Hudson’s life is our life’s work.

ONTARIO’S DOCTORS

Judy and Hudson
Port Credit, ON

OMA Public Information Campaign Phase 2
New “Life’s Work” series profiles Ontario patient care experiences, physician expertise

Practice Management
Improving practice efficiency

OMA Archives — Mediscope ’59
A look back at monumental OMA-sponsored public health education “extravaganza”

OMA 2010 Annual General Meeting
Calendar of events, Section program listings, Seminar and workshop registration form

Day in Primary Eye Care
Practical approaches to common eye problems

Physician Assistants
Update on collaborative efforts to advance the physician assistant role in Ontario
You get a complete software package of billing, scheduling, medical records, product support and updates for $199 per computer annual licence fee.

What is the catch? There is none. Now you can enjoy the Windows experience because we designed Klinix for Windows. It is easy to install, learn, and use.

Now you have the freedom to buy your computer products as you please. The “Designed for Windows” logo makes buying your own computer products simple.

OHIP Billing
1. Service codes for all specialties
2. EDT (Electronic Data Transfer)
3. OBEC
4. Reads OHIP’s fee schedule disk

Alternative Payment Programs
1. FHG (Family Health Group)
2. FHN (Family Health Network)
3. HSO (Health Services Organization)
4. APP (Alternate Payment Plan)
5. AFP (Alternate Funding Plan)
6. PCN (Primary Care Network)

Support Mon-Fri—8am to 8pm
You work long hard days caring for your patients. You deserve convenient hours of support for your OHIP Billing. You deserve to be served by a well-staffed team of skilled people who care about your problem when you call.

On-Site Training—$50 per Hour
Contact us to learn which training partner serves your area.

Scan Documents-Eliminate Paper
You eliminate paper by scanning documents into the patient profile. You set up folders within the patient profile to organize electronic documents and files.

Backups—Fast and Simple
You backup your Klinix database in seconds because of how we work with Windows. You can use any storage device designed for Windows when backing up Klinix.

Toll Free 1-877-SAVE-199
Available 24 hours to take your order

Our 120 Day Warranty
Your satisfaction guaranteed in the first 120 days or return Klinix Assess for your money back. No fine print. Klinix is a member of Better Business Bureau. You can see our business reliability report at www.bbb.org. We are confident you will like what you see.

Customer Quotes
“I particularly appreciate the service of the support team. They are courteous, knowledgeable, and prompt to answer questions.”

Dr. Tony Leung of Toronto

“I was surprised there were no hidden fees and how well Klinix compares to the much more expensive products. Fantastic support staff.”

Dr. Linda Keeton of Hamilton

“I used EZBill for ten years and Klinix...It’s just SUPERIOR”

Dr. Esther Silver of Richmond Hill

“...the user interface is a breeze to use. You can’t find a better product at this unbeatable price.”

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Section Chairs

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Cardiology  W. Hughes
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Clinical Teachers  B. Woodside
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Geriatrics  A. Baker
GP Psychotherapy  D. Cree
Group Practice  G. Maley
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HSO Physicians  J. Craig
Hyperbaric Medicine  A.W. Evans
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Infectious Diseases  N. Rau
Internal Medicine  M. Wilson
Interns and Residents  A. Toren
Laboratory Medicine  B. Mullen
Medical Students  C. Nowik, C. Symonette

Nephrology  B. Nathoo
Neurology  R. Yufe
Neuroradiology  A.J. Fox
Neurosurgery  F. Gentili
Nuclear Medicine  J.P. Cliché
Obstetrics and Gynecology  B. Mundle
Occupational and Environmental Medicine  M. Cividino
Ophthalmology  W.K. Brydon
Orthopedic Surgery  D. Fleming
Otolaryngology - Head and Neck Surgery  O. Smith
Palliative Medicine  D. Robinson (Acting Chair)
Pediatrics  H. Yamashiro
Physical Medicine and Rehabilitation  D. Berbrayer
Plastic Surgery  D.S. Woolner
Psychiatric Hospitals, Schools  J. Fareau-Weyl
Psychiatry  D. Brownstone
Public Health Physicians  H. Shapiro
Radiation Oncology  G. Morton
Reproductive Biology  C. Librach
Respiratory Disease  H. Ramsdale
Rheumatology  P. Baer
Rural Practice  R. Dawes
Sleep Disorders  A. Soicher
Sport Medicine  W. Elliott
Surgery, General  P. Barron
Surgical Assistants  D. Esseer
Thoracic Surgery  R. Zeldin
Urology  F. Papanikolaou
Vascular Surgery  W.R. Tanner

(OMA Committee Chairs, see page 6)
Surprisingly, many physicians have not reviewed their insurance coverage in several years.

Your health is not the only thing that changes over time. Events take place during a lifetime that can alter your financial situation.

- Marriage
- Children
- Buying a home and/or cottage
- Practice matures and income increases
- Retirement.

Your insurance may not have kept pace with your changing needs. A regular review of your insurance is essential to providing adequate protection for you and your family. The OMA provides the services of professional non-commissioned Insurance Advisors.

Contact OMA Insurance today by phone (1.800.758.1641 / 416.340.2918) or e-mail (info@omainsurance.com) and arrange to have your insurance needs reviewed.

The best time to find out if you have enough insurance is before you need it.
Phase Two of the OMA “Life’s Work” campaign presents a compelling twist, as patients discuss their interactions in the health-care system, and the critical role that their individual physicians have played in helping them to overcome a serious illness or health-care challenge.

The OMA recently launched the second phase of the “Life’s Work” public information campaign across Ontario. New multimedia ads profile patients’ health-care stories, with a focus on physician expertise and knowledge. Also, the campaign has introduced a public call to action, with the OMA inviting patients to share their experiences with the health-care system via an online survey. “Life’s Work” is part of a three-year strategic communications plan designed to enhance support for physicians among influential audiences, remind policymakers of the unique relationship between physicians and patients, and strengthen the OMA’s position in anticipation of future policy discussions.

The 130th OMA Annual General & Council Meeting will take place April 29 to May 2 at the London Convention Centre. Highlights include the Adam Linton Memorial Lecture, Annual Women’s Health Care Seminar, and Awards Presentations and Gala Ceremony, as well as seminars and workshops on medical billing, retirement planning, and media training. Pre-registration is advised.

In February 2008, the OMA first reported on its efforts to lead the introduction of physician assistants (PAs) into the province’s mix of health-care providers. An update describes the many collaborative initiatives and demonstration projects underway to advance the PA role in Ontario.

The treatment of amblyopia, diagnosis and management of glaucoma, diabetic retinopathy, classification of vision loss, and identification of sight-threatening disorders presenting as red eye were among the featured topics at the 32nd Day in Primary Eye Care for Family Physicians.

Mediscope ‘59 was Canada’s first large-scale public health fair. Held at Toronto’s Exhibition Place more than 50 years ago, the wildly popular event set a new standard for Ontario physicians’ long-standing tradition of championing public health education.

A total of 41 reforms will be introduced to the Ontario automobile insurance industry in September. The reforms are intended to enhance consumer choice and protection, streamline transaction systems, and increase efficiencies.

Ontario Medical Review • March 2010
Humalog® (insulin lispro injection), Humalog® Mix25® (25% insulin lispro injection, 75% insulin lispro protamine suspension) and Humalog Mix50® (50% insulin lispro injection, 50% insulin lispro protamine suspension) are indicated for the treatment of patients with diabetes mellitus who require insulin for the maintenance of normal glucose homeostasis. Humalog® insulins are also indicated for the initial stabilization of diabetes mellitus. Humalog® (insulin lispro injection) is a short-acting insulin analogue and is for use in conjunction with a longer-acting human insulin such as Humulin® N except when used in a subcutaneous insulin infusion pump. The Humalog® family of insulins is contraindicated during episodes of hypoglycemia and in patients sensitive to insulin lispro or any of the excipients they contain. Any change in insulin or human insulin analogue should be made cautiously and only under medical supervision. The effects of mixing Humalog®, Humalog® Mix25®, or Humalog Mix50® with either animal-source insulins or human insulin preparations produced by other manufacturers have not been studied. This practice is not recommended.

References:

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COLUMNS

36 Practice Management: strategies to improve practice efficiency

There are many strategies that can be employed to help improve efficiency in the medical office, from maximizing current resources and modifying established practices, to adding new resources or different processes into daily routines. To help ensure that your strategies for efficiency are successful, choose an approach that best aligns with the way you think.

39 Doctor's Business: managing mortgage payments — options for consumers

Choosing how to best manage mortgage loan payments and balances is largely determined by careful consideration of current interest rate levels, coupled with speculation as to how rates are expected to change over the months and years ahead. With interest rates at historic lows, and the prospect of potential rate increases in the not-too-distant future, it might be an ideal time to review mortgage payment options and amortization periods.
# Committee Chairs

## Agreement

(OMA-Ministry of Health and Long-Term Care)

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<td>Agreement Board Co-ordinating Committee</td>
<td>S. Wooder</td>
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<td>Forms Committee</td>
<td>A. Studniberg</td>
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<td>Joint Committee on the Schedule of Benefits</td>
<td>P. Conlon</td>
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<td>Medical Audit Oversight Committee</td>
<td>D. Hellyer</td>
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<td>D. Weir</td>
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<td>Physician LHIN Tripartite Committee</td>
<td>T. Nicholas</td>
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<td>Workplace Safety &amp; Insurance Board Steering Committee</td>
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## Governance

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<td>Governance Committee (Board Co-ordinating Committee)</td>
<td>B. Woodside</td>
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<td>Annual Meeting Planning Committee</td>
<td>K. Arnold</td>
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<td>Audit Committee</td>
<td>R. Mann</td>
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<td>Committee on Committees</td>
<td>R. Mann</td>
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<td>J. Willett</td>
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<td>Nominations Committee</td>
<td>K. Arnold</td>
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<td>Staffing Working Group</td>
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## Health Policy

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<td>Health Policy Committee (Board Co-ordinating Committee)</td>
<td>S. Chris</td>
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<td>Revalidation Committee</td>
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## Member Services

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<td>Insurance Committee</td>
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<td>Physician Health Program Advisory Committee</td>
<td>D. Puddester</td>
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<td>Physician Leadership Training and Development</td>
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<td>Working Group</td>
<td>J. Willett</td>
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<td>Quality Management Program-Laboratory Services</td>
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<td>Advisory Council</td>
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## Public & Political Advocacy

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<td>Communications Advisory Committee (Board Co-ordinating Committee)</td>
<td>M. MacLeod</td>
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<td>Outreach to Women Physicians Committee</td>
<td>J. Weisbloom</td>
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<td>Political Action Committee</td>
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As the Review goes to press this month, the OMA is rolling out Phase Two of our Life’s Work public information campaign across the province of Ontario.

Life’s Work is a multifaceted strategic communications initiative that aims to reinforce public recognition of Ontario physicians as leading advocates for our patients and a stronger health-care system.

Further, the campaign is designed to ensure a consistent, prominent presence for Ontario physicians in the public eye, and in the eyes of key decision-makers in the health-care arena and the provincial legislature.

Our messages celebrate the unique relationship between physicians and patients, and emphasize the clinical expertise of Ontario doctors.

Phase One of the campaign, which ran from November to January, portrayed the physician perspective. A number of OMA members from different clinical specialties described how and why they chose a career in medicine, and how their personal experiences have influenced the care they provide.

Phase Two presents a compelling twist, as patients discuss their interactions in the health-care system, and the critical role that their individual physicians have played in helping them overcome a serious illness or health-care challenge (see pp. 9-11).

The new OMA ads will appear in major newspapers throughout the province, on billboards and transit shelters. Like Phase One, we will also target the vicinity of Queen’s Park to ensure that members of provincial parliament, cabinet, the health minister and premier, are routinely greeted each workday with the OMA’s campaign slogan and messages.

We have produced a second TV spot to promote Life’s Work. The ad will air during major news broadcasts in Ontario, as well as Hockey Night in Canada. We are also utilizing the Internet to further our reach. Banner ads will be featured on some popular media websites, like globeandmail.com, to promote the campaign.

As we look ahead to the next provincial election, the OMA will be articulating our priorities for the health-care system, and we intend to pursue these issues with all political parties with the goal to have as many of our health priorities included in the respective party election platforms.

Phase Two of Life’s Work invites the public to join us in this effort by completing a brief online survey that sets out patients’ experiences with the Ontario health-care system, their level of satisfaction with the system, and suggestions for change or improvements.

The survey findings will help to inform our pre-election planning. Of course, OMA members are encouraged to log on to the survey and provide your input to the process as well.

The survey, along with the print and broadcast advertising elements of the campaign, are featured prominently on the OMA Home Page (www.oma.org/media/lifeswork.asp). Please take some time to visit the site and review the materials.

The OMA Board and the Communications Advisory Committee are proud of the Life’s Work campaign. This initiative reflects the direction of OMA Council to develop long-term strategic communications planning and enhanced public relations initiatives.

Thank you to the patients and physicians who have stepped up to share their personal experiences with the people of Ontario.

We will continue to undertake efforts to advance public support and recognition for Ontario physicians, and to champion the interests of our patients and members alike.

