Social Media & Clinical Practice: harnessing benefits and managing risk

Editorial
The impacts of Ministry cuts emerge, OMA exploring legal options

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Calendar of events, registration information

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New OMA advertisements highlight patient impacts of government cuts to care

Epilepsy Management
New Ontario guidelines for medical management of epilepsy in adults and children

Day in Primary Eye Care
Symposium highlights, tips for family physicians

Insurance Update
The facts about insurance, addressing common misperceptions
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Linda Vorano
Administrative Assistant
Div of Genetics and Metabolics
The Hospital for Sick Children

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### Board of Directors

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| 3 | Dr. C. Cressey, Palmerston |
| 4 | Dr. V. Tandan, Hamilton  
Dr. R. Tytus, Hamilton |
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Dr. C. Cannon
The OMA Physician Health Program is a confidential service for physicians, residents, medical students and their family members. Our caring, helpful, health-care professionals offer assistance to those who may be experiencing problems ranging from stress, burnout, emotional or family issues, through to substance abuse and psychiatric illness.

Confidential Toll-Free Line 1.800.851.6606
php.oma.org
8 Editorial: impacts of Ministry cuts emerge, OMA exploring legal options

The uncertainty and unpredictability associated with the government’s cuts, combined with its heavy-handed tone and approach, is fuelling frustration among physicians and a call for concrete action. The OMA has been working with our external legal counsel to explore legal options available to us in light of recent Supreme Court rulings. As the OMR goes to press, material is being developed for members that will set out a series of potential legal avenues that we may choose to pursue in response to the Ministry’s unilateral cuts. These options will be discussed in detail at the OMA Annual General and Council Meeting.

10 Strategic communications update: new OMA ads highlight patient impacts of government cuts

The OMA recently introduced the next phase of our ongoing provincewide strategic advertising campaign, which highlights the personal/patient impact of government’s unilateral cuts to health care. The ads provide specific examples of how government cuts will impede the provision of quality health care in Ontario, and the issues that are arising around co-ordination of care and access to specialists.

16 OMA Annual General & Council Meeting: calendar of events, registration information, Section programs

The 135th OMA Annual General and Council Meeting will be held April 30 to May 3 at the Hilton Toronto Hotel. Featured events include a Council Policy Session on Health System Transformation and Sustainability, Primary Care Billing Seminar, 16th Annual Women’s Health Care Seminar, Awards Presentations and Presidential Installation, and the Adam Linton Memorial Lecture, to be presented by renowned author Margaret Atwood.

20 Day in Primary Eye Care for Family Physicians

The 37th Annual Day in Primary Eye Care Symposium featured more than 20 lectures, panels and workshops on practical approaches to treating common eye problems that present to primary care physicians. Key topics included pediatric strabismus and amblyopia, pediatric emergencies in the first six months of life, an approach to diplopia, an update on glaucoma, and age-related macular degeneration.

24 New provincial guidelines for medical management of epilepsy patients

The new Provincial Guidelines for the Management of Epilepsy in Adults and Children, introduced in January 2015, will provide assistance in the medical management of epilepsy to primary care providers, pediatricians, community neurologists, and others who care for individuals with epilepsy. The guidelines include best practices for epilepsy diagnosis and treatment, as well as resources for physicians and patients.

31 Getting the most out of social media for your clinical practice

Social media facilitates the flow of information between physicians and other health providers, their patients, and the public. This type of media channel can be used for multiple purposes: to improve communication, establish or maintain relationships, disseminate information, educate patients, and assist in practice management. But while there are benefits to using social media tools in clinical practice, there are also risks. This month’s cover feature outlines a strategic approach to harnessing the power of social media to help physicians realize the benefits of increased interactivity and connectivity with their patients, colleagues, the health care system, and society in general, while managing the risks.
There isn’t one thing we’d like to sell you.*

* Any insurance company can sell you individual insurance products piece by piece. It’s good for business. But because OMA Insurance is strictly not for profit, our non-commissioned advisors focus first on providing doctors with objective advice – unbiased insurance solutions that give you the coverage you need, when you need it, at every stage of your life and career. Nothing superfluous. But nothing overlooked.

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Not for profit. All for doctors.
34 Insurance Update: the facts about insurance, part 2 — addressing common misperceptions

In December 2014, Insurance Update addressed some common misunderstandings and inaccuracies with respect to the OMA Insurance program. This month, we continue our look at some of the misperceptions and sentiments typically associated with insurance, provide a fresh perspective on how insurance works, and describe why it is advantageous to have a great provider like OMA Insurance by your side when choosing products and settling claims.
## Section Chairs

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<td>Eye Physicians and Surgeons of Ontario</td>
<td>Dr. T. Hillson</td>
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<td>Hematology and Medical Oncology</td>
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<td>Vascular Surgery</td>
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The Ontario government has put its budget ahead of patients, and turned its back on a long-standing collaborative partnership with the Ontario Medical Association and the province’s physicians.

The uncertainty and unpredictability associated with the government’s cuts, combined with its heavy-handed tone and approach, is fuelling frustration among physicians and a call for concrete action. Physicians are seeing the profound negative impact of the government’s unilateral cuts on their patients. The government has remained unwilling to come back to the table even to discuss a freeze on physicians’ fees for two years. That freeze would be contingent on the government agreeing to reverse its unilateral action, fund ALL the necessary growth in medical services and remove the hard cap on the physician services budget and the planned clawbacks from physicians if this budget is exceeded.

On behalf of our patients, our members, and the health care system, we must find a way to influence the government’s irresponsible approach to physician services. At the end of January 2015, the Supreme Court of Canada issued three decisions that substantially change the constitutional principles and legal environment within which OMA/government negotiations occur.

As a result, the OMA has been working with our external legal counsel to explore the legal options available to us in light of the recent Supreme Court rulings. As the OMR goes to press, material is being developed for members that will set out a series of potential legal avenues that we may choose to pursue in response to the unilateral cuts imposed by the Ministry of Health and Long-Term Care. These options will be discussed in detail at the upcoming OMA Annual General and Council Meeting.

Also, the Board will be seeking member input to a survey developed by our Physician Activity Working Group that will measure physicians’ interest in pursuing a broad range of activities to influence the government’s current agenda. The survey will be conducted using our innovative ThoughtLounge platform, and invitations will be issued to individual members via email.

Our strategic advertising campaign has been revamped with a new series of ads that highlight the personal impacts of government’s unilateral cuts to care. The ads, which are previewed on pages 10-11, focus on the challenges associated with co-ordination of care and access to specialists that will affect many patient groups, such as stroke and Alzheimer’s patients. The campaign will be featured in targeted regional print publications, prominent news and information websites, Facebook, and transit shelters surrounding Queen’s Park.

The short-term and long-term consequences of this government’s arbitrary measures and imposed cuts to medical services are beginning to show in areas across the province with reports of impeded patient access to care, and emerging physician recruitment and retention problems.

In the city of Hamilton, where I practise, the OMA worked with The Hamilton Spectator, local established physicians, medical students and residents, which resulted in a front-page feature article on the damaging effects of the government’s decision to freeze physician entry to Family Health Teams and the very real and immediate impacts that this unilateral measure is having on the community.

Those affected include not only primary care doctors working in teams, but all allied health professionals working in these models, rostered patients, local specialists who take referrals from groups, and of course medical students and residents who have trained in these teams with the full expectation that this
choice would be available to them upon graduation.

The OMA is working closely with our medical students and residents to provide information to those adversely affected by the government’s actions, and to extend the Association’s resources and support.

We have been contacted by numerous students and residents, as well as many physicians looking to recruit new colleagues, expressing their serious concern about the Ministry restricting team-based care. Some of these members have expressed their intent to relocate or establish practice in other provinces or the United States.

There is a global demand for physicians. In fact, a recent study by the Association of American Medical Colleges projects a shortfall of up to 90,400 physicians in the United States by 2025, as the demand for physicians south of the border continues to outpace supply. That’s over three times the total number of practicing physicians in Ontario. Clearly, the province needs to retain its physicians, not drive doctors to other jurisdictions.

The Ministry’s decision to eliminate internal medicine, cardiology, gastroenterology, and nephrology physicians from billing Chronic Disease Assessment Premium (E078) has prompted grave concern among these specialists about the impact on their patients. Many of these physicians are facing up to a 30% decrease in their gross practice revenue, resulting in a need for significant change to their practice and their ability to deliver high-quality care to these complex patients with chronic diseases. This is another example among many that is garnering public attention as the reality of the government’s cuts takes hold.

The impact of unilateral cuts, a capped physician services budget, and the spectre of reconciliation and potential clawbacks is damaging physician morale and will ultimately lead to diminished public confidence in the health care system.

The OMA media relations and public affairs staff is working closely with grassroots members and physician groups in many disciplines and communities to raise public awareness and understanding of how government cuts will influence health care today and in the future. Please contact the OMA at info@oma.org, or visit the website (www.oma.org) and share your experience.

Also, the OMA Health Care Advocates program is available to assist members with arranging meetings with local MPPs and other government officials. To learn more about the program, or to join our growing network of physician advocates, please contact: political.actionnetwork@oma.org.

The OMA will be communicating in the coming weeks to provide full details of our legal options, as well as related advocacy and member action initiatives.

We are updating the member website on a continuing basis as new information becomes available, and we will report all relevant news to members as quickly as possible via our various communications channels.

Please take the opportunity to contact the OMA and provide your input and suggestions. Thank you for your continuing support.

Dr. Ved Tandan
OMA President

Have a question?

Contact the OMA Response Centre:
A knowledge-based team who can respond to a variety of questions directly, or connect you to the person who can answer your question.

info@oma.org
1.800.268.7215 (press 0)
Care Not Cuts!

Strategic Communications Update: new OMA ads highlight patient impacts of government cuts

by Nancy Dale
OMA Public Affairs Department

The OMA recently introduced the next phase of our ongoing provincewide strategic advertising campaign, which highlights the personal/patient impact of government’s unilateral cuts to health care.

