

# DOCTORS OF BC REPORT TO MEMBERS 2016-17

Reports of the CEO, President, and Chair of the Board  
2016 Business Session and General Assembly Draft Minutes  
Auditors' Report and Financial Statements  
Annual Reports of the Council on Health Promotion  
Annual Reports of Doctors of BC Committees and Councils  
Annual Reports of Sections and Societies  
Annual Reports of External Committees and  
Affiliated Organizations

**doctors  
of bc**

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## REPORT OF THE CEO

### HIGHLIGHTS AND ACHIEVEMENTS THIS YEAR

Allan Seckel, QC

In order to provide the best service and value to our members, it's important that Doctors of BC staff have a clear sense of purpose. For this reason, we have developed our purpose statement, "Together, let's make a difference so our doctors can make theirs."

This simple, clear statement reminds us that everything we do as employees of Doctors of BC ultimately leads to one outcome—to enable physicians to make a positive difference for the benefit of the profession, patients, and the health care system. In 2016 staff and physicians worked together on a number of fronts to achieve this outcome.

After 2 years of planning and extensive consultations, members voted in favor of a major change to the way we govern our organization—from a 39-member board to a dual-model consisting of a representative assembly and a new smaller board. This significant shift gives us a smaller, more nimble, and flexible board that will be able to make more timely decisions on behalf of our members, and a new representative assembly that will provide wide-ranging representation from all geographical areas of the province—GPs/FPs and specialists, those practising in rural and First Nations communities, medical students, residents, and those members in the early years of practice.

We also moved forward in a significant way in our collaborative work with government and health authorities. The General Practice Services Committee (GPSC) continued to play an influential role in shaping the Patient Medical Home and the move toward more team-based primary care in our province. Through the GPSC, we successfully advocated for doctors' offices to remain at the centre of primary care delivery. We also advocated for an approach to team-based care that will allow physicians and other allied health care providers, through the Divisions of Family Practice, to develop local community solutions to meet local challenges.

A total of 60 medical staff associations are now up and running as part of the facility engagement initiative supported through the Physician Master Agreement.

The goal is to strengthen relationships and engagement between facility-based physicians.

The collaborative teams made great strides in implementing the Child and Youth Mental Health Substance Use Collaborative (CYMHSU), which broke down silos across a wide range of groups to enable more timely access to care for our young people.

These are just some of the highlights of the achievements this year. All the collaborative programs provide an avenue through which physicians have a strong voice and ability to influence the way health care decisions are made—decisions that impact the profession, the work environment, and the ability to provide the best quality care to patients.

Doctors of BC took another important step to ensure better advocacy on behalf of physician members in local communities by introducing regional advisors and advocates (RAAs). The RAAs are Doctors of BC staff who are the points of contact for members seeking services or support from the organization, and they help physicians access these services in a way that is easy and timely. And because the RAAs are spread throughout the province, they know and understand local challenges faced by our members.

We also introduced two policy papers that support our engagement and advocacy efforts on behalf of the profession: one on supporting the health of caregivers and the other on improving health care performance.

Our service department team continues to provide good value to members in their insurance, Telus, and other offerings.

I want to thank all the staff at Doctors of BC who work hard to make a positive difference and provide value for you, our members. There is much to do, and I look forward to continuing to build on the achievements made this year.

—Allan Seckel, QC  
Chief Executive Officer



## REPORT OF THE PRESIDENT

### **BETTER TOGETHER**

Alan Ruddiman, MBBCh

As a profession, we have collectively accomplished much this past year. One of our most significant achievements is the move toward our new governance model. With a new dual-model structure, one that includes a smaller governance-oriented board and an inclusive representative assembly, we will have broader and greater representation for all our members and sections. For the first time, a truly representative body in our association will have an equal number of specialists and GPs — a balance that is extremely important to our ability to govern in a democratic, equitable, and considerate way.

Another issue of great importance for our organization is the ongoing promotion and advancement of medical professionalism. When we work together as GPs and specialists to embrace medical professionalism, we can have an influential voice in shaping the care our patients receive. I have met and interacted with many physicians in all stages of their careers, in every geographic region, who are committed to making a positive difference in health care. We have pockets of communities of practice in all corners of our province where physicians have made it their business to understand and support their patients and their vulnerable populations. It has been truly inspiring to see and experience this firsthand.

As a physician still active in practice, and now likely in the latter third of my career, I take great pride in understanding and supporting our doctors of tomorrow — our medical students and resident physicians. I have truly enjoyed spending quality time with our younger members this year. In them, I see the potential for great leaders. They are determined to make a positive change in health care. I have also enjoyed encouraging our more experienced doctors to step up as mentors to these young professionals as they seek to establish medical careers in BC.

The work of our collaborative programs with government and health authorities has moved forward largely in a constructive way. The work of building relationships and advocating for our profession with the goal of reaching agreements that benefit the profession and our patients is not always easy, but it is well worth the effort. Physicians have much to offer as front-line health care experts. I hope that in the coming year, great strides are made particularly within our hospitals where physicians will feel more valued, and their broader voices will be heard legitimately and strongly. This area in BC's health service delivery deserves significant attention and oversight.

I wish to thank the members of the Board, the staff of Doctors of BC, and most appropriately all of our members for their support. It has indeed been an honour to serve as your president, and I look forward to continuing to support our organization and our profession as we move on to meet the challenges ahead.

It's only appropriate that I end this report by stating that as a profession, we are always better together!

—Alan Ruddiman, MBBCh, Dip PEMP, FRRMS  
President

“For the first time, a truly representative body in our association will have an equal number of specialists and GPs — a balance that is extremely important to our ability to govern in a democratic, equitable, and considerate way.”



## REPORT OF THE CHAIR OF THE BOARD

### AN ORGANIZATION OF INFLUENCE

Mark Corbett, MD

The Doctors of BC vision statement sets out our goals as an organization: to provide fair economic reward and professional satisfaction for physicians, and to create a favorable social, economic, and political climate in which members can provide the citizens of BC with the highest standard of health care. In 2016, we completed the third year of a 3-year strategic plan, confident that progress has been made in engaging with membership and our health profession partners, providing expanded and excellent member services, and creating and maintaining a supportive organization where advocacy has remained a major focus.

Renovations to our building at 1665 West Broadway are complete and the new meeting rooms and board rooms on the first floor are fully operational. Our staff of over 200 remains dedicated to the operations of our association under the guidance of CEO Mr Allan Seckel and the committed professionals of the senior executive management team. We are indebted to all of them for their tireless support and encouragement in the development and achievement of our goals.

It is the strong working relationships between all levels of our staff, our Board delegates, and an engaged and still expanding membership that informs and supports the organization. Those relationships are the reason for the well-deserved reputation Doctors of BC has as an organization of influence in the development of health care policy and the provision of health care services for the patients of BC.

As the result of a historic referendum in which members overwhelmingly supported creating a new governance model, all Board delegates will complete their terms following the June 2017 Board meeting, and the new model will become operational in September. The Board has functioned extraordinarily well in the past year, with delegates fully engaged and prepared, and has established and enjoyed a culture of respect, compassion, and understanding. Board members are very busy people with their practices and family responsibilities, yet

willingly take the extra time to work on behalf of all our physician members. Sincere thanks are due to all of them, and I wish them well in whatever roles they choose within either the new Board or the new Representative Assembly. It has been a pleasure and privilege to serve with them all.

—Mark Corbett, MD  
Chair of the Board

### Highlights of the work of your Board of Directors over the past year:

- Developing a proposal for governance reform (approved by members in a referendum) and subsequent transition planning.
- Overseeing 3-year financial plan and approving annual budget.
- Reviewing and approving joint collaborative mandates.
- Supporting facilities engagement and development of medical staff associations.
- Expanding and improving member benefits.
- Continuing work toward a new strategic plan.
- Overseeing statutory and reporting committees.
- Supporting the work of the Nominating Committee, which screens for highly qualified applicants to populate our committees.

# DOCTORS OF BC ANNUAL BUSINESS SESSION & GENERAL ASSEMBLY

DRAFT MINUTES—Pan Pacific Hotel, 4 June 2016

## CALL TO ORDER

Mr Seckel called the meeting to order at 9:40 a.m. and welcomed members to the Pan Pacific Hotel. He then invited members to stand and observe a moment of silence in remembrance of colleagues who passed away in the last year.

## 1. ELECTION OF CHAIR

Mr Seckel advised that he has received the name of Dr Michael Golbey as nominee to chair the Business Session. He inquired if there were any additional nominations, and there being none:

### MOVED/SECONDED

#### RESOLUTION AGM16/06/04-01

That Dr Golbey is acclaimed as chair of the 2016 Annual Business Session.

**CARRIED**

## 2. MEETING STANDING RULES

*Distributed material: Doctors of BC (BCMA) 2016 Annual General Meeting Meeting Standing Rules*

Dr Golbey assumed the role of chair. He gave an overview and inquired if there were any questions. There being none, a motion to adopt the Meeting Standing Rules was introduced:

### MOVED/SECONDED

#### RESOLUTION AGM16/06/04-02

That the 2016 Annual General Meeting Standing Rules are adopted as circulated.

**CARRIED**

## 3. ELECTION OF RESOLUTIONS COMMITTEE

Dr Golbey called for nominations to the Resolutions Committee. He reviewed the purpose of the committee in assisting members to draft motions that are in compliance with the Society Act and the bylaws of the organization, and to ensure that they do not overlap each other. Two nominations were received:

### MOVED/SECONDED

#### RESOLUTION AGM16/06/04-03

That Drs Alan Gow, Trina Larsen Soles, and Alexander Frame are acclaimed as members of the Resolutions Committee.

**CARRIED**

Dr Golbey then acknowledged and introduced the members of the executive: President Charles Webb, President-Elect Alan Ruddiman, Past President Bill Cavers, Chair of the General Assembly Trina Larsen Soles, Secretary/Treasurer Eric Cadesky, and Board Chair Mark Corbett.

## 4. APPROVAL OF AGENDA

*Distributed material: Doctors of BC Annual Business Meeting and General Assembly Agenda 4 June, 2016*

Dr Golbey referred the members to the distributed draft agenda and inquired if there were any additions or deletions. There being none:

### MOVED/SECONDED

#### RESOLUTION AGM16/06/04-04

That the agenda for the Doctors of BC Annual Business Meeting and General Assembly for 4 June 2016 is adopted as circulated.

**CARRIED**

## 5. APPROVAL OF 2015 MINUTES

*Distributed material: Doctors of BC Annual Business Meeting and General Assembly for 6 June 2015*

Dr Golbey invited members to review the minutes of last year's meeting and he inquired if there were any errors or omissions. There being none:

### MOVED/SECONDED

#### RESOLUTION AGM16/06/04-05

That the minutes of the Doctors of BC Annual Business Meeting and General Assembly for 6 June 2015 are approved.

**CARRIED**

## 6. PRESIDENT'S REPORT

*Distributed material: President's Report in the Annual Report*

Dr Charles Webb spoke of the privilege and pleasure it has been to be the president of the Doctors of BC over the past year and he acknowledged the dedication and hard work that his colleagues were doing across the province. Dr Webb then led the meeting in a review of the President's Report provided in the Annual Report. Dr Webb spoke about the various initiatives undertaken in the past year, including the positive results from the

young member engagement, the enthusiasm regarding the new governance structure, and the one patient-one record initiative.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-06**

That the report of the president is accepted.

**CARRIED**

**7. CHIEF EXECUTIVE OFFICER'S REPORT**

Mr Allan Seckel drew members' attention to his written reports in the Annual Report and White Report. He noted the key activities over the year, including the physician engagement initiative, the progress of the renovations to the building, and the organization's certification as a great place to work. Mr Seckel also noted that the litigation that had been ongoing for many years is now concluded and most of the legal costs have been repaid.

The members joined Mr Seckel in thanking the executive team for their efforts over the past year.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-07**

That the report of the chief executive officer is accepted.

**CARRIED**

**8. CONSIDERATION OF THE REPORT OF THE STATUTORY NEGOTIATING COMMITTEE**

Dr David Attwell, chair of the Statutory Negotiating Committee, noted that since there have been no active negotiations, there is no written report. Dr Attwell answered a question from the membership.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-08**

That the report of the Statutory Negotiating Committee is accepted.

**CARRIED**

**9. CONSIDERATION OF THE REPORT OF THE BOARD OF DIRECTORS**

Dr Mark Corbett, Board chair, noted that the report is available online in the White Report. Dr Corbett reported that the Board continues to oversee the steady progress along the path of the Strategic Plan.

Dr Corbett provided highlights of the Board's work over the past year. He noted the Board will maintain its focus in two key areas in the coming year: governance and member engagement.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-09**

That the report of the chair of the Board of Directors is accepted.

**CARRIED**

**10. CONSIDERATION OF THE REPORT OF THE AUDIT AND FINANCE COMMITTEE**

*Distributed material: Financial statements of British Columbia Medical Association, for the year ended 31 December 2015*

*Presentation: Financial statement highlights*

**10.1 PRESENTATION OF FINANCIAL STATEMENTS**

Dr Michael Curry led members in a detailed review of the 2015 financial statements. He highlighted key variances from the prior year. Dr Curry noted that the society has a surplus of approximately \$3.7 million, \$1.9 million of which is from the insurance settlement. He noted that the statements were in compliance with guidelines for not-for-profit organizations regarding reserves.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-10**

That the audited financial statements for 2015 are accepted.

**CARRIED**

Dr Curry addressed questions from the membership.

**10.2 CONSIDERATION OF THE AUDITOR'S REPORT**

Dr Michael Curry invited members to review the Report from the Auditor in the Annual Report.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-11**

That the report from the auditor is accepted.

**CARRIED**

**10.3 APPOINTMENT OF AUDITOR**

Dr Michael Curry spoke of the excellent work of KPMG LLP and a motion to appoint that firm as auditors for the current fiscal year was introduced:



**MOVED/SECONDED  
RESOLUTION AGM16/06/04-12**

That the firm KPMG LLP is appointed as auditors for the Doctors of BC for the 2016 fiscal year.

**CARRIED**

Dr Curry led a discussion on membership dues noting that the number of members has been increasing, provided a breakdown of the membership as of 31 December, and noted that membership dues have remained stable over the past few years due to increasing membership. There was a proposal from the Audit and Finance Committee that there be no increase to the BC Doctors membership fees for 2017.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-13**

That there be no BC Doctors dues increase for 2017

**CARRIED**

**11. GOVERNANCE COMMITTEE**

Dr Bill Cavers reviewed the committee's identified priorities and progress on each of the priorities, including the restructuring of the association's governance, noting that the restructuring proposal will go online for the purposes of consultation with the membership.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-14**

That the report of the Governance Committee is accepted.

**CARRIED**

**11.1 NOMINATING COMMITTEE**

Dr Robin Routledge referred to the report of the committee on page 32 of the White Report. Dr Routledge acknowledged the passing of Phil White and his many contributions to the committee.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-15**

That the report of the Nominating Committee is accepted.

**CARRIED**

**11.2 ELECTION OF THREE MEMBERS-AT-LARGE OF  
AUDIT AND FINANCE COMMITTEE**

Dr Golbey advised that three members-at-large were sought for the Audit and Finance Committee.

Dr Golbey then called for nominations from the floor. Nominations were received from Drs Khandelwal, Curry, Corbett, and Chiu. Each of the nominees present was requested to speak briefly to the membership regarding their interest in being elected. Dr Curry read a statement from Dr Chiu. There were four nominees for the three vacancies and Dr Khandelwal withdrew his nomination. Dr Golbey noted that Drs Curry, Corbett, and Chiu are appointed by acclamation.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-16**

That the three members-at-large for the Audit and Finance Committee are Drs Curry, Corbett, and Chiu.

**CARRIED**

**12. INTRODUCTION OF NEWLY ELECTED OFFICERS**

The newly elected officers were introduced: Secretary/Treasurer David Wilton, Chair of the General Assembly Eric Cadesky, President-Elect Trina Larsen Soles, President Alan Ruddiman, and Past President Charles Webb.

**13. CONSIDERATION OF THE REPORT OF THE TARIFF  
COMMITTEE**

*Distributed material: Page 38 of the Doctors of BC 2015/16 White Report*

Dr Brian Winsby referred the members' attention to the report in the White Report and inquired if there were any questions.

**MOVED/SECONDED  
RESOLUTION AGM16/06/04-17**

That the report of the Tariff Committee is accepted.

**CARRIED**

Dr Winsby addressed questions from the membership.

**14. CONSIDERATION OF THE REPORT OF THE SPECIALISTS OF BC**

*Distributed material: Page 54 of the Doctors of BC 2015/16 White Report*

Dr John Falconer referred members to the distributed report and provided an updated report on the activities of Specialists of BC.

**MOVED/SECONDED**

**RESOLUTION AGM16/06/04-18**

That the report of the Specialists of BC is accepted.

**CARRIED**

**15. SOCIETY OF GENERAL PRACTITIONERS OF BC**

*Distributed material: Page 53 of the Doctors of BC 2014/15 White Report*

Dr Ken Burns referred members to the written report in the White Report, provided a brief update, and inquired if there were any questions. Dr Burns addressed questions from the membership.

**MOVED/SECONDED**

**RESOLUTION AGM16/06/04-19**

That the report of the Society of General Practitioners of BC is accepted.

**CARRIED**

**16. NEW BUSINESS**

Members presented their views and concerns on access to patient care following a discussion on both primary and specialty care.

**MOVED/SECONDED**

**Resolution AGM16/06/04-20**

That the SGP and the Doctors of BC engage with the Ministry of Health, UBC, and health authorities to support the education of future physicians in longitudinal primary care and that this be considered for future negotiations.

**CARRIED**

**MOVED/SECONDED**

**Resolution AGM16/06/04-21**

That the Doctors of BC, SGP, and Specialists of BC engage with the Ministry of Health, UBC, and health authorities to develop and address an appropriate physician resource plan and strategic roadmap to meet the needs of the populations of BC.

**CARRIED**

**MOVED/SECONDED**

**Resolution AGM16/06/04-22**

That the meeting be adjourned.

**CARRIED**

**CONCLUSION**

There being no further business the Business Session concluded at 11:40 a.m.

**GENERAL ASSEMBLY**

Dr Trina Larsen Soles took the chair and called the General Assembly to order at 11:41 a.m. She reviewed the purpose of the General Assembly to review the reports of the standing committees, councils, sections, and affiliated organizations.

**1. REPORTS OF ALL STANDING AND AD HOC COMMITTEES**

Dr Larsen Soles drew members' attention to the reports of all standing and ad hoc committees in the White Report and inquired if there were any questions. There being none she thanked the members who volunteer on these committees.

**2. REPORTS OF ALL SECTIONS**

Dr Larsen Soles next drew members' attention to the reports of all sections and inquired if there were any questions. There were no comments.

**3. REPRESENTATIVES TO ORGANIZATIONS**

Dr Larsen Soles invited members to review the reports of the representatives to organizations and inquired if there were any questions. There were no questions.

**4. ANY BUSINESS ORIGINATING IN OR RELATING TO AFFILIATED MEDICAL SOCIETIES OR ASSOCIATED SOCIETIES WHICH IS SIMILAR OR BENEFICIAL TO ANY OF THE PURPOSES OF THE ASSOCIATION**

Dr Larsen Soles asked if there were any questions regarding the affiliated medical societies or associated societies. No questions came forward.

**5. RELATIONS BETWEEN THE ASSOCIATION AND THE CMA**

Dr Larsen Soles asked if there were any questions regarding the relationship between Doctors of BC and the CMA. No questions came forward.

**6. RECOMMENDATIONS TO THE CMA DELEGATES, TO THE DIVISIONAL REPRESENTATIVES TO THE CMA GENERAL COUNCIL, AND TO THE ASSOCIATION REPRESENTATIVES TO THE CMA COMMITTEES**

Dr Larsen Soles invited questions on the agenda item. There were none.

**CONCLUSION**

There being no further business the General Assembly meeting concluded at 11:49 p.m.

**MOVED/SECONDED**

That the General Assembly meeting be adjourned.