Dr. Suzanne Strasberg
OMA President
March 15, 2010
Ontario Medical Student Bursary Fund

6th Annual Fundraising Golf Tournament

Friday, June 18th, 2010 - 7:45 am Shotgun Start
Angus Glen Golf Club - Host Site of the 2002 and 2007 Canadian Open

$400 per ticket / $1,600 per foursome. Price includes: 18 holes of golf with cart, breakfast, lunch, Participation in golf contests with many great prizes!! Partial tax receipts will be issued to those who pay directly to OMSBF

ALL PROCEEDS FUND STUDENT BURSARIES FROM OMSBF

Call Sandra Zidaric, Senior Campaign Director at 1-800-268-7215 ext. 2985 or 2259 to register or become a sponsor. Or visit: www.oma.org/Student/tournament/golftournament.htm

RESERVE NOW! LAST YEAR’S TOURNAMENT SOLD OUT EARLY!

Special thanks to our sponsors:

PLATINUM TEE

Gold Tee

Silver Tee

Bronze Tee

White Tee

Media Sponsor

NATIONAL POST
Online banners invite public participation

**OMA “Life’s Work” Campaign phase two underway:**

*multimedia ads profile patients’ health-care stories, physician expertise*

by Nancy Dale
OMA Public Affairs and Communications Department

Phase One of the OMA public information campaign, “Your Life is Our Life’s Work,” featured practicing physicians from a variety of backgrounds and specialties sharing stories about how and why they chose a career in medicine, and how their personal experiences impact the care they provide to patients.

The provincewide multimedia campaign was displayed prominently in the area surrounding Queen’s Park, and viewed regularly by Premier Dalton McGuinty, Minister of Health and Long-Term Care Deb Matthews, and members of provincial parliament.

Some of the physicians featured in the campaign — who had dealings with Premier McGuinty during the time that phase one was in progress — said the campaign was definitely being noticed at Queen’s Park; one physician in particular told of the Premier commenting that he saw her “every day on his way into work.”

Health Minister Matthews, in conversation with OMA President Dr. Suzanne Strasberg, referenced that she saw the campaign in her London riding and at Queen’s Park.

The media reported on the campaign as well. In a November 23, 2009 column entitled “McGuinty had better prepare to do battle over health care,” *Globe and Mail* columnist Adam Radwanski outlined how the “Premier and Ministers pass a series of ads extolling the virtues of Ontario’s doctors... plastered all around Queen’s Park by the OMA as a rather obvious plea to avoid making health care the province’s next battleground.” Mr. Radwanski said “McGuinty — a Premier who doesn’t like picking fights with anyone, let alone those in the life-saving business — would surely follow the advice.”

As a follow-up to the success of phase one of “Life’s Work,” the OMA launched phase two of the campaign on March 15. The second phase features patient experiences in the health-care system, with a focus on physician expertise and knowledge.

Giving a voice to 11 patients with diverse backgrounds from across Ontario, the stories touch on a variety of topics, such as family planning, cancer treatment and diagnosis, and disease management.

From the emergency room to the family physician clinic, patients relay personal experiences about how, when it mattered, their physician had the expertise necessary to provide them with appropriate care (see sample ads, pp. 10-11).

The campaign is part of a three-year communications plan designed to enhance support for physicians among influential audiences, remind policy-makers of the relationship that physicians have with their patients, and strengthen the OMA’s position in anticipation of future policy discussions.

The new ads are running in strategic media markets across Ontario, with a distinct emphasis on Queen’s Park. Advertising includes outdoor transit shelter and subway station posters, billboards, and print ads in regional and provincial newspapers, such as *The Globe and Mail, Toronto Star* and *National Post*. Also, a 30-second television commercial will air in March and April during CTV News, CBC’s The National, Focus Ontario, and Hockey Night in Canada.

New to the campaign is an online presence. With ads placed on a number of media websites, such as www.torontostar.com and www.globeandmail.com, the OMA is inviting patients to visit the OMA website (www.oma.org), where they can share their experience with the health-care system via a short survey.

The survey results will help the OMA develop priorities for the health-care system in advance of the 2011 provincial election. It is hoped that the political parties will, in turn, include OMA priorities in their respective campaign platforms.

The OMA would like to thank the patients who shared their personal stories about their journey through the health-care system.

For more information on the campaign, or to complete the survey, visit www.oma.org.
A few years ago, my wife and I wanted to start a family. It didn’t come easily for us. But our doctor made us comfortable, she listened, and she knew exactly what we needed to do. She guided us through the process of getting pregnant, and now we have two beautiful kids who are her patients too.”

Joee
Markham, ON

Joee’s life is our life’s work.

ONTARIO’S DOCTORS

Share your views on health care at oma.org
“After I gave birth, something didn’t feel right. I couldn’t breathe. My doctor sent me to a specialist, who recognized right away that my heart was failing. He diagnosed me with pulmonary hypertension, a rare and deadly lung disease. Thanks to him, I’ll be around for my daughter’s first birthday.”

Carol
Georgetown, ON

Carol’s life
is our life’s work.

ONTARIO’S DOCTORS

Share your views on health care at oma.org
Good Health Matters

HELPING YOU ACHIEVE A BETTER STATE OF MIND

The OMA Physician Health Program is a confidential service for physicians, residents, medical students and their family members who may be experiencing problems ranging from stress, burnout, emotional or family issues, through to substance abuse and psychiatric illness. The OMA Professionals Health Program is a confidential service provided to health professionals.

Confidential Toll-Free Line 1.800.851.6606
php.oma.org
SUMMARY OF EVENTS

Thursday, April 29
0900 – 1630
Women’s Health Care Seminar
Throughout the day —
Section Annual Meetings

Friday, April 30
0730 – 1700
Annual Meeting Registration and Viewing of Exhibits
Throughout the day —
Section Annual Meetings
1000 – 1200
Media & Government Relations Training Seminar
1000 – 1700
Medical Billing Seminar
1200 – 1400
Adam Linton Memorial Feature Luncheon
1400 – 1700
Retirement Planning Seminar

Saturday, May 1
0730 – 1700
Council Registration
0900 – 1700
Annual Meeting of Council
1230 – 1330
Council Luncheon
1830 – 2400
Awards Presentations, Presidential Installation, Gala Dinner/Dance

Sunday, May 2
0730 – 1200
Council Registration
0900 – 1300
Annual Meeting of Council
1300
Council Luncheon
(lunch will be available “to go” for those who are unable to remain)

11TH ANNUAL WOMEN’S HEALTH CARE SEMINAR — THURSDAY, APRIL 29
The OMA Outreach to Women Physicians Committee presents the 11th Annual Women’s Health Care Seminar, “What’s New in Prevention in Women’s Health,” on April 29 at the London Convention Centre. Featured topics include: Vitamin D Benefits, GI Diet, Cancer Prevention, and Leadership, Negotiation and Advocacy (see page 18 for more details).

MEDIA & GOVERNMENT RELATIONS TRAINING SEMINAR — FRIDAY, APRIL 30
The OMA Public Affairs and Communications Department is offering a training seminar that will take place on Friday, April 30 from 1000 – 1200. Jason Lietaer, who most recently served as a senior advisor to Prime Minister Stephen Harper, will speak about the ways to make your message and arguments stand out in a crowded environment, drawing on experience as a top lobbyist, communicator and political advisor to two Ontario premiers. He will examine real-world examples of communication efforts gone right (and wrong) and explain what they mean for the OMA. What special tools do doctors have at their disposal? How can we use them? And what can we learn from American rock band Rage against the Machine? There’s something for everyone in this presentation. Participants will have the opportunity to learn about the importance of fostering relationships with members of the media and key decision-makers within government; developing and conveying clear and effective messages; and the most effective methods to influence government and key decision-makers.

MEDICAL BILLING SEMINAR — FRIDAY, APRIL 30
The Education and Prevention Committee (EPC), in conjunction with the Section on General and Family Practice, will host a Medical Billing Seminar on Friday, April 30 from 1000 – 1700. The seminar will focus on the many changes introduced in the Schedule of Benefits, effective October 1, 2009. The EPC breakout session will focus on Special Visit Premiums and Most Responsible Physician Premiums. Topics for the Section on General and Family Practice session will include “Updating Your Billing Skills” and “Uninsured Services Program – Increasing Patient Service Levels While Getting Paid Fairly.”

ADAM LINTON MEMORIAL FEATURE LUNCHEON — FRIDAY, APRIL 30
The 18th annual Adam Linton Memorial Feature Luncheon and lecture will be presented on Friday, April 30, from 1200 - 1400, as part of the Annual General Meeting. The lecture honours the memory and accomplishments of Dr. Adam Linton, OMA President from June 1991 to January 1992. Dr. Linton was a nationally renowned educator who spent much of his time working to improve Ontario’s health-care system. The lecture will be given by Dave Williams, Canadian astronaut, physician and aquanaut. Dr. Williams is one of the most accomplished astronauts ever to participate in the NASA space program. He has two space shuttle missions under his belt and also holds the Canadian record for spacewalks. He is also one of the very few people who has lived in both space and underwater. There is no charge for this event, thanks to a generous contribution from the Canadian Medical Association, and its subsidiary, MD Management (see advertisement on page 15).
Pre-registration is required for all Section meetings taking place Thursday, April 29 and Friday, April 30. To register, complete and submit the Registration Form appearing on page 16 of this issue, or register online at: http://www.oma.org/forms/oma agm.htm. Note: to register for the OMA Council Meeting on Saturday, May 1 and Sunday, May 2, please contact Suzi Mijango, OMA Membership Services, at 416.599.2580 or 1.800.268.7215, ext. 2975, or via e-mail (suzi.mijango@oma.org).

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<tr>
<td><strong>ADDICTION MEDICINE</strong></td>
<td>Thursday, April 29</td>
<td>Executive Meeting (Executive Members only) 1800 – 2000</td>
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<td>Annual General Meeting 2000 – 2100</td>
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<td><strong>CHRONIC PAIN</strong></td>
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<td>Scientific Session</td>
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<td>Fibromyalgia:</td>
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<td>Bringing Hope through Better Patient Care 0900 – 10:00</td>
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<td>Annual General Meeting 1315 – 1415</td>
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<td>Sleep Disorders and Chronic Pain 1415 – 1515</td>
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<td>by Dr. Eldon Tunks, MD, FRCP</td>
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<td>Emeritus Prof Psychiatry, McMaster</td>
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<td>The Many Faces of Moderate Pain 1530 – 1630</td>
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<td>by Dr. Alan Kaplan MD, CCFP(EM), FCFP</td>
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<td><strong>GENERAL AND FAMILY PRACTICE</strong></td>
<td>Friday, April 30</td>
<td>Update your Billing (Executive Members only) 0845 – 0915</td>
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<td>Skills with Dr. Tom Falloon (in conjunction with the Education and Prevention Committee)</td>
<td>1400 – 1600</td>
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<td>Annual Business Meeting 1700 – 1830</td>
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<td><strong>GP PSYCHOTHERAPY</strong></td>
<td>Friday, April 30</td>
<td>Executive Meeting (Executive Members only)</td>
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<td>Scientific Session</td>
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<td>CBASP Part I</td>
<td>0930 – 1100</td>
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<td>by Dr. Sian Rawkins, MD, FRCP</td>
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<td>CBASP Part II</td>
<td>1400 – 1530</td>
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<td><strong>HSO PHYSICIANS</strong></td>
<td>Friday, April 30</td>
<td>Annual General Meeting and Dinner 1800 – 2100</td>
<td>1800 – 2100</td>
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<tr>
<td><strong>ONTARIO PSYCHIATRIC HOSPITALS &amp; HOSPITAL SCHOOLS</strong></td>
<td>Friday, April 30</td>
<td>Scientific Session Update on the CANMET Guidelines for Treatment of Bipolar Disorder</td>
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<td>by Dr. Tom Janzen</td>
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<td><strong>ONTARIO PSYCHIATRIC HOSPITALS &amp; HOSPITAL SCHOOLS (continued)</strong></td>
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<td>Section Meeting</td>
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<td><strong>OPHTHALMOLOGY</strong></td>
<td>Friday, April 30</td>
<td>Executive Meeting (Executive Members only) 1500 – 1800</td>
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<td><strong>PEDIATRICS</strong></td>
<td>Friday, April 30</td>
<td>Scientific Session</td>
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<td>The Pediatrician’s Role in Management and Prevention of Childhood Obesity</td>
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<td>State-of-the-Art Update on Immunizations</td>
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<td><strong>PHYSICAL MEDICINE AND REHABILITATION</strong></td>
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<td><strong>PHYSICAL MEDICINE AND REHABILITATION (continued)</strong></td>
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<td>Psychovocational Assessments – What Every Physiatrist Needs to Know</td>
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<td>by Dr. Lorne Switzman, PhD, Clinical Psychologist</td>
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<td>Emotionality and Depression in Stroke 1000 – 1045</td>
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<td>by Dr. Vinjamuri R. Chari, MD, FRCP, Physiatrist</td>
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<td>Botulinum Toxin Treatment of Cranio-Cervical Dyskinesias 1100 – 1145</td>
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<td>by Dr. Earl Consky, MD, FRCP, Movement Disorders Neurologist</td>
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<td>Lunch/Business</td>
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<td>Update: Auto legislation</td>
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<td>by Dr. Arthur Ameis</td>
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<td>Interprofessional Practice: Pros and Cons</td>
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<td>by Dr. Jeffery H. Robertson, MD, FRCP, FACC</td>
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<td>OHIP EMG Fee Codes In Ontario: Past, Present &amp; Future</td>
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<td>by Dr. Hossein Amani, MD, FRCP</td>
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<td>Dr. John Flannery, MD, FRCP</td>
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<td>Dr. Michael Nicolle, MD, FRCP, D. Phil.</td>
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<td><strong>PSYCHIATRY</strong></td>
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<td>by Dr. Tom Faloon</td>
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<td>Introductions:</td>
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<td>Dr. David Berbrayer</td>
<td>0745 – 0845</td>
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<td>Is this Client able to Return to Work? 0800 – 0845</td>
<td>0800 – 0845</td>
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<td>by Mary Stergiou-Kita, BSc(OT), MSc, PhD candidate, Graduate Department of Rehabilitation Science, University of Toronto</td>
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ANNUAL MEETING OF COUNCIL — GENERAL INFORMATION

RETIREMENT PLANNING SEMINAR — FRIDAY, APRIL 30
The OMA is holding an information session on Retirement Planning on Friday, April 30 from 1400 – 1700. Topics covered include: “Insuring” a healthy financial retirement; investment planning for retirement; and fundamentals of winding down a practice. Spouses are welcome!

