We CAN make health care better: Alberta doctors share ideas in AMA videos!

Building the new AMA website

With your support, AMF can promote history of medicine

TD Insurance Meloche Monnex/AMA Scholarship awarded
Looking Back and Looking Forward

Dennis W. Jirsch, MD, PhD
EDITOR

Recent allegations about deaths of patients waiting for ER or cancer care, physician intimidation and payments to silence unruly physicians have provoked a tsunami of protest from docs and citizens alike.

At a rally at the Alberta Legislature in the spring, the crowd was in high dudgeon and broke into chants of “Fumigate the Leg.”

The Health Quality Council of Alberta (HQCA) has been charged with reviewing things and has promised updates every three months and a final report in early 2012. A five-member Advisory Panel will advise and assist CEO Dr. John Cowell.

It’s certainly a blue-ribbon group:

• Zakheer Lakhani, CM, MD, FRCP, cardiologist, Royal Alexandra Hospital, and a clinical professor, University of Alberta Department of Medicine
• The Honorable A. Anne McLellan, PC, OC, strategic adviser with Bennett Jones LLP, and former Liberal member of Parliament, minister of Health and deputy prime minister
• Art Price, P.Eng, the chair and CEO of Axia NetMedia Corporation and executive director, founder and principle owner of the Sunterra Group
• Simon Sutcliffe, MD, FRCP, oncologist, and the president of the International Network for Cancer Treatment and Research, and past president of the BC Cancer Agency
• The Honorable Allan H. Wachowich, QC, LLD, former chief justice of the Court of Queen's Bench of Alberta

They’ll investigate and analyze issues purportedly relating to safety and patient care for ER treatment and cancer.

As well, they’ll look at the role and process of physician advocacy in a review that will be provincial in scope and conducted under the aegis of the Alberta Evidence Act so as to provide evidentiary protection for an expected profusion of documents and testimonies of participants.

The HQCA review will be closed-door, with access to financial and other records. But it won’t be able to subpoena persons or force them to give evidence. The health minister argues that a full judicial review would take years and would be expensive.

Review or inquiry, the stakes are pretty large.

Several physicians have said they’d come forward but only with the indemnity possible with judicial protection, while others, generally representing organizations, have been less forthcoming.

Carl Sagan said, “There is a lurking fear that some things are not meant ‘to be known,’ that some inquiries are too dangerous for human beings to make.” Sagan went on to disagree with this notion, and so do I.

We’re getting a “review” at this point, although calls for a process with more heft continue. The allegations of misconduct are serious, me thinks. Since we’ve gotten to this point of murk and innuendo, I’d vote for a full inquiry.

Review or inquiry, the stakes are pretty large.
Our health care organizations are quasi-governmental agencies.

And those of us still enamored with the prospect of democracy will recall that democracy’s impetus came from the egregious afflictions that are possible with autocratic rule, when all is done in secret.

American jurist Sandra Day O’Connor may have said it best: “A fundamental premise of American democratic theory is that government exists to serve the people. Public records are one portal through which the people observe their government, ensuring its accountability, integrity and equity while minimizing sovereign mischief and malfeasance.”

As former US Supreme Court Justice Louis D. Brandeis opined: “Sunlight is said to be the best of disinfectants.”

Then, too, maybe a review will discover systemic issues, with regimes that are overlarge, over-controlled and anything but patient-centered.

Yes, all may be revealed to be the Work of Innocents and well-meaning ones at that. If this isn’t the case, however, I’ve little time for talk of retribution.

We live “going forward,” as accountants and business folk are wont to say, and I’ll be happy enough to see the air cleared, particularly if things are better for all concerned here on in.

I’d hope that our “review” – already of uncertain scope, of undetermined powers and of short timelines – will look far enough back.

I reckon much of the misery that abounds has to do with the precipitous, unplanned and ill-advised removal of circa 20% of health care funding, some 15 years ago, in a hasty effort to balance the books under former premier Ralph Klein.

Those around in those daft days will recall that all hell broke loose, with hurried reorganizations and mass confusion.

The last thing government and regional health authorities’ bigwigs wanted at the time were public vocalizations about how bad things were, and I suspect any code of silence developed at the time has persisted to date.

This delving into the “mysteries of state” comes at an interesting time, however, when governments at all levels pay at least lip service to calls for greater openness and transparency, but cloak most decisions in secrecy.

Certainly indiscriminate WikiLeaks disclosures are problematic with security issues, privacy issues and collateral damage. But we need to open the black box of our health care history.

It’s time for sunlight. Clear the decks. Fumigate the Legislature and beyond. Let’s move forward.

If we want to go forward, we’ll have to balance these competing interests since there is no accountability without transparency.

I hope we aren’t yoked, to our great detriment, to models of governance and management that have been too glibly copied from the for-profit sector.

We’re only too well aware of the problems inherent in command-and-control leadership, when results matter more than the ethics and processes used to derive them.

We need an informed and involved public as well as an informed, involved body of professionals, as I see it, if things are to improve.

It’s time for sunlight. Clear the decks. Fumigate the Legislature and beyond. Let’s move forward.

We deserve it. We all deserve it.

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### FEATURES

6. **We CAN make health care better: Alberta doctors share ideas in AMA videos!**

In a new video series – *Prescription Alberta: Ideas from Your Doctors™* – on YouTube, physicians across the province show how to harness clinical knowledge, compassion, teamwork and creativity to solve problems, overcome obstacles and put Patients First® today.

8. **The AMA then and now**

The Alberta Medical Association (AMA) has provided more than a century of leadership and support for physicians’ role in the provision of quality health care.

11. **Building the new website**

Planning is underway for a new AMA website, which is expected to launch in January 2012.

18. **Dr. Sayeh Zielke granted TD Insurance Meloche Monnex/AMA Scholarship**

Dr. Zielke received $5,000 when granted the scholarship recently. Cardiology patients in Alberta will benefit, too.

22. **With your support, the AMF can promote history of medicine**

To support the history of medicine in Alberta, please consider adding a tax-deductable donation to the Alberta Medical Foundation (AMF) when renewing AMA dues again this year.

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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.
We CAN make health care better: Alberta doctors share ideas in AMA videos!

Dr. Carolyn A. Lane, at Calgary's Riley Park Maternity Clinic, is one of about 25 physicians providing maternity and delivery care and who work to improve care for moms and babies in cooperation with the local hospital. One program provides on-call service in the home and one on-call group in the hospital. (From the AMA's new video series, Prescription Alberta: Ideas from Your Doctors™, Marvin Polis, video producer, Stimulant Strategies Inc.)

"Doctors drive 80% of the resources in the system every day; we know what’s working and what’s not. That’s why we have a duty to talk about what we think is good for patients."

"I think as doctors we have more to do than look after individual patients," reflects Alberta Medical Association (AMA) President Dr. Patrick J. (P.J.) White. "After all, doctors drive 80% of the resources in the system every day; we know what’s working and what’s not. That’s why we have a duty to talk about what we think is good for patients."

"Delivering advocacy, accountability and a vision for the future are not extras for..."
physicians,” emphasizes Dr. White. “These things are our responsibility.” *Prescription Alberta: Ideas From Your Doctors™* provides 90-120 second vignettes to show how doctors are filling that responsibility today and their vision for the future.

*Prescription Alberta: Ideas From Your Doctors™* provides 90-120 second vignettes

A sampling of what you will see:

These stories and more can be viewed in the videos.

When the local hospital is built to handle 3,500 deliveries a year but actually does 6,000, what can be done to prevent delay in caring for moms and babies when they need it the most?

**Dr. Carolyn A. Lane, Calgary:** “The Riley Park Maternity Clinic has approximately 25 physicians providing maternity and delivery care. One program provides call in the home and our call group provides call in the hospital. . . .”

Everyone faces the end of life eventually. How can the system help patients and families deal with this most difficult transition?

**Dr. Eric A. Wasylenko, Okotoks:** “Here at this hospice and others in Alberta, we give people an opportunity to live in a home-like environment. We think that really important pillars of community palliative and end-of-life care are people’s homes and so we have the opportunity to participate in an integrated palliative care network. . . .”

It can be difficult to see a family physician in a timely fashion. How has one primary care network (PCN) solved the problem?

**Dr. Jana Holden, Leduc:** “In this PCN, and without adding a lot of resources, but with teaching us some new skills and ways to approach things, most patients can come in within a day or two to see me now without having a special problem that’s urgent or emergent. And we can usually accommodate medicals or check-ups within a week or two quite easily, often within a day or two. . . .”
Dr. Patrick J. (P.J.) White’s presidential term for the Alberta Medical Association (AMA) marks a significant milestone in the history of the association. He is the AMA’s 100th president.

What follows are some historical highlights for more than a century of AMA leadership and support for physicians’ role in the provision of quality health care.

1920s: A grant to Dr. J.B. Collip’s studies helps lead to insulin discovery.

1920s
• The AMA becomes responsible for education and public relations.
• A grant to Dr. J.B. Collip’s studies helps lead to insulin discovery.

1930s
• Annual physician refresher courses at the University of Alberta (U of A) are subsidized by the AMA.

1940s
• The AMA supports prepaid medical care or health insurance. Extensive development by the profession is followed by government-created Medical Services (Alberta) Incorporated, providing more than 90% of Albertans with prepaid medical care until it was replaced by compulsory federal Medicare in 1969.

1950s
• AMA insurance plan is established for members.
• AMA advises physicians in each community to ensure physician availability through emergency call services.

1960s
• Name change to Alberta Medical Association from Canadian Medical Association, Alberta Division.
• AMA takes over activities related to fees and to benefits paid on behalf of patients under the government insurance program, and most committee work is directed to health matters.

1970s
• A new Cancer Act passes following an AMA brief about cancer services in Alberta.
• Let’s Talk public relations campaign informs the public, media and government about issues of common concern, raising the profession’s profile and making the public aware of the AMA’s stance on various issues.

1980s
• AMA’s campaign persuades Alberta’s government to drop its suggested health care budget cap because of increasing utilization of health services.
• AMA establishes a negotiating mechanism with the Provincial Government to enhance the association’s role in decision-making regarding annual adjustments to the AHCIP Schedule of Medical Benefits.

1990s
• Members accept in 1992 a new master agreement negotiated by the AMA and Alberta Health. It includes, for the first time, a global budget for fee-for-service physicians.
• A Patients First public awareness campaign in November-December 1995 draws feedback from more than...
50,000 Albertans who responded to the call to “Tell Us Where It Hurts.” About two weeks after the campaign began, the minister of Health announced funding cuts planned for 1996-97 to the regional health authorities (RHAs) would not proceed. Members strongly supported the AMA’s leadership in such a campaign.

- The AMA plays a pioneering role in establishing the Rural Locum Program in 1991. The program helps to find replacement physicians for rural communities when a community’s physician needs time off.

1990s: A Patients First public awareness campaign draws feedback from more than 50,000 Albertans. About two weeks after the campaign began, the minister of Health announced that funding cuts planned for 1996-97 to the RHAs would not proceed.

2000s: Alberta doctors counsel parents about the dangers of secondhand smoke for children.

- The AMA, in partnership with Alberta Health and Wellness and RHAs, completes an eight-year trilateral master agreement, effective April 1, 2003 to March 31, 2011, with financial reopeners March 31, 2006 and March 31, 2008. This agreement is groundbreaking because it allows the three equal partners to establish a health care system founded on collaboration and innovation.

- Alberta doctors counsel parents about the dangers of secondhand smoke for children. To assist physician counselling, the AMA provides members with a handout that explains why smoking in vehicles or at home is dangerous to the health of youngsters and what parents can do to minimize the risks.

- In 2007, the AMA produces We Are the Alberta Medical Association, a timeline highlighting 25 years of additional health advocacy (www.albertadoctors.org/Advocacy/Positions).

- In September of that same year, the AMA works with the CPSA to oppose Bill 41 that proposed to limit the power of health profession regulatory bodies. Several changes were secured, particularly that the minister of Health and Wellness cannot act unilaterally to take over the college or some of its functions, as originally proposed. Instead, any such action must be a decision by the whole cabinet.

• In November 2008, with the Alberta Centre for Injury Control and Research, the AMA launches the public awareness campaign Finding Balance – Preventing a fall before it happens. Continued into 2011, the public advocacy program – to prevent seniors’ falls – advances the AMA’s health promotion/injury prevention focus and supports its vision of Patients First®.

• In February 2009, the AMA opposes proposed Bill 52 that would have given the minister of Health and Wellness the ability to compel physicians to share information from their office electronic medical records (EMRs) with the provincial electronic health record. After a public consultation in which the AMA had a leadership role, the legislation is satisfactorily amended and endorsed by the AMA.

Amendments address major issues regarding privacy, confidentiality and use of a patient’s personal health information – such as masking of information and audit trails – and the role of the CPSA and other regulatory bodies in determining professional standards for the sharing of patient information.

In October 2009, in a submission to the Minister’s Advisory Committee on Health, the AMA proposes that Alberta should consider its own Alberta Health Act that “would lay out the objectives and program principles” for the province’s health care system. It could replace some existing legislation, and could include “the rights and responsibilities of patients” as well as “the responsibility and accountability of funders and managers to patients and society more broadly.”

- In 2001, ADIUM Insurance Services Inc. is established as a wholly owned insurance agency to administer the group insurance plans and individual insurance products for AMA members. AMA’s group products include: Disability, Office Overhead Expense, Life, Critical Illness, Accidental Death & Dismemberment and AMA Health Benefits Trust Fund.

- Throughout 2002-04, the AMA is vocal at several municipal smoking bylaw hearings in Calgary, Edmonton and St. Albert. The AMA has supported many other communities in their efforts to become smoke-free and has urged the provincial government to take legislative action on the issue of smoking.
And, given the doctor-patient relationship with physicians’ responsibility to be advocates for patients, legislation should include “recognition and protection of organized medicine and the unique role of physicians within the health care system.” The act eventually tabled by government in December 2010 reflected the consultation and included provisions for a health charter. The act has not yet been proclaimed.

- In October 2010, Alberta physicians vote to accept Canada’s first-ever provincial set of medical staff bylaws. The bylaws, negotiated by the AMA and Alberta Health Services (AHS), replaced nine individual sets of bylaws that formerly existed under the now-disbanded RHAs. These bylaws were also the first to enshrine the profession’s Code of Conduct and professional obligations as the primary driver of physician behavior in delivering services within AHS.

During the course of bylaw development, concerns are raised about physicians’ ability to speak out and advocate for patients and the health care system. In response, and to clarify physicians’ professional responsibility for patient advocacy (including speaking in the media), AMA president Dr. Christopher J. (Chip) Doig, CPSA Registrar Dr. Trevor Theman and then AHS president and CEO Stephen Duckett, PhD, issue a joint letter to Alberta physicians in June.

The letter assured physicians that all three parties supported physician advocacy for patients, opening with: “Patient advocacy is one of the most important ways in which health care can be improved. The Alberta Medical Association stands behind any physician who advocates on behalf of his or her patients. Similarly the CPSA and AHS also strongly support and encourage patient advocacy.”

Also in October, the AMA releases AMA Vision for Primary and Chronic Care, a discussion paper detailing a more robust primary care system predicated on the highly successful primary care networks established by the 2003-11 trilateral master agreement. The strategy called for improvements such as: improving patient access with more patient-centred, physician-led primary care teams, including nurses, pharmacists, social workers, psychologists, physician assistants, etc.; enhancing access by empowering patients to access physicians via telephone and the Internet; promoting better information, efficiency, safety and care with an EMR for every Albertan.

AMA’s first president – Dr. George A. Kennedy

Dr. George A. Kennedy was in the vanguard that brought full-time physicians to the prairies, built the hospitals, introduced medicine and surgery, and set the professional example to be followed.

He was born on April 16, 1858 in Dundas, Ontario. After attending medical school at the University of Toronto, Dr. Kennedy graduated in 1878. Before accepting a commission as a North-West Mounted Police (NWMP) surgeon, he was an intern for six months in Hamilton, Ontario.

His commission took him across Alberta, including Fort Walsh, Calgary and Fort Macleod. Dr. Kennedy’s practice stretched northward 150 miles from the American border to 150 miles from the Rocky Mountains, near the Saskatchewan border.

In 1887 he left the NWMP and went into general practice in Fort Macleod, where he stayed the rest of his life.

Dr. Kennedy brought the first pharmacist to Alberta, to Fort Macleod – John D. Higginbotham, who became the first president of the Alberta Pharmaceutical Society.

Immediately following an 1889 Canadian Medical Association (CMA) meeting in Banff, Alberta, Dr. Kennedy was elected president of the newly formed Northwest Territories Medical Association (NTMA).

The NTMA became the Alberta Medical Association in 1906, a year after Alberta and Saskatchewan became provinces.

We gratefully acknowledge Dr. J. Robert Lampard for this content from his outstanding volume, Alberta’s Medical History: “Young and Lusty, and Full of Life.”
Building the new AMA website

The card-sorting exercise is just one way to find out what AMA members need before building a new website.

Over the past year, we’ve carried out focus groups and surveys of AMA members to discover how our current website needs to change.

What do members want? Members would like a more modern-looking site with an easier way to find the information they need.

We’ve also found that they’d like to be able to fill in forms online, access an online AMA event calendar, comment on President’s Letters and other AMA publications, contact AMA leaders, and manage their AMA membership and other transactions online.

We should be able to provide many of the services when the new site launches; the target date is sometime in January 2012.

Joel McGovern, Director, Information Systems, AMA, and his team have been prioritizing which of these services we can provide and when.

Since joining the AMA in March as the website manager, I’ve met with staff from more than 20 AMA areas to discuss who uses their website content and why they use it.

We’ve also talked about ways to make the current content more accessible and useful to members and what new information members need.

The ultimate aim is to bring over only essential, useful information to the new website, so that we make it easier for members to access our services online and to participate and contribute to the association.

Watch for updates about the new website as planning continues.

Thanks, volunteers, for helping with the website card-sorting exercise. Left to right: AMA staff Dr. Richard G. Johnson, Consultant, and Cindy Trueman, Coordinator, Health Economics; Joanne J. Askewe, Administrative Assistant, Professional Affairs; Charlene G. Daniel, Meeting Coordinator & Administrative Assistant, Executive Office; Kathy Garnsworthy, Website Manager, Public Affairs; and Aisling Campbell, Observer, Board of Directors, AMA, and Medical Students’ Association Representative, University of Alberta Medical School. (© by Steve Fisher, Yellow Pencil.)
General Pediatrics Residency Program Director

The Department of Pediatrics, Stollery Children's Hospital, University of Alberta, is inviting applications for a half-time General Pediatrics Residency Program Director. The Department of Pediatrics has an expanding and innovative program which provides a comprehensive learning environment across the spectrum of general pediatrics as well as 13 pediatric subspecialties. This program is fully accredited by the Royal College of Physicians and Surgeons of Canada. This position is supported by a part-time Associate Program Director as well as the Department of Pediatrics' Executive Committee, including the Director of Pediatric Education, and reports to the Department Chair.

Duties for this position include:
- Providing detailed strategic direction and leadership to the Division of General Pediatrics' education mandates and functions, ensuring all policies, programs, and initiatives are consistent and supportive of the organization's mission, vision, and values, and acting as a role model through strong relationships and visibility, and through effective communication (with annual review)
- Chairing the Pediatric Residency Training Committee, including developing an overall education plan of the program with annual review, developing goals, and objectives for the program including each of its rotations, recruitment of new trainees into the program in accordance with Faculty policies and procedures, and ensuring appropriate evaluation procedures, methodologies, and follow-up
- Participating fully in all activities of the Postgraduate Medical Education (PGME) Council, which includes the communication and implementation of decisions taken in relation to PGME at the University of Alberta, and bringing forward issues to the PGME Council
- Regularly reviewing and remaining aware of documents from the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) in relation to training requirements, accreditation, credentialing, etc.

The successful candidate will have demonstrated superior skills in education leadership and communication and possess clinical leadership skills and scholarly accomplishments in teaching. Interested applicants must hold an FRCP(C) in Pediatrics or a subspecialty of either general pediatrics or any pediatric subspeciality, and be eligible for licensure in Alberta.

Interested candidates are asked to submit an up-to-date curriculum vitae outlining their current clinical interests and educational leadership experience, as well as a complete teaching dossier.

The Department of Pediatrics is supported by a very competitive and generous Academic Alternate Relationship Plan (AARP).

Located in Edmonton, Alberta, Canada, the Faculty of Medicine & Dentistry, within the University of Alberta, is one of Canada's premier research intensive and health education institutions, and has been internationally recognized as one of the world's top 50 medical schools and as one of Canada's premier health education institutions. The University of Alberta is one of the top 100 teaching and research universities in the world, serving 37,000 students with more than 14,000 faculty and staff. Founded a century ago, the University has an annual budget in excess of $1.4 billion and attracts more than $500 million in external funding. The University of Alberta offers close to 400 undergraduate and graduate programs in 18 faculties. Edmonton, with a growing population of over one million, is the cosmopolitan capital of Alberta. With an abundance of services, beautiful river valleys, community activities, and attractive living accommodations, this energetic city has something for everyone. For more information, visit www.ualberta.ca and www.edmonton.ca.

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Closing Date: Will remain open until filled.

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Attn: Dr. Susan Gilmour
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The University of Alberta and Alberta Health Services 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 peoples.
Michal (Mike) S. Kalisiak, a Calgary dermatologist, an Alberta Medical Association (AMA) Representative Forum (RF) delegate and Canadian Medical Association’s Young Physician Leader for 2011, shares his concern about the lack of awareness of the risks associated with tanning beds.

At the last RF meeting, the AMA passed two resolutions concerning the use of tanning beds – one dealing with regulation of tanning facilities, including health warning requirements, and the other with banning access to tanning facilities by children and youth under 18.

Awareness of the risks associated with tanning beds, however, is regrettably not as widespread as that of other public health concerns. Tanning beds, also known as sunbeds, tanning booths or indoor tanning devices, are a major factor in the development of skin cancer.

In Alberta, tanning beds were used over the past year by 12.3% of the population, including 16.5% of those 18- to 24-years-old. In the US, nearly 28 million people frequent tanning salons, most of them light-skinned girls and women aged 16 to 29.

Tanning industry revenues have increased five-fold over the past two decades. Popularity of tanning beds has been increasing mainly due to aggressive marketing by the tanning industry but also because of the social desirability of a tanned appearance. In addition, indoor tanning has been promoted as a way of increasing levels of vitamin D.


Based on 19 different studies, the authors concluded that using tanning beds before the age of 35 increases the risk of malignant melanoma by 75%.

This review provided the impetus for IARC to raise the classification of UV-emitting tanning devices to Group 1 (“carcinogenic to humans”), similar to substances such as tobacco and arsenic. In 2009, WHO made an additional recommendation that tanning devices not be used by youth and children under 18.

At the same time, it is important to realize that malignant melanoma is the most common of all cancers for young adults 25- to 29-years-old, and the second most common form of cancer in the 15- to 29-years-old age group.

In the US over the past 30 years, the incidence of melanoma among white girls and women aged 15-39 years has more than doubled.

Multiple jurisdictions have introduced tanning industry controls. In Brazil, tanning bed and tanning service sales were banned outright in 2009. All Australia states have banned artificial tanning for teens.

Among European countries, Belgium, France, Germany, Great Britain, Portugal, Scotland and Spain now restrict tanning bed use for persons under 18. In France, strict regulations require personnel training and forbid any claims of health benefits of artificial tanning.

In the US, more than 35 states regulate the indoor tanning industry in some way. Eleven states ban the use of tanning devices by minors and 18 restrict access by requiring parental consent or accompaniment.

In addition, multiple initiatives are ongoing at the federal level. In fact, part of US President Barack Obama’s Health Care Reform bill included a 10% tax on tanning services, effective July 1, 2010.

In general, there is little regulation of the tanning industry in Canada. New Brunswick was the first province to regulate it with a ban of access to minors under 18 since 1992, although there are significant gaps in compliance.

More recently, the initiative led by Doctors Nova Scotia resulted in legislation banning the use of tanning beds for those under 19 in that province, in addition to other regulations. And, just this past January, the City of Victoria, BC, introduced a landmark bylaw to ban indoor tanning to those under the age of 18.

Several myths about tanning beds persist despite unequivocal evidence to the contrary.

• **Myth:** Tanning beds are a “natural” source of vitamin D.

  **Truth:** Vitamin D synthesis requires UVB radiation. Tanning beds emit mostly UVA radiation (to reduce burning), which does not produce vitamin D. So the increase in skin cancer risk due to UVA is much greater than any benefit of vitamin D production from the small amount of UVB present. Vitamin D can be more safely obtained by eating a healthy diet and by taking widely available oral supplements. In addition, the cost of supplements is significantly less than that of indoor tanning sessions. Moreover, tanning beds
- Often emit several times the amount of UVA radiation than one would obtain from the mid-day sun.

- **Myth:** A base tan from a tanning bed will provide good skin protection against sunburn.
  
  **Truth:** January is one peak time for indoor tanning, when many teens tan before spring break. A tan offers very limited protection from sunlight or burning and, at most, is equivalent to a sunscreen with SPF of just 2-4, which is not enough to provide any meaningful protection.

- **Myth:** Tanning beds are a safe way to acquire a tan.
  
  **Truth:** As stated above, tanning beds are associated with an increased risk of skin cancer and so are not safe. They are most likely even more dangerous than the sun, as many devices emit levels of radiation 10-15 times the intensity of the mid-day summer sun.

- **Myth:** Tanning will make you look better.
  
  **Truth:** UV exposure causes premature skin aging and, while initially the tan may look nice, with prolonged exposure tanning will lead to skin freckling, sun spots, telangiectasia, wrinkles and a leathery look.

- **Myth:** Tanning makes you look healthy.
  
  **Truth:** While tanning has been associated in some cultures with a “healthy” appearance, it is important to recognize that it is the skin’s attempt to protect itself from environmental stress caused by UV light. At the biochemical level, activation of the tanning process requires UV-induced DNA damage to activate the p53 protein that, in turn, activates the pathway leading to increased melanin production. In other words, tanned skin is damaged skin.

- **Myth:** Tanning beds are a good treatment for seasonal affective disorder (SAD).
  
  **Truth:** SAD treatment, in addition to other modalities, involves either bright-white light, various visible light wavelengths or blue light with a wavelength of about 460 nm – not UV light with wavelengths of 400 nm and below as found in tanning devices. While tanning-bed lamps may leak some blue light, the risks of tanning for this purpose clearly outweigh the benefits. In addition, purchasing a bright-light device will be less expensive than paying for tanning sessions.

For more information:

- Canadian Dermatology Association’s *Indoor Tanning is Out* Campaign: [www.dermatology.ca/indoortanning/index.html](http://www.dermatology.ca/indoortanning/index.html)
- American Academy of Dermatology supports an outright ban on production and sale of tanning equipment for non-medicinal purposes. However, until that can be achieved it supports multiple state and federal initiatives to limit access to tanning beds: [www.aad.org/skin-care-and-safety/skin-cancer-prevention/indoor-tanning](http://www.aad.org/skin-care-and-safety/skin-cancer-prevention/indoor-tanning)
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Custodian vs Affiliate
Many more questions than answers

Jonathan P. Rossall, QC, LLM
PARTNER, MCLENNAN ROSS LLP

Alberta’s Health Information Act1 (HIA) is not really about “health information” at all. OK, maybe a little.

But largely, the HIA focuses more on the concepts of collection, use and disclosure and, more importantly, who can perform these actions.

The individuals/bodies performing these actions are characterized as either “custodians” of health information or “affiliates” of those custodians.

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So, in reality, the HIA is really about the custody of health information.

One would think a piece of legislation that focuses on the duties and responsibilities of custodians or affiliates of custodians would define those terms. So another controversial statement – the HIA does not define what a “custodian” or an “affiliate” is.

Oh, it certainly tells you who a custodian is2 by listing such entities at length (including “health service providers designated in the regulations as a custodian”).

From that list, presumably, one is supposed to glean what characteristics a custodian should have.

The HIA also tells you what sorts of relationships lead to the characterization of “affiliate” without actually telling you what an affiliate is.

But nowhere in the HIA is there a precise definition indicating what a custodian is or what characteristics or attributes make one a custodian.

Compounding the problem, neither our courts nor the Office of the Information and Privacy Commissioner appear to have judicially considered this critical point.

Yet, it is a pressing issue given the rapid changes in the means by which health information is being collected, stored, used and disclosed.

The rules of engagement place all the responsibility for these actions on the shoulders of the custodians of the information, yet do not precisely tell us who they are, leaving us with more questions than answers.

Where this becomes especially contentious is a situation seen more and more frequently where a corporate custodian, such as Alberta Health Services (AHS) or Alberta Health and Wellness, takes the position that employed or contracted health care providers are – “by definition” – affiliates solely as a result of the contractual relationship, without regard to the actual circumstances surrounding the collection, use or disclosure of the health information.

The result is that a physician, in that circumstance, is required to abdicate his or her “custodial” status and the responsibilities and duties that go with that status.

This is a risky proposition for the physician if, in fact, the stamping of affiliate status turns out to be wrong, and the physician has lost control of the patient’s health information.

Section 1(3) of the HIA states that “…a custodian who is an affiliate of another custodian is deemed not to be a custodian while acting in the capacity of an affiliate.” That last phrase, it is submitted, may be the key to assessing the distinction between custodial and affiliate status.

In determining whether a health service provider is a custodian or an affiliate, one must look at the capacity the individual is acting in, not just the legal relationship between the custodian and the affiliate.
Why is this important? Because under the HIA, custodians have very significant duties and responsibilities vis-à-vis health information.

Those responsibilities are founded in the physician-patient relationship and concurrent duties of confidentiality. They include a duty to protect and ensure the accuracy of the health information.

It is axiomatic that it is difficult to fulfill those duties and obligations if you do not have custody of the information because you have been relegated to the role of affiliate.

It would make sense, then, to examine the nature of the relationship between the health care provider and the patient, in order to ascertain whether the provider is acting as a custodian or is acting as an affiliate of another custodian.

In that regard, it might be helpful to look outside the four corners of the HIA.

The *Oxford Dictionary* defines custodian as “a person who has responsibility for or looks after something.”

This is of some assistance, as clearly in the context of the HIA the custodian has defined duties and responsibilities relative to health information (which is the “something” that the custodian is looking after).

The same dictionary defines “custody” as “the protective care or guardianship of someone or something,” thus injecting the notions of “protection” or “guardianship” into the mix.

From this we can infer that a custodian under the HIA must be acting in a protective role, and must have responsibility for the integrity and accuracy of health information.

So, in the context of a patient’s visit to an acute care facility, who is the custodian of the health information?

The patient is seen by a physician or other health care provider who is an employee/contractor of the facility owner.

The actual data is stored in the facility’s server/database, so arguably the facility owner is responsible for the integrity and security.

But arguably, the physician who actually provides the care is responsible for the accuracy of the health information and is more than just an affiliate.

Can they both be custodians? Is there such a thing as “joint custody”?

In an ambulatory-care environment, the patient may be coming to see a particular caregiver.

In that instance, the caregiver must be responsible for the integrity, accuracy and security of the health information generated as a result of the encounter.

But what if the ambulatory care facility is owned by AHS? Does it have responsibility as well? Is custodial status a “now-and-forever” thing?

Can a physician be a custodian during the encounter but when finalized information is downloaded to the electronic medical record, does the status of custodian transfer to the party managing the record?

And what if that party happens to be AHS? Can it enjoy dual status (i.e., that of information manager and custodian)? If so, what are the rules that differentiate between the two?

These are all questions without clear answers for now.

Clear answers are essential, however, as patients’ health information becomes more and more exposed to collection, use and disclosure.

In the interim, physicians are well advised to take the high road and assume that their responsibility, their guardianship or their custodial role (if you will), relative to their patients’ health information, continues notwithstanding the nature of their relationship with other custodians.

Physicians are well advised to take the high road and assume that their responsibility, their guardianship or their custodial role (if you will), relative to their patients’ health information, continues notwithstanding the nature of their relationship with other custodians.

References
1. Revised Statutes of Alberta 2000, c. H-5 (HIA) and amendments thereto.
2. Health Information Act, s. 10(1)(f).
3. Health Information Act, ss. 60 and 61.
4. The Privacy Commissioner says yes to this one. ■
Dr. Sayeh Zielke

granted TD Insurance Meloche Monnex/AMA Scholarship

On May 31, Dr. Sayeh Zielke was granted the $5,000 TD Insurance Meloche Monnex/Alberta Medical Association Scholarship to further her clinical training in echocardiography and Adult Congenital Heart Disease (ACHD), an area of training of increasing demand in Alberta.

This is the 21st year the scholarship has been awarded.

As her scholarship application references indicated, Dr. Zielke’s tremendous sense of responsibility to patients and colleagues, her kindness and compassion, excellent clinical skills, leadership abilities and organizational skills make her a very worthy candidate for the scholarship.

Dr. Zielke completed her internal medicine residency in Calgary, as well as a cardiology fellowship.

In July she began a prestigious 18-month fellowship in echocardiography and ACHD at the University of Oxford (Oxford, UK) and Royal Brompton Hospital (London, UK). Training possibilities, especially in Canada, are limited.

Royal Brompton Hospital is a highly specialized centre in ACHD with a large patient volume, great expertise and advanced technology.

The training program at Oxford will allow for solid formal training, as well as exposure to new technology such as three-dimensional echocardiography. Dr. Zielke’s training will include both clinical and research components.

In 2010, Dr. Michael W. Aucoin, of Calgary, received the scholarship to gain additional education in medical practice within areas of health or resource inequity and experience in a holistic approach to the world.

Visit the AMA website (www.albertadoctors.org/AwardsScholarships/MonnexAMA) to view the list of other recipients who have also been recognized for their tremendous work.

How can you apply for the scholarship?

Scholarship applicants must meet the following eligibility criteria:

• Be an AMA member.
• The proposed program should 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, in an established practice, wishes supplemental training.
• Be enrolled and accepted in a clinical program at least three months in length at a recognized educational facility.

Priority will be given to a physician seeking additional training in a clinical area of recognized need in Alberta.

For more information, email Ava L. Butterworth, Administrative Assistant, Public Affairs, AMA (ava.butterworth@albertadoctors.org).
Client experience has always been at the heart of TD Insurance’s strategy. In addition to providing assistance in times of need, TD Insurance owes its clients the right protection at the right price. Accordingly, the company strives to give customers the kind of outstanding experience that stays with them beyond the initial contact.

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More than just a measure, CEI is first and foremost a journey.

To raise the bar and turn clients into promoters, we conducted market research to identify and prioritize attributes of the experience clients truly value when it comes to client service or claims services.

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Finally, the CEI leaves room for constant improvement so everyone at TD Insurance can look for new ways to exceed customer expectations.

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Feedback — The give and take

Many of us are afraid of feedback — both to give and to take (receive) — often because we lack the skills.

Providing regular, good quality feedback is one of the most important ingredients in effective and productive relationships. Feedback is structured information someone provides another person about the impact of his or her actions or behavior.

When done in the right way and with the right intentions, giving and receiving feedback can be a path for growth.

Make feedback a two-way conversation, not a speech.

Giving feedback

Giving good feedback is a skill that takes practice.

Note the following guidelines and tips. The same principles apply whether feedback is being delivered from a manager/supervisor to an employee, from employee to supervisor or laterally with colleagues.

1. Prepare. Remind yourself that the purpose of feedback is to improve the situation or performance. You’ll often get much more from the conversation when feedback is improvement-oriented rather than harsh or offensive.

2. As you prepare, self-reflect. Asking yourself, “What have I done to contribute to this person’s success or lack of success?” can yield important insights. Acknowledging these areas and deciding what you, yourself, can change can be a very effective part of the feedback conversation.

3. Establish a safe place to talk where you won’t be interrupted or overheard.

4. Whenever possible, ask permission. “I’d like to give you feedback about... Is that OK with you?”

5. Effective feedback focuses on a specific behavior the person can do something about, rather than on personality. Be as specific as possible by being descriptive. For example, “The report you wrote was articulate, well written and concise. The effort you put into it was evident.” (Instead of saying, “Good report.”)

Or, “It’s frustrating for me when we lose valuable time. If you arrive late, we can’t discuss everything we had hoped to. It’s important we spend focused time on this as the team is relying on us for a good decision.” (Instead of saying, “You were late for the meeting.”)

6. Provide feedback in a timely manner so it is tied as closely as possible to the behavior. An exception is a highly emotional situation, in which case it’s a good idea to wait until things are calm.

7. Effective feedback stays away from “why.” Asking why is asking about a person’s motivation, which often causes people to get defensive.

8. Make feedback a two-way conversation, not a speech. Use pauses. Give the person time and space to think.

9. Don’t exaggerate and avoid using words like “never” and “always.” Use “I” statements to ensure you stay focused on your perspective. Say, “I was frustrated when you were late for the meeting.” (Rather than, “You are always late.”)

10. Ask the person for his or her perspective. For example, “What is your reaction to this?” Or,
Effectively receiving feedback is also a learned skill.

14. Catch the person doing well. Follow up on your conversations; observe and recognize changed behavior. Recognition is a powerful motivator.

Taking (receiving) feedback

Effectively receiving feedback is also a learned skill. We often have an urge to rationalize and take feedback quite personally. Getting skilled at receiving feedback can be a key factor in your own learning and growth.

Some tips:

1. Regularly encourage people to give you feedback. For example, “What did you think about the way I chaired the meeting?” Be specific and give people time to think about what they want to say.

2. Listen openly and don’t interrupt. This is an opportunity to learn about yourself and how your actions affect others.

3. Ask for clarification if you’re not sure you understand.

4. Try not to be defensive, to justify or reject the information. You don’t have to agree, but it’s important to hear the other person.

5. Remain objective and calm. Give your reaction or ask for time to think about it. Ask for suggestions.

6. Reflect on the information received and check with other people if you’re not sure about the validity of the feedback received. Take time to evaluate and decide how you are going to apply it.

The more practice you get at the give-and-take of feedback, the better you will become at it, and it will inevitably become a most useful tool for a more productive and harmonious workplace.

Good luck!

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

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With your support, AMF can promote the history of medicine

Dawna Gilchrist, MD, FRCPC, FCCMG
PRESIDENT, ALBERTA MEDICAL FOUNDATION

“History is the witness that testifies to the passing of time; it illumines reality, vitalizes memory, provides guidance in daily life and brings us tidings of antiquity.” – Cicero

On behalf of the Alberta Medical Foundation (AMF), thank you Alberta Medical Association (AMA) members for your generosity and support.

The AMF is grateful to the members of the AMA who make these activities possible through their generosity and support.

The AMF, an organization within the AMA, is dedicated to promoting the history of medicine within Alberta.

Last year, we solicited donations from the AMA membership during the association’s membership renewal period. More than 140 individual members made donations to the AMF totalling over $12,000.

Those generous donations will allow us to continue to provide support for activities across the province to promote the history of medicine.

For many years, we have financially supported History of Medicine courses and conferences for medical students at the University of Alberta (U of A) and the University of Calgary. We are very pleased to be able to continue to support them, especially as other venues for student presentations in this subject have been lost.

This year, we also supported medical student and resident participation in the International Society for History of Neurosciences/International Society for the History of Behavioral Social Sciences meeting, in Banff, in June.

These courses and conferences allowed medical students to research and present topics in the history of medicine, as well as attend seminars presented by noted medical historians.

AMA members may have heard some of the presentations through the Margaret Hutton Lecture Series, presented by medical students at the AMA annual general meetings.

In addition to supporting courses and conferences, we have been able to donate medical history books (previously kept at Alberta House, which were largely unavailable for research or reading) to the Rawlinson Rare Book Collection at the U of A.

We hope to be able to continue to distribute books and historical artifacts to appropriate archives across the province to keep these items preserved and available for future readers and researchers in the history of medicine.

Once again, the AMF is grateful to the members of the AMA who make these activities possible through their generosity and support. We hope members will consider supporting these projects again this year.

Tax-deductable donations to the Alberta Medical Foundation may be made with the renewal of AMA dues again this year. Please consider adding a donation to your dues to support the history of medicine in Alberta.
Stigma is a problem for physicians within the house of medicine. And stigma is a problem for the patients we serve.

It refers to beliefs and attitudes towards mental health and mental illnesses that lead to negative stereotyping of people and prejudices against them and their families.

Discrimination, or enacted stigma, refers to the various ways in which people, organizations and institutions unfairly treat people living with mental health problems or illnesses, often based on acceptance of these stereotypical and prejudicial beliefs and attitudes.

Alberta physicians who access Physician and Family Support Program (PFSP) services address, manage and cope with the stigma of mental health issues every day.

Roughly one third of calls to PFSP in 2010 were related to mental health, psychiatric disorders and addictive disorders; another third related to family and relationship issues.

These callers recognize the value personally and professionally in receiving confidential, appropriate care. These physicians realize the value of early intervention, treatment, recovery and renewed engagement with their lives.

They appreciate there is a difference between illness and occupational impairment. Generally, most callers continue to work while receiving assistance. Some take the time required to improve their individual health issue and take a medical leave-of-absence from work.

They all appreciate the mantra: Healthier physicians, healthier patients.

Potentially, this has enormous value to patients struggling with similar health issues – to appreciate that physicians are human, too, and that physicians have improved knowledge and attitudes regarding mental illness and are aware of discriminatory behavior towards those with mental illness.

Perhaps we could work together and address negative media regarding mental illness.
The negative media portrayal of those with mental illness as violent or threatening to others, as less competent or trustworthy, or in an unsympathetic manner is markedly inaccurate. And it contributes to stigma and discrimination.

Dr. Heather Stuart, a prominent Canadian researcher on stigma and mental illness and a consultant to the Mental Health Commission of Canada (MHCC), adds that negative media is profoundly distressing to people with mental illness and to their families, and has social repercussions.

We need to continue to model proactive approaches to our health.

For example, many individuals will not tell their employers about their illnesses or disorders lest their trustworthiness, predictability or competence be questioned.

Mental illnesses sometimes are concealable. Sometimes those with depression, for example, successfully conceal symptoms to avoid what they perceive would be negative responses and consequences.

In Barney et al’s 2009 qualitative study regarding the nature of stigmatizing beliefs and seeking help, some respondents agreed that depression was not apparent to others so it did not attract stigma.

However, the downside is that recognition and treatment are hampered or does not happen at all. Respondents faced considerable fears of stigmatizing responses, in anticipation and in actuality. They had greater reservations regarding work colleagues.

This study reflected the general population, yet is relevant to the concerns of physicians when ill.

It also speaks to a concerning fact of medical culture. We do not always recognize when a colleague requires support.

While it has been said in the past, “work is the last to go,” it behooves us to become more knowledgeable regarding symptoms or signs of mental illness or addiction. We need to continue to model proactive approaches to our health for ourselves and our colleagues.

As professionals, we must never wait until work begins to be impacted before we seek assistance. And we must never wait to support a colleague in getting assistance.

How do physicians become champions? Will some or many of us contribute to the “living library” of those with experiences of ill mental health or addiction, to share our own stories whether with colleagues or the public?

This is one of the most effective and key strategies to address stigma-discrimination – direct contact with someone who has been a patient or a consumer.

Jean E. Wallace, author of Mental health and stigma in the medical profession, shares the story of a physician who had been treated for bipolar disorder for 30 years: “That only by making the mental illness personal, by connecting the illness with someone we know, will the power of stigma in the medical profession be weakened.”

The distances between colleagues need to be reduced. It is important, as health care providers, that we are aware of the impact of stigma in our workplaces, for ourselves and for our patients.

I suspect most of us have some awareness when stigma-discrimination occurs in our workplaces. Do we sometimes play a part in this? How often do we do the right thing and address a stigmatizing comment or behavior in the moment?

A 2008 survey targeting psychiatrists, by the Canadian Psychiatric Association (CPA) Working Group on Stigma, includes a multi-part question with the root:

“Do you have a personal story or experience with stigma and/or discrimination towards a patient with mental illness?”

• 79% responded in the affirmative.

All physicians must be aware of “diagnostic overshadowing,” a term utilized in stigma-research literature and by the MHCC.

That is, patients with issues of mental health and addiction should not be “diagnostically overshadowed” and receive lesser health care services than those without a mental illness diagnosis.

The literature and affected patients are clear that this happens in all services and branches of medicine.

All health care providers must change and confront vernacular and stigmatizing language use when describing patients with mental health and addiction issues.

Otherwise, it not only adversely impacts the patient, it perpetuates stigma. It may adversely impact the physician or other health care team members who may have similar conditions.

Notably, one of the priority action items arising from the 2008 CPA survey was that:
• Stigma and discrimination towards people in the emergency room must be addressed.
• 89% of respondents strongly agreed or agreed with that priority.7

Psychiatry and mental health services have tolerated multiple “structural inequities” in our health care system, likely contributing to illness-treatment gaps.

Is this, in part, because mental health professionals and psychiatrists are also stigmatized by our colleagues? Is this, in part, because mental health professionals we have contributed to the stigmatization of our patients and their families?

The call to action is clear. And so the stigma issue circles back to us and our culture of medicine. Is stigma alive in our culture of medicine and what is the cost?

Do we model and mentor self-care? Do we recognize the barriers to physicians, at all career stages, to becoming proactive about their health? Are we less knowledgeable than we could be?

What are our attitudes toward colleagues or trainees with mental illness or addiction?

Is there a practice of “career-prospect overshadowing”? That is, are some careers limited because of knowledge of personal health issues? Is this based on diagnosis, rather than occupational impairment?

What are the expectations and responses of systems and organizations towards physicians suffering from mental health issues, including addiction?

PFSP case-coordination service experience continues to be positive as we work with physicians and organizations (whether a clinic, health authority, a department or university) in assisting physicians to successfully return to work following an illness episode.

Is stigma alive in our culture of medicine and what is the cost?

While we recognize this is a relatively small group of physicians, trainees and workplaces, our aim is that there is generalization of positive knowledge, attitude and behavior in all medical workplaces. We hope patients benefit, in turn.

The mental health of physicians is a national matter. Over the last year, the Canadian Medical Association (CMA) prepared and published Physician Health Matters: A mental health strategy for physicians in Canada8 (available at cma.ca).

The report identified four strategic directions.

1. Increase knowledge and skills regarding physician mental health issues.
2. Improve access to a range of mental health services and programs for physicians.
3. Create learning and work environments that support the mental health of physicians.
4. Monitor, evaluate and research physician mental health needs, services and policies.

Additionally, a 2010 CMA and strategic collaborators workshop, Ending stigma and achieving parity in mental health: A physician perspective,9 reinforced our professional engagement in addressing stigma and discrimination as an imperative.

These reports remind us that Alberta physicians, the Alberta Medical Association and PFSP are on the right track with regard to our mission, vision and processes for physician health and, yet, there are many miles more to travel.

Whether we are medical or surgical specialists, family physicians or psychiatrists, we have a professional responsibility to all of our patients, not only to get our house of medicine in order but to address stigma wherever we find it.

This would be true influence and leadership in medicine.

References
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Jonathan Chevreau, Financial Times columnist & author of "The Unemployed City"

To purchase the updated version of Professional Corporations: The Secret to Success, please call our toll free number 1-888-315-0058 or visit our website at http://www.tpcfinancial.com
Is your computer secure?

Personal computers are frequently attacked by unwanted software (malware), such as viruses, worms, spyware and Trojan Horses, that try to load themselves onto your computer without your permission.

The best defense is to practise safe computing and ensure your security software is up-to-date.

Safe email practices

User carelessness makes it difficult for even the best security software to function effectively. Most of us have learned to ignore email messages from banks we’ve never used and from African princes wanting to share their money with us.

But malware can also be hidden in messages that seem to come from friends or relatives, particularly those who use free email systems such as Yahoo or Hotmail.

Safe Internet browsing

Most browsing programs now offer limited protection by blocking some pop-up windows.

But some websites seem to have developed ways to display them anyway. If this happens, do not click on anything inside the unwanted window.

Try to remove it by clicking the browser’s Back control or clicking on the X in the upper right of the window. If that fails, you may have to shut down your browser.

Is your security software up-to-date?

Until this month, I had been using the McAfee anti-virus program and had it set to update automatically. A recent article in Consumer Reports gave it a very low rating, so I checked to see if my version was updated.

To my surprise, it was an older version that was 13 months out-of-date and had not given me any warning that my computer was at risk. Take a lesson from that and check your own security software to make sure it is up-to-date.

Get professional help

I was lucky to get assistance from the university’s Information Technology (IT) department. With my permission, they were able to take over my computer remotely and install new anti-viral software and several tools that would scan my computer and repair any existing problems.

The IT department in your local health region may be able to provide similar support.

Spybot


Spybot is a free tool the IT technician recommended to check my computer for malware. It detected and removed a number of unwanted and out-dated items.

CCleaner

www.piriform.com/ccleaner

CCleaner is another recommended free tool that can check and clean up system files, data files and Internet-related files.

It can also check and repair your main Registry file that may be cluttered with bits left over from programs used in the past but have now been deleted. In my case, it found more than 800 items that could be deleted from the registry.

Microsoft security essentials


The IT technician recommended this free security program from Microsoft, but my computer refuses to install it. This may be because I still have some undetected malware program blocking it or there is a conflict with other security software.

I’ve since read reviews that suggest it is not as effective as other
free programs in detecting and removing threats. It was not even mentioned in the Consumer Reports article.

**Microsoft Safety Scanner**


Microsoft has recently provided this tool. It scanned every file on my computer for threats. The full scan took more than three hours, but it detected several Trojan horse threats.

**AVG anti-virus**

free.avg.com/ca-en/homepage

After my computer refused to load the Microsoft program, I installed the free version of the AVG anti-virus software. I selected it because it had been highly rated in a recent Consumer Reports article and a friend has been happy with the commercial version.

**Avira**

www.avira.com/en/avira-free-antivirus

Avira is another free anti-viral program that Consumer Reports scored slightly higher than AVG. I have not tried it.

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The bottom line

After you finish reading this article, why not go to your own computer and check that your security software has been updated recently.

Your comments and suggestions are welcome. Please contact me: barrie.mccombs@rpap.ab.ca
T 403.289.4227

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Pseud’s Nook

The ludicrous attempt to bamboozle the population into thinking Alberta Health Services (AHS) Inc. is a corporation saving billions of dollars, rather than a proliferating government bureaucracy, continues with renewed vigor despite the departure of Dr. Stephen “Cookie” Duckett.

Word is that Dr. D will be a fixture in Alberta for a lot longer, having bought a house in an exclusive area of Edmonton with his dismissal loot. From the beauty of the river valley, he will be able to lob cookies, muffins and assorted revelations at his former employers – the latest bun chuck being the shock and horror that some phone calls may have been made so that a Super Elite toff living somewhere like Saskatchewan Dr might have been seen in clinic a day or two earlier than Joe the Plumber.

With the stroke of a pen, Dr. D outlawed this dark practice.

In 36 years working in Alberta, I’m ashamed to say I have never actually had the honor of being contacted by an MLA, MP or VIP for an upgrade in service.

The corporate branding baloney does, however, provide a nifty sleight-of-hand maneuver to justify an upgrade in salaries, and buttresses the silly notion that if a bloated salary is not paid, these corporate titans will go elsewhere.

Some chance. Where else can you be a titan with no chance of your company going bankrupt? And where else can you be responsible only for emails and committee meetings and for nothing real?

Alberta used to be a plain-speaking kind of place. No longer. The muff and flummery of the corporate world derived from third-rate business schools and leadership courses has infested Wildrose country.

Perhaps we need some blowback. Private Eye, the British satirical magazine, has run a column for 30 years called “Pseud’s Corner.” Here, readers send in examples of unctuous and grovelling flim-flam for public fun and exposure.

As a disciple of my friend, Lord Gnome (editor of Private Eye), I hereby announce the opening of a new Digest pseudo-column: “Pseud’s Nook.”

If Lord Gnome objects to the similarity of name and initiatives litigation, I will retaliate and – as one reader of Aberdeen’s The Press and Journal is said to have done – respond by ceasing to borrow any more Private Eye magazines from Gwyn, who kindly passes them on to me.

For the opening quotation of “Pseud’s Nook,” I’ve chosen one from a recent AHS email from somebody entitled executive vice president of strategy and performance: “Alberta Health Services is, in and of itself, an innovation.”

I made a mistake (in and of itself) the other day by complying with an appeal to provide feedback on the exciting concepts behind two new AHS “values.”

These brilliant new values may make it to being add-on values to the original core values of transparency, engagement, respect and accountability and may even become core values in and of themselves.

Winnie the Pooh’s nervous friend, Piglet, cannot have quivered more with anticipation at the opportunity of feedback than I did.

Clicking on the inviting blue letters “values,” I was swiped into a special questionnaire. What were the issues I was to be quizzed on?

The first question was about whether the original four core values, in and of themselves, would lead to AHS being a values-led brand. I didn’t know.

The second question was, “Do you agree the term ‘learning’ should be used to describe one of our core values?” I was given choices of “strongly agree” to “strongly disagree.”
It is clear that advertisements for doctors must improve.

And here is the advertisement for what is called executive vice president, people and partners. Ah-ha!

“Your leadership will set the tone as the organization sets benchmarks for the delivery of care. . . . You will become the Chief Listening Officer and promoter of cooperation at AHS. . . .” (Don’t worry, the Spy Shop in Calgary sells anti-bugging devices for your office and phones. – Assoc. Ed.)

“Be the Keeper and Ambassador of the AHS brand with the people of Alberta. . . .” (The Keeper of the Brand, a noble and ancient hereditary post. – Assoc. Ed.)

“Your ‘anything is possible when you work together’ attitude has helped you to become a difference-maker through massive organizational change. . . . Your ability to sell the vision, lead transformative change and make it come alive operationally will determine the future of AHS.” (Not good doctors, nurses? – Assoc. Ed.)

The danger, of course, is that the people who fill these jobs are likely to think they are god-like beings – Sai Baba’s of the AHS – producing nuggets of gold from various orifices to those sitting around committee tables.

Examples of this kind of eyewash have become so common that I ask again, what has become of the old Alberta value of plain speech?

Perhaps it’s the fault of the headhunters, a group of people making buckets of cash doing what we used to do ourselves, using the telephone and a simple advertisement. It is clear that advertisements for doctors must improve.

Here’s a suggestion to advertise for a general practitioner in Alberta: “ Widely recognized as a questioning, skeptical individual who resists silly change-for-change sake, you have average but extremely peccable qualifications with a personality that can withstand interference in your day-to-day activities by people with little knowledge but plenty of chutzpah and self-esteem, who offer free advice and emails outlining strangely obvious values.

“Yours will be a beginning-to-end involvement in patient care, teaching and administration with no fixed hours. In fact, it will be endless until you drop. You are responsible for all failures.

“You are an ideas person and any good new ideas must be cheerfully submitted to the relevant executive vice-president, who will establish a working group to develop it. There is no end to this contract.”

And to finish, a couple of pieces of non-AHS material that I’ve enjoyed and which are the sort of stuff eligible for “Pseud’s Nook”: “It’s a joy that will spill over into the months and years to come, as the people welcome their modern-day prince and princess into their lives.

“The wedding is just the beginning – but they’re off to a wonderful start. And as William and Katherine drove away into the sunset in a

(Ah – those two new core values: Learning and performance. I see now. – Assoc. Ed.)

It blathers on: “A generalist leader with impeccable credentials in the transformation of a complex organization, you have turned visions into realities through enterprise-wide thinking and operational improvement. Your mandate here will be huge. . . .” (As will your income. – Assoc. Ed.)
vintage Aston Martin Volante DB 6 Mk11, 325-HP convertible later that day, it’s evident this is a love story not even Hollywood could have made better.” (Suzanne Moutis in “The Wedding of the Century,” Special Collector’s Edition, April 29, 2011.)

And from the Calgary Schools system, a Calgary Board of Education special: “Intelligent Accountability: The failure to get accountability right plagues all reform efforts. Andy Hargreaves unlocked the door to intelligent accountability when he observed that, ‘. . . accountability is the remainder that is left when . . . responsibility has been subtracted.’

“Intelligent accountability involves a set of policies and practices that: Actually increases individual and especially collective, capacity so that shared responsibility carries most of the weight of effective accountability; makes internal and external accountability almost seamless; leaves external accountability to do its remaining, more manageable task of necessary intervention.” (Michael Fullan, “The Big Ideas Behind Whole System Reform.”)

I expect to be intimidated for this month’s column and to appear in front of a Royal Commission. Please send in examples from emails and the media of bafflegab, mush-talk and gibberish to “Pseud’s Nook.”

Oh, Dr. Eagle – perhaps another AHS value that might be considered? Plain talk.

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Contact: Ann
T 403.948.4168
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annvdventer@gmail.com

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C-era (cardiometabolic evaluation and risk assessment) in Calgary is seeking a part- or full-time general internist to join our team of six general internal medicine specialists, two cardiologists, one endocrinologist and one emergency physician. Our mandate is rapid assessment and identification of atherosclerosis and aggressive management of risk factors for heart disease and stroke. Getting referrals from all emergency room departments and over 800 referring general practitioners, C-era sees approximately 600 new patients each month. Our services include: consultations, exercise stress testing, 24-hour holter, blood pressure monitoring and nuclear stress testing.

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Contact: Dr. Alykhan Nanji
Medical Director,
C-era Medical Clinic

CALGARY AB

Med+Stop Medical Clinics Ltd. has immediate openings for part-time physicians in our four Calgary locations. Our family practice medical centres offer pleasant working conditions in well-equipped modern facilities, high income, low overhead, no investment, no administrative burdens and a quality of lifestyle not available in most medical practices.

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

CALGARY AB

Medical Express, new state-of-the-art clinic in downtown Calgary, is looking for physicians to join our team. We have high support-staffing levels on site, including registered nurses and pharmacists. Attractive overhead and great medical team. If you are interested in receiving more information, please call.

Contact: Aamir Chaudhary
T 403.930.1007
aamir.chaudhary@medicalexpress.ca

CALGARY AB

Celebrating more than 30 years of excellence in serving physicians, MCI Medical Clinics (Alberta) Inc. provides quality practice support in nine locations throughout the city.

Contact: Margaret Gillies
TF 1.866.624.8222, ext. 433
practice@mcimed.com
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CALGARY AB

Newly built computerized medical clinic in southwest Calgary, in the thriving and growing Springbank Hill community, has space available for family physicians or specialists. Walk-in shifts available for various days/evenings/weekends. Rexall pharmacy is near the clinic.

The clinic is an active member of the Calgary West Central Primary Care Network and has a full-time chronic disease management nurse and part-time pharmacist. The clinic also has specialists including a pediatrician, two gynecologists and an addiction specialist.

Contact: Dr. Ronald Lim
ronlim1@shaw.ca or
Monica
T 403.240.2221
C 403.703.8707

CALGARY AB

ViVe Medical has openings for physicians interested in joining our new modern clinic in one of southwest Calgary’s most desirable neighborhoods, West Springs. Our clinic has plenty to offer – friendly staff, fully implemented electronic medical records (Wolf Medical Systems), 10 examination rooms, advertising, plenty of parking and an obstetrician on site. We are looking for part- or full-time family or walk-in doctors with practice or willing to

or human resource burdens. MCI Medical Clinics (Alberta) Inc. provides quality practice support in nine locations throughout the city.
accept new patients. For this great opportunity to establish or grow your practice, please contact us.

Contact: Jolie  
T 403.217.6453, ext. 8  
joliehirsch@yahoo.ca or  
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denniscwleung@gmail.com

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C 403.880.2040  
sdada@wellpointhealth.ca or  
C 403.680.8885  
jlewis@wellpointhealth.ca  
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Partnership opportunity available. Silent business partner/developer seeking doctor(s) for a new medical walk-in clinic. We will provide all leasehold improvements and there are no lease payments. Turn-key operation in exchange for negotiated percentage of revenue. Easy access to new building in prime location. Surface and underground parking. We have new condos in the same complex – accommodations can be negotiated in the package.

Contact: Gurmeet Sidhu  
C 780.264.1200  
mtnviewinn@gmail.com

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T 780.476.0744  
tombray@telusplanet.net

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The Glenrose Rehabilitation Hospital is looking for a physician interested in geriatrics to provide ongoing medical care for six inpatient beds being followed by an interdisciplinary team. Hours are flexible. Remuneration is competitive and on a per-hourly basis through a clinical alternate relationship plan. After-hours in-hospital coverage is provided.

The ideal candidate is a member of the Canadian College of Family Physicians. Certificate in care of the elderly and/or clinical experience working with older adults would be considered an asset.

If you are interested in pursuing geriatrics in a friendly, supportive interdisciplinary environment or have any questions, please contact us.

Contact: Dr. Hubert Kammerer  
T 780.920.4773  
hkamm@yahoo.com or  
Dr. Elisa Mori-Torres  
elisa.mori-torres@albertahealthservices.ca  
T 780.910.2509

EDMONTON AB

New medical centre in Edmonton is seeking part- and full-time physicians to set up practice. Centre will start with clinics and pharmacy. Rent and utilities are free and no income split.

Contact:  
T 780.884.4304  
carenesscenter@hotmail.com

EDMONTON AB

Congenial, west-end, small-group family practice clinic is looking for another physician to join, starting part time and working to full time in the next two years. Clinic is well organized, using Wolf Medical Systems electronic medical records and affiliated with Edmonton West Primary Care Network. Laboratory and X-ray facilities on site.

Contact:  
Dr. Gloria Mok or  
Dr. Deborah Rowand  
T 780.486.3515  
gloriamok1@gmail.com

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Part- or full-time family physicians required to join a well-established, busy family practice in west Edmonton. X-ray, laboratory, ultrasound, mammogram, MRI/CT, stress test, MIBI, holter recording and pharmacy on site. Excellent environment, state-of-the-art clinic with professional staff. Reasonable overhead.

Contact:  
T 780.483.1777  
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EDSON AB

Excellent location, close to Edmonton and Jasper. Seeking a family physician to share workload in established rural practice. There are 12 doctors in the clinic. Town population is 10,000. ➤
EDMONTON AB

Alberta Health Services (AHS) is inviting applications for five full-time family physician positions at the East Edmonton Health Centre. This is a combined clinical practice and teaching environment and successful candidates will be encouraged to hold clinical academic colleague appointments in the Department of Family Medicine at the University of Alberta, Faculty of Medicine and Dentistry.

These positions are open to physicians who wish to establish a new full-time practice within an interdisciplinary setting, supporting a vulnerable, culturally diverse, complex population. Remuneration for these positions will be on a fee-for-service basis.

East Edmonton Health Centre is a newly constructed facility situated in east/central Edmonton serving a population of 60,000. The centre opened in December 2009 providing various co-located primary health care services to an under-resourced community. On-site programs include public health (immunization clinics, healthy beginnings, speech and language, dental and seniors services), child and adolescent mental health, addiction and adult mental health, children and adult home care, birth control clinic, sexually transmitted infections clinic, an antenatal and community perinatal program that provides medical services to at-risk pregnant women and Region 6 Child and Family Social Services.

The new Family Medicine Clinic opening in early fall will offer unattached clients access to an interdisciplinary primary care team including family physicians, nurse practitioners, registered nurses, licensed practical nurses, mental health/social workers, dietitians and cultural support workers. The team will work closely with community agencies and external partners such as the local primary care networks to provide comprehensive primary care services.

Besides an attractive new state-of-the-art clinic, AHS will provide management and infrastructure support including an on-site manager, security, building maintenance, billing services, clerical, medical supplies and information technology. Underground parkade access is available for a monthly fee. Clinic operations will be fully computerized with electronic medical records.

Interested applicants must hold an MD or equivalent, be eligible for a license to practise medicine in Alberta and have completed a residency in family medicine. Physicians seeking a part-time practice are also encouraged to apply and will be considered.

All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. Alberta Health Services 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 men and women, including persons with disabilities, members of visible minorities and Aboriginal persons. Applications will be considered as of June 1, however, the competition will remain open until a suitable candidate is found.

To apply, please forward a copy of your curriculum vitae and a letter of interest to:

Contact: Karen DeViller
Site Director,
East Edmonton Health Centre
karen.deviller@albertahealthservices.ca

LETHBRIDGE AB

Meyer Clinic is looking for a family physician to join the new clinic. Building is four-years-old.

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Contact: Dr. Johan Meyer
T 403.381.6797

PONOKA AB

The Halvar Jonson Centre for Brain Injury is seeking a rehabilitation physician or generalist physician. The facility has a unique comprehensive program that offers longer-term rehabilitation to survivors of traumatic or other acquired brain injury. The program uses an interdisciplinary team approach to rehabilitation. In addition to rehabilitation team leadership, the physician serves as the admitting doctor and is responsible for day-to-day medical care.

The position is hospital-based and is located within the Centennial Centre for Mental Health and Brain Injury in Ponoka.
On-call responsibilities are shared with the other programs in the facility. On-call work is fee-for-service with an additional generous on-call stipend. Remuneration for regular duties is fee-for-service with an administrative stipend for contributing to the program management team.

Contact: Dr. Doug Urness  
T 403.783.7643  
doug.urness@albertahealthservices.ca  
Dr. Zaheera Jassat  
T 403.783.7897  
zaheera.jassat@albertahealthservices.ca

SHERWOOD PARK AB

Alberta Health Services (AHS) is inviting applications for family physician positions at the Health First Strathcona-Urgent Care Centre to support after-hours coverage. Health First Strathcona Clinic has unique hours and is open from 5:30 p.m. until 1 a.m. every day, year-round. The successful candidate will work in a multi-disciplinary team with nurses, nurse practitioners and an ortho-tech.

This urgent care centre sees a variety of clinical presentations from uncomplicated cases to acute illness and sports injuries. Most patients are discharged home after appropriate assessment, investigation and management. A small number are transferred to an emergency room for further investigations and management. Lab and X-ray are available for the full shift. Current ACLS is a requirement. Interested applicants must hold an MD or equivalent, be eligible for a license to practise medicine in Alberta and have completed a fellowship in family medicine. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. Alberta Health Services 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 men and women, including persons with disabilities, members of visible minorities and Aboriginal persons.

Interested physicians are invited to send their résumé and contact information to:

Contact: Dr. Lorraine Mann Hosford  
Medical Lead, Health First  
lorraine.hosford@albertahealthservices.ca

SLAVE LAKE AB

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Contact: Merylin Hodge  
T 780.825.0746 or  
Dr. John Keaveny  
T 780.849.4155  
F 780.849.4574  
assocmed@telus.net

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Contact: Sheila Cousineau  
Business Manager, St. Albert and Sturgeon PCN  
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STRATHMORE AB

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Contact: Dr. Ward Fanning
T 403.934.5205 (office)
403.934.3934 (home)

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Contact: Belinda Harris
officemanager@medi-kel.net

PERTH WESTERN AUSTRALIA


Contact: Elma Panzic
Swan Medical Group
280 Great Eastern Highway
Midland Western Australia 6056
swanmed@iinet.net.au

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Contact: Lorna Duke
Manager, Physician Services
Medicentres Canada
T 780.483.7115
edmphs@medicentres.com
Shannon Klassen
Coordinator, Physician Services
T 403.291.5599
calphys@medicentres.com

SLAVE LAKE AB

Slave Lake Family Medical Clinic requires a locum for summer months, three-to-six month periods during the year, as well as a full-time physician.

Contact: Daniel Payne
T 780.849.2860
780.849.4009 (home)
danielsl@telusplanet.net

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Contact: Dr. David Belcher
T 780.542.4202
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