Work with a lawyer in drafting and formalizing the agreement.

- **Consider a team agreement for your entire clinic staff.** This may outline shared goals and expectations for your entire team and will support ongoing collegiality.

**PRIVACY MATTERS**

- **Ensure that you are compliant with the Health Information Act.** Privacy and confidentiality are central components of your practice.

- **Make an informed decision regarding electronic medical record (EMR) software.** Starting your practice from scratch today likely leads you directly to the decision to use an EMR. This will define how you maintain a patient’s record and how you do your billings because most often billing software is integrated into EMR software. Making an informed decision is important.

You may base your decision on an EMR that you have previously used, but also consider funding...
and reimbursement opportunities provided in Alberta through the Physician Office System Program (POSP), as not all EMR software vendors are eligible for these opportunities.

- **Know the basics about billing.** Take advantage of billing advice and support offered by the AMA.

- **Take responsibility for coding your services for billing.** You know your patients best and can bill to the fullest extent, including third-party billing or uninsured services. Coding your services for billing should not be delegated; it takes minimal time and will offer a high return on investment.

- **Consider setting up a menu of services** when it comes to third-party billing or uninsured services, that your practice charges for and ensure you have a process for informing the patient in advance. Establish a process for collecting the fees such as providing an invoice to the patient. Be prepared.

**BUILDING YOUR TEAM**

- **Know the basics about hiring and terminating.** Review provincial labor standards around hiring and terminating for which you are legally responsible.

- **Establish a human resources (HR) plan for your practice.** Minimize the challenges that come with being an employer as well as maximize employee satisfaction. Basic elements of an HR plan include role position descriptions, reporting structure, pay grids, and a performance management plan. In addition, outlining clear expectations in an employee handbook can result in better outcomes and avoid hidden costs of employee turnover.

**TAXES AND NUMBERS**

- **Remember – the taxation process for business owners is different than for an individuals.** It's important that you anticipate paying tax to Revenue Canada. The process for paying tax in your first year of business will be different than in subsequent years. Ask your accountant to assist you with planning to put aside the anticipated amount of tax owing on a monthly basis for your first year so that you have the funds to pay taxes at the end of the year. In your second year, Revenue Canada will advise you of the required timing for submission of taxes owing (at least quarterly).

- **Your business will need a separate bank account, even if you are not incorporating a professional corporation.**

- **Maintain your system of recordkeeping, and keep and file all your receipts for business expenses.**

**BACK TO THE OVERALL STRATEGY**

- **Determine a long-term financial plan that includes your retirement, maternity/paternity/sabbatical leave and closing your practice.** Contact PMP and/or MD Physician Services for assistance in establishing your strategy.


The Practice Management Program is available to assist in a number of areas related to the effective management of your practice. For assistance, please contact Linda Ertman at linda.ertman@albertadoctors.org or phone 780.733.3632.
Your home and contents are major investments that need to be properly insured. With prices on the rise, it is important to have adequate coverage should you ever suffer a loss. You can purchase endorsements to cover specific items particularly suited to the needs of professionals, like members of the Alberta Medical Association.

REPLACEMENT VALUE COVERAGE

This is the most common option that people add to their home coverage. That’s because home insurance policies usually include replacement value coverage for the building, but not for its contents.

- Typically, the contents of your home are only insured for actual cash value (ACV) – in other words, the value of the item, minus depreciation.

Example:

- A stereo you purchased five years ago for $2,000 is stolen. Today, it might only have a cash value of $600. Even though it might cost $2,000 or more to replace it with something of similar quality, ACV coverage will only pay $600.

If you have replacement value coverage:

- You can replace the stereo with one of similar kind and quality, within a specified timeframe; and
- Be paid for the full replacement cost – regardless of what it is actually worth after five years.

COVERAGE FOR SPECIFIC VALUABLES

Tips:

- With any expensive purchase, make sure to keep sales receipts, photographs and other information (make, model, serial number), and obtain a professional appraisal.
- Make sure to update your inventory of belongings any time you acquire anything of value.

JEWELLERY AND FURS

Most policies include limits on the amount and type of coverage available for items like jewellery and furs.

- Many insurance providers have a limit of about $3,000 on valuables like these. Don’t forget: if you make a claim, you also have to pay the deductible.
- If you have an item that exceeds the limit, you may want to purchase optional coverage for it and use the basic policy limit to cover your smaller valuables.
- When you purchase optional coverage for valuables, there is usually no deductible. But as noted above, if you make a claim for an expensive item under your standard coverage, with the limit of $3,000, you would also have to pay the deductible.

FINE ART

As with other valuables, there are dollar limits on coverage for works of art in insurance policies.

- Generally, you will need to purchase additional coverage that provides broader protection – for example, if the art is temporarily loaned out or moved. The cost will depend on a number of factors, including:
  - The type of art.
  - Where it will be displayed or stored.
  - Whether or not it will be loaned out.

With any expensive purchase, make sure to keep sales receipts, photographs and other information, and obtain a professional appraisal.
Tips:

• Find out if your property insurance provider offers an appropriate policy. Some companies offer specialized fine art coverage.

• Some insurers may have experts who can provide additional help to ensure your collection is properly protected from risks like theft and water, smoke or fire damage.

OTHER ADDITIONAL COVERAGE

In addition to coverage limits on theft of valuables like jewellery, furs and fine art, there may be specific dollar limits for certain items. In this case, you may want to consider buying extra coverage for the following items:

• Cash and negotiable securities.
• Silverware.
• Collections, including coins, stamps and cards.
• Bicycles.
• Boats and watercraft.
• Computer software.

ADIUM Insurance Services Inc. is a wholly owned subsidiary of the Alberta Medical Association. ADIUM administers the group Disability, Office Overhead Expense, Term Life, Critical Illness, Accidental Death & Dismemberment, AMA Health Benefits Trust Fund, Student Disability Insurance and PARA Disability and Life Insurance plans.