COUNCIL ORIENTATION SESSION — FRIDAY, APRIL 30
The Chair and Vice Chair of Council will be holding a Council orientation session for Delegates. The session will focus on providing participants with: a) information on their role as Council Delegates and; b) information on the process for developing and submitting motions to Council. A session will be held on Friday, April 30 from 1830 – 1930.

ANNUAL MEETING OF COUNCIL — SATURDAY AND SUNDAY, MAY 1 - 2
Council is the governing body of the Ontario Medical Association. The power to vote and put forward resolutions is limited to Council Delegates, elected by the members of each OMA Branch Society, District and Section. However, any OMA member who registers is entitled to attend the meeting as an observer. Council will meet on Saturday and Sunday, May 1 and May 2, 2010.

AWARDS PRESENTATIONS, PRESIDENTIAL INSTALLATION, AND GALA DINNER/DANCE — SATURDAY, MAY 1
OMA members are invited to join in celebrating the many contributions and accomplishments of our medical colleagues. The evening commences at 1830 with the Presidential Installation and awards presentations. A brief reception will follow at approximately 1930 and dinner will be held at approximately 2000. A dance will take place after the dinner. The gala dinner and awards evening is presented, in part, by a generous contribution from the Canadian Medical Association and its subsidiary, MD Management.

REGISTRATION
To register for meetings on Thursday and Friday, April 29 and 30, please complete and return the Registration Form which appears on page 16. Members may also register online at: http://www.oma.org/forms/omaagm.htm.

To register for Council on Saturday and Sunday, May 1 and 2, please contact Suzi Mijango, OMA Membership Services, tel: 416.599.2580 or 1.800.268.7215, ext. 2975, or e-mail: suzi.mijango@oma.org.

HOTEL RESERVATIONS
Rooms have been reserved at the London Hilton at the rate of $129 for either single or double occupancy. You may telephone the hotel directly at 1.800.210.9336, or contact Hilton Worldwide Reservations at 1.800.HILTONS (1.800.445.8667). Please specify the Ontario Medical Association when making a reservation to ensure you receive this rate. The deadline for hotel reservations is March 30, 2010. After this date, reservations will be accepted on a space-available basis only.

ANNUAL MEETING 2011
The 131st OMA Annual and General Council Meeting will be held in Toronto, Ontario, at the Toronto Downtown Marriott Eaton Centre, from Thursday, April 28 to Sunday, May 1, 2011.

Adam Linton Memorial Feature Luncheon

Guest Speaker:
Dr. Dave Williams, Canadian Astronaut, Physician and Aquanaut

Friday, April 30 – 1200 – 1400
London Convention Centre
London, Ontario

Note: seating for this event is limited. To register, please complete and submit the Registration Form on p. 16 of this issue, or register online at: http://www.oma.org/forms/omaagm.htm
### Registration Form

Pre-registration is required for all meetings. Registration must be received by April 23, 2010.

Please complete one registration form for each person attending, and return it by mail or fax to: Jennifer Csamer, Conference Planning, Ontario Medical Association, 150 Bloor Street West, Suite 900, Toronto, ON M5S 3C1, or fax to 416.340.2244.

You may also register online at: http://www.oma.org/forms/omaagm.htm. Questions regarding registration may be directed to: Ms. Csamer at 416.599.2580 or 1.800.268.7215, ext. 3461, or via e-mail: jennifer.csamer@oma.org

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Please indicate any special needs ☑

### SEMINARS AND WORKSHOPS

**Thursday, April 29**

- 11th Annual Women’s Health Care Seminar ☑
  (Please refer to page 18 or more details.)

- 11th Annual Women’s Health Care Reception ☑

**Friday, April 30**

- Adam Linton Memorial Feature Luncheon ☑

- Council Orientation Session ☑

- Media and Government Relations Training Seminar ☑

- Medical Billing Seminar: GP Specialist ☑

- Retirement Planning Seminar ☑

*(NOTE: A credit card is required to complete registration for the Retirement Planning Seminar. Credit card will be charged $25 only if a registrant does not attend, or late cancellation is received. Cancellations must be received in writing, fax or e-mail at least 72 hours in advance of the seminar.)*

### SECTION MEETINGS

Members unable to attend an OMA Section Annual Meeting in person may have the option to participate via teleconference. Details will be included in your Section’s flyer.

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<th>Scientific/ Educational</th>
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*(NOTE: This event is no charge for Section dues-paying members. $50 fee for non-dues paying members.)*

- Physical Medicine and Rehabilitation ☑ ☑ ☑
  *(NOTE: This meeting is taking place at the OMA office, 150 Bloor St. W., Toronto)*

- Psychiatry ☑

### AWARDS CEREMONY, PRESIDENTIAL INSTALLATION, GALA DINNER DANCE **Saturday, May 1** ☑ @ $75

TOTAL __________________

Please indicate any special dietary requirements.

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*Payable to the Ontario Medical Association.*
The Section on General & Family Practice Executive is delighted to have Buzz Hargrove, Past President of the Canadian Automobile Workers’ union, speak at its J.J. Lynch Memorial Lecture, to be held following the Section’s Annual Meeting Dinner in London on April 30 at 7:00 p.m.

While President of the CAW, Mr. Hargrove had a reputation as a tough and successful advocate for CAW members, and physicians could learn and benefit from his experiences. With OMA negotiations looming during difficult economic times, his topic — “Driving a Hard Bargain in Challenging Times” — is particularly relevant and, with an opportunity to ask questions, we are looking forward to a lively evening.

This lecture is open to all OMA members and guests. There is a charge of $50 for the dinner, which starts at 7:00 p.m.

The Section may provide a direct bus service from Toronto to London to make it easier for physicians to attend. If you are interested in this service, please contact Paddy Morton at patricia.morton@oma.org.

An afternoon billing session precedes the lecture from 2:00 p.m. to 5:00 p.m. Dr. Tom Faloon will present on “Updating Your Billing Skills,” and Dr. Jonathan Marcus will provide advice on “Uninsured Services Programs.” These lectures are part of the day-long “Billing information and Support Seminar – Billing & Fee Code Updates,” which begins at 10:00 a.m. Family physicians are encouraged to sign-up for the full-day event, however, members are welcome to attend just the afternoon presentations.

Please join the Executive and other members at the SGFP’s Annual Business Meeting from 5:00 p.m.–6:30 p.m. to learn what the Section has been doing this past year, and what is planned for the future.

A reception will follow.
11th Annual Women’s Health Care Seminar
“What’s new in prevention in women’s health”

Thursday, April 29, 2010 • 9:00 a.m. – 4:30 p.m.
London Convention Centre, 300 York St., London, ON

The OMA is proud to welcome the Founder of War Child Canada and Order of Ontario recipient, Dr. Samantha Nutt, who will deliver this year’s keynote address.

9:00 - 9:15  Welcome and Introductions
9:15 - 10:15  Keynote Speaker
10:15 - 11:00  Preventive Disease Diets – G.I. Diet
11:00 - 11:15  Nutrition Break
11:15 - 12:00  Gynecological Cancer Prevention
12:00 - 12:45  Vitamin D Recent Developments for Prevention in Women
12:45 - 1:45  Leadership Series: Negotiating and Conflict Management
1:45 - 3:15  Lunch and Awards Ceremony – OMA President
3:15 - 3:30  Nutrition Break
3:30 - 4:15  Prevention in Dermatology
4:30 - 6:30  Wine and Cheese Reception

Dr. Samantha Nutt
Dr. Irene Hramiak
Dr. Joan Murphy
Dr. Reinhold Vieth
Dr. Suzanne Strasberg
Janice Stein
Dr. Denise Wexler

This event is complimentary to OMA members, and has been accredited in previous years for CME credits. To register, visit www.oma.org/forms/omaagm.htm, or contact Jennifer Csamer at 1.800.268.7215, ext. 3461, or via e-mail (jennifer.csamer@oma.org).
The OMA bylaws were amended at the November 2009 Council Meeting to require Section elections be held by mail or electronic ballot, effective January 1, 2011.

The purpose of the bylaw changes is to ensure that all members of a Section have the opportunity to vote for their Section’s Executive members and delegates to OMA Council.

As a result of these changes, the OMA has amended its Section Rules and Regulations template. Over the next few months, Section Chairs will receive a copy of the proposed changes to their Rules and Regulations, and will be requested to discuss and review these amendments at their 2010 Section Annual Meetings.

While the new bylaws come into effect January 1, 2011, the Committee is aware that three Sections have already opted to hold their 2010 elections by mail/electronic ballot.

The OMA is available to assist Sections interested in exploring this option, and to answer any questions concerning the new election procedures. Please contact the OMA Constituency Services Department at 1.800.268.7215 or 416.599.2580, and speak to Nicole Scott (ext. 3303) or Sharmann Grad (ext. 2912).

Note: as a reminder of the current bylaw requirements concerning both Section and Territorial Division elections of Executive members and delegates to Council, please refer to the article entitled “Council Passes Strict Accountability Measures for OMA Sections and Territorial Divisions: New Bylaws Aim to Strengthen Member Representation,” which appeared in the December 2007 issue of the Ontario Medical Review (available online at: https://www.oma.org/pcomm/omr/dec/07committee_structure.pdf).
## e-Learning Courses

We are pleased to let you know about our online courses through the CyberMed e-Learning program. Currently there are 24 courses available online, all of which are offered complimentary to OMA members and their staff. A complete listing of e-learning courses is below and full descriptions can be found on the CyberMed website at www.oma.org/cybermed/online.

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## In-class Seminars

We are continuing to assess how we can best deliver relevant training to physicians and their staff. Based on changing physician needs over the last 18 months, we will be suspending our current programming for in-class seminars at the OMA. We are working with OntarioMD to ensure physicians have access to training and support resources as we focus on assisting physicians who are transitioning to new technology and implementing electronic medical records systems (EMRs).

## Registration

For more information or to register, please visit www.oma.org/cybermed. You may also contact us by phone at 416.599.2580/1.800.268.7215, ext.3088, or e-mail at cybermed@oma.org.
Physician assistants:

OMA welcomes newest members of Ontario medical teams

by Jenny X. Chen
OMA Public Affairs and Communications Department

In February 2008, the OMA first reported to members on the Association’s efforts to lead the introduction of a new role — the physician assistant (PA) — to the province’s mix of healthcare providers. The following is an update on the many collaborative initiatives underway to advance the physician assistant role in Ontario.

PAs are highly trained, mid-level health providers who offer a broad range of services under the supervision of physicians. They are non-regulated health professionals, like paramedics, and operate under the direct orders and medical directives of licensed physicians.

In 2007, the Physician Assistant Implementation Steering Committee was established to guide the development, implementation and evaluation of the PA initiative. The Committee is co-chaired by the OMA and the Ministry of Health and Long-Term Care, with OMA Board Director Dr. Deborah Hellyer representing the Association.

“In order to make physician working lives easier in some regards, and provide optimal care to patients, we have to look at other practice models. By utilizing PAs, we’re actually expanding an interdisciplinary type of model,” says Dr. Hellyer.

“The OMA has always been supportive of interprofessional types of care,” she explains. “In order for the PA piece to work, you have to have physicians on board.”

Windsor family physician and former OMA President Dr. Albert Schumacher has been very satisfied with the addition of a PA trainee to his family practice. “I think that if we can find a way to afford them into the system, it would certainly help extend our reach and coverage for patients,” says Dr. Schumacher.

The Ministry of Health and Long-Term Care, in partnership with the OMA, has introduced physician assistants into demonstration projects in emergency departments, hospitals and community health centres across the province. Approximately 59 PAs currently staff emergency departments and other hospital areas; five are employed at community health centres.

The OMA is also acting as administrative leader in investigating the physician-employed model of implementing PAs. There are currently six PAs employed directly by physicians in Ontario: two in diabetic care management and four in long-term care facilities.

Originally designed to operate between 2008 and 2010, these two-year demonstration projects have all been extended after generating promising preliminary feedback. Plans for project expansion include filling 20 more PA positions in emergency departments, and introducing 20 PAs into Family Health Teams.