**CARRIED**

<b>Doctors of BC Board Officers &amp; Delegates 2016-17</b>	
President	Alan Ruddiman
Past President	Charles Webb
President-Elect	Trina Larsen Soles
Chair of the General Assembly	Eric Cadesky
Honorary Secretary Treasurer	David Wilton
Chair of the Board	Mark Corbett
District #1	Robin Saunders
District #1	David Harris
District #1	Eugene Leduc
District #2	Robin Routledge
District #2	Anthony Booth
District #3	Lloyd Oppel
District #3	Joanne Young
District #3	Alex She
District #3	Brad Fritz
District #3	David Kendler
District #3	Vanessa Brcic
District #3	Geoffrey Ainsworth
District #4	Tommy Gerschman
District #4	Lisa Gaede
District #5	Vacant
District #6	Jeffrey Dresselhuis
District #7	Yusuf Bawa
District #7	Peter Barnsdale
District #8	Jacob (Jack) Kliman
District #9	Jannie du Plessis
District #10	Barbara Blumenauer
District #11	Dan Horvat
District #12	Vacant
District #13	Alan Gow
District #13	Vacant
District #14	Cheryl Hume
District #15	Vacant
District #16	Jasper Ghuman
District #16	Sanjay Khandelwal

# INDEPENDENT AUDITORS' REPORT

To the Members of British Columbia Medical Association (Canadian Medical Association - B.C. Division)  
(dba Doctors of BC):

## **Report on the financial statements**

We have audited the accompanying financial statements of the British Columbia Medical Association (Canadian Medical Association - B.C. Division) (dba Doctors of BC), which comprise the statement of financial position as at December 31, 2016, the statements of operations, changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

### *Management's Responsibility for the Financial Statements*

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

### *Auditors' Responsibility*

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### *Opinion*

In our opinion, the financial statements present fairly, in all material respects, the financial position of the British Columbia Medical Association (Canadian Medical Association - B.C. Division) (dba Doctors of BC) as at December 31, 2016 and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

## **Report on other legal and regulatory requirements**

As required by the Societies Act (British Columbia), we report that, in our opinion, the accounting policies applied in preparing and presenting the financial statements in accordance with Canadian accounting standards for not-for-profit organizations have been applied on a basis consistent with that of the preceding year.

"KPMG LLP"  
Chartered Professional Accountants  
April 21, 2017  
Vancouver, Canada

## Statement of Financial Position

Year ended December 31, 2016, with comparative information for 2015

	2016	2015
<b>Assets</b>		
Current assets:		
Cash	\$ 8,929,708	\$ 17,230,466
Accounts receivable (notes 3 and 11)	2,354,397	2,339,652
Prepaid expenses	407,375	568,736
Short-term investments (note 4)	1,770,354	7,812,535
	<u>13,461,834</u>	<u>27,951,389</u>
Investments (note 4)	21,373,857	18,442,378
Investment in BCMA Agencies Limited (note 5)	51	51
Capital assets (note 6)	8,695,749	4,564,723
Cash held for designated holding accounts (note 7)	1,070,236	1,087,899
	<u>\$ 44,601,727</u>	<u>\$ 52,046,440</u>
<b>Liabilities and Net Assets</b>		
Current liabilities:		
Accounts payable and accrued liabilities (note 11)	\$ 2,350,965	\$ 10,121,046
Prepaid membership dues	1,843,096	1,999,824
Group life premiums accounts	372,653	403,345
Group insurance accounts	2,019,814	1,802,863
	<u>6,586,528</u>	<u>14,327,078</u>
Designated holding accounts (note 7)	1,070,236	1,087,899
Deferred contributions (note 8)	632,175	974,687
	<u>8,288,939</u>	<u>16,389,664</u>
Net assets:		
Internally restricted (notes 2 and 9)	7,214,312	9,971,142
Investment in capital assets	8,695,749	4,564,723
Unrestricted	20,402,727	21,120,911
	<u>36,312,788</u>	<u>35,656,776</u>
Commitments (note 10)	<u>\$ 44,601,727</u>	<u>\$ 52,046,440</u>

See accompanying notes to financial statements.

Approved on behalf of the Board:

Mark Corbett, MD  
Chair of Board of Directors

## Statement of Operations

Year ended December 31, 2016, with comparative information for 2015

	2016	2015
Revenue:		
Membership dues	\$ 19,145,532	\$ 18,801,575
Less dues collected for Canadian Medical Association	(4,783,204)	(4,643,920)
	14,362,328	14,157,655
Contributions for designated programs (note 8)	827,405	766,665
Insurance administration fees	2,762,751	2,330,774
Management fees	2,288,000	2,258,000
Investment and miscellaneous income	1,305,065	3,303,934
Building rents	932,074	1,033,733
	22,477,623	23,850,761
Expenses:		
Building - rented portion	\$ 684,418	\$ 599,164
Committee costs (note 12)	2,161,088	2,445,163
Consulting and professional fees	1,009,726	996,951
Designated programs expenses (note 8)	827,405	766,665
Marketing and communications	486,288	590,294
Occupancy	893,246	666,108
Office	2,525,300	1,986,713
Physician health program	750,000	300,000
Salaries and benefits	12,255,998	11,752,706
Loss on disposal of capital assets	228,142	-
	21,821,611	20,103,764
Excess of revenue over expenses	\$ 656,012	\$ 3,746,997

See accompanying notes to financial statements.

BRITISH COLUMBIA MEDICAL ASSOCIATION (CANADIAN MEDICAL ASSOCIATION – B.C. DIVISION)  
(dba Doctors of BC)

**Statement of Changes in Net Assets**

Year ended December 31, 2016, with comparative information for 2015

	Internally Restricted (note 2)										2015 Total	
	Student bursary fund	Staff reward and recognition fund	Professional development fund	Medical care fund	Negotiations stabilization fund	Capital asset replacement fund	Indemnification fund	Total	Investment in capital assets	Unrestricted		2016 Total
Net assets, beginning of year	\$ 2,000,000	\$ 85,600	\$ 77,279	\$ 3,000,000	\$ 1,000,000	\$ 3,808,263	\$ -	\$ 9,971,142	\$ 4,564,723	\$ 21,120,911	\$ 35,656,776	\$ 31,909,779
Interfund transfers (note 9)	-	-	50,000	1,000,000	-	1,000,000	135,000	2,185,000	-	(2,185,000)	-	-
Excess (deficiency) of revenue over expenses	-	-	(6,829)	-	-	-	(126,738)	(133,567)	(1,051,278)	1,840,857	656,012	3,746,997
Net change in investment in capital assets	-	-	-	-	-	(4,808,263)	-	(4,808,263)	5,182,304	(374,041)	-	-
<b>Net assets, end of year</b>	<b>\$ 2,000,000</b>	<b>\$ 85,600</b>	<b>\$ 120,450</b>	<b>\$ 4,000,000</b>	<b>\$ 1,000,000</b>	<b>\$ -</b>	<b>\$ 8,262</b>	<b>\$ 7,214,312</b>	<b>\$ 8,695,749</b>	<b>\$ 20,402,727</b>	<b>\$ 36,312,788</b>	<b>\$ 35,656,776</b>

See accompanying notes to financial statements.

## Statement of Cash Flows

Year ended December 31, 2016, with comparative information for 2015

	2016	2015
Cash provided by (used in):		
Operating:		
Excess of revenue over expenses	\$ 656,012	\$ 3,746,997
Items not involving cash:		
Amortization	823,136	461,573
Amortization of bond premium	(76,880)	(20,736)
Loss on disposal of capital assets	228,142	-
Change in accrued interest	(185,370)	(11,385)
	1,445,040	4,176,449
Change in non-cash operating working capital:		
Accounts receivable	(14,745)	84,517
Prepaid expenses	161,361	(303,131)
Accounts payable and accrued liabilities	(7,770,081)	7,428,532
Prepaid membership dues	(156,728)	38,517
Group life premiums accounts	(30,692)	(30,617)
Group insurance accounts	216,951	98,474
	(6,148,894)	11,492,741
Investments:		
Purchase of investments	(2,262,427)	(10,365,604)
Proceeds from sale of investments	5,635,379	9,802,370
Purchase of capital assets	(5,182,304)	(1,640,881)
	(1,809,352)	(2,204,115)
Financing:		
Decrease in deferred contributions	(342,512)	(895,879)
Increase (decrease) in cash	(8,300,758)	8,392,747
Cash, beginning of year	17,230,466	8,837,719
Cash, end of year	\$ 8,929,708	\$ 17,230,466

See accompanying notes to financial statements.



## Notes to Financial Statements

Year ended December 31, 2016

The British Columbia Medical Association (Canadian Medical Association - B.C. Division) (dba Doctors of BC) ("Doctors of BC") is a not-for-profit organization incorporated as a corporation without share capital under the Society Act (British Columbia). On January 23, 2017, Doctors of BC filed its transition application under the Societies Act (British Columbia). Doctors of BC promotes a social, economic and political climate in which its members may provide the highest standard of healthcare services. Doctors of BC assists all physicians practicing in the Province of British Columbia by negotiating fee schedules and benefits on behalf of those physicians who practice medicine on a fee-for-service, sessional basis or other alternative methods of payment. Doctors of BC is exempt from income taxes.

### 1. Significant accounting policies:

The financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations in Part III of the CPA Canada Handbook.

#### (a) Revenue recognition:

Doctors of BC follows the deferral method of accounting for contributions. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. Externally restricted contributions are recognized as revenue in the year in which the related expenses are recognized. Contributions restricted for the purchase of capital assets are deferred and amortized into revenue on a straight line basis, at a rate corresponding with the amortization rate for the related capital assets.

Investment income is recognized as revenue when earned. Membership of Doctors of BC is voluntary and therefore member dues are recorded when received. Revenue from insurance administration fees, management fees, and building rents is recognized when the services are provided.

#### (b) Short-term investments and investments:

In accordance with Doctors of BC's investment policy, investments and short-term investments consist of corporate and government bonds, and money market funds.

Short-term investments are classified as such when they have a maturity date of less than one year.

#### (c) Capital assets:

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments which extend the estimated life of an asset are capitalized. When a capital asset no longer contributes to Doctors of BC's ability to provide services, its carrying amount is written down to its residual value.

Capital assets are amortized on a straight-line basis over the assets' estimated useful lives as follows:

	Years
Building	30
Building improvements	4 to 15
Furniture and fixtures	10
Computer equipment	3
Office equipment	5

## Notes to Financial Statements

Year ended December 31, 2016

### (d) Use of estimates:

The preparation of the financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year.

Significant items subject to such estimates and assumptions include the determination of useful lives for amortization of capital assets, carrying amount of capital assets, and provisions for contingencies. Actual results could differ from those estimates.

### (e) Financial instruments:

Doctors of BC's financial instruments include cash, accounts receivable, short-term investments, investments, and accounts payable and accrued liabilities. Short-term investments and investments are solely comprised of bonds and money market funds.

Financial instruments are recorded at fair value on initial recognition and, other than investments in equity instruments that are quoted in an active market, are subsequently recorded at cost or amortized cost, unless management has elected to carry the instruments at fair value. Doctors of BC has not elected to carry any such financial instruments at fair value. Financial assets are assessed for impairment on an annual basis at the end of the fiscal year if there are indicators of impairment.

## 2. Internally restricted net assets:

Doctors of BC has set up internally restricted funds which are approved by the board of directors to support the following activities:

- (a) Student bursary fund ensures that there will be adequate funding for the medical student bursary program.
- (b) Staff reward and recognition fund is established to reward and recognize employee contributions to Doctors of BC.
- (c) Professional development fund is designed to provide staff and officers with financial support when attaining graduate or post-graduate degrees.
- (d) Medical care fund is established to enhance the ability of physicians to provide quality medical care. These funds enable Doctors of BC to campaign for the economic rights of all physicians in the Province of British Columbia (the "Province").
- (e) Negotiations stabilization fund is utilized to offset the budgeting fluctuations for negotiations as the expenditures can vary significantly from year to year.
- (f) Capital asset replacement fund is set aside to fund additions to capital assets.
- (g) Indemnification fund was established to reimburse certain physicians' time and expenses for participating in Doctors of BC's legal proceedings.

The board of directors restricts the use of funds for operations by way of a resolution whereby only funds in excess of the internally restricted fund balances are available for the general operations of Doctors of BC. The internally restricted amounts may be used for special projects with the approval of the board of directors.

## 3. Accounts receivable:

As at December 31, 2016, accounts receivable includes allowance for doubtful accounts of \$3,430 (2015 – \$7,521) and amounts due from related parties of \$725,349 (2015 – \$177,507) (note 11).

## Notes to Financial Statements

Year ended December 31, 2016

### 4. Short-term investments and investments:

Short-term investments and investments are comprised of bonds as follows:

	Greater than 1 year	Less than 1 year	2016	2015
Bonds	\$ 21,373,857	\$ 1,770,354	\$ 23,144,211	\$ 26,254,913

The bonds mature between 2017 and 2021 (2015 - between 2016 and 2021).

### 5. Investment in BCMA Agencies Limited:

Doctors of BC owns 100% of the share capital of BCMA Agencies Limited ("Agencies"), and has accounted for its investment using the equity method. For the year ended December 31, 2016, included in investment and miscellaneous income is Doctors of BC's share of Agencies' income of nil (2015 - nil). As at December 31, 2016, Agencies had assets of \$68,838 (2015 - \$399,484), liabilities of \$68,787 (2015 - \$399,433) and retained earnings of \$51 (2015 - \$51). For the year ended December 31, 2016, Agencies earned revenue of \$337,011 (2015 - \$399,433) and had expenses of \$337,011 (2015 - \$399,433), with cash used in operations of \$322,127 (2015 - cash provided by operation of \$336,564).

### 6. Capital assets:

	Cost	Accumulated amortization	2016 Net book value	2015 Net book value
Land	\$ 1,000,000	\$ -	\$ 1,000,000	\$ 1,000,000
Building	4,329,760	4,329,760	-	-
Building improvements	9,386,140	3,124,011	6,262,129	2,330,008
Furniture and fixtures	1,622,907	337,047	1,285,860	707,417
Computer equipment	1,777,248	1,629,488	147,760	165,969
Office equipment	55,498	55,498	-	-
Work-in-progress	-	-	-	361,329
	\$ 18,171,553	\$ 9,475,804	\$ 8,695,749	\$ 4,564,723

### 7. Designated holding accounts:

Doctors of BC holds funds in cash that are designated for specific contracts that Doctors of BC administers. The activities of these accounts are not reflected on Doctors of BC's financial statements. The balance of these designated holding accounts is as follows:

	2016	2015
Benefit funds held in reserve	\$ 463,817	\$ 672,839
Other holding accounts	606,419	415,060
	\$ 1,070,236	\$ 1,087,899

## Notes to Financial Statements

Year ended December 31, 2016

### 8. Deferred contributions:

Deferred contributions represent unspent externally restricted contributions received by Doctors of BC for use on specific purposes. Changes in deferred contributions are as follows:

	2016	2015
Balance, beginning of year	\$ 974,687	\$ 1,870,566
Add net amount transferred in (out) during the year	484,893	(129,214)
Less amount recognized as revenue in the year	(827,405)	(766,665)
Balance, end of year	\$ 632,175	\$ 974,687

These deferred contributions consist of funds restricted for the following purposes:

	2016	2015
Government funded committees	\$ 229,103	\$ 229,103
General practice services committee	176,900	269,740
Protocol steering committee	89,262	246,873
Shared care and scope of practice committee	75,821	61,647
Specialist services committee	48,384	167,324
Lab reform committee	12,705	-
	\$ 632,175	\$ 974,687

### 9. Restrictions on net assets:

During the year ended December 31, 2016, the board of directors internally restricted a total of \$2,185,000 (2015 - \$2,500,000) of its unrestricted net assets to the professional development fund, medical care fund, capital asset replacement fund and the indemnification fund. Internally restricted amounts are not available for other purposes without approval by the board of directors.

### 10. Commitments:

Doctors of BC has committed to equipment leases until 2019. The minimum annual lease payments are as follows:

2017	\$	26,882
2018		17,477
2019		10,452
	\$	54,811

### 11. Related party transactions:

Doctors of BC has balances due from and payable to programs that are funded by the Province and for which Doctors of BC exercises significant influence. Each of these programs is controlled by a committee, on which there is equal representation between representatives of the Province and members of Doctors of BC, as governed by the Physician Master Agreement. Doctors of BC exercises significant influence over these programs by virtue of its equal representation on these committees. The purposes of the programs are to improve delivery of health services and patient health outcomes and/or provide services to doctors as described in the Physician Master Agreement. The activities of these programs are not reflected in the operations of Doctors of BC.

## Notes to Financial Statements

Year ended December 31, 2016

The balances due from related parties included in accounts receivable are as follows:

	2016	2015
GPSC Collaboratives Program	\$ 386,106	\$ -
Physician Health Program	61,312	53,792
Shared Care Programs	142,776	123,715
Specialist Services Programs	135,155	-
	<u>\$ 725,349</u>	<u>\$ 177,507</u>

The balances due to related parties included in accounts payable and accrued liabilities are as follows:

	2016	2015
GPSC Collaboratives Program	\$ -	\$ (5,959,983)
Specialist Services Programs	-	(663,527)
	<u>\$ -</u>	<u>\$ (6,623,510)</u>

### 12. Committee costs:

For the year ended December 31, 2016, committee costs includes honoraria paid to directors of \$407,236 (2015 - \$437,714).

### 13. Financial risks:

Doctors of BC manages its investment portfolio to earn investment income and invests according to a policy approved by the board of directors. Doctors of BC is not involved in any hedging relationships through its operations and does not hold or use any derivative financial instruments for trading purposes.

Doctors of BC believes that it is not exposed to significant interest-rate, market, credit or cash flow risk arising from its financial instruments.

Additionally, Doctors of BC believes it is not exposed to significant liquidity risk as all investments are held in instruments that are highly liquid and can be disposed of to settle commitments.



# ANNUAL REPORTS

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# ANNUAL REPORTS OF THE COUNCIL ON HEALTH PROMOTION

## COUNCIL ON HEALTH PROMOTION

DRS I. GILLESPIE, CHAIR; K. CADENHEAD, NUTRITION;  
R. GALLAGHER, GERIATRICS AND PALLIATIVE CARE;  
L. OPPEL, ENVIRONMENTAL HEALTH; C. RUMBALL,  
EMERGENCY AND PUBLIC SAFETY; R. WILSON,  
ATHLETICS AND RECREATION; DRS C. DY,  
M. FLANAGAN, C. MAHESWARAN, D.F. SMITH,  
H. SWINKELS, S. SZE; MS S. GARRETT (INVITED GUEST).  
STAFF: MS M. ADAIR, MS B. HODGSON, MS K.  
SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS,  
MR J. WONG.

With a focus on community health, health promotion, and quality of health care, the Council on Health Promotion (COHP) plays a large role in our association through its subcommittees, advocacy work, policy papers, and public campaigns.

We continue to align our work with the Doctors of BC's strategic plan by advocating for health promotion in a manner that influences positive change in population health. Over the next year, COHP will focus on a new policy project. We received 10 excellent project proposals and are refining methods to review and select priority issues for our policy recommendations to the Board. This work includes delegating tasks to subcommittees and making the process more transparent and accountable. Succession planning and good role modeling are part of our work too.

Here is an update on COHP's 2016-17 key activities:

**Activity 1:** Policy paper on physician support for informal caregivers, *Circle of Care: Supporting Family Caregivers in BC*. This paper was published on 18 October 2016. Dr Romyne Gallagher, Mr Jon Wong, and the working group did an excellent job on this policy project. Board members commented on how important and timely the paper was when they approved it and thanked the Council for its good work. Barb MacLean, Executive Director of Family Caregivers of British Columbia, said in a press release that, "We are thrilled with the policy focus of this paper, and to our knowledge it is a first in Canada. We expect it to help accelerate a shift in health care culture and policy towards patient- and family-centred care."

**Activity 2:** Resolutions for Board approval. COHP submitted resolutions that the BC Caucus took to the Canadian Medical Association's General Council meeting in August. Over half the motions came from COHP and its subcommittees, underlining the important role this Council plays in shaping important health promotion issues at a national level.

**Activity 3:** Oversight and facilitation of subcommittee health promotion initiatives. COHP oversees five subcommittees whose work continues to focus on advocacy, member and community engagement, and information sharing. The details of the work of the five subcommittees are summarized by their chairs throughout this annual report.

Thank you to all for supporting COHP's work. We look forward to celebrating the 60th anniversary of COHP during Canada's sesquicentennial.

—Ian Gillespie, MD, FRCPC, DABPN  
Chair

## ATHLETICS AND RECREATION COMMITTEE

DRS R. WILSON, CHAIR; J. CROOKHAM, T. GERSCHMAN,  
D. KSIENSKI, R. REMICK, K.P. SOLMUNDSON,  
J.E. TAUNTON; MR R. JONCAS (SPORTMEDBC). STAFF:  
MS M. ADAIR, MR P. HIGGINS, MS B. HODGSON,  
MS K. SAUNDERS, MS S. SHORE, MS H. THI,  
MS D. VICCARS, MR J. WONG.

The major focus of the Athletics and Recreation Committee continues to be concern over the physical activity levels of British Columbians. As more and more data become available, it is evident that we are falling far short of the physical activity guidelines set by Health Canada.