ADIUM also has access to individual products to help meet special risk or other unique insurance requirements that members may have.

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AMA Disability Insurance can help you avoid going into debt or using your retirement savings to take care of everyday expenses such as loans, mortgage payments and credit card bills.

- Competitive group rates
- AMA Premium Discount (20% in 2013)
- Monthly tax-free benefit
- Coverage includes HIV/Hepatitis B or C Benefit*
- Optional coverage is available**
  - Guaranteed Insurability Benefit
  - Cost of Living Adjustment
  - Own Occupation
  - and more!

Applying is easy!
1. Watch for more information coming to you soon, or
2. Go to the Disability Insurance page at www.albertadoctors.org/AdiumInsurance/Disability for more information and to download the application

Plans available for students, residents and physicians

* Certain restrictions may apply
** For more information visit www.albertadoctors.org/AdiumInsurance/Disability or contact an ADIUM insurance advisor
The Alberta Medical Association (AMA) is calling for Achievement Award nominations for individuals who have contributed to the improvement of the quality of health care in Alberta.

The AMA Medal for Distinguished Service is given to a physician(s) who has made an outstanding personal contribution to medicine and to the people of Alberta, and in the process has contributed to the art and science of medicine while raising the standards of medical practice.

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

Nominations for 2013 must be submitted by April 30. The awards will be presented at the AMA’s fall 2013 annual general meeting in Edmonton.

To request a nomination form for these awards, please contact Janice Meredith, Administrator, Public Affairs, AMA: janice.meredith@albertadoctors.org, 780.482.2626, ext. 291, toll-free at 1.800.272.9680, ext. 291 or visit the AMA website www.albertadoctors.org.

In 2012, three physicians were recognized with Medals for Distinguished Service.

• Dr. Ian R. Lange, Calgary
• Dr. Eldon R. Smith, Calgary
• Dr. D.H. Ross Truscott, Calgary

In 2012, two individuals were recognized with a Medal of Honor.

• Vivian Mushahwar, PhD, Edmonton
• Shirley van de Wetering, Calgary
As physicians, we know the importance of preventive medicine and the social determinants of health. We encourage our patients to eat right, get enough sleep, stay warm and exercise 30 minutes daily. We tend to regard these activities as choices that are simple to make. It is easy to forget that, for some vulnerable Albertans, there is little choice – these opportunities for health are simply out of reach.

Thinking of what living that way might be like, I tried to imagine myself as a teenager with no home, no family, not even a place to go in the middle of winter.

The days are short, the nights are long and dark, and the wind can be bitter. Cold is something that I live with; it is always just around the corner. “Couch surfing” is only an option for so long; eventually I run out of places to stay. At 9 p.m., the public buildings begin to close. The security guards have already informed me that “loiterers” must move on. Every time I try to settle in a warm place, I’m asked to move along. There is no place to store what belongings I have and those belongings do not include money.

On week nights, there is school in the morning. Without a warm place to sleep, when I get to school, I will probably fall asleep once I am warm. As a result, chances are good that I am not doing well in school. If I find a full-time job it means I might be able to find a place to stay warm. Or maybe not, as I have nothing to write in the “contact phone number” box on job applications.

This reality is so far outside my experience that I can hardly comprehend it. There is, though, a way I can help.

I have never had to face being homeless or having to choose between shelter and school or shelter and food. In these circumstances, would I have made it to where I am now?

For the last four years, the Professional Association of Resident Physicians of Alberta (PARA) has collected used backpacks and bags filled with essentials for people in need at shelters across the province. This year’s campaign will be the second one in which I have had the privilege to participate. Last year, I had the opportunity to tour the Youth Empowerment and Support Services (YESS – previously, the Youth Emergency Shelter Society). I helped drop off the donations at the end of the campaign and was able to see...
I have never had to face being homeless or having to choose between shelter and school or shelter and food. In these circumstances, would I have made it to where I am now? Probably not.

Thinking back to times in my own life when the “going got tough,” I recognize that I had an amazing amount of support, including my family, friends and mentors. I think about all the opportunities that life has afforded me and the fact that I have always had options; there has always been a Plan B. In my moments of self-doubt, my survival was never in question. There were always people who could help me pick myself up when I fell and encourage me to try again. It can be easy to take this support for granted, until you realize there are people who do not have any.

In the previous three years, PARA has partnered with two shelters for the PARAdime – Youth Empowerment and Support Services (www.yess.org) in Edmonton and the Calgary Drop-in and Rehabilitation Centre (www.thedi.ca). We are excited that, this year, resident physicians in Red Deer are partnering with the Safe Harbour Society (wwwSAFEHARBOURSOCIETY.ORG) and resident physicians in Grande Prairie are partnering with Rotary House (www.ROTARYHOUSE.CA) to do more in our communities. We know that these donations are valued. Last year, Mark Powers, a staff member at the Drop-in Centre in Calgary told us that the PARAdime donation:

“... takes a huge pressure off. Saying no we don’t have this or that, takes a toll on the staff and clients. It is so hard to refuse something to someone in dire need. [PARA's donation] changes this so we can say yes, here you go, be safe with your new backpack. Being able to say something positive, brings positive change.”

When our group of resident physicians dropped off the donations last year, it was clear that they enabled the shelter staff to do a lot and, for the individuals with little support who use these shelters, they make a big difference.

Recognizing this need, PARAdime collection sites have been set up in hospitals in Calgary, Edmonton, Grande Prairie and Red Deer. We invite all staff and students to help us give a hand to the most vulnerable in our communities. Please look in your closets and pantries and help make someone’s winter a little warmer.

For more information on the PARAdime and the location of the collection bins, visit http://www.para-ab.ca/news.aspx?nID=742.
Calling for 2013 TD Insurance Meloche Monnex/AMA Scholarship applicants

Picture it: $5,000 of assistance for additional training in a clinical area of recognized need in Alberta. If that fits your situation, apply for the TD Insurance Meloche Monnex/Alberta Medical Association (AMA) Scholarship.