Feedback from PA demonstration projects

Interim evaluations of physician assistant demonstrations indicate that PAs can reduce wait times and enable physicians to focus on more complex patients.

Dr. James E. Deacon, who works two days a week at a nursing home in Kingston, emphasizes the positive impact his physician assistant, Nancy Bonaparte, has had on the facility.

“There were two physicians looking after a moderate-sized nursing home with 180 beds with no one else to provide services and nobody else to share call. We were coming to the point where we were seriously considering resigning from the home because the workload was untenable, particularly the call,” explains Dr. Deacon. “Then we were lucky enough to get into the pilot project with the physician assistant.

“It’s made a big difference in the physician life. They [PAs] do admission histories and physical exams. They go to case conferences and do day-to-day rounds looking after the acute problems that come up. They extend your ability to do more, and to delegate some things that don’t require a physician,” says Dr. Deacon.

Positive testimony regarding PAs is also common to facilities like hospital emergency departments, where the shortage of doctors can leave one
Physician alone overnight without adequate medical personnel to handle a sudden influx of patients, or the emergence of more complex cases.

PA Nancy Bonaparte expects that her work has made the nursing home experience better for medical staff and patients alike.

“The nursing staff has medical support Monday to Friday, 8 to 4. For residents themselves, if there’s a problem, they can get seen sooner instead of waiting for the designated time that Dr. Deacon is in,” says Ms. Bonaparte. “And the families love it just for the fact that I tend to have more time to be able to sit and explain things to them.”

Before working with Dr. Deacon, Ms. Bonaparte was trained as a PA in the Canadian military (historically, the Canadian Forces has trained and employed physician assistants for more than 50 years).

In 2002, Manitoba became the first Canadian province to implement physician assistants under the title of “clinical assistants.” The American Medical Association supported the introduction of PAs to the American medical system in the early 1970s. As of December 2008, more than 73,000 PAs are employed in the United States, where there are over 140 PA training programs.

**Ontario-trained PAs**

Currently, two academic programs in Ontario offer training and certification for physician assistants. The first program was established at McMaster University in 2008, and the second was introduced in January 2010 by the Consortium of PA Education — a collaborative effort between the University of Toronto, Northern Ontario School of Medicine, and Michener Institute for Applied Health Sciences to offer a U of T degree.

For successful applicants who have already finished two full years of post-secondary education, these two-year programs offer comprehensive clinical exposure, as well as academic courses comparable to those presented to medical students.

“They (PAs) need to have the broad background so they can understand, work with, and think like physicians,” says Dr. John P. Cunnington, director of the McMaster Physician Assistant Education Program.

At the conclusion of these programs, graduates take the National Physician Assistant Certification Examination administered by the Canadian Association of Physician Assistants.

PAs are distinguished from other mid-level providers, such as nurse practitioners, in that while both groups share a common general scope of practice, PAs cannot treat patients independently without physician delegation. In addition, PAs can have evolving scopes of practice, and can be trained to perform tasks that may be specific to the physicians’ practices or areas of specialty.

As the first class of Ontario-trained physician assistants has yet to graduate, demonstration projects are currently staffed by PAs with military backgrounds, PAs trained in the U.S., and other internationally trained medical graduates who participate in integration programs before entering PA demonstration sites.

**Liability**

“The OMA was able to guide the whole process along looking at various aspects of it because, initially, there were some areas of major concern. One was potential liability,” says Dr. Hellyer.

When asked about potentially negative consequences of hiring PAs in the physician-employed model, Dr. Deacon stresses that, “it depends on the physician and how comfortable he or she is in being an employer. You take on certain responsibilities that way — you are liable and responsible for their decisions.”

PAs employed by hospitals are insured under the hospital’s comprehensive general liability insurance, and the Canadian Medical Protective Association (CMPA) also offers protection for supervising physicians. In addition, PAs should carry adequate professional liability insurance.


**Billing**

One of the largest obstacles to the integration of PAs into the Ontario health-care system lies in billing procedures that do not adequately account for the services provided by these physician extenders. Under the current OHIP fee schedule, physicians are not paid for delegated care, unless they are actively involved in the services provided.

The OMA has proposed that an
amendment to the fee schedule be explored to compensate supervising physicians for all work delegated to PAs.

Recently, the Registered Nurses’ Association of Ontario (RNAO) issued public statements questioning the competency of PAs trained in Ontario, their status as an unregulated profession, and their ability to reduce health-care costs.

In response, OMA President Dr. Suzanne Strasberg observed that, “At a time when Ontario's doctors are advocating for increased collaboration between health-care professionals, especially with nurses and nurse practitioners, it’s unfortunate that the RNAO is not following our lead.” Dr. Strasberg re-emphasized the OMA’s support for physician assistants.

Although details regarding billing, regulation, and physician assistant education require continuing consideration, Dr. Hellyer is optimistic about the project’s future sustainability.

“The nice thing is that, because of what has happened in Ontario and Manitoba, there’s really more of a national strategy, and the Canadian Medical Association (CMA) has been involved in that aspect,” says Dr. Hellyer. “More provinces have come on board and the PA project has really taken off.”

The CMA, in partnership with the Canadian Association of Physician Assistants, recently issued a 28-page “Physician Assistant Toolkit,” which answers common questions from physicians about the role of PAs, including funding and employment models, liability, regulation, education and certification. The guide is available online at: http://www.cma.ca/index.cfm/ci_id/86599/la_id/1.htm.

References
4. Physician Assistant Hospital Demonstration Project – Application/Information Package. 2007 March.
The treatment of amblyopia, diagnosis and management of glaucoma, diabetic retinopathy, classification of vision loss, and identification of sight-threatening disorders presenting as red eye, were among topics addressed during the 32nd Day in Primary Eye Care for Family Physicians, held December 12 in Toronto.

**Update on Amblyopia**

Dr. Megumi Iizuka, lecturer, University of Toronto, presented “An Update on Treatment of Amblyopia: Summary of the Pediatric Eye Disease Investigators Group (PEDIG) Studies.”

Dr. Iizuka told delegates that amblyopia is characterized by defective visual acuity with no demonstrable abnormality of the visual pathway.

“Amblyopia is not immediately resolved by wearing glasses. It occurs when the visual system is still developing, and is unilateral and/or bilateral,” she said.

The initial period of visual maturation is approximately age six or seven. However, older children may still be amenable to amblyopia therapy with some effect.

Dr. Iizuka provided the following summary of the PEDIG Studies:

- Refractive correction alone is a powerful amblyopic treatment modality for young children with anisometropic amblyopia.
- Atropine and patching produced improvement of similar magnitude, and the atropine treatment was better tolerated than patching.
- There was no statistically significant difference in improvement in visual acuity between two hours of patching and six hours of patching a day after four months of treatment.
- Performing near (i.e. close-up) activities does not enhance visual acuity outcome when treating amblyopia with two hours of daily patching.
- Weekend atropine provides an improvement of visual acuity of a magnitude similar to that in the daily atropine-treated group.
- In amblyopia treatment of children aged seven to 17, optical correction alone improved visual acuity by two or more lines in about 25% of patients. However, most patients were left with a residual visual acuity deficit.
- In amblyopic treatment of children aged seven to 17, treatment with atropine or patching led to similar degrees of improvement (17% response rate with atropine versus 20% response rate with patching) in moderate amblyopia.

**Update on Glaucoma — Part 1: Diagnosis**

Dr. Yvonne Buys, professor, University of Toronto, presented a two-part lecture on the topic of glaucoma.

In her first lecture, entitled “An Update on Glaucoma — Part 1: Diagnosis,” Dr. Buys told delegates that although past definitions of glaucoma included elevated intraocular pressure (IOP), many patients with an IOP more than 21 mmHg never develop glaucoma (ocular
hypertension), and there are individuals with glaucoma whose IOP never exceeds 21 mmHg (low/normal tension glaucoma). She also reported that up to 50% of individuals with glaucoma do not have IOP higher than 21 mmHg on screening.

“It is important to understand that vision loss in glaucoma is slow, progressive, and irreversible,” said Dr. Buys. She described it as a disease without symptoms, except in the very late stages, and patients are generally not aware that they are losing vision.

“Testing visual acuity alone with the Snellen Chart may reveal 20/20 vision in the presence of advanced nerve head and field damage,” said Dr. Buys. She added that comprehensive eye examination, including measurement of IOP, evaluation of the drainage angle, optic nerve, and visual fields, is necessary for the early diagnosis of glaucoma.

Dr. Buys told delegates that examination of the optic nerve is the most important part of the examination for glaucoma, and the optic nerve head may be examined with a direct ophthalmoscope.

She outlined the procedure by explaining that the optic nerve consists of bundles of nerve fibres formed by the axons of the ganglion cells, and these axons form an arcuate pattern above and below the maculo-papillary bundle (nerve fibres from the macula to the temporal disc). A distinct horizontal raphe separates superior nerve fibres from the inferior nerve fibres in the temporal retina. Using the slit lamp for binocular viewing, and specialized lenses, one is able to view the optic nerve head stereoscopically, allowing more accurate interpretation of the characteristic glaucomatous changes of the nerve.

Dr. Buys told delegates that the features of the glaucomatous optic disc include the following:
1. Cupping: less than 10% of the normal population has a cup:disc ratio of more than 0.5.
2. Disc asymmetry: less than 7% of the normal population has a cup:disc ratio of more than 0.1 difference between the two eyes.
3. Notching: localized thinning or loss of the neuroretinal rim.
4. Excavation: undermining of the disc edge or neuroretinal rim.
5. Disc hemorrhage: flame-shaped hemorrhages on or near the optic nerve head.
6. Nerve fibre layer defect: loss of the nerve fibre layer (ganglion cell axons) prior to their joining together to form the optic nerve may be detected as a loss in the normal retinal striations.

Dr. Buys reported that computerized perimetry or visual field testing enables accurate, reproducible testing, facilitating detection of glaucoma and progression of the disease.

She advised that the recently published Canadian Ophthalmological Society evidence-based clinical practice guidelines for the management of glaucoma in the adult eye is a good resource.

**Update on Glaucoma — Part 2: Management**

In her second lecture, “An Update on Glaucoma — Part 2: Management,” Dr. Buys told delegates that glaucoma can be treated with medical therapy, laser therapy, or surgical therapy.

In medical therapy, medication in the form of eye drops, in several major pharmacological classes, are used to lower IOP. They act either by decreasing aqueous fluid production in the ciliary epithelium, or by improving aqueous outflow via the trabecular meshwork or the uveoscleral route, or a combination of both.

Dr. Buys noted that a major challenge in the treatment of glaucoma is poor compliance, and that education of the patient is extremely important.

She listed the mechanism and the major side-effects of the most commonly used drugs:
- **Prostaglandin agonists**
  - **Mechanism:** improves uveoscleral outflow.
  - **Major side-effects:** iris colour change, lash growth, trigiasis.
- **Beta adrenergic blockers**
  - **Mechanism:** decreases aqueous fluid production.
  - **Major side-effects:** cardiac failure, heart block, bronchospasm.
- **Carbonic anhydrase inhibitors**
  - **Mechanism:** decreases aqueous fluid production.
  - **Major side-effects:** GI upset, malaise, renal stones, aplastic anemia.
- **Alpha agonists**
  - **Mechanism:** decreases aqueous fluid production, increases uveoscleral outflow.
  - **Major side-effects:** contact allergy, hypotension in children.
- **Cholinergic agonists**
  - **Mechanism:** improves trabecular outflow.
  - **Major side-effects:** miosis, brow ache, decreased vision, especially with cataracts.
- **Alpha agonists**
  - **Mechanism:** decreases aqueous fluid production, increases trabecular outflow.
  - **Major side-effects:** pupil dilation, macular edema, tachycardia.
- **Hyperosmotics (for emergency use)**
  - **Mechanism:** establishes a concentration gradient and draws fluid from the eye.
  - **Major side-effects:** diuresis, cardiovascular overload, renal insufficiency, stroke.

Dr. Buys said that argon laser trabeculoplasty (ALT) or selective laser trabeculoplasty (SLT) is considered when medical therapy fails to control intraocular pressure adequately. Laser cyclophotocoagulation is considered for glaucoma that is resistant to standard medical and surgical treatments.

In surgical therapy, trabeculectomy is a surgical technique that establishes a route for aqueous fluid to escape the eye while maintaining a system closed to the external environment. If needed, in patients with coexisting cataract, this technique can be combined with cataract surgery.

Tube shunt placement is an alternative surgical technique considered when trabeculectomy fails or is un-
Day In Primary Eye Care

suitable. A tube placed within the eye shunts fluid out to a distal reservoir placed under the conjunctive on the outside of the globe.

Update on Diabetic Retinopathy
In a presentation entitled “An Update on Diabetic Retinopathy,” Dr. Daniel Weisbrod, lecturer, University of Toronto, reported that diabetic retinopathy is the leading cause of new cases of blindness in people aged 20 to 74 in the United States and Canada.

He noted that without proper screening, patients can have significant retinopathy before visual loss even occurs.

In terms of treatment, Dr. Weisbrod told delegates that primary prevention is the key, and that blood sugar and blood pressure control, and monitoring blood lipids, are vital, as well as smoking cessation and weight loss, when required.