Physicians and patients are deeply concerned about the government’s arbitrary cuts to care, and how these cuts will affect patients and their families. The new OMA advertisements, shown below and opposite, reinforce recognition of Ontario’s doctors as champions of patient care, outlining how we believe the government’s cuts will put health care at risk.

The OMA ads strongly state: “Cuts to Healthcare Mean Cuts to Your Family’s Care.” The ads provide specific examples of how government cuts will impede the provision of quality health care in Ontario, with a particular focus on the impacts to Alzheimer’s and stroke patients, and the issues that will arise around co-ordination of care and access to specialists.

The OMA message will appear as a quarter-page ad in regional print publications across Ontario, online through a variety of news and information websites, including Facebook, and in high-traffic transit spaces around Queen’s Park. The OMA call to action remains strong: “Tell the Premier and your MPP you support care not cuts at OntariosDoctors.com.”

Paid advertising is just one component of the OMA’s integrated strategic communications plan, which also includes earned and social media, stakeholder engagement, and member education and advocacy work. Visit www.OntariosDoctors.com to learn more about all facets of the OMA campaign.
Cuts to healthcare mean cuts to your family's care.

Tell the Premier and your MPP you support care not cuts at OntariosDoctors.com

#CareNotCuts
Join the OMA’s THOUGHTLOUNGE

Is your voice the piece that’s missing?

Help shape the health-care conversation. To learn more, visit us online at www.oma.org/ThoughtLounge
ONTARIO MEDICAL ASSOCIATION

DEDICATED TO DOCTORS. COMMITTED TO PATIENTS

Chief Executive Officer

As the representative of Ontario's physicians, the Ontario Medical Association advocates for the health of Ontarians and provides leadership for an accessible, high quality health care system.

With more than 33,000 members and 250 staff, the OMA represents physicians with the Government of Ontario and acts on behalf of doctors, upon whom all of us depend for health care, medical research and education. Working closely with the OMA's Board and Council, the CEO will be seen as a consensus leader and facilitator for the Association, as the OMA seeks to influence public policy decisions at this critical time in the health care system. Ontario's financial pressures are driving health system reform. There has never been a time where leadership from the medical profession in the health care system has been more important.

The CEO’s operational and governance responsibilities include oversight of all of the OMA's diverse services and activities. In addition to policy, government relations, negotiations, communications and advocacy, these include: Engagement and Program Delivery, Membership Administration, Insurance Services, and the Physician Health Program. The CEO works closely with the OMA’s subsidiary companies, the two largest of which are OntarioMD and the Institute for Quality Management in Healthcare.

As the CEO of the OMA, you will be the Association's principal advisor and financial steward. You will promote the core values of the OMA internally and externally, and will encourage dialogue among members and stakeholders, managing to positive results and ensuring constructive communication. Politically astute, you will navigate the complex political landscape with openness, integrity, passion and patience. Progressive and solutions-oriented, you will assist the medical profession to work in a collaborative way on behalf of patients and members and to contribute to a stronger health care system.

Your credentials as a consensus leader and builder are impeccable, whether you’re a senior health care executive, physician leader, corporate leader, or the CEO of a not-for-profit organization. With excellent relationship-building skills, you are accomplished at working with multiple stakeholders. And, most of all, you are determined to make a difference in a complex and changing health care system.

To explore this exciting opportunity, contact Penny Mirams or Hayley Becker in our Toronto Office at 416-366-1990, or email your resume in confidence to hayley.becker@odgersberndtson.ca or online at http://www.odgersberndtson.ca/en/careers/12683
Ministry unilateral amendments to physician APP/AFP agreements

Physician Alternative Payment Plan and Alternate Funding Plan (APP/AFP) groups have received correspondence from the Ministry of Health and Long-Term Care explaining the Ministry’s plan to unilaterally amend APP/AFP Agreements (this includes primary care APP/AFPs).

The Ministry’s letter states that the current Agreement will “end and be replaced” with changes for different APP/AFPs that include reduced funding, and elimination of certain funding premiums. The letter also states that “a new Agreement would be formed with the Ministry if…” the group continues to provide the services under the APP/APP Agreement. (Note: the language in these letters slightly varies for the different APP/AFP Agreements).

What the Ministry has written is difficult to understand. The Ministry has informed the OMA that its letter means:
1. The Ministry is giving APP/AFP groups notice that it is terminating the current agreement, in accordance with the termination provision of the current funding agreement, and
2. The Ministry is offering to enter into a “new agreement” with the group as of June 1 that is on the same terms as your current agreement, except that it will pay a reduced amount that will vary depending on the funding agreement. (Note: the date may vary depending on the agreement)

The OMA’s view is that these letters clearly do not state Point 1 above, and we expressed this to this Ministry. However, the Ministry disregarded our submission.

For Point 2, it is legally possible to enter into a deemed agreement (i.e., by not replying, you are deemed to have accepted the Ministry’s “new agreement”). However, the OMA is not certain how this would work given that it does not appear the Ministry has properly terminated current agreements.

Accordingly, the Ministry is taking the position that AFP/APP Agreements can be amended to the terms it has set out without following the formal amending process described in each AFP/APP Agreement, and if a group objects, the Ministry will terminate that group’s agreement as permitted under the group’s agreement.

Each group will need to evaluate the terms proposed by the Ministry and decide if the terms are acceptable or if it is preferable to terminate the agreement and revert to payment via fee-for-service.

If you have any questions, please contact OMA Legal Services at LegalServices@oma.org.
End of Life Planning and Care (EOLPC): Office Posters Available

End of Life Planning and Care is important at any stage of life. As part of the OMA’s commitment to increase awareness and to promote *Having the Talk* (on End of Life Planning and Care), the OMA is providing members with complimentary posters on dispelling common misconceptions on End of Life Care and to encourage patients to ask their physician about EOLPC.

86% of Canadians have not heard of Advance Care Planning and only 9% of Canadians have spoken to their doctor about their care at end of life. The OMA and our members can all play a role in changing this: Order your EOLPC Posters today!

**You can order the following posters:**
- Common Misconceptions on End of Life Care (Myth Buster)
- Ask Us (about End of Life Planning and Care)

Visit www.oma.org/eolpc to order free EOLPC posters!

*Please contact eolpc@oma.org for more information or if you have any questions.*
### 135th OMA Annual General and Council Meeting

**Thursday, April 30 – Sunday, May 3, 2015**

**Hilton Toronto Hotel**

Pre-registration for all meetings is required. You may register online at www.oma.org/AGM

#### SUMMARY OF EVENTS

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(see page 17 for details)
FRIDAY, MAY 1
Primary Care Billing Seminar Presented by Dr. David Schieck (0900 – 1200)
Are you currently practising in a Primary Care Model and would like to learn more about billing? This billing seminar reviews Q codes, preventive care bonuses, comprehensive care obligations and much more. A question and answer period will be available for specific items not covered during the presentation.

Spring 2015 Rural Caucus Meeting (0900 – 1200)
The Spring Rural Caucus Meeting is open to Council Delegates who are already registered to attend OMA Council. The meeting will provide an update on topics discussed at the Fall 2014 Rural Caucus Meeting, and will focus on two timely topics of importance to rural physicians. To register for the Spring 2015 Rural Caucus Meeting, contact Janice Tam, OMA Constituency Services, at janice.tam@oma.org.

Adam Linton Memorial Feature Luncheon (1200 – 1400)
The 23rd annual Adam Linton Memorial Feature Luncheon and lecture will be presented on Friday, May 1, 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. This year’s lecture will be presented by Margaret Atwood. A winner of many international literary awards, including the prestigious Booker Prize, Margaret Atwood is the author of more than 30 volumes of poetry, children’s literature, fiction and non-fiction. She is perhaps best known for her novels, which include The Edible Woman, The Handmaid’s Tale, The Robber Bride, Alias Grace, The Blind Assassin, Oryx and Crake, and The Year of the Flood. Ms. Atwood will discuss the importance of literacy and the arts on a community’s health. There is no charge for this event, thanks to a generous contribution from the Canadian Medical Association and its subsidiary, MD Financial Management.

Council Policy Session (1400 – 1700)
The OMA is holding a Council Policy Session on Friday, May 1, from 1400-1700, that will bring Council members together to focus upon a single emerging policy issue. The topic this year is Health System Transformation & Sustainability.

Orientation Session for New Council Delegates (1730 – 1830)
The Chair and Vice Chair of Council will be holding an Orientation Session for new and returning Council Delegates. This brief informational session will focus on your role as Council Delegates and how to get your voice heard at Council. You are encouraged to sign up for the session being held on Friday, May 1, from 1730-1830, at the Hilton Toronto Hotel (room to be confirmed). Please contact Catherine Nanckoo, Strategy and Governance, to pre-register for the session by April 17, at 416.599.2580 or 1.800.268.7215, ext. 3280, or email catherine.nanckoo@oma.org.

SATURDAY, MAY 2 AND SUNDAY, MAY 3
Annual Meeting of Council
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.

Awards Presentations, Presidential Installation and Gala Dinner/Dance (1830 – 2400)
This event will take place at The Carlu, 444 Yonge Street, 7th Floor, Toronto. OMA members are invited to join in celebrating the many contributions and accomplishments of our medical colleagues. The evening commences at 1830 with the awards presentations and presidential installation. A brief reception will follow at approximately 1930 and dinner will be held at approximately 2000. A dance will take place after dinner. The gala dinner is presented, in part, by a generous contribution from the Canadian Medical Association and its subsidiary, MD Financial Management.

GENERAL INFORMATION

REGISTRATION BEGAN ON MARCH 1, 2015
To register for all meetings, including Council, please register online via the following link: www.oma.org/AGM. You may also register for Council by contacting Jennifer Csamer, Strategy and Governance, at 416.599.2580 or 1.800.268.7215, ext. 3461, or email jennifer.csamer@oma.org.

