

Results of our survey
on pay fairness **6**

Q&A: Calculating
overhead **16**

The OMA's issues
with relativity **22**

Time limit for
malpractice lawsuits **32**

The Medical Post

The Independent Voice For Canada's Doctors since 1965



**Will fee relativity
ever be solved?**

Welcome
to your **NEW**
Medical Post



It's about time.
Yours.

We get it.
You want more from your EMR.

Your EMR is the backbone of your clinic.
You need an EMR that's powerful and easy-to-use.
So you can spend time on what matters most.

Isn't it time you considered joining the more
than 20,000 physicians who use a TELUS Health
EMR solution?

Learn more at telushealth.com/itsabouttime

Contents

VOLUME 54 NO. 1

UPFRONT

4

Editorial

An introduction to the new *Medical Post* and what to expect from this and future issues

6

Rounds

Your feelings on relativity, by the numbers; controversy at the Doctors Nova Scotia board; the importance of #CanadaWaits

FEATURES

8

Fixing relativity

What the nations' medical associations are doing to address pay inequity and why doctors should be optimistic

16

Q&A: The challenges of calculating overhead

One of the few researchers to study physician expenses outlines the challenges around measuring them accurately

22

The OMA's balancing act

An investigation into a longstanding problem with the CANDI relativity methodology in Ontario and the recent efforts to fix it

26

The rural pay gap

A case study from a northwestern Ontario clinic and one relativity issue that profoundly affected young family doctors

BACK PAGES

30

Clinical courage

Dr. Sarah Giles on living with uncertainty in rural practice and why rural doctors need to trust their gut

32

The time limit for malpractice lawsuits

Patients have a deadline to sue their doctor but as Bill Rogers writes, it's not always clear when the clock starts ticking

34

Solve my problem: How to deal with harassment

Four doctors offer their advice on what to do when your patients are verbally abusing your staff

39

PMHx: Dr. James Barry's 60-year secret

On the scandal that broke after the death of one of the greatest surgeons of the Victorian era

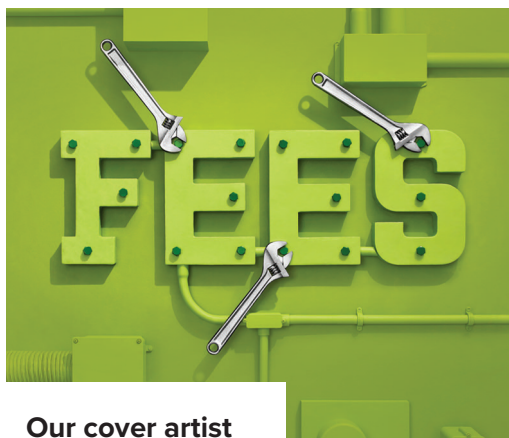
39

Practice Gem: Catch Phrases

A few phrases to add a little levity to your patient encounters

35

Classifieds



Our cover artist

Toronto conceptual visual artist and director Justin Poulsen will be producing all of the covers for the *Medical Post* this year. He often uses props which he builds and then photographs to create cover images. "There's an aspect of tangibility that I strive for that a computer-generated image alone doesn't satisfy," said Poulsen, who graduated from the Alberta College of Art and Design.



Next Issue: April

BOOSTING PHYSICIAN RESILIENCE is the theme for the next print issue of the *Medical Post*, coming in April. We'll not only have results from our survey on physician resilience, but we'll also look at what parts of the health-care system contribute to burnout for doctors. We'll look at what can and is being done to improve the underlying causes of this scourge and create a call to action.

EDITORIAL

Salutations

The *Medical Post* magazine has a new size, a new look and each issue will focus on a theme. Up first? Physician fees

Welcome to your new *Medical Post*. As you can see the size of the magazine has changed. As well, we are going to be published six times a year and each issue will focus on a theme. For this issue, it's fees.

We spent a lot of time thinking about what the six themes will be. To make sure the content is focused on physician concerns, we surveyed 500 Canadian doctors on fee and income issues and the insights we gained drove the kinds of coverage decisions we made. The results are interesting in and of themselves and you can see for yourself in VITALS on page 6.

People become journalists for a range of reasons. I personally like explanatory journalism. I'm interested in taking a complex subject that matters to the physician community and trying to

unpack it so that I can understand it and, in doing so, help readers better understand it. My cover story on page 8 looks at attempts by various medical associations to improve income and fee relativity. I admit I started my reporting feeling like income inequity was an eternal and unsolvable problem, but as I spoke to doctors across the country I became more optimistic. Read the story and you'll see why.

Associate editor Tristan Bronca looks at some of the same issues in Ontario, including in an investigative article on page 22 where he examines concerns about the OMA's CANDI formula (a tool to improve pay equity).

This will be the pattern: each issue going deep on a topic. The issue after this in April will look at boosting physician resilience.



COLIN LESLIE EDITOR-IN-CHIEF

“We are going to be published six times a year and each issue will focus on a theme.”

Lastly, even though this is a “new-look” *Medical Post*, you'll still find some features and elements you liked in our previous large-size magazine: the Rounds pages include short quotes from news makers with Auscultations. The Back Pages section features familiar physician columnists as well as items such as Solve My Problem (p. 34) and PMHx, our medical history feature (p. 39).

We've enjoyed making the new *Medical Post* magazine. We hope you like it too. **MP**

THE MEDICAL POST

PRESIDENT, ENSEMBLEIQ CANADA

Jennifer Litterick
jlitterick@ensembleiq.com

GROUP BRAND DIRECTOR, HEALTHCARE

Janet Smith
jsmith@ensembleiq.com

VICE PRESIDENT/GENERAL MANAGER

Michael Cronin
mcronin@ensembleiq.com

AUDIENCE DEVELOPMENT

MANAGER
Lina Trunina
ltrunina@ensembleiq.com

EDITOR-IN-CHIEF

Colin Leslie
cleslie@ensembleiq.com

ASSOCIATE EDITOR

Tristan Bronca
tbronca@ensembleiq.com

WEB OPERATIONS

MANAGER
Valerie White
vwhite@ensembleiq.com

DIRECTOR OF

PRODUCTION & DESIGN,
CANADA

Derek Estey
destey@ensembleiq.com

PRODUCTION MANAGER

Lisette Pronovost
lpronovost@ensembleiq.com

ART DIRECTOR

Nancy Peterman
npeterman@ensembleiq.com

GRAPHIC DESIGNER

Erin McPhee

SALES

BRAND DIRECTOR

Martin Rissin
mrissin@ensembleiq.com

ACCOUNT MANAGE

Norman Cook
ncook@ensembleiq.com

ACCOUNT MANAGER

Scott Tweed
stweed@ensembleiq.com

QUÉBEC GROUP

PUBLISHER
Caroline Bélisle
cbelisle@ensembleiq.com

ACCOUNT MANAGER

Pauline Shanks
pshanks@ensembleiq.com

CLASSIFIEDS

Nancy Dumont
ndumont@ensembleiq.com

CORPORATE OFFICERS

EXECUTIVE CHAIRMAN
Alan Glass

CHIEF OPERATING OFFICER
& CHIEF BRAND OFFICER

Richard Rivera

CHIEF BUSINESS

DEVELOPMENT OFFICER
Korri Stagnito

PRESIDENT OF

ENTERPRISE SOLUTIONS/
CHIEF REVENUE OFFICER

Ned Bardic

PRESIDENT & EXECUTIVE

DIRECTOR, P2PI
Mike McMahon

CHIEF DIGITAL OFFICER

Joel Hughes

CHIEF HUMAN

RESOURCES OFFICER
Jennifer Turner

PHYSICIAN ADVISORY BOARD

DR. GILLIAN ARSENAULT
community medicine

DR. BENJAMIN BARANKIN
dermatology

DR. ERIC CADESKY
family medicine

DR. MARIO ELIA
family medicine

DR. FERRUKH FARUQUI
family medicine

DR. TARYL FELHABER
GP in oncology

DR. JANET FRIESEN
family medicine

DR. SARAH GILES
family medicine

DR. LARA HAZELTON
psychiatry

DR. COURTNEY HOWARD
emergency medicine

DR. ALAN KAPLAN
family medicine

DR. JORDYN LERNER
resident, public health

DR. EDWARD LEYTON
integrative medical

psychotherapy

DR. BERNARD MARLOW
family medicine

DR. DUNCAN ROZARIO
general surgery

DR. DAVID SATOK
family medicine

DR. PUNEET SETH
hospitalist

DR. CHRISTOPHER SUN
family medicine

DR. SHAWN WHATLEY
rural medicine

DR. IRVIN WOLKOFF
psychiatry

DR. HIROTAKA
YAMASHIRO

pediatrics

The Medical Post

SUBSCRIPTION SERVICES

Phone: 1-844-694-4422 Fax: 1-844-815-0700

between 9 a.m. to 5 p.m. EST weekdays

Email: medicalpost@canadianhealthcarenetwork.ca

Online: www.CanadianHealthcareNetwork.ca/subscribe

Subscription prices: 1 year: \$65; 2 years: \$120

Outside Canada: \$100 per year;

Single copy price: \$12; Groups: \$46 per year;

Outside Canada single copy: \$16

REPRINTS, PERMISSIONS AND LICENSING

Please contact Wright's Media

Email: ensembleiq@wrightsmedia.com Phone: 1-877-652-5295

FIND US ONLINE

The *Medical Post's* online home is CanadianHealthcareNetwork.ca. Registration is free and easy. Medical students and residents welcome.

Canadian
HealthcareNetwork.ca



Contents copyright © 2018 by Stagnito Partners Canada Inc., may not be reprinted without permission. The *Medical Post* receives unsolicited features and materials (including letters to the editor) from time to time. The *Medical Post*, its affiliates and assignees may use, reproduce, publish, re-publish, distribute, store and archive such submissions in whole or in part in any form or medium whatsoever, without compensation of any sort. The *Medical Post*, ISSN-0025-7435, PM Agreement No. PM42940023, established 1965, is published 6 times per year except for occasional combined, expanded or premium issues, which count as two subscription issues by EnsembleIQ, 20 Eglinton Avenue West, Suite 1800, Toronto, Ontario, M4R 1K8. Montreal Office: 1425 René Lévesque ouest, 2e étage, Montréal, Québec, H3G 1T7. Printed in Canada at Transcontinental



EnsembleIQ
SMARTER TO MARKET

EnsembleIQ
HEALTHCARE
GROUP

For your adult patients with type 2 diabetes

Equipped for glycemic control.

~5 million
patient-years of
experience.¹



Trajenta® is indicated in adult patients with type 2 diabetes mellitus (T2DM) to improve glycemic control.

- **Monotherapy:** In conjunction with diet and exercise in patients for whom metformin is inappropriate due to contraindications or intolerance.
- **Combination therapy:** with metformin when diet and exercise plus metformin alone do not provide adequate glycemic control; with a sulfonylurea when diet and exercise plus a sulfonylurea alone do not provide adequate glycemic control; with metformin and a sulfonylurea when diet and exercise plus metformin and a sulfonylurea do not provide adequate glycemic control.

 **Trajenta**®
(linagliptin) 5mg tablets

Simple, once-daily dosing with one 5 mg dose.^{2*}

– Independent of ethnicity,[†] BMI,[‡] mild or moderate hepatic impairment,[§] and renal function.^{||}

BMI = body mass index.

* Please see the Product Monograph for complete dosing and administration information.

† No dose adjustment is required based on race. Race had no obvious effect on the plasma concentrations of linagliptin based on a composite analysis of available pharmacokinetic data.

‡ No dose adjustment is required based on BMI.

§ Use of Trajenta® in patients with severe hepatic insufficiency is not recommended.

|| Use of Trajenta® in patients with ESRD (eGFR <15 mL/min/1.73 m²) and those on dialysis should be with caution.

Please refer to the product monograph at www.TrajentaPM.ca for important information about:

- Contraindications in patients with type 1 diabetes or diabetic ketoacidosis.
- Relevant warnings and precautions regarding congestive heart failure, patients using insulin, hypoglycemia, glycemic control, use in patients with severe hepatic insufficiency, pancreatitis, hypersensitivity reactions, use in immunocompromised patients, use in patients with End Stage Renal Disease (ESRD) or on dialysis, bullous pemphigoid, skin monitoring, use in special populations (e.g., pregnant and nursing women), hepatic function (should be assessed before starting treatment and periodically thereafter), and interactions with strong inducers of P-gp or CYP3A4 (monitoring recommended).
- Conditions of clinical use, adverse reactions, drug interactions and dosing recommendations.

The product monograph is also available by calling 1-800-263-5103 ext. 84633.

References: 1. Boehringer Ingelheim (Canada) Ltd. Data on File. s00042091-01.

2. Boehringer Ingelheim (Canada) Ltd. Trajenta® Product Monograph. December 22, 2016.

Trajenta® is a registered trademark of Boehringer Ingelheim International GmbH, used under license.

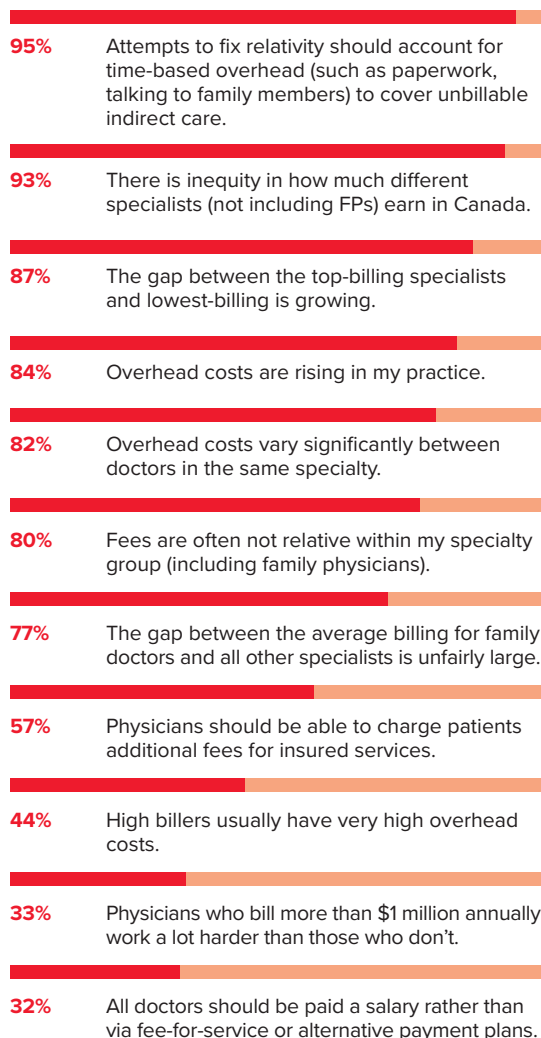


VITALS

Doctors' views on relativity

The *Medical Post* got responses from nearly 500 Canadian doctors and medical students to an online survey we conducted in late 2017. Here's the percentage who agreed with the following statements:

AGREE



DISPATCH

A challenge to board solidarity?

It was on **Sept. 22, 2017** that the board of Doctors Nova Scotia (DNS) voted to oppose the proposed federal tax changes to small businesses that will impact incorporated doctors. Two months later, the board decided to remove Dr. Monika Dutt of Cape Breton from the board.