“Screening for diabetic retinopathy is important,” said Dr. Weisbrod. He suggested that Type 1 diabetics should have their eyes examined after disease duration of five years, while Type II diabetics should have their first eye exam at the time their diabetes is diagnosed because a significant number have treatable eye disease at the onset.

Classification of Vision Loss
Dr. Robert Adam, ophthalmology resident, McMaster University, delivered a presentation entitled “Classification of Vision Loss,” and outlined how to approach the patient with sudden vision loss.

Dr. Adam reported that attention to the vital eye signs is crucial, and the differential diagnosis will be formed based on the extent of visual acuity loss, as well as the presence or absence of a relative afferent pupillary defect (RAPD).

He advised that, after documenting the pupils and examining the anterior segments of both eyes, “Don’t be afraid to dilate the eye and look at the optic nerve and retina carefully, as many vitreous conditions, such as vitreous synechiae or detachment, will have a normal examination.”

Dr. Adam noted that most retinal tears and retinal detachments will be difficult to see, but if they are seen, this clinches the diagnosis.

“Macular disease may show blood exudation in the macula, and retinal vascular disease may show areas of whitening causing a cherry red spot or areas of hemorrhage,” he said, adding that all acute optic neuropathies cause swelling of the optic nerve.

Dr. Adam provided some examples of conditions that relate to vitreous disease:

- Syneuressis equals liquefaction, which causes floaters. True floaters move with the eye, and are seen best on a white, well-lit background. If the floaters are chronic, they are not an emergency. However, if they are accompanied by flashes of light, new onset floaters should be seen within two to three days at the most.
- Vitreous detachment occurs when the liquefied vitreous pulls away from the retina and causes flashes. True flashes are white, linear, brief, and seen best in the dark. On history, these flashes cannot be differentiated from a retinal tear, therefore, new onset flashes should be assessed within two days.
- Vitreous hemorrhage is a collection of blood in the vitreous, often common in diabetics, but with many other causes as well. There is variable visual acuity. A normal pupil exam may find blunted red reflex and obscured retina on fundoscopy.

In discussing retinal disease, Dr. Adam told delegates that, with a retinal detachment, the vision is variable. A history or visual field exam should have fixed, non-mobile or slowly advancing scotoma “curtain defect,” and a history of flashes and floaters preceding detachment.

Some of the risk factors for retinal disease include high myopia, family history, intraocular surgery, and trauma.

With macular disease, the vision is variable, the pupils are normal, and there are many possible causes.

Retinal vascular disease occurs when central retinal artery occlusion produces a sudden dramatic loss of vision with RAPD. If there is a cherry red spot with a whitening of the retina, Dr. Adam advised delegates to “think of a cerebrovascular accident (CVA) that will require a stroke clinic work-up.”

Red Eye — How to Identify Sight-Threatening Disorders
Dr. Lawrence Weisbrod, lecturer, University of Toronto, concluded the program with a presentation entitled “Red Eye — How to Identify Sight-Threatening Disorders.”

Dr. Weisbrod told delegates that it is vital to distinguish potentially vision-threatening disorders that present as “a red eye.”

He warned that unless the doctor is absolutely certain of the diagnosis and is able to monitor for side-effects, steroids should not be given.

“As a general rule, most of the vision-threatening causes of the red eye cause pain, photophobia, and decreased vision, and it is important to assess this in the examination,” said Dr. Weisbrod.

He told delegates that when examining the red eye, the following conditions must be considered as vision-threatening: orbital cellulitis, iritis, angle closure glaucoma, scleritis, corneal ulcers (infections), endophthalmitis, and trauma, such as hyphema, chemical injury, or penetrating injury.

“Taking a history from a patient with a red eye is of utmost importance,” said Dr. Weisbrod, “and doctors should look for secondary symptoms, such as pain, photophobia, vision loss, discharge, and ask about onset, duration, and any associating factors that can help identify certain causative agents.

“Always ask about trauma — blunt, sharp, chemical, or thermal. And, in the medical history, ask for a list of all medications being taken, including over-the-counter medications and herbal remedies.”
and any allergies that may be present...patients should be asked about recent or past ocular history, including surgeries and topical medications,” concluded Dr. Weisbrod.

OMR

Endnote

a. The Pediatric Eye Disease Investigator Group (PEDIG) is a collaborative network dedicated to facilitating multicentre clinical research in strabismus, amblyopia and other eye disorders that affect children. The network, which was formed in 1997, is funded by the National Eye Institute (NEI). The NEI is a part of the U.S.-based National Institutes of Health, which is the branch of government that funds medical research. There are currently over 60 participating sites (offices) with over 120 pediatric ophthalmologists and pediatric optometrists in the United States, Canada and the United Kingdom participating in the network (Source: PEDIG public website — http://public.pedig.jaeb.org/ViewPage.aspx?PageName=General_Info).

Reference


Barbara Klich is a Toronto-based freelance writer.

Eye Care Treatment Tips for Family Physicians

“In chemical injuries to the eye, irrigate until you are sure that you are (at) ph 7.0, and document that.”

Dr. K.D. McReelis, Peterborough Regional Health Centre

“Given that shining a light in one eye will cause constriction of both pupils, swinging the light quickly to the other eye will produce an equal pupillary constriction in both eyes.”

Dr. Lawrence Weisbrod, University of Toronto

“We see that 20% of patients with multiple sclerosis have optic neuritis as the initial presenting sign; 50% of the patients have optic neuritis at some point during the course of the disease; and almost 100% of patients with MS have evidence of sub-clinical optic neuritis.”

Dr. Katherine Cao, University of Toronto

“All acute optic neuropathies cause swelling of the optic nerve, so fundoscopy is crucial to diagnose these conditions. If a relative afferent pupillary defect (RAPD) is present, but the nerve looks normal, look again, or think of retrobulbar optic neuritis.”

Dr. Robert Adam, McMaster University

“It is impossible for a contact lens to “get behind the eye,” though the superior fornix is deep and it can get lost up in there.”

Dr. John Lloyd, University of Toronto

“Remember the blink rate is 10 to 30 times per minute, average is about 15; this decreases to as low as four to seven times per minute with computer tasks, contributing to dry eye symptoms.”

Dr. John Lloyd, University of Toronto

“It is very important that diabetics of any age have routine eye examinations, whether they are symptomatic or not.”

Dr. Daniel Weisbrod, University of Toronto

“Abnormal eye movements suggest neurological or orbital masses, the origin of which is outside the globe.”

Dr. Robert Adam, McMaster University

“Graves patients with changes in colour vision, vision loss, corneal exposure, conjunctival chemosis, and diplopia, require early referral.”

Dr. Edsel Ing, University of Toronto
OMA-sponsored health fair a remarkable initiative in Ontario physicians’ long tradition of championing public health

by Ruth Teper, OMA Information Management Department
Matthew Radford, OMA Public Affairs and Communications Department

It was a public health education “extravaganza” that captivated more than 160,000 people from across the province and beyond, drawing opening-day crowds so enormous that the local fire marshal was forced to lock the doors on three separate occasions as a public safety measure.¹

On Thanksgiving Day, 1959, the country’s first large-scale health fair — dubbed “Mediscope ’59” — opened its doors in the Queen Elizabeth Building of Toronto’s Exhibition Place. The week-long event was unlike anything that had ever been presented in Canada.

With its roots firmly planted in the growing realm of public health education and promotion, Mediscope was planned and organized over a three-year period by the Ontario Medical Association, in conjunction with various allied professions, voluntary health agencies, and departments of the provincial and federal governments.

Featuring a total of 50 exhibits, which covered everything from mental illness to internal medicine, Mediscope not only drew record crowds, it also attracted high-profile political luminaries, such as the lieutenant-governor of Ontario, the minister of health, and the minister of education — all of whom were in attendance during the event’s grand opening.

“Mediscope went a long way to bring understanding between the public and the profession and within the profession itself, not because of the money that was spent, but because the exposition allowed the public to see what we are doing, and gave doctors the opportunity of learning some of the viewpoints of the public,” said Dr. Glenn Sawyer, the General Secretary of the OMA at the time.²

Mediscope wasn’t the OMA’s first prominent foray into the public health arena.

At its inaugural annual meeting in June 1881, the OMA identified “the prevalence of unsanitary conditions which were endangering the health of citizens” — this led to the establishment of Ontario’s Public Health Act.³ In 1898, the OMA passed a resolution challenging the workload and environmental conditions of Ontario public schools, which led to the Ministry of Education forming a committee to rectify the situation.⁴

While there are many examples of the Association’s early efforts championing public health initiatives, the sheer size and ambition of Mediscope set a new standard.

One factor that made this event so successful was the enthusiastic participation of physicians.

In 1959, the OMA had approximately 5,800 physician members. Of these, 1,200 physicians from 100 communities across the province volunteered their time and energy to Mediscope, including being on hand at each of the exhibits to

¹ It was a public health education “extravaganza” that captivated more than 160,000 people from across the province and beyond, drawing opening-day crowds so enormous that the local fire marshal was forced to lock the doors on three separate occasions as a public safety measure.¹

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⁴ In 1898, the OMA passed a resolution challenging the workload and environmental conditions of Ontario public schools, which led to the Ministry of Education forming a committee to rectify the situation.⁴
answer questions, and further explain many of the topics being presented.

Of the 50 exhibits at Mediscope, the OMA produced 30, including a show-stopping, transparent “talking” lucite model of a woman, built in Cologne, Germany, especially for the event. The model cost $20,000 (the equivalent of more than $132,000 today⁵), and was underwritten by the Toronto Daily Star, which also sponsored a naming contest for the exhibit, complete with a $1,000 prize. The winning entry, “Lehra” — submitted by Jean McCrimmon of Toronto — was derived from the German verb lehren, meaning “to teach” (see sidebar, page 31).

Mediscope also included exhibits on surgery, anesthesia, the human eye, the heart, and the birth of a baby. This last exhibit used models to show the various stages of development of a fetus over the nine-month gestation period, portraying both a natural delivery through the birth canal, as well as a caesarean section.

To help ensure Mediscope’s public health message reached as many young people as possible, physicians extended invitations to schools within a 100-mile radius of Toronto to participate in organized tours of the event.

In addition, every Ontario secondary school outside the 100-mile radius that had more than 250 students was invited to send two pupils — the top male and top female science students — as guests of the OMA.

As a result, not only did more than 400 students from around the province have their travel arrangements paid for by the OMA, but many of the students were also hosted in the homes of Toronto-area physicians during their stay.

Members of the OMA Women’s Auxiliary took more than 15,000 Ontario students on guided tours of Mediscope, which included an exhibit on careers in medicine where students could speak to physicians and various other health professionals on the educational requirements and nature of medical careers.

After the success of Mediscope ‘59, the OMA was approached by the Canadian National Exhibition to repeat the event, leading to a second Mediscope being held in 1961. The space for the second event was not large enough to display all of the original exhibits, but with most of the original participants and key displays intact, the event was once again a great success.

Mediscope set the bar for many of the important public health and education initiatives that the OMA has advanced in subsequent decades. These include, for example, smoking cessation, mandatory seatbelt use, reducing accidental injury rates among the elderly, ensuring safe drinking water, and encouraging the use of helmets while cycling.

More recent health promotion initiatives include the OMA’s call for caloric menu labeling in restaurants, legislation aimed at reducing preventable injuries and fatalities resulting from all-terrain vehicle accidents involving children, and legislation banning the use of cellphones while driving.

OMA Archives recently prepared an exhibit on Mediscope, which is on display in the members’ area at the OMA office in Toronto. The exhibit consists of historical photographs and print materials from both Mediscope events (note: some of the images included in the exhibit appear on pages 30-31).

Physicians who are in possession of any historic items (e.g., documents, photographs, etc.) that they feel may be of interest to the OMA Archives, are encouraged to contact Ian Wolfe, OMA Information Management Department, via e-mail (ian.wolfe@oma.org), or by phone at 416.599.2580, or toll-free at 1.800.268.7215, ext. 2914.

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Physicians who are in possession of any historic items (e.g., documents, photographs, etc.) that they feel may be of interest to the OMA Archives, are encouraged to contact Ian Wolfe, OMA Information Management Department, via e-mail (ian.wolfe@oma.org), or by phone at 416.599.2580, or toll-free at 1.800.268.7215, ext. 2914.
“Lehra,” Mediscope ‘59’s transparent talking physiology exhibit, was modelled on a 29-year-old German woman who represented the average proportions of a female body, standing 171.5 cm tall. The model was coated with a rubber composition that, once hardened, was then peeled off to form the mould for the transparent “skin.”

Lehra illustrated human physiology through a network of arteries, veins, nerves, and a lymphatic system in her body that were made from red, blue, yellow and green plastic coloured wires. She also had bones made of metal and organs sculpted from plastic.

Situated in a 1,300-seat theatre, Lehra’s presentation was 17-minutes long and had three showings an hour, which were typically filled to capacity. Her show would begin with the lights in the theatre dimming and her brain lighting up. Then, through a tape-recorded message, Lehra would take participants on a guided tour of the various components and systems of the human body.

In her final message to the audience, Lehra said, “I have made the unseen visible to you. You have seen the intricate parts, which function harmoniously together to keep us in good health of mind and body. Please guard them in your daily living by using good sense in the care of the house in which you live but once.”

After Mediscope was disbanded, and the cost to store the exhibits became prohibitive, Lehra (along with many of the original Mediscope exhibits) was donated to the Ontario Science Centre (OSC), where she is still on display. Gus Dassios, OSC Designer and Artifacts Officer, stated “On behalf of everyone at the Ontario Science Centre, and the 40 million people who have visited us since we opened in 1969, I would like to thank the Ontario Medical Association for its generosity.”
Insurance Update

Ontario automobile insurance reforms to take effect September 1, 2010:

enhanced consumer choice and protection, streamlined systems among key priorities

by Veronica Walpole, CIP, CAIB

In June 2008, the Superintendent of the Financial Services Commission of Ontario (FSCO) invited all interested parties to submit any concerns and suggest changes to improve Ontario’s automobile insurance system. The Superintendent received 90 submissions from consumer groups, health-care providers, insurers, insurance brokers, agents, legal professionals, and individual consumers, including accident victims.

Ontario Minister of Finance Dwight Duncan recently introduced reforms to automobile insurance based on many of the recommendations provided by the FSCO, and which were contained in the “Financial Services Commission of Ontario’s Five-Year Automobile Insurance Review” report. These reforms, 41 in all, will take effect on September 1, 2010.

The reforms are intended to benefit consumers in three main areas:

• Provide more choice to consumers when purchasing automobile insurance coverage.
• Streamline the automobile insurance systems to reduce transaction costs and increase efficiencies.
• Provide consumers with more protection by giving easier access to benefits, regulate insurers’ rating practices, and work with the medical community in the treatment of accident victims.

The majority of these changes affect the Accident Benefits section of coverage. According to Minister Duncan, “if you’re injured in an automobile accident in Ontario, you’re covered under these new proposals. No matter who’s at fault in the accident, you’ll have access to income replacement, medical and rehabilitation, and other benefits.

“These changes will make the application process simpler, reduce the number of assessments that you’ll have to have, and make it easier for you to gain access to your accident benefits. The results would be that more accident benefit dollars go to treating accident victims.”

The new Statutory Accident Benefits Schedule (SABS) includes the following changes:

• Under the new Medical and Rehabilitation Accident Benefits coverage, expenses for treatment and assessment for minor injuries sustained in a car accident will be capped at $3,500.
• Replacing the existing Pre-Approved Framework Guideline for Grade I and II Whiplash Associated Disorders with a new Minor Injury Guideline for accidents occurring on or after September 1, 2010.
• Providing standard medical and rehabilitation coverage for non-catastrophic claims of $50,000, with optional coverage of $100,000 to $1,100,000.
• Offering standard attendant care coverage for non-catastrophic claims of $36,000, with optional coverage of $72,000 to $1,072,000.
• Supplying optional caregiver, housekeeping and home maintenance benefits for non-catastrophic claimants.
• Assessment costs would be limited
to $2,000 per assessment (regardless of whether they are requested by the claimant or insurer), and the fee for completing forms (including any assessment required to complete the form) would be capped at $200. The fee would be included as part of a claimant’s medical and rehabilitation accident benefits. Insurer examinations would also be limited to $2,000 per assessment, and rebuttal examinations would be completely eliminated.

- Providing payment for in-home assessments only to claimants who have sustained more than a minor injury.
- Offering $2,500 for accounting reports to support income-replacement benefits claims.
- Merging treatment plans and applications for approval of assessments or examinations into one process.
- Providing adjusters with discretion in the use of insurer examinations.
- Creating a definition for “incurred expense.”
- Simplifying and consolidating the rules that govern claims processing.
- Eliminating a number of approved forms.

Other changes brought about by the reforms include the following:

- Where there may be a dispute regarding which insurer is liable to pay for statutory accident benefits, claims will not be deflected and claimants will receive payments without delay, pending a resolution.
- Insurers will be required to provide timely access to applications for benefits, and the applications need only be submitted to one insurer, rather than all insurers who may be liable. Applications must be processed without delay, and insurers are prohibited from preventing or discouraging claimants from submitting applications to them.
- Insurers will be prohibited from using credit information, such as credit rating, credit score, or other personal financial information to treat consumers differently when requesting quotations for automobile insurance, and must provide them with the lowest rate they have available. This includes prohibiting insurers from requiring that a consumer consent to the collection and use of this information before an insurance quote is provided.
- An option will be introduced for consumers to reduce the tort deductible for pain and suffering awards to $20,000 from $30,000.
- A $500 deductible option will be added for Direct Compensation — Property Damage claims.
- The rating of accidents that occur on or after September 1, 2010, will be prohibited where the insured is 25% or less at fault.

The need for reform has been a hot topic, and headlines warning of double-digit premium increases have consumers worried. Drivers in Ontario already pay more for automobile insurance than anywhere else in the country. However, on the flip side, Ontarians have had the most generous Accident Benefits coverage resulting in higher claims costs. In some cases, these costs are as much as ten times the average of other provinces.

Whether the changes brought about by these reforms will have the intended effect on automobile insurance remains to be seen, and may not be evident for several years. In the interim, the insurance industry and its regulators face several complicated challenges, including balancing premium, coverage and profitability so insurers stay in Ontario, and educating insurance industry employees and brokers to ensure consumers receive the information they need to make intelligent choices, and not risk sacrificing coverage in order to find ways to reduce the cost of premiums.

OMR

Veronica Walpole is Assistant Vice-President, Group Solutions, Willis Canada Insurance.

The preceding article, prepared by Willis Canada Insurance, is provided for information purposes only.
A summary of current health legislation and policy developments

• Changes to Regulations Under the Midwifery Act
• Ontario Hospital Association Prototype Bylaws

by OMA Health Policy Department

CHANGES TO REGULATIONS UNDER THE MIDWIFERY ACT

The Ontario government passed Bill 179 (Regulated Health Professions Law Statute Amendment Act, 2009) in December 2009. The Act amended several health-related statutes. As a result of Bill 179, several changes have been made to the regulations under the Midwifery Act. These changes include the following: a midwife now has the ability to independently administer, by injection, 11 new substances. Also, a midwife now has the ability to independently prescribe an additional 15 drugs. Finally, a midwife may now use any drug on the order of a physician. Previously, midwives could only use a drug on a physician’s order if the drug appeared on a designated list in the Midwifery Act regulations. Details about these changes can be accessed online through the Ontario Gazette (http://www.ontario.ca/ontprodconsume/groups/content/@gopsp/@ontgazette/@gazettes/documents/document/ont06_023599.pdf), or by contacting the OMA Health Policy Department.

OMA Staff Contact: Ada Maxwell (ext. 2942)

ONTARIO HOSPITAL ASSOCIATION PROTOTYPE BYLAWS

The Ontario Hospital Association (OHA) has just published its revised Prototype Bylaws, which are meant to be guidelines for all provincial hospitals as they develop and revise their own local hospital corporation bylaws. The last time the Prototype Bylaws were updated was in 2003. This is the first time that the OHA did not jointly pursue Prototype Bylaw development with the OMA, and the OHA has informed its members that this is because “the OMA declined to continue discussions with the OHA” on bylaw issues. This is misleading, as the OHA unilaterally decided to withdraw from the Prototype Hospital Bylaw partnership. The OMA’s Legal Services and Health Policy departments, in co-operation with the Canadian Medical Protective Association (CMPA), are reviewing the OHA Prototype Bylaws and will inform members of their analysis when it is complete.

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Improving practice efficiency: 
align your “strategies for efficiency” with the way you think

by Grant Lum, MD

Would you like to make better use of your limited time, energy, and money? If so, then it would be prudent to examine ways to manage your medical practice more efficiently.

On the one hand, efficiency can often be improved by maximizing your current resources, and introducing some modifications to established routines and practices. On the other hand, improved efficiency might best be achieved by adding new resources, or different processes, into your daily routine.

No matter how you approach it, achieving optimal efficiency is ultimately about having the necessary information and resources in place to get the job done as quickly and effectively as possible — and with the least amount of money and energy wasted.

**Strategies for efficiency**
There are many strategies you can employ to help improve efficiency in the medical practice. However, to ensure these strategies are successful, the approach you choose should align with the way you think.

For instance, if you’re a “list” person, you could begin by listing the things you feel aren’t working well in your practice. For example:
- Patient files are difficult to locate.
- Over-scheduling is a problem.
- There are too many interruptions in the day from phone calls, impromptu meetings with staff, or patients who simply “drop in” with complex problems.

Once you’ve articulated the challenges, develop a list of possible solutions. For example:
- Change the patient filing system.
- Schedule time for phone calls and meetings.
- Leave a buffer of empty slots on your schedule for emergencies.

After you’ve brainstormed solutions, create a list of “first actions” that you must implement to resolve your challenges, and schedule a meeting with your administrative staff to obtain their input.

Following the meeting, you may decide to ask your office manager to research new patient filing systems. Or you might review your schedule and ask staff to block off some “buffer” zones throughout each day to address some of the urgent issues that typically arise.

If you’re more of a “process” person, you might approach the challenge of improving efficiency by looking at a typical day’s operations to determine how various steps might be improved. For example, you could review the chain of events surrounding a typical patient encounter, which might involve the following:
- The patient calls and is booked for an appointment.
- The patient comes into the office and is registered.
- The patient’s file is retrieved and given to doctor.
- The patient is seen by doctor; the doctor makes notes in the file and
makes suggestions to patient; the doctor possibly writes a prescription or referral, or fills out a requisition for testing.

- The patient leaves the office.
- The doctor returns the patient file to staff.
- The doctor codes the file for billing purposes; a staff member bills OHIP for the visit.
- A staff member reconciles the billing to ensure proper payment has been received.

Next, you might review the specific activities that take place at each stage of the patient encounter to see whether greater efficiencies can be achieved. For example:

- When a patient calls the office to book an appointment, does your automated attendant pick up the call and triage the patient to the correct receptionist, or is there a staff person who always picks up calls? If the staff person is busy, is there voicemail available? How many messages can the voicemail-box hold? How long before the call is returned? Is there more than one staff person who returns calls, and, if so, how do you decide who returns the call?

By carefully reviewing this crucial first step in the patient encounter, you may discover that some of your established processes may be easily modified to achieve greater efficiencies.

If you repeat this careful review for the rest of the steps in the chain of events, you may discover additional minor modifications which, when combined together, can lead to significant overall improvements in the use of time, energy, and money.

Finally, some people approach the task of increasing efficiency by looking at ways to address broad-based management issues, such as improving space planning, general workflow, and human resource planning, and/or introducing electronic medical records, phone system, scheduling system, billing/finance processes, or other computer systems into the practice environment.

Notably, in taking a broad-based approach, you will find that each of the categories mentioned has experts who can provide valuable advice — sometimes for free. There are also practice management consulting companies that offer advice in some, or all, of these areas.

To be sure, reviewing all practice processes at once can be an overwhelming task. However, by taking small steps, and aligning your strategies for efficiency with the way you think, you can make efficiency planning and implementation as effective and straightforward as possible.

Dr. Grant Lum is a sports medicine physician, and Medical Director of Athletic Edge Sports Medicine in Toronto.

The Practice Management column is provided by the OMA Member Services Department. Do you have a topic or question you would like to see appear in the Ontario Medical Review? Please let the Practice Advisory Services team know at 416.340.2911, or 1.800.268.7215, ext. 2911, or e-mail: practiceadvisory@oma.org.

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- incorporation and annual renewal for physicians
- incorporation of Family Health Teams and other physician structures

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Choosing how to best manage mortgage loan payments and balances is largely determined by careful consideration of current interest rate levels, coupled with speculation as to how rates are expected to change over the months and years ahead.

Amortization period
Most present-day mortgage providers offer a wide variety of structure and payment options.

For example, interest rate terms and payments can be “fixed” for a specified time period, usually between one and five years, or “floating,” where the interest rate is allowed to move up and down with changes in the prime rate.

Years ago, the term of the interest rate and the term of the mortgage (i.e., the amortization period) were identical, and of lengthy duration. For example, a 25-year mortgage had a guaranteed interest rate for 25 years, and payments were made each month for a period of 25 years.

With current fixed-rate mortgages, the amortization period and the interest rate period are usually different. The interest rate may be guaranteed for five years, and then renewed after five years for another term based on the prevailing rate at the time of renewal. The payments are set using an amortization period that is different from the interest rate term (e.g., 25-year and 20-year amortization periods are most commonly used, although borrowers can choose shorter amortization periods).

The choice of the amortization period affects the amount of the payment. Generally speaking, the monthly payment may rise by a small amount if the amortization period is decreased from 25 years to 20 years.

For example, a five-year closed mortgage of $100,000 at 4%, with a 25-year amortization period, has a monthly payment of $526.02. If the amortization period is dropped to 20 years, the payments increase by $78.23, to $604.25 per month. However, while the monthly rate will be a little higher, there will be 60 fewer monthly payments to be made over the entire term, thus resulting in thousands of dollars in savings.

More frequent and extra payments
Most mortgages permit additional lump-sum or periodic payments to be scheduled, which in effect reduces the amortization period and saves substantial interest over the course of the mortgage.

In the 25-year mortgage example provided above, the monthly payment is $526.02. If the individual pays an additional $100 per month, the amortization period drops by six years, to 19 years. If the payment is increased by $200 per month, the amortization period drops by 9.6 years, to 15.4 years. A one-time lump-sum payment of $5,000 reduces the amortization period by two years.

Another option is to make payments more frequently than once a month, which saves on interest costs. Using the same example of a $100,000, 25-year mortgage, the monthly payments of $526.02 could be changed to 26 bi-weekly payments of $263.01 (50% of the
Refinancing a mortgage

Most fixed-term mortgages are closed (i.e., not negotiable prior to the end of the interest guarantee period). This means that while it may be possible for a mortgage holder to refinance a mortgage in the middle of a term on request, he or she would likely incur a substantial penalty — perhaps thousands of dollars — which might not make refinancing worthwhile.

The reason for the penalty is that the institution holding the mortgage will typically have an “off-setting” financial vehicle (e.g., a guaranteed investment certificate) that it must in turn collapse in order to renegotiate the mortgage. Since the institution itself may bear a cost to collapse its investment prior to term — particularly if interest rates have changed since the mortgage was initially arranged — this cost will be passed on to the mortgage holder.

If the mortgage is for a fixed term and it is open, then it can be renegotiated at any time without penalty. However, an open mortgage for a particular term will have a higher interest rate (often 1% higher) than that of a closed mortgage with a similar term.

Flexible mortgages

Flexible mortgages offer the opportunity to pay down substantial amounts of principal (within certain specified limits) at any time without incurring a penalty. This may present the best opportunity to pay off a mortgage in as short a timeframe as possible.

Flexible mortgages can take a number of forms. Some offer nothing more than a conventional mortgage at a floating interest rate that varies according to the prime rate; the payments must cover the monthly interest amount, while any additional payments will go to pay down the principal.

Other types of flexible mortgages operate more like a line of credit that is secured by the value of the property, up to a maximum amount. They require a specific minimum payment each month based on the amount of the loan outstanding. The mortgage amount can be increased as long as the approved limit is not exceeded. Interest on the loan is based on the amount owing, is charged on a daily basis, and fluctuates with changes in the prime interest rate.

The more sophisticated flexible mortgage vehicles combine a loan with a chequing and savings account — some also offer a credit card for convenience. These mortgages can be used like a total money management system. They permit individuals to keep their balance as low as possible, which allows them to pay off and consolidate other debt — such as credit card balances — within the mortgage, thus exchanging high-interest credit card rates for much lower interest mortgage rates. The mortgage account can also be used to pay routine expenses (e.g., monthly hydro or gas bills) by cheque, Internet banking, or debit card.

The flexible mortgage account has several advantages, and may be an attractive option in the right circumstances. Studies have shown that it is usually more advantageous to opt for a flexible interest rate mortgage rather than a fixed-rate mortgage — at least for a period of time (unless, of course, interest rates rise substantially during the period in question).

However, to truly take advantage of a flexible mortgage, the mortgage holder must continue to pay down the mortgage balance at every opportunity, and not be tempted to only pay the minimum amount required each month.
INDICATIONS AND CLINICAL USE

Humalog® (insulin lispro injection), Humalog® Mix25® (25% insulin lispro injection, 75% insulin lispro protamine suspension), and Humalog Mix50® (50% insulin lispro injection, 50% insulin lispro protamine suspension) are indicated for the treatment of patients with diabetes mellitus who require insulin for the maintenance of normal glucose homeostasis. Humalog® insulins are also indicated for the initial stabilization of diabetes mellitus. Humalog® (insulin lispro injection) is a short-acting insulin analogue and is for use in conjunction with a longer-acting human insulin, such as Humulin® N except when used in a subcutaneous insulin infusion pump.

CONTRAINDICATIONS

The Humalog® (insulin lispro) family of insulins are contraindicated during episodes of hypoglycemia (for details see SYMPTOMS AND TREATMENT OF OVERDOSAGE) and in patients sensitive to insulin lispro or any of the excipients they contain.

SPECIAL POPULATIONS

Renal Impairment: Some studies with human insulin have shown increased circulating levels of insulin in patients with renal failure. In a study of 25 patients with type 2 diabetes and varying degrees of renal function (from normal to severe impairment, including endstage renal failure), the pharmacokinetic differences between Humalog® and human regular insulin were generally maintained. However, the sensitivity of the patients to insulin did change, with an increased response to insulin as the renal function declined. Careful glucose monitoring and dose adjustments of insulin, including Humalog®, may be necessary in patients with renal dysfunction.

Hepatic Impairment: Some studies with human insulin have shown increased circulating levels of insulin in patients with hepatic failure. In a study of 22 patients with type 2 diabetes, impaired hepatic function did not affect the subcutaneous absorption or general disposition of Humalog® when compared to patients with no history of hepatic dysfunction. In that study, Humalog® maintained its more rapid absorption and elimination when compared to human regular insulin. Careful glucose monitoring and dose adjustments of insulin, including Humalog®, may be necessary in patients with hepatic dysfunction.

SAFETY INFORMATION

WARNINGS

Due to their quick onset of action, the Humalog® (insulin lispro) family of insulins should be given within 15 minutes before a meal.

When necessary, Humalog® (insulin lispro injection) may be given shortly after a meal instead (within 20 minutes of the start of the meal). When used in a subcutaneous insulin infusion pump, Humalog® should not be diluted or mixed with any other insulin. Patients should carefully read and follow the insulin infusion pump manufacturer’s instructions and the INFORMATION FOR THE PATIENT insert before use.

Hypoglycemia is the most common adverse effect associated with insulins, including the Humalog® family of insulins. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations. Glucose monitoring is recommended for all patients with diabetes.

Any change of insulin or human insulin analogue should be made cautiously and only under medical supervision. Changes in purity, strength, brand (manufacturer), type (insulin lispro, regular, NPH, etc.), species (beef, pork, beef-pork, human), and/or method of manufacture (recombinant DNA versus animal source insulin) may result in the need for a change in dosage.

PRECAUTIONS

General: Humalog® (insulin lispro injection) had a similar safety profile to Humulin® R over the course of the clinical studies although its efficacy has not been studied in clinical trials beyond one year. Humalog® has been shown to control hemoglobin A1C levels as effectively as human insulin in comparator studies specifically designed to study meal-time therapy without optimization of basal insulin regimens. Once a patient is using Humalog®, reassessment and adjustment, as necessary, of the basal insulin regimen (dosage and number of injections) have been shown to optimize overall glycemic control.

ADVERSE REACTIONS

Rarely, administration of insulin subcutaneously can result in lipodystrophy (depression in the skin) or lipohypertrophy (enlargement or thickening of tissue). Patients should be advised to consult their doctor if they notice any of these conditions. A change in injection technique may help alleviate the problem.

To report any adverse events, please contact Eli Lilly Canada Inc. at 1-888-545-5972.

ADMINISTRATION

DOSAGE

The dosage of Humalog® (insulin lispro injection), Humalog® Mix25® (25% insulin lispro injection, 75% insulin lispro protamine suspension), or Humalog Mix50® (50% insulin lispro injection, 50% insulin lispro protamine suspension) is determined by a physician in accordance with the requirements of the patient. Although Humalog® insulins have a quicker onset of action and shorter duration of activity, dosing is comparable to regular human insulin. The dosage of a Humalog® insulin, like all other insulin formulations, is dependent upon the individual patient requirements. The dose and number of insulin injections should be adjusted to maintain blood glucose concentrations as close to normal as possible.

Additionally, the dosage may be required to be increased in diabetes patients with renal impairment, during intercurrent illness and/or emotional disturbances. Adjustment of dosage may also be necessary if patients undertake increased physical activity or change their usual diet.

New Patients: Patients receiving insulin for the first time can be started on a Humalog® insulin in the same manner as they would be on an animal-source or human insulin.

Patients should be monitored closely during the adjustment period.

Transfer Patients: When transferring patients to a Humalog® insulin, use the same dose and dosage schedule. However, some patients transferring to a Humalog® insulin may require a change in dosage from that used with their previous insulin.

Analysis of a database of type 1 diabetic patients indicated that basal insulin requirements increased by 0.04 U/kg, while Humalog® requirements decreased by 0.03 U/kg, after one year of treatment. For type 2 diabetic patients, both short-acting and basal insulin requirements increased slightly after one year of treatment with both Humalog® and Humulin® R.

Optimizing Glycemic Control: In order to achieve optimal glycemic control, changes in total daily dosage, the number of injections per day, and/or timing of injections may be necessary when using a Humalog® insulin.

Once a patient is using Humalog®, reassessment and adjustment, as necessary, of the basal insulin regimen (dosage and number of injections) have been shown to optimize overall glycemic control.

STUDY REFERENCES


SUPPLEMENTAL PRODUCT INFO

THERAPEUTIC CLASSIFICATION
Anti-Diabetic Agent

PHARMACOLOGY

Humalog® (insulin lispro injection) is absorbed more rapidly than regular soluble insulin from s.c. sites of injection and also has a shorter duration of action. Due to its quick onset of action, Humalog® should be given within 15 minutes.
before a meal. When necessary, Humalog® may be given shortly after a meal instead (within 20 minutes of the start of the meal).

s.c. injected regular insulin typically results in serum insulin concentrations that peak later and remain elevated for a longer time than those following normal pancreatic insulin secretion in non-diabetic. When regular insulin is used to control postprandial glucose, adequate control is often not achieved because the amount of regular insulin necessary is not achievable in postprandial glucose excursion often leads to late hypoglycemia. By producing more rapid and higher serum insulin concentrations with a shorter duration of activity (2 to 5 hours), Humalog® decreases glucose excursion and stops after meals with less chance for hypoglycemia.

A glucoseclamp study was performed in healthy volunteers, in which a 10 U dose of Humalog® was compared to Humulin® R. Doses were given s.c.; an additional 10 U dose of i.v. regular insulin was given as an absolute reference. Humalog® showed statistically higher peak concentrations (Cmax), which occurred earlier than Humulin® R (tmax). Total absorption was comparable, with area under the curve (AUC) values of serum concentration vs. time which were not statistically different (see Table 1 and Table 2).

Table 1: Pharmacokinetics of Humalog® Compared with Humulin® R in Healthy Volunteers

<table>
<thead>
<tr>
<th>Mean±SD</th>
<th>Humalog®</th>
<th>Humulin® R</th>
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<tbody>
<tr>
<td>tmax (h)</td>
<td>5±30</td>
<td>10±40</td>
</tr>
<tr>
<td>Cmax (mg/mL)</td>
<td>3.2±1.33</td>
<td>1.79±0.77</td>
</tr>
<tr>
<td>AUC (mg/min/mL)</td>
<td>36±52.2</td>
<td>423±71.8</td>
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Results predicted from a pharmacokinetic/pharmacodynamic link model.

Subsequent pharmacokinetic studies in type 1 patients confirmed that a significantly faster increase in serum insulin levels and a shorter plasma half-life resulted from an injection of Humalog® when compared to Humulin® R (see Figure 1).

![Figure 1: Humalog®](image)

Figure 1: Humalog® R (n=10) and Humalog® (n=10) (Mean dose 15.4 U)

Mean Serum Insulin Concentrations in Type 1 Patients Following Injection of Humulin® R and Humalog® (Basal 0.2 U/ml/min/kg insulin infusion)

Posterprandial and overall glycemic control

In clinical studies after 1 year, the decrease in glucose excursion during and after meals with Humalog® was consistent, although not always significant, when compared to Humulin® R. However, there was no significant difference in hemoglobin A1C levels between the two treatment groups. These studies were specifically designed to study meal time therapy without optimization of basal insulin regimens.

Subsequent clinical studies have demonstrated that in an intensive insulin treatment regimen with basal insulin optimization, Humalog® controls postprandial glucose and contributes to lower hemoglobin A1C levels to a greater degree than regular human insulin, without increasing the risk of hypoglycemia.

Hypoglycemia

The frequency of hypoglycemia was not statistically significant in 1-year parallel studies Humalog®, n=543; Humulin® R, n=565), but was significantly less with Humalog® therapy in a 6-month crossover study in type 1 patients (n=108) which also demonstrated a significant reduction in nocturnal hypoglycemia with Humalog®.

Use in Pumps

When used in subcutaneous insulin infusion pumps, treatment with Humalog® has been shown to result in lower hemoglobin A1C levels compared to regular human insulin without increasing the risk of hypoglycemia. In clinical trials that compared Humalog® with regular human insulin, Humalog® consistently showed significantly lower HbA1C improvement in the range of 0.3% to 0.6%.

PRECAUTIONS

Unusual disturbances in carbohydrate metabolism due to refractory changes are reserved during the early phase of effective management. However, since alteration in osmotic equilibrium between the lens and ocular fluids may not be stable for a few weeks after initiating therapy, it is wise to postpone treating with new corrective lenses for 3 to 6 weeks.

Additional adjustment of dosages may be required during intercurrent illness and/or emotional disturbances such as anxiety. Any rapid- or short-acting insulin formulation should be used with caution in patients with gastroparesis. However, some patients with gastroparesis may benefit from postprandial administration of Humalog® which has been shown to provide postprandial glycemic control similar to that observed by human insulin injection pre-prandially and prolonging the postprandial dosing approach, the insulin dose can be adjusted according to the actual caloric intake and/or the observed rise in blood glucose following a meal.

Transferring Patients from Other Insulins: Patients taking a Humalog® insulin may require a change in dosage from that used with their usual insulins. If an adjustment is needed, it may occur with the first dose or during the first several weeks or months.

A few patients who have experienced hypoglycemic reactions after transfer from animal-source insulin to human insulin have reported that the early warning symptoms of hypoglycemia were less pronounced or different from those experienced with their previous insulin. However, the counterregulatory and symptomatic (autonomic and neuroglycopenic) responses to hypoglycemia were studied and found to be superimposable for insulin lispro and regular human insulin.

Patients whose blood glucose is greatly improved, e.g. by intensified insulin therapy, may lose some or all of the warning signs of hypoglycemia. Therefore, patients who have demonstrated an allergic reaction to other insulins may demonstrate an allergic reaction to Humalog® insulin. Local allergy in patients occasionally occurs as redness, swelling, and itching at the site of insulin injection. This condition usually resolves in a few days to a few weeks. In some instances, this condition may be related to factors other than insulin, such as irritants in the skin cleansing agent or poor injection technique. Systemic allergy may cause rash, including pruritus over the whole body, shortness of breath, sweating, reduction in blood pressure, fast pulse, or swelling. Severe cases of generalized allergy may be life-threatening (see CONTRAINDICATIONS).

Use in Pregnancy: Humalog® can be used in pregnancy if clinically indicated. Data on a large number of exposed pregnancies do not indicate any adverse effect of Humalog® on pregnancy or on the health of the foetus/newborn. It is essential to maintain good glucose control in both gestational diabetes and throughout pregnancy in type 1 and type 2 patients. Insulin requirements usually decrease during the first trimester and increase during the second and third trimesters.

Patients with diabetes should be advised to inform their doctor if they are pregnant or are contemplating pregnancy. Careful monitoring of glucose control, as well as general health is essential in pregnant patients with diabetes.

Nursing Mothers: The use of Humalog® insulins in nursing mothers has not been studied. Diagnostic who are nursing may require adjustments in insulin dose and/or diet.

Pediatric Use: Clinical trials have been performed in children (61 patients aged 3 to 11) and children and adolescents (441 patients aged 9 to 18 years), comparing Humalog® to regular human insulin. Humalog® showed better postprandial blood glucose control while maintaining a similar safety profile.

As in adults, Humalog® should be given within 15 minutes before a meal. When necessary, Humalog® may be given shortly after a meal instead (within 20 minutes of the start of the meal).

The safety and effectiveness of Humalog® Mix25® (25% insulin lispro injection, 75% insulin lispro protamine suspension) and Humalog Mix50® (50% insulin lispro injection, 50% insulin lispro protamine suspension) in children have not been established.

Drug Interactions: Drug interactions with insulin formulations including Humalog® insulins may include the following:

- Insulin requirements may be increased in the presence of agents such as oral antidiabetic agents, salicylates, sulfa drugs, certain anticonvulsants, monoamine oxidase inhibitors, beta-adrenergic blockers, alcohol, angiotensin converting enzyme inhibitors and angiotensin II receptor blockers.

- Insulin requirements may be increased by medications with hypoglycemic activity such as corticosteroids, thionamides, certain lipotropic drugs (e.g. niacin), estrogen, oral contraceptives, phenergan, and thyroid replacement therapy.

Hormones that tend to counteract the hypoglycemic effects of insulin include growth hormone, cortisol, glucocorticoids, thyroid hormone, and glucagon. Epinephrine not only inhibits the secretion of insulin, but also stimulates glycogen breakdown to glucose. Thus, the presence of such diseases as acromegaly, Cushing's syndrome, hyperthyroidism, and pheochromocytoma complicate the control of diabetes. The hypoglycemic action of insulin may also be antagonized by diphenhydramine.

Insulin requirements can be increased, decreased, or unchanged in patients receiving diuretics.

The physician should be consulted when using other medications in addition to a Humalog® insulin.

SYMPTOMS AND TREATMENT OF OVERDOSE

With the rapid onset of action of the Humalog® (insulin lispro) family of insulins, it is important that the insulin analogue be given close to mealtime (within 15 minutes before a meal). When necessary, Humalog® (insulin lispro injection) may be given shortly after a meal instead (within 20 minutes of the start of the meal). A significant deviation could put the patient at risk of hypoglycemia.

Insulins have no specific overdose definitions because serum glucose concentrations are a result of complex interactions between insulin levels, glucose availability and other metabolic processes. Hypoglycemia may occur as a result of an excess of insulin or insulin lispro relative to food intake and energy expenditure or in patients who have an infection or become ill (especially with diarrhea or vomiting).

Symptoms are likely to appear anytime when the blood of sugar concentration falls below 3.0 mmol/L (50 mg/100 mL), but may occur with a sudden drop in blood glucose even when the value remains above 3.0 mmol/L (50 mg/100 mL). Hypoglycemia may be associated with lassitude, confusion, palpitations, headache, sweating and vomiting. Mild hypoglycemic episodes will respond to oral administration of glucose or sugar-containing foods. Correction of moderately severe hypoglycemia can be accomplished by intramuscular or subcutaneous administration of glucose, followed by oral carbohydrate when the patient recovers sufficiently. Patients who fail to respond to glucagon must be given glucose solution intravenously.

Patients who are unable to take sugar orally or who are unconscious should be treated with intravenous administration of glucose at a medical facility or should be given an injection of glucose (either intramuscular or subcutaneous). The patient should be given oral carbohydrates as soon as consciousness is recovered. See Product Monograph for complete prescribing information.

Full Product Monograph is available at www.lilly.ca.

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3650 Cariwest Ave.
Toronto, ON, M1N 2E8

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Date of Revision: June 11, 2009

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OFFICE SPACE AVAILABLE
14,000 SQ. FT. MEDICAL BUILDING: Newer, modern, excellent air quality, parking. 360 College St. near former Doctors Hospital, fine restaurants, shopping. Present tenancies: pharmacy, medical doctors, dentists, and computer retailer. Suites from 600 to 2,000 sq. ft. Attractive terms and rates. For viewing or more info, contact Antonio Figueira (416) 318-5337, or afigueira@trebnet.com, HomeLife/ Cimerman R.E. Ltd., Brokerage.

BOXGROVE MEDICAL CENTRE — NOW OPEN: Four-storey, 60,000 sq. ft. medical building located at the 9th Line and Highway 407. Prime medical space available for lease. X-ray, lab, rehab and urgent care on-site. For info, contact Howard at (416) 357-7509.

BRAMPTON — PENDALE BOVAIRD SQUARE: Medical units available for lease or sale in this newly built plaza. Family physicians, walk-in clinics welcome. Surrounded by new homes. Fronting Bovaird Drive and backing onto public parks and houses. Contact Adnan Bashir, Vice President, at (416) 300-1515.

CENTRAL TORONTO — FOREST HILL: 970 sq. ft. medical or dental office. Waiting room and four examining rooms. Prestige location, available April 1. Free parking. TTC directly out front. Comfortable ambiance, “just like home.” E-mail (officemedical@rogers.com).

DUFFERIN/CLARK: A turnkey medical office up to 2,500 sq. ft. Great location, four exam rooms and a reception, free parking. Beside dentist, physiotherapist, dietician, and a pharmacy. Dense residential and commercial area. Call Hany at (647) 501-4269.

FINCH/HWY. 400: Family doctor looking for another family doctor or specialist to cost-share office space in modern medical building. Call (416) 739-7878.

MISSISSAUGA — CLINIC FOR LEASE: Stand-alone building close to Credit

EMPLOYMENT ADVERTISING POLICY

The Ontario Medical Review is required to comply with the provisions of the Ontario Human Rights Code 1981 in its editorial and advertising policies. Advertisers must observe the following requirements under the Code:

Section 5(1) – Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status, or handicap; section 23(1) - The right under section 5 to equal treatment with respect to employment is infringed where an invitation to apply for employment or an advertisement in connection with employment is published or displayed that directly or indirectly classifies or indicates qualifications by a prohibited ground of discrimination.

Following are the classified advertising deadline dates for the next six issues.

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NEAR CREDIT VALLEY HOSPITAL: Prime ground floor space within Meadowvale Professional Centre, suits X-ray/imaging lab or other clinic. Steps to bus hub and GO Train. MDS, pharmacy and rehab in building. Ample free parking. Lowest rates. Flexible finance and incentive packages. For more information, contact Debalee at (905) 567-7539, ext. 29, or e-mail (mpc@conceptcomputer.com).

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TIRED OF RENTING: An enterprising group of select professionals seeks a doctor from each area of specialization to join them in developing and retaining ownership of professional centres in a number of strategic locations in Toronto and surrounding areas of southern Ontario. Contact Don Carroll (416) 417-7052, or e-mail (don.carroll@statimdiagnostics.com).

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MEDICAL UNIT FOR SALE in a very busy building located at Kennedy/Finch. Well upgraded, with five patient observation rooms. Lots of potential for South Asian community family physician(s). Prime location in an excellent professional building. Please call (416) 891-8291 or (416) 880-9613.

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KITCHENER, ON — SUMMER LOCUMS required for family practice. Busy, organized, computerized, four MD practice. Congenial staff and colleagues. No hospital work, no call. 70:30 split. Contact Meg at (519) 725-4070.

Positions Vacant

90:10 SPLIT OR FLAT RENT: Brampton, Markham, Etobicoke. Brand new, bright, clean medical centres seeking GPs for walk-in and family practice. F/T or P/T. Relocate or start a new practice. New grads and specialists welcome. EMR or paper. Turnkey. Call in strictest confidence (416) 403-1810.

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ASSOCIATE MD NEEDED to join family doctor in Mississauga: 80/20. X-ray & lab on-site. Please call Dr. Afsar at (905) 279-6661 or (416) 575-9031. E-mail (mississauga.md@rogers.com).

ATTRACTIVE SPLIT: Very busy, established professionally run clinics in north Etobicoke seeking MDs to join existing group of seven MDs. Flexible hours and shifts. Very pleasant staff and patient profile. E-mail (alkarim@damji.ca), or call Dr. Damji at (416) 834-2807.

BAYVIEW/RICHMOND HILL — Busy clinic requires shift coverage on Fridays and Saturdays. FHG bonus available. Contact Dr. Lorne Kliman at (416) 284-3759, or e-mail (lornekliman@gmail.com).

BRAMPTON — GENERAL MEDICAL OPPORTUNITY: 25 years established family practice in Brampton looking for a fourth MD, family practice or otherwise, in a mutually supportive relationship. Both family practice and/or walk-in clinic practice available. On-site X-ray, pharmacy and lab. Call Dr. Tautkus at (905) 846-0592.

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FAMILY PHYSICIANS NEEDED for a community health centre in west Toronto. Work within an interdisciplinary team to provide comprehensive primary health care and health promotion to clients of all ages, on and off-site, including home visits. Two part-time positions (17.5 hrs./week), permanent and contract, salary range $62,230 - 74,972 (under review), plus on-call fee, incentives, and excellent benefits. To apply, or for more information, please call the Director, Clinical Services, at (416) 604-3361, or e-mail kasia@4villages.on.ca.

FULL-TIME OR PART-TIME medical doctors required for a busy walk-in located at downtown Mississauga. Please call Adel at (416) 904-2929, or office (905) 897-6160.

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Hwy. 401 AND VICTORIA PARK (Cassandra Clinic): State-of-the-art, fully computerized (Practice Solutions EMR), walk-in clinic and family practice. Open six days a week. Available 10 a.m. to 7 p.m. Full- day and half-day shifts. 70:30 split up to 75:25 based on monthly income. Call Dr. Fouda at (416) 331-9111, or e-mail (cassandra.clinic@gmail.com).

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ROLL UP YOUR SLEEVES! Volunteer positions open for community-based medical development project in Guyana. Seeking physicians, nurses, midwives, public health specialists, pharmacists, laboratory technologists for projects in February, June and October. Volunteer fees are tax deductible. Contact Sarah Zelcer, Director of International Projects & Education, at (416) 964-7698, ext. 15, or e-mail (sarah@veahavta.org). Website (www.veahavta.org).

SPECIALISTS — BRAMPTON, ONTARIO: Dermatologist, pediatrician, internist, and psychiatrist required for medical centre with several GPs and large patient base. Attractive modern office with seven days/week reception service. Fee-for-service split or low flat monthly rate. Tel. (416) 949-3830, fax (647) 340-2586. E-mail (bramptonfamilyhealth@gmail.com).

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WANTED PSYCHIATRIST: To see our clients once per month at one of our group homes for review and medication monitoring. Our residents are dual diagnosed and autistic adolescents and young adults. As well, to be available by phone for consultations when needed. Approx. 30 to 37 clients. Staff support and assistance provided. Time spent for this is approx. four hours per month. Please call Magda Zecevic, Executive Director, at (416) 941-9474.

PRACTICES

ORANGEVILLE, ON: Well-established family practice available July 2010. Physician retiring. Live and practise in a beautiful, four-season recreation area one hour drive from downtown Toronto. Join a 20-physician FHO, 26-physician FHT, supported by on-site nurse practitioners, dietician, diabetic educator, lifestyle counsellor, RT and psychologists. Modern medical building with five family physicians, surgeon and internist, pharmacy and ample free parking. Office fully equipped, EMR records and software transferable. Walk into a busy and
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