HOTEL RESERVATIONS
Rooms have been reserved at the Hilton Toronto Hotel at the rate of $209 for either single or double occupancy. You may telephone the hotel directly at 416.869.3456 or 1.800.267.2281. When reserving, please indicate that you are attending the meetings of the Ontario Medical Association to ensure you receive the preferred rate. The deadline for reservations is March 30. After this date, reservations will be accepted on a space-available basis only.

NOVEMBER 2015 COUNCIL MEETING AND ANNUAL MEETING 2016
The 2015 Fall Council Meeting will be held on Saturday, November 21 and Sunday, November 22 in Toronto at the Hilton Toronto Hotel. The 136th OMA Annual and General Council Meeting will be held in Niagara Falls at the Sheraton on the Falls from Thursday, April 28 to Sunday, May 1, 2016.
Pre-registration is required for all meetings at www.oma.org/AGM. This schedule is preliminary and may be amended. Your Section flyer outlining agenda items will be distributed in the coming weeks.

ANNUAL OMA COLLABORATIVE SESSION ON MENTAL HEALTH
Thursday, April 30
1900 – 2100

Friday, May 1
• Annual General Meeting
  0830 – 0930
• Annual OMA Collaborative Session on Mental Health
  0930 – 1200

CHRONIC PAIN
Friday, May 1
• Scientific Session
  0830 – 1030
• Annual General Meeting
  1100 – 1200

CLINICAL HYPNOSIS
Thursday, April 30
• Executive Meeting (Executive Members Only)
  1730 – 1830
• Annual General Meeting
  1830 – 1930

COMPLEMENTARY MEDICINE
Friday, May 1
• Annual General Meeting
  1900 – 2200

EYE PHYSICIANS AND SURGEONS OF ONTARIO (EPSO)
Friday, May 1
• Executive Meeting (Executive Members Only)
  1500 – 1700
• Annual General Meeting and Dinner
  1800 – 2030

GENERAL AND FAMILY PRACTICE
Friday, May 1
• Annual General Meeting
  1700 – 1830
• Reception and Dinner
  1830 – 2100

GENERAL INTERNAL MEDICINE
Friday, May 1
• Executive Meeting (Executive Members Only)
  1830 – 1900
• Annual General Meeting and Dinner
  1900 – 2200

GROUP PRACTICE
Friday, May 1
• Annual General Meeting
  1100 – 1200

HOSPITALIST MEDICINE
Friday, May 1
• Scientific Session
  0900 – 1100
• Annual General Meeting
  1100 – 1200

NEPHROLOGY
Friday, May 1
• Annual General Meeting and Dinner
  1830 – 2130

NEUROLOGY
Friday, May 1
• Annual General Meeting
  1900 – 2100

PHYSICAL MEDICINE AND REHABILITATION
Friday, May 1
• Scientific Session
  - 0745 – 1200
  - 0745 – 0800
    Introduction and Registration
  - 0800 – 0900
    “The Blood and Guts” of Complementary Medicine for the Physiatrist — Part 1
    Dr. Gordon Ko
  - 0900 – 1000
    “The Blood and Guts” of Complementary Medicine for the Physiatrist — Part 2
    Dr. Gordon Ko
  - 1000 – 1100
    Chronic Pain Assessment and Management: Teaching Our Patients How to Recognize and Treat Their Painful Conditions
    Dr. Hillel Finestone
  - 1100 – 1200
    Electrodiagnosis and Prognosis of Peripheral Nerve Traumatic Injuries
    Dr. Larry Robinson
• Annual General Meeting
  1400 – 1600
WHAT'S YOUR PLAN?

16th Annual Women’s Health Care Seminar

Your Life in Medicine:
Staying Happy and Engaged in your Career

Thursday, April 30, 2015, Hilton Toronto Hotel, 8:30 a.m. - 4:30 p.m.

Topics Include

Career Shifts  Managing Disruptive Behaviour

Early, Mid and Late Career Considerations

Featuring keynote speaker Dr. Mamta Gautam

The 16th annual Women’s Health Care Seminar is complimentary to OMA members, and has been accredited in previous years for CME credits. To register, visit www.oma.org/AGM, or contact Jennifer Csamer at 1.800.268.7215, ext. 3461, or via email at jennifer.csamer@oma.org.
Symposium Highlights

37th Annual Day in Primary Eye Care for Family Physicians:

key topics — pediatric strabismus and amblyopia, pediatric emergencies in first six months of life, an approach to diplopia, glaucoma update, age-related macular degeneration

by Barbara Klich

The 37th Annual Day in Primary Eye Care Symposium featured more than 20 lectures, panels and workshops on practical approaches to treating common eye problems that present to primary care physicians. Key topics included pediatric strabismus and amblyopia, pediatric emergencies in the first six months of life, an approach to diplopia, an update on glaucoma, and age-related macular degeneration.

The symposium attracted more than 200 delegates to Toronto in December 2014, including family physicians, residents, and ophthalmic assistants.

Hosted by Program Chair Dr. Lawrence Weisbrod, the event was sponsored by the OMA Section of Eye Physicians and Surgeons of Ontario, Canadian Ophthalmological Society, Association of Ontario Ophthalmologists, and Academy of Medicine, Toronto. Following are highlights of the day’s proceedings.

Pediatric Strabismus And Amblyopia

Dr. Michael Richards, Associate Staff, The Hospital for Sick Children, delivered a presentation entitled “Pediatric Strabismus and Amblyopia.”

Dr. Richards told delegates that strabismus, or misalignment of the eyes, affects about 4% of children. It may be the first sign that a serious ocular or intracranial problem may cause vision loss (amblyopia) if untreated. Some of the causes include:

• Uncorrected refractive error.
• Poor vision in one or both eyes — (e.g., from cataract, intraocular tumour, retinal disease).
• Orbital problem (e.g., mass, trauma).
• Neurological problem (e.g., peripheral cranial nerve III, IV, or VI palsies, brain tumour).

“In the first four weeks, some normal infants have a small amount of eye misalignment that is variable. However, constant or large angle strabismus is not normal, and by four months of age all infants should have straight eye alignment,” he said.

In amblyopia, there is decreased vision caused by abnormal visual experience, and this affects about 3% of children. Dr. Richards advised that early detection and treatment of amblyopia is essential to prevent permanent vision loss.

For strabismus, the visual acuity measurement screening includes four standard tests: corneal light reflection, cover test, alternating cover test, and extra ocular movements in the cardinal positions of gaze.

The Brückner test is recommended for examining children who are too young or irritable to co-operate with the standard screening tests for strabismus.

“In addition to being easy and child friendly, the Brückner test offers combined screening for strabismus, refractive error, and unequal pupils,” said Dr. Richards.

He advised delegates to “adjust the ophthalmoscope for the largest, brightest spot, stand one metre from the patient, look through the peep hole, and focus on the iris.”

Dr. Richards summarized the steps to performing the two-stage Brückner test:
Step 1 — Illuminate both pupils at the same time:
  a. Check position of corneal light reflection.
  b. Check pupil size.
  c. Assess red reflex (symmetric = normal).
Step 2 — Illuminate one eye at a time:
  d. Check pupillary construction.
  e. Observe for re-fixation eye movements (as in alternative cover test).

He emphasized that extra ocular movements, pupils, and eyelids go together in the eye examination. An abnormality in one warrants examination of the other two — this is a key to distinguishing diagnoses.

Dr. Richards recommended referring a child to an eye specialist if any of the following conditions are found:
• Constant or large angle strabismus at any age.
• Incomitant strabismus at any age.
• Any strabismus persisting at four months of age.
• Asymmetry of red reflex on Brückner test.
• Parent concern about eye alignment or vision.

**Pediatric Emergencies In The First Six Months of Life**

Dr. Robert Adam, Lecturer, University of Toronto, discussed “Pediatric Emergencies in the First Six Months of Life.”

Dr. Adam told delegates that close inspection of the eye in infants is of utmost importance in their care. He described the following conditions that may present in infants, and advised steps for treatment.

• **Ophthalmia neonatorum**
  Conjunctivitis in the first month of life may result from the passage of the baby through the birth canal, which may be affected by bacterial presence, viral infection, chlamydia, gonorrhea, or a chemical from antibiotic drops/silver nitrate, if used.
  Chlamydia/gonorrhea is an ocular emergency, as it can invade the intact cornea and perforate the globe. It requires systemic treatment.

• **Nasolacrimal duct obstruction**
  Nasolacrimal duct obstruction will present with discharge, crusting, and increased tears. This condition can be managed with correct massage: the eyeball will move laterally; a firm circular motion will help to send hydrostatic forces down the nasolacrimal duct to open the obstruction.
  Dr. Adam reported that 88% to 98% of such cases resolve with eight months of massage. He then instructed delegates in the procedure, as follows: “Place the pad of the forefinger in the sulcus between the medial canthus and the side of the nose over the lacrimal sac and then push posteriorly towards the occiput.”

• **Congenital glaucoma**
  Congenital glaucoma in an infant is an emergency, and must be referred
He told delegates: “Diplopia may be the first symptom of an occult, ominous neurological disorder, and early diagnosis is crucial in many cases. A systematic neuroanatomic approach to diplopia can lead to an accurate diagnosis without extensive investigations.”

Dr. Sundaram noted that the two fundamental mechanisms for diplopia include ocular misalignment and ophthalmic aberrations; the key clue to differentiate between the two is whether the patient has monocular or binocular diplopia.

Ocular misalignment will result in images falling in non-corresponding areas of the retina in each eye, and thus appear to be in two different spatial locations causing binocular diplopia. Binocular diplopia resolves when covering either eye. Monocular diplopia can be associated with ocular causes such as abnormalities in the cornea, iris, lens, and the retina.

“This type of diplopia persists when the fellow eye is occluded. It can also be psychogenic in origin,” said Dr. Sundaram.

He advised that a detailed history is imperative in localizing diplopia, and this includes “the onset of the symptom, if the diplopia is vertical or horizontal, worsening with any particular direction of gaze, fluctuations in the severity of the symptom, ptosis, lid retraction/lag, fatigability, ocular pain/redness, proptosis and other associated neurological symptoms.”