Doctors can and do play an important role in promoting the importance of physical activity with our patients. We continue to build on the success of the Walk With Your Doc (WWYD) event held during the week of Move for Health Day on 10 May. Information about this event can be found on the WWYD website. As a lead-up to the event, a Prescription for Health involving physical activity is given to patients along with an invitation to the walk in their community. More of these events are being hosted by the local Divisions of Family Practice. While these events are important, we recognize that to broaden their success we must collaborate with others in the community. This year we are encouraging a connection with the local Recreation and Parks Association. We hope that this can lead to more patients getting involved in their community activities and thereby sustain an increase in their physical activity levels.

In the fall our focus will be back on school children through the Be Active Every Day initiative. This challenge invites school-age children to be active for 60 minutes every day for 1 month. Additionally, they will learn the Live 5-2-1-0 healthy living message, which stands for eating 5 fruits and vegetables, limiting screen time to 2 hours,



getting 1 hour of activity, and drinking 0 sugar-sweetened beverages daily. Doctors are asked to be ambassadors to their neighborhood school and encourage the kids to Be Active Every Day for the month of October, which coincides with International Walk to School Month. We will also focus on encouraging school children to be more involved in after-school activity programs as a way of increasing their physical activity levels. Doctors are encouraged to participate in these two important events.

We wish to draw awareness to the overall importance of the four factors to good health: being physically active, not smoking, maintaining a healthy diet, and limiting alcohol consumption. Together, these can prevent 80% of cardiovascular disease, lung disease, and diabetes, and 40% of cancers, which are the leading causes of death.

The committee continues to be concerned about injury and safety in sport. Concussion and its appropriate management will be a focus of the committee in the future.

—Ron Wilson, MD  
Chair

## EMERGENCY AND PUBLIC SAFETY COMMITTEE

DRS C. RUMBALL, CHAIR; J. BRUBACHER, G. DODD, J. GHUMAN, M. MURTI, R. PURSELL, P. YOON; MR S. MACLEOD (SUPERINTENDENT OF MOTOR VEHICLES). STAFF: MS M. ADAIR, MS B. HODGSON, MS K. SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS, MR J. WONG.

Although the committee's mandate remains unchanged, committee members (with the support of the Council on Health Promotion) changed the committee name from Emergency Medical Services Committee to Emergency and Public Safety Committee (EPSC) to better reflect the breadth of the committee's current activities and responsibilities.

The EPSC continued to fulfill its role of being the physician's voice in matters relating to traffic safety both for motorists and vulnerable road users, such as cyclists and pedestrians. The EPSC has benefited from a strong relationship with RoadSafetyBC and the Superintendent of Motor Vehicles. Over the past year, the EPSC continued to liaise with the Driver Fitness Advisory Group, the Provincial Road Safety Steering Committee, and the BC Injury Prevention Alliance. Issues of impaired and distracted driving, the reporting of medically unfit drivers, increased speed limits on designated highways, and general road and traffic safety concerns were discussed as matters of

business. We continue to anticipate that the predicted legalization of the recreational use of marijuana in 2018 will require medical input toward establishing legal provincial standards for defining impairment.

Over the past year the committee has paid particular attention to issues of disaster preparedness, especially those relating to an enhanced response role for primary care physicians and primary care clinics modeled on the expertise acquired from the earthquakes in Christchurch, New Zealand. The EPSC will continue to support the establishment of similar programs throughout BC and advocate for greater physician participation in disaster preparedness to improve clinical input into disaster planning. Patients with ongoing health care needs (secondary victims) must continue to have access to services while the system focuses on the primary victims of a disaster.

In the past year, committee members have submitted *BCMJ* articles on marijuana-impaired driving (October 2016) and inflight medical emergencies (April 2017).

—Chris Rumball, MD  
Chair

## ENVIRONMENTAL HEALTH COMMITTEE

DR L. OPPEL, CHAIR; MS SONIA BABOVIC; DRS R. COPES, B. HORNE, J. LU, C. MAHESWARAN, M. MURTI, E. YOUNG. STAFF: MS M. ADAIR, MS B. HODGSON, MS K. SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS, MR J. WONG.

The Environmental Health Committee (EHC) advises Doctors of BC on matters related to human health and the environment. In addition, EHC develops expertise within the medical profession on the impact of the environment on health.

Over the last year the EHC focused on:

- Producing *BCMJ* articles on water recycling and on addressing radon exposure in BC.
  - Monitoring the issue of environmental contamination from active and inactive mines.
  - Considering issues relating to crumb rubber, fracking, and microplastics.
- Upcoming topics include:
- Identifying and addressing the clinical effects of climate change.
  - Establishing a stronger partnership with the BC Centre for Disease Control.

—Lloyd Oppel, MD  
Chair

### GERIATRICS AND PALLIATIVE CARE COMMITTEE

DRS R. GALLAGHER, CHAIR; M. CHUNG, R. JONES, D. MAY, L. MCCOY, J. SLATER; MS J. TRIMBLE. STAFF: MS M. ADAIR, MS B. HODGSON, MS K. SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS, MR J. WONG.

This year many members of this committee were involved in the completion and release of *Circle of Care: Supporting Family Caregivers in BC*. The policy paper was released in October 2016 and received positive media coverage. It highlights the work and stress of being a caregiver to someone with chronic illness and how unpaid caregivers are an integral yet often invisible part of BC's health care system. The policy paper advocates for formal recognition of caregivers as partners in care and for refundable tax credits for caregivers. As part of the project, a practice toolkit was also developed to help doctors:

- Identify caregivers.
- Involve caregivers in patient care.
- Monitor the health of caregivers.
- Provide information and support to caregivers.

The committee developed the following resolutions from the caregiver policy paper that were approved at the Canadian Medical Association General Council meeting:

- The Canadian Medical Association recommends research into and education for health care providers concerning the unique challenges of managing pain in older adults.
- The Canadian Medical Association recommends that the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain include consideration of pharmacokinetic and pharmacodynamic factors specific to older adults.

Lastly, two *BCMJ* articles drafted by the committee were published. One highlighted the caregiver policy paper, and the other focused on pain management in older adults.

—Romyne Gallagher, MD  
Chair

### NUTRITION COMMITTEE

DRS K. CADENHEAD, CHAIR; I. HALE, M. HINCHLIFFE, P. MARTIQUET, M. SWEENEY; MS C. BUCKETT (PHSA), DR T. MIHALYNUK (HEALTHLINK BC), MS M. YANDEL (MINISTRY OF HEALTH). STAFF: MS M. ADAIR, MS B. HODGSON, MS K. SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS, MR J. WONG.

The Nutrition Committee's mandate is to advise Doctors of BC on public health issues pertaining to nutrition, using scientific, evidence-based research, and to advocate for disease prevention and improved nutrition and health for the population of BC. The committee works closely with the Healthy Living Branch of the Ministry of Health and HealthLink BC on projects and policies to help support physicians provide nutrition counseling to patients.

Over the past year, the committee focused on the prevention of childhood obesity by supporting provincial programs such as Shapedown and MEND, and community programs such as the Sustainable Childhood Obesity Prevention through Community Engagement (SCOPE), which uses the Live 5-2-1-0 healthy lifestyle message. As chair of the Nutrition Committee, I have had the pleasure of participating on the SCOPE advisory team.

As sharing evidence-informed resources and tools is a key component of the committee's work, we have also helped disseminate the new Pediatric Nutrition Guidelines (Six Months to Six Years) with BC physicians and their teams. This guideline is available on Provincial Pathways and the Ministry of Health website.

The committee has drafted several articles that were published in the *BCMJ* over this past year on topics including approaches to weight management (May 2016) and the use of supplements (November 2016). Our focus for these articles is to alert and inform physicians on topical nutritional issues.

—Kathleen Cadenhead, MD  
Chair

# ANNUAL REPORTS OF DOCTORS OF BC COMMITTEES AND COUNCILS

## ALLOCATION COMMITTEE

DRS S. KHANDELWAL, CHAIR; M. HILL, D. SCHAEFFER.  
STAFF: MR B. BRZEZYNSKI (AS OF JULY 2016), MR T.  
MACPHERSON (UNTIL JUNE 2016), MS D. MAYHEW.

The 2017-18 year is the second of three successive annual iterations of the Allocation Committee. This year's joint Doctors of BC-government committee is tasked with allocating \$8 million to adjust the service contract and salary agreement payment ranges for alternative payment (AP) physicians. AP physicians work primarily in BC's health authorities and represent approximately 1880 full-time equivalents (FTEs) across 51 physician practice categories.

The primary mandate of the committee is to fund adjustments to the ranges in response to physician recruitment and retention challenges, and to address issues of equity. If a final consensus decision is not rendered by 31 March 2017, the \$8 million of funding will be divided equally among all FTEs.

The committee initially asked for submissions from all AP physicians concerning the mandate. We then met internally with the Doctors of BC Alternative Payment Physician Issues Committee (APPIC) in October 2016 to review our interests and core objectives in advance of the first meeting with government. As of the time of writing this report, we have met five times with the government delegates and are in the final stages of coming to agreement on the 2017-18 allocation.

The collaborative nature of our strategic direction as an organization can be noted in this committee. As an organization, we hope to engage with the Ministry of Health and with our physician colleagues to bring about better health outcomes for all residents of BC.

It has been a privilege to work with the members and staff of this committee on behalf of the members of Doctors of BC.

—Sanjay Khandelwal, MD  
Chair

## ALLOCATION SUPPORT COMMITTEE

DRS D. BRABYN, CHAIR; Y. BAWA, C. BELLAMY,  
S. DJURICKOVIC, R. JONES.

The Allocation Support Committee (ASC) was established by the Doctors of BC Board in 2010 to provide ongoing support to the allocation process. The ASC's terms of reference include a responsibility to determine an appropriate FTE model required for one allocation process to the Sectional Allocation Forum.

The past year has been quiet except for a request from the board for the ASC to review changing the 0.5% cutoff for the one fee allocation process. After considering input from the sections, a report was presented at the 23 September 2016 board meeting. As there was no consensus on how to change the cutoff, the board approved the recommendation to not change the current process.

Once again I would like to thank the committee members for their diligence and useful input, and Doctors of BC staff for helping guide the committee and providing all the necessary data and calculations.

—David Brabyn, MB ChB  
Chair

## ALTERNATE PAYMENT PHYSICIANS ISSUES COMMITTEE

DRS R. TUKKER, CHAIR; C. BOOTH, J. CARD, J. DOWN,  
S. FEDDER, C. FITZGERALD, D. MCGREGOR,  
P. TONSETH, D. WILTON. STAFF: MR B. BRZEZYNSKI,  
MR T. MACPHERSON, MS D. MAYHEW.

There were three meetings of the Alternative Payment Physician Issues Committee (APPIC) over the past year: 13 April and 31 October 2016, and 8 March 2017.

The committee also assisted on a few other important initiatives. Members of APPIC spent a great deal of time reviewing the 28 applications for adjustments to the service contract and salary agreement ranges submitted to the Allocation Committee. At our October meeting, APPIC members, together with the appointed Doctors of BC members of the Allocation Committee, reviewed the applications as a group. The input from APPIC was considered very helpful by the Allocation Committee as they prepared to adjust the ranges.

Finally, APPIC would like to acknowledge the work of two long-serving members who will be stepping down from the committee. Dr Catherine Fitzgerald and Dr Chris Booth have served on APPIC for many years. Their dedication and hard work representing AP physicians are greatly appreciated.

—Roderick Tukker, MD  
Chair

### **AUDIT AND FINANCE COMMITTEE**

DRS M. CURRY, CHAIR; M. CHIU, M. CORBETT, S. KHANDELWAL, T. LARSEN SOLES, D. WILTON; MR M. HARTWICK. STAFF: MS J. PHILLIPS, MR A. SECKEL, MS S. VERGIS.

Doctors of BC continues to maintain a strong and secure financial position, and a detailed report of the association's finances will be presented at the AGM.

The committee met four times during the year and fulfilled its duties and responsibilities by:

- Reviewing and recommending approval of the budget to the Board of Directors.
- Reviewing the monthly financial reports and monitoring the expenditures of various committees and projects to ensure they are within budget.
- Supervising the annual audit conducted by KPMG LLP. (The committee meets twice a year with the auditors, first to review and approve the audit planning document, then to receive the audited financial statements, review recommendations from the auditors, and discuss any changes to accounting practices that may affect Doctors of BC.)
- Reviewing and recommending approval of the Doctors of BC annual financial statements and report to the Board of Directors.
- Allocating funds to maintain adequate reserves to cover contingencies and provide for capital and long-term projects.
- Directing the investment of the Doctors of BC reserves.
- Following the progress and cost implications of the renovations of 1665 West Broadway.
- Overseeing policies and ensuring governance is in place for the financial management of all funding, ensuring the funds are segregated and accounted for in compliance with financial best practices, and providing a framework for administration of the programs.
- Overseeing compliance with government regulations. (Recently, the Canada Revenue Agency has shown a greater interest in reviewing the accounting practices of not-for-profit organizations.)

I would like to extend my thanks and appreciation to the committee members for their energy, insight, and time, and to the staff of Doctors of BC for their excellent work and support.

—Michael Curry, MD  
Chair

### **AUDIT AND INSPECTION COMMITTEE**

DRS V. DAVIS, CHAIR; DR J. BURAK (CPSBC); MR E. DOLHAI (PUBLIC REP); DR B. GREGORY (DOCTORS OF BC). GUESTS: DR S. DADACHANJI (BILLING INTEGRITY PROGRAM); MS C. JONES (SECRETARIAT); MS K. KICKBUSH (MINISTRY OF JUSTICE); MR E. MACHIN (BILLING INTEGRITY PROGRAM); MS M. THELISMA (AUDIT AND INVESTIGATIONS BRANCH); MS G. WILSON (BILLING INTEGRITY PROGRAM).

The Audit and Inspection Committee (AIC) is composed of representatives of the Doctors of BC, the College of Physicians and Surgeons of BC, the public, and MSP. The panel approves audits of physicians' services and billing practices, reviews all audit reports, and recommends to the MSC whether recovery of funds should be pursued.

There were two changes to the committee membership this year. In October, Dr Kit Henderson chaired his last meeting after many years of service. Dr Vern Davis, previously the medical consultant to the Billing Integrity Program, was appointed as the new chair. As well, Dr Wendy Amirault, Doctors of BC representative, was replaced by Dr Brian Gregory. Doctors of BC thanks Drs Henderson and Amirault for their dedication and commitment to the physicians of the province.

The AIC continues to have difficulty retaining auditors, which is causing a problem in completing existing audits. Extra-billing audits are a priority for the AIC this coming year and will also divert resources away from individual physician audits. The Patterns of Practice Committee will be expressing their concern to the MSC on the delay in completing audits currently underway.

—Brian Gregory, MD  
Doctors of BC representative

### **AWARDS COMMITTEE**

DRS K. PATON, CHAIR; D. ETCHES, K. MCKEEN. STAFF: MS A. GRAY.

The Awards Committee has the pleasant task of identifying and recommending individuals, both in the medical community and in the community at large, for recognition of their accomplishments at various levels and in a selection of arenas: local, provincial, and national; medical, volunteerism, philanthropy, and leadership; general and specific. These awards are the CMA Honorary Membership Award (14 this year), the Doctors of BC Silver Medal of Service Award, the Don Rix Award for Physician Leadership, and the Change-

maker Award. These awards provide an opportunity to showcase hardworking doctors and their efforts to the public, the media, the health authorities, and the government.

This committee serves the Doctors of BC overall strategic objectives by promoting the visibility of professional excellence and innovation and celebrating achievement in the public eye and within the profession. It also engages the membership in the recognition of their colleagues. It provides a humbling catalogue of the energy, drive, and creativity of dedicated individuals in their efforts to improve health and health care delivery and serve the public.

The committee's greatest challenge is garnering submissions for consideration of awards. This year, we were successful in obtaining the most diverse applications yet by using the network of previous awardees and an enhanced call for nominations. As well, we assisted in the application process when requested by the nominators.

In 2016-17, the committee met both by teleconference and in person to minimize travel expense and maximize participation from areas beyond the Lower Mainland. In between meetings, we conducted business by e-mail and telephone. We used an updated electronic technology to share documents and spare trees. New medals were struck, and a new recognition of potential midcareer leaders honoring a deceased dedicated member is underway.

The committee is delighted to serve Doctors of BC in this way, and would be pleased to hear from members who would like to honor colleagues. We also thank Ms Aria Gray for her professional service and attentiveness.

—Katherine E. Paton, MD, FRCSC  
Chair

### **BC MEDICAL JOURNAL**

DRS DAVID R. RICHARDSON, EDITOR; J. CHAHAL (AS OF JULY 2016), D.B. CHAPMAN, A.I. CLARKE, B. DAY, S.E. HAIGH (UNTIL MAY 2016), T.C. ROWE, C. VERCHERE, W.R. VROOM. STAFF: MS M. ADAIR, MR J. DRAPER, MS J. JABLKOWSKI, MS K. SURALIWALLA.

The *BCMJ* Editorial Board consists of unique individuals from various backgrounds and specialties. I remain in awe of their collective insights on medical literature and would like to thank them for their hard work in making the *BCMJ* a publication we can all be proud of. The Editorial Board meetings continue to be the highlight of my month. There is even an unsubstantiated rumor started by myself that an upstart American medical journal (we're looking at

you, *NEJM*) wiretapped our meetings to discover the secrets of our success.

In 2016 Dr Susan Haigh retired from the *BCMJ* Editorial Board after 22 years of excellent service to her fellow physicians. Her intellect and compassion will be sorely missed and we wish her the best in the next chapters of her life. Her successor, Dr Jeevyn Chahal, is a general practitioner from Kamloops. Dr Chahal brings the valuable perspective of a general practitioner from the Interior. Her passion, dedication, and experience are a welcome addition to the team.

The *BCMJ* staff deserve the most credit for keeping the journal running smoothly. Mr Jay Draper, managing editor, through his calm leadership, makes sure everything happens as it should. He also handles the difficult job of keeping the editor in line without complaint or hope of compensation. Ms Kashmira Suraliwalla, senior editorial and production coordinator, knows something about everything and fortunately uses this knowledge for the force of good. Ms Joanne Jablkowski, associate editor, applies her vast skills in many ways to the *BCMJ*, including writing, editing, online work, and social media.

In August 2016 the *BCMJ* conducted an online survey of Doctors of BC members to gather your insights and understand your needs, preferences, and behaviors. The survey sampled approximately one-third of active members, and we received a healthy response rate of 24%. Overall, BC physicians consider the *BCMJ* a valuable, unique source of information on other members, medicine in BC, and association news. Read more about the survey findings at [www.bcmj.org/pulsimeter/bcmj-member-research-results](http://www.bcmj.org/pulsimeter/bcmj-member-research-results).

Lucky physicians from across Canada and even Australia participated in the *BCMJ*-organized "Quintessential Mexico" CME cruise in February 2017. A good time was had by all and valuable pearls were gained through the excellent lectures provided.

The *BCMJ* is a unique publication written by and for the physicians of BC. Please ensure its continued excellence by sending in your research, opinions, letters, and comments, and follow its presence on Twitter (@BCMedicalJrnl) and Facebook ([facebook.com/BCMedicalJournal](https://www.facebook.com/BCMedicalJournal)). You can rest assured we will work diligently to maintain the *BCMJ* to its expected high standard.

—David R. Richardson, MD  
Editor

### CLINICAL FACULTY WORKING GROUP

DRS D. HAUGHTON, DR G. PARHAR, CO-CHAIRS;  
L. DINDO, S. TULSIANI. UBC: MS D. DREFFS,  
DR G. PARHAR, MS S. PAUL. STAFF: MS D. MAYHEW,  
MR P. STRASZAK.

The Clinical Faculty Working Group (CFWG) is a joint committee of UBC Faculty of Medicine and the Doctors of BC that was convened in 2011. CFWG consists of three UBC faculty administrators and three Doctors of BC representatives. Their responsibilities are to consult on compensation and other issues affecting clinical faculty and to make recommendations to the Dean of Medicine.

Since the large-scale 2015 survey that Doctors of BC conducted, CFWG has focused primarily on the nonmonetary issues affecting clinical faculty that the survey highlighted, including the difficulty of balancing teaching with patient care, the administrative burden involved with teaching appointments, and the lack of support or connection to UBC. We appreciate that UBC staff have made great effort over the last 2 years to improve efficiencies, address communication issues, and improve the delivery of the clinical faculty services. In particular, a great deal of work has been done to build a system to track, label, and remunerate undergraduate clinical teaching by physicians, and this system has recently begun to be implemented across the province.

The survey also showed that members were frustrated with the level of compensation for clinical faculty work, but the dean precluded any increases for 2 years, delaying the next review of compensation to 2017.

In January 2017, Doctors of BC conducted a second large-scale survey of physician clinical faculty members. As in 2015, over 1000 clinical faculty members responded, and the results were remarkably similar.

CFWG met several times in February 2017 to review both the new survey and progress on the implementation of the 2015 recommendations. The focus now is on developing joint recommendations to the dean to address both the monetary and nonmonetary issues identified in the 2017 survey. We expect to finalize the consultations and develop the recommendations in April 2017.

—David A. Haughton, MD  
Co-Chair

### CONTINUING PROFESSIONAL DEVELOPMENT NUCLEUS COMMITTEE

DRS I. SCHOKKING, CHAIR; B. HOBSON, T. MORTON,  
C. NEWTON, C. NORTHCOTT. EX OFFICIO: DRS B. LYNN  
(UBC CPD); S. JOHNSTON (RCCBC). STAFF: DR S. BUGIS,  
MR R. HULYK, MS G. LYNCH-STANTON.

The Continuing Professional Development (CPD) Nucleus Committee continues to play a unique role in helping coordinate and network the many Doctors of BC initiatives, such as Divisions of Family Practice, medical staff associations, and efforts to steer revalidation toward continuous quality improvement (CQI) rather than continuous quality assurance (CQA).

We aim to increase engagement by all BC physicians, providing a networking opportunity for the CME coordinators to learn from and build on each other's experience, identify the gaps in available CPD activities, and advocate for activities and resources. We also advocate for educational resources, which include physicians in their own journey of lifelong learning: maintaining and improving their competence and personal and professional growth. This is particularly salient as the provincial privileging process evolves to where physicians are involved proactively.

There were four motions passed at the 2016 AGM:

- **Motion 1:** The Doctors of BC fund representatives from Divisions of FP, medical staff associations, medical educators, and faculty development leads to attend the annual CPD leaders' meeting.
- **Motion 2:** The CPD Committee strongly endorses the development and accessibility of a practice improvement hub and recommends that the joint clinical committees support and fund it.
- **Motion 3:** The Doctors of BC facilitate a collaborative, coordinated, and integrated educational initiative which guides systematic CQI/CPD that satisfies provincial privileging and licensing requirements. This initiative should be guided by the CANMEDS 2015 competencies.
- **Motion 4:** The Doctors of BC support a network integrating CPD initiatives with distributed medical education programs. Teach ourselves what we are teaching our learners so we can all be agents for change.

All BC community CPD coordinators are invited to the spring AGM. This year we have also invited section heads and representatives from Divisions of Family Practice and medical staff associations. For the sixth year, we are appending a CMA Physician Leadership Institute course that generates \$50 000 in revenue. Once again, it is sold out and waitlisted. This year's course is Leadership Strategies for Sustainable Physician Engagement.

The theme of this year's conference (held in conjunction with the AGM) is CQI Really Is CPD: How Do We Shorten the Distance Between Them?

—Ian Schokking, MD  
Chair

### **COUNCIL ON HEALTH ECONOMICS AND POLICY**

DRS D. MILLIKEN, CHAIR; E. CADESKY, E. CHANG, T. GERSCHMAN, J. GHUMAN, D. HORVAT, G. HUTCHINSON, T. LARSEN SOLES (2016), T. MONK, L. OPPEL, J. OTTE, A. RUDDIMAN, M. TAYLOR (2016), E. WEISS. MEDICAL UNDERGRADUATE SOCIETY GUESTS: MS E. MITCHELL, MS C. SCHILLERS (2016). RESIDENT DOCTORS OF BC GUESTS: DRS J. KANCIR (2016), G. MITRA (2016), E. STEWART. STAFF: MS M. ADAIR, MS K. SAUNDERS, MS S. SHORE, MS H. THI, MS D. VICCARS, MS T. WEBB, MR J. WONG.

The Council on Health Economics and Policy (CHEP) is mandated to assist the Doctors of BC Board on key developments of health care policy and support communications with the profession, the public, and the government. Under the guidance of the Board, CHEP works to review key issues that affect the delivery of health care services within BC and seeks consensus within the medical profession to produce policy that addresses the economics, organization, and management of the health care system; ensuring that the voice of the profession is heard at the federal, provincial, and interprovincial levels.

This past year CHEP addressed many issues relating to physician practice and safety, health care delivery, health information technology, and health system design and renewal.

In April 2016, CHEP published the policy statement "Preventing Violence in Healthcare," which recognizes the importance of a safe workplace for all health care providers, including physicians. Violence within the workplace has been a significant issue, and the policy provides recommendations for stakeholders to ensure that meaningful physician input and involvement in developing, implementing, and assessing initiatives is present. The statement suggests supporting improved training and education on violence prevention tailored for physicians; pursuing opportunities to contribute physician perspectives in provincial violence prevention planning and policy making; and working with health authorities to enhance physician involvement in health and safety planning for the development of safety standards in health care facilities.

At the beginning of 2017, CHEP published a suite of commitments and recommendations from Doctors of BC to all health care stakeholders to improve BC's health care system as a whole. The policy paper, "Improving BC's Health System Performance," is a framework that builds on what physicians have learned in their own local and provincial quality improvement efforts. It also further develops the current foundation of collaborative work underway across the province. In addition, the paper draws on an understanding of some well-recognized international health systems and organizations that have achieved sustainable improvement, and highlights their strategies to support improving the quality of health care provided in BC. The strategies include engagement, collaboration, measurement, evidence-based improvement efforts, and provincial training and leadership. This work aims to highlight the important contributions of physicians in quality improvement and recommend how to better support clinical leadership to improve our health care system.

CHEP also produced a policy statement, "Professional Autonomy," that speaks to the variety of issues facing physicians at both the individual and the collective level, and the importance of physicians being able to advocate freely and professionally on behalf of good patient care. Thus, it relates to and expands upon concepts of professional relationships as discussed in our 2013 policy paper, "Medical Professionalism." Through this developed policy, CHEP and the Doctors of BC support the right of individual physician advocacy to achieve the shared aim of delivering high-quality patient care and of encouraging partners in health care delivery to recognize, support, and protect three fundamental principles of our professional status: self-regulation and accountability, personal responsibility for decision making in medicine, and responsibilities for engagement and advocacy on behalf of our patients.

Additional policy work underway at the time of writing includes developing a statement to address the need for a collaborative chronic pain strategy in BC. The aim is to arrive at better approaches for practitioners who attend those patients who present with chronic pain conditions by providing recommendations to support multidisciplinary, community-based assessment and treatment options.

CHEP assists the Board to ensure that Doctors of BC continues to be an authoritative voice on health policy issues and management of health resources. To that end, it constantly scans the environment to stay on top of emerging issues and opportunities.

I would like to thank all CHEP members for their commitment and contributions over the past year, and staff colleagues for their prompt and professional advice and assistance that has made our tasks much lighter. It has been my pleasure to be the chair for the past year.

—Donald Milliken, MD  
Chair

## **COUNCIL ON PUBLIC AFFAIRS AND COMMUNICATIONS**

DRS C. WEBB, CHAIR AND PAST PRESIDENT; V. BRCIC; T. GERSCHMAN; T. LARSEN SOLES, PRESIDENT-ELECT; A. RUDDIMAN, PRESIDENT; D. WILTON. STAFF: MS M. ADAIR, MS J. CAVERS, MR A. SECKEL, MS S. SHORE.

In cooperation with the Communications and Public Affairs Department, the Council on Public Affairs and Communications (CPAC) continues its mandate to identify issues that may have a political impact on the association, and to provide support to the president in his or her role as the official spokesperson. CPAC also collaborates with CHEP and COHP to coordinate strategies and provide feedback from a public and political perspective.

CPAC has developed an alternative spokesperson protocol to be used when the Doctors of BC official spokesperson, the president, is unavailable to speak with media for any reason. This protocol will be shared with the new Board and Representative Assembly at their inaugural meetings in September.

In its engagement with government during an election year, CPAC remains nonpartisan and continues to build relationships with the most influential MLAs regardless of party.

I am proud of the work of this committee and have been honoured to serve as chair this past year. It was a pleasure to work with a great team of committee members and Doctors of BC staff, and I thank everyone for their dedication and hard work.

—Charles Webb, MD  
Chair

## **DOCTORS OF BC-WORKSAFEBC LIAISON COMMITTEE**

DRS C. JACKSON, P. ROTHFELS, CO-CHAIRS; MR G. DALMER; DRS C. DUNN, C. MARTIN, E. WEISS. WORKSAFEBC STAFF: MS C. AKIZUKI. DOCTORS OF BC STAFF: MS F. FERDOWSI, MR R. HULYK.

With the WorkSafeBC agreements ratified in July 2015, this committee increased its existing role to include mid-term addition or modification of WorkSafeBC fee items. This change in scope gives WorkSafeBC and Doctors of BC greater flexibility to review issues and consult with individual physicians and appropriate section groups, and make the necessary changes to fee items. It also allows for greater collaboration between the committee and the Projects and Innovation Committee (PIC), and it will provide an opportunity to address challenges on certain fees without the need to wait for the next round of negotiations.

A focus for the committee this year was resolving a number of issues emerging from the agreement related to expedited surgery and trauma fees and services. Following several discussions with WorkSafeBC and with the support of Doctors of BC staff and negotiators, a resolution was reached. Both physicians and WorkSafeBC are looking to implement these solutions, recognizing some challenges still exist.

Other issues discussed during 2016 include preventing violence in the workplace, general billing concerns and creating billing tips, and access to education regarding WorkSafeBC coverage.

I would like to thank the members of the committee for their assistance. Any Doctors of BC members with concerns about their interactions with WorkSafeBC are invited to contact this committee by emailing Farnaz Ferdowsi at [fferdowsi@doctorsofbc.ca](mailto:fferdowsi@doctorsofbc.ca).

—Colin Jackson, MD  
Co-Chair

## **DOCTORS OF BC-WORKSAFEBC PROJECTS AND INNOVATION COMMITTEE**

DRS T. GOETZ, C. MARTIN, CO-CHAIRS; I. CONNELL, E. WEISS. WORKSAFEBC: MR G. DALMER, DR M. DELGARNO, MR P. WHALEN. WORKSAFEBC STAFF: MS C. AKIZUKI. DOCTORS OF BC STAFF: MS F. FERDOWSI, MR R. HULYK.

In accordance with the 2015 Doctors of BC-WorkSafeBC agreement, the Projects and Innovations Committee (PIC) was created to identify areas for improving both disability management of injured workers, and quality and efficiency of care for injured workers. PIC develops and implements pilot projects for new care models or refinements of existing models from the external physician community and WorkSafeBC.

PIC provides opportunities for physicians to improve patient care and modernize the delivery of care, with the



potential development of new fee codes. It also provides opportunities for WorkSafeBC to develop and evolve care models that improve the clinical and functional outcomes of injured workers and return-to-work rates. Input from Doctors of BC at the committee has been difficult, so WorkSafeBC will be asked to identify areas of care inadequacy and work on generating solutions.

In 2016 PIC continued to work on a Radiology/Epidemiology Statement project and the Moran Restrictions/Limitations Form project. The former has pilot projects started in Kelowna, focusing on improving physician and patient understanding of the significance of report findings while reducing additional costs. The latter focuses on testing a new form that helps inform case managers and medical advisors on restrictions, limitations, rehabilitation, planning, and reintegration into the workforce. PIC has also received and reviewed several proposals that will be underway in mid-2017. New projects include the Form F8/F11 uptake, occupational dermatology, and educational apps.

PIC continues to accept new project proposals on improving outcomes and efficiency of care for WorkSafeBC patients, and improving communications or lowering administrative barriers between doctors and WorkSafeBC. For more information please contact Farnaz Ferdowsi: fferdowsi@doctorsofbc.ca or 604 638-6059.

—Thomas Goetz, MD  
Co-Chair

## GENERAL PRACTICE SERVICES COMMITTEE

DR S. ROSS, MS W. HANSSON/MR D. HUGHES,  
CO-CHAIRS. DOCTORS OF BC: MR M. ARMITAGE, DR  
J. HAMILTON, DR G. MAZOWITA, MS S. OOMS, MS N.  
SOUTH. HEALTH AUTHORITY REPRESENTATIVES: MS D.  
ARSENEAULT/MR J. GIESBRECHT (IHA), DR B. BURNS/  
DR R. CROWE (VIHA), MS M. HAWKINS (FHA), MS P.  
MULROY (NHA), MS C. PARK (VCHA), DR N. SKURIDINA  
(FNHA). DOCTORS OF BC STAFF: MS D. BALES, MS G.  
BEKIOU, DR J. CLARKE, DR C. CLELLAND, MS A. GODIN,  
MS C. GRAFTON, DR B. HEFFORD, MS L. KIRBY,  
MS A. LETTO, MS S. PAPADIONISSIOU, MS C. RIMMER.  
MINISTRY OF HEALTH STAFF: MS A. MICCO,  
MS J. RICHARDS.

Under the Physician Master Agreement, the GPSC has a specific mandate to serve as a vehicle for representatives of government, the Doctors of BC, and the Society of General Practitioners to work together on matters affecting the provision of services by general practitioners in British Columbia.

Since its inception in 2002 when morale was low and professional satisfaction was poor, the GPSC has worked with the other joint collaborative committees (JCCs) to improve patient care and doctor job satisfaction, while influencing health system change. The GPSC has come a long way since the professional quality improvement days when the message was pay us, train us, value us, and support us.

We took that message to heart with the development of incentive fees and various programs and initiatives that improved the way doctors deliver care to patients. In 2015, we went even further and conducted a successful visioning exercise where we asked GPs how they saw the future of primary care and their role in that future. We took their input along with the strategic plans of the Doctors of BC and the Ministry of Health, the work of the other JCCs, the priorities of the health authorities, and the lessons learned from A GP for Me, and with the Ministry of Health were able to develop a common vision of the future of primary care. That vision sees an integrated system of care with the Patient Medical Home as the foundation.

The Patient Medical Home BC has been adapted from the College of Family Physicians' model. It sees the patient at the centre with the service attributes of comprehensiveness, coordination, commitment, contact, and continuity wrapped around the patient. This is very similar to the way we have always practised; the difference is the opportunity for team-based care, networking of physicians and other allied health personnel, and using data to inform practice and quality improvement.

We are supporting this model through our Practice Support Program (PSP). PSP supports physicians to look at their panels, assess where they are with the 12 attributes of a Patient Medical Home, and understand quality improvement.

We continue to work with the Divisions of Family Practice and health authorities to support communities as physicians and other allied health professionals work in teams and form networks. Divisions are expanding on what they learned from A GP for Me and other initiatives to engage physicians and develop their local plans.

In this integrated system, physicians and physician networks will be better connected to community services, including specialized, acute, and residential care and diagnostics. It is important to engage our specialist colleagues early in the development of this integrated model of care to ensure that all voices are heard. These connections support the Ministry of Health's four priority areas of complex medical patients and frail seniors,

mental health, cancer care, and surgical care. All of the work of the GPSC is focused on developing the Patient Medical Home and integrated system of care.

Other areas of focus include the following:

- Through our Recruitment and Retention Committee, we have developed a state-of-the-art website, [www.Practiceinbc.ca](http://www.Practiceinbc.ca), which shares all recruitment and retention information in one centralized spot.
- Our Maternity Care for BC program continues to provide support for physicians who want to improve their skills in providing maternity care.
- The SFU Leadership and Management Development Program is supporting its seventh cohort with uniformly positive response from attendees.
- The GPSC provided funding to the Shared Care Committee's Child and Youth Mental Health and Substance Use Collaborative, which celebrated its Legacy Congress in March 2017. GPSC applauds its decision to support this collaborative; our children and youth will benefit from better access and treatment for mental health.
- Pathways, the referral tool, continues to roll out around the province, with continued praise for its usefulness.

The development of evaluation tools has gone hand in hand with all of this, so that we have data to show the good work that we know is happening.

It has been a pleasure to co-chair the GPSC with Wendy Hansson and Doug Hughes from the Ministry of Health.

—Shelley Ross, MD  
Co-Chair

## GOVERNANCE COMMITTEE

DRS B. CAVERS, CHAIR; M. CORBETT, J. DRESSELHUIS, M. GOLBEY, A. GOW, A. RUDDIMAN, C. WEBB. STAFF: MS C. CORDELL, MS C. DONNELLY, MR A. SECKEL.

The Governance Committee is a Doctors of BC statutory committee. Its mandate includes advising and making recommendations to the Board on governance issues such as best practices, governance structures, policies, and standards. It also oversees the evaluation of the Board and committee members, reviews committee terms of reference, advises the Board on issues related to elections, and reviews requests for Doctors of BC representation on committees of other organizations.

This year the majority of the Governance Committee's attention was focused on the ongoing review of the Doctors of BC's governance structure and the development of a new structure for recommendation to

the Board. Since last year's report, the committee undertook a second membership consultation on a new model consisting of a small board and a medium-sized representative assembly. The committee reviewed the membership feedback and spent the fall engaging with interested parties and finalizing a proposal for a 9-member Board and a 104-member representative assembly. The board approved sending this proposal to a referendum of the members, which passed with 92.5% of the votes cast in favour.

I would like to thank the sections, societies, Board, and the general membership for their input and guidance. I would like to particularly thank the members of the Governance Committee and Dr Jim Busser for their interest, engagement, and support of this whole process, and also Ms Cathy Cordell for her many hours of work and her patience.

The Governance Committee is, at the time of writing, thoroughly embroiled in developing transition plans for moving to the new model.

This will be my last report as chair as my term of office ends after the first meeting of the new representative assembly on 14 September 2017. It has been an honor and a pleasure serving you.

—Bill Cavers, MD  
Chair

## GUIDELINES AND PROTOCOLS ADVISORY COMMITTEE

DRS J GRAY, CO-CHAIR; D. CHANDLER, M. DAWES, A. HARRIS, B. HOBSON, D. HOLMES, A. LEE, D. NGUI, T. PARNELL, J. PAWLOVICH, H. RANCHOD, J. STEWART, A. TEJANI, D. WILSON. MINISTRY OF HEALTH: MS W. HANSSON, CO-CHAIR (UNTIL OCTOBER 2016); MS S. OOMS, CO-CHAIR; DR S. LEE, D. MCTAGGART, MR W. PANG. STAFF: DR S. BUGIS, MS T. DEVENISH, DR A. GARG, DR B. HEFFORD.

The Guidelines and Protocols Advisory Committee (GPAC) is an advisory committee to the Medical Services Commission and a joint collaboration between the Doctors of BC and the Ministry of Health. GPAC is mandated to provide recommendations to BC practitioners on delivering high-quality, appropriate care to patients in common medical situations, with particular focus on circumstances in BC. These recommendations are published as easy-to-read clinical practice guidelines under our brand name, BC Guidelines, on our website, [www.BCGuidelines.ca](http://www.BCGuidelines.ca).

### **Guidelines and Protocols Published in 2016-17 Existing guidelines revised:**

- Chronic Obstructive Pulmonary Disease (COPD): Diagnosis and Management (revision of 2011 version)
- Palliative Care for the Patient with Incurable Cancer or Advanced Disease—Part 1: Approach to Care (update of 2010 version)
- Palliative Care for the Patient with Incurable Cancer or Advanced Disease—Part 2: Pain and Symptom Management (update of 2011 version)
- Palliative Care for the Patient with Incurable Cancer or Advanced Disease—Part 3: Grief and Bereavement (update of 2011 version)

### **New guidelines developed:**

- Special Endocrine Testing

### **New partner guidelines:**

- A Guideline for the Clinical Management of Opioid Use Disorder (2017)—Developed by the BC Centre on Substance Use and the Ministry of Health.
- Hypothermia Accidental Hypothermia: Evaluation, Triage & Management (2016)—Developed by Dr Doug Brown (emergency physician, Royal Columbian Hospital) and the BC Accidental Hypothermia Working Group.
- Upper Gastrointestinal Cancer (Suspected) Part 1: Esophagus and Stomach (2016)—Developed by the Family Practice Oncology Network.
- Upper Gastrointestinal Cancer (Suspected) Part 2: Pancreatic Cancer, Neuroendocrine Tumours of the Pancreas and Duodenum, and Cancer of the Extrahepatic Biliary Tract (2016)—Developed by Family Practice Oncology Network.

### **Guidelines and Protocols in Development in 2016-17**

#### **Existing guidelines being revised:**

- Frailty in Older Adults: Early Diagnosis and Management
- Thyroid Function Tests
- Vitamin D
- Testosterone Testing

#### **New guidelines being developed:**

- Ultrasound Prioritization Guideline (in collaboration with the Medical Imaging Advisory Committee)
- Prostate Specific Antigen Testing
- Opioid Use Disorder (summary version)

#### **Other GPAC updates include the following:**

- GPAC is seen as a leader in guideline development in

BC and is increasingly approached by stakeholders seeking to collaborate. New collaborative relationships began with the Medical Imaging Advisory Committee, Trauma Services BC, the BC Centre on Substance Use, and BC's Agency for Pathology and Laboratory Medicine, among others.

- UBC Family Medicine resident Dr Matthew Toom developed a BC Guidelines mobile app, which was released in March 2017.
- GPAC attended the BC College of Family Practice Fall Medicine Conference and St. Paul's CME conference to reach out to our target audience of BC practitioners, promote our guidelines, and increase brand awareness. Our booths continue to be very popular and we receive positive feedback on our guidelines, requests for updated USBs, and enquiries about the mobile app. The new guideline Special Endocrine Testing was the most popular at each conference.

—Jim Gray, MD  
Co-Chair

### **INSURANCE COMMITTEE**

DRS M.A. MCCANN, CHAIR; M. CURRY, A. FRAYNE, R. JONES, L. VOGT. STAFF: MS S. LUCIUK, MS A.M. O'DRISCOLL, MS K. PELLETIER.

The Insurance Committee met throughout the year to study, review, and enhance the various insurance plans offered to our members. The committee monitored the plans to ensure they are financially sound and conducted negotiations with the various supplying insurance carriers and brokers. Additionally, the committee advocated on behalf of individual members who contacted the committee for insurance assistance.

In 2016 the committee worked on implementing various enhancements for physicians, such as the addition of higher disability insurance coverage and providing coverage for medical students. In conjunction with approval from the Board of Directors, the committee arranged to implement no-cost student life insurance for medical students to cover them throughout medical school. The premium for this student coverage is being subsidized by Doctors of BC. Subsequently, the committee also put forward a recommendation for no-cost student disability insurance, and that awaits approval.

The committee completed a due diligence examination of the legal expense insurance program implemented in 2015 for all members, and determined it was too costly considering its relatively low use. The committee

recommended discontinuing the program effective 31 December 2016, which was accepted by the Board of Directors. The committee will research potential alternatives to the legal expense insurance plan for consideration over the coming year.

**Summary of Plans**

- Physicians Disability Insurance (PDI—premiums sponsored by the Medical Services Commission)
- Disability Income Insurance (supplemental to the PDI plan)
- Life Insurance (term life plan shared with the AMA and SMA)
- Professional Expense Insurance
- Critical Illness Insurance
- Accidental Death and Dismemberment Insurance (AD&D)
- Health Benefits Trust Fund (health and dental plans for physicians, families, and medical staff)
- Office Contents and Liability, Homeowners, Optional Automobile, Directors and Officers, Personal Liability Umbrella Policy (brokered through Mardon Group Insurance)
- MEDOC Travel Insurance (brokered through Johnson Inc.)
- Specialty Insurance (individual coverage offered by Doctors of BC Advisors through various carriers to meet unique member needs)

**Premiums Received in 2016**

	<b>No. Insured</b>	<b>\$ Premium</b>
PDI	7906	16 000 000
Disability Income	3197	3 079 862
Life	5077	4 265 183
Professional Expense	1023	850 597
AD&D	1355	260 268
Health Benefits Trust Fund	3678	9 079 452
Critical Illness	1910	1 199 663
Office Contents/Homeowners		6 817 704
MEDOC Travel Plan		793 944
Specialty Individual Coverage		798 452
<b>Total</b>		<b>43 145 125</b>

**Insurance Advisory Services**

Doctors of BC, together with other provincial medical associations, is part of an insurance alliance with MD Financial Services. As an outcome of this alliance, the participating provincial associations, including Doctors of BC, have taken responsibility for fulfilling all lifestyle insurance products (e.g., term life, disability, critical illness, office overhead), including individual products.

To facilitate this activity, BCMA Agencies Ltd., a wholly-owned subsidiary of Doctors of BC, offers members access to the complimentary insurance review and planning services of licensed, noncommissioned insurance advisors. The goal of the advisors is to provide members with objective advice regarding their Doctors of BC and other third-party insurance programs. This service has been extremely well received by members.

—Michael A. McCann, MD  
Chair

**JOINT BENEFITS COMMITTEE**

DRS M.A. MCCANN, CO-CHAIR; M. CORBETT, S. RABKIN; MR J. COOK. MINISTRY OF HEALTH: MR R. MURRAY, CO-CHAIR; MS E. ACKERMAN. STAFF: MS S. LUCIUK, MS J. PHILLIPS, MS S. VERGIS.

The Benefits Committee is responsible for general oversight and administration of the benefit plans as outlined in the Benefits Administration Agreement. The primary function of the committee is to oversee and allocate funds between the negotiated benefit programs: the Physicians Disability Insurance (PDI), the Contributory Professional Retirement Savings Plan (CPRSP), the Continuing Medical Education Fund (CME), the Parental Leave Program (PLP), and the Canadian Medical Protective Association Dues (CMPA) Rebate Fund. While the Physician Health Program is the other benefit program outlined in the Benefits Subsidiary Agreement, its budget does not fall under the jurisdiction of this committee.

The 2014 Benefits Subsidiary Agreement outlines specific funding to be allocated to the benefit programs until 2018-19. The committee has been directed to use surplus funds in any of the benefit programs other than CMPA Rebate program to maintain the benefits at their 31 March 2014 levels.

For 2016-17 the CPRSP maintained its maximum basic benefit and length of service benefit of \$4020 and \$3430 respectively, with a minimum income threshold for the length of service benefit of \$60 000 gross. This minimum income is reviewed by the Benefits Committee biennially.

The maximum CME benefit for 2016 was \$1800. The entitlement amount will be paid automatically to physicians, provided they have been revalidated by the College of Physicians and Surgeons to ensure that they have completed their educational requirements for licensing.

The PLP maintained its maximum benefit of \$1000 per week for 17 weeks. The program allows physicians who

work up to 15 hours per week to claim a half benefit and/or to claim their 17 weeks of benefit over a 1-year period, making the benefit more accessible.

CMPA dues have again increased in 2016. Though the funding under the current Benefits Subsidiary Agreement contained substantial new CMPA Rebate funding, it has not been possible to fully reimburse CMPA dues, and this will likely continue to be the case for the term of this agreement. Consequently, the Benefits Committee needed to develop a new allocation methodology for the CMPA rebate based on two principles approved by the Doctors of BC Board of Directors: eliminate the current cross-group subsidization of the CMPA rates by allocating the rebate based on 2016 rates, and establish cross-group subsidies for only those high-risk work codes where CMPA increases will result in recruitment and retention issues.

The PDI benefit has been maintained at the \$6100 per month maximum. The PDI benefit provides a 1-year maximum benefit payment for disabilities occurring between age 65 and 70 as well as a partial residual benefit. The increasing number of physicians, other demographic changes, and increased claims experience has affected the performance of the PDI plan over the last couple of years, and so it was necessary to allocate additional funding to the program to maintain the benefit level.

The table below outlines the benefit levels over recent years.

<b>Program</b>	<b>Year</b>	<b>Benefit Maximum</b>	<b>Program Funding</b> <i>(millions)</i>
PLP	2014-15	\$1000/wk	\$5.30
	2015-16	\$1000/wk	\$4.30
	2016-17	\$1000/wk	\$4.80
CME	2014-15	\$2300	\$22.54
	2015-16	\$1800	\$18.82
	2016-17	\$1800	\$18.50
PDI	2014-15	\$6100/mo	\$14.00
	2015-16	\$6100/mo	\$16.33
	2016-17	\$6100/mo	\$19.50
CPRSP	2014-15	\$7600	\$53.57
	2015-16	\$7450	\$54.17
	2016-17	\$7450	\$53.70
CMPA	2014-15	n/a	\$25.00
	2015-16	n/a	\$48.20
	2016-17	n/a	\$45.90

—Michael A. McCann, MD  
Co-Chair

## JOINT STANDING COMMITTEE ON RURAL ISSUES

DR A. RUDDIMAN, CO-CHAIR, DOCTORS OF BC, (OLIVER); MR R. FRECHETTE, CO-CHAIR (MINISTRY OF HEALTH). SECRETARIAT: MS S. YULE (MINISTRY OF HEALTH). MEMBERS: DRS N. HUMBER (LILLOOET), E. MARQUIS (PRINCE GEORGE), S. MOOLA (NELSON), J. SOLES (CLEARWATER). ALTERNATES: DRS J. CARD (MACKENZIE), S. MCLAREN (NELSON). MINISTRY OF HEALTH: MR J. ENGLISH, MS S. WALKER. MINISTRY ALTERNATE: MR D. BLACKIE. HEALTH AUTHORITY REPRESENTATIVES: DR J. BESELT (VIHA), DR D.R. BROWN (VCH), DR R. BURNS (VIHA ALTERNATE), DR S. MACDONALD (IHA), MS S. MCDONALD (FNHA), DR B. TEMPLE (NHA). GUESTS: MR D. BLACKIE (MINISTRY OF HEALTH), DR R. MARKHAM (RCCBC), MS C. MARTIN (MINISTRY OF HEALTH), DR J. PAWLOVICH (REAP), MS M. TYE (MINISTRY OF HEALTH). STAFF: MR J. AIKMAN, MS M. CORMIER, MS A. MACDONALD, MS T. WEBB.

The Joint Standing Committee on Rural Issues (JSC) is a joint collaborative committee (JCC) of the Doctors of BC and the Ministry of Health that manages the Rural Subsidiary Agreement. It is the formative JCC and has been in place since 2000. The goal of the JSC is to enhance the availability and stability of physician services in rural and remote areas of BC by addressing some of the unique, demanding, and difficult circumstances physicians face in providing those services.

The JSC continues to manage its broad suite of the available funding and resources for BC's rural programs. Examples include the Rural Retention Program (RRP), the locum programs, the Northern Isolation Assistance and Travel Program (NITAOP), and the Rural Continuing Medical Education (RCME) Program, among others.

In alignment with its 2016-17 work plan, the JSC has continued to improve many of the rural programs, including the transition of the locum programs to Health Match BC with the goal being to provide a full-service program to both host and locum physicians. It is expected that the Locums for Rural BC program will be fully transitioned by early 2017. As well, the JSC conducted a first-phase evaluation of the NITAOP program and established a subcommittee to make recommendations to improve the RCME program. It is expected that changes resulting from these evaluations will be implemented in 2017.

A significant milestone for the JSC has been identifying, selecting, and appointing UBC Rural Chair with a \$5 million legacy endowment to enhance the delivery of rural health care services throughout the

province. In addition to the endowment, operational funding of \$350 000 per year will be provided over the next 5 years to support the development of a distributed provincial network of rural health researchers and the establishment of a Dean's Advisory Committee on Rural and Remote Health. Further, in keeping with its mandate and goals to support rural education, the JSC has extended its funding of \$250 000 annually to the Rural Pre-Medicine Program at Selkirk College in Nelson until 2020.

Other highlights of 2016-17 include developing a plan for rural surgical and obstetrical networks and working with the BCEHS and government to improve rural patient transport. The JSC was also able to implement a virtual care initiative, which allocates \$500 000 to each health authority (total \$2.5 million) to work with a community or region to make health services available through virtual care to underserved rural areas. A principle of the virtual care initiative is that it must support and/or be an extension of primary care services.

As part of achieving its goal to address chronic physician vacancies, the JSC continues to support the Sustainable Communities Initiative (\$2.5 million) where health authorities identified communities that would benefit from developing sustainable health service delivery systems via funding support. Burns Lake (NHA), Mount Waddington (VIHA), South Okanagan-Similkameen (IHA), Ahousat (FNHA), and Bella Coola and Bella Bella (VCH) each receive support through this initiative to a maximum of \$500 000.

To recognize the ongoing pressures and address chronic rural physician vacancies, the JSC continues to provide the bulk of the funding to the Practice Readiness Assessment Program (PRA-BC), which assesses internationally trained GP/FP physicians seeking BC licensure. The program intends to increase the supply of practice-ready family physicians to BC, and the JSC has agreed to support it until March 2019 for a total of \$7.6 million. The 3-year return-of-service commitment required by this program has resulted in 33 family physicians and 5 RCPSC specialists being placed in underserved rural communities. It is too soon to know whether this program will successfully retain physicians in rural communities, but initial feedback has been positive.

The JSC continues to provide funding for, and work closely with, the Rural Education Action Plan (REAP), the RCCbc, and the Rural and Remote Division of Family Practice. This includes providing support to annual events such as the Rural Locum Forum and the Rural Health Conference, and committing funding over the next 3 years for a \$1000 stipend to any rural physician who

attends the national annual SRPC Rural and Remote Conference. REAP provided 30 Rural Interest Awards of \$5000 each to medical students who showed an interest in rural medicine. Additionally, REAP continues to provide funding to third- and fourth-year medical students and residents who participate in rural rotations in RSA communities. During 2016-17, REAP facilitated skill enhancement training for rural physicians and locums through its Advanced Skills and Training Program and the new Rural Skills Upgrade Program in areas of need, including oncology, anesthesia, obstetrics, and emergency medicine. The Closer to Home CME program has advanced and now provides funding for groups of rural physicians to bring courses to their communities, and the new Rural eMentoring BC (ReMBC) program has now been launched in School District 20 (Trail).

The RCCbc hosted the annual Rural Emergency Continuum of Care Conference in Prince George in May 2016, with more than 200 speakers, students, and residents attending. RCCbc engaged broadly with physicians through its recognized partner networks on issues as diverse as physician resiliency and health system innovation.

The Care Course was delivered 13 times in 2016-17. RCPD launched the Clinical Coaching for Excellence program for GPAs and is developing it for GPs with enhanced surgical skills (including GPAs and their nursing colleagues). The New to Practice Mentorship Program was expanded and launched their second and third cohorts of mentor and mentees. RCCbc, in collaboration with the Rural and Remote Division of Family Practice, hosted the third Rural Locum Forum in Nanaimo.

For the past decade the JSC has meaningfully hosted and conducted one of its yearly meetings at an offsite venue in a rural BC community in order to reach out to the local physicians, attend their health authority acute care facility where one exists, and experience the challenges faced in that community. In September 2016 the meeting was held and hosted on Quadra Island. The 2017 rural meeting is scheduled to be hosted in Golden, in the northeast Kootenays.

It is with tremendous pride that I thank the JSC committee members for their skillful rural medicine leadership and their enthusiastic commitment, creativity, and patience. These rural physician JSC members as appointed by the Doctors of BC Board have shown tireless dedication in scheduling and attending meetings despite the challenges that arise from traveling from rural and remote parts of our province. They continue to devote considerable time and effort to ensure that all the

rural programs are managed and supported at the highest possible level. Rarely does one get the opportunity in our professional lives to interact with such a competent, thoughtful, collegial, hardworking, and a thoroughly friendly group of people—our JSC members, our RCCbc peers and REAP consultants, and our Doctors of BC staff.

I am, on occasion, at a loss for sufficient words and gratitude to acknowledge the efforts of our Doctors of BC staff. Mr Jim Aikman, Ms Meredith Cormier, Ms Ann Macdonald, and Ms Tania Webb have yet again provided outstanding, consistent, and timely work of a tremendously high quality and calibre in support of the committee and for me in the role of co-chair. We and all of our rural colleagues are most indebted to them!

—Alan W. Ruddiman, MBCh  
Co-Chair

### LAB REFORM COMMITTEE

DRS C. BELLAMY, CHAIR; J. O'CONNELL, C. SHERLOCK.  
STAFF: MS C. CORDELL, MR P. MELIA.

The committee was active with a number of important issues this year.

First, the laboratory medicine clinical and academic pathology workload modeling process was completed in March 2016 with a tabling of recommendations by the Project Management Committee for the addition of 16 new clinical pathologists and 12 new academic pathologist positions for the province. These recommendations were accepted and the hiring process is almost complete. The Lab Reform Committee is now addressing various contractual concerns that have arisen from these allocations. We are also liaising with the ministry to re-engage them in establishing a bipartite framework for ongoing discussion and refinement of workload models in clinical and anatomical pathology.

The committee has had several meetings with Mr John Andruschak, executive lead, and Dr Jim Cupples, VP, Medicine of the new Provincial Lab Agency (BC Agency for Pathology and Laboratory Medicine). The next major milestone for the agency will be recommending service delivery models of clinical and anatomical pathology for BC. The target date for these recommendations is November 2017. We will continue to work with agency staff to ensure that the process is open, transparent, and fair.

Finally, the committee has been involved in a number of pathologist contract issues throughout the province and we are committed to bringing equity to this process.

I would like to thank all the committee members for their tireless commitment, and Dr Ken Berean, president of the BC Association of Laboratory Physicians, who was invited to the meetings to facilitate communication with the membership.

—Chris Bellamy, MD  
Chair

### MEDICAL-LEGAL LIAISON COMMITTEE

MR J. WEBSTER, CHAIR. DOCTORS OF BC: DR S. BUGIS. COLLEGE OF PHYSICIANS AND SURGEONS: DRS A. MCNESTRY, H. OETTER. LAW SOCIETY OF BC: MR C. BRANSON, MS B. BUCHANAN. MR D. MARTIN, MR M. SLATER, MR M. THOMSON. STAFF: MS C. CORDELL.

The mandate of the committee is to mediate and settle disputes between physicians and lawyers on issues of compensation for legal services provided (e.g., medical legal reports). There were no meetings of the committee in 2016, as the chair was able to resolve all complaints referred to the committee informally.

—Jack Webster, QC  
Chair

### MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

DR R. HALPENNY, CHAIR (GOVERNMENT). DOCTORS OF BC: DRS M. CHOW, B. NORTON, W. RIFE. GOVERNMENT: MR. C. KINSLEY, MS S. TAYLOR. PUBLIC: MS. J. CODE, MR. K. WIRKER.

The Medical Services Commission (MSC) is a nine-member statutory body composed of three representatives from government, three members nominated by Doctors of BC, and three public members who are nominated jointly by Doctors of BC and government to represent MSP beneficiaries. Currently one of the public member positions is unfilled.

Appointments to the commission are made by the lieutenant governor in council.

The MSC administers the Medical Services Plan (MSP) in accordance with the Medicare Protection Act and Regulations. The MSC schedules approximately 10 one-day meetings annually in either Victoria or Vancouver, including an annual planning day.

### **Mandate**

The mandate of the MSC is to facilitate reasonable access throughout the province to quality medical care, health care, and diagnostic facility services for BC residents.

### **Responsibilities**

The responsibilities of the MSC are to ensure that all BC residents have reasonable access to medical care and to oversee the provision, verification, and payment of medical services in an effective and cost-efficient manner. The MSC directly oversees the physicians' fee-for-service budget of approximately \$2.6 billion. The MSC also signs off on over \$1 billion of services that are not within the fee-for-service budget, and over which the MSC has less direct responsibility and oversight.

The commission is a cosignatory to the Physician Master Agreement together with the Provincial Government and Doctors of BC.

### **Activities**

The MSC oversees and receives reports from the Reference Committee, the Guidelines and Protocols Advisory Committee, the Advisory Committee on Diagnostic Facilities, the Audit and Inspection Committee, and the Patterns of Practice Committee. The commission functions as an administrative tribunal for beneficiaries and practitioners in such matters as dispute about nonresident and out-of-country MSP coverage, and makes the final decision on any dispute over fee items not resolved by the Tariff Committee.

The MSC monitors the use of all fee-for-service activities in order to manage the available amount. Legal issues occupy a significant portion of the MSC's resources. This includes oversight of audit and billing integrity programs, and extra billing.

### **Publications**

The MSC Annual Report provides an accounting of the business of the committee, its subcommittees, and other delegated bodies. The MSC Financial Statement (Blue Book) contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year. They are both available online. The work of the MSC is supported by the staff of Doctors of BC, the Ministry of Health, and the MSC. Their work is greatly appreciated.

—Bryan Norton, MD  
Doctors of BC representative

### **NEGOTIATIONS COORDINATING GROUP**

DRS D. ATTWELL, CHAIR; P. ASQUITH, S. FEDDER, H. FOX, N. HUMBER, F. KOZAK, T. LARSEN SOLES, G. MACKIE, H. STRECKER, D. WILTON. STAFF: MR J. AIKMAN, MR T. MACPHERSON, MR P. STRASZAK.

The Negotiations Coordinating Group did not meet this year and has nothing to report.

—David Attwell, MD  
Chair

### **NEGOTIATIONS FORUM**

DRS D. MCTAGGART, CHAIR; D. ATTWELL, Y. BAWA, C. BOOTH, I. COURTICE, J. CUNNINGHAM, S. GOODCHILD, B. GREGORY, D. HAUGHTON, A. MEYER, A. RUDDIMAN, K. SCHULTZ, W. SIU, N. WALTON, I. WATERS. STAFF: MR J. AIKMAN, MR T. MACPHERSON, MS D. MAYHEW, MR P. STRASZAK.

The Negotiations Forum typically meets only during active negotiation cycles. It did not meet this year, and therefore has nothing to report.

—Douglas W.R. McTaggart, MD  
Chair

### **NOMINATING COMMITTEE**

DRS C. HUME, CHAIR, Y. BAWA, M. KARPMAN, T. LARSEN SOLES, R. ROUTLEDGE, T. SOROKAN, C. WEBB. STAFF: MS C. DONNELLY.

The Nominating Committee is a statutory committee with the mandate to solicit and review applications for committee appointments for recommendation to the Board. It is the conduit through which members become involved with their professional organization, and it is key to the engagement process that is one of the strategic aims of Doctors of BC. The committee responsible for ensuring that all internal committees are populated with members and that Doctors of BC is represented in the public domain at the local, provincial, and national level. It reports directly to the Board and at the Annual General Meeting to all members.

All committee members are involved in a detailed process of reviewing all applications and respectfully considering the skill sets, qualities, experience of all candidates along with the needs and demographics of the committee being applied for. In the assessment of applicants, the committee aims to safeguard a balance on committees between experience and skill with the



need to encourage the participation of new members or sectors not represented.

The Nominating Committee currently recommends members-at-large to 58 different committees:

- 4 statutory committees.
- 13 standing committees (with 5 subcommittees and 2 ad hoc committees).
- 14 joint committees.
- 7 MSC advisory committees, including the Medical Services Commission.
- 13 external committees.

When needed, there are additional CMA committees and the BC Caucus to the CMA General Council Annual Meetings for which positions must be filled.

The 2016-17 year has been busy and productive for the Nominating Committee. The committee met for 6 full days where it considered the applications from 138 members and appointed 39 members to 32 committees.

With the recent vote to change the governance structure of Doctors of BC to a smaller board and a representative assembly (RA), the Nominating Committee will also change. There will still be seven members, but the composition will change from three to two Board directors (appointed by the Board), with the president and president-elect as ex officio voting members. The members-at-large will change from two to three, and they will be nominated by the general membership and then elected by the RA. This year those elections will take place at the RA meeting on 14 September.

The committee's mandate will also change concerning the "failure to nominate" process. Bylaw Section 13.6 states:

If after the date specified for the return of completed nominating papers there is not at least one nomination for any position to be elected by either the membership or the Representative Assembly, the Nominating Committee shall nominate one eligible member for each such position for which no nomination was received, in accordance with a process determined by the Board.

The Nominating Committee, with the guidance and support of the Governance Committee, will identify a process for soliciting nominations in the event of such a failure to nominate and present this to the Board for its consideration.

—Cheryl Hume, MD  
Chair

## OVERHEAD COMMITTEE

DRS B. FRITZ, CHAIR; M. BAKER, E. CHANG, C. JACKSON, K. WONG.

The Overhead Committee was established in 2015 at the direction of the Doctors of BC Board to undertake a new physician overhead cost study. MNP was selected as the consultant to conduct a study on both a traditional overhead approach and a new model office approach to allow for a comparison.

This year the committee had a number of meetings with the societies and sections to discuss the two approaches, to answer their questions, and to get their feedback. These meetings were useful in refining the approaches and for addressing any concerns raised.

The committee provided a progress report to the Board at their meeting on 23 September 2016. One issue raised by the sections required an increase in the number of physicians to be surveyed for the traditional overhead study. The necessary additional funding to respond to this request was approved. A second item approved by the Board was the approach to determining the overhead if a section has a low response rate (e.g., a formula to reduce the section's overhead ratio calculated in the 2005 overhead study).

The overhead survey will be sent out to a random sample of physicians in March 2017. Data collection for the model office approach is expected to start later in the summer 2017. While the details for the model office study are being finalized, participation will be open to all physicians and is voluntary.

—Bradley Fritz, MD  
Chair

## PATTERNS OF PRACTICE COMMITTEE

DRS L. VERHULST, CHAIR; S. DADACHANJI (MSC), J. EVANS, A. SEAR (COLLEGE OF PHYSICIANS AND SURGEONS), M. SZPAKOWICZ. STAFF: DR S. BUGIS, MS S. FOX, MS J. GRANT, MS T. HAMILTON, MR R. HULYK.

The Patterns of Practice Committee (POPC) welcomed a new chair this year, Dr Lorne Verhulst. Members bade farewell with many thanks to the outgoing chair, Dr Keith White, for his leadership and wisdom over the years. The committee also welcomed two new members, Dr Janet Evans and Dr Nick Szpakowicz, and was pleased to have Dr Andrew Sear continuing as the College of Physicians and Surgeons representative. The process is underway to fill one remaining vacancy.

The POPC is an advisory committee to the Medical Services Commission (MSC), with secretariat support from Doctors of BC. Doctors of BC members are appointed by its Board with final approval by the MSC. The chair is nominated by the committee members and appointed by the MSC. The College appoints its representative.

The POPC's mandate, among other things, is to advise the MSC on appropriate patterns of practice and billing, which overlaps the role of the Guidelines and Protocols Advisory Committee (GPAC). To this end, we are strengthening our ties with the GPAC, and the POPC chair will attend GPAC as a guest. We also look at billing rules that may lead to inadvertent problems with billing, and frequently make representations to the sections and the Tariff Committee when we feel rules need clarifying or amending to protect physicians from liability.

The mandate to educate physicians about their patterns of practice and billing is filled in large part by the production of "mini-profiles." These are a summary of the MSP-produced annual physician profile. We totally depend on the ministry for the production of the annual profile. We will soon have in-house capacity to produce the mini-profiles summary.

Last year, Dr White and Ms Juanita Grant, Manager of Audit and Billing, spoke about the audit pitfalls to several sections, divisions, IMGs, residents, and other interested stakeholders. The attendance ranged from 20 to over 100, and the feedback has been positive. This year there are already 20 speaking events booked as the demand for this service increases.

The committee has a Ministry of Health representative, and senior staff from the Ministry of Health's Billing Integrity Program who attend on occasion as guests and resources. We work closely to ensure fairness in the criteria for selecting cases, appointing auditors and inspectors, and the dispute resolution process (which can take the form of negotiated settlements or hearings).

Through the Audit Working Group (AWG), we also work closely with ministry medical consultant and Billing Integrity Program (BIP) staff between POPC meetings. Among the concerns we are dealing with at the AWG are the timeliness of the profiles production, possible enhancements of the profile system (which has not been upgraded for more than 15 years), type of practice comparison groups definitions, and the timeliness of audits after cases have been selected. The committee is concerned that the BIP resources are spread very thin with the MSC direction to add auditing for alleged extra billing to their mandate without providing additional resources.

The POPC is not in a position to advocate for any individual physician involved in a billing dispute with the ministry. We remain at arm's length from these cases.

I look forward to my term as chair of the committee and continuing the good work started by those who held this position before me.

—Lorne Verhulst, MD  
Chair

### PHYSICIAN HEALTH PROGRAM STEERING COMMITTEE

DR C. MAHESWARAN, CO-CHAIR (DOCTORS OF BC),  
MR D. BLACKIE, CO-CHAIR (MINISTRY OF HEALTH).  
DOCTORS OF BC: DRS Y. BAWA, A. KRISHNAMOORTHY.  
MINISTRY OF HEALTH: DRS S. LAWRIE, D. WILLIAMS.  
STAFF: DR A. CLARKE.

The Physician Health Program (PHP) of BC helps physicians and their families by fostering an environment of health and wellness through prompt personalized assistance with a variety of issues, including physical health, mental health, addictions, and difficult relationships, and by advocating for the individual and collective health of physicians. The PHP Steering Committee is tasked with producing a multiyear strategic plan for the program that aligns with the priorities of the funders. It must also approve annually a work plan and budget for the upcoming year, and a report of the previous year's activities, along with policies that serve as decision-making guides for staff in the day-to-day operation of the program.

On 31 March 2016 involvement with the College of Physicians and Surgeons of BC in the funding and governance of the PHP ended. On 1 April, a new committee of six members assumed responsibility. To ensure continuity during the transition to the new structure, the funders each agreed to nominate two of the four remaining members of the previous committee to initial terms on the new six-member committee. Each funder nominated one additional member and selected a co-chair. The new committee had its first meeting on 20 June, and met again on 22 August, 26 September, and 28 November. During these four meetings the new committee approved a work plan and budget for 2017, a report of activities for 2015, and a revised strategic plan for 2017–19. A project to redesign the program's website was also approved, and the new site was launched in the first quarter of 2017.

—C. Maheswaran, MD  
Co-Chair

**PROVINCIAL MOCAP REVIEW COMMITTEE**

MR E. HARRIS, CHAIR; DRS S. BUGIS, S. EBERT, R. MOORE.

The Provincial MOCAP (Medical On-Call Availability Program) Review Committee has a mandate to implement the recommendations of the MOCAP Redesign Panel of May 2013 as well as ongoing responsibilities that include reviewing collected data, ensuring consistent application of MOCAP principles, and having a role in resolving disputes. In February 2016 MOCAP call groups were able to collect data about their on-call activities. A second opportunity was provided in September 2016 for certain groups that had particular challenges with the first collection. The data have been extensively reviewed and analyzed for validity and completeness. A tool is under development using this data in a way that will help the health authority make decisions about MOCAP groups and also provide a mechanism for addressing concerns from existing or possible new groups. This tool will be used in conjunction with the health authorities' other criteria for allocating MOCAP that include, among other factors, patient need and special programs.

—S.P. Bugis, MD  
Doctors of BC representative

**REFERENCE COMMITTEE**

MEMBERSHIP: CONFIDENTIAL

The Reference Committee acts in an advisory capacity to the Medical Services Commission. It reviews disagreements between MSP and physicians about specific services rendered under the MSC payment schedule and makes recommendations to resolve these disputes.

The Reference Committee last met in June 2016. During that meeting, the committee reviewed 18 new cases. The committee is pleased to welcome a new plastic surgery representative at our May 2017 meeting.

—Chair

**REQUISITION COMMITTEE**

DR C. CLELLAND, CO-CHAIR (DOCTORS OF BC); MS J. PHILLEY, CO-CHAIR (MINISTRY OF HEALTH). DOCTORS OF BC: DRS T. MAUNG, R. WELSH. MINISTRY OF HEALTH: MR W. TOURNQUIST. MINISTRY OF HEALTH STAFF: MR V. YAN. DOCTORS OF BC STAFF: DR S. BUGIS, MS F. FERDOWSI.

The Requisition Committee has been actively meeting over the past year through one in-person meeting in September and five teleconference meetings. In September 2016 the committee reviewed the strategic direction for the coming year with the knowledge that, due to changes in the Laboratory Services Act effective 1 October 2016, the responsibility for all laboratory requisitions would move under the direct jurisdiction of the Minister of Health. The mandate of the Requisition Committee in the future will be to standardize nonlaboratory outpatient diagnostic requisitions and support the evolution of the provincial health care system, including transition to an electronically enabled system for ordering outpatient diagnostic services.

After approval by the Medical Services Commission (MSC) of the Requisition Committee Revitalization Project Strategic Plan, the committee finalized a revised terms of reference (TOR) with agreement in principal on funding support. After review and approval by the Doctors of BC, the revised TOR is expected to go to the MSC later in spring 2017 for final approval. The committee has finalized a consolidated policy document that will be sent for stakeholder review prior to being submitted for approval by the Doctors of BC Board and MSC.

To improve efficiency of workflow, the committee has formalized its operational procedures and implemented tools to monitor the progress of developing and revising standard outpatient requisitions. It has also formalized a standard form to capture stakeholder feedback for new and revised requisition forms.

The committee continues to work closely with its stakeholders groups, including the Ministry of Health and Guidelines and Protocols Committee (GPAC). It has worked to strengthen and expand its engagements with existing and new stakeholders and groups such as the BC Radiology Association, Medical Imaging Advisory Committee, and Doctors of BC Physicians Technology Office.

I would like to thank the committee members for their hard work, insight, and diligence during the past year. I would also like to give a special thank you to both the Ministry of Health and Doctors of BC staff whose hard work makes our committee's efforts effective.

—Catherine Clelland, MD  
Co-Chair

## REVIEW COMMITTEE

MS J. KORBIN, CHAIR. THE MEMBERSHIP IS APPOINTED ONCE A SECTION INITIATES AN APPEAL.

The Review Committee has not met over the past year and has nothing new to report.

—Judi Korbin  
Chair

## RURAL ISSUES COMMITTEE

DRS G. AVERY, CHAIR; J. CARD (MACKENZIE), N. HUMBER (LILLOOET), C. HUME (TRAIL), E. MARQUIS (PRINCE GEORGE), T. LARSEN SOLES (GOLDEN), S. SOHMER. ALTERNATES: DRS M. JOHNSTON (BLIND BAY), S. MOOLA (NELSON). GUESTS: DRS C.S. JOHNSTON (OLIVER), O. KALACI (RESIDENT DOCTORS OF BC REPRESENTATIVE), R. MARKHAM (VALEMOUNT), A. RUDDIMAN (OLIVER). STAFF: MR J. AIKMAN, MS M. CORMIER, MS T. WEBB.

The Rural Issues Committee (RIC) is a standing committee of the Doctors of BC Board that advises on issues affecting rural medicine and the working conditions of physicians practising in rural areas of BC. Through the Doctors of BC Board, the committee is also responsible for providing direction for rural negotiations with government.

The RIC has provided continual support to the Joint Standing Committee on Rural Issues (JSC) on many issues affecting rural health care, including the transition of the locum programs to Health Match BC, improvements to the RCME program, the development of rural surgical obstetrical networks, the continued support for rural education, and the continued evaluation of the rural programs. As well, the RIC dedicated a significant amount of time helping to prioritize areas of funding to inform the JSC 2017-18 work plan.

Additionally, RIC members were involved in developing the Practice Readiness Assessment BC (PRA-BC) program which assesses internationally trained physicians. A 3-year required return of service has resulted in 33 family physicians and 5 RCPSC specialists being placed in underserved rural communities. It is too soon to know whether this program will successfully retain physicians in rural communities, but initial feedback has been positive. The RIC continues to debate various critical issues affecting rural physicians, including the current process of provincial privileging, rural patient transport, how we support our rural colleagues committing their time to mentoring residents,

and virtual medicine.

I would like to thank the members and guests of the RIC for their drive and commitment to highlight and advocate for the remote and critical rural communities of BC, and for working diligently to provide innovative provincial solutions to address key challenges and emerging issues to rural practice. The RIC has been instrumental in providing experiential advice to the JSC in support of the quality of rural care throughout this province and will continue to do so.

As always, our staff support has been invaluable, and my thanks go to Mr Jim Aikman, Ms Meredith Cormier, and Ms Tania Webb.

—Granger Avery, MBBS  
Chair

## SHARED CARE COMMITTEE

DR G. HOAG, MS M. COPES, CO-CHAIRS. MR B. ABBOTT, DRS K. HUGHES, J. LI, G. MAZOWITA, E. MONIWA, S. ROSS, G. WATSON.

The Shared Care Committee is mandated to support collaborative change by engaging family physicians, specialists and other health professionals to work together to identify issues and trial innovative solutions. As the committee's initiatives have matured, successful work has been shared and adapted across communities, and in some cases, across the country. Additionally, the Shared Care Committee provides coordinating support to the shared activities of the joint collaborative committees (JCCs).

Following are updates of initiatives underway in all health regions across the province.

### Child and Youth Mental Health and Substance Use Collaborative

Over the past year the 2600-plus participants of the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative have continued efforts to increase access to mental health and substance use services and supports for BC's children and youth. This includes completing a series of online education modules ([www.learninglinks.ca](http://www.learninglinks.ca)), a blended billing guide for psychiatrists, and a standardized ER protocol.

A learning session and a final congress were held this past year. At the final congress in March, two legacy items were introduced to encourage spread of successful community strategies for CYMHSU as the collaborative starts to wrap up over the next few months. These are a new *Legacy Magazine*, which tells the in-depth story of

the collaborative, and the Collaborative Toolbox, a website developed to provide a one-stop shop for many of the resources created, tried, and tested by the collaborative since 2013. Both these items will help foster sustainability as Shared Care supports the completion and transition of the collaborative's activities until the end of the year.

### **Polypharmacy Risk Reduction Initiative**

The Polypharmacy Risk Reduction Initiative (PPhRR) supports specialist and GP collaboration to reduce risks of multiple medications that impact seniors—especially frail seniors. PPhRR continues to partner with GPSC's Residential Care Initiative to develop physician mentors and clinical resource materials provided as components of the initiative. Currently 25 of 35 Divisions of Family Practice are involved.

In acute care, work is being done with regional pharmacy services and local hospitals to promote the development of discharge medication processes. The expansion of this initiative is being prototyped in four communities that are developing a medical home approach. The initiative has engaged with the FNHA Healthy Medication Use program, and continues to have input into developing a national approach to PPhRR through involvement with similar initiatives in other provinces.

### **Partners in Care/Transitions in Care (PiC/TiC) Program**

There are 67 projects currently underway in the PiC/TiC program. The projects encourage engagement and collaboration with community partners to improve the flow of care between providers (PiC) and care settings (TiC).

This past year, PiC and TiC were amalgamated into one program and an overview was created for those entering into a partnership with the Shared Care Committee.

Next steps include the implementation of a collective evaluation framework that aligns all individual projects with a program framework and reporting structure.

### **Teledermatology**

The Teledermatology Initiative supports the use of digital technology and the Internet to improve access to dermatological consults for family physicians in urban, remote, and isolated communities in BC. With nearly 5000 completed consults, the program continues to work toward developing specialist fee recommendations and finding a provincial web-platform.

### **Simplifying the Journey**

Working in partnership with the BC Patient Safety and Quality Council, the Shared Care Committee took the lead in planning and presenting the JCCs interactive event, Simplifying the Journey, on 1 March in Vancouver. With 380 participants, this full-day session provided the opportunity for family physicians, specialists, allied health providers, policy leaders, patients, and families to learn from each other and align efforts in building a truly integrated system of care. Seven breakout sessions presented a wide range of topics focused on primary care, surgical services and quality care in rural communities. With a highly positive response and many suggestions from this year's attendees, planning is already underway for next year's event.

Finally, as the committee plans for the next few years, it will leverage the lessons learned to spread and sustain models for its work. It will also continue to work with the GPSC, Specialist Services Committee, and the Joint Standing Committee on Rural Issues to integrate activities that improve care for priority patient populations, address health system priorities, and create a more positive experience of care for both patients and providers.

—Gordon Hoag, MD  
Co-Chair

### **SPECIALIST SERVICES COMMITTEE**

DRS S. VIRANI, CO-CHAIR, DOCTORS OF BC; DR R. CARERE, CO-CHAIR, HEALTH AUTHORITIES, (PROVIDENCE). DOCTORS OF BC: DRS A. ATTWELL (ALTERNATE), M. CHOW, G. HOAG (ALTERNATE), A. KARIMUDDIN (ALTERNATE), K. LEE, C. MORRIS. MINISTRY OF HEALTH: MR B. ABBOTT, MS M. COPES, MR R. MURRAY. HEALTH AUTHORITIES: DRS A. DIGNEY, S. GRAY, ALTERNATE (VIHA), R. MCFADYEN (VIHA), D. MUTHAYAN, ALTERNATE (FRASER HEALTH), M. OGBORN, ALTERNATE (IHA), R. PARKER, ALTERNATE (FNHA), B. WAGNER, ALTERNATE (VCHA), MS CANDICE MANAHAN, ALTERNATE (NHA). GUESTS: DR K. HUGHES (SHARED CARE COMMITTEE), MS A. ELVIDGE, DR J. FALCONER (SPECIALISTS OF BC). STAFF: MS M. ADAIR, MR J. AIKMAN, MS L. ANDERSON, MS E. BABCOCK, MS C. BECK, DR S. BUGIS, MS A. CHAN, MS A. DENHAM, MS A. GODIN, MS K. HILL, MS C. INNES, MS C. MYLES, MR A. HUNDAL, MR A. LEUNG, MS A. MACDONALD, MS A. MCMASTER, MS K. STEIN, MS J. WILLS, MR J. YU.

In 2016–17 the Specialist Services Committee (SSC) continued to support specialists by working in collaboration with the Doctors of BC, Ministry of Health,

and health authorities. The SSC developed a 3-year strategic plan (2016–19) and a work plan for 2016–17 that focused on three priority areas: engaging physicians, enabling health system improvement, and supporting specialists to deliver quality care.

**Key Activity 1: Engaging Physicians Facility Engagement Initiative**

The Facility Engagement Initiative had an active year with 58 sites currently involved: 20 approved for full funding, 33 in the startup phase, and 5 having expressed interest. The Facility Engagement Management System (FEMS), a web-based information system that provides overall business management support for the sites and reporting and evaluation at the program level, continues to be deployed and enhanced. Currently, there are seven sites that are actively using FEMS, and training continues for all sites receiving their full funding allocation.

A UBC academic team is implementing an evaluation plan for the Facility Engagement Initiative. The evaluation examines the development of physician engagement at the system level with the evolution of relations between the Ministry of Health, health authorities, Doctors of BC, and local organizations representing facility-based physicians, as well as specific facility-based initiatives developed in the context of the initiative. Two primary stages will be assessed: the work being conducted to move interested sites to the stage of full funding, and the effectiveness of strategies in which funded sites prioritize and implement specific actions to increase engagement. Progress to date includes developing data collection tools, pilot testing survey instruments, interviewing the facility engagement liaisons, developing an adapted short version of an engagement survey, and finalizing case-study selection criteria.

**Physician Quality Improvement Initiative**

The SSC launched the Physician Quality Improvement (PQI) Initiative to enable front-line physicians to bring forward a project that would be supported by dedicated technical staff positions funded by SSC and housed within the health authority. Additionally, physicians are being provided QI and leadership training within their region. The PQI initiative has been created through a collaborative effort with the health authority, with joint management of a steering committee with representation from the SSC, patients, clinically active physicians, and the health authority.

In 2016–17 all six health authorities had approved funding proposals and are at different stages of implementing their programs. For 2017–18 the target is

to support 100 physician-led QI projects and QI training provided to 500 physicians through this initiative.

**Key Activity 2: Enabling Health System Improvement**

The SSC continued to support specialist-led quality and innovation projects to improve patient care. The projects are local, regional, and provincial in scope, with many addressing key health system priorities and patient populations such as surgical quality and access, seniors and frail-elderly, mental health and substance use, and rural and First Nations Health, among others. SSC continues to support these projects through discussions on project sustainability, continued alignment with health authority priorities, and reporting and accountability requirements.

The SSC also contributed to the health system redesign fund to compensate specialists for being involved in time-limited projects and activities initiated by the health authorities.

**Key Activity 3: Supporting Physicians to Deliver Quality Care**

SSC has monitored the changes it made to its fees in November 2015. After a review of their use and with feedback from specialty section heads, the SSC approved minor changes to better align use with the original intent of the fees. The SSC also worked with specialty sections receiving labor market adjustment fee funding to review and adjust use within the fixed budget amounts. An evaluation framework has been designed to assess the impact of the fees, which will be done in 2017–18.

Through the SSC’s Leadership and QI Scholarship Fund, over 100 specialists were supported to attend various leadership and QI training courses, including the UBC Sauder Physician Leadership Program.

Overall it has been a very busy and productive year implementing the committee’s work plan. In particular, the SSC has created a good foundation to expand on its work in the Facility Engagement and Physician Quality Improvement initiatives.

—Sean Virani, MD  
Co-Chair

**STATUTORY NEGOTIATING COMMITTEE**

DRS D. ATTWELL, CHAIR; H. FOX, F. KOZAK, T. LARSEN SOLES, G. MACKIE, D. WILTON. STAFF: MR J. AIKMAN, MR T. MACPHERSON, MR P. STRASZAK.

The Statutory Negotiations Committee (SNC) did not meet in 2016, but meets this year to develop proposals

for an exploratory process with government as an alternative to the 2016 midterm Physician Master Agreement (PMA) renegotiations.

The 2014-2019 PMA includes a provision that permits limited negotiations during the term of the agreement. The process was designed to establish a safe environment for the parties to discuss fundamental system issues “of mutual interest” outside the context of fee negotiations and not subject to dispute resolution. These negotiations were to begin in February 2016 and conclude in December 2016. Government did not detail its priorities until November 2016, which precluded a midterm PMA renegotiation; however, an opportunity was presented to allow for a limited, nonbinding consultation process on areas of mutual interest. By engaging in this process, Doctors of BC has an opportunity to better understand government’s issues in advance of the 2019 PMA negotiations and could inform other joint initiatives currently underway.

Government seeks to explore collaborative approaches to address the criticisms in the 2014 auditor general’s report on physician services and its other priorities in the following areas:

- Measuring quality and cost-effectiveness.
- Value-based approach to compensation.
- Realigning the PMA joint committees.
- Physician supply and distribution.

As a result, on 20 January 2017, the Doctors of BC Board approved the formation of four midterm consultation committees, one for each of the priority areas identified by government. The mandate of each of these midterm committees is to achieve a better understanding of, and formulate potential areas of agreement on, issues of major importance to government. Each committee consists of members from the SNC and each joint collaborative committee relevant to the topic area.

The SNC will meet regularly throughout the midterm consultation process to monitor the progress of, and provide strategic direction to, the consultation committees on PMA negotiation issues. It is expected that the midterm consultation process will be complete by September 2017, at which time comprehensive preparations for the 2019 PMA negotiations must begin.

—David Attwell, MD  
Chair

## TARIFF COMMITTEE

DRS B. WINSBY, CHAIR; E. AYMONG, D. BRABYN, E. CADESKY, B. GREGORY, A. KARIMUDDIN, R. MOORE, E. SHUKIN, P. STEINBOK, M. SZPAKOWICZ. MSP: DR K. BARNARD, DR R. DYSKTRA, MR B. HART, MS B. LOUIE, MS M. TY. STAFF: MR J. AIKMAN, MS L. HARTH, MS C. INNES, MS T. SMEDBOL, MR R. TIAGI, MS V. WATSON.

The Tariff Committee would like to thank departing members Drs D. Brabyn and P. Steinbok for their time serving on the committee, and welcome new members Drs B. Gregory and A. Karimuddin. This year the Tariff Committee also welcomed Dr Kelly Barnard, a new representative from MSP. Dr Barnard recently retired from the public service, returning Dr Dykstra to our committee.

This committee meets regularly as a forum to exercise persuasion, hopefully leading to consensus between presenting physician advocates, our dedicated staff, and MSP guests, to advance the day-to-day mercantile arrangements and expectations of the parties.

We examine and review new procedures and their requested tariffs, and we discuss changes in fee levels, as requested by sections or the Ministry of Health, as well as preamble changes and interpretations. Sections are encouraged to meet directly with MSP to frankly share each other’s expectations.

The Tariff Committee is subordinate to the Doctors of BC Board of Directors; therefore, all of the committee’s suggestions and recommendations must be reviewed and approved by the Board. Specific examples of the 20 or so monthly agenda items this past year include, among other things, creating a working group to examine and recommend medical assistance in dying (MAID) tariffs, continuing to implement recruitment and retention funds, working with sections and representatives to find middle ground in the multiple consultation and transfer of care world, working with chronic pain management interventionists to amend the Fee Guide, and consulting with stakeholders.

—Brian Winsby, MD  
Chair

# ANNUAL REPORTS OF SECTIONS AND SOCIETIES

## **BC ANESTHESIOLOGISTS' SOCIETY**

DRS D. SWEENEY, CHAIR; S. DANDINA, K. HONEYWOOD, A. LAU, B. MERRIMAN, C. SMECHER, M. TRAYNOR.

In 2016-17 the British Columbia Anesthesiologists' Society (BCAS) continued its long-standing and proud tradition of advancing both the professional and the economic interests of anesthesiologists in the province.

Among other provincial initiatives, we are currently participating in the first wave of review of the provincial hospital privileging standards and engaging various stakeholders (including the Provincial Surgical Executive Committee) in discussions about the patient-centred perioperative surgical home model of care.

In its recent policy paper on surgical services, the BC Ministry of Health identified an undersupply of both anesthesiologists and specialty nurses as barriers to increasing patients' access to surgery. Novel approaches are needed to help resolve these human resource challenges, and we are working diligently toward this objective.

With the support of the Doctors of BC economics staff, we have also been busy implementing new funds arising from the Physician Master Agreement. Subject to MSP approvals, which are currently pending, our proposals would support a more integrated approach to delivering perioperative care, providing patients with a higher-quality and less-fragmented surgical journey.

On the professional development front, last December we hosted in Vancouver the 51st annual BCAS/WSSA Combined Scientific Meeting, with almost 200 anesthesiologists from across BC and Washington State taking part. As an added member benefit, we also expanded our selection of accredited academic workshops, which have been favorably received by participants.

In the coming year, we hope to build on the successes of the past and help lay the foundation for the successful expansion of surgical capacity, which is urgently needed by tens of thousands of wait-listed British Columbians.

—Desmond Sweeney, MD, FRCPC  
Chair

## **BC ASSOCIATION OF LABORATORY PHYSICIANS**

DRS K. BEREAN, PRESIDENT; C BELLAMY, R. CLEVE, A. FINN, J. LO, M. MOSS, J. O'CONNELL, T. SMITH, L. STEELE, M. TROTTER, S. VERCAUTEREN.

In 2016 the British Columbia Association of Laboratory Physicians (BCALP) successfully concluded a project with the Ministry of Health to correct long-standing deficiencies in staffing laboratory physicians in the province. This primarily affected the teaching hospitals in the Lower Mainland and clinical pathology laboratories elsewhere. In January 2015 Deputy Minister of Health Dr Stephen Brown informed the Doctors of BC/BCALP that the ministry was committing up to \$10 million of new funding per year, effective 1 April 2016, to fund additional academic and clinical pathology FTEs, contingent on recommendations from academic and clinical pathology workload modeling studies to support such an allocation.

The Project Management Committee decided to form five work groups for this project: hematopathology/transfusion medicine, medical microbiology, medical biochemistry, general pathology, and academic. The inaugural meeting was held on 19 May 2015, and over the next 8 months the groups met and refined the workload models. Anatomic pathology workload was measured using the L4E model developed by Dr Raymond Maung of Kamloops. This model has been extensively modified over the past 10 years and is used by pathology groups across Canada. The clinical pathology workload models adopted were developed in Victoria. As a result of this project, 28 new positions were created in laboratory medicine for physicians in BC. By the end of 2016, the majority of these positions were filled or individuals had been identified for later start dates.

The other major project this year was creating the Agency for Pathology and Laboratory Medicine. This agency was formed as a result of the Laboratory Services Act, passed in 2014, which enabled a single governance, funding, and service delivery oversight body of all publicly funded medical laboratories in BC. The agency established a number of standing committees and discipline working groups in 2016. Most of the physicians involved in these are active BCALP members, and there is an ongoing dialogue between BCALP and the agency during its early development.

—K. Berean, MD  
President



**SECTION OF ALLERGY AND IMMUNOLOGY**  
**BC SOCIETY OF ALLERGY AND IMMUNOLOGY**

DRS S.Y. KIM, PRESIDENT; R. CHANGE,  
 TREASURER; A. KANANI, PAST PRESIDENT;  
 D. STARK, ECONOMICS REPRESENTATIVE.

The Section of Allergy and Immunology comprises 36 pediatric and adult allergists and immunologists.

Our society continues to educate family doctors through our well-attended Annual Update for GP program through the UBC Continuing Professional Development.

The pediatric and adult training program at UBC will graduate more well-trained allergists in the near future.

We are currently organizing the BC Society of Allergy and Immunology Conference 2017 in Parksville to better connect allergists and immunologists across the province, as well as network new graduates with members who are retiring or have retired.

—Seung Y. Kim, MD  
 President

**SECTION OF COMMUNITY AND RURAL  
 SPECIALISTS OF GENERAL INTERNAL  
 MEDICINE OF BC**  
**SOCIETY OF COMMUNITY AND RURAL  
 SPECIALISTS OF GENERAL INTERNAL MEDICINE  
 OF BC**

DRS R.Y. SHAW, PRESIDENT; J. GRACE, D. MYERS, M.  
 O'BRIEN, PAST PRESIDENTS; M. BERNARD, M. LEE, K.  
 MCLEOD, A. PALEPU, J. WU.

The Section of Community and Rural Internal Medicine has had an eventful and productive year. The section will be submitting a formal request to change its name to Section of General Internal Medicine to reflect the merger of community and rural internal medicine with academic members who continue to rely on each other's support and collaboration to promote generalist and comprehensive care.

General internal medicine has seen a tremendous growth in its membership over the last 15 years, from 50 members to 150 members 8 years ago to now over 300 members.

Across BC, general internists provide around-the-clock inpatient and outpatient care to acutely sick patients in community hospitals from Kitimat to Fort St. John to Cranbrook to Port Alberni. They also provide clinical teaching to medical students and medical residents in major and community academic teaching hospitals.

The explosive growth in the number of general

internists reflects the increasing need for medical specialists to provide comprehensive care for acutely and critically ill patients in an aging population across all communities. General internists not only assess and diagnose complex patients comprehensively, but also perform critical procedures such as endotracheal intubation, ventilation support, central line placement, diagnostic and therapeutic thora, para, and lumbar-centesis, elective and urgent electrical cardioversion, bedside ultrasound examination, trans-venous pacemaker placement, ECG and holter monitor interpretation, and pacemaker interrogation.

In the coming years, the section looks forward to working with health authorities and the ministry to improve the care of complex medical patients, to drive quality improvements by using medically relevant and rigorous data on health outcomes, to continue close collaboration with our subspecialist colleagues, and finally, to address the challenge of communicating within our section with over 300 members in over 30 community and academic hospitals spread across a vast area.

—Robert Y. Shaw, MD, FRCPC  
 President

**SECTION OF DERMATOLOGY**

DRS E. TUYP, PRESIDENT; C. HONG, PAST PRESIDENT  
 AND ECONOMICS REPRESENTATIVE; S. KALIA,  
 TREASURER; S. ROSSI, SECRETARY.

Dermatology still has the greatest workforce shortage in the province. It has the largest number of posted opportunities on the Health Match BC website relative to both size of the section and the length of time it would take for the UBC Department of Dermatology and Skin Science graduates to fill these positions—at least 10 years. By that time, a similar or greater number of dermatologists can be expected to have retired considering their average age. Recruitment is hamstrung by BC having the lowest dermatology fees in the country.

Despite these statistics there has been no concerted action by the government or UBC Medical School to solve the problem. Indeed, UBC Medical School's latest interest in dermatology has been to threaten to take away the dedicated week of dermatology training of third-year medical students.

The past year has seen the retirement of Dr Annette Lam (North Vancouver), Dr Marie Prihoda (Coquitlam), and Dr Cecil Sigal (Vancouver). A dermatologist in Kamloops continues commuting to his practice in

Newfoundland. Wait lists are no longer increasing as communities are now appearing that have no dermatologist to wait for.

Dermatology is one of the first specialist sections to experience severe workforce shortages. The response does not augur well for other sections about to experience the same.

The Section of Dermatology looks forward to working within the new governance structure of Doctors of BC.

—Evert Tuyp, MD  
President

## SECTION OF EMERGENCY MEDICINE

DRS A. HAUGHTON (BCCH), PRESIDENT; S. FEDDER (RICHMOND), SECRETARY, APP COMMITTEE CHAIR; K. LINDSAY (SPH), TREASURER. MEMBERS-AT-LARGE: DRS P. BALCAR (RCH-APP REP), J. BRAUNSTEIN (RCH-HA/IT/WEBSITE); A. CHAHAL (VGH-APP REP); Q. DOAN (BCCH PHYSICIAN EXTENDERS/ CONFERENCE/ACADEMIC MEDICINE); M. ERTEL (KELOWNA, FFS CHAIR); B. FARRELL (VICTORIA GENERAL-HA/IT); J. GHUMAN (SMH-FFS AND HA/IT REP); A. GILCHRIST (DELTA-APP REP); S. HAMERSLEY (CAMPBELL RIVER-SMALL SITES LIAISON); J. HEILMAN (CRANBROOK-HA/IT); M. HOLLOWAY (LANGLEY-FFS ADVISORY); K. HUTCHISON (RIH-KAMLOOPS-HA/IT); J. MCGROGAN (LGH-HA/IT); G. MCINNES (KELOWNA-FFS REP); K. MCMEEL (NANAIMO-APP REP); L. OPPEL (UBC-PROVINCIAL PRIVILEGING PROJECT); R. STREET (RCH-OVERCROWDING/HA/IT); N. SZPAKOWICZ (SURREY-FFS/MEMBERSHIP); K. WEIBE (CHILLIWACK-FFS REP).

### Executive

The Section of Emergency Medicine (SEM) has an active executive, with diverse representation of emergency physicians: regional, educational certification, academic vs clinical, urban vs rural, FFS vs APP. Meetings of the executive remain open to all interested members. Our AGM is on Monday, 15 May 2017, after our annual Spring in Vancouver Emergency Medicine Conference.

### Membership

Membership in the section in 2015-16 exceeded 400.

### APP Issues

Although the recent Physician Master Agreement (PMA) did not create a rational, long-term process to address prospectively the problem of increased patient utilization

at APP emergency sites, limited money was set aside, and health authorities each year allocate this funding to some of the APP groups under their auspices. SEM each year “runs” our workload model, developed with the Ministry of Health, with up-to-date numbers from each of 18 emergency department sites, to inform each health authority’s decision-making process.

Contract negotiations with health authorities are beset by new language, particularly regarding invoicing of hours that is inconsistent with the FTE definition agreed on in the 2002 PMA. Constant vigilance by all APP emergency groups is imperative.

Many APP groups are following the lead of St. Paul’s Hospital, revisiting the option of returning to an FFS model out of frustration with inadequate responsiveness of the ministry to increased emergency department patient volumes and disputes over egregious APP contract language.

### Collaboration with Government to Improve the System

Emergency doctors are participating in collaborative committees, such as the Emergency Services Advisory Committee, and are seeking ways to hold all parts of the system accountable and help the system measure tangible but clinically relevant data.

Emergency medicine remains the government’s most natural potential ally in creating and maintaining a sustainable health care system. For our emergency departments to function well, every other part of the system must be working; we have no “favorites.”

### Overcrowding and Access Block: Addressing the Ongoing Crisis in Emergency

We again surveyed all BC emergency departments this year to evaluate where progress has been made over the last 5 years. Overcrowding is at a crisis point as many hospitals are continuously over 100% capacity, leaving admitted patients blocking emergency stretchers for hours, if not days. All sites now have the goal of a 10-hour “door-to-door” time, and measure the percentage compliance with this rule.

The Fraser Health Authority CEO has made the situation in his health authority dramatically worse by eliminating overcapacity protocols that shared the burden of admitted patients awaiting inpatient beds throughout all the hospital wards. The cost to individual emergency department patients and staff is obvious; the cost to the rest of the system is hidden, but likely immense. Difficulties in emergency physician and nurse recruitment and staffing at some sites offer evidence that we are at a tipping point.

### Electronic Health Record

The section gathered input from emergency physicians and health authority administrators across the province, with help from Doctors of BC Policy Department, to draft the *SEM Position Paper on EMR in Emergency Departments*. Summary points follow:

- Doctors of BC's Section of Emergency Medicine recognizes the potential benefits of responsive and effective electronic medical record (EMR) and computerized provider order entry (CPOE) systems and supports a trial of their integration into emergency departments in BC if adequate design, transition, training, and mitigation strategies are in place and funded.
- To ensure the optimal integration and use of EMR and CPOE systems in emergency departments, the Section of Emergency Medicine recommends:
  - Standardization across emergency departments of EMR and CPOE systems that are easily navigated, seamlessly integrated, and field tested by end-users for safety and efficiency.
  - Development, in consultation with ER physicians and allied health providers, of an implementation strategy that, at a minimum, addresses transition planning, education and training, and mitigation of potential negative impacts on health care services for patients in BC emergency departments.
  - Robust and regular evaluation of, and transparent reporting on, the impact of these systems on productivity and the quality of patient care provided.

The EMR and CPOE systems in VIHA and VCHA clearly were not designed with these principles, and hence the rollout has ranged from stalled to catastrophic.

—David A. Houghton, MD  
President

### SECTION OF ENDOCRINOLOGY AND METABOLISM *ENDOCRINOLOGY AND METABOLISM SOCIETY OF BC*

DRS M. DAHL, PRESIDENT; D. KENDLER, S. SIRRS.

There are approximately 50 specialists in adult endocrinology in BC with the majority located in the Lower Mainland, Greater Victoria, and Nanaimo. We lost three endocrinologists last year, which is a significant concern when wait times for existing practitioners are long. There are no endocrinologists in Northern Health Authority or Interior Health Authority. Human resource planning for endocrinology services continues to be a

challenge. We've been pleased to continue our Specialist Services Committee virtual consultation initiative as a method of addressing this problem. However, growing use of this fixed budget means that our ability to continue to provide services is limited. The program is sufficiently important that members voted to fund a portion through allocation of future MSP fee increases in 2018.

We appreciate the careful consultation and support of the Doctors of BC as part of the governance redesign project and look forward to being involved in the new model.

We would like to mark the passing of Dr Hugh Tildesley in 2016. Hugh was a dedicated and expert physician who cared deeply about patient care, health advocacy, and mentorship. We are all indebted to him.