Prior to Sept. 22, Dr. Dutt along with hundreds of doctors signed an open letter supporting federal Finance Minister Bill Morneau's "proposal to end certain tax benefits currently available to incorporated physicians, while acknowledging there are deficits in the existing employment structure for many physicians."

After Sept. 22, Dr. Dutt was active in social media discussions about the tax proposal. I read as many of those as I could find. I didn't find her ever saying, explicitly, "I support the tax proposal" but she made comments that were close. After the *Medical Post* ran the transcript of Vancouver FP Dr. Rita McCracken's statement to a Senate committee supporting the open letter, Dr. Dutt commented: "Thank you Rita for your statement—and Dr. Dickson for your response. I don't have much else to say other than I agree with both of you." (Dr. Robert Dickson of Calgary had written a comment supporting Dr. McCracken.)

The DNS board, like many in Canada, follows so-called board solidarity rules. "Once the board has made a decision, the decision belongs to the whole board. The duty of loyalty requires a member to stand behind the board's decisions," according to the DNS board's code of conduct.

So, did Dr. Dutt violate board solidarity? In a statement, board chair Dr. André Bernard wouldn't say, only noting: "I can assure you that a sitting board member would never be removed for simply having a dissenting opinion. There is more to this matter that can't be shared, but I hope that you'll trust the board's decision."

These are tricky issues for doctors who may be on multiple boards. What do you do if two boards you're on disagree? Resign from one, I heard. But not easy stuff for passionate doctors.—COLIN LESLIE



ROUNDS



AUSCULTATIONS

“The data in EMRs belongs to our patients.”

—Dr. Guillaume Charbonneau, president of the College of Family Physicians of Canada, arguing it is wrong for EMR vendors to ask for payment from doctors and researchers doing quality-improvement analyses.

“I pushed past the men lined up for the bathroom stall where I used water from the toilet to mix up my hit.”

—Dr. Grant Matheson, a former family doctor, describing the last time he used drugs in his new book *The Golden Boy* (this scene was in the airport on the way to rehab).

“Early retirement in (rural) communities is of particular concern.”

—Dr. Lindsay Hedden (PhD), a researcher at the Vancouver Coastal Health Research Institute, whose research revealed B.C. doctors are retiring earlier than expected and that rural doctors are retiring 2.3 years earlier than urban physicians.

Sources: CanadianHealthcareNetwork.ca • *The Golden Boy: A Doctor's Journey with Addiction* • CanadianHealthcareNetwork.ca

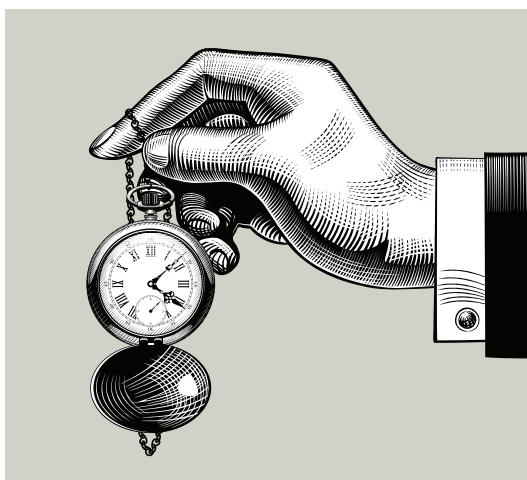
DISPATCH

Beyond the politics of waiting

Wait times are the perennial shame of the Canadian health-care system. You've seen the data. The fact that it's familiar has made it, at once, easy to talk about but difficult to get people to care about. Wait times for surgeries and specialist consultations blew past their benchmarks long ago, and at the current rate, it seems unlikely they'll ever get so long that a critical mass of people will say enough. It's our slowly boiling frog.

In this frustrating state of affairs we need more creative ways to talk about the problem. The latest is a social media campaign called #CanadaWaits. It began with a call out in early December from health pundit André Picard of the *Globe and Mail* who asked nearly 70,000 people to share stories of their waits in the Canadian health system. The responses were many things. Mostly, they were outrageous (one patient who had been frequently in and out of the ER with seizures was told it would be five years before an initial consult with a neurologist).

The hashtag is now a fixture in the tweets of many health-care advocates. Odds are if you're still



tweeting about #CanadaWaits, it's because you have strong feelings about medicare or spend the majority of your time on Twitter berating Canadian politicians.

What was great about the campaign was that, for a while, it managed to separate itself from the attendant ideological agendas that hamper efforts to get the public involved. #CanadaWaits was really *just* about the people who needed a new knee, or psychiatric treatment, or who wanted to go home after six days in the ER. It placed the focus squarely on how much waiting sucked, which is often too easy to forget. —TRISTAN BRONCA

Fixing relativity

Fee and income relativity concerns have been around for a long time in Canada but now a path to progress is becoming clear **BY COLIN LESLIE**

PART 1: A pernicious problem

As a doctor, it's easy to despair about fee and income inequity in Canada. The problem has been around for a long time, definitely since the start of medicare. During my research for this article I even came across a 1986 document from an Ontario Medical Association (OMA) special committee on economic disparities that said the OMA "has been struggling with the issue of relativity since it first approved a tariff in 1922."

Attempts to fix relativity have seen some modest successes—but mostly failure. The acronyms for the initiatives in Ontario alone start to blur: OMA RVS, RBRVS, RVIC and CANDI.

Vancouver's Dr. Brad Fritz, chair of the Doctors of BC overhead committee and chair of the negotiations forum, said there was the big Relative Value Guide effort in the mid-1990s in British Columbia "that actually got right to the end and had some pretty good numbers, but the board of the BCMA in the day . . . kowtowed to pressure from the high-earning sections which said they would all leave the association. Even though the constitution said they had to implement the results, (the board) refused to do that and then they just went back and changed the constitution the next year. There's never been very good efforts since to (do) a broad relative value fee approach."

This has been the challenge for provincial and territorial medical associations across Canada: Even when relativity fixes are developed, the political will to use them has often faltered.

"While there is constant talk, debate, etc. on relativity in many provinces—Ontario especially—there has been very little implemented action. People say

that relativity has not worked or it's a failure and that is not the appropriate view in my opinion," said Boris Kralj, a health analytics, economics and management consultant now in private practice. However, for 23 years—until December 2017—he worked for the OMA, ending as chief information and analytics officer. "Given how little it was used, is it any wonder that one does not see tangible results? I think (any methodology/formula) needs to be used for a sustained period of time before one can declare success or failure.

"The other challenge, in my opinion, for gauging success on relativity is that no one has a specified tool (to track) progress—what exactly are you trying to do with the relativity formulas? What is the measure used? Most are, I would

think, trying to minimize the dispersion or variation of standardized incomes, but how exactly?"

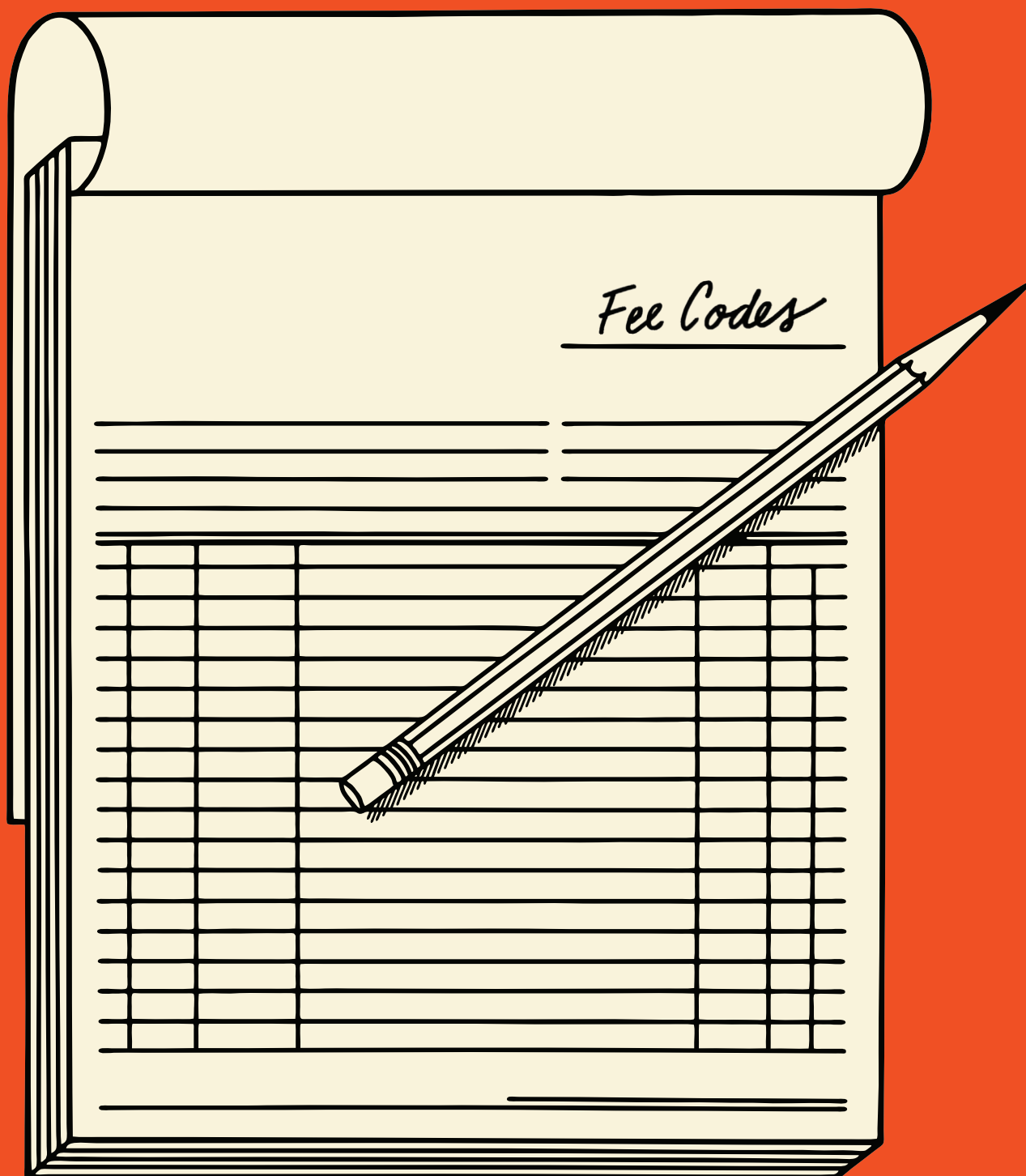
With this issue of the *Medical Post* we're examining physician income inequity in Canada, attempts to fix it, and how doctors feel about it. On page 10 you'll see the 20 Years Chart where we asked the Canadian Institute for Health Information to provide custom data to illustrate how the income of full-time doctors has changed by specialty and province over two decades. It has some stunning findings in it but an income relativity chart can only be part of the picture. It doesn't get at all the factors we need to consider when we think about the value of physician labour such as risk, technical skill and effort, and the number of patients a doctor sees.

Three income bands

When looking at our 20 Years Chart on the next page, the current pay data for doctors offers important context. Below are the average gross clinical payments per doctor by province in 2015/16. The figure for Quebec doctors is \$325,096 but is not listed below because Quebec doesn't provide data we used in 20 Years Chart.

Alta.	\$380,384	→	TOP BAND
P.E.I.	\$366,934		
Sask.	\$353,856	→	MIDDLE BAND
Ont.	\$348,056		
Man.	\$343,944		
N.B.	\$290,457	→	LOW BAND
B.C.	\$284,918		
N.L.	\$275,781		
N.S.	\$262,154		

Source Canadian Institute for Health Information



The 20 Years Chart

Compensation increases by province and specialty

BY COLIN LESLIE

HOW TO READ THIS TABLE

This table tells us how different specialties have done in terms of average compensation over a 20-year period for select provinces.

1996 line: Average gross fee-for-service (FFS) payment per physician who received at least \$100,000 in fee-for-service payments for 1995/96

2016 line: Average gross payment per physician who received at least \$100,000 for 2015/16. However, Alberta and Saskatchewan numbers are gross FFS payment because gross payment data is not released at the specialty level for these two provinces.

Up line: Percentage increase over 20 years. Thus "100%" means compensation doubled.

* Data was suppressed because there were between 1 and 4 doctors.

n/a No doctors.

So why are we comparing FFS in 1995/96 to 2015/16 gross payments? Well, pretty much every doctor was FFS in 1995/96 so that was the whole game then and CIHI only began reporting average gross payments at the specialty level in 2014/15. But with the rise of alternate payment plans in the last two decades, gross payments are now the more accurate measure of the totality of full-time doctor compensation. CIHI prepared this data at the request of the *Medical Post* and we cut off all doctors billing less than \$100,000 to try and make this a measure of full-time clinical doctors.

Why not pathology and radiology?

For these specialties, the proportion of funding that comes from the medical care plan versus hospital budgets is not consistent across the country so CIHI does not think it appropriate to include these specialties.

SPECIALTY		N.L.	P.E.I.	N.S.	N.B.
Family medicine	1996: \$174,698 2016: \$269,646 up: 54%	\$199,159 \$305,091 53%	\$162,098 \$259,368 60%	\$179,154 \$293,636 64%	
Internal medicine	1996: \$238,486 2016: \$436,945 up: 83%	\$246,714 \$463,958 88%	\$196,156 \$295,296 51%	\$275,917 \$439,872 59%	
Cardiology	1996: N/A 2016: \$584,346 up: *	N/A N/A	N/A \$281,824	N/A \$622,797	
Gastroenterology	1996: N/A 2016: \$469,470 up: *	N/A N/A	N/A \$260,663	N/A \$570,206	
Neurology	1996: \$135,390 2016: \$330,510 up: 144%	N/A *	\$164,235 \$330,392 101%	\$219,815 \$392,398 79%	
Psychiatry	1996: \$228,027 2016: \$293,396 up: 29%	\$265,807 \$369,571 39%	\$183,733 \$272,937 49%	\$193,039 \$328,161 70%	
Pediatrics	1996: \$150,401 2016: \$308,160 up: 105%	\$194,707 \$349,670 80%	\$172,208 \$253,640 47%	\$206,666 \$329,349 59%	
Dermatology	1996: * 2016: \$535,696 up: *	* *	\$301,945 \$421,123 39%	\$212,409 \$546,215 157%	
Physical medicine	1996: N/A 2016: * up: *	N/A *	\$161,290 \$245,272 52%	\$159,942 \$342,885 114%	
Anesthesia	1996: \$174,685 2016: \$430,271 up: 146%	\$156,788 \$340,300 117%	\$178,592 \$335,704 88%	\$179,509 \$350,467 95%	
General surgery	1996: \$248,770 2016: \$375,041 up: 51%	\$330,000 \$466,250 41%	\$243,973 \$393,223 61%	\$271,900 \$471,847 74%	
Thor./card. surg.	1996: \$324,316 2016: \$552,798 up: 70%	N/A N/A	\$287,214 \$429,063 49%	\$272,542 \$510,788 87%	
Urology	1996: \$348,607 2016: \$585,034 up: 68%	* \$397,922	\$220,176 \$510,716 132%	\$267,263 \$479,650 79%	
Orthopedic surgery	1996: \$234,381 2016: \$467,285 up: 99%	* \$467,101	\$292,163 \$369,726 27%	\$278,003 \$385,465 39%	
Plastic surgery	1996: * 2016: \$523,132 up: *	N/A *	\$250,034 \$416,366 67%	\$238,229 \$444,514 87%	
Neurosurgery	1996: * 2016: * up: *	N/A N/A	\$214,453 \$534,445 149%	\$192,912 \$522,121 171%	
Ophthalmology	1996: \$317,703 2016: \$807,930 up: 154%	* \$587,965	\$307,850 \$675,592 119%	\$342,394 \$780,617 128%	
Otolaryngology	1996: \$365,174 2016: \$607,816 up: 66%	* *	\$275,158 \$400,445 46%	\$264,708 \$486,999 84%	
Ob/gyn	1996: \$256,876 2016: \$391,703 up: 52%	\$294,050 \$458,739 56%	\$227,961 \$308,682 35%	\$226,835 \$396,918 75%	
Total specialists (excluding FPs)	1996: \$239,831 2016: \$415,065 up: 73%	\$258,616 \$428,334 66%	\$221,054 \$335,597 52%	\$245,560 \$420,936 71%	
TOTAL DOCTORS	1996: \$203,214 2016: \$340,027 up: 67%	\$218,442 \$355,341 63%	\$188,854 \$298,514 58%	\$207,023 \$351,224 70%	

Why no comparison—"Up" line—data for cardiology and gastroenterology? Those two specialties were grouped under internal medicine in 1996 so it isn't possible to compare change over 20 years.

Why no Quebec data? The data-sharing agreements between the government of Quebec and CIHI does not authorize CIHI to release 1995/96 data for Quebec so we excluded the province here. ♦

ONT.	MAN.	SASK.	ALTA.	B.C.	AVERAGE
\$217,799 \$363,879 67%	\$167,286 \$343,048 105%	\$191,290 \$303,561 59%	\$186,223 \$364,447 96%	\$187,970 \$273,416 45%	\$191,915 \$317,853 66%
\$354,539 \$451,670 27%	\$255,258 \$458,082 79%	\$316,278 \$496,769 57%	\$249,913 \$588,641 136%	\$289,521 \$435,394 50%	\$283,692 \$438,705 55%
N/A \$650,086	N/A \$673,892	N/A \$891,407	N/A \$683,480	N/A \$731,072	N/A \$613,164
N/A \$594,988	N/A \$620,404	N/A \$721,966	N/A \$624,139	N/A \$580,685	N/A \$539,637
\$295,618 \$337,551 14%	\$206,231 \$381,613 85%	\$231,278 \$368,451 59%	\$224,991 \$471,462 110%	\$254,058 \$339,066 33%	\$237,741 \$343,355 44%
\$196,801 \$268,993 37%	\$168,191 \$335,920 100%	\$241,574 \$342,753 42%	\$188,835 \$398,027 111%	\$172,824 \$293,456 70%	\$184,897 \$316,088 71%
\$256,123 \$317,349 24%	\$184,301 \$352,301 91%	\$187,732 \$308,691 64%	\$201,029 \$381,913 90%	\$229,465 \$321,331 40%	\$217,779 \$332,683 53%
\$304,102 \$425,129 40%	\$257,487 \$829,832 222%	\$202,291 \$362,511 79%	\$358,774 \$915,752 155%	\$302,332 \$372,443 23%	\$277,443 \$429,064 55%
\$223,485 \$312,493 40%	\$118,318 \$402,197 240%	* \$789,940	\$253,063 \$409,867 62%	\$190,868 \$245,589 29%	\$210,957 \$315,155 49%
\$218,632 \$456,248 109%	\$124,792 \$423,406 239%	\$191,632 \$335,507 75%	\$225,586 \$430,401 91%	\$197,689 \$406,214 105%	\$202,794 \$438,704 116%
\$298,659 \$489,009 64%	\$228,634 \$528,766 131%	\$232,829 \$424,174 82%	\$270,236 \$545,603 102%	\$283,865 \$472,506 66%	\$264,495 \$485,373 84%
\$455,408 \$631,753 39%	\$302,892 \$550,432 82%	\$471,108 \$927,649 97%	\$471,565 \$850,383 80%	\$398,759 \$658,323 65%	\$328,749 \$600,367 83%
\$325,342 \$513,590 58%	\$237,963 \$477,249 101%	\$276,180 \$466,884 69%	\$277,687 \$659,235 137%	\$348,191 \$506,379 45%	\$293,716 \$495,491 69%
\$299,776 \$483,550 61%	\$218,022 \$467,923 115%	\$319,914 \$602,010 88%	\$283,385 \$547,332 93%	\$257,613 \$433,510 68%	\$266,491 \$455,477 71%
\$277,740 \$392,923 41%	\$271,866 \$666,766 145%	\$229,263 \$500,063 118%	\$290,391 \$572,744 97%	\$249,553 \$451,386 81%	\$246,644 \$409,468 66%
\$285,939 \$639,470 124%	\$212,947 \$751,094 253%	\$304,088 \$868,139 185%	\$266,925 \$206,964 -22%**	\$299,715 \$631,166 111%	\$265,308 \$581,543 119%
\$358,074 \$773,604 116%	\$372,970 \$916,754 146%	\$469,572 \$1,176,179 150%	\$372,374 \$1,254,770 237%	\$365,702 \$944,698 158%	\$329,728 \$776,914 136%
\$369,568 \$455,991 23%	\$185,568 \$485,192 161%	\$396,483 \$561,761 42%	\$337,478 \$709,517 110%	\$260,638 \$489,507 88%	\$301,362 \$460,542 53%
\$314,454 \$460,463 46%	\$232,205 \$424,654 83%	\$290,905 \$467,004 61%	\$281,643 \$540,018 92%	\$270,019 \$381,549 41%	\$273,722 \$445,515 63%
\$290,007 \$428,306 48%	\$218,640 \$452,777 107%	\$275,556 \$480,774 74%	\$257,493 \$539,406 109%	\$260,051 \$423,353 63%	\$254,421 \$429,133 69%
\$251,909 \$396,250 57%	\$192,963 \$395,056 105%	\$223,585 \$387,907 73%	\$215,683 \$431,061 100%	\$216,395 \$342,438 58%	\$220,870 \$371,917 68%

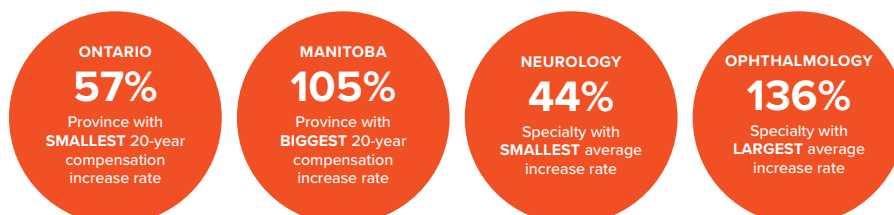
FPs 20-YEAR REMUNERATION INCREASE	
Manitoba	↑ up 105%
Alberta	↑ up 96%
Ontario	↑ up 67%
N.B.	↑ up 64%
N.S.	↑ up 60%
Sask.	↑ up 59%
N.L.	↑ up 54%
P.E.I.	↑ up 53%
B.C.	↑ up 45%

BIGGEST OVERALL INCREASES	
1.	253% Manitoba neurosurgeons
2.	240% Manitoba physical medicine
3.	239% Manitoba anesthesiologists
4.	237% Alberta ophthalmologists

SMALLEST OVERALL INCREASES	
1.	14% Ontario neurologists
2.	23% Ontario otolaryngologists
3.	23% B.C. dermatologists
4.	24% Ontario pediatricians



** Wait. Alberta neurologists' income fell 22% over 20 years? Probably not. Remember we had to use FFS averages for Alberta and Saskatchewan for 2015/16 numbers and it is known that neurosurgery is a specialty predominately paid through alternative payment plans. So this is surely a false negative as the decrease is more likely due to a shift in payment programs as opposed to less pay per physician. These are the numbers but other Alberta and Saskatchewan results with specialties where there has been a significant shift to alternative payment plans will also be influenced.



PART 2: Better data on expenses

We've seen ham-fisted attempts to fix relativity by attacking high billers. The Ontario government has imposed a series of unilateral cuts since 2012, some across-the-board and others that were targeted. As Kralj noted, "the Ministry of Health and Long-Term Care has justified some of the cuts as relativity-based, in that they were made to higher-billing specialties that they deemed over-valued. But that is not based on any methodology other than gross billings."

Simply cutting high-earning specialties is unsophisticated and wrong because it isn't necessarily reflective of net income. Expenses play a major role. A well-known 2012 study on overhead conducted by researchers at St. Michael's Hospital/ICES found that though Ontario ophthalmologists had the second-highest gross billings in the province, their overhead was much higher than most. Judged by net income, they were only the eighth-highest earning specialty.

Up until the 1990s it was possible to get physician overhead information from Revenue Canada but a policy change nixed that and since then we have been relying on self-reported estimates of overhead (the St. Michael's Hospital study came from National Physician Survey data, which is all self-reported). Now, two new association projects are set to produce more sophisticated numbers.

I spoke to Dr. Fritz of Doctors of BC by phone just before my flight from Toronto to Victoria for the holidays. He explained that the association is in the final stages of a three-quarter-million-dollar project where they have enlisted chartered accountancy and business advisory firm MNP LLP to get detailed overhead data. "It has to do with a bunch of different things: How much do you spend on rent? How much on professional dues? How many staff do you have?" MNP provided phone numbers doctors could call for instant feedback during the survey in case they had questions about any aspect of the survey. As well, all survey participants had to provide their tax returns.

MNP has asked over 1,200 full-time B.C. doctors across a range of specialties to participate and is expecting just under 50% of them to complete the survey. "We have what they (MNP) feel is a statistically significant number of responses for each section," Dr. Fritz said.

The data is going to be used to develop something Alberta already has: model offices by specialty. "If you're a family doctor working in a group," Dr. Fritz said, "your model office would cost so much per square foot for rent, professional dues, auto expenses . . . staffing. And we would put together what looks like a model office. Now that doesn't mean everyone's office is the same as the model but it would give

us an idea. And the advantage of the model office is it frees you to update in the future: if rents were so much per square foot in 2017 and in 2022 they are so much per square foot, you just change the number."

Data from these studies should be applicable elsewhere in Canada. For example, any differences between the overhead of a vascular surgeon in Vancouver and one in Toronto could be easily adjusted with a model office approach.

PART 3: Other relativity components

Better overhead data will take us a long way but after that there are some questions about the value of different types of physician work. It does not make sense, of course, to say the take-home pay for all doctors should be the same. The Alberta Medical Association's (AMA) big Income Equity Initiative is aiming to unpack some of the other components.

Calgary pediatrician and AMA president Dr. Neil Cooper said the association decided to start the Income Equity Initiative—a shared project with Alberta Health conducted by Deloitte LLP—about a year ago. At present, an overhead study similar to the one in B.C. is underway but the initiative includes two other studies: one on the number of hours worked, and one on training. "We'll come up with a model

FP 20-year income changes

In our examination of how different specialties' incomes changed over a 20-year period on the previous page, we found that in two provinces gross incomes for family doctors almost doubled: Manitoba (up 105%) and Alberta (up 96%).

We reached out to Doctors of Manitoba but the association declined to comment. Alberta Medical Association president Dr. Neil Cooper said: "Bottom line is: yeah, we've done O.K." But he also pointed out that the AMA has prioritized overhead

coverage when they received new provincial funding allocations. Family doctors have high overhead, which accounts for part of the rise. He also argued that Alberta has seen higher inflation over the last 20 years compared to the rest of Canada so family doctors are basically just keeping up. In Alberta, he said, "everything is paid higher. In fact, if you look at any profession or the Alberta wages, physicians have actually been moving a little bit slower than

the rest of the population. So generally, most Alberta workers get paid more than in other parts of the country."

At the bottom of the table, B.C. family doctors saw their income rise 45% over the last two decades—the same as inflation. We asked Dr. Trina Larsen Soles, president of Doctors of BC, whether B.C. family doctors have grounds to feel short-changed? She said the association's economics team quibbled with the numbers—that maybe some targeted funding arranged through the divisions of family

practice or other funding wasn't counted. She also pointed out that there's "pretty significant collaborative work with the ministry here and (when) you compare this to Ontario and the current toxic relationship" she said she believes there's a value to the medical "culture" in B.C. Lastly, she said: "That fact that our contracts have been accepted by a significant majority of doctors—like well over 90% every time we send one out—would certainly imply that there's some degree of satisfaction with what we've negotiated." —COLIN LESLIE

Man., Alta.
see most growth;
B.C. least

now to start studying how many hours people work at things and how much time they spend doing things; comparing their hours during the daytime versus the hours during the evenings and weekends; comparing on-call times, all that is going to be part of this time study,” Dr. Cooper said. “And then also to look at the effect of training. So how many years do you need to train to get to that position and . . . how does that affect your length of career.”

Though those three—overhead, hours worked and training—are the big components of the Income Equity Initiative, it’ll also examine competitiveness (how much specialists earn in other provinces) and other factors, Dr. Cooper said. The studies should be complete by summer 2018 and the AMA is going to decide what to do with the results at its fall Representative Forum (RF).

I was back in Toronto in early January and something they were calling a “bomb cyclone” was barreling up the east coast. Rumour had it that might close the Doctors Nova Scotia (DNS) offices in Halifax for a day—and cancel my interview with Kevin Chapman, director of finance and partnerships for DNS. But the storm didn’t drop any snow and although incredible winds took out power for much of the city, Chapman did make it into the office where he explained how the Physician’s Manual Modernization Project has worked. The five-year long project to completely redo the fee schedule is in its final stages and was co-sponsored by DNS and the N.S. Department of Health and Wellness. Chapman was the co-chair for DNS and Dr. Anne Tweed, a plastic surgeon, was the co-chair and medical consultant for the department of health.

Chapman said the project came out of the sense that the physician fee manual was out of date. “We ended up with all kinds of difficulties. Physicians would get audited and because the manual was outdated . . . they might have performed a procedure that wasn’t in the manual. So, they used a lookalike code. And when you compared it to the operative record, it said . . . you did one thing and the operative record

would say something else. So, we had a bit of a disconnect.” But “we (also) had a lot of concerns around integrity of information. If we wanted to learn how many rhinoplasties were done, for example, we didn’t have confidence in the data because physicians could have used any number of different codes.”

To develop a “new book” the project leads looked around and ultimately went with SNOMED CT for diagnosis and CPT (Current Procedural Terminology) for service delivery. Now CPT is what is used by the U.S. Medicare/Medicaid system and because it uses a **resource-based relative value unit (RVU)** system it essentially has relativity “baked in”—which gives Nova Scotia doctors some interesting options.

To map and validate the new fee codes over the old codes, the project got input from about 250 N.S. doctors—called “beacons”—including representatives from every specialty. At present the new fee code book is nearly complete, Chapman said. Now a new fee committee with more autonomy under the new contract is going to look at how to roll it out, likely this fall. But there’s a big question: Do they keep the same fee dollar value for any given procedure as the old fee schedule or do they change the pay for that procedure to what the RVU framework within CPT suggests? The new fee committee has not yet addressed this issue.

Chapman said, “if all I want to do is look at what is the percentage change by service, say plastic surgery under the old system was 12% of everything billed. Under the new system, they might be 14% of everything billed. What would tell me, relatively speaking, plastic surgery was undervalued in the old system?” But because the exercise was intended to be revenue-neutral, if the RVU system finds that some fees are undervalued, it is also going to find that others are over-valued and that might suggest that some specialties are over-compensated.

Now why—some doctors might ask—are exercises like this “revenue neutral”? Well, it is a hard sell to say to a provincial government right now: “Look, we’ve determined that physician fees are

How do RVUs account for relativity?

Relative Value Units

(RVUs) are the backbone of how the U.S. determines the value of physician labour. Not only are RVUs the foundation for the giant Medicare/Medicaid programs, most U.S. private insurers use them and in many cases they are used to measure productivity for salaried doctors. RVUs have a practice expense and work component. U.S. specialty societies play a role in keeping RVU values as accurate as possible because their physicians are asked to estimate the time and intensity (mental effort, physical effort, technical skill and psychological stress) of a service and compare that to other services.

inequitable—can you give us a 20% boost in the physician services budget this year and then we can fix it and we’re all good?”

PART 4: The political challenge

Membership-based groups such as medical associations struggle with relativity. It can feel like a no-win situation to many doctors. In some provinces doctors are Randed, meaning they are forced to pay membership fees and the medical associations have an agreement with the provincial government which makes them the official negotiator for the profession. But concern about angry sections quitting an association and trying to negotiate on their own with government is always an issue.

“Even though the Doctors of BC are the official entity for negotiating with the government,” Dr. Fritz said, “there have been various times in the past where one section or another has said, ‘You know, we’re going to go negotiate separately.’ Fortunately, no government (in B.C.) in the past has actually agreed to that, but

CHOOSE FIBRISTAL® FOR THE TREATMENT OF UTERINE FIBROIDS



More than **500,000 women** have been treated with **FIBRISTAL®** in over 77 countries²

THE ONLY ORAL MEDICATION INDICATED FOR UTERINE FIBROIDS^{*1,3}

FIBRISTAL® is indicated for the intermittent treatment of moderate to severe signs and symptoms of uterine fibroids in adult women of reproductive age. The duration of each treatment course is three months.¹

For additional information relating to contraindications, warnings, precautions, adverse reactions, drug interactions, dosing information, and conditions of clinical use, please consult the product monograph at http://fibrystal.ca/docs/Fibrystal_Product_Monograph_E.pdf. The product monograph is also available by calling us at 1-800-668-6424.

* Comparative clinical significance has not been established

REFERENCES: 1. FIBRISTAL® Product Monograph, Allergan Pharma Co., October 2017. 2. Data on file, Allergan Inc., September 2017. 3. Data on file, Allergan Inc., December 2017.

FIBRISTAL® and its design are registered trademarks of Allergan Sales, LLC, used under license by Allergan Pharma Co. ALLERGAN® and its design are trademarks of Allergan Inc. © 2018 Allergan. All rights reserved.




Pr **fibrystal**®
ulipristal acetate

Mandatory dues and official negotiator

Here, for select provinces, are where doctors are Randed (meaning they are forced to pay membership dues to their medical association) and where the medical association is the official negotiator for doctors:

PROVINCE	MANDATORY DUES	OFFICIAL NEGOTIATOR
N.L.	✓ Yes	✓ Yes
N.S.	✓ Yes	✓ Yes
N.B.	✓ Yes	✓ Yes
Ont.	✓ Yes	✓ Yes
Sask.	✓ Yes	✓ Yes
Man.	✓ Yes	✓ Yes
Alberta	✗ No	✓ Yes
B.C.	✗ No	✓ Yes

Source Provincial medical associations

it doesn't mean at some point or other they might not decide to divide and conquer like they did in Quebec*. There is a reason that Quebec had the worst fee schedule in the country."

*The Quebec Medical Association doesn't negotiate compensation. Instead the FMOQ, Quebec's GP federation, negotiates fees for family doctors and the FMSQ, Quebec's specialists' federation, for all other medical doctors, and there seems to be little interest in joining together to negotiate. Quebec doctors are in the middle of the pack nationally for average compensation but at one point they lagged behind other provinces.

So even when relativity solutions have been used in Canada they usually take the form of a negotiated fee increase to bring up undervalued specialties. In Ontario in the last couple of decades there have only been three years where there were allocations based on a relativity formula: 2009 (via RVIC) and in 2010 and 2011 (via CANDI). Half of the aggregate allocation for each of those years was given across the board to every specialty regardless of relativity. The other half was allocated to specialties that were considered undervalued according to the relativity formula. The size of the allocation depended on how

undervalued they were.

But there's an inherent slowness to that approach. The initiative for Alberta doctors aims to go further. "We may find out through our studies that there is no inequity," AMA president Dr. Cooper said. But if there is inequity and if we tried to fix it "just with allocations, we'd probably be looking at 500 years before we achieved equity." So, the RF voted on approving the use of reallocation—in other words taking money from one area and giving it to another.

"Our goal is to get it done in around five years," Dr. Cooper said. "That's the goal."

PART 5: Final thoughts

As I've thought about all this over the last few months, a few things struck me:

- **It is important to acknowledge income differences but not fixate on high-earning specialties.** "Say you cut some super high fee in half that is billed by just 10 doctors in the province, well that isn't going to be enough to fund a dollar increase in your GP office visit," said Dr. Trina Larsen Soles, president of Doctors of BC. That really struck me.

"If a fee is going down, it cannot go down any more than 10% a year."

Some high-earning specialties are so small that cutting their fees isn't going to help raise others much. Solutions should be about fairness and relativity formulas are complex. If you use good data and agree to accept the results, it then wouldn't be fair to reject the results when they aren't what you imagined them to be (if, for example, they show a high-earning specialty in your province is undervalued).

- **Look for ways to make fee code reductions palatable.** No one likes to see a fee they use go down but there are ways to make it more tolerable. Under a previous master agreement, a joint Doctors Nova Scotia/government steering group was given the power to lower and raise fees, but they had a rule: "If a fee is going down, it cannot go down any more than 10% a year," noted DNS's Chapman. They applied that rule to cataract surgery fees. Look for solutions like that.

- **Come with an open heart.** Say some relativity initiative comes to your province and say it determines your specialty is over-valued. You're going to feel like the relativity formula didn't get all the unique nuances of your specialty's expenses or how hard you work. You're going to want to attack the numbers. That's human nature and psychology of a loss stuff. Just recognize that and try to come with an open heart.

So, if we're getting better data and an association like the AMA is able to fix relativity in five years (if, of course, their studies determine there is inequity), that is going to put incredible pressure on other medical associations. The phrase that always rings in my head about trying to fix relativity is that it's "Tough but important work." **MP**



Q&A

The challenges of calculating overhead

BY COLIN LESLIE

Dr. Jeremy Petch (PhD)
of St. Michael's Hospital
in Toronto.

THOUGH SEVERAL MEDICAL associations are in the process of conducting studies on the costs of running a clinic, the best available examination in Canada for now remains the 2012 study (based on 2010 numbers) by Toronto's St. Michael's Hospital and the Institute for Clinical Evaluative Sciences (ICES). Lead author Dr. Jeremy Petch (PhD), then a researcher at St. Michael's but now leading the hospital's data and analytics strategy, discussed the study with *Medical Post* editor-in-chief Colin Leslie.

Q: How did the overhead study come about?

What we were really after when we started looking at physician overhead was a better understanding of physician net income. My colleagues had published an ICES Atlas showing gross public payments from the government to physicians in, I believe, 2011. That is a much easier thing to do because that is public data. But the study to understand net income really came out of the contract dispute between the government of Ontario and Ontario's doctors in 2012. The government was quoting unadjusted figures of how much it was paying physicians and the OMA was responding with really broad strokes around overhead and it struck us that neither side was really capturing the facts on the ground, so we wanted to bring some dispassionate data to the conversation and generate as accurate as possible estimates for net income from public payments.

Q: How did you go about trying to estimate net income?

Immediately we discovered that getting accurate data about overhead is extremely difficult because physician overhead data is really held at the level of the individual physician or the practice group. It really is between them and Revenue Canada. So we decided the most reasonably accurate way of capturing this was through physician self-report. We reached out to the people who administered the National Physician Survey and discovered that in 2010 they had asked a question about overhead. We were able to work

with them to produce a custom data cut that would be Ontario-specific and would report physician overhead by specialty. We were able to combine that at the aggregated specialty level with the data we already had from ICES to generate estimates for each specialty for net income. We had their information on gross, we had their information on overhead, so we were able to do a pretty simple subtraction to generate a rough mean for net income.

Q: When you went through the data what surprised you?

One thing that didn't surprise us at all was the immense variation in the amount of overhead that different specialties pay. For us, it was a really important finding because generally when people would talk about overhead, they would talk about physicians generally. And that is really tough. We found that physicians generally have an average overhead of 28% but that's not very meaningful when some specialties have overhead of only 11% and others have overhead of 44%. There's huge variation between the specialties.

One thing that surprised us was just how much accounting for overhead changed the rankings of specialties. So ophthalmology was second highest in gross billings but when you took into account overhead they actually dropped to eighth for net income. Accounting for overhead can really change things. Other specialties that looked like they were low earners such as emergency medicine, actually jumped quite a lot when you account for the fact that they tend to have much lower overhead than some of their colleagues in the community.

Q: What are the challenges with self-reported estimates of overhead? How reliable is it?

That is probably among the biggest limitations of our study—we had to use self-reported data. We obviously would prefer to use an objective measure. It is difficult to say whether those estimates are going to be higher or lower than the actual overhead. But I guess what I'd say is: we used the best data available.

Q: Had the National Physician Survey basically asked doctors plainly, "How much is your overhead?"

That is exactly right. And it may be that some doctors interpreted that to be "Oh, that's just the cost of operating my practice." Others might have interpreted that as, "That's all my CMA fees as well as the cost of my medical office assistant." It is tough to say how individual physicians responded. You can expect a certain amount of variation but I do think the broad strokes are reasonably accurate across specialties. There's not much reason to think that radiologists would have interpreted that question really differently than, say, emergency physicians.

Q: Is overhead variable within specialties?

There does actually tend to be quite a lot of variability within specialties but it depends on the specialty. Hospital-based physicians—for example, oncologists and emergency doctors and anesthesiologists—tend to have low variability and pretty low overhead. Whereas physicians who are almost exclusively community-based, for example family physicians, tend to have low variability and high overhead. But for specialties that have practitioners both in the community and in hospitals—for example diagnostic radiologists—they have enormous variability in how much overhead they are paying.

Q: What was the reaction in the physician community to your study?

It was a bit mixed but I think generally physicians love data and they love information. I think they appreciated the limitations of the study but they also appreciated the effort to actually provide some hard data—that we weren't just kind of guessing. There was definitely some relief within the ophthalmology community, specifically because they finally felt vindicated that something they've been saying for years was actually backed up by some hard data; namely, that while their gross incomes are high, they do have very, very high overhead as a specialty.

Q: Is overhead rising faster than the consumer price index?

I've certainly heard that claim. Unfortunately, we don't have longitudinal data about physician overhead specifically, so I'm not able to comment on it. But one thing I would emphasize is I haven't seen good data that would establish that.

Q: Are there any countries or health systems that are doing a particularly good job of measuring overhead?

Often the policy question is really around net income rather than overhead specifically. We did recently publish a paper attempting to compare net income for oncologists and radiologists and we did that with colleagues from Britain, France, the U.S. and Australia. What we found was that every country had its own unique challenges in generating accurate estimates of net income. Some of those challenges come on the payment side, because many of those systems are mixed public and private and so maybe you get good estimates of the public income but you have trouble getting the private income. In Canada, most of the payment is public though even here there are some challenges with the difference between, say, WSIB payments versus ministry of health payments, as an example. We face limitations in every one of them. The only thing I would add is that some would suggest Canada used to do a better job of tracking this than it does now. There was an income policy tax change in 1992, I believe, when we had much more accurate publicly reported information about all professions' incomes and net incomes. When that policy change went through we lost access to that data. But I think it does point to where the best data for this exists: Revenue Canada. Taxation data is where we're going to be able to find good information about overhead, and ultimately net income. If we consider that important, and we think that is an important policy question, that's really where we have to get it. **MP**



Take home after overhead

Here are the results of the **ICES/Toronto's St. Michael's Hospital 2012** study ranking bottom-earning to top-earning specialties in Ontario:

SPECIALTY	GROSS PAYMENTS BY FTE	OVERHEAD	NET INCOME FROM PUBLIC SOURCES
Psychiatry	\$193,000	\$43,282	\$149,718
Pediatrics	\$261,300	\$84,406	\$176,894
Neurology	\$271,900	\$85,352	\$186,548
Physical medicine and rehabilitation	\$251,000	\$58,383	\$192,617
Internal medicine	\$271,500	\$72,049	\$199,451
Rheumatology	\$299,200	\$94,487	\$204,713
Endocrinology	\$275,600	\$70,609	\$204,991
Emergency medicine	\$235,000	\$29,950	\$205,050
Family medicine	\$300,100	\$92,437	\$207,663
Plastic surgery	\$348,500	\$114,099	\$234,401
Dermatology	\$383,400	\$146,881	\$236,519
ALL PHYSICIANS	\$334,700	\$94,322	\$240,378
Otolaryngology	\$436,400	\$158,847	\$277,553
Orthopedic surgery	\$412,900	\$125,185	\$287,715
Respirology	\$349,300	\$59,870	\$289,430
Medical oncology	\$330,600	\$37,887	\$292,713
General surgery	\$410,500	\$112,735	\$297,765
Obstetrics/gynecology	\$446,100	\$142,722	\$303,378
Urology	\$433,900	\$121,535	\$312,365
Anesthesiology	\$395,900	\$54,459	\$341,441
Ophthalmology	\$604,600	\$257,793	\$346,807
Cardiology	\$531,000	\$152,280	\$378,720
Radiation oncology	\$432,400	\$41,121	\$391,279
Gastroenterology	\$534,400	\$115,698	\$418,702
Cardio/thoracic surgery	\$525,400	\$104,187	\$421,213
Vascular surgery	\$545,000	\$108,074	\$436,926
Nephrology	\$557,200	\$84,249	\$472,951
Diagnostic radiology	\$606,700	\$119,856	\$486,844



ARE FOOD CRAVINGS CONTRIBUTING TO OBESITY IN YOUR PATIENTS?¹

OBESITY IS A **CHRONIC DISEASE** THAT WAS SHOWN
TO AFFECT 1 IN 4 CANADIANS IN 2011-2012.^{2,3}

A CHRONIC DISEASE THAT
REQUIRES A LONG-TERM APPROACH.^{1,3,4}



Valeant is committed to
research in obesity.

References:

1. Akabas S, Lederman SA, Moore, BJ. Textbook of obesity: biological, psychological and cultural influences. Wiley-Blackwell 2012.
2. Navaneelan T, Janz T. Adjusting the scales: *Obesity in the Canadian population after correcting for respondent bias*. Statistics Canada, Catalogue no. 82-624-X. Health at a Glance. May 2014.
3. Canadian Medical Association, News Alert: CMA recognizes obesity as a disease. Accessed online on January 15, 2018 at: <https://www.cma.ca/En/Pages/cma-recognizes-obesity-as-a-disease.aspx>
4. 2006 Canadian clinical practice guidelines on the management and prevention of obesity in adults and children. CMAJ April 10, 2007, Vol. 176, No. 8.

INTRODUCING SHINGRIX

HELP **PROTECT** YOUR PATIENTS AGED 50+ FROM SHINGLES¹



SHINGRIX

HERPES ZOSTER VACCINE (NON-LIVE
RECOMBINANT, AS01_B ADJUVANTED)

NOW AVAILABLE IN CANADA

**SHINGRIX demonstrated >90% efficacy
in all age groups studied vs. placebo^{1*}**

	Age	SHINGRIX (n/N)	Placebo (n/N)	% Efficacy (95% CI)
Data from ZOE-50 [†]	50–59	3/3,492	87/3,525	96.6% (89.6, 99.4)
	60–69	2/2,141	75/2,166	97.4% (90.1, 99.7)
Pooled data from ZOE-50 and ZOE-70 [†]	70–79	19/6,468	216/6,554	91.3% (86.0, 94.9)
	≥80	6/1,782	68/1,792	91.4% (80.2, 97.0)

SHINGRIX is indicated for prevention of herpes zoster
(HZ, or shingles) in adults 50 years of age or older.¹

Learn more at **ThinkSHINGRIX.ca**



Most serious warnings and precautions:

- **Administration:** Do not administer the vaccine intravascularly, intradermally or subcutaneously

Other relevant warnings and precautions:

- A protective immune response may not be elicited in all vaccinees
- Not for prevention of primary varicella infection or treatment of HZ or postherpetic neuralgia
- Postpone in those with acute severe febrile illness
- Use with caution in those with thrombocytopenia or any coagulation disorder
- Syncope following or before any vaccination as a psychogenic response
- Use in special populations such as pregnant or nursing women or pediatrics (<18 years of age) has not been established
- Limited data in immunocompromised adults 50 years of age or older

Adverse events:

- Solicited local and general adverse reactions that occurred in clinical trials within 7 days of vaccination in subjects aged 50–69 and ≥70 years respectively were: pain (85.6%, 69.2%), redness (38.5%, 37.7%), swelling at the injection site (28.5%, 23.0%), myalgia (53.0%, 35.1%), fatigue (51.3%, 36.6%), headache (45.2%, 29.0%), shivering (33.1%, 19.5%), fever (25.9%, 14.3%), gastrointestinal symptoms (20.5%, 13.5%)
- Unsolicited adverse reactions that occurred in clinical trials within 30 days of vaccination in ≥1% of subjects and ≥2-fold higher than placebo recipients included chills (3.5%), injection site pruritus (2.2%), and malaise (1.7%)

For more information

Please consult the product monograph at gsk.ca/SHINGRIX/PM for important information relating to dosing and administration, adverse reactions, contraindications and drug interactions which have not been discussed in this piece. To request a product monograph, or to report an adverse event please call 1-800-387-7374.

* Two multi-centre, randomized, observer-blind, placebo-controlled trials in subjects 50 years of age and older who received two doses of SHINGRIX (n=14,645) or placebo (n=14,660) at 0 and 2 months. Primary efficacy analysis was of the Modified Total Vaccinated Cohort (mTVC): all subjects randomized who received a second dose of the vaccine and did not develop a confirmed case of shingles within one month after the second dose. Randomization was stratified by age in years: 50–59, 60–69, 70–79 and ≥80 in an 8:5:3:1 ratio (ZOE-50); 70–79, ≥80 in a 3:1 ratio (ZOE-70). Subjects were followed for the development of shingles for a median of 3.1 years (ZOE-50; range: 0–3.7 years) and 3.9 years (ZOE-70; range: 0–4.5 years). Primary endpoint was vaccine efficacy as measured by the reduction in herpes zoster risk.

† Vaccine Efficacy (VE) adjusted by age strata and region.

Reference: 1. SHINGRIX Product Monograph, GlaxoSmithKline Inc., October 13, 2017.

Trademarks are owned by or licensed to the GSK group of companies.
©2018 GSK group of companies or its licensor.



SHINGRIX
HERPES ZOSTER VACCINE (NON-LIVE
RECOMBINANT, AS01, ADJUVANTED)

THE OMA'S



BALANCING ACT

A Medical Post investigation on the Ontario Medical Association's internal efforts to fix a problem with the CANDI formula

BY TRISTAN BRONCA

CANDI IS A BLACK BOX. Few besides health economics wonks in Ontario fully understand how it works. But many doctors have a strong opinion about it.

CANDI stands for “Comparison of Adjusted Net Daily Income” and it is a formula to calculate the value of a day’s work, in any medical specialty. It takes average gross income and multiplies it by modifiers such as the amount of non-fee-for-service work performed, overhead, skill requirements and work effort.¹

¹ Certain inputs to the formula such as gross billings and non-fee-for-service work are ministry of health numbers provided to the medical association through a data-sharing agreement. They change every year. But most others, such as overhead, were first calculated by a 2011 PricewaterhouseCoopers study. They haven’t changed in the last seven years.

The resulting number is known as Adjusted Net Daily Income—ANDI—a score that allows for a comparison between specialties that are otherwise incomparable. In the association’s history, this tool is the closest anyone has come to being able to fairly contrast the value of the medical services performed by, say, a psychiatrist and a surgeon.

Boris Kralj is a health analytics, economics and management consultant now in private practice. For 23 years he worked for the Ontario Medical Association, most recently as chief information and analytics officer (he retired last year), which makes him one of the few people who understands the intricacies of CANDI.

He explained that the formula was developed in 2009 and was “used” only twice. In the 2008 physician services agreement, doctors and the health ministry decided that two of three relativity funding allocations (in 2010 and 2011) should be paid out according to CANDI’s methodology. Specialties with below average ANDI scores—such as neurology, geriatric medicine, respirology, psychiatry and general practice—received two to three times more than specialties with higher scores. The most overvalued specialties—which according to CANDI, include diagnostic radiology, cardiology and nuclear medicine—received none of those relativity allocations.

Those payments were worth millions of dollars, meaning that even if doctors don’t understand exactly how CANDI works, there are good reasons for them to be interested in it.

CANDI’S PROBLEM

CANDI is not perfect. During an educational session on CANDI to the OMA council in 2016, Kralj showed how much the ANDI scores for different medical specialties changed between 2008/09 and 2015/16. Ideally, the relativity allocations should have levelled the ANDI scores, but they didn’t exactly. Some specialties that were below the average, such as emergency medicine, saw their scores drop, while others on the far end of the spectrum, such as radiology and ophthalmology, saw them increase. In these cases, the inequities actually got worse.

Some of those problems may be ironed out with more time and larger funding allocations. But there’s also a bigger problem with CANDI which has to do with the “daily” part of the formula.

In order to fairly compare specialties, CANDI doesn’t include after-hours or weekend work. Surgical specialties have special fee codes that allow economists to identify a surgery or a delivery performed in the middle of the night

and exclude it from CANDI so it doesn’t skew a surgeon’s ANDI score. The problem is non-surgical specialties don’t really have these codes, so at least some of their after-hours work improperly affects their ANDI score.

Kralj said the OMA has been aware of this issue with the data since the formula was first created, and at every attempt at negotiations they have asked the ministry of health to introduce a tracking code that would allow the OMA to correct it (he said the ministry has always said it would be too onerous to update the computing system). He also said this has been documented in at least two reports to the OMA board and council, one in 2009 and another in 2012. According to those reports, the problem was particularly acute for three specialties.

However one of those specialties is also, according to CANDI’s methodology, the most overvalued: radiology.²

² In fact, the after-hours issue for radiologists is believed to be even more punitive than it is for the other specialties. According to a report titled Estimating the Magnitude of Error from Major Systemic Bias in the CANDI Formula, “all physicians perform work after-hours that is not captured by CANDI. Radiology is the only section where after-hours work and on-call work are not captured by CANDI.”



THE AFTER-HOURS MODIFIER

While Kralj was adamant that the reports on the issues related to after-hours work data were available to any OMA member who was interested in them (he said hard copies are sent to all council members 10 days before the meetings and later uploaded to the OMA member website) the group representing radiologists—the Ontario Association of Radiologists (OAR)—has claimed the full scope of the issue was never disclosed to them. They claim the data was suppressed.

Sources who wished to remain anonymous explained that the OAR only found out about this issue just before the current round of contract negotiations with government, which began Sept. 2017. (The OAR did not respond to requests for comment on this story.) At that point, the OAR approached the OMA board to find out what percentage of the total workload for radiologists was deemed “after hours.”

Based on available OHIP data, it was just 3.6%.

Both the radiologists and the current OMA leaders seemed to agree that figure was far too low and needed updating, as did the numbers for several other specialties. What that number should be, however, is still a matter of some debate.

The problem is being addressed by the OMA’s relativity review committee (RRC), which surveyed all specialties to determine whether the OHIP data fairly reflected actual after-hours and weekend work. According to documents presented to the board and obtained by the *Medical Post*, the RRC suggested—based on its consultations with the section—that the average percentage of after-hours work for a radiologist was 18.8%. It was a significant jump from the existing OHIP data, but not even the largest of all the specialties.³

³ It was actually the fourth largest, behind nuclear medicine (which claimed their percentage of after-hours work ought to be 23.3% higher than OHIP data), radiation oncology (21.3% higher) and nephrology (20.1% higher). Nearly 30 specialties of the 60 that were consulted suggested that a higher percentage of their work was done after-hours than OHIP data suggested, but for the majority there was less than a five-percentage-point difference.

However, according to an internal OAR memo sent to radiologists at the beginning of Jan. 2018, the OAR also conducted its own comprehensive analysis of hospital data which, it said, “convincingly showed” the average radiologist did about 40% of their work after hours—a figure that was more than twice as high as the one calculated by the relativity committee.

The OMA’s economics department typically tries to verify these figures, but they couldn’t in this case because they didn’t have access to the OAR’s source data. However, Kralj did say that the OMA board can approve changes—or allow the negotiating team to adjust—these after-hours modifiers without verification from OMA Economics if they felt such changes were warranted.

This was one of those cases. OMA president Dr. Shawn Whatley would not say by how much these CANDI variables were adjusted, but he did confirm the board approved changes to after-hours modifiers for all specialties, including radiology.

“We’re updating everyone,” he told the *Medical Post*.

THE DECISION-MAKING APPARATUS

The governing body of the OMA is not the 24-member board, but the 200-plus member council. They meet twice a year, at which point there is always some discussion about pay relativity. Dr. Del Dhanoa, the chair of the OMA’s relativity committee and a radiologist, delivered the last update at the most recent council meeting held the weekend of Nov. 25, 2017.

While Dr. Dhanoa did not respond to our requests for comment, the *Medical Post* learned that at the time of this meeting, the relativity committee’s work was still incomplete and he was bound by several strict confidentiality agreements. For these reasons, the issues with CANDI, the relativity committee’s survey results and the OAR study were never discussed. (It is, however, worth noting, that Dr. Dhanoa presented the survey results and the discrepancies in after-hours work to the OMA board on Nov. 21, the week before the council meeting.)

Around this period, the relativity committee was continuing to solicit submissions from nearly 60 specialty sections. In addition to that, the heads of those sections were also meeting regularly with the OMA negotiations committee to inform them directly of their specialty-specific concerns, including about relativity. All signed non-disclosure agreements.

The idea that the negotiating committee should consult the section heads, and keep them updated during negotiations, came from a motion at the general meeting of members in the summer of 2016. That meeting was called so members could vote on a controversial tentative physician services agreement that was reached during what some saw as a secret set of negotiations between the OMA’s former leadership and the ministry (it was heavily criticized and eventually voted down).

The motion was to make sure nothing like that ever happened again.

A SMALL BUT INFLUENTIAL SPECIALTY

The OMA’s leaders are engaged in a constant balancing act to ensure multiple competing interests are represented.

Radiology is a relatively small specialty, with about 1,000 practitioners across Ontario (by comparison, family medicine, the largest, has over 30,000). In the last two years, however, the specialty has made a concerted push to ensure it is represented in the OMA leadership.

There are, for example, now two radiologists on the OMA’s 24-member board: Dr. Dhanoa and Dr. David Jacobs. In addition to Dr. Dhanoa, there is a second radiologist on the nine-member relativity committee. There is also one radiologist, Dr. David Kelton, on the negotiations committee, the group that has been in direct contact with ministry of health representatives during contract negotiations.

In the memo to radiologists, the OAR said that “many changes have occurred for the better at the OMA.” This included a turnover of “old guard OMA board members and senior staff”—a group that included Boris Kralj—“permitting new people to be involved who are

committed to a more democratic and effective organization.”

The OAR claims that under the current OMA leadership, their voices “are being heard for the first time in years.” Other specialties worry those voices will now drown out their own.

In July 2017, the *Medical Post* asked Dr. Whatley why higher-earning specialties, such as radiology, were proportionally overrepresented on the relativity committee. He said that, despite the OMA’s efforts to ensure fairness, an eight-member committee would never be properly representative.

“People want their own person on the committee, but it can’t be about having your own person,” he said. “It has to be about having the best person with the best skills to deliver the best performance on such an incredibly important topic.”

“It’s really important that this not become an issue of identity politics,” he cautioned.

But not everyone felt the issue could be dismissed. Dr. Robert Yufe, a neurologist, later commented on the story on the *Medical Post’s* website, saying it was a “classic case of putting the fox in charge of guarding the henhouse.”

NO SIGNIFICANT CHANGE TO ANDI SCORES

The after-hours modifier is not an inconsequential aspect of CANDI. According to a report titled *Estimating the Magnitude of Error from Major Systemic Bias in the CANDI Formula*, even a small change could drop radiology’s ANDI rank two or three spots, making it less overvalued than specialties such as ophthalmology, gastroenterology and cardiology. However, a more drastic change such as one based on the data from the radiologist’s study (which, again, suggested about 40% of their work was done outside of the regular work day), radiologists could theoretically drop 17 spots on the ANDI spectrum to the middle, somewhere between laboratory medicine and neurology. Were that to happen, they would no longer be seen as overvalued.

Inside sources who wished to remain anonymous said it would be almost

“Inside sources who wished to remain anonymous said it would be almost inconceivable for the OMA board to approve a change that drastic given the existing perception and pay of radiology.”

inconceivable for the OMA board to approve a change that drastic given the existing perception and pay of radiology. “They know it wouldn’t fly,” one said.

That source couldn’t offer specifics on the board’s decisions but did say that to the best of their knowledge there was not “much change in ANDI positions.”

“Radiology is still to the right of CANDI,” meaning they are still considered overvalued; “psychiatry is still to the left,” the source said.

INTO ARBITRATION

What distinguishes CANDI from the OMA’s historical attempts to address relativity is that the ministry isn’t involved with the calculations. In the past, relativity models were developed bilaterally, meaning the ministry and the OMA worked together. But with CANDI, it is up to doctors to sort it out.

But now, it’s not really up to them anymore.

On Jan. 16 the OMA announced that it had triggered the binding arbitration process in which three independent arbitrators—one mediator and two other legal representatives appointed by the ministry and the OMA, respectively—would determine the terms of the physician contract.


“This is something new,” Dr. Whatley told the *Medical Post*. He explained that

typically the OMA board and council would have to vote on significant changes to relativity models but now they won’t have that chance. This is relevant because there are seven criteria the arbitrators are bound to consider when deciding on the terms of the contract. Three of them are related to fairness of pay between doctors.⁴

⁴ These relativity criteria were one of the primary reasons the binding arbitration framework was opposed by many physicians from higher-paid specialties. Nevertheless, the framework was approved during a general meeting of members in June 2017.

But that doesn’t mean all this work on CANDI has been for nothing. The arbitration proceedings could run into October and both the OMA and the ministry will soon be preparing presentations to the arbitrators. “Our submissions must be outstanding,” Dr. Whatley said in a communication to members announcing the beginning of arbitration.

But that raises the question: outstanding for whom? The OMA is bound to represent all members but with less funding to go around, the leaders are walking an increasingly fine line in trying to do so. Every step—and misstep—may be worth many millions of dollars. **MP**



THE RURAL PAY GAP

Why was a clinic in the town of Nipigon, Ont. flooded with applications from first-year doctors and what does it say about relativity?

BY TRISTAN BRONCA

When doctors talk about relativity, it's almost always about the pay inequities between specialties. But the topic is much broader than that, which becomes clear when you begin asking what to do about those inequities. Do you look at fees? Income? Both? What about

the payments to equalize things? How should they be distributed? How much is enough? Work hours, market forces, biases, overhead—each of these are points of inexhaustible discussion.

But one question that rarely gets asked is how these concerns affect physicians at the practice level.

Over the course of the *Medical Post's* reporting, we discovered one of the places this was having the most significant impact was in the family health clinics of northwest Ontario. Unlike more-talked-about pay inequities it did not involve specialists, only family doctors—in some cases even those practising in the same team.

A POINTLESSLY EXPENSIVE FIGHT

In Ontario, the introduction of family health organizations (FHOs) brought about a relatively new way to pay family doctors. It was meant to be part of a move to a more comprehensive version of primary care, where capitated payment models, which allowed doctors to spend more time with individuals, supplemented standard fee-for-service models, which encouraged volume and efficiency.

The move to FHOs has proven very popular, especially among the newest generation of FPs who have been trained to operate in these teams. But not all doctors—particularly those who had grown accustomed to fee-for-service practice—were interested in being a part of the model. Dr. John Fotheringham, a family doctor in the town of Nipigon, remembers that when the model was first introduced, one of his senior colleagues had even spent \$18,000 of his own money fighting the government's order to have him moved to an FHO.

It's not uncommon for physicians in the underserved part of northern Ontario to amass large patient rosters and this doctor was no different. Dr. Fotheringham estimated this colleague had more than 2,500 patients and he would have been earning a comfortable living doing fee-for-service work, grossing in excess of \$300,000 a year. But when he was forced into a capitated model, not only was there less pressure to see as many patients as quickly, but his income more than doubled, to over \$750,000. To resist the move to the FHO was a pointlessly expensive legal fight.

He wasn't the only one either. There are perhaps many dozens of these legacy fee-for-service doctors now practising in FHOs in the province's northwest.

"Northwestern Ontario has a population of around 500,000 people, which is like a city block in Toronto," Dr. Fotheringham said. That is, of course, an exaggeration but he used it to make a point: With such a small number of doctors, the government may not have noticed such a significant pay rise. It wasn't a priority. But, if you count the hundreds of doctors throughout the province who have moved from fee-for-service to FHOs, that pay rise becomes a more noticeable budget item, even if few of the individual increases were as extreme as those of the doctors in the northwest.

A FLOOD OF APPLICATIONS

The FHOs created a pay disparity between senior doctors and their junior colleagues who were still building their patient rosters but, as with any industry, such pay disparities are often to be expected. The bigger problem was that when the government tried to rein in spending, it was new doctors who were hardest hit.

Dr. Fotheringham saw this first-hand. For several years, he and his colleagues at his clinic in Nipigon, Ont. have operated at a shortage. The provincial ministry of health determined that their patient catchment should be serviced by about five doctors but their team had only four, and they had struggled mightily to find someone to help them with the workload.

Then, at the end of Nov. 2017, something entirely unexpected happened. Dr. Fotheringham said he and his colleagues were about to settle on a locum candidate when they were flooded with applications from first-year doctors.

"We went from having no hope of ever having five doctors, to having a waiting list," he said. "We all could have quit and still had five full-time doctors, plus two competing offers for full-year locums." He said that in a single week, they received more than double the number of applications that they did in the last five years combined.

UNIQUE GEOGRAPHICAL QUIRK

Dr. Fotheringham attributed the influx of applications to what he called a "unique geographical quirk." In 2015, Ontario's ministry of health restricted the number of new physicians who could enter FHOs. Those restrictions applied everywhere except in underserved areas, like many parts of Ontario's northwest. However, the ministry also imposed a cap on how many patients those first-year doctors could roster and thus, how much they could earn. The figure topped out around \$175,000, which, after overhead, expenses and taxes, meant annual take-home pay could dip as low as \$60,000. This cap affected all first-year doctors in any FHO in Ontario, including in the underserved northwest.

Dr. Fotheringham, however, didn't work in an FHO, so first-year family doctors were not subject to any such cap. The group was also, compared to other towns, relatively close to Thunder Bay, meaning family doctors could come to work with Dr. Fotheringham's group without uprooting their home lives (this was the "geographical quirk").

While the FHO roster cap is only in place for a physician's first year (doctors in their second and third years go on to make comparable sums to other doctors in the FHO), it just so happened that many



"It clicked when my doctor and I discussed Trulicity®."*

- Once-weekly dosing
- Ready-to-use pen†
- Preattached, hidden needle†

*Fictitious patient. May not be representative of all patients.

Trulicity 1.5 mg demonstrated A1c reduction comparable to liraglutide in a non-inferiority, open-label study.†§
Change from baseline in A1c at 26 weeks: Trulicity 1.5 mg + metformin, -1.4; liraglutide + metformin, -1.4; $p < 0.001$ for non-inferiority.

Trulicity is indicated for the once-weekly treatment of adult patients with type 2 diabetes mellitus to improve glycemic control, in combination with:

- diet and exercise in patients for whom metformin is inappropriate due to contraindication or intolerance.
- metformin, when diet and exercise plus maximal tolerated dose of metformin do not achieve adequate glycemic control.
- metformin and a sulfonylurea, when diet and exercise plus dual therapy with metformin and a sulfonylurea do not achieve adequate glycemic control.
- prandial insulin with metformin, when diet and exercise plus basal or basal-bolus insulin therapy (up to two injections of basal or basal plus prandial insulin per day) with or without oral antihyperglycemic medications, do not achieve adequate glycemic control.

once weekly
trulicity
(dulaglutide) injection
0.75 mg/0.5 mL, 1.5 mg/0.5 mL

Clinical use:

Trulicity has not been studied in combination with basal insulin. Trulicity is not a substitute for insulin. Trulicity should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis.

Contraindications:

- Patients with a personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- Pregnant and nursing women

Most serious warnings and precautions:

Risk of thyroid C-cell tumours: In male and female rats, dulaglutide causes dose-dependent and treatment duration-dependent thyroid C-cell tumors after lifetime exposure. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Other relevant warnings and precautions:

- Heart rate increase
- Prolongation of PR interval
- Hypoglycemia (in combination with a secretagogue or prandial insulin)
- Systemic hypersensitivity, including postmarketing reports of serious reactions (e.g., anaphylactic reactions and angioedema)
- Pancreatitis
- Systemic hypersensitivity
- Not studied in pediatric patients
- No dose adjustment required in patients over 65 years of age
- Hepatic or renal impairment
- Recent myocardial infarction, unstable angina and congestive heart failure

For more information:

Please consult the product monograph at www.lilly.ca/TrulicityPM/en for important information relating to adverse reactions, drug interactions, and dosing information which have not been discussed in this piece. The product monograph is also available by calling us at 1-888-545-5972.

Reference: 1. Trulicity Product Monograph. Eli Lilly Canada Inc., June 15, 2017.

[†] Clinical significance has not been established.

[‡] The recommended starting dose for Trulicity is 0.75 mg once-weekly.

[§] 26-week, randomized, open-label, parallel group, multicentre, active-controlled, phase III non-inferiority study. Patients received either 1.5 mg Trulicity once weekly (n=299; baseline A1c 8.1%) or 1.8 mg liraglutide once daily (n=300; baseline A1c 8.1%). Treatment was added to background therapy with metformin (≥ 1500 mg/day). All n-values refer to intent-to-treat population. Primary endpoint was change in A1c from baseline to week 26 between once-weekly Trulicity and once-daily liraglutide.

TRULICITY is a registered trademark owned by or licensed to Eli Lilly and Company, its subsidiaries or affiliates.

© 2017, Eli Lilly and Company. All rights reserved.



PP-DG-CA-0016

once weekly
trulicity[®]
(dulaglutide) injection
0.75 mg/0.5 mL, 1.5 mg/0.5 mL

first-year doctors reached the government-imposed limit around the end of October. Dr. Fotheringham said in hindsight, he isn't surprised so many decided to seek work elsewhere rather than sticking it out for the last two months.

"This is sort of an extreme example, but you have to remember some of these doctors were nurses and physiotherapists who were earning more than \$60,000 before they went to medical school," Dr. Fotheringham said. Later in the year, new doctors began fanning out even farther across Ontario's north-west, seeking work in towns such as Geraldton, more than two hours from their homes in Thunder Bay.

APPROPRIATELY DIRECTED RESENTMENT

Nearly every doctor who spoke with the *Medical Post* emphasized that on a day-to-day level, relativity doesn't affect how they do their job. They insisted that no matter the real or perceived pay gap—or how fair or unfair it might be—it almost never crosses their mind when they're interacting with a colleague, and it certainly doesn't affect their interactions with patients.

Dr. Fotheringham pointed to ophthalmology as a personal example. He said these doctors aren't making more money "because they're being greedy and they're jacking their fees up." It's because they can now accomplish certain tasks in three minutes that used to take 30. He told the *Medical Post* that as a resident, he worked with an ophthalmologist who used to scold him for being too slow. He remembered that it would take him longer to hook up an I.V. than it did for the surgeon to perform the surgery.

"And unless every jurisdiction suddenly drops their fees, you could just go to the next province over or the U.S.," he said. To resent the ophthalmologist for this seemed nonsensical, he added, like being bitter about someone else winning the lottery.

Dr. Fotheringham said the same sentiment holds true for young family doctors in FHOs, as well as the ones who have left them. For the most part, they see their senior colleagues as leaders and mentors in the team. Moreover, some of those legacy doctors feel guilty about earning as much as they do, and many reinvest their earnings in the team, providing kickbacks for junior colleagues who pick up their coverage. It's a symbiotic relationship.

Dr. Fotheringham argued that the people who resent the higher-paid family doctors most are not other doctors, but the ones who moved them into these models in the first place. They are, after all, the ones who have to pay them. **MP**

Back Pages



Clinical courage

Rural practice often requires living with a lot of clinical uncertainty, trusting one's gut and a willingness to see how things develop

The term “clinical courage” is common in the world of remote and rural medicine. A recent robust discussion of the term and its meaning occurred on the Society of Rural Physicians of Canada’s listserv. The discussion showed that, as with so many things, clinical courage means different things to different people.

I remember that my first family medicine residency evaluation had an unfamiliar tick box: “Deals well with clinical uncertainty.” As a new resident, this seemed bizarre. I didn’t realize that

we were allowed to be uncertain at times. It took me a few months to understand that not every patient complaint linked directly to pathology, that many things got better with time and that some concerns merited reassurance and watchful waiting rather than immediate referral, tests or imaging.

In short, during residency I learned that sometimes the best treatments require physicians to have enough clinical courage to sit on our hands. But it takes experience to say, “I’m not sure what is going on but it doesn’t strike



BY DR. SARAH GILES

me as something life-threatening. Let’s keep an eye on it. I’ll see you back in the clinic in three weeks, earlier if x, y or z happens.” Learning to sit and wait and learning that there isn’t always an answer requires clinical courage.

There’s also the brand of clinical courage needed when doing something for the first time. Rural family physician Dr. Sarah Newbery said the term “captures what I feel with everything that I do for the first time (from the management of a new ER presentation to the first MAiD discussion or Suboxone start I had).” She pushes the idea further by asking if it’s “time to make ‘courage’ the next ‘c’ in the curriculum development work of medical education?”

It makes sense that if we are going to encourage our residents to show clinical courage that we select medical school applicants who demonstrate that trait or at least an aptitude for it. But how do we select for clinical courage? Who will successfully navigate the trepidation, fear, and excitement of working without a CT scanner or a surgeon in a small town? How do we differentiate that person from someone who will be reckless with lives? Is the skydiver more likely to have clinical courage than the book-lover?

We need to teach clinical courage and demonstrate it for our students if we hope to see them exhibit it. They need to understand that while some issues are black and white, initial presentations often come in shades of grey. A patient complaining of a feeling of pre-syncope

could be anxious, anemic, have hyperthyroidism, valvular disease, be drinking too much caffeine or have a variety of other problems. After a careful history and physical, we can order every test in the book or we can choose tests wisely and, with a tincture of time, see how things develop. As doctors, we have a duty to patients but also a duty to use public resources wisely—something we must teach our young charges.

Clinical courage also means learning to trust our gut. As we learn more and more about the enteric nervous system, I believe that my “gut” instinct is likely an unconscious awareness of patient peril that my conscious mind can’t quite name. Clinical courage means respectfully arguing with anyone who will listen why a patient needs an urgent consult or transfer despite stable vital signs. It means running the very real risk that your patient will be sent out on a very expensive medevac only to return later with the label of “normal.” It’s the courage to be wrong while knowing that those who cry wolf will have a harder time getting their patients accepted the next time ‘round.

As one astute listserv member pointed out, clinical courage should never be a replacement for necessary tools and staff. There will always be different levels of comfort among practitioners. Doctors who train in major urban centres are unlikely to be comfortable practising in remote environments and vice versa. But it should never be the role of administrators to insist that a physician accept a lack of equipment or staff that she feels is vital.

For instance, I firmly believe that tranexamic acid must be present in any remote community in which I work. It is a drug that costs less than \$2 per dose and can be lifesaving, especially when blood products aren’t kept in the community. Administrators have told me countless times that “no doctor has asked for it in the past.” That, of course, may well be true (though more often than not, I find that it is on the local formulary and simply not in stock), but it is non-negotiable for me. I’m not a prima donna, but my clinical courage has nothing to do with a lack

“Many doctors self-triage themselves out of providing acute care.”

of essential medicines. I can do a much better job at stopping life-threatening bleeding with tranexamic acid than with external pressure alone. My personal expectation is that if I have drug or piece of equipment when in the field with Médecins sans Frontières, I should have it in Canada (and you would be surprised how many locations fail to meet that expectation).

Many doctors self-triage themselves out of providing acute care and situations needing an abundance of clinical courage. I believe that some doctors subconsciously create very long waits for clinic appointments (with no same-day slots) so that patients with any degree of acute illness will be forced to go to a walk-in clinic or the emergency room instead. Further, there are those who send multiple patients per day to the emergency room with minor complaints. These doctors likely experienced a bad outcome at some point that they haven’t worked through and have lost some of their clinical courage. While there needs to be room for all types of doctors in medicine, we also need to work to the fullest extent of our training. I don’t know how to help doctors regain clinical courage in the assessment and treatment of patients with acute concerns, but there must be a way.

Clinical courage means different things to different people. It may even mean something different to the same person at various stages in their career. In the end, it’s important to recognize the fact that our jobs aren’t easy and sometimes just showing up at work requires more courage than some of us are willing to let on.

DR. SARAH GILES is a locum family/ER physician from Ontario.



Money. Politics. Practice. Sex.

The Medical Post stories you won't get in this magazine

Sign up for our Monday-to-Friday morning e-newsletter for content that hasn't been in the magazine. Registration is free and easy for Canadian doctors and medical students. You can do this at the online home of the Medical Post: **CanadianHealthcareNetwork.ca**. Don't worry: we won't give anyone your email address.

The
Medical Post



The time limit for malpractice lawsuits

Ontario patients who launch a malpractice lawsuit have a two-year deadline, but it's not always clear when that clock starts ticking

A malpractice lawsuit has been thrown out of an Ontario court because the patient waited too long to launch it. The rule against “sleeping on your rights” is ancient, first codified in English law during the era of Shakespeare. The wisdom behind it is obvious: litigating about events that occurred too far in the past is a bad idea. Memories fade, evidence gets lost, and no one should have to live in never-ending fear of being sued. So there needs to be a deadline, and in Ontario it is two years. If you don't go to court within that time, you're out of luck. However, a vexing question often arises, and in this case it did: When does the two-year clock start ticking?

It starts ticking on the day the plaintiff first knew, or ought to have known, that they were wronged. In this case the court found that the patient, who claimed she was given an overdose of Botox, had sufficient actual knowledge to launch a lawsuit on the day she received her last injection. This was based on her behaviour. She complained to various medical professionals. She sought a lawyer. She attempted to engage the media and publicize the purported wrong-doing. She lodged a complaint with Health Canada. She even tried to press criminal charges against the defendant physicians for “poisoning” her system. What she failed to do was start a lawsuit.



BY BILL ROGERS

When she finally did go to court, she was immediately met with the doctor's (successful) summary judgment motion to time-bar her. She tried to argue that even though she had raised hell shortly after her last Botox injection, it was not until much later that she got hold of her actual medical charts and records. If the clock started on the day she got those, she said, her lawsuit would not be time-barred. No, said the court. The charts and records did not contain any new facts. They were not a game-changer. She was out of luck.

In another Ontario case, this one involving breast implants gone wrong, the situation was not as straightforward. The patient had not demonstrated actual knowledge of wrongdoing by complaining to doctors, lawyers, etc. So the court ruled that it was the day she first received a medical opinion about what happened that the clock started ticking. A medical opinion is often (but not always) required to start the clock. After all, it can be well-nigh impossible for a layperson to tell if a doctor did anything blameworthy. A bad outcome doesn't prove anything—bad outcomes are usually not the result of medical negligence. So unless it's something obvious, like a surgeon leaving a glove inside the patient's body, or amputating the wrong leg, a medical opinion may be necessary to trigger the running of the limitation period.

Here the opinion was provided by a plastic surgeon who also acts as a medico-legal expert. He advised the aggrieved patient that she had been “disfigured,” and that her breasts were “deformed.” He opined that the doctor who installed the implants should not have used saline ones; he should have placed the implants in front rather than behind the muscle; and he ought to have

done a mastopexy at the same time as the breast augmentation procedure, rather than have the two done separately.

In spite of this veritable call to arms, the patient delayed launching a court action until the medical opinion was turned into a “formal” written one, compiling necessary evidence, and packaged into a format ready for court. This delay proved fatal to her case.

Time-barring her claim, the court ruled that the formal written opinion contained nothing the patient didn’t already know. “All of the essential facts were known to her,” said the court, “as a result of meeting with the plastic surgeon.” The court went on to draw a distinction between the “discoverability” of a claim versus the assembling of evidence and the formatting of an expert opinion to help make the claim “winnable.” To discover a claim, said the court, “the plaintiff need only have in her possession sufficient facts upon which she could allege negligence. Additional information will support the claim, and help to assess the risk of proceeding, but is not needed to discover the claim.”

The question of when the clock starts ticking is never easy to answer. Even appeal court judges disagree about it, as illustrated by a case involving a woman whose left buttock was burned by a small fire that took place in the operating theatre. Two of the three Ontario Court of Appeal judges time-barred her claim on the basis that she knew right away—or ought to have—that she was wronged, because her posterior suffered second-degree burns during what was supposed to have been a simple skin-tag removal procedure.

“The patient knew immediately after the surgery,” the judges said, “that she had suffered a burn or lesion which was not located at the surgery site and which she did not expect. She had the facts to know that something went wrong for which the surgeon and/or the hospital was responsible. With those facts, she had the basis of an allegation of negligence.” In other words, if an inexplicably and badly burned gluteus maximus isn’t enough to start the clock, what is?

“Memories fade, evidence gets lost, and no one should have to live in never-ending fear of being sued.”

However, the third judge disagreed. True, he said, the patient knew right away she had a burnt backside, but she didn’t know until much later whether it was caused by negligent actions of the doctor, or by an equipment malfunction. Most of the experts felt it was the latter: they thought the electrocautery machine used for removing skin tags was defective, and caused an electrical burn. But it turned out the cause of the injury was actually that the doctor had left a pool of prepping solution, 70% alcohol, on the operating table next to the patient’s buttock. It caught fire.

The dissenting judge felt the mere fact that the patient had suffered an obvious burn was not enough to compel a court action—she may have known she was wronged, but she didn’t know by whom. If it had been defective equipment, then the hospital would be at fault, not the doctor. It wasn’t until she learned the doctor had negligently allowed a pool of flammable liquid to accumulate near the buttock, and therefore he could be a target of the lawsuit, that the clock should start ticking. But this judge was outvoted, thus showing that this question will always be a vexing one.

BILL ROGERS is a Toronto lawyer and writer covering medical and pharmaceutical issues. Readers with legal news can contact him at bill@rogersfamilylaw.com

SOLVE MY PROBLEM

What should I do if patients are harassing staff?

GET BOTH SIDES

I get the patient in and ask their side of the story because there are always two. I check to make sure there are no ongoing mental health or stress issues I can help with. I warn the patient that harassment will not be tolerated and they will be fired if it continues.

I have been very lucky and have had only two instances as a GP in the last 25 years. My secretary is great but firm with the patients and they love her. —**DR. JOHN CROSBY**

IF VALID, FIRE PATIENT

I am surprised there is even any discussion. If a patient is harassing staff, after appropriate due diligence to make sure the concerns are valid, you discharge the patient from your practice. In person preferably but in egregious cases by registered letter. Your provincial licensing body probably has guidelines on this. Consult them. In keeping these patients on, you are certainly not helping your staff and by not allowing your patient to see the consequences of their actions you are not helping them either. —**DR. BRIAN KNIGHT**

GET TRAINING FOR STAFF

Always back up your staff. It's funny how patients can be sweet as pie to the doc, but rude and entitled to the staff, and it is important that your staff feel comfortable letting you know who these patients are.

However, make sure that staff have appropriate training in conflict management so they can handle difficult patients without escalating the situation. Patients may be anxious, in pain, or upset and take it out on the staff; acknowledging patients' distress and not taking things personally goes a long way to deflating potential communication difficulties. Health authorities often offer these types of courses. If not, it's worthwhile investing in private training in order to keep everyone happy and retain good staff.

—**DR. CAROLINE FERRIS**

YOU'RE THE FINAL SAY

Luckily, I haven't had to deal with this often but my staff and I have a plan if it happens.

The first rule is to deal with the issue early. A disgruntled patient harassing your staff is not something you want recurring on a regular basis.

Second, if my staff cannot deal with the issue themselves, they punt it up to the next level: Me. They don't get paid to take abuse. Come to think of it, neither do I, but I do have the final say. And having the physician speak calmly and directly to the patient about the problem is often good enough to defuse the issue by itself.

"Sorry, Mr. Stubborn, but I'm not accepting new patients even if they are family members. My wife promised to divorce me if



DR. JOHN CROSBY
An FP in Cambridge, Ont.



DR. BRIAN KNIGHT
A part-time chronic pain doctor in Edmonton



DR. CAROLINE FERRIS
An FP in Surrey, B.C.



DR. MICHAEL SIMON
An FP in St. John, N.B.

I spend one more late night in the office." Or "No, Mr. Cynical, I was not late because I was on the golf course, but rather because the computers went down in the hospital again and we had to write out all our orders in triplicate."

"However, make sure that staff have appropriate training in conflict management so they can handle difficult patients without escalating the situation."

Most patients back off when confronted by the facts. They may not be happy with the answer they get but at least they understand the underlying reasons.

Of course, if a patient doesn't relent, you can't have them disrupt the office. After appropriate warnings, they must be released from your practice. —**DR. MICHAEL SIMON**

Next Problem

Are physicians' children entitled? How do you keep them grounded?

Send solutions to cleslie@ensembleIQ.com by March 1.

Classifieds

C-01 CONFERENCES / SYMPOSIA

CME @ SEA **BRITISH ISLES & BRITISH OPEN**

Potpourri of Medicine Update 2018
UP TO 35 CME HOURS
12 Nights | July 13-25, 2018 | **CELEBRITY ECLIPSE**

INCLUDES (oceanview or higher for 1st & 2nd guests)

Classic Beverage Package for two **PLUS**
Free Internet OR **\$300 Shipboard Credit/cabin***

ONLY 30 STATEROOMS LEFT. BOOK TODAY!

1-888-523-3732 **www.CMEatSEA.org**

New bookings only and cannot be combined with any other offer, promotion or price program. *Stateroom prices include all onboard accommodation, meals in the main restaurants, activities and events as described. Free house beverage package, plus free internet or \$150 shipboard credit are for 1* and 2* guests in a stateroom for Oceanview and higher. Guests must select the same perks at the time of booking. 2 perks expire on 2/28/2018. CMEatSEA reserves the right to make changes, correct errors or omissions. BP/PA #28364.

doctors- n-tour.ca
meeting and vacation concepts

2018 OVERSEAS CME

BALI - ISLAND OF THE GODS
Alternative Medicine & a cultural immersion - festivals, beaches, food and dance
April 13 - 29, 2018 - Cdn\$5,995 (inc air)

SOUTH AFRICA (ADD ON VIC FALLS!)
Cape Town, Garden Route, Zululand, Kruger ++
Apr 16 - May 2, 2018 - Cdn\$8,495 (inc air)

2018 FALL UPCOMING - PRE-REGISTER NOW!

Malaysia / Singapore (Sep 15 - 30, 2018)
Eastern Europe India (Sep 21 - Oct 6, 2018)
Galapagos / Peru (Oct 12 - 27, 2018)
South Africa (Nov 16 - Dec 1, 2018)

WINTER 2019 PREVIEW - PRE-REGISTER NOW!

Chile / Argentina (Jan), Bhutan / Myanmar (Feb)
New Zealand (Mar), Iceland (May)

Cost efficient doctor / companion invoicing
Full brochures at: www.doctorsontour.ca
Contact 416-231-8466 • 1-855-DOC-TOUR (362-8687)
info@doctorsontour.ca

McMaster Muskoka Seminar Series

Exciting resort CME at both Deerhurst Resort, Huntsville, Ontario and Blue Mountain Resort, Blue Mountains, Ontario
4 Week long seminars
Monday-Friday Mornings

Choose from July 9th-13th, Jul 23rd-27th, July 30th-August 3rd, and August 13th-17th

For topics and more information please contact: Alicia Di Iulio
MMS2018@mcmaster.ca

pri-med CANADA **MAY 9-12, 2018**
NEVER STOP LEARNING
TORONTO, ON
THE INTERNATIONAL CENTRE - HALL 2



Affordable registration fees:
EARLY BIRD PRICING
ONLY \$110.00+ TAX
AFTER APRIL 20TH \$175.00+ TAX
pri-med.ca/Canada

REGISTER WITH INVITATION CODE **MP1**

Canada's Primary Care CME Conference and Exhibition

- **25 Mainpro+ CME sessions**
UofT DFCM Accreditation: This Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 15 Mainpro+ credits.
- **13 Mainpro+ Workshops**
- Industry Symposia Sessions
- Optional **Pre-Conference Day**
- Interactive **Exhibit Hall**
- Network with **3,600+** peer clinicians

PROGRAM DEVELOPED BY:



C-21 MEDICAL SERVICES

Retiring, Moving, Closing your Practice?
You need **PROFESSIONAL** help!
Canada's Most Comprehensive Document Solution Provider

DOCUDavit Solutions

FREE Paper & Digital storage
Pick-up & Packing services
Notification to patients
Personalized Website
Digital copy for all patients records

Contact us today!
1-888-781-9083, Ext. 105
sales@docudavit.com
www.docudavit.com


CERTIFIED QUALITY SYSTEM - ISO 9001:2008
CERTIFIED INFORMATION SECURITY
MANAGEMENT SYSTEM - ISO 27001:2013

FREE RECORD STORAGE
and Practice Closure Services

 Get up to **1,000 AIR MILES®** Reward Miles (Call for details)

Paper & Digital - #1 in Canada
RSRS® 1-866-272-2209
info@RSRS.com

*** Trademarks of AM Royalties Limited Partnership used under license by LoyaltyOne, Co. and RSRS. **For qualifying full time primary care physicians.

FREE to RETIRING, MOVING and CLOSING PHYSICIANS

Patients and Regulatory bodies notification
Storage boxes and pick-up of patient charts
Apply also to EMR and Hybrid practices
Scanning of all charts - copy for the physician
Secure storage for the full term

Call 1-800-775-0093
Records Management Ltd. www.recordsregistry.ca

Retiring?
Moving?
Closing?

FREE BOOK

Practice Closure and Transfer Planner & Timetable

Everything you need to prepare to close or transition your medical practice

PlanAhead.ca
1-866-272-2209, Ext. 2

Out of Storage Space?

Let us scan or store your inactive patient records.

Contact DOCUDavit Solutions
1-888-781-9083 ext. 105
medicalrecords@docudavit.com
www.docudavit.com

DOCUDavit Medical Solutions

Queen's University
Department of Family Medicine
Three (3) Full-Time
Academic Family Physicians



The Department of Family Medicine seeks full-time academic family physicians.

- One (1) Academic Family Physician
- One (1) Academic Family Physician - Research
- One (1) Academic Family Physician - Research Director (incumbent will be eligible for an endowed chair)

The preferred candidates will have a combination of academic and clinical experience, with demonstrated clinical expertise in family medicine, will exhibit strong potential for innovative and scholarly research, and provide evidence of an ability to work in an interdisciplinary, collaborative environment.

Clinical responsibilities will be based at the Queen's Family Health Team in Kingston and include taking call approximately one (1) night per month and three (3) weekends per year.

Academic responsibilities include a combination of teaching, supervision of undergraduate and postgraduate learners and scholarly activity.

Preference will be given to applicants who can provide evidence of current involvement and commitment to education through the submission of an educational dossier and the identification of referees who can attest to the applicant's educational expertise. A Master's level degree is considered an asset. Applicants who have demonstrated a strong commitment and track record of leadership in primary care research may be eligible for an endowed chair. Experience in Indigenous Health or Competency-Based Medical Education would be an asset.

Applicants must be eligible for licensure with the College of Physicians and Surgeons of Ontario on or before the appointment start date, and candidates should have a current, valid certification from the College of Family Physicians of Canada.

The University invites applications from all qualified individuals. Queen's is committed to employment equity and diversity in the workplace and welcomes applications from women, racialized/visible minorities, Indigenous/Aboriginal peoples, persons with disabilities, and LGBTQ+ persons. All qualified candidates are encouraged to apply; however, in accordance with Canadian immigration requirements, Canadian citizens and permanent residents of Canada will be given priority.

To comply with federal laws, the University is obliged to gather statistical information as to how many applicants for each job vacancy are Canadian citizens / permanent residents of Canada. Applicants need not identify their country of origin or citizenship; however, all applications must include one of the following statements: "I am a Canadian citizen / permanent resident of Canada"; OR, "I am not a Canadian citizen / permanent resident of Canada". Applications that do not include this information will be deemed incomplete.

The University will provide support in its recruitment processes to applicants with disabilities, including accommodation that takes into account an applicant's accessibility needs. If you require accommodation during the interview process, please contact Laura Kennedy in The Department of Family Medicine at 115 Clarence Street via email: laura.kennedy@dfm.queensu.ca or phone 613-533-9303 x 73007.

Review of applications will commence immediately and continue until the position is filled.

Applicants are asked to send a curriculum vitae, the names and contact information of three (3) referees and a letter outlining how current qualifications and experience match our requirements to:

Dr. Michael Green, Head

Department of Family Medicine, Queen's University

220 Bagot Street, PO Bag 8888, Kingston, Ontario K7L 5E9

Tel: (613) 533-9300 x 73959 Fax: (613) 533-9301

Email: apply@dfm.queensu.ca Email: apply@dfm.queensu.ca

**MEDICAL CLINIC / WALK-IN
CLINIC IN GUELPH**

We are looking for a Doctor to join our Medical Clinic which is located in a highly populated area of Guelph/ON. There is one Doctor now, one nurse & one full time Reception. Ready to start from the first day with no extra expenses.

**For more information
Call Mike at 647-994-6050**

**SEEKING FAMILY
PHYSICIAN TO JOIN
GROUP PRACTICE**

Scarborough clinic equipped with the latest technology, located on the ground floor of a very busy complex housing multiple services. Guaranteed income and low overhead.

**Please contact
Dr. Li at 416 315-3700
or email: drlihw@gmail.com**

**CCN CERTIFIED
CARDIOLOGY OFFICE**

invites a new Cardiologist to join our team of 4 physicians. Ideal for new cardiologist building practise or moving an existing practice. Great splits, highly professional staff and full service included

**Contact us today for more info.
admin@avdiagnostics.ca
www.avdiagnostics.ca**

**FAMILY PRACTICE IN
BELLEVILLE, ON.**

Available due to physician retirement. Member of a large FHO. Modern office, with EMR (Telus/PS), computers in every room, HRM online appointment booking, etc. Situated on the Bay of Quinte and next door to picturesque Prince Edward County. A wonderful community in which to practice medicine and bring up a family!

Email: bellevilledr@gmail.com

**FAMILY PRACTICE-
SOMERSET, MB**

A well established clinic for 30 years. Located 100 minutes from Winnipeg. 1500 active patients in a catchment area of 4000 population. ACCURO EMR. FFS with overhead expenses around 25%. Hospital located 8 minutes away (18 beds with 3 emergency beds) with on call opportunity with exceptional supporting colleagues. CT& MRI and specialty services 40 minutes away in regional center.

**Contact: somerset@mts.net
phone: 204 744 2265.**

**FAMILY PHYSICIAN NEEDED
to join a busy clinic in Vaughan.**

**Please contact Shahin @
416-220-7540 or by email
biohc2389@gmail.com**

C-01 POSITION VACANT



Physicians Needed for one or more shifts per week

Ideal Candidates: Psychiatrists, Internists, Pain Specialists and Family Physicians

Located in all major cities across Canada

Canabo Medical Clinic is a referral only clinic. We incorporate evidence-based medicine in combination with expert opinion to provide a safe approach to treating the needs of patients suffering from chronic and disabling illnesses to improve their quality of life.

We offer:

- Flexible hours/shifts with part-time & full-time positions available
- Competitive fee-for-service split
- Comprehensive cannabinoid therapy training for patient evaluations
- Opportunity to be involved in research
- Turnkey operations with full administrative and allied health care support

Our Mandate:

- Establish a Center for Excellence in Prescription Cannabinoids and Medical Marijuana
- Educate Community on Prescription Cannabinoids and Medical Marijuana
- Research Prescription Cannabinoids and Medical Marijuana

To learn more, contact:



johnphilpott@cmclinic.ca
1-902-442-0653



**At some point,
reality kicks in...**



**LOOKING TO
RETIRE?**

**NEED
MEDICAL
SPACE?**

**LEASE
UP FOR
RENEWAL?**

**NEED A
TRANSITIONING
SOLUTION?**

Let's Talk

Contact us in confidence today!

Email: practice@mcimed.com

Call 416 440 4040 EXT105



We've been doing this for 30 years! No more leases.

Move in or transition your existing practice to one of our established clinics. Join our team and feel the difference.

MCI THE DOCTOR'S OFFICE™ is one of Canada's largest, most established management groups with 20+ clinics. We are actively recruiting for Physicians like you! Reach out & call us today

LET US BE YOUR EXIT STRATEGY

mcithedoctorsoffice.com

NORTH BRAMPTON- FAMILY PHYSICIAN NEEDED IN BUSY WALK-IN CLINIC

Family Practice opportunity available. Elegant office, organized, paperless, doctor-run. Daytime, evening or weekend shifts available with flexible hours. Full support and EMR training provided.

For more information please e-mail: vankirkdrs_205@yahoo.com



**THE OSHAWA CLINIC GROUP IS RECRUITING
PHYSICIANS IN THE FOLLOWING SPECIALTIES:**

**DERMATOLOGY
NEUROLOGY
RHEUMATOLOGY
GERIATRICS**

The Oshawa Clinic is Canada's largest multi-specialty medical group practice with full diagnostic services. The Oshawa Clinic is in close proximity to Toronto, as well as cottage country. We offer excellent compensation arrangements with a turnkey set-up. An information package is available upon request. All enquiries will be handled in strict confidence.

For more details, contact:

Harry Horricks, CEO

Tel 905 721-3500

Email hhorricks@rogers.com

www.oshawaclinic.com

**CLASSIFIED ADVERTISING
ndumont@ensembleiq.com**

1 877 687-7321 ext.:1266

CLASSIFIEDS

NEW WALK IN CLINIC VENTURE IN CAMBRIDGE SUITABLE FOR NEW GRADUATE.

Free ownership offered
to right candidate.
Work with a team of physicians.
Excellent opportunity.
New building, great location.

Please email your interest and
resume at fhdoctor@gmail.com

GREAT OPPORTUNITY FOR A FAMILY PHYSICIAN OR A PSYCHIATRIST IN OTTAWA WITH MINIMAL OVERHEAD

Wellington medical clinic needs a
family physician (family/walk-in) or a
psychiatrist to work part time or full
time with an option to own a clinic
for minimal overhead cost. Out of
province doctors who are willing to
relocate to Ottawa are welcomed.

Contact: **Emad Keryakos**
613-276-8980
emad.sobhy1@gmail.com

MISSISSAUGA, ON.

WALK-IN / FAMILY PRACTICE

Busy well established Medical
Clinic. Walk-in and Family Physi-
cians needed.

email: Clinic.wqd@gmail.com
or phone 416-995-1600



MedVisit
Doctors Housecall Service
Housecall Physicians
Part or Full-time

Greater Toronto including Mississauga and Brampton

- Afternoon, evening or weekend shifts
- Experienced drivers available to
accompany physicians

Contact Adam Wilson: 416-697-9319
recruitment@homedoctor.ca
www.homedoctor.ca

1,100 SQ. FT. OFFICE SPACE IN BRAMPTON

Three exam rooms & one
kitchen, ideal for family
physician or specialist. Rate
negotiable. Internet & EMR
ready. Free patient parking.
Pharmacy, X-ray & lab on-site.
Centrally located on Queen St. E.
between Brampton Civic & Peel
Memorial hospitals.

Contact: Doris

Email:
drollsurgoff@outlook.com

PART TIME/ VERY PART TIME FAMILY DOCTOR

- Excellent pay
- Flexible schedule
- Minimum 8 hours a month
- Retired/semi retired
doctors welcome
- RN/PA support

Family friendly, collegued
modern practice

Please email
fhdoctor@gmail.com

\$300.00/hr

Internal Medicine (General and
Subspecialist), Pediatrician,
Surgeon, for busy outpatient
clinic in Mississauga.

Dr. Stein (416) 464-0238

Help for Today.
Hope for Tomorrow.

Alzheimer *Society*

BEAUTIFUL VICTORIA B.C. OPPORTUNITY

Well established busy walk-in
clinic, with family practices on
site, looking to add more owners
or sell clinic outright. Attractive
business/practice opportunity.

Reply to
victoriacclinic@gmail.com

From the Medical Post

eCortex.ca

online
medical
CME

FAMILY MEDICINE OPPORTUNITY

Family physician is required for a large fully capitated practice in the largest and first FHO/FHT in the Thousand Islands region of the SE LHIN. The practice has 1800 fully capitated patients with an excellent case mix from prenatales, newborns to elderly care with a focus on wellness and chronic disease management in an evidence based philosophy. The opportunity to assess and work up from first presentation to fascinating diagnosis occurs almost daily. Brockville has a full service general hospital with most specialties available including interventional radiology, CT, ICU and busy ER. The tertiary centres of Queen's and Ottawa U are one hour away.

The interested candidate would relocate to Brockville and be prepared to reap the benefits of a busy practice from day one. The office infrastructure is turnkey with modern equipment, is fully computerized and paperless with Telus PS and the EMR. We have an excellent administrator and nurse who know the patients very well and work well as a team. As part of the larger FHO/FHT, you would enjoy all of the benefits of being involved in a larger peer group for clinical and practice management, shared call and after hours clinics. In addition to the capitated practice, the opportunity exists to be involved in FP Obs, ER, Hospitalist, Palliative care, surgical assisting and elderly care homes. Teaching affiliations with Queen's and Ottawa's U are available and sought after.

This is a career move, into a long established, respected practice with appreciated patients and a very respectful, supportive specialty faculty. The income is well above average, expenses are typically small town rates, with an opportunity to invest in the office building if desired. Brockville has an excellent mix of schools as well and St-Lawrence College and offers wide ranging four seasons activities for a growing family and adults alike.

If this sounds like the practice you've been dreaming of, email me at drstevemcmurray@gmail.com.

The timing is fluid and flexible and different transition options could be entertained.

Sign up for the Medical Post's
Doctor Daily e-newsletter
Registration is free
and easy for physicians at:

Canadian
HealthcareNetwork.ca

PMHx

Dr. James Barry's 60-year secret

A famous surgeon who nearly took his most remarkable achievement to the grave

Dr. James Barry had a simple, albeit strange, dying wish: to be buried in the clothes he was wearing. He did not want anyone washing his body, as was custom. No prepping or prettifying. No examination. No undressing whatsoever.

Dr. Barry had been a British military surgeon with a remarkable list of achievements. By his retirement, he had risen to the rank of Inspector General, the second-highest medical post in the British Army. He was one of the first to perform a cesarean in which both the mother and child survived. At virtually every hospital at which he was stationed—in Cape Town, Mauritius, Jamaica, the West Indies, Corfu, and eventually Canada—the mortality rate dropped. He embraced sanitation standards that were unconventional in the 19th century (anaesthetics and antiseptics had yet to be invented). He became a champion for better care, not only of soldiers but also the local poor and imprisoned.

But Dr. Barry also had several quirks. He wore padding under his clothing to make his slight frame appear more robust and, even with the stacked heels he regularly wore, he only stood just over five feet tall. He had a high-pitched voice and an effeminate manner. Despite this, or one might say because of it, he had a fiery temper (Florence Nightingale was once on the receiving end). He cursed incessantly. He also acquired a reputation as a lothario, which was strange because few had actually seen him with a woman.

Many were suspicious of these eccentricities. So perhaps it shouldn't be surprising that the charwoman who prepared Dr. Barry's body for burial did not honour his final wishes. She said she found that Dr. Barry was "a perfect woman" and that the marks on his body even suggested that he had given birth to a child himself—a fact that Dr. Barry had managed to keep secret from nearly all but his most trusted confidants. The charwoman attempted to blackmail

the physician who treated Dr. Barry on his deathbed and when the physician refused to pay, she went to the press.

Dr. James Miranda Barry was born Margaret Ann Bulkley and had assumed the identity of a man in order to attend the prestigious Edinburgh Medical School. The most popular theory is that Dr. Barry took on the new identity and kept it a secret for nearly 60 years solely out of ambition. In 1813, when he was certified as a physician, women were forbidden from studying medicine and it would be nearly 50 years before Dr. Elizabeth Anderson was recognized as the first woman to graduate with a medical degree in Britain.

But other theories have arisen. When questioned by the press, Dr. R. Mackinnon, the physician who the charwoman attempted to blackmail, told the media he simply assumed Dr. Barry was a hermaphrodite (or intersex in modern terms, though this theory has since been discredited). Contemporary LGBTQ theorists have suggested that Dr. Barry may have been transgendered, and that he freely and willingly identified as a man (which is why we have referred to Dr. Barry as "he" in this article).

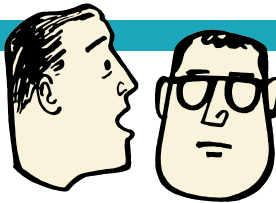
But it's impossible to be sure. Whatever the case, the Victorian standards of the day ensured that all but a few knew why Dr. Barry did what he did (even the Canadian doctor who examined him for a chest infection didn't think it was odd that the patient insisted he conduct the examination in the dark).

British military command was embarrassed by these revelations and placed Dr. Barry's file under lock and key for the next 100 years to avoid what it felt would be further humiliation. But that only created more intrigue. To some extent, it still persists today.

—TRISTAN BRONCA



PRACTICE GEM



Catch Phrases

I feel that it is a useful addition to one's medical practice to have catch phrases for patient encounters. These lines can show that you are easygoing and provide the occasional chuckle. Here are a few that I have picked up over the years from colleagues and some I've come up with myself:

- On completing the patient encounter: **"Well, you're good for another 10,000 miles"**

- When discussing age spots like seborrheic keratoses: **"These are weeds in the garden of life"** (FYI, patients hate the term "old age spots.")
- On discharging a patient or returning them to their primary care provider: **"Well, you've graduated!"**
- For patients who followed your directions and got better as a result: **"Today my friend, you get a gold star"** —DR. BENJAMIN BARANKIN



**THIS IS ONE
FOR THE AGES.**



YouAreUNLTD is a radically new communication platform that redefines and shifts perceptions in how we talk about aging. We shine a light on the inspiring products, services and people that empower consumers to embrace healthy aging.

It's time we change our perspectives and challenge the traditional views on aging.

Join us and learn how you can enhance your practice today at YouAreUNLTD.com



**YOUARE
UNLTD.**

The new voice of active aging