Scholarship applicants must be seeking additional training in a clinical area of recognized need in Alberta, be an AMA member, plus be enrolled and accepted in a clinical program of at least three-months’ duration in a recognized educational facility.

The proposed program must be supplementary to completion of a Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada certification program, or the physician may be in an established practice and wishing supplemental training.

To request a 2013 scholarship application form, please contact Janice Meredith, Administrator, Public Affairs, AMA. Visit the AMA website (www.albertadoctors.org).

Applications must be received by March 29.

Scholarship recipients during the last three years were:

- 2012 Dr. Gabriel Fabreau, Calgary (fellowship in general medicine, Harvard Medical School).
- 2011 Dr. Sayeh Zielke, Calgary (fellowship in Echocardiography and Adult Congenital Heart Disease).
- 2010 Dr. Michael W. Aucoin, Calgary (working with the underserved).

Visit the AMA website (https://www.albertadoctors.org/about/awards/tdama-scholarship).

DID YOU KNOW THAT YOU CAN COMMENT ON THE PRESIDENT’S LETTER?

You can now post comments and discuss issues raised in the President’s Letter with other Alberta Medical Association (AMA) members.

COMMENTING IS EASY:

- Go to the latest President’s Letter.
- Sign in to the AMA website. (That way, we know you’re a member.)
  You’ll see the gold Member Sign-in box at the top right of every website page.
- 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.
Check out DynaMed
on the Canadian Medical Association website
A valuable reference tool for physicians and other health care professionals at the point-of-care

SEARCH OTHER SERVICES
The links in this section return you to the CMA Clinical Resources page. If you have been using DynaMed for an extended period, your CMA link may have expired and you will have to re-enter your CMA user name and password. The “Canadian CME Information” link describes how to have your use of DynaMed automatically recorded for study credit from the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

SEARCH WINDOW
You can quickly conduct a search by entering search terms into the window provided. It is also possible to browse topics alphabetically or by clinical category. A small “question mark” logo next to the search window takes you directly to the help menu. The help topics include video tutorials, including one on “Basic Searching.”

SEARCH RESULTS
A search produces a list of titles that match your search terms. Click on the title to display the article that best matches your desired topic.

ARTICLES
While viewing a particular article, tools are available to return to the list of search results, expand to the full text of all sections, go back to the table of contents or change the size of the displayed text. You can also search for a specific term within the full text of the current article.

A “Tools” menu on the right side of the display shows additional tools to enable you to receive alerts about future changes to this particular article, print it, email it to a colleague, or create a link to the article that can be embedded in an electronic medical record. Some articles provide links to related full-text journal articles available in the EBSCO Host database.

MOBILE APP
An app is available to allow access to DynaMed from a variety of mobile devices. The details of how to set this up for the CMA subscription are provided in the “Mobile” link on the main menu of each page.

CALCULATORS
The Calculators link in the main menu provides links to a wide range of clinical calculators, including medical equations, clinical criteria, decision trees, units and dose converters, and the MedCalc 3000 medical calculator.

YOUR COMMENTS AND SUGGESTIONS ARE WELCOME

Please contact me:
bmccombs@ucalgary.ca
T 403.289.4227

J. Barrie McCombs, MD, FCFP

CANADIAN MEDICAL ASSOCIATION (CMA) CMA.CA

In this issue, we’ll look at the “DynaMed” clinical resource on the CMA website. To get started, log onto the CMA website, then click on “Clinical Resources/K4P” at the top of the page. A link to DynaMed is located in the menu on the left side of the Clinical Resources page.

OVERVIEW
DynaMed is a clinical reference tool for physicians and other health care professionals for use at the point-of-care. With clinically organized summaries for more than 3,200 topics, it provides a useful resource for answering clinical questions arising during practice.

MENU BAR
A menu bar at the top of every DynaMed page provides links back to the Home page, an opportunity to subscribe to a weekly newsletter, information about use on mobile devices, clinical calculators and the extensive list of help files.

SPOTLIGHT
This section displays recent news items and updates.

WEB-FOOTED MD
Historian Tony Judt in *Reappraisals: Reflections on the Forgotten Twentieth Century* remarks on the surfeit of information in our lives: “Most people in the world outside of sub-Saharan Africa have access to a near infinity of data.” Nothing new here, but Judt’s observation is pertinent as we head into the 2013 version of the mid-winter alpine Continuing Medical Education (CME) and Continuing Professional Development (CPD) conference/meeting/retreat season.

“We have a surplus of information and a deficit of critical reflection,” echoed radiologist and physician health advocate Dr. Richard Gunderman at the 2012 International Conference on Physician Health during a workshop entitled “How popular culture undermines our health.” We don’t need to drive winter roads to Banff for medical information when the practice-altering evidence is available 24/7 at the ends of our fingers.

So why do some of us choose to go, and go back? What motivates us to trade one of our precious weekends for hours in the car, to forego a day or two’s income, to sleep in a less comfortable bed and to return home with a few CME credits in our complimentary conference bag?

And why does the Physician and Family Support Program (PFSP) continue to infuse a number of these events with presentations on managing sleep and fatigue, creating a healthy workplace, recognizing stigma, avoiding burnout and dealing with adverse events? PFSP speakers make regular appearances at Emergency Medicine for Rural Hospitals, the annual Alberta Medical Students’ Conference and Retreat (AMSCAR) at the Banff Centre, Cabin Fever for Family Medicine preceptors in Kananaskis, the Alberta College of Family Physicians Annual Scientific Assembly and the March meeting of the Alberta Psychiatric Association.

It’s about evidence-based medicine, but not entirely. What other expectations do we or should we have for these events? Apart from skis and chronic fatigue, what do we bring with us – and what enduring value do we hope to take away?

It’s impossible for any conference to meet the unique educational, social and recreational needs of all comers. The building blocks of CPD are evolving. Different groups whip up one conference flavor or another through innovation, emphasis and compromise.

In 2012 the Vancouver Island Emergency Conference “Top 5 in 5” featured a series of five-to-10 minute presentations on “essential” emergency medicine topics. The medical students at AMSCAR routinely include a large number of sessions focused on self-care during their winter weekend in the mountains. A group of Edmonton anesthesiologists and their families get together for a March weekend in Banff. They emphasize outdoor recreation, food and family-friendly activities and, on Sunday morning, give over a couple of hours to CME.

There is more than one way to skin the conference cat, in the mountains or in the city.

**AND SPEAKING OF GREAT CONFERENCES!**

This year on November 15 and 16 the Alberta Medical Association (AMA) and PFSP (supported and assisted by the Canadian Medical Association [CMA]), will host the third Canadian Conference on Physician Health in Calgary. Attendance has grown at successive conferences since the inaugural 2009 event in Vancouver. Participants and presenters include: physicians; residents and medical students; academics and clinicians doing research in physician health; members of physician health programs like PFSP; physicians who look after physicians; individuals responsible for the undergraduate medical education and postgraduate medical education at medical schools; and representatives of provincial regulatory organizations.
One special challenge in organizing a physician health conference is to have it do what it says. More and more these days, the form and content of conferences are attempting to do more than fill our heads with best practice evidence, whether that information is about physician health, family medicine or general surgery.

There are many elements of a conference that should contribute to the well-being of the participants: the venue, including layout and arrangement of large and small meeting rooms; chairs and seating; lighting and acoustics; food and beverages; start and end times for the day; number and length of sessions and breaks; opportunities for individual participation; and time for collegial networking among peers and presenters. I have heard Dr. Gunderman repeat the adage that it is from suffering that wisdom comes. He wasn’t including medical conferences in that regard.

I used to think it was a mistake to view CME as a break or surrogate holiday. Colleagues, some in two physician families, remind me that a good multi-purpose weekend can combine learning with refreshing downtime for couples and families.

Our pre-conference attitudes and expectations help determine how much we enjoy or benefit from any particular event. Harrison Owen, the man most closely associated with the Open Space approach to conferences, asks a valuable question in that regard:

[Is] it possible to combine the level of synergy and excitement present in a good coffee break, with the substantive activity and results characteristic of a good meeting?

Mr. Owen thinks the coffee breaks are just as important as the keynotes. [In the interests of full disclosure, I’m a coffee enthusiast, especially of the artisan medium roasts.]

The majority of us are not well served by an agenda that resembles an overbooked office or conjures up memories of endless afternoons in medical school lecture halls. Remember, the conference is created for you, and not the reverse. A conference is like an all-inclusive buffet. You need to make sensible choices – or risk overeating.

SEVEN SUGGESTIONS FOR A HEALTHIER CONFERENCE EXPERIENCE

1. One night get to bed earlier than usual. Wipe an hour off your chronic sleep deficit.

2. Don’t be afraid to skip at least one session per day. You won’t miss the credit hours – and you’ll be just as smart come Monday morning. Use the free time to have a nap, meet with a colleague or your spouse for conversation over tea or coffee, or go for a walk.

3. Plan an “event” outside the conference venue. In Banff you might visit the Wild Flour Bakery Cafe, an exhibition at the Whyte Museum of the Canadian Rockies, Willock & Sax Gallery, or take in an evening concert at the Banff Centre.

4. Disconnect. Turn off your phone for a day. Avoid texting and emailing during the breaks between sessions. Instead, have a face-to-face conversation with a fellow participant.

5. Practice being mindful. Currently you can claim one credit hour for each hour you are physically present for a session. Rumor has it in future we’ll be able to apply a Bonus Time Modifier for the actual time we were paying attention to the speaker or fellow participants.

6. Go for meaning. At the end of each day, answer Rachel Remen’s three part daily review:
   a. What surprised me today?
   b. What inspired me?
   c. What touched my heart?

7. A change is as good as a rest. And vice versa. Before returning home, write down one way in which you have changed (personally and professionally) as a result of your conference experience. Have you grown in some way? In what way are you better off for having shown up?

I look forward to connecting with colleagues at sessions in Banff and Calgary this year (or just going for coffee).

References available upon request.

CANADIAN CONFERENCE ON PHYSICIAN HEALTH

Planning is currently underway for the Calgary conference, November 15-16. Judging from the content of previous events (including the international versions of the conference – most recently 2012 Toronto), the agenda will feature the science and the art of physician health. Theory, research and the realities of practice in 2013 will likely jostle for participants’ attention.

Previous keynote speakers have addressed burnout and resilience at all stages of the medical career, physician suicide, practitioner health and its links to patient safety and quality care. Poster displays, debates and small group sessions have looked at reconciling individual self-care initiatives with the need for organizational interventions, hours of work, stigma and mental health, workplace health, illness versus impairment in occupational health, leadership in physician health at all organizational levels, and the range of services provided by physician health programs across the country and around the world. Visit https://www.albertadoctors.org/physician-health-conference.
Get the 411 on "Lobbying 101"

Alberta’s medical students are getting involved in the political process to make a difference in health care.

Is there a need for political advocacy in the medical profession? Medical students at the University of Alberta (U of A) and University of Calgary (U of C) think so. On November 25, 2012, a group of them gathered to participate in “advocacy training,” which included a presentation on lobbying by the Alberta Medical Association’s (AMA’s) Ronald A. Kustra, Assistant Executive Director, Public Affairs.

University of Alberta medical student Mila Luchak knows the importance of political advocacy in advancing the quality of health care. Now in her second year of studies, Ms Luchak is an active member of the Political Advocacy Committee, a student-led initiative that looks at different issues impacting medical education, such as admissions, tuition and education.

“I was really interested in looking at systemic changes to improving patient care,” said Ms Luchak. “The committee is one way for students to come together, advocate for a particular idea and make a difference.”

One of the major initiatives organized by the committee is an annual “Political Action Day” (sponsored by the AMA) where medical students from across the province make a trip to the Alberta Legislature and lobby Members of the Legislative Assembly (MLAs) on a particular issue determined by the committee. This year, the committee looked at “the need for physicians who are able to relate to and effectively serve the … aboriginal populations in rural Alberta.”

“We want physicians to practice culturally-safe medicine,” said Ms Luchak. “We need to know how to relate to our patients, especially in aboriginal communities.”

“The government can support this by promoting outreach and mentorship programs, so that students can be more exposed to aboriginal health issues.”

On the day before their visit to the Legislature, medical students attended a training session organized by the committee. Mr. Kustra kicked off the session with a presentation entitled “Lobbying 101.”

“It’s important to find out the MLA’s background,” said Mr. Kustra in his presentation. “You want to try and find something that you can connect with on a personal level.”

“You treat everyone in politics with respect,” he added. “You want to walk out of their office with a relationship with that MLA.”

Mr. Kustra also spoke about what to expect from the students’ meetings with the MLAs.

“What you’re starting today, some of you may have to continue to do five years from now,” he said. “You have to plant a seed with a few MLAs and follow up later.”

“Don’t expect anyone to give you five stars right away.”

According to Ms Luchak, Mr. Kustra’s presentation on lobbying was a real eye-opener to all the medical students.

“He did a great job of giving us a broad overview of how to approach a politician,” said Ms Luchak. “That’s important because not a lot of students have had this kind of opportunity.”

The entire experience – the training and the visit to the Legislature – has only added to Ms Luchak’s view that political advocacy is a crucial skill to have and develop as physicians.

“From choosing the topic, doing the background research ... and bringing it to the political and faculty levels ... was a great experience.”
MEDICAL STUDENTS DISCUSS ABORIGINAL HEALTH INITIATIVES WITH MLAs

On November 26, 2012, 40 medical students from the U of C and U of A met with more than 30 MLAs and put political advocacy into practice by discussing the importance of aboriginal health initiatives in medical schools. Students discussed ways to promote and expand current outreach programs to ensure diversity within our medical classes and the curriculum. Students received positive responses in their discussions with MLAs. The Political Advocacy Committee will continue to pursue this issue and many others throughout the coming year.

– Mila Luchak, U of A medical student, class of 2015.
Improving health outcomes in the community, one group at a time

Thanks to the Emerging Leaders in Health Promotion grant program, medical students are working in their local communities to tackle bullying and promote healthy choices.

This is the last of our series covering the 2012 recipients of the Alberta Medical Association’s (AMA’s) Emerging Leaders in Health Promotion grants. Like the ones we’ve covered before, these two projects are very different in scope but still focus on health promotion in the community. One seeks to reduce homophobia, discrimination and bullying in schools. The other has brought medical students into Calgary’s inner-city to spread the message on healthy choices to the city’s homeless population. Both projects are making a difference in the lives of those who face day-to-day challenges.

PROMOTING MENTAL HEALTH CAPACITY AMONG LGBTQ YOUTH

Matthew Mazurek has been a champion for the LGBTQ community – an acronym that stands for lesbian, gay, bisexual, transgendered and queer. A medical student at the University of Alberta (U of A), Mr. Mazurek founded the Sexual Orientation and Gender Identity Advocacy Committee in 2009. The goal of the committee is to raise awareness on the health issues faced by individuals in this broad community.

“Right now, there is an epidemic of intimidation and harassment directed at LGBTQ youth,” said Mr. Mazurek. “We want to empower them to help end classroom bullying by spreading the message that discrimination against LGBTQ persons is not acceptable.”

Last year, the committee partnered with the U of A’s Institute for Sexual Minority Studies and Services to develop student-led workshops aimed at reducing homophobic discrimination. Working with teachers and community leaders, LGBTQ student leaders spoke to 15 different schools in the Edmonton area over the past year. Each workshop would work through a variety of activities designed to dispel common myths, provide clarification of LGBTQ terminology and encourage students to take a stand against bullying. Students would also have the opportunity to share their personal experiences with homophobic bullying.

“The workshops have won acclaim from teachers and students,” said Mr. Mazurek.

But the issue is about more than bullying, he added. In fact, studies show that when LGBTQ youth experience hostile environments, the resulting stressors can translate into measurable disparities in health outcomes and behaviors.

“As doctors in training, we have a unique responsibility to be leaders and mentors within our communities to advocate for the health of our friends, families and neighbors,” said Anthony Lott, a medical student and an active member of the advocacy committee. “Medical students can play a key role in supporting LGBTQ youth by dissolving these prejudices and forming supportive climates in both schools and communities.”

For more information on the Sexual Orientation and Gender Identity Advocacy Committee and their workshops, visit www.uofasga.org.

STUDENT-RUN CLINIC HEALTH EDUCATION SERIES

A group of medical students have rolled up their sleeves to offer support to Calgary’s underserved communities. First- and second-year medical students from the University of Calgary (U of C) founded the Student-Run Clinic in 2011 with the aim of providing medical services to those who may have difficulty accessing care. In addition, with the support of the AMA grant, the participating medical students have organized a series of information sessions to their patient population, dealing with a variety of relevant health topics.

“The main goal for the sessions is to be able to provide our patient population with the knowledge and skills to make healthier choices,” said Caley Shukalek, a second-year medical student at the U of C. “We
want to provide information on common illnesses relevant to their lifestyle as well as where they can access community resources.”

At the time of writing, Mr. Shukalek and his group have hosted five information sessions; two were held in January. All sessions are held at Inn from the Cold, a temporary emergency shelter for homeless families.

“The demographic at the shelter consists of mostly single parents,” said Mr. Shukalek. “We ran sessions that focused on issues they identified – topics including head lice, skin infections and hand hygiene.”

“While many topics covered are common knowledge to some, both students and attendees believed it was important to refresh them in their mind.”

The response to the sessions has been very positive, and the shelter has requested additional sessions for next year on different topics such as immunization for children and adults. For Mr. Shukalek, the experience in organizing the sessions has added to his passion for health promotion.

“The importance of education and prevention in health care – in terms of cost effectiveness and efficiency – is something that students and clinicians should focus on,” said Mr. Shukalek. “Having seen some of the issues in our inner-city, I wanted to aim for those things with the information sessions.”

“We see that there are a lot of patients who really need health services, but unfortunately there is some discrimination against them in the current system,” he added. “From accessing urgent care or more second-line services such as physiotherapy, there is a need to advocate for these patients.”

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This year marks the 10th year of the Alberta Medical Association (AMA) Section of Rural Medicine’s Tarrant Scholarship. The scholarship was created in 2004 to encourage medical students interested in rural medicine to eventually set up practice in smaller communities.

To date, the scholarship has awarded more than $250,000 to 24 medical students. It is one of Alberta’s largest unrestricted medical school undergraduate awards and provides a full year’s tuition to its recipients. It is awarded each fall by the Section of Rural Medicine to third-year medical students at the University of Alberta (U of A) and the University of Calgary (U of C).

The scholarship is named in honor of the late Dr. Michael Tarrant, a Calgary family physician. Dr. Tarrant championed rural medical undergraduate education and helped establish ongoing rural roots for future physicians. The scholarship is presented to students who have demonstrated an interest in, and dedication to, rural medical issues during their undergraduate years.

A medical student is eligible to apply for the 2013 scholarship if he or she is:

• Entering third-year medical school at the U of A or the U of C this fall.
• Interested in a career in rural medicine in Alberta.
• Demonstrating an interest in and dedication to rural medical issues in undergraduate work.

The Tarrant Scholarship application form is available on the AMA’s website at www.albertadoctors.org. The application deadline is May 6.

Scan to read about previous recipients of the Tarrant Scholarship or visit www.albertadoctors.org/tarrant.

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You know you’re in small town Alberta when the taxi driver fills out your receipt in full detail and signs and dates it. Mr. Allaudin Merali and I, however, have been used to receiving blank receipts from a smiling driver and filling out these details ourselves – and that’s reasonable because we’re trusted. The Chinese Communist Party has a similar problem but Wang Qishan, the Party’s anti-corruption bloke says: “Trust cannot replace supervision.” And he should know.

Reading this morning about alleged kickbacks in the construction industry in metro Lamont, east of Edmonton, it seems my old friend Jean Latreille may have something. Jean, a Quebecker, says English Canada has this superior attitude to the passage of bulky brown envelopes (here Jean pushes his head up in an arrogant frown) as if it never happens here. “They don’ admit it ‘appens,” he says. “But – p’fou – it ‘appens a lot. We know that.”

And I think it’s happening with increasing frequency right here in Alberta. But let’s still believe that Quebec leads the way.

Here’s a little Invisible Worm story with an Alberta connection about what may be one of the bigger heists in medical history. I have my sources. Pull out my toenails and you won’t get anything.

Does anyone remember Dr. Arthur Porter? He was a radiation oncologist at the Cross Cancer Institute in Edmonton back in the 80s. Dr. Porter set up a private prostate cancer foundation when most of us were worrying about paying off the mortgage. A clubbable, smart bloke, plummy accent, who liked a chuckle; you’d be happy to spend a few hours with him over a drink or dinner. He left to be head of radiation oncology in London, Ontario, then went to Detroit.

The next time I hear about Dr. Porter, he’s “director-general” and chief executive officer of the McGill University Health Centre (MUHC). No particular surprise there. But I cleaned out my ears when I heard he was on the board of Air Canada (its new slogan: “We’re Not Happy Till You’re Not Happy” – this naturally does not apply to board members who have free flights anywhere Air Canada flies).

Then when I heard him on a CBC radio interview a couple of years back introduced as chair of the board of the Canadian Security Intelligence Service (CSIS) – our very own “M”: (“Any thug can kill, Bond. I need you to take your ego out of the equation.”) – I fell into an acute state of cognitive dissonance. And OMG, he was also a Queen’s Privy Councillor.

Dr. Porter led the team for MUHC choosing the contractor to build its new super-hospital – a $1.3 billion deal. At the last minute the contract was switched from some other French company and was awarded to your favorite Quebec company, SNC Lavalin, whose CEO was recently arrested – perhaps not unrelated to a missing $22.5 million from the MUHC project sent to “agents” overseas.

I did try to contact Dr. Porter for comments (something along the lines of “this is a vicious witch-hunt”) on these despicable insinuations. But it’s currently difficult to find him despite large numbers of people wanting to chat. Busy, busy, I suspect, running racy night clubs in the Bahamas.

To round off this unfortunate tale, another famous radiotherapist, Dr. Karol Sikora, happens to be what is termed a “business partner” of Dr. Porter. Dr. Sikora is definitely the sort of bloke you’d like – amiable, bright, good fun. Readers of Alberta Doctors’ Digest will immediately recall the September/October 2010 article entitled “A Sorry Tale of Foolish Prognosticating” featuring the above Dr. Sikora who received a mouth watering honorarium for a grim but mercifully inaccurate prognosis on a Mr. Abdelbaset Ali Mohmet al-Megrahi, a convicted and jailed Libyan Pan Am Flight 103 bomber, who had a positive bone scan from prostate cancer and was given three months to live by Dr. Sikora. In retrospect this was not so much foolish (given the size of his payment from the Libyan Government) as foolhardy.

It was heart-warming to see Mr. Al-M skip down the steps from the aircraft in Tripoli to a joyous crowd waving Scottish Lion Rampant flags. He lived happily for three more years after being released by a truly compassionate Scottish Government. Dr. Sikora has also lived happily.
The busy involvement of SNC Lavalin in Libya prior to the sad passing of Muammar, the People’s Great Leader and Lover of Outdoor Camping, has led to some interest by police forces around the world in SNC Lavalin’s alleged activities in trying to spirit the Gaddafi family to safety in the new world. Some silly folk with too much time on their hands are prematurely jumping to conclusions about connections between SNC Lavalin, Dr. Porter, the Gaddafis and Dr. Sikora.

SNC Lavalin continues to strenuously deny any connection with the Gaddafi family despite the Mexican authorities detaining another of their agents suspected of looking for comy squatting quarters for the said family to erect their tents. It’s time this dodgy construct was sluiced down the toilet where it belongs.

Drs. Porter and Sikora meantime are stamping out disease and curing the sick and infirm somewhere in the West Indies by opening stem cell research clinics.

The Quebec RCMP are biding their time, given the difficulty of sifting evidence from some of the darker corners of the world. I have myself sailed among the many picturesque islands of the West Indies without having to trouble the local police with my entries and exits. This tip may come in handy for anyone running out of space in their passport.

Well … as Inspector Clouseau (of the Pink Panther) said: “There is a time to laugh and a time not to laugh and this is not one of them.”

So, back to the Invisible Worm: Is that Annelide flying through the night in the howling storm here in Alberta? Well, things seem to be winging that way, but in a more down-home, Alberta kinda way. No brown envelopes here. No sir.

The French think it’s acceptable (as I do) to exaggerate “après la chasse, pendant l’amour et avant l’élection,” but what we’ve seen after the provincial election appears to be more than exaggeration. Oh-ho, much more - verging on terminological inexactitudes of denotation and connotation (or “Porkies” as simple folk would say): Memos of Understanding signed and then dishonored as soon as elected; $450,000 political contributions from a drug retailer; deliberately useless commissions of inquiry into queue jumping instead of examining the real problem; arrogance and bullying; obfuscations and denials that juicy contracts have been awarded to insiders; taxpayer money going into Not Your Father’s Party coffers; and jobs for insider boys and girls.

Listening to the earnest, sincere and reasonable Mr. Fred Horne, the current Not Your Father’s Party Health Minister, I’m reminded of John Crosbie – my favorite politician (at least he had a sense of humor) – warning that “the most important thing in politics is sincerity, and once you can fake that, you’ve got it made.”

The most important thing in politics is sincerity, and once you can fake that, you’ve got it made.

And what advice to offer in these trying times?

I do like Latin quotes. At the time of learning a bit of Latin I didn’t like them at all; they seemed sonorous, stilted and obvious. But they do add a bit of dash. And they remind one that nothing much changes over the centuries.

So, I quoted Latin to the annual general meeting of the Bow Valley Primary Care Network (PCN) at the end of November 2012 held in Abegweit House in Banff, a cozy heritage building overlooking the Bow River and now gifted to the White Museum.

Bow Valley’s Dr. Blaney and I had chatted a few weeks before about what I would say.

“Something light,” she said. “Any topic you want.”

I decided on “Aequam memento, rebus in arduis, servare mentem” (“In arduous situations, remember to keep calm”) from Horace, the lyrical poet, 65-8 BC (who also brought us “nil desperandum,” “carpe diem” and other pithy quotes). I thought it apt enough in these uneasy times living with Alison in Wonderland.

The Bow Valley PCN seems to be working well. The group agreed to set up a pilot pain clinic in Banff. This is what entrepreneurial medicine is all about. The hastily conceived “family care clinics” (FCCs) may be useful in downtown Calgary or Edmonton, and liked by those patients who want to chat about this and that at seven at night (“She was so nice, that nurse practitioner … really took her time with me!”); the hourly rates will be attractive to those young grads who don’t want the hassle of getting involved in a proper practice; and the FCCs will be loved by an inevitably proliferating bureaucracy. But they will be expensive, duplicative, disruptive and will run counter to the obvious cost containment activities of the family doctor as the proper gatekeeper to the health care system. And who will be blamed for the inevitable leap in costs? Not your Not Your Father’s Party.

It’s all very regrettable and disturbing to peace-loving, law-abiding Albertans. But we’re going to have to get used to it – or at least to raise the level of oversight on our elders and betters. Modifying John Kenneth Galbraith’s advice, I’d say the era of confidence and trust of politicians has come to an end in Alberta and one could better argue the importance of unremitting suspicion. The shenanigans from our Not Your Father’s Party leaders here in the last few months confirm that we have a hard few years ahead. We are seeing a bracing surge of forked tongue speech such that “Read My Lips” is no longer helpful advice.

The problem, dear readers, is simple and it’s our fault. You cannot have a political party in power for more than 40 years without sick roses wilting all over the place. I assure you, you ain’t heard nothin’ yet. The whole history of democracy – what the wars, battles, skirmishes and assassinations were all about was this: Heave the blighters out after eight or at the most 10 years.
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tombray@telusplanet.net

EDMONTON AB
Alberta Health Services’ Clinical Department of Addictions and Mental Health, is to expand our complement of general practitioners who provide non-psychiatric medical care.

Alberta Hospital, Edmonton sits on a self-contained campus of 275 acres in northeast Edmonton. It is a 304-bed facility offering adult rehabilitation, forensic psychiatric inpatient and community services. The facility is currently undergoing a $15 million redevelopment which is due to be completed in 2014 that will add an additional 80 in-patient beds.

Our general practitioners tend to the various medical needs of our psychiatric patients. From baseline physical assessment to day-to-day management of chronic illnesses including: hypertension, diabetes, hypercholesterolemia, pulmonary and gastroenterological issues. Minor procedures such as sutures may be done on site. In situations requiring more emergent or complex treatment, patients are transferred to other facilities as appropriate.

These physicians work days Monday to Friday seeing patients in-clinic and providing treatment. They may also see patients on the unit as necessary. On-call service is typically not required. Remuneration is on a fee-for-service basis.

The successful candidates will have an MD, preferably with a CCFP designation, and will be eligible for licensure in the province of Alberta. Experience with psychiatric patients is an asset as well as an ability to deal with patients in crisis.

Interested, qualified persons should submit their curriculum vitae with the names of three references to:

Dr. P.J. White,
Facility Medical Director
Alberta Hospital, Edmonton
T 780.342.5438
F 780.342.5233
pjwhite@med.ualberta.ca
Applications began being reviewed on November 6, 2012, however, the competition will remain open until all positions are filled.

We thank all applicants for their interest; only those individuals selected for an interview will be contacted. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority.

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

**EDMONTON AB**

Alberta Health Services and Covenant Health, in partnership with the University of Alberta, Faculty of Medicine & Dentistry, are inviting applications from emergency physicians to join the Department of Emergency Medicine in the Edmonton Zone.

This busy, high-intensity department consists of 155 physicians working at nine sites within the Edmonton Zone ranging from community-based hospitals to some of Canada’s busiest level one trauma centers.

The smallest sites include Devon, Leduc, Fort Saskatchewan and Stony Plain. Family physicians provide coverage on a rotational basis in addition to community practice.

Community hospitals include Grey Nuns Community Hospital, Misericordia Community Hospital, Northeast Community Health Centre and Sturgeon Community Hospital. At these sites a dedicated pool of emergency physicians work eight-hour shifts days/nights/weekends approximately 12-14 shifts per month.

The tertiary sites include the University of Alberta Hospital, the Stollery Children’s Hospital and the Royal Alexandra Hospitals. These centers provide high-acuity emergency services including care of trauma and transplant patients.

These are dedicated emergency physicians working eight-hour shifts days/nights/weekends approximately 10-14 shifts per month.

Edmonton Zone hospitals are affiliated with the University of Alberta and serve as important training facilities for residents and students. The Faculty of Medicine & Dentistry has been internationally recognized as among the world’s top-50 medical schools and as one of Canada’s premier health-education institutions. Individuals interested in education of trainees are encouraged to apply for clinical academic colleague appointments in the academic Department of Emergency Medicine.

The comprehensive range of acuity offered by facilities in the Edmonton Zone, combined with the prospect of academic involvement, creates opportunities for physicians to find a working environment that complements their skill-set, professional interests and workplace preferences. Remuneration for these positions, depending on the site, is either fee-for-service billing or a group billing model. Regardless of the payment model, Alberta’s emergency physicians are among the highest paid in North America.

Successful applicants will have or be eligible for certification in emergency medicine with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and be eligible for licensure with the College of Physicians & Surgeons of Alberta. Residents who apply must be eligible for licensure with the College of Physicians & Surgeons of Alberta. Residents who apply must be eligible for licensure with the College of Physicians & Surgeons of America.

Successful applicants will have or be eligible for certification in emergency medicine with the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and be eligible for licensure with the College of Physicians & Surgeons of Alberta. Residents who apply must be eligible for licensure with the College of Physicians & Surgeons of America.

We thank all applicants for their interest; only those individuals selected for an interview will be contacted. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority.

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

EDMONTON AB

Blue Spruce Medical Centre has immediate openings for two part- or full-time family physicians or general practitioners. New or experienced, as well as eligible foreign medical graduates are welcome. We are a very busy family practice clinic in north Edmonton. We perform many common family practice procedures as well as cosmetic and laser procedures, and would be a great opportunity for hands-on training if interested. Split is 27/73; walk-ins available if interested. Guaranteed daily income is $1,100. Relocation allowance available, conditions apply.

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T 403.934.4444 (office)
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MARCH 17-APRIL 1
Focus: Cardiology, infectious diseases and psychiatry
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MARCH 27-APRIL 6
Focus: Technology in clinical practice
Ship: Paul Gauguin

MEDITERRANEAN
MAY 17-29
Focus: Endocrinology and rheumatology
CME: By McGill University
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AUGUST 4-11
Focus: Respiration and obesity
Ship: Navigator of the Seas

BALTIC AND RUSSIA
JUNE 22-JULY 6
Focus: Gastroenterology, endocrinology and infectious diseases
Ship: Celebrity Eclipse

ALASKA GLACIERS
JULY 12-19
Focus: Hospitalist update
Ship: Celebrity Solstice

AUGUST 18-25
Focus: Renaissance in primary care
Ship: Celebrity Century

BLACK SEA
JULY 22-AUGUST 4
Focus: Neurology, cardiology and chronic pain
Ship: Regent Seven Seas Mariner

ICELAND AND NORWAY
SEPTEMBER 1-13
Focus: Rheumatology and sports medicine
CME: With the Ontario Medical Association
Ship: Adventure of the Seas

RHINE RIVER
SEPTEMBER 29-OCTOBER 6
Focus: Mental health and the law
Ship: Avalon Felicity

ITALY, MALTA AND ISRAEL
OCTOBER 8-19
Focus: Internal medicine and surgery
Ship: Azamara Journey

BERMUDA
OCTOBER 13-20
Focus: Geriatric medicine review
Ship: Explorer of the Seas

SOUTHERN TRANSATLANTIC
NOVEMBER 20-DECEMBER 8
Focus: Cardiology and rheumatology
Ship: Regent Seven Seas Mariner

MEKONG RIVER
NOVEMBER 26-DECEMBER 11
Focus: Clinical medicine update
Eight-day land tour and seven-day river cruise

SINGAPORE TO HONG KONG
DECEMBER 9-23
Focus: Dermatology
Ship: Volendam

AUSTRALIA AND NEW ZEALAND
JANUARY 20-FEBRUARY 13, 2014
Focus: Endocrinology and women’s health
CME: With the Ontario Medical Association
Ship: Celebrity Solstice
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