Our thanks to Ms Alyson Thomas and Dr Sam Bugis for their expert assistance with all our sectional matters.

—Marshall Dahl, MD  
President

### SECTION OF GENERAL SURGERY

DRS M. DICKESON, PRESIDENT; A. KARIMUDDIN, PAST PRESIDENT; T. SCOTT, PRESIDENT-ELECT; N. NGUYEN, TREASURER; H. HWANG, ECONOMICS REPRESENTATIVE. MS T. BUGIS, EXECUTIVE DIRECTOR. ECONOMICS COMMITTEE: DRS S. COWIE, M. DICKESON, H. HWANG, D. JENKIN, A. KARIMUDDIN, S. MALIK, N. NGUYEN, S. SAMPATH, E. WOO. REGIONAL REPRESENTATIVES: DRS C. BABCOCK (FHA); D. JENKIN (VIHA); T. SCOTT (VCHA); T. SWANSON (NHA); T. WALLACE (IHA); C. ZROBACK (RESIDENT MEMBER).

The Section of General Surgery has had another busy and very successful year.

### Economics

The section has continued to work with the Tariff Committee to establish a fee guide that reflects evidence-based surgical practice including the latest laparoscopic procedures and other innovations. We have successfully proposed and funded a surcharge for surgical procedures on patients with a BMI greater than 35, to be implemented 1 April 2017.

We focused the remainder of our allocation on trying to address some of the lower fees in our guide. With this allocation we will bring most of our fees within 70% of the Alberta Fee Guide and some a little higher. Remember to update your billing programs after 1 April 2017.

A list of new fees and other economic updates was

presented at our AGM in conjunction with the BC Surgical Annual Spring Meeting this May at Tigh-Na-Mara Resort on Vancouver Island. After the AGM, we hosted the first-ever job fair for our members.

### **Advocacy**

Our executive has attended several meetings on your behalf, including ones sponsored by Doctors of BC and the Society of Specialists. In October we held an executive retreat from which flowed the concept of the job fair. All fourth- and fifth-year residents and interns are invited to meet surgeons from around the province, some of whom are recruiting for their hospitals, others who are slowing down and may have spots in the next few years.

We also continue to advocate politically for our members and patients. We are working on a new brochure that showcases the surgeon as teacher, giving of his or her time to teach new surgeons.

### **Membership**

We are pleased that most of the general surgeons of the province pay their annual dues to the section; thereby we truly do represent you. Residents, too, can join our section at no cost, and we are delighted to host an annual reception for them at our AGM. Retired members stay in touch with section matters for a fee of \$100.

It has been my privilege to be your president for the past three years and I will be completing my term at the AGM. I will be turning the reins over to the most capable hands of Dr Tracy Scott, who has been working with us for the past year as president-elect. I feel confident that the next few years will see the continued success under her lead. None of our successes would be possible without the support of our executive members, and I give special thanks to Dr Hamish Hwang for his tireless work to advance our section's interests again this year. Your executive is a committed group working together to represent you and our profession. Please continue to bring your ideas forward.

—Mark Dickeson, MD  
President

### **SECTION OF HOSPITALIST MEDICINE**

DRS M. PALETTA, PRESIDENT; K. NAIR, TREASURER; R. TUKKER, SECRETARY; D. HARRIS, PAST PRESIDENT; L. DINDO, S. KHAN, V. YOUSEFI.

The Section of Hospitalist Medicine spent 2016 focusing on improved engagement with its membership, reviewing its governance bylaws, and planning for a BC Hospitalist Education Day to occur in April 2017. We are excited to embed our AGM within a day dedicated to improving both clinical education and program management strategies. We are hopeful this will provide excellent networking and mentoring experiences for our leaders throughout BC.

Our section's members replaced dysfunctional doctor-of-the-day-type programs in a few further Fraser Valley hospitals and grew in numbers on Vancouver Island and in the Interior Health Authority. Hospitalists took the lead in several important QI projects improving health outcomes in stroke, advance care planning, and sepsis.

The Canadian Core Competencies for Hospital Medicine were more widely circulated and incorporated into the development our R3 programs run through Royal Columbian, and used more extensively in the education of Family Practice R1 and R2 trainees in the various hospitals where they receive part of their core medicine training as part of hospitalist programs.

Updating our Provincial Privileging Dictionary, supporting ongoing contract negotiations, and advocacy initiatives will keep the section busy in 2017. With over 130 dues-paying members, the section is proud to be emerging as one of the largest non-GP sections in our organization. That's a credit to the good work of the executive and many active section members.

—Michael Paletta, MD  
President

### **SECTION OF INFECTIOUS DISEASES BC INFECTIOUS DISEASES SOCIETY**

DRS D.A.N. FERRIS, PRESIDENT; G. DEANS, VICE PRESIDENT; Y. ARIKAN, TREASURER; T.S. STEINER, SECRETARY; W. GHESQUIERE, A. HAMOUR.

The British Columbia Infectious Diseases Society (BCIDS) represents 56 practising infectious diseases specialists in the province. We currently have 30 full members, which include Royal College-certified specialists, and 3 associate nonvoting members, which

include retired, student trainees, and noninfectious diseases physicians. Our specialty section continues to deal with international infectious diseases crises, including multidrug resistant organisms and the ongoing Zika virus epidemic spreading through the Americas.

Our society continues to be active in both the Doctors of BC and Specialists of British Columbia. Significant disparity issues face nonprocedural internal medicine subspecialists, including infectious diseases consultants. The section continues to apply correction funds derived from the Physician Master Agreement 2014 to reduce disparity between our subspecialty section and those of our colleagues in general internal medicine and the procedural subspecialties of medicine.

Budgetary overruns in the Specialist Services Committee (SSC) has resulted in threats to the labor market adjustment (LMA) codes including our HIV care fee code 33645 and home IV management fee code 33655. All telephone advice fee codes under the SSC are also at risk for restrictions and prorating. As a result, our section held a referendum in February 2017 which had 42 of the 56 members voting (75% response rate). There was unanimous agreement to reject prorating of these fee codes. Twenty-seven of 42 (64%) agreed that services should be discontinued if the fee code cannot be maintained at current levels once budget limits were achieved. We continue to be willing to work with the Specialist Services Committee as well as the Specialists of BC and Doctors of BC to resolve this budgetary crisis. Our hope is for a negotiated settlement before the budget is exhausted.

We also continue to support a uniform application of the Medical On-Call Availability Program (MOCAP) for all health authorities across British Columbia. We await the MOCAP data collection that was undertaken in February 2016 and again in September 2016 so that our colleagues who are not currently offered MOCAP coverage, particularly in Fraser and Northern Health, can partake in this program.

Our 2016 AGM was held in conjunction with the 19th annual Infectious Diseases Update on 4 November 2016, in Victoria. The meeting was attended by eight of our full voting members.

I acknowledge and recognize all of the work that Dr Wayne Ghesquiere and his team provided in organizing this educational weekend and dedicating a room for our AGM. We are planning to hold our 11th AGM in conjunction with the Infectious Diseases Update in Victoria on Friday evening, 3 November 2017. The positive financial situation of the BCIDS will result in fixed membership fees for 2017.

I personally acknowledge the dedication and service

that my executive colleagues have provided over the last year, including Dr Greg Deans, vice president; Dr Yasemin Arikan, treasurer; Dr Ted Steiner, secretary; Dr Wayne Ghesquiere, member-at-large and representative of Island Health; and Dr Abu Hamour, member-at-large and representative of the Northern Health Authority. We continue to be the professional voice for infectious diseases specialists within BC and will provide leadership and guidance to the Doctors of BC and the Specialists of British Columbia. We will continue to work closely with the Specialist Services Committee, our local institutions, health authorities, and the provincial government to address infectious disease threats to the population of BC.

Our society extends its deepest gratitude to my administrative assistant, Ms Tracy Fold, who continues to provide exceptional services and is an ongoing resource to all our members. We also extend our gratitude to Ms Alyson Thomas at Doctors of BC, who provides administrative assistance. We acknowledge the support provided by Lainie Burgess, administrative director at the UBC Division of Infectious Diseases, in helping to maintain our current membership list.

BC infectious diseases specialists continue to confront any potential microbial challenges that face the population of the province. We are the pre-eminent specialists that address communicable diseases threats, including multidrug resistant organisms as well as novel viruses, while maintaining appropriate antimicrobial stewardship and supporting good infection control practices.

—Dwight A.N. Ferris MD, FRCPC  
President

## **SECTION OF ORTHOPAEDICS BC ORTHOPAEDIC ASSOCIATION**

DRS K. WING, PRESIDENT; K. PANAGIOTOPOULOS, SECRETARY-TREASURER. REGIONAL DIRECTORS: DRS S. ARNEJA, K. BALL, J. SPLAWINSKI (IHA); E. CALVERT, A. YOUNGER (VCHA); P. DRYDEN (VIHA); D. NELSON; R. PURNELL (NHA); R. SCHWEIGEL, D. WICKHAM (FHA). DIRECTORS-AT-LARGE: DRS T. GOETZ, V. JANDO, S. KRYWULAK, M. MORAN, R. OUTERBRIDGE, D. PLAUSINIS. WSBC LIAISON: DR C. JACKSON.

The AGM of the BC Orthopaedic Association (BCOA) will be held on 12 May 2017 in conjunction with Orthopaedic Update. The following is a brief summary of the priorities and projects of the BC Orthopaedic Association of the past year.

### Timely Access to Orthopaedic Care in BC

Our country's universal health care system was created over 50 years ago. At that time, only 10% of the population was 65 or older. By 2030, this age group will make up 25% of the population. This is also the group that requires the most orthopaedic care—to relieve pain and restore mobility impaired by degenerative conditions. Our health care system at the national, provincial, and regional levels has not kept pace with the demand, and our patients do not have timely access to the care they need.

We call on our national and provincial governments—our partners in health care—to help us provide immediate care for all urgent orthopaedic problems and appropriate care within 90 days for all other nonemergency orthopaedic problems.

In BC right now, many innovative approaches and new programs already underway offer solutions to the issues we face in providing the best and most timely care. We have gathered solid data that support these initiatives and are happy to share both the quantitative and qualitative research we have done to date.

Orthopaedic health care teams need the financial and management resources to deliver the best and most affordable care possible. Centralized, multidisciplinary intake clinics have been identified as a way to streamline and speed up the assessment and treatment of most patients. However, innovative models need sufficient hospital resources to make sure all orthopaedic patients can get timely surgical solutions when needed. There are also human resource issues we must all tackle to get the system working optimally.

### BCOA Access to Care Survey

The BCOA conducted an anonymous online survey in the fall of 2016 on access to care. We had 82 responses, an excellent return from the 150 practising orthopaedic surgeons in BC. The results were not surprising, but they provide quantifiable information:

- Almost 80% of respondents said they support Dr Brian Day's court case asking for private insurance. Over three-quarters (76%) favor having a hybrid private-public health care system like that of the United Kingdom, and almost 58% want to see substantive and innovative changes to the current system. Not one respondent opted for status quo.
- The majority (66%) of respondents do not believe their nonemergency patients are seen for their first diagnostic consultation within a reasonable period of time, and 83% do not believe their patients get surgery within a reasonable period of time.

- Over half (57%) of the respondents said the average waiting time for them to see these GP-referred patients is 1 to 6 months, another 40% said it was between 7 and 18 months.
- Almost three-quarters of those surveyed (73%) said their patients wait between 4 months to 1 year for surgery after the initial diagnosis. Only 7% get surgery in under 3 months and 6% wait 1 to 2 years.
- Almost one-quarter (24%) of respondents spend 100% of their time on MSP or WorkSafeBC patients, and another 64% spend only up to 10% of their time on work that is *not* MSP or WSBC.

Our membership believes access to care is vitally important to everyone in BC and, indeed, in Canada. The BCOA is dedicated to the health and safety of our patients and want always to be part of working toward improving our health care system.

### Wait Time Initiative

The BCOA continues to work with Cambian to collect wait time data and is providing meaningful data that facilitate ways to best manage surgical wait lists and effectively manage resource allocations. BCOA and Cambian are working to expand collaboration with more physicians and EMR applications participating in wait time reporting, referral triage, and patient-reported data.

### Hip Fracture Redesign Project

This project is a coordinated, evidenced-based initiative to develop hip fracture registries, performance measurements, and implementing best practices, including enhanced recovery after surgery (ERAS). The results are more patients receiving surgery within 48 hours, improved recovery with fewer complications, fewer days in bed, more effective rehab, and quicker return to the community. This project was piloted at eight sites and is now expanding to hospitals throughout the province. Clinical resources and educational videos have been developed and are available.

### WorkSafeBC

On 1 November 2015 WorkSafeBC moved to a new system for payments of expedited services under the new agreement with Doctors of BC. The BCOA has worked over the last year to resolve issues related to expedited care and after-hours surcharges, and continues to work to resolve issues with multiple fee codes.

—Kevin Wing, MD  
President

## SECTION OF PAIN MEDICINE

### *PAIN MEDICINE PHYSICIANS OF BC SOCIETY*

DRS O. WILLIAMSON, PRESIDENT; B. LAU, SECRETARY;  
P. ETHERIDGE, TREASURER; G. LAUDER, S. WISEMAN.

The Pain Medicine Physicians of BC Society (PMPOBC) was formed in December 2015 and became associated with the Doctors of BC in February 2016. Its purpose is to:

- Represent physicians from all disciplines who practise in the area of pain medicine.
- Participate in the Doctors of BC, and to represent the society on the Council of Specialists of the Society of Specialist Physicians and Surgeons of British Columbia.
- Advance the scientific, educational, professional, and economic welfare of pain medicine physicians in BC.
- Promote the highest quality of health care delivery for the people of BC.

The society is one of the few multidisciplinary sections of the Doctors of BC with membership that includes specialists and family physicians—addiction physicians, anesthesiologists, geriatric medicine physicians, interventional radiologists, neurologists, neurosurgeons, obstetricians/gynecologists, orthopaedic surgeons, palliative care physicians, psychiatrists, and rheumatologists. Members come from across BC's metropolitan, urban, and rural communities.

Here are the highlights of the society's activities:

- PMPOBC has provided the Doctors of BC leadership team with expert advice on pain management, co-sponsored a successful board motion calling for Doctors of BC to develop a chronic pain policy, and represented society members at the Tariff Committee, both to introduce new procedural codes and to modify existing codes. The society has also been engaging with other sections on issues of common interest.
- The society has actively engaged the College of Physicians and Surgeons of BC in seeking revisions to the Professional Standard and Guidelines for the safe prescribing of drugs with potential for diversion and misuse, as well as on the credentialing of physicians and community facilities that provide interventional pain services.
- Members of the society have been instrumental in developing and implementing the UBC Pain Medicine Resident Program and are actively involved in the education of medical students, residents and fellows; allied health professionals; people living with pain; and the general public.
- Members have been actively engaged in provincial, national, and international pain initiatives.

- The society works collaboratively with Pain BC to coordinate advocacy for the one in five British Columbians who are living with persistent pain to have timely and affordable access to appropriate care.

PMPOBC looks forward to the continuing support of the Doctors of BC leadership team and invites all other sections to collaborate with us to more efficiently and effectively deal with issues of mutual interest. We wish to acknowledge and thank the BC Psychiatric Association for awarding us an advocacy grant to enable the foundation of our society.

—Owen D. Williamson, MD  
President

## SECTION OF PALLIATIVE MEDICINE

DRS S. MINHAS, PRESIDENT; W. YEOMANS, PAST PRESIDENT; G. KIMEL, TREASURER AND SECRETARY.  
EXECUTIVE MEMBERS: DRS N. APOSTLE (PROVIDENCE); P. EDMUNDS (VCH), B. FELAU (VIHA); P. HAWLEY (PHSA); I. REDDY (NHA); S. SZE (IHA). ADMINISTRATIVE ASSISTANT: MS K. INMAN.

The Section of Palliative Medicine (SPM) has been busy this past year with many pursuits within education, defining and clarifying roles and responsibilities, and working to expand palliative care services in BC.

SPM represents physicians who provide specialized palliative care to individuals living with life-threatening illnesses, including those who are vulnerable and approaching the end of their lives. It is made up of a group of highly skilled and specialized physicians who provide excellent end-of-life care. Palliative care physicians manage patients with significant symptoms that can otherwise reduce their quality of life. They continue to see firsthand how serious illnesses can lead to intense suffering for patients and their families, and they are devoted to relieving this suffering. They see patients whose suffering is emotional or existential rather than physical, and in these instances they work with multidisciplinary teams to reduce and alleviate this suffering. Programs involve education, mentorship, and comprehensive clinical care.

The World Health Organization definition of palliative care explicitly excludes hastening of death so that patients can be reassured that their life will not be shortened by receiving palliative care. Early access to palliative care improves quality of life for patients, families, and their caregivers. Many studies have shown that with early and timely access to palliative care, patients live better, with less symptom burden, and with

the same or longer survival than those who do not receive such support.

SPM has been working diligently this year to advocate for timely, early access to palliative care services. The goals are ongoing to the expansion of palliative care education, access, and services within BC. We will work in ongoing partnership with other professionals involved. We recognize and respect that the spectrum of end-of-life care may include patients who choose physician-hastened death or medical assistance in dying (MAID). While we are committed to providing the highest level of care for our patients, direct participation of palliative care physicians in MAID falls outside the scope and tenets of palliative medicine. This is in accordance with the internationally accepted definition of palliative care.

—Shikha Minhas, MD  
President

## SECTION OF PEDIATRICS *BC PEDIATRIC SOCIETY*

DRS A. POYNTER, PRESIDENT; M. BEIMERS, PAST PRESIDENT; W. ABELSON, SECRETARY-TREASURER; W. ARRUDA, J. BALFOUR, A. CHOMIN, A. EDDY, K. GROSS, N. JAIN, K. MILLER, A. LEE, K. SCHULTZ, T. SOROKAN, P. THIESSEN, G. WARD.

The vision of the BC Pediatric Society is that all BC infants, children, adolescents, and their families will attain optimal physical, mental and social health. To accomplish this vision, the society will:

- Work with allied care providers, government, regional, provincial, and national organizations.
- Support the professional needs of its members.

Our advocacy work this year centred on the following themes:

- **Economics:** We have reviewed information from the data collected from the transition project team, including consultation with community pediatricians, family physicians, and adult specialists. We have also considered information from the child and youth mental health collaborative. There are some current fee codes from MSP, GPSC, and SSC that apply to some of the work to be done such as conferences, telephone discussion, and acceptance of new complex patients. We have put forward a new fee from community pediatricians to facilitate transition of patients 16 to 19 years of age.

- **Mental health:** We are partnering with the Ministry of Children and Family Development and the Child and Youth Mental Health and Substance Use Collaborative to address access to mental health services for children and youth with serious mental illness. We are also active on a number of committees on the collaborative, and our members have joined various local action teams.
- **Transition:** We received a grant from the SSC, which focuses on the transition process as community pediatricians transfer patients into adult care. We are currently in the pilot stage of this work, using resources developed after consultation with community pediatricians.
- **Education:** We continue to talk to various parties on an initiative to link pediatricians to schools. These links could take a variety of forms, from providing school-based health services to designating particular community pediatricians to match with a school and provide consultation services.
- **Immunization:** We worked very hard this year with partners to get the HPV vaccine publicly covered for all boys. This effort has been successful, with the announcement by the province of coverage starting in September 2017.
- **Childhood obesity:** We are focusing on our school-based program SipSmart, aimed at reducing sugar-sweetened beverages in grades 4 to 6. We have just finished work on a grant from the Ministry of Health to update this resource.
- **Secure care:** A working group has been established to look at the possibility of secure care for severely addicted youth within an integrated set of services.
- We have recently completed a survey of pediatricians in BC and we are now analyzing the results. In terms of education opportunities, we have a blanket CME accreditation for evening journal club dinners, which we present approximately every 4 months. These dinners are broadcast via telehealth and WebEx throughout the province. We also partnered with the Children's/Women's Hospital Division of Neonatology for our annual 2-day CME in 2016. Planning is underway for 2017. Finally, we maintain a website targeted at both physicians and families ([www.bcpeds.ca](http://www.bcpeds.ca)) that contains a number of resources for both audiences.

—Aven Poynter, MD  
President



**SECTION OF PSYCHIATRY****BC PSYCHIATRIC ASSOCIATION**

DRS B. MATHEW, PRESIDENT; A. BATES, PRESIDENT-ELECT; R. RANDHAWA, SECRETARY; K. STEVENSON, TREASURER/INTERIOR REPRESENTATIVE; C.-A. SAARI, PAST PRESIDENT; C. BOOTH, SESSIONS REPRESENTATIVE; P. CAMPBELL, PSYCHOSOMATIC MEDICINE REPRESENTATIVE; P. CHAN, GERIATRIC PSYