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$40,000 raised for medical student bursaries.

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Editor:
Dennis W. Jirsch, MD, PhD
Co-Editor:
Alexander H.G. Paterson, MB ChB, MD, FRCP, FACP
Editor-in-Chief:
Marvin Polis
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Richard G.R. Johnston, MD, MBA, FRCP, FRCP, FACC, FAAC
Immediate Past President:
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Alberta Medical Association
12230 106 Ave NW
Edmonton AB  T5N 3Z1
T 780.482.2626  TF 1.800.272.9680
F 780.482.5445
amamail@albertadoctors.org
www.albertadoctors.org

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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.

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COVER PHOTO: Dr. Kimberley P. Kelly gets the Alberta Medical Association Youth Run Club off and running. (Provided by Marvin Polis)

MORE 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 including pdf, ebook and podcast versions. 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.
Our technologies comprise the tools and processes we have invented to make our lives better and include our burgeoning computer wizardry. But they all have unintended consequences. I’ve written earlier about the minor malady called “Blackberry thumb,” but consider that our present frenetic, time-rushed world is an ailment largely attributable to our digital achievement.

Let me review our history. Some 10,000 years ago our ancestors – former hunter-gathers – settled down to farm grain crops and domesticate cattle. This likely meant a more certain food supply but included unforeseen consequences as stable population clusters developed and required rules regarding ownership, conduct and taxes. Though the increased contact of people in fixed locations fostered the development of language and systems of writing, there were disadvantages. Our history of warfare was promoted by the so-called Agricultural Revolution as groups of people developed disputes over ownership of valued resources and this was augmented by technologies of better weaponry.

The commingling of farmers and their families with livestock encouraged transmission of a variety of bacterial and viral illnesses to man. Indeed tuberculosis, brucellosis, rabies, malaria, measles, smallpox and syphilis all originated in animals. The list goes on, to include the various flu “bugs” we’re scared of as well as the AIDS virus. Some regard the Agricultural Revolution as our first big mistake. Who would have thought that something as banal as tying up an auroch – the cow precursor – would change us all forever?

It seemed innocent enough as well, centuries later, when Benedictine monks started to develop mechanical clocks. In the sixth century, Pope Benedict had ordered followers to pray at seven specified times during the day and church bells sounded the time for worship. Clocks became the equivalent of iPhones before long. Everyone wanted one, and by the 14th century the mechanical clock had become common as it became more accurate and smaller. The clock transformed both work and personal lives, accentuating “time used, time wasted and time lost.” Once timepieces were available, it was a small jump to focus on regular production and working hours. Things would never be the same.

Our single most important technical advance had ties to religion as well. Johannes Gutenberg developed the printing press so that he could print indulgences for the church as well as his magnum opus, the Bible. Quickly, books became widely available, literacy grew and the dispersion of thoughts and experiences of others determined the religious and political upheaval of the Middle Ages.

It’s said we spend in the order of nine hours a day watching a television screen, a computer monitor or the screen on our mobile phones. Youngsters have grown up with these things and a typical teenager sends or receives over 3,000 text messages each month.

The Industrial Revolution, from the mid-1700s to the mid-1800s has been called the Age of the Machine. It marked the transition away from hand production as machines for spinning cotton and weaving wool were developed and as the coal-fired steam engine became the common source of power. Industrialization led to the creation of the factory, which in turn meant job loss for many craft and artisan workers. In response, certain unemployed workers turned their animosity toward the machines that had taken their jobs and began destroying factories and their machines. Such vengeful citizens became known as Luddites, supposed followers of folklore hero Ned Ludd, who broke two mechanical knitting machines in a fit of rage in 1779. The term Luddite has
Technology has become our newest god, charged with solving all our problems including disease, debility – even death. On some level, we must know this is impossible.

In 1936 British mathematician and cryptographer Alan Turing created plans for a computing device that served as blueprint for the modern computer. The first mainframe computer, assembled in the 1940s, was agonizingly slow. Faster, more powerful computers have developed at breakneck speed as processing power has doubled every three years. The plethora of computer-based devices that followed has remade our personal and work lives. It’s said we spend in the order of nine hours a day watching a television screen, a computer monitor or the screen on our mobile phones. Youngsters have grown up with these things and a typical teenager sends or receives over 3,000 text messages each month.1

The drive for endless efficiencies has revolutionized our work and personal lives. Work for all but the most privileged has become an endless search for efficiency, producing more widgets at less cost. The ubiquitous machine for nearly all of us has become the computer, and our standard work process generally involves email.

We haven’t escaped as medical practitioners. Our digitized systems are all about measuring things, especially costs, as we and our patients are notional cogs in a larger, bureaucratic machine. For practitioners with their own sub-technologies of procedures this has meant more pay for more widgets, angiograms, or TURP’s, etc., per unit of time. For many in health care, however, this has meant employment that is impermanent and insecure. Witness the continuing cycles of hiring/firing nurses and the musical chairs of health care bureaucrats as governance/administrative structures are constantly rejigged in attempts to do things ever more cheaply.

So work has extended to all hours of day or night with our ubiquitous communications technologies and more stringent deadlines. Complaints about multitasking abound, never mind the mind’s demonstrable inability to do several things at once. Even as work lives have become ever more difficult, our personal lives have not fared much better. As the vagaries of work have displaced us from our historic communities, close to family and friends, our communities become ever more “virtual,” replete with all our media, but inadequate and insufficient nonetheless. With Google at our fingertips we are all experts and often uncivil ones at that. Online experience shows that we are only too ready to deride one another, and even as we continue to buff our profiles on social networks, we are ready to move on at the first hint of tedium.

As Nicholas Carr has pointed out, in his aptly named text, “The Shallows,”2 the Internet has re-modeled us. We flit from text to text via hyperlinks, scanning quickly, ceaselessly moving on. Our concentration suffers and our written works have come to mirror the staccato of our browsing activities. Although many celebrate our new tools as we outsource memories to the web, we must remember this differs fundamentally from what goes on in our noggins. Biological memory, in contrast to a computer’s fixed recall, is a dynamic thing that depends on context and continual reprocessing. Memories change, every time we visit them. To the extent that we relegate our memories to a digital world we replace dense, rich connections with the fixed ones of the digital world. We risk outsourcing important aspects of our intellect and identity. As playwright Richard Foreman3 puts it, we risk replacing our former selves with “pancake people – spread wide and thin” as we scamper through the vast networks of information that can be accessed by the touch of a button.

Technology has become our newest god, charged with solving all our problems including disease, debility – even death. On some level, we must know this is impossible. There are two aspects to our lives. One is amenable to the offerings of science and technology. The other part – to my mind the part of us we recognize as self – remains mysterious, as we realize that our lives are inexorably linked to matters of the heart and the exigencies of fate and fortune through time.

Our personhood requires our presence here – no substitutes, please! – or we are lost. To the extent that we pretend we can be counterfeit, we shirk responsibility, and become more shallow versions of the persons we might otherwise be.

We have tools – great tools – but they remain tools and not replacement parts. We must learn to handle them well and carefully.

Caveat emptor.

References
The Alberta Medical Association (AMA) is making a major investment in our Youth Run Club for healthy kids and communities. We invite you to bring these resources to where you, your family and your neighbors live.

Picture an elementary school near you. Imagine it's a sunny morning and the air is ringing with the excited voices of children and the pounding of running shoes on pavement. A happy pack of red-cheeked kids emerges from the schoolyard and jostles its way along the street. A few teachers run in the group, but who's that other adult out in front, calling out encouragement? It's a local doctor. Wait! Could it be you?

Yes! It could!

If you would like to participate in a school run club – a little or a lot – or talk to kids about nutrition and exercise or any other suggestions you might have to get kids’ feet on the tarmac, we can help.

You’ve heard in recent months about the AMA initiative called Many Hands™ that celebrates the wonderful volunteer contributions of physicians at home and abroad. We continue to praise and recognize these generous activities. It’s time now to kickstart the other side of Many Hands™: encouraging physicians to get involved as volunteers and helping you to do so. As the Many Hands™ slogan says: Many Hands™ make light work, make better communities and make a better world.

And we are putting our money where our mouth is. The AMA’s Board of Directors has selected the AMA Youth Run Club, piloted earlier this year with great success, as our own flagship project to give back to the province (www.albertadoctors.org/advocating/ama-youth-run-club). It supports healthy kids, communities and members.

So we are rolling out resources of all kinds to help you get kids running where you live. If you would like to participate in a school run club – a little or a lot – or talk to kids about nutrition and exercise or any other suggestions you might have to get kids’ feet on the tarmac, we can help. With our partners, Ever Active Schools (www.everactive.org), we can assist with planning, promotion, logistics, run coordination, swag for kids and more.

It might be a school that your kids attend. You might not be a parent at all. You might want to participate but not know which school to choose. It doesn’t matter. Just let us know. We will follow up and get you started – whatever getting started might look like. We just need to know there are physicians wanting to be involved.

Email runclub@albertadoctors.org for more information or to volunteer.

Dr. Kimberley P. Kelly and Alexander Scrimger participate in the AMA Youth Run Club. (photo provided by Marvin Polis and Dr. Kimberley P. Kelly)
Alberta’s doctors are giving heart and soul to the causes near and dear to them.

Many Hands™ – Alberta doctors and medical students making a difference.

Here are projects in which Alberta doctors and medical students are involved.

**Hitting the ground running:**
Dr. Kimberley P. Kelly helped to develop the AMA Youth Run Club, a pilot project aimed at helping educate Alberta’s school-aged kids on the importance of regular physical activity. This project is a partnership between the AMA and Ever Active Schools.

**The power of a photograph:**
University of Alberta medical student Greg Sawisky used photojournalism to capture his classmates’ personal stories: the reasons they chose medicine and the life events that shaped their decision.

**The happiest place on earth:**
Calgary pediatrician Dr. Neil D.J. Cooper makes dreams come true by helping medically fragile children visit Disneyland through his work with Dreams Take Flight.

**Heart and soul:**
Calgary cardiologist Dr. Anmol S. Kapoor helps the South Asian community take control of their heart health through the DIL (Do It for Life) Walk.

**Seeing success:**
Edmonton ophthalmologist Dr. Matthew T. Tennant and a medical team from Edmonton’s Royal Alexandra Hospital help restore vision for those crippled by blindness in Cameroon.

**Building expertise:**
Dr. Jean-Francois Lemay, a Calgary physician, is helping Haiti rebuild its medical community through the development of a surgical course for the four universities. With the help of the University of Calgary’s Global Health and International Partnerships, the course has trained more than 200 students, readying them to become interns.

**Creating a family tradition:**
Sylvan Lake family physician Dr. Raymond R. Comeau has embarked on several medical missions through A Better World Canada. Last June, Dr. Comeau accompanied a group of University of Alberta medical students – including his own son – to Kenya.

**Uncharted waters:**
Last May, Calgary physician Dr. Andrew W. Kirkpatrick put his experience and expertise to work serving on Mercy Ships’ African Mary, while it was docked in Togo, West Africa. Each year the ship visits a different country, docking in the harbor and providing as much surgical care as possible.

**Share your story**
To share your story, please email Alexis D. Caddy, Communications Consultant, Alberta Medical Association, at alexis.caddy@albertadoctors.org.
Page, ID badge, patient list and the coffee thermos – these are the usual things I see my wife take to work. You see, I have the privilege of experiencing first-hand the glamorous lifestyle lived by junior members of the medical profession, as I’m married to a doctor. As such, I’ve been allowed to peek behind the curtain and to experience the trials and tribulations endured by those of you starting out in your medical careers.

I have experienced the agony of the Canadian Resident Matching Service (CaRMS), albeit second-hand, and I know all about the excruciating experience known as “Match Day.” For those of you starting a fellowship in Alberta, the emotions experienced during the CaRMS process is now a thing of the past – you’ve made it! For those that have just started your residency in Alberta, there is comfort in knowing that you won’t need to deal with CaRMS again for several years.

Now that you’ve arrived at this stage in your career, you should start to think about the future and, more specifically, what you want to do with your medical career. You devoted enormous amounts of time to perfecting your craft. You studied hard and endured all those weekends and nights doing on-calls throughout your residency. Now is the time to ask that very important question: Where do I go from here? As you progress up the medical ladder, your earning potential increases. Arguably the single most important question that a doctor must decide is whether to continue working for Alberta Health Services or to open one’s own practice. This article briefly describes the forms of business organizations commonly used by doctors in private practice. If you have ever considered working for yourself, then read on.

Firstly, there is no universal one-size-fits-all business model as each individual’s circumstances are different. In addition, there are benefits and constraints in each business organization. As your business matures and your circumstances change, it is important to re-assess whether your current business organization is still the best fit for you. It is quite common for professionals to transform their business organization as the practice evolves and matures. Legal and financial advisors can assist in determining for you the most suitable model. The majority of doctors buy into a practice, and as such, the type of business organization is already dictated by the current owners. But regardless of whether you start out on your own or buy into an existing practice, it is good to know the basics.

**Sole practitioner**

This is the purest and most straightforward business organization. As a sole practitioner you and you alone control the destiny of your business. This means that all contracts are entered into in your name and that you are personally liable for debts incurred by the business. In a nutshell, you are the business and the buck stops with you. The main benefit of carrying on business as a sole practitioner is that the start-up costs are minimal. Since you are the business, you pay the usual personal tax rate, so your losses from any given year can be carried forward to subsequent years. The disadvantage of this model is that you are personally liable for all debts incurred by the business, and in addition, you might be paying too much tax under the current personal tax rate depending on how much you earn from your practice.

**Partnership and limited liability partnership**

There are essentially two types of partnerships. There is the ordinary partnership and the limited liability partnership (LLP). As the name suggests, a partnership is “the relationship that subsists between persons carrying on a business in common with a view to profit.”
Alberta, the Partnership Act sets out the legal framework for this business organization. The term “joint and several liability” is the defining feature of this business vehicle. Essentially, this arrangement is akin to a marriage, whereby you are bound by the acts or omissions of your partner(s). Just like a marriage, it is important that you know and trust your partner(s) because each and every partner has the power and authority to bind the other partners. Partnerships are governed by arrangements made between the individuals, therefore the terms and conditions should be agreed to prior to entering into a partnership. Some basic questions which should be addressed are: how to share the profit and loss of the business; how to resolve disagreements between the partners; and what happens when a partner leaves or dies. It is always preferable for partners to resolve their issues without the involvement of the courts, therefore it is highly advisable for the parties to draft a partnership agreement so that the parties know exactly what will happen in case certain issues or disagreements arise.

In an ordinary partnership, each and every partner is liable for the acts of the other partners. Most professionals (doctor, lawyers, dentists), however, operate their business as an LLP because this provides a layer of protection. In an LLP, partners are not liable for the acts of their fellow partners unless they were involved in the negligent act themselves. Besides this very important element, in all other ways an LLP functions the same as an ordinary partnership.

Professional Corporation (PC)

A corporation is a legal person under the law and therefore it can do such things as hold property, enter into contracts and hire employees. Since corporations are a separate legal entity, the defining feature of this business organization is “limited liability.” I won’t say too much on this subject because corporations cannot practice medicine. However in Alberta, professionals are allowed to incorporate and practice as a PC. There are stringent restrictions on what a PC can do. For instance, the PC’s activities are restricted to the practice of the profession of its member. Therefore if you choose to incorporate, your PC can only be involved in activities related to the practice of medicine. In addition, PCs do not offer limited liability. Many professionals find it advantageous to incorporate and operate their business as a PC. The three main benefits of a PC are potential income splitting, tax deferral and lower overall taxes paid on the first $500,000. However, there are disadvantages: incorporation is costly and complex; business losses cannot be flowed through to shareholders of the PC; and PCs must abide by a burden of greater regulation and compliance matters. However, even with its disadvantages, many medical professionals choose to incorporate because PCs can provide the aforementioned potential tax savings and tax deferral benefits.

Final thoughts

There are two very important things to stress here. First, there is no one-size-fits-all business model. Second, as your practice evolves and the circumstances in your life change, you should consider whether your current business organization is still the best fit for you. Prevention is always better and cheaper than being forced to deal with unwanted issues after the fact, so it is advisable that you obtain legal, financial and tax guidance before you branch out to start your own practice. However, if after reading this article you are still pondering whether to work for yourself, you’ll need to consider commercial leases and employment contracts. Then the fun really begins.

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 at www.albertadoctors.org. (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.
RENW your AMA/CMA membership and continue to receive important benefits

As an Alberta Medical Association/Canadian Medical Association (AMA/CMA) member, receive AMA/CMA benefits and services, plus information about other issues important to physicians.

The new membership year started October 1. If you have not yet renewed, you can do so via one of the following methods:

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

Membership forms and information packages were mailed in September. They will vary depending upon member category and may include the following:

- Letter from the AMA president.
- @ your service membership guide.
- Membership form.
- Medical Liability Reimbursement Administration Policy.
- Continuing Medical Education Administration Policy.
- Postage-paid return envelope.

Membership questions? Contact AMA Membership and Benefits Team Leader, Kirsten M. Sieben at:

780.482.0323
Toll-free 1.800.272.9680, ext. 323 or kirsten.sieben@albertadoctors.org.

Scan to find out how you can join or renew your membership, or visit www.albertadoctors.org/membership.

SHORT AND TWEET!
Get the latest AMA news in 140 letters or less

Twitter is a great way for you to get the latest AMA:

- News, events and announcements.
- President’s Letter and other publications.
- Important information from other medical associations.

HOW CAN YOU FIND US?

- Already have a Twitter account? Follow us at http://twitter.com/Albertadoctors.
- Don’t have a Twitter account? Signing up for Twitter is fast, easy and free. Just go to https://twitter.com/. You can open an account in under a minute. Check in regularly at http://twitter.com/Albertadoctors or see the most recent tweets on the AMA website, e.g., the Twitter box on www.albertadoctors.org/media. We’ll be tweeting new items almost every day. Join us!
Don’t commute to work. GO FOR A WALK.

Brookfield Homes offers a range of homes less than 30 minutes away from the new South Health Campus — on foot, on picturesque trails and pathways. (It’s not really commuting at all.)

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- TOWNHOMES from the $300’s
- STACKED TOWNHOMES from the low $240’s

**CRANSTON**
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- STACKED TOWNHOMES from the low $240’s
- SIDE-BY-SIDE HOMES from the $300’s
- SINGLE FAMILY HOMES from the low $320’s

**AUBURN BAY**
- SIDE-BY-SIDE HOMES from the $300’s
- SINGLE FAMILY HOMES from the $330’s

**30 MINUTE AMBLE**

**10 MINUTE STROLL**

**5 MINUTE HOP**

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Brookfield Homes
The Best Places to Call Home
Setting staff wages is one of the more mysterious processes in most privately owned clinics. There’s a closed door meeting. Someone throws out some numbers. Someone shares what a sister-in-law makes at another clinic. Some debate ensues (maybe) and the physician partners emerge from the room with wage rates. Is there any consistent method or rationale? Is there a true reflection of market rates? Is it equitable for all staff? Does it send the right messages to staff? Maybe. Maybe not.

The following are some common mistakes made in determining wages and pay raises.

1. Starting everyone at the same rate

Wage rates should take into consideration the required skills, responsibilities and decision-making level of each given position. A clinical assistant should not have the same starting wage as a receptionist if the skill level and aptitude required for the two positions are different. Further, each new staff member coming into the role will have a different level of experience and competency, therefore, it is not a given that a new employee starts at the bottom of the wage range for that position.

2. Using years of service as the only factor for increases

Some of the highest paid staff in clinics are not the most outstanding performers or in possession of special skills: They are the highest paid because they’ve simply been there the longest. While years of service should factor into setting wages, employee performance should be the main determinant of pay raises.

3. Failing to define a maximum rate for positions

Every position should have a defined upper limit. No matter how excellent your filing clerk is or how long he/she has worked for you, there is a market limit to what a file clerk earns. Once that maximum is reached, increases (other than cost-of-living increases) are only earned through attaining significant new skills or taking on, tasks with greater responsibility and independent decision-making.

4. Giving everyone the same raise

Giving a poor performer the same raise as other staff sends a message that good performance doesn’t matter. If a staff member consistently lacks diligence, isn’t reliable or has a poor attitude toward patients or colleagues, their wage should be one of the tools used to communicate that this is not acceptable. Further, it is highly demoralizing to those who work with them to see continued poor behavior rewarded with wage increases.

5. Circumventing the wage setting process

We know it happens. Lack of consistency in determining wages or use of bonuses to circumvent established rates will eventually result in inequity and unhappy staff. Furthermore, bonuses tend to be based on emotion and the “like-ability factor” rather than sound rationale and excellent work performance. Unless very clearly linked to performance goals, bonuses become an expectation and are meaningless for motivation. Don’t count on wages or bonuses being held in secret between staff; they rarely are.

Without a wage grid and an established process, it is likely that your clinic has made one or more of the mistakes listed above. The remedy is to develop a wage grid that is tailored for your clinic. A wage grid generally has three to five steps for each job band and might look something like this:
In broad strokes, the process to create and administer a wage grid is as follows:

1. **Minimum and maximums ranges are determined** for each position or group of similar positions based on internal (intra-clinic) and external (outside job market) equity and the compensation philosophy of the clinic (e.g., we want to be 5% above market average). In looking at external equity it is important that job duties/expectations are considered and not just the job title. A medical office assistant (MOA) at one clinic may have a very different level of responsibility, decision-making and skills required than a MOA at another clinic. The respective wages may or may not be relevant for comparability.

   With respect to internal equity, caution needs to be taken not to underpay newer employees to offset the wage costs of long-term employees. Further, although some exceptions exist for professional staff, if your clinic manager has responsibility for staff, higher level decision-making and managing the business, there should be a perceptible increment that reflects this.

2. **Each employee is assessed and placed on a step** for their job according to their current competency with the requirements of the job.

3. **Communicate the grid to all staff** so that they can see the path and earning potential of their job, setting realistic expectations and providing incentive to continue to develop their competencies. It also demonstrates consistency and equity.

4. **Over time, employees advance up the steps** based on continued development of their competencies and consistent strong performance.

5. **The entire grid is reviewed and adjusted regularly** to reflect the cost of living adjustment (COLA). This means that your minimum/maximums for each range as well as each step are adjusted to incorporate COLA.

What is the biggest challenge with using a wage grid? Once the wage grid is established and agreed upon it is critical that the grid be followed. If the grid is undermined by physicians giving personal bonuses to specific staff members or making exceptions, you no longer have a grid. It is then back to the closed-door meeting and waving of the magic wand.

*If you would like assistance with setting up a wage grid for your staff or have any other practice management questions, please contact Linda A. Ertman, Practice Management Program Coordinator, at 780.733.3632 or linda.ertman@albertadoctors.org.*
We've improved the claims process for the Health Benefits Trust Fund

Are you aware that the Alberta Medical Association (AMA) offers a competitive health and dental program called AMA Health Benefits Trust Fund (AMA HBTF)? Consider joining more than 2,400 of your colleagues who are currently enrolled.

AMA HBTF provides extended health care and dental plans to help cover expenses that are not paid for by the provincial health insurance plan. You may enrol yourself, spouse and children, and optionally, your full-time employees during September 1 to October 31 each year.

Two distinct plans are offered

Core Plan – a basic, competitively priced, extended health care and dental plan through Alberta Blue Cross. No proof of good health is required. For as little as $57.50/month, you can secure valuable benefits, including Out of Country Emergency Travel Insurance.

Cost-Plus Plan – a flexible self-insured plan to cover additional eligible health expenses as incurred. There is no premium to participate in the Cost-Plus Plan, and there’s a $25 administration fee for each Cost-Plus claim submitted. You can put as many items as you wish onto the same claim. Compare that with outside trust funds, which generally charge 5% to 10% of the value of the claims, e.g., $125 to $250 administration fee for a $2,500 claim. (You must be on the Core Plan in order to access the Cost-Plus Plan.)

I believe that many physicians are already familiar with the concept of Core Plan. In exchange for a monthly premium, Alberta Blue Cross covers each plan member for a pre-determined set of benefits. The Cost-Plus Plan, on the other hand, is quite different from traditional insurance plans. You are essentially covering the benefits yourself as an incorporated or unincorporated physician, albeit in a tax-effective manner.

The way how I usually explain Cost-Plus is to think of it as a health-spending account, but you determine the account amount based on your practice structure. As with all financial matters, we strongly recommend our members discuss their specific circumstances with their tax advisors to ensure their particular set-up satisfies Canada Revenue Agency’s (CRA’s) requirement for private health services plans.

Three improvements to the Cost-Plus Plan claims process in 2013

• Receipt-less claims: There is no need to mail in your original paper receipts or benefit statements.
• Pre-authorized payment is now available to fund your Cost-Plus Plan claim. There is no need to write us a cheque.
• Claim forms can now be faxed, emailed or mailed to AMA’s ADIUM Insurance Services.
Sample of eligible medical expenses for AMA HBTF Cost-Plus Plan

Fees billed by:

- Physician/surgeon.
- Acupuncturist.
- Registered nurse.
- Psychologist.
- Registered massage therapist.

Medical equipment and supplies:

- Crutches.
- Diabetic supplies.
- Speaking aids.
- Artificial eye or limb.

Other medical expenses:

- Ambulance – ground and air.
- Dentures.
- Premiums for extended health care and dental insurance plans, including AMA HBTF Core Plan, and Alberta Health and Wellness “non-group coverage.”

Vision care:

- Prescription eyeglasses.
- Prescription contact lenses.
- Laser eye surgery.

Facilities:

- Nursing home care.
- Home care by a caregiver.
- Care in a special school, institution or other place for a mentally or physically handicapped dependent.

Excess costs:

- Deductibles, co-insurance amounts and amounts above annual maximums under the AMA HBTF’s Core Plan or other group/private medical plans.

Ineligible medical expenses:

- Fitness classes and membership.
- Expenses incurred for purely cosmetic procedures.
- Non-prescription drugs, and over-the-counter drugs obtained without a prescription.

This is a sample, but not all-inclusive, list of expenses deemed eligible and ineligible for reimbursement through the AMA Health Benefits Trust Fund’s Cost-Plus Plan. Refer to CRA website for a more detailed list of eligible expenses.

Example demonstrating the advantage of using the Cost-Plus Plan:

Physician incurs medical expenses of $1,000 that are not reimbursable by the Core Plan (e.g., major dental).

Cost without utilizing Cost-Plus Plan:
- Pre-tax income required: $1,639
- Top marginal tax rate: 39%

Cost to physician using the Cost-Plus Plan: $1,000
- Cost-Plus Plan administration fee: $25
- Total cost to business: $1,025
- Total savings: $1,639 minus $1,025 = $614

For more information or to sign up, please go to http://bit.ly/13HhBe3 or contact your non-commissioned, licensed insurance advisors from AMA’s ADIUM Insurance Services.

Mona Yam – Calgary and southern Alberta
mona.yam@albertadoctors.org

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kelly.guest@albertadoctors.org

Did you know that you can now download a podcast of Alberta Doctors’ Digest from iTunes? If you don’t have time to read the whole issue, listen to the professionally produced interviews and stories while you commute to your office or do other things at work or at home. You’ll find each issue at http://bit.ly/Wg7YpO.
A few short months ago, Prince William and the Duchess of Cambridge, Kate Middleton, once again became headline news as the world eagerly awaited the arrival of their first child and England’s next king-in-waiting. In 2011, I had the pleasure of seeing the royal couple during their first official tour to Canada, which included a stop in Calgary. I joined fellow royal-watchers and ex-pats in the hot sun as we awaited the arrival of the royal entourage at the University of Calgary’s Ward of the 21st century Research and Innovation Centre. In true celebrity fashion, the couple arrived a fashionable hour later than scheduled, but were quickly forgiven. How often can one say they have seen the likely future King and Queen of England?

Kate’s pregnancy, while unique in that she was carrying the third in line to the British throne, would in all likelihood have been considered low risk (from a medical point of view). With this designation, she would have had four publicly funded options for a health care provider in Alberta to manage her prenatal care and delivery: 1) a midwife, 2) a family physician specializing in low-risk obstetrics, 3) an obstetrician, or 4) a maternal-fetal medicine (MFM) subspecialist.

Midwifery first became a publicly funded health service in Alberta in April 2009 and has been governed by the College of Alberta Midwives since January 2013. More recently, this past June, Alberta Health Services announced $37 million in additional funding for midwifery over the course of three years. This funding is to be distributed to the more than 74 midwives currently practicing in Alberta, who delivered approximately 3% of the province’s infants in 2012. If Kate Middleton chose this option, she would be referred to the Alberta Association of Midwives’ website, which lists all the midwifery practices in the province. She would then be free to pick her provider of choice and deliver in either the hospital, a birthing center or at home. As part of their service, midwives also typically provide post-partum care and support for both mom and baby.

Alternatively, Kate could have chosen a family physician specializing in low-risk obstetrics to follow her pregnancy. Typically, most family physicians are comfortable with initiating prenatal care, but care beyond the second trimester (or sometimes earlier) is often referred to a family physician specializing in low-risk obstetrics. It is difficult to estimate the number of family physicians currently practicing low-risk obstetrics, but there are now more than 10 low-risk obstetric clinics.
in Alberta, which effectively streamline the prenatal care of thousands of Albertans each year. To give some sense of the impact of this group of physicians, approximately 32.5% of the deliveries in Calgary in 2012 were performed by family physicians. Most of these physicians also provide care for the newborn in the first week following delivery or accept the newborn into their general practice for ongoing care.

Collaboration between midwives, family physicians, obstetricians and maternal-fetal medicine subspecialists ensures Albertans have a safe place to go to welcome their babies.

Alternatively, Kate might have considered the services of a specialist for her pregnancy, and these would have included an obstetrician, or a MFM subspecialist. This group specializes in managing high risk, complicated pregnancies involving either maternal co-morbidities or fetal conditions. Obstetricians are also skilled at operative deliveries. However, low-risk patients make up a modest part of any obstetrician’s practice. Altogether, this group of specialists delivered 7,947 babies, or 45.9% of Calgary’s newborns in 2012 and offer the bulk of obstetrical services in the province.

Regardless of which health care provider the royals chose, Kate would be reassured that the primary goal of all these providers would be a healthy mom and healthy baby. Albertans are fortunate to have four publicly funded options to accommodate the thousands of deliveries in Alberta each year. The collaboration between midwives, family physicians, obstetricians and MFM subspecialists ensures Albertans have a safe place to go to welcome their babies – royal or otherwise – into the world.
One of the big challenges of teaching children about being healthy is explaining complex medical concepts to them. However, medical student recipients of the Alberta Medical Association’s (AMA’s) Emerging Leaders in Health Promotion grant have found ways to do just that.

Whitney Houston was pretty accurate when she sang, “I believe the children are our future. Teach them well and let them lead the way,” in her hit song Greatest Love of All.

Once children are taught the importance of something, they usually become little advocates for the cause. In fact, that’s how recycling became so popular in the 1990s in Canada. The program was introduced and taught to children at school who then brought the concept home to their families. Recycling went from being an obscure concept to a mainstream one – and rather quickly.

This innovative approach doesn’t just apply to recycling; it’s also being used to change children’s health habits. Many organizations are teaching children about the benefit of a healthy lifestyle in the hopes they will become part of the solution.

**Kids battle bugs**

Jonathan Seto, an Emerging Leaders in Health Promotion grant recipient, has volunteered at the Calgary International Children’s Festival for many years by helping with various crafts and activities. Once he was accepted to medical school at the University of Calgary (U of C), he wanted to give back to the festival by helping to educate children about hand hygiene.

It probably doesn’t come as a surprise to parents that the one thing children probably share most often is germs. If one child becomes sick, it seems inevitable all the other ones will too!

Mr. Seto saw a need to educate children about this important topic because most children don’t realize how easily and quickly germs can spread. He and the volunteers came up with a great way to explain the concept of sharing germs that was easy for children to understand. The festival, which celebrates creativity, was the perfect event to explore the limitless methods pathogens use to infiltrate the body.

To help demonstrate the concept of sharing germs, the children were invited to turn the “Infection Prevention Wheel” which was covered in a non-toxic power that only shows up under a black light. A child would spin the wheel which would give them a scenario in which germs are spread. For example, sharing food with a friend when you have a cold or not covering your sneeze. The children were then asked what was wrong with the situation and how they can prevent spreading germs.

After spinning the wheel and answering the question, their hands were put under the black light to show them that they acquired “germs” from touching the wheel. They were subsequently shown how to properly sanitize their hands – including under their fingernails and between their fingers. The children’s efforts were visually reinforced once they placed their hands under the black light again and the powder (or germs) was gone.

“Using the non-toxic powder helped the kids understand how germs are spread without us even realizing it,” said Mr. Seto. “It’s a bit hard for kids to visualize something happening on a microscopic level, but this demonstration really helped.”

The children were given construction paper and other art supplies to make their own “bugs” or germs. It also served as a little reminder about the principles they learned about hand hygiene. At the same time, it was also a learning experience for the volunteers to see how children imagined the virtually invisible bacteria or viruses.

“Getting the kids to design their own bacteria or virus helped them understand the concept at a macroscopic level,” said Mr. Seto. “It was interesting to see how different the bacteria and virus looked from child to child.” Mr. Seto hopes that understanding the children’s perspective of germs will aid in improving educational approaches and activities in the future.

The tent was staffed at all times by medical students and other U of C volunteers. The festival took place from May 22-25 and about 500 children visited the tent each day.

Dr. Joseph V. Vayalumkal, Medical Officer of Infection Prevention & Control at the Alberta.
Doctor for a day

Medical students at the University of Alberta (U of A) held the second annual MiniDocs event on April 23. This year’s annual event was organized by Emerging Leaders in Health Promotion grant recipients Phil Quon and Kerry Wong.

“Kerry and I had participated in the event last year and we really enjoyed it,” said Mr. Quon.

“We wanted to build upon the success of MiniDocs so we decided to organize this year’s event.”

Twenty medical students oversaw seven stations, each relating to a particular organ system such as heart, lungs and bones. The medical students would teach the children about the different system and what diseases may affect that system. Following the education portion, the children participated in a hands-on activity like a game or demonstration. For example, at the triage station children applied the skills they learned throughout the day by diagnosing and treating a mock patient.

“I got involved with MiniDocs because it combined two things I love – teaching and working with children,” said Mr. Quon. “I really enjoyed watching the kids have fun learning about medicine.”

The event was a big success and 35 children participated in the program. All of the camp attendees had previously volunteered as a patient for clinical skills sessions. Many participants wished MiniDocs could be longer and wanted to come back next year. In fact, Ms Wong overheard one child telling his parent that he wanted to be a doctor instead of a spy after attending MiniDocs.

“When children begin to learn about different parts of the body it also acts as preventative health care,” said Ms Wong. “They begin to recognize how making poor lifestyle choices can impact their health.”

In addition to educating participants about various body systems and healthy lifestyle choices, the camp addressed a pressing need for medical students in search of pediatric patients for clinical skills sessions. This need was also the inspiration for MiniDocs as a way for first- and second-year students to show appreciation to the children who’ve helped them learn.

“As medical students we spent a lot of time learning about different diseases,” said Ms. Wong. “It’s really valuable to us to have hands-on experience particularly with pediatric patients.”

Scan for more information about the AMA’s Emerging Leaders in Health Promotion grant program webpage or visit www.albertadoctors.org/emerging-leaders.
North/South Doctors’ Golf Tournament a swinging success

College of Physicians & Surgeons of Alberta/Alberta Medical Association tournament raises $40,000 for medical student bursaries.

Collette Deschenes | COMMUNICATIONS COORDINATOR, CPSA

Physicians, medical students, residents and health care community leaders from across the province came out July 22 to the Red Deer Golf and Country Club in support of Alberta’s next generation of physicians. The rain held off as golfers hit the links, enjoyed a buffet breakfast, BBQ lunch and prize draws.

Congratulations to the skill and draw prize winners, and thank you to everyone who participated. We hope to see you all out on the course again next year!

A special thank you to all of our sponsors, including presenting sponsor TD Insurance Meloche Monnex and eagle sponsors Sun Life Financial and MD Physician Services.

To see more photos from the tournament visit our Facebook page (www.facebook.com/AlbertaMedicalAssociation).

CPSA Assistant Registrar Dr. Kenneth J. Gardener (L) and medical student Jance G. McGale (R) before heading out on the course. (provided by CPSA)

Participants join their teammates and head to their golf carts. (provided by CPSA)

Medical student Andrew Wing, CPSA Registrar Dr. Trevor W. Theman and medical student Matthew Moore (L to R) stop to wave hello before heading to the next hole. (provided by CPSA)

Dr. Joe Hopfner sets off to hit the links. (provided by CPSA)

Tammara Francis of Sunlife Financial accepts her draw prize – a $250 Golf Town gift certificate. (provided by CPSA)

Medical residents Rhett Taylor (L) and Michael Stamm (R) pose as they take a break at the snack shack. (provided by CPSA)

Medical student Matthew Moore is the lucky winner of the 50/50 Mulligan draw. (provided by CPSA)
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WEB-FOOTED PHYSICIAN

Computer addiction -
A career spanning punch cards to iPads logs out

The addict
You know you are an Internet addict when you go to a party and introduce your partner as “myspouse@home.com.” That line ended my first “web-footed” article in the September 1997 Alberta Doctors’ Digest.

I became addicted to computers in 1973, after I took an “introduction to computers” evening course at the University of Calgary (U of C). The computer filled the whole room and required special cooling. Today, the average smartphone probably has more computing power. We learned to write a simple computer program that added up a column of numbers and printed out the total. Each line of the program and the data were written on an individual card. The deck of cards was then fed into the computer and then you waited your turn for the results to be printed. I was fascinated and decided to take other computer courses.

The pusher
I went from “addict” to “pusher” in 1983, when I co-taught a computer course for Continuing Medical Education. We used the “Commodore Pet,” one of the first personal computers. There were so few machines available that two students had to share one computer. I remember that the physicians in the course were fascinated by a spread-sheet program that calculated how small increases in a monthly mortgage payment would shorten the payment period.

The hard stuff
In 1991, I became the director of the medical information service at the U of C. Our goal was to provide rural physicians with answers to questions arising in their medical practice by sending articles from the medical literature. As more Internet-based medical resources became available, the program gradually evolved into the “virtual library for rural physicians” where the physicians could conduct their own searches on the Internet and get the answers more quickly.

Addiction #2 - fiddling around
I sometimes joked that I started playing with computers to relieve the stress of working with patients. Now that I was using computers every day in my job, I needed relief from them. So I bought a fiddle in 1995 and became addicted to Celtic and Old-Time fiddle music.

A bird in the palm
The “Palm Pilot” handheld computer was introduced in 1997 – an ancestor of today’s smartphones. Now physicians could obtain medical information right at the bedside. The next few years were exciting, as new computers and medical software were being developed very rapidly. I enjoyed introducing other physicians to computers through various courses and Alberta Medical Association initiatives.

Addiction #3 - square dancing
In 2007, I went to a week-long fiddle camp with my partner, Carole Cormier. Every evening after our classes, there would be a square dance. We enjoyed it so much that we joined a club when we got back to Calgary. Square dancing is a great way to get both a physical and mental workout. You also meet a lot of nice people. Give it a try sometime!

Retirement
By 2011, the resources offered by the virtual library were also available from the Canadian Medical Association, so the program was discontinued. It started as a three-year contract and lasted almost 20 years.
Addiction #4 - square dance calling

My latest way to fend off dementia is to become a square dance caller. It is like playing chess with real people. You move them around the floor with moves like Dosado, Allemande Left and Right and Left Grand and get them back to their home position before the music ends. My computer skills pay off as I use an iPad computer and MP3 music files when some callers are still using 45 rpm records (remember them?). I also have a computer program that shows the dancers moving on the screen as I write new dance routines.

The bottom line

Now that I’m retired, my other addictions have moved computers from a passion to a tool. I’m not keeping up on the latest developments, so this will be my last regular column. Over the last 16 years, I hope that I have helped our readers to gain a better understanding of computer technology.

Editor’s note

The Web-footed MD column was originally called the Web-footed Physician. Dr. McCombs always liked that alliteration, so we reprised the old title for his last article.

The AMA says "Thank You!"

As he retires as the AMA’s Web-footed Physician, I’d like to thank Dr. McCombs for his tireless efforts over so many years to guide his fellow physicians through the intricacies of cyber-space. We are all so busy – although typically fascinated with technology – and often there is little time to feel comfortable with new hardware, software or the latest online research tools.

Whether it was how to become competent on the latest computer gadgetry (without hurling anything out the window) or navigating through online libraries that have the information to make our practices better, he showed us the way many times. Dr. McCombs can set down his mouse and know that he has taught many and taught us well.

Thank you, Dr. McCombs. You will be missed.

Regards,

Allan S. Garbutt, PhD, MD, CCFP
President
The Canadian Conference on Physician Health (CCPH) will take place at the Hyatt Regency in Calgary, November 15-16. The conference planning is the collaborative work of the Canadian Medical Association’s Canadian Physician Health Institute, and the Alberta Medical Association’s Physician and Family Support Program. This year’s conference is the third in a series that began in Vancouver in 2009 and continued in Toronto in 2011. About 300 physicians, residents and students from across Canada are expected to attend.

Canadian psychiatrist, Dr. Michael Myers will be the opening keynote speaker. Dr. Myers has worked in the area of physician health through most of his career. Now working at SUNY-Downstate Medical Center in Brooklyn, he was, for more than two decades, the director of the Marital Therapy Clinic at St. Paul’s Hospital in Vancouver. Over the years he has provided care for hundreds of physicians, residents, medical students and their families. Many of our colleagues struggle in their intimate relationships. In 2012, 44% of the 1,200 calls to PFSP’s 24-hour help line was for assistance with relationship and family issues.

Myers is well-suited to address the conference’s major theme: “Harnessing wisdom across generations to promote physician health.” He will review the checkered history of physicians’ awareness and actions to maintain their own health and he promises to “start a conversation about where to set our priorities for research, teaching, relationship with technology, self-care and clinical practice.”

A major conference objective is to provide colleagues with opportunities to pause, and talk about our own health. Workplace concerns as they affect our health will feature prominently during the two-day conference. University of Calgary internist Dr. Jane B. Lemaire has a research interest in physician health in addition to her regular clinical duties. Dr. Lemaire co-authored, along with Wallace and Ghali, “Physician wellness: a missing quality indicator” [Lancet 2009; 374:1714-21], a major review of physician self-care from the triple perspectives of the individual, the profession and health care systems. Anticipate good measures of common sense and passion for her subject when Lemaire speaks on Friday afternoon about: “The medical profession: Caution! Entering a hazardous (yet rewarding) work zone.”

At the CCPH 2011 in Toronto, the featured debate was, “Be it resolved that physicians (and trainees) should be subject to restrictions on their works hours in the same way that pilots and truck drivers are.” Two years later that conversation takes a new direction, partly in light of recent studies of resident hours of work. Desai et al looked at a group of residents after the 2011 ACGME duty hour restrictions were introduced. Their study, published in JAMA Internal Medicine, concluded that new restrictions on work hours were, “associated
> with increased sleep duration during the on-call period and with deteriorations in educational opportunities, continuity of patient care, and perceived quality of care.” The conversation about resident work hours is not over.

The conference program will provide formal and informal occasions for conversations about topics of crucial importance to the training of healthy physicians. In planning this conference, organizers asked what sorts of venues and pedagogical techniques best promote the sharing and application of knowledge. Experience teaches us that some of our most fruitful encounters with colleagues take place during the breaks, outside the conference rooms.

The e-C@fe is a venue that breaks new ground for this conference. The e-C@fe will feature Wifi, quality caffeinated (and decaf) beverages, healthy pastries, moderately comfortable chairs, and a limited number of five-minute presentations about some of the three billion websites, TED Talks, YouTube videos, and online courses and resources directly or indirectly related to your health. Knowledge baristas will be on hand in the e-C@fe to facilitate discussion, ensure that the technology behaves and the coffee is hot.

The e-C@fe will provide a relaxing physical space for participants to reflect on how, where and under what circumstances we do our best learning and teaching. Think of the e-C@fe as a caffeinated venue for small groups of peers who support each other’s learning, or just “a clean, well-lighted place” to sit and fire off a few texts and emails.

Evidence for peer group support to boost resilience and avoid burnout is in the work of researchers like Jensen and Trollope-Kumar in their qualitative study, “Building Physician Resilience,” Can Fam Physician 2008;54:722-9. Consider a refreshment stop in the e-C@fe, before or after J. Kinley’s Friday morning session: “Physician resilience: using peer groups as a professional development tool.”

Two presentations by PFSP assessment physicians will demonstrate the richness of subject matter on offer at a conference dedicated to physician health. On Friday afternoon, assessment physician Dr. Diane M. Westerhoff, along with Reg Crowshoe and Heather Hirsch will present, “All my relations: An Albertan Blackfoot worldview that can change the paradigm for personal wellness.”

On Saturday, Edmonton emergency physician, artist and photographer, Dr. Mark A. Cherniwchan, will present: “The technological tribe: How wisdom moves within the clinical workplace in the new millennium.” Dr. Cherniwchan is a leader on the PFSP education team. He is known for presentations that combine visual sparkle and intellectual bite.

The Friday evening social event features a reception at the Art Gallery of Calgary. Musician and radio personality, Tim Tamashiro, and his jazz quartet will be playing. A juried exhibition of photographs by physicians,
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What’s new at albertadoctors.org?
The cat definitely stays in the bag

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Take a listen to Alberta Doctors’ Digest

Did you know that many of the Alberta Doctors’ Digest articles we post on our website now also include podcast interviews?

One recent example is Dr. Alexander H.G. Paterson’s wry guide to retirement for boomer physicians.

His article shares thoughts on getting older (he missed his 50th high school reunion – “I look for familiar faces, then realize with a shock that I shouldn’t be looking at the bunch leaning on the bar but at the old grizzled guy sitting in the corner nursing a whisky”).

He also has some very practical financial and other advice for boomer physicians looking to move gracefully into their retirement years. In the podcast, Dr. Paterson talks with Alberta Doctors’ Digest Editor-in-Chief Marvin Polis about how he came to write the article. Sitting through a rather “tedious” medical conference in Chicago, he realized with mixed feelings that this might his last one, which started him thinking about the financial (and perhaps more importantly) the emotional side of retirement.

Read and listen to “Lost in transition: A guide for boomers” (article and podcast) at http://bit.ly/1SV69jG

Changes coming to the Many Hands™ website

Many of you have been following your colleagues’ inspiring stories on the Many Hands™ part of our website (www.albertadoctors.org/advocating/many-hands). All of these stories celebrate the ways our members give back in communities here and around the world.

The AMA now has its own Many Hands™ project – a made-in-Alberta version of the youth run club founded by our colleagues at Doctors Nova Scotia. (See cover story “We want your feet!”)

A pilot project last spring brought the new AMA Youth Run Club to 74 schools and 4,086 students across Alberta. This fall, the project will roll out to schools across the province.

Look for changes on our website this fall that make information and stories about the Youth Run Club a central part of the AMA Many Hands™ website.

Share your story

If you have stories to tell – whether you’re helping with a run club event in your local school, another local initiative or donating your time and expertise half a world away – let us know.

Just get in touch with the AMA’s Alexis D. Caddy (alexis.caddy@albertadoctors.org) and we’ll get back to you for all the details.

SHARE YOUR STORY
IN A DIFFERENT VEIN

Three museums and a flood: An August holiday week in Alberta

“\(\text{It is more important to know what sort of a patient has a disease than what sort of a disease a patient has.} \)\n- Sir William Osler

Alberta’s patients now come from widely different backgrounds. Our culture is no longer predictable and uniform, if it ever really was. We took a car ride this August to see the countryside and visit three strange museums and scratch the surface of different lifestyles outside the big cities.

Vulcan is 130 kilometers southeast of Calgary. I had never been there. But Spock has. He is a part of Vulcan heritage and has a bronze statue on the main street erected in 2008 to commemorate his visit. On the Saturday of the August long weekend, we drove down for the town’s 100th anniversary festivities – Vulcan being the heartland or at least a vital organ of this province.

As we approach the town through fields of harvested wheat, Vulcan seemed to be in the middle of nowhere but Big Sky. Two second world war aircraft from Nanton made a fly-past to herald the start of the parade and we heard the pipe band in the distance marching to Scotland the Brave.

This was a real parade. The Calgary Stampede and Edmonton K-Days parades are a bit phoney and contrived by contrast. Those garbage trucks with sluicing, whirling brushes sweeping up the dung from a few horses; the precise measured distances between each float; the prissy stepping marching bands – these were absent from Vulcan’s celebration. To service more horses and ponies than the Stampede, we had a slightly embarrassed lad with a wheelbarrow and another with a scooper strolling along mid-way through.

Tractors old and new (one misfiring vintage tractor didn’t make it – coughing its last by the side of the road), ancient harvesters like Heath Robinson contraptions, fire engines, vintage cars lovingly maintained through winters in the garage, farm families with their own floats: the Henderson’s (five generations), the Stenson’s etc., and one magnificent old stage coach. Dr. Leonard R. Wade (2011 Alberta College of Family Physicians Family Physician of the Year) and nurse in horse-drawn buggy (“Live Long and Prosper” on the buggy’s side – the Planet Vulcan’s motto, don’t you know) were there and even the Old Folk’s Peter Dawson Lodge had a float with a real resident in bed!

A visit to Vulcan without a look at Canada’s only Trekcetera Museum would be like going to Paris and missing the Louvre.

And as always – the Shriners – in scores. Where do they come from? You don’t see them in real life. Squeezed into little derby cars, maroon fezzes on their heads, they scooted in circles and figures of eight along the parade route. Their float, an “Oriental Band,” included musicians dressed in sheets and towels held firm with head bands. They ironically tooted on horns a recognizable “Sheik of Araby” on this weekend of “high alert” with closures of American and other embassies around the Middle East.

They threw candy scrambles for the kids. The “clown unit” appeared – how many times have I seen this: a clown offers a lady at the roadside a button hole flower. She accepts with grace. Another clown with a hidden watering can in hand follows behind and sluices the recipient with water. Laughter.

The politicians were out in force. Danielle Smith, Leader of the Official Opposition, smiled and waved graciously from an open car – for this is the heartland of Wildrose. She looked comfortable and received polite applause.
“What do you think of Danielle?” I asked a man in a Stetson beside us.

“Nice lady,” he said. “Understands farmin’ folk.”

“I thought this was PC country?”

“They’re city folk,” he said. (Red Queen take note).

Horses, ponies, cowboys and cowgirls. Our dog, sat well-behaved on the road, barking at a passing pony and causing a commotion among other dogs and a few skittish horsey moments. And of course, there was a Star Trek float.

A visit to Vulcan without a look at Canada’s only Trekcetera Museum would be like going to Paris and missing the Louvre. My photo was taken beside the Spock Memorial Statue. Michael Mangold, co-owner of the museum, moustachioed and dressed snazzily in boots, waistcoat and bootlace tie led us around the display ($8/head) – memorabilia from movies: a dinner plate and a nine-inch piece of the first-class staircase-banister from Titanic, a plastic table and chairs from Brokeback Mountain - and, wow, the boots worn by Heath Ledger, all displayed in neat glass-panelled cabinets.

I quivered with anticipation on entering the Star Trek room expecting to see Captain Kirk, Dr. “Bones” McCoy, Scotty and the lovely Lieutenant Uhura (whom I once had a crush on) – and Dr. McCoy’s medical gizmo – the one he fed symptoms into and which spat out a medicine filled syringe that cured you. That was my generation, the original generation. Why, “Beam me up, Scotty,” is part of the language!

But no! There was a only a 10 x 4 inch length of yellow cloth from a Captain Kirk shirt – for Trekcetera Museum is really a costume museum. Excellent displays of clothing worn by characters I had never heard of. Who is Captain Kathryn Janeway anyway? And the Cardassians?

Michael asked “How was it?” when we left, and I mentioned the slight (not to be discouraging) disappointment about the absence of the Original Generation and not even Captain Kirk’s yellow shirt. Michael became animated.

“Way outside our budget. It’s $80,000 for a Captain Kirk shirt. We’re not there yet,” he said.

On the way back to Calgary we stopped at High River for lunch hoping to support local business. It was a sad place with only a few downtown businesses open – and still the noise of water pumping from basements, piles of drywall and ruined furniture – and something I’ve never seen before – a garage sale with sign: “EVERYTHING FREE.”

The street setting for the “Heartland” series was deserted. “The Hitchin’ Post” was doing good business (“Cheryl was OK. The water came lappin’ up but with the concrete foundation, no damage to the Hut.”) Season’s
Café and Eatery had a $10 buffet and a sign: “Please sign the bill when using your evacuation vouchers.”

The signposts don’t have directions for The World Famous Gopher Hole Museum in Torrington but you soon stumble on it. The $2 entry is about right for what you see and the time you’re likely to spend there: stuffed gophers (actually Richardson ground squirrels) dressed up and housed in display cabinets about the size of a gopher trap, in anthropomorphic poses like ploughing and preaching. The cheerful lady behind the counter was small with quick movements – a bit like a gopher in fact. I was taken with the gopher posing as a preacher in church. This religious display foreshadowed the next museum – the one I really had my eyes on.

Through stunning Badlands country we made our way to Big Valley and the Creation Science Museum. Big Valley has the Canadian Pacific Railway Museum, and a forthcoming Museum of Tools, but it’s the Creation Science that is the most notorious. Housed in a cabin opposite the Railway Museum it was empty this holiday Sunday. We paid our $6.

Did life on earth begin with an intelligent designer creating various species and then letting them loose all at once? These two species went on a mission to find out. (provided by Dr. Alexander H.G. Paterson)

The cleanliness lady behind the counter at the World Famous Gopher Hole Museum was small with quick movements – a bit like a gopher in fact.

On this hot afternoon it was hard to focus on the arguments for “creation science” and against “conventional science.” It was all densely argued out, my good friend Charles Darwin being the chief enemy.

The display materials were well laid out. The main messages were: that Darwin wasn’t really a scientist (his degree was in theology). I didn’t know that but knowing a few less-than-impressive scientists who actually have degrees, that one washed off me. Darwin looked at the evidence and drew his hypotheses (not conclusions) from what he observed. His Theory of Natural Selection was never meant to be a final answer.

A second argument was that the timing of the ages of the earth, the ascent of man, and the dinosaur era was all wrong and that everything was much more recent than millions of years ago. A stone carving of two brontosaurs (“No! They’re Apatasours!” says Pierce, my six-year-old grandson) linking necks beside other recognizable animals in Carlisle Cathedral suggested that dinosaurs were roaming the UK in the 13th century AD. While some of you might think this a bit weak, these brontosaurs resembled photographs I’ve seen of the Loch Ness Monster. As a firm believer in the reality of that beast, the creation people are on to something here.

The lineage of the “Kings of Britain” (more accurately the Kings of England) especially the Tudors (a bunch of Welsh horse thieves) from Adam and Eve are displayed in a copy of an old parchment. Please note that the Kings of Scotland never claimed lineage from Adam and Eve but from a bloke called Jock Thomson. Putting the Tudor Taffies forward as evidence of anything but fraud, gluttony, savagery and arrogance is a fatal flaw in the argument of their origin from Adam and Eve.

The absence of transitional fossil forms is another creationist argument for species – specific creation. Darwin’s finches and their beaks are blown off by arguing that change in the shape of a beak is no evidence of a species change and is merely adaptive change.

It all boils down to literal belief in the King James (another dodgy character) Bible which states: “In the Beginning was the Word, and the Word was with God, and the Word was God.” If you consider that the Bible might be a beautiful book of metaphor and poetry written by wise fellows sitting around a stone table near...
the Golan Heights two or three thousand years ago, then swallowing the displayed model of Noah’s Arc as evidence of the Flood is hard.

I may be weird because I have no problem with Darwin’s Theory of Evolution (and the likelihood of its future modification) and I have no issue with the notion that there may be an intelligent designer behind evolution. I just can’t buy the literal interpretation of the Bible that each species has the Intelligent Designer leaning pensively on elbow designing them and letting them loose all at once, us included.

One of the messages at the Creation Science Museum was that Darwin wasn’t really a scientist (his degree was in theology). I didn’t know that but knowing a few less-than-impressive scientists who actually have degrees, that one washed off me.

Too often evidence is moulded, forged, squeezed and battered (frequently by conventional scientists as well as by creation scientists) to fit the biases or hopes and desired conclusions of the observer rather than letting an idea emerge, phoenix-like from quiet contemplation and detached consideration of the observation.

We signed the visitors’ book.

“Can I interest you in a text,” said the young custodian and he handed us a sheaf of pamphlets explaining how one could be darned sure of eternal salvation.

By this time I was getting weary and the dog outside was whining. We were the only people in the museum that afternoon compared to the busy Gopher Museum – proof that Albertans are more interested in stuffed gophers than the Origin of Man.

Postscript: The following weekend The Alberta Ride to Conquer Cancer 2013 (after the six weeks delay due to flooding) had a good turnout from the doctors. Veterans from last year’s deluge and mud-fest felt that the 220 kilometers was almost a piece of cake. As 1,700 of us cyclists waited at the start, Calgary’s Mayor Nenshi set the jolly tone with the opening comment of his short speech:

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Contact: nreddy@telusplanet.net

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Contact: Dr. Louise Feddema
Bow River Medical Clinic
T 403.609.1118
louise.feddema@yahoo.ca

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

Contact: Dr. J.A. Deane
T 780.463.7466

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Contact: Catherine
catherinem@live.ca

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T 780.756.7700

University of Alberta
Faculty of Medicine & Dentistry, Department of Family Medicine and Alberta Health Services (AHS)

Director of Postgraduate Medical Education

Competition number: A108620350

Closing date: Will remain open until filled.

The University of Alberta (U of A), Faculty of Medicine & Dentistry, Department of Family Medicine, in collaboration with AHS, is inviting applications for an academic family physician to lead one of Canada’s pre-eminent family medicine residency programs. This is a full-time, contingent, tenure-track faculty position. The academic salary and rank for the position will be commensurate with qualifications and experience and will be supplemented by the department’s academic Alternate Relationship Plan.

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among the world’s top 50 medical schools. AHS is Canada’s largest provincial health authority providing accessible, coordinated, quality health services for all Albertans. The department is a champion of clinic-based medical education, the triple C curriculum and rigorous primary care research. The residency program utilizes urban and rural sites throughout northern and central Alberta to train more than 200 first, second and third-year residents annually. The program is fully accredited and a leader in competency-based assessment integrated horizontal training and distributed education.

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Leadership experience is required, as is certification by the College of Family Physicians of Canada or equivalent. Applicants must also be eligible for licensure with the College of Physicians & Surgeons of Alberta. Candidates with a relevant advanced degree or an education management certificate earned or in progress are preferred.

Details about the Department of Family Medicine can be found at www.familymed.med.ualberta.ca and information about the Faculty of Medicine & Dentistry can be found at www.med.ualberta.ca. Further information about AHS can be found at www.albertahealthservices.ca.

Interested individuals should submit an up-to-date curriculum vitae, along with the names and current addresses of three references to:

Dr. Lee A. Green
Professor and Chair
Department of Family Medicine
University of Alberta
205.23 College Plaza
Edmonton AB T6G 2C8

Applications began being reviewed on June 1; however, the competition will remain open until the position is filled.

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Contact: Mel
msnhurowych@synergymedicalclinic.ca
www.synergymedical.ca

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Contact: Dr. Sunil Datar
10-110 Jennifer Heil Way
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