Dr. Sundaram stressed that investigations depend on the suspected cause of diplopia, and noted the following:

- Patients with oculomotor nerve palsy with pupillary involvement should have an urgent CT or MR angiogram to rule out a posterior communicating artery aneurysm.
- When orbital disorder such as thyroid opthalmopathy or orbital pseudotumor is suspected, MRI of the orbits is the preferred imaging modality.
- In patients with cranial polynuropathy or brainstem lesions, MRI of the brain is indicated.
- Patients with ocular myasthenia gravis should have acetylcholine receptor antibodies and an electromyography.

Dr. Sundaram told delegates that treatment of the diplopia depends on the cause: “Most of the ischemic oculomotor cranial nerve III, IV, and VI palsies begin to resolve spontaneously over a period of approximately six to 12 weeks. In such cases, patching an eye would be the best management. Patients with chronic, persisting diplopia may require prismatic or surgical correction.”

An Update On Glaucoma: Diagnostics And Therapeutics

Glaucma was the topic of two lectures by Dr. Catherine Birt, Associate Professor, University of Toronto.

Dr. Birt reported that, “Approximately 1% of the population will have some form of glaucoma and early diagnosis is vital. This is the leading cause of irreversible blindness worldwide, and the commonest cause of blindness in people of African heritage in North America.”

Knowledge of the risk factors will help indicate patients to refer for assessment. These include: an elevated intraocular pressure, increasing
age, family history of glaucoma, black race, and systemic conditions such as diabetes, hypertension, hypotension, migraine, and being myopic.

Dr. Birt noted that in the past, the definition of glaucoma included an elevation in the intraocular pressure (IOP) over 21 mm Hg. However, many individuals with IOP over 21 mm Hg do not develop glaucoma, and there are people with glaucoma whose IOP is never over 21 mm Hg.

"Therefore, an elevated IOP is neither necessary or sufficient to make a diagnosis of glaucoma, and persistent elevation of IOP is currently considered to be a major risk factor and is the only known modifiable risk factor," she concluded.

Diagnosis must include a full medical history. The physician must ask about symptoms, family history, ethnic background, prior eye problems (including treatments and surgeries), current medication use, and general health issues such as diabetes, high blood pressure, asthma, and drug allergies.

Dr. Birt told delegates that it is important to examine the front of the eye for signs of secondary glaucoma, and examine the back of the eye to assess the amount of damage and stage of the disease.

"This aids in treatment decisions and the target pressure recommended for the individual," she said.

Dr. Birt reported the following key points with respect to glaucoma:

- Glaucor is increasingly an important public health concern due to the aging population.
- Once peripheral or central vision is lost from glaucoma, it can never be restored by any form of treatment.
- Early detection is critical as progression of the disease and permanent blindness can be prevented by appropriate treatment.

There are five main classes of anti-glaucoma medications: prostaglandin analogs, beta blockers, adrenergic agonists, carbonic anhydrase inhibitors (oral and topical), and parasympathomimetics (reversible and irreversible).

Dr. Birt also discussed acute angle closure glaucoma. Symptoms include: halos and rainbows around lights, blurred central vision, red eye, dilated pupil, ocular and periorbital pain, nausea and vomiting.

The risk factors for acute angle closure glaucoma include people with anatomically small anterior chamber volumes relative to the lens size, hyperopia, increased age, and having first-degree relatives with the condition. Acute angle closure glaucoma is also three-to-four times more prevalent in females, and there is a higher prevalence in Inuit and Chinese populations.

**Age-Related Macular Degeneration**

Dr. Daniel Weisbrod, Assistant Professor, University of Toronto, presented "An Update on Age-Related Macular Degeneration."

"The causes of age-related macular degeneration (AMD) are generally unknown, but probably multifactorial, and likely involve degenerative, inflammatory, and genetic factors," reported Dr. Weisbrod.

The two forms of the disease are non-exudative (dry) AMD, and exudative or neovascular (wet) AMD. Treatment of dry AMD includes antioxidant vitamins such as Vitalux and PreserVision, which are specially formulated vitamins indicated in patients with moderate or severe dry AMD. These treatments are associated with a decreased risk of disease progression, and vision loss of 20% to 25%.

Other factors in the management of dry AMD include cessation of smoking, UV protection, and a diet rich in fish and vegetables. Patients should be educated, and report any changes such as loss or distortion in vision so they may be promptly evaluated by an ophthalmologist.

Dr. Weisbrod told delegates that treatment for neovascular AMD employs anti-vascular endothelial growth factor (anti-VEGF) agents, and this is now the standard of care in choroidal neovascularization (CNV), secondary to neovascular AMD.

He reported that vascular endothelial growth factor (VEGF) is the primary angiogenic factor involved in proliferation and migration of endothelial cells. It is up-regulated in hypoxic states, such as retinal vascular diseases, including diabetic retinopathy and retinal vein occlusions. VEGF is necessary and sufficient for the development of neovascular AMD. Anti-VEGF agents used in clinical practice include ranibizumab (Lucentis), bevacizumab (Avastin) and, most recently, aflibercept (Eylea). These medications are delivered by intravitreal injection.

Dr. Weisbrod reported that, "Lucentis is a recombinantly-produced, humanized, monoclonal antibody fragment to all VEGF isoforms. It is approved for use in the eye and has proven to be effective and safe in the treatment of AMD in two randomized controlled trials."

These studies showed stabilization of vision in 95% of patients, and significant vision improvement in 40% of patients treated with intravitreal Lucentis.

Eylea is the most recent medication to be approved for the treatment of neovascular AMD. It inhibits VEGF and placental growth factor (PGF).

Barbara Klich is a Toronto-based freelance writer.

**References**


Epilepsy System Improvements

New provincial guidelines for medical management of epilepsy patients:
best practices for diagnosis and treatment; resources for physicians and patients

by Epilepsy Implementation Task Force

The new Provincial Guidelines for the Management of Epilepsy in Adults and Children, introduced in January 2015, will provide assistance in the medical management of epilepsy to primary care providers, pediatricians, community neurologists, and others who care for individuals with epilepsy.

The guidelines illustrate best practices for the diagnosis and treatment of epilepsy in adults and children, including special considerations for managing epilepsy as it relates to pregnancy, contraception and menopause. They also include information relevant to:
- Patient education and followup.
- Initiation of drug treatment and monitoring.
- The treatment of those patients with epilepsy who present with a variety of comorbidities.

The guidelines were developed by Critical Care Services Ontario (CCSO) in collaboration with the Epilepsy Implementation Task Force (EITF), a working group under Provincial Neurosurgery Ontario (PNO), composed of surgeons, specialists, primary care providers, administrators and community advocates.

The EITF is mandated to advise on improving access across the continuum of care, establish standardized diagnostic and surgical protocols across epilepsy centres, and develop supports for primary care providers.

Of the approximately 95,000 Ontarians living with epilepsy, 30% have a drug-resistant or "medically refractory" form of the disease.¹ A key objective of the new guidelines is to assist in the diagnosis of, and referral process for, those patients with this condition. When a diagnosis is made, the individual now can be referred to one of seven Comprehensive Epilepsy Programs in Ontario (see sidebar, at right), where they are assessed in an epilepsy monitoring unit for further treatment options. This may include potential referral to one of four provincial Regional Epilepsy Surgery Centres of Excellence for consideration of curative epilepsy surgery.

"There is an 80% chance that appropriately selected patients with medically refractory epilepsy will be seizure-free after surgery, resulting in far better outcomes with respect to seizure freedom, improved quality of life, and reduction of psychosocial comorbidities,"² said EITF Co-Chair Dr. Carter Snead, a pediatric neurologist at the Hospital for Sick Children.

Dr. Snead noted that recent investments in diagnosis and treatment of med-

Comprehensive Epilepsy Programs In Ontario

District Epilepsy Centre (DEC)
The following DECs house a comprehensive epilepsy program that provides all appropriate epilepsy-related clinical services except epilepsy surgery:
- Health Sciences North
- Hamilton Health Sciences (Adult and Pediatric)
- The Ottawa Hospital
- Children’s Hospital of Eastern Ontario

Regional Epilepsy Surgery Centre of Excellence (RESC)
The following RESCs provide a comprehensive epilepsy program that offers all the services available in a DEC, as well as epilepsy surgery, including facility for intracranial monitoring:
- London Health Sciences Centre (Adult and Pediatric)
- Hospital for Sick Children
- University Health Network (Toronto Western Hospital)
ically refractory epilepsy have improved access and capacity for surgery.

“We want community practitioners to know surgery is a viable option, and system improvements have been made to provide Ontarians with epilepsy more choices to manage their condition and improve quality of life,” he said.

Currently, less than 2% of the potential surgical candidates obtain surgery in Ontario. These epilepsy system improvements speak to a broader effort to ensure that Ontarians affected by epilepsy are able to access comprehensive, evidence-based, quality health care at the right time and in the right place.

The guidelines form part of a series of publications developed by CCSO and the EITF. The next set of guidelines will focus on transitional care for adolescent patients with epilepsy who are moving from family-centred pediatric care to individual patient-centred adult care.

The complete Provincial Guidelines for the Management of Epilepsy in Adults and Children are available online at www.criticalcareontario.ca (click on “Toolbox” and then “Library”).

To help ensure that patients receive the right care at the right time, the Epilepsy Implementation Task Force has also developed a flow chart, entitled “Epilepsy Patient Flow by Provider” (see page 26). The chart is a high-level depiction of the process each provider should follow in order to appropriately diagnosis and manage a patient with epilepsy.

References

Outline For Seizure Assessment

The following information appears in Appendix 3: Outline for Seizure Assessment, of the Provincial Guidelines for the Management of Epilepsy in Adults and Children, available online at www.criticalcareontario.ca.

Associated Factors
- Age
- Family history
- Developmental status
- Behaviour
- Health at seizure onset
- Precipitating events other than illness — trauma, toxins

First Nonfebrile Seizure
- Health at seizure onset — febrile, ill, exposed to illness, complaints of not feeling well, sleep deprived
- Symptoms during seizure (ictal)
- Aura: subjective sensations
- Behaviour: mood or behavioural changes before the seizure
- Preictal symptoms: described by patient or witnessed
- Vocal: cry or gasp, slurring of words, garbled speech
- Motor: head or eye turning, eye deviation, posturing, jerking (rhythmic), stiffening, automatisms (purposeless repetitive movements such as picking at clothing, lip smacking), generalized or focal movements
- Respiration: change in breathing pattern, cessation of breathing, cyanosis
- Autonomic: pupillary dilatation, drooling, change in respiratory or heart rate, incontinence, pallor, vomiting
- Loss of consciousness or inability to understand or speak
- Duration of seizure

Symptoms Following Seizure (Postictal)
- Amnesia for events
- Confusion
- Lethargy
- Sleepiness
- Headaches and muscle aches
- Transient focal weakness (Todd’s paresis)
- Nausea or vomiting

References
Toronto Western Hospital doubles capacity of epilepsy monitoring unit

Toronto Western Hospital is home to Canada’s largest adult epilepsy monitoring unit (EMU), with the capability of now handling up to 10 patients, double the hospital’s previous capacity. Each patient can be monitored for several days through video and EEG recordings to locate the source of a patient’s seizure and epilepsy process. The results are then used to guide the best possible treatment plan for them.

The EMU is part of Toronto Western’s Epilepsy Program. The program also includes an epilepsy clinic which assists patients who have not been successful in managing their epilepsy symptoms.

According to the International League Against Epilepsy, any patient who has failed two anticonvulsant medications tried in succession over two years suffers from medically refractory epilepsy.1 Patients fitting these criteria should be considered for referral to the Epilepsy Program at Toronto Western Hospital. Patients who are referred to the epilepsy clinic will be seen by a neurologist for a full diagnostic investigation to pinpoint the possible cause of the seizures and determine the best treatment option.

Patients admitted to the EMU are also monitored to determine whether they are candidates for surgery. Ontario is similar to other jurisdictions, where it can take an average of 22 years from the time of an epilepsy patient’s first seizure until the time surgery is received.2 Yet, there is up to a 74% success rate for typical medically refractory epilepsy patients who do undergo surgery.3

If surgery is ruled out as a treatment option, the hospital’s epilepsy team can provide recommendations and support physicians in the long-term management of a patient’s care. The Epilepsy Program also provides genetic testing and other diagnostic assessments to help refine an epilepsy diagnosis (e.g., Dravet Syndrome, PCDH19), which can improve symptom management.

For more information on the epilepsy monitoring unit, visit http://wwwuhn.ca/KNC/PatientsFamilies/Clinics_Tests/Epilepsy_Monitoring_Unit/Pages/what_expect.aspx. Referrals may be faxed to Nicole Williamson, Epilepsy Clinic, Toronto Western Hospital, at 416.603.6402.

References
• Relationship Between Child Abuse and Mental Disorders in Canada
• College of Physicians and Surgeons of Ontario Transparency Initiative
• End of Life Planning and Care in Ontario: Palliative Care Standards

by OMA Health Policy Department

Relationship Between Child Abuse and Mental Disorders in Canada
The Canadian Medical Association Journal (CMAJ) recently published an article on child abuse and mental disorders in Canada that physicians should be aware of. National data was examined to review the prevalence of child abuse (physical abuse, sexual abuse, and exposure to intimate partner violence), and its association with mental conditions, including suicidal ideation and suicide attempts. Strong associations were found between child abuse and mental conditions. This study is consistent with previous findings. It also offers new insight by examining a greater number of child abuse types, in addition to more mental conditions in one study.

The CMAJ article advises that providers, particularly those caring for patients with mental health problems, should be aware of the relationship between child abuse and mental conditions. Further, it suggests that efforts to prevent child abuse could lead to reductions in the prevalence of mental disorders, suicidal ideation and suicide attempts.

The full article can be found online at http://www.cmaj.ca/content/early/2014/04/22/cmaj.131792.full.pdf. OMA Staff Contact: Dara Laxer (ext. 2925)

College of Physicians and Surgeons of Ontario Transparency Initiative
Beginning in 2012, the College of Physicians and Surgeons of Ontario (CPSO) undertook an initiative to review how it could make more physician-specific information available to the public. This has been a multi-step process.

The CPSO is currently conducting a stakeholder consultation regarding five additional categories of physician information that may be made available to the public. These categories include: cautions-in-person, specified continuing education and remediation programs, criminal charges, licences in other jurisdictions, and discipline findings in other jurisdictions.

The OMA has been closely involved at all stages of the transparency initiative and is in the process of reviewing these most recent proposals. The OMA believes that patients have a right to information, however, physician information that is made public must be contextual and relevant. The OMA has also stated that public interest must be balanced with every physician’s right to fair process. OMA Staff Contact: Ada Maxwell-Alleyne (ext. 2942)

End of Life Planning and Care in Ontario: Palliative Care Standards
The Clinical Council of the Hospice Palliative Care Provincial Steering Committee has developed the Essential Minimum Clinical Standards for Hospice Palliative Care in Ontario. The Provincial Clinical Standards (PCS) are a set of 12 interconnected clinical standards built upon the best and most current evidence in palliative care. The PCS document also outlines critical actions, next steps and directional documents for each standard. The PCS document, with the standards, is now posted on the End of Life Planning and Care page of the OMA public website (www.ontariosdoctors.com/EOLPC).

The Clinical Council is an inter-professional council composed of 11 palliative care clinicians with diverse and relevant palliative care skill sets. Council members were selected by the Hospice Palliative Care Provincial Steering Committee. The Clinical Council is chaired by Dr. Denise Marshall, Provincial and Cancer Care Ontario Palliative Care Lead.

Please email any inquiries regarding End of Life Planning and Care to eolpc@oma.org.

OMA Staff Contact: Ada Maxwell-Alleyne (ext. 2942)

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OMA Staff Contact: Ada Maxwell-Alleyne (ext. 2942)
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- Services available
- For rent (equipment)
- For sale (equipment)
- Upcoming events
- Miscellaneous

RATES: $50 for first 4 lines (minimum), each line approximately 35 characters; $5 per line thereafter; $5 for each line of contact information. Spot colour billed at $20 per issue.

DEADLINES: Copy deadline, notice of cancellation and/or changes to existing advertisements must be submitted in writing no later than the 10th of the month prior to the month of publication.

REGULATIONS: The Ontario Medical Review reserves the right to make editorial changes to classified ads.

The Ontario Medical Review is required to comply with the provisions of the Ontario Human Rights Code 1990 in its editorial and advertising policies, and assumes no responsibility or endorses any claims or representation offered or expressed by advertisers. The OMR urges readers to investigate thoroughly any opportunities advertised.

For more information, please contact: Vita Ferrante, tel. 416.340.2263 or 1.800.268.7215, ext. 2263, email: vita.ferrante@oma.org

BOARD REPORT

Summary of resolutions

OMA Board of Directors Meeting
February 4-5, 2015

- “That the Board re-appoint Mr. Kevin Netterfield and Mr. Anthony Knight to the Board Insurance Committee for another two-year term.”

- “That the Board approve the submission to the College of Physicians and Surgeons of Ontario draft policy Planning For and Providing Quality End-of-Life Care.”

COUNCIL REPORT

Summary of resolutions

OMA Special Council Meeting
January 31, 2015

Motions
A motion is a proposal that the Association do something or express an opinion about something. Main Council motions are decisions of the Association that are legally binding upon it. Council Members’ Period motions are not legally binding upon the Association — they merely direct the Board of Directors to investigate a matter and to report back to Council.

Approval of Agenda
- “That the Council agenda be approved.”

Motions Carried
- “That Council supports the counter offer given to the Ontario government that includes a 0% (zero percent) fee increase for Ontario physicians, for a time period of two years, between April 1, 2014 and March 31, 2016, with the proviso that the government continue to fund all necessary growth in the health care system.”

- “That Council supports the decision of the OMA Board to reject the government’s final offer for physician services.”

- “That Council encourages all physicians in the province to take an active role at the local level to engage in lobbying efforts.”
11th Annual
Ontario Medical Student Bursary Fund
Charity Golf Tournament

Friday, May 29, 2015 - 7:45 a.m. Shotgun
Angus Glen Golf Club (North Course) - Markham, ON

$500 per ticket / $2,000 per foursome
Includes: 18 holes of golf with cart
Breakfast & lunch
Golf contests with great prizes
And much more!

Register today at
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Gold: OMA
Ontario Medical Association

Silver: Sun Life Financial

Bronze: Mercedes-Benz

For more information about the Ontario Medical Student Bursary Fund or the Golf Tournament, please contact us at omsbf@oma.org or 1.800.268.7215, ext. 2985.

*As of March 1, 2015

Media:
THE GLOBE AND MAIL
Getting the most out of social media for your clinical practice:
how to harness the benefits and manage risk

by Naheed Dosani, MD, CCFP
Stephen Pomedli, MD, MSc, CCFP
Yen Yen Yip, OMA Engagement and Program Delivery

With the ubiquity of Internet usage, social media is now a mainstream part of life for many individuals. Approximately two-in-three Canadians use social media today; among these users, about 63% check social media updates on a daily basis.¹

As an established part of “Web 2.0,” social media refers to a range of web-based and mobile technologies that connect people through text, audio, photos, and video, changing the way information is produced, obtained, shared, and consumed.²

Where information used to be delivered from provider to user in a top-down manner, today’s world of Web 2.0 is flattening established barriers and hierarchies in knowledge exchange by providing tools for everyone to participate in online conversation. With the rise of user-generated content, communication has evolved from a “one-way street” to a more decentralized, user-driven and interactive process.

Medicine is not immune to this phenomenon. Patients have established online virtual communities to learn about medical conditions, share personal experiences, and seek and offer support. Physicians are also included in these online communities centred on health and medicine. In a 2013 Canadian Medical Association survey of physicians, about 40% of respondents had joined a physician-oriented online community, 45% had participated in an online discussion on a medical topic, while about one-in-three recommended an app to a patient.³

As physicians become more familiar with social platforms, their use of them becomes increasingly sophisticated. In a study of 411 Canadian physicians who use Twitter, the average annual number of tweets per user increased from 470 in the first year of activity, to 543 in the following year.⁴

The benefits of social platforms are many, but — as with any emerging innovation — there are risks. However, physicians who employ a strategic approach in utilizing these tools for their clinical practice can reap the benefits of increased interactivity and connectivity with their patients, colleagues, the health care system and society in general.

How To Harness Social Media
Social media facilitates the flow of information between physicians and other health providers, their patients and the public. This type of media channel can be used for multiple purposes: to improve communication, establish or maintain relationships, disseminate information and educate patients.

Physicians can harness the power of social media for the following five overarching purposes to deliver an impact on their clinical practice.

1. Medical Education
Physicians are generally self-directed lifelong learners. The use of social platforms for medical education and conference-based discussions is becoming dominant among physicians who use social media, and has enabled increased learner engagement, feedback, and collaboration.

For instance, physicians can follow Twitter feeds of academic journals such as the Canadian Medical Association Journal and the Lancet, and follow key opinion leaders, leading researchers and academics in their relevant fields of practice. Medical educators can use the same platforms to engage with learners. With Twitter, blogs and other online learning networks, physicians can catch
up remotely on medical conferences, participate in virtual journal clubs, or easily share useful links to articles, videos and other resources for discussion with colleagues.

2. Clinic/Practice Management
Social platforms have been successfully used by clinics to assist in the management of practices. For instance, the Quinte Pediatrics Clinic connects with patients on Twitter, YouTube, Facebook, Pinterest and Instagram. Opening hours, appointment hours, attending physicians, and the availability of services (e.g., flu shots) are communicated to patients and the public through these channels, enhancing practice efficiency.

3. Professional Networking
The delivery of health care can be isolating as some physicians work and operate in geographical, institutional and specialty-specific silos. With the increased connectivity of social networking, physicians can establish wider and more diverse professional networks and nurture collaborative relationships.

Platforms such as LinkedIn allow physicians to make new connections and maintain relationships with thought leaders and peers across different specialty fields and geographies. The Rounds, an exclusive professional network created specifically for Canadian physicians, provides a way for physicians to connect, communicate and collaborate in a secure environment compliant with the federal Personal Information Protection and Electronic Documents Act (PIPEDA) and the U.S. Health Insurance Portability and Accountability Act (HIPAA). (Note however that physicians in Ontario are governed by the Ontario Personal Health Information Protection Act [PHIPA].)

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<th>Social Media Platforms</th>
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<td><strong>Primary Area(s) of Application</strong></td>
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<td>The Rounds</td>
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4. Advocacy
Physicians can better engage with the public through online advocacy for social justice and health issues at the municipal, provincial and federal levels of politics. For instance, a Twitter campaign was launched in 2013 to address controversial changes to refugee health benefits introduced by the federal government; it generated 250,000 tweets and engaged 15 million Twitter users within the span of three weeks — dramatically elevating the level of public awareness.

5. Health Engagement
Social networks can turn health messaging “viral” so it spreads rapidly among people through frequent shares on email and social platforms. Innovators in health engagement include Dr. Mike Evans, a staff physician at St. Michael’s Hospital and Associate Professor of Family Medicine at the University of Toronto, who creates ingenious “whiteboard” videos on health education topics targeted at the public. His nine-minute video on the benefits of exercise, “23 and ½ Hours,” has generated over four million views.5

A wide range of social media platforms can be leveraged for these purposes, some of which are presented in the table on p. 32. These platforms have become increasingly interconnected: for instance, users can post links to their blogs or YouTube creations through tweets, LinkedIn or Facebook pages.

Taking A Strategic Approach
Given the array of social networking platforms, users may want to be strategic in deciding which platforms are right for them. Each physician has unique personal priorities — a medical student may be interested in professional networking while a family physician running a clinic may want to focus more on practice management. Different platforms are designed to meet different purposes, and they should be chosen based on these personal objectives and priorities.

Physicians also have to consider who they wish to be interacting with through social media. The characteristics and profile of this target audience — which can range from the public, patients, to other physicians and health care organizations — will help determine which media is the most appropriate.

The amount of resources that a physician is able to devote is another determinant. Sending messages through Twitter, for instance, requires a lower investment of time and effort compared with the creation of a YouTube video.

Managing The Risks
Despite their involvement in social networking platforms, most physicians believe social media tools can pose potential risks. In the 2013 CMA survey, about 90% of respondents expressed concern regarding the professional and legal ramifications of such use. Common key issues include:

- Patient confidentiality: The principle of patient privacy is not unique to social media — privacy is paramount and identifiable patient information should never be shared. Physicians need to exercise caution and should never discuss details of individual patients on any unsecured electronic communication platform.
- Professionalism: Online and elsewhere, physicians need to retain appropriate boundaries of the patient-physician relationship, and ensure collegiality with colleagues. Physicians have to be mindful that online material runs the risk of widespread dissemination, and that inappropriate online behaviour can erode the reputation of the individual and the profession. Relationships have to be kept professional and respectful.
- Other legislative issues: While users may feel less inhibited when engaging in online communication, they are still subject to libel, defamation, and copyright laws. Remember that electronic postings are permanent and do not offer anonymity.

When in doubt, physicians should consult guidelines related to social media use issued by the CMA, Canadian Medical Protective Association (CMPA), and the College of Physicians and Surgeons of Ontario (CPSO). Any interactions with patients via the Internet generally, or social media specifically, should be discussed with the CMPA beforehand.

Dr. Naheed Dosani is a Palliative Care and Family Physician at William Osler Health System, St. Michael’s Hospital & the Inner City Health Associates. He recently completed his fellowship in Palliative Medicine at the University of Toronto and prior to that, his residency in inner-city Family Medicine, where he served as Co-Chief Resident of St. Michael’s Hospital Family Medicine Residency Program. You can follow Dr. Dosani on Twitter @NaheedD.

Dr. Stephen Pomedli is a Family Practice Physician in Toronto and a Health Innovation Fellow at the Women’s College Hospital Institute for Health System Solutions and Virtual Care. He recently completed his fellowship in global health, and is passionate about health policy and health care delivery in Canada. You can follow Dr. Pomedli on Twitter @pomedli.

References
The facts about insurance — part 2: addressing common misperceptions

by Bruce Palmer
Managing Director, OMA Insurance Services

In the December 2014 issue of OMR, Insurance Update addressed some common misunderstandings and inaccurate statements with respect to the OMA Insurance program. This month, we continue our look at some of the misperceptions and sentiments typically associated with insurance, and provide a fresh perspective on how insurance works, and why.

“So I need to make a claim — Isn’t that what insurance is for?”

Insurance is a contract of indemnity, which means that it is intended to return you to the same economic situation that you were in immediately prior to the occurrence of a “fortuitous event” — i.e., one that happens by chance rather than intention. In essence, insurance is designed to protect you, or “indemnify” you, from sudden financial losses caused by an event you did not expect, and could not have prevented.

If, however, an event is considered to be predictable — or becomes predictable — and a policy is already in place, then you can expect an insurer to try and change or terminate the insurance contract, subject to its terms, and the premiums may increase, as illustrated in the following examples:

- I once had a client whose car was constantly being broken into while parked in the same spot overnight. The thieves would break a window and steal whatever was in the car. After the third time this occurred, the insurance company increased the man’s deductible and removed glass coverage from his vehicle. My client was furious. “Why are they doing this?” he complained. Yes, he had made three claims in five weeks, “But isn’t this what insurance is for?” Well, not exactly. After the second break-in, it became “predictable” that his car was going to be broken into if he kept parking it in the same spot, yet he deliberately chose to continue parking there. Windows are expensive, and while insurance claims for break-ins did not affect his premium, every broken window was quickly eating up far more than my client was paying in premiums. In fact, after the first claim, the costs of the additional claims were being paid for by all the other policyholders insured by this insurance company. So it’s important to remember that insurance is for the unexpected events, not the expected ones.

- Similarly, I have had clients who really want to purchase travel insurance whenever they are traveling against their physician’s advice, or while they are medically unstable. I understand why they may want to travel: for some, it’s a long-planned trip that might truly be their last chance to travel with family; for others, getting away is important for stress relief and recovery from personal ailments. Whatever the reason, invariably, many either cannot obtain travel insurance or have restrictions placed on their coverage. Again, the question “Isn’t this what insurance is for?” is often asked. What these clients may not realize is that people
who travel against medical advice, or while medically unstable, will have a dramatically increased probability of requiring medical attention while away from home, thus putting them at greater risk. Insurers are not going to give these clients the premium and coverage that has been created for normal-risk clients. This does not mean that higher-risk clients cannot travel, it just means that an insurance company does not want to assume the financial responsibility for the very probable outcome of these particular clients’ actions.

The work of insurance providers is not magic. They have 100 cents to every dollar just like everyone else, and they have no source of income other than premiums and the investment income generated by those premiums over the years. If, for example, an insurer pays out 75% of its premiums in claims (and this is not an unusual figure), then it is collecting $1.33 for every $1 it pays out, plus it’s bringing in revenue from the investment income.

The simple truth is that most policyholders will pay much more into their insurance plans than they will ever receive back through making claims. The only reason insurance works is precisely because the premiums of the many pay for the losses of the few. If suddenly it were to become “the many” having claims then there would be no economic sense in using insurance to cover the loss.

With auto and property insurance, for example, a person could buy $2 million liability coverage for less than $1,500 per year. Besides collision coverage for their car, this $2 million policy potentially provides:

- Up to $2 million in coverage for liability in damage done to others in an accident;
- Plus legal costs to be defended in court or avoid the costs of going to court;
- Plus medical expenses if the driver gets injured in an accident;
- Plus lost income, and other ancillary financial losses due to an accident;
- Plus medical coverage and lost income coverage for all the passengers in the car, any pedestrians that were hit, and any occupants of any other vehicle involved in the accident;
- Plus medical coverage for when the policyholder is a passenger in the car, or a pedestrian or a cyclist involved in an accident that involves a motor vehicle.

Over the course of a typical driving life (age 16 to 76), this means a person may very well pay up to $300,000 in total for the above auto insurance cov-

If you keep in mind that insurance is fundamentally about managing risk, not building wealth, then you will never be disappointed.

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This is another comment that I often hear from clients, and to appreciate why it’s a misperception requires an understanding of how insurance works for both the insurance provider and the policyholder.

For the policyholder, having insurance makes sense because we simply do not always know when something bad is going to happen. For instance, hypothetically, if we knew in advance the exact day we might suddenly become disabled, and that day was far enough into the future, we could simply save money in a bank account rather than pay for disability insurance. But since we don’t know if, or when, something like that might occur, spending a nominal amount on a disability insurance policy (usually just pennies on the dollar each year) is a rational alternative to waking up every morning with the risk that you and your family could be facing financial ruin before nightfall.

Yet, paying money for something that may never be needed leads some policyholders to believe that they are either wasting their money, or “deserve something back” if they don’t make any claims over a number of years. To understand why this isn’t so requires an understanding of how an insurance provider operates.

If you keep in mind that insurance is fundamentally about managing risk, not building wealth, then you will never be disappointed.
have full protection from day one, and insurance makes a great deal of sense.

If you keep in mind that insurance is fundamentally about managing risk, not building wealth, then you will never be disappointed.

“All insurers are the same: insurance is just a commodity.”

I have to admit that sometimes the insurance industry tries to convince you that insurance providers really are “all the same,” selling themselves as nothing more than the cheapest available coverage. However, I have worked for insurance companies, agents and brokers, and as a consultant to the industry, and I know that not all insurance companies are the same, and that not all insurance is the same.

Companies are indeed very different, and the approaches they take to serving you — from their perspective on pricing and risk selection to the way they look after you at claim time — vary a great deal.

No company is perfect, but the very best insurers select customers they are good at serving, which is why it is advantageous to have a great provider like OMA Insurance on your side when dealing with a company.

Practically speaking, there is a big difference between experiencing a large property insurance loss with a great insurance company, and experiencing the same loss with a company that isn’t so great. For example, while there may be no noticeable difference in service and outcome between two providers if your claim is for a broken windshield, there can be an enormous difference when settling a disability claim. In the latter instance, it’s important to deal with an insurance provider who understands physicians and their strong work ethic — like the great providers available through OMA Insurance.

Moreover, rather than treating each disability claim as a potential fraud case, OMA Insurance develops a close relationship with our providers to ensure our members do not have to worry about their finances while they are worrying about getting back to work.

“Insurance is strange.”

OK, I actually agree with this sentiment. Insurance is rather “strange” — or at least that’s how it seems at times.

As a consumer of insurance, you are paying a fixed price today for an unknown event, of unknown duration, unknown magnitude, and unknown consequences, that may or may not happen at some point in the future.

For every kind of insurance but life insurance, you are really hoping that you are pre-funding an event that never happens. And for life insurance, you know the payout will not happen during your lifetime. In fact, a good number of you will never have the opportunity to find out how good or bad your insurer is doing at handling claims, and for those of you who do, you will find out too late for the information to influence your original policy purchase decision.

Perhaps the “strangeness” of insurance is precisely why it is so wise not to deal with strangers when arranging for coverage.

Nobody can tell you what conditions are going to be like in 30 years should you finally experience a short-term disability. You never know for certain who will ultimately have to deal with your estate once you’re gone. You don’t know for sure if that car behind you is going to stop for that same red light you just stopped for. Even increasingly advanced forecasting cannot predict which weather “event” is likely to affect your home.

When claims happen, knowing who will be there beside you matters. Knowing that they know about you counts. Having the peace of mind that there is an entire team of dedicated professionals working for you is important — it may even mean the difference between great, and not so great, protection for you and your family.

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Interested individuals should forward their curriculum vitae or inquiries to:

**Julie Tataryn, Medical Recruitment:**
medicalrecruitment@prhc.on.ca
IN MEMORIAM

The OMA would like to express condolences to the families and friends of the following members.

Baldwin, William Edward
Toronto
University of Toronto, 1962
April 2014 at age 76

Beitel, Allan
Toronto
McGill University, 1976
April 2014 at age 67

Carbone, Renzo
Toronto
University of Bologna, 1952
November 2014 at age 87

Catton, Pamela Anne
Toronto
University of Ottawa, 1977
December 2014 at age 61

Connolly, John Gerald
Toronto
University of Toronto, 1949
December 2014 at age 90

Cowan, Donald Henry
Toronto
University of Toronto, 1956
December 2014 at age 82

Dacre, Arthur John Irving
Waterloo
University of London, 1950
January 2015 at age 88

Deans, J.R.A.
Belleville
University of Birmingham, 1962
January 2015 at age 76

Fay, William Patrick
Sudbury
National University of Ireland, 1966
November 2014 at age 72

Haldenby, David Alan
Waterloo
University of Toronto, 1959
November 2014 at age 79

Hayes, Herbert Nathan Gillis
Burlington
Queen’s University, 1963
December 2014 at age 75

Hrnchiar, Andrew
Nepean
McGill University, 1958
October 2014 at age 82

Kazdan, Martin Stephen
Toronto
University of Toronto, 1954
November 2014 at age 84

Khare, Dhananjay Vidyadhar
Belleville
Nagpur University, 1960
December 2014 at age 77

Lachowski, Richard John
Ancaster
University of Toronto, 1978
November 2014 at age 60

Lansdown, Edward Leslie
Toronto
University of Manitoba, 1957
December 2014 at age 87

Sussman, H. Leonard
London
University of Cape Town, 1946
December 2014 at age 92

Wilderspin, Kenneth
Kingston
University of London, 1955
October 2014 at age 87

The OMA publishes brief notices about deceased members as a service to their colleagues. Information concerning these members should be sent to carlene.nash@oma.org. If you know a colleague or a relative of a deceased member who has practice-related questions and needs advice, or would like an information package on winding down a practice, please have them contact Practice Management and Advisory Services at 1.800.268.7215, or email practicemanagement@oma.org.
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Sales Representative or Kevin Crigger, Broker
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Email: droll2010@hotmail.com

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Tel. 416.722.5790 (cell)
Email: robynb@sympatico.ca

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Email: maryums@shefamedicalcentre.com

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Beacon Hill Professional Centre, Stouffville: New prime medical/professional building now available for lease. Two storey, 28,620 sq. ft. in Stouffville’s business core. Located in fast developing, most sought after Beacon Hill Business Park surrounded by residential communities. Distinctively designed, ample parking, professionally landscaped grounds. Immediate occupancy. Contact: Stephanie Settembri Tel. 905.761.7707 Email: sales@gottardogroup.com Website: http://gottardoconstruction.gottardogroup.com/175mostar.php

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Boxgrove Medical Centre: For lease. Four storey, 60,000 sq. ft. medical building located at 9th Line & Hwy, 407. X-ray, lab, rehab & urgent care on-site. Tel. 416.357.7509

Brampton — medical office to rent or share: Fully furnished, large office and exam rooms with full EMR. Springfield professional building, next to Brampton Civic Hospital. Contact: Dr. Abou-Seido Tel. 416.450.4088

Busy location on Bathurst Street: X-ray, ultrasound, lab, pharmacy on-site. Suitable for walk-in, family practice, dermatologists or other specialties. New practice or relocation. Contact: Roshani Tel. 647.989.3108

Elegant office facility available in Richmond Hill: Space can be designed for one or two obstetricians/gynecologists. General and OB/GYN ultrasound laboratory providing sonohysterograms and ultrasound-guided biopsies also available in the building. Fully licensed surgical facility on premises. Opportunity for infertility or cosmetic gynecological procedures. Tel. 905.884.6998

Etobicoke, ON: Prime office, street level at Dundas & Kipling. Close to subway and bus stop. Four exam rooms & two charting rooms. Contact: Ash Tel. 416.220.9792

FT/PT medical doctors required for a busy family doctor/walk-in clinic located at Victoria Park/O’Connor Drive. Tel. 416.315.7709 Email: ultimate298@ltjdkate.com

Guelph, ON — physicians/specialists needed for growing medical centre: A 22 exam room turnkey family practice. Full-time positions available, using Practice Solutions EMR. Knowledgeable, flexible staff, great modern work environment. Currently six practices in well-established medical centre in addition to a pharmacy, physio/osteo group, and Life Labs. Very congenial progressive-minded group, part of the Guelph FHT and Phoenix FHO. Medical centre located within The Village by the Arboretum, Guelph. The Village is a development of 497 single family detached and town homes, as well as 81 mid-rise condominiums and assisted-living units, built on a 112-acre site located adjacent to the University of Guelph’s 500-acre Arboretum. The VBA offers an active adult lifestyle within the Guelph city limits and near the cultural offerings of a large university and a vibrant urban community. Email: dinder@afmci.com

Location, location, location: Prime downtown Mississauga, Hurontario & Dundas. Prime medical office space available in a busy medical building. Fully furnished. Free staff underground parking. Free parking for patients. Move-in ready, Lab facility on-site. Contact: John Wissa Tel. 416.616.8070 Email: john.wissa@thpharmacy.com

Medical building for lease at 535 Park Street: Behind Grand River Hospital, Kitchener. Available space approximately 3,000+ sq. ft. Good for general practice, walk-in clinic, orthodontist, medical lab, etc. Parking space available. Contact: Paul Kanwai Tel. 519.496.4598 Email: kirpal_kanwai@yahoo.com

Medical Centre at The Boardwalk on the west side of K-W, a local initiative for integrated health care. Exceptional building with turnkey space for grads and GPs new to the region, specialist clinic, and essential medical services (cardiac testing imaging, lab, pharmacy). Now open. Contact: Cynthia Voisin Tel. 519.744.6464 Email: cvoisin@theboardwalkmedical.com or bstoneburgh@par-med.com

Medical office space for lease — Victoria Park & Eglinton: Reception area + three private rooms (two with sinks) + additional work space with sink and built-in cabinets. Freshly painted with new carpet. Adjacent pharmacy with wheelchair access. TTC at corner. Three hospitals within 10 km. $1,200/month + taxes and utilities. Contact: Gloria Dear, Sales Rep. Royal LePage Terreque Realty, Broker Tel. 416.496.9220 Email: gloriedear@royallepage.ca

Medical space available in Markham area: Excellent location, very reasonable rent. New development up the road. Contact: Jack Tel. 647.283.1883

Medical suites available: Akron Medical Building (Lakeshore Blvd. — Parklawn), Southern Etobicoke (Mimico), high density, rapidly growing, underserviced area of Toronto. All services on-site including walk-in clinic. Turnkey, risk-free rent. Contact: Domenic Rando Tel. 416.985.1396 Email: rando@rovers.com

Mississauga & Whitby: Medical office space available ranging from 700 – 3,000 sq. ft. Free parking. Close to public transit, restaurants & shopping. Dense residential area unserviced by health practitioners. Contact: Konini Management Tel. 905.823.9847
Niagara Falls is in need of family physicians: Take your family practice where it’s needed! Come check out our professional medical buildings in Niagara Falls. Currently available units range in size from 754-1,600 sq. ft. There are many benefits right on-site such as: medical laboratories, X-ray, ultrasound, group practices, specialists & pharmacies. Let us work with you in designing the most suitable office space for your needs. We offer attractive terms. Call for more information. Contact: Alvin Schellenberg Tel. 289.292.0526, ext. 31

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NorthWest Healthcare Properties REIT (TSX: NWH.UN) — Canada’s Healthcare Landlord: We own full-service, professionally managed medical office buildings in Ontario and across Canada. Turnkey construction management available. Competitive lease rates and attractive building amenities. We help you help your patients. Contact: Dave Casimiro Tel. 416.366.2000, ext. 4302 Email: dave.casimiro@nwhp.ca Website: www.nwhp.ca

PAR-Med Realty Ltd.: Specializing in medical office building leasing, property management, and building sales. We have over 70 medical office buildings in our portfolio throughout Ontario. For leasing inquiries: Contact: Brad Stoneburgh Tel. 416.364.5959, ext. 403 Email: bstoneburgh@par-med.com Website: www.par-med.com

Rent incentive for MD: A fully renovated 14-year old busy walk-in/family medicine office near Davisville subway is looking for MDs. Great to build a practice from scratch. For details, please call. Contact: Nadia Tel. 416.483.2555

Replacement for retiring family doctor: Spadina/Dundas location. Mandarin or Cantonese speaking required. Tel. 416.596.8529

(continued)
Scarborough location: Ground floor 1,200 sq. ft. or 1,750 sq. ft. space, seven minutes away from Rouge Valley Centenary Hospital in a neighbourhood plaza looking for a doctor or a group of doctors to establish a walk-in clinic. In a densely populated area with many new immigrants and students. Space also available on second floor. There is a possibility of rehab centre, physiotherapy, acupuncture, registered massage therapy, hearing aid, medical equipment store as options as well. Bus stop at property. Plaza has a huge pylon sign. Ample parking. For further information, or to view the property, please phone or email.
Contact: Manju Jain
Tel. 416.916.3200
Email: mjain48@yahoo.com

Vaughan, ON: Near Yonge Street south of Hwy. 407. Beautiful four bedroom, five-and-a-half bathrooms, three self-contained basement apartments and a 900 sq. ft. permitted home office (reception, three offices and washroom), suitable for live/work medical professional. For sale by owner.
Contact: Matin
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Email: nasacount2000@yahoo.ca

REAL ESTATE

Contact: Dr. Malik
Tel. 416.209.5604

Mississauga, four bedroom, furnished executive home for rent: Near Credit Valley Hospital, easy commute to Milton, Georgetown, Oakville. Fully furnished, hardwood floors, two-car garage, large deck and yard, piano, pool table, two fireplaces, finished basement. John Fraser school district. Available August 1. One or two-year lease.
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Private sale — Dr. Forrest’s house: Beautifully restored century house located in downtown Mount Albert. A great income property boasting many original architectural details. Zoned C1 and residential. Solid red brick house on quarter acre lot. Partially finished basement. Over 5,000 sq. ft. plus separate heated building. Ideal for much needed medical health clinic in this growing town with potential for many other uses. Live where you work, plus rental income. Owner occupied. 20 minutes north of Greater Toronto Area. Must be seen. $764,900. Please call or email.
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Email: estavro@yahoo.com

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Contact: Dr. Stein
Tel. 416.464.0238

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Malpractice in Pain Medicine Medico-legal Conference

Date: September 19, 2015 (Saturday) 08:00-16:30
Place: Chestnut Residence and Conference Center, 89 Chestnut Street, Toronto

This is a very unique conference focusing on the medico-legal aspect of pain practice. The objectives are to help healthcare professionals understand the litigation process and prevent a potential compliant or litigation. The speakers include senior staff from CMPA, CPSO, expert lawyers from plaintiff and defendant sides, as well as medical expert.

The program includes panel discussion on 3 contentious issues in pain practice, overview of pain-related claims in CMPA and CPSO and interactive short discussion.

Program and registration is through the link:
www.usra.ca/mpcon.php
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Brampton, Ontario: Full-time/part-time family physicians and GP psychotherapist required for busy family practice/walk-in clinic. Attractive modern office. Option to join FHG. High fee-for-service split or flat monthly rate. Best EMR. Tel. 416.949.3830 Fax: 647.340.2586 Email: bramptonfamilyhealth@gmail.com

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Courtice, ON: Green Valley Medical proudly presents Courtice Walk-in Clinic. A family practice/walk-in clinic in Clarington seeking family physicians to work walk-in shifts; full time, part time, or casual. Flexible options available. No commitment required! Potential future option to join FHG if interested. Return-of-service designated area. 25/75 FFS split with guaranteed minimum rate. Pharmacy, PTs and RMTs on-site. EMR based. Please email for more information. Email: info@courticewalkin.ca

Disera Medical Centre, Thornhill: Family physician opportunity to join established and growing family health group. Start your own practice or have sporadic walk-in shifts at first. Fully equipped, spacious exam rooms with EMR. Well-developed specialist’s support for referrals. We handle all administrative and billing issues. Educational activities and teaching opportunities are available. Opportunity of transferring rostered patients to guarantee a stable income. Call for details. Contact: Dr. Star Tel. 416.312.1233

Downtown Toronto: Bay and Bloor, part-time MD needed. We are a long-established vein and cosmetic clinic in the heart of Yorkville. We will provide training in sclerotherapy for new doctors. It is an interesting and fast-paced position with experienced nurses and administrative staff support. Please contact us for more information. Contact: Maria DLC Tel. 416.927.0533 Email: yvclive.ca

Downtown Toronto — Yonge and College new medical office: Close to many hospitals. High traffic, high visibility. New, fully equipped medical office in busiest part of Yonge St., 13 exam rooms, plus three offices. EMR or paper, P/T, F/T, one of many GPs. Move existing practice or build up from walk-in clinic. Very attractive split or flat rent. Contact: David Tel. 416.895.4745 Email: enerhealth@on.aibn.com

Family physician, specialist doctors — Brampton, ON: Our busy clinic is seeking family physicians and specialists to join our team. We are a satellite location of a family health team (FHT) and work with other allied health care professionals. Very large patient demand, rapidly expanding patient area. Flexible P/T or F/T hours. Can move an existing practice or build up from walk-in work. Full OSCAR EMR with laboratory on-site, many high-tech improvements for patients, including online appointment booking, online viewing of lab results, online messaging of health providers and staff. Full administrative support. The split is highly competitive. For more information, please phone or email. Tel. 647.271.6466 Email: amit.arya@hqic.ca

Family practitioner/ walk-in/psychiatrist/ENT/pain specialist needed to join our well-established medical centre with 40 plus doctors in Scarborough. Extremely busy and congenial work atmosphere. Full EMR. Contact: Dr. Thomas Van Tel. 647.227.5088 Email: thomvan@rogers.com

Full-time or part-time medical doctors required for a busy walk-in located in downtown Mississauga. Contact: Adel Tel. 416.904.2929, 905.897.6160 (office) Email: cornerstonepractitioners@gmail.com

Growing practice in Brampton seeking new family doctor. Competitive split. Email: cornerstoneimedical@gmail.com

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Website: www.johnstmedicalwalkinclinic.com

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Tel. 647.479.7789
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Tel. 416.229.2399
Website: www.medicalpsychclinic.org

Contact: Dr. Tom Burko
Tel. 416.631.0298 or 1.800.355.6668
Email: drburko@medvisit.ca
Website: www.medvisit.ca/doctors

North of Richmond Hill (Toronto GTA): Busy clinic, fully equipped, EMR, ECG, lab & pharmacy inside looking for FT/PT family and walk-in physician, and those who would like to relocate their office. Negotiable offer, rent or split.
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Tel. 416.873.9080
Email: alirezashahkar@yahoo.com

Email: drjoel@rogers.com

North York & Scarborough clinics located inside Loblaws and very busy shopping mall. Very busy walk-in clinics/family practice seeking family physicians and specialists. Physicians required for walk-in shifts as well as opportunity to relocate an existing practice or build a new practice. Flexible hours and very attractive split.
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Contact: Sara
Tel. 905.479.2571
Email: drjohal@outlook.com

### Yonge & Finch

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FT/PT needed for a busy clinic. EMR, flexible hours.

Tel. 416.826.3004
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### Corunna, ON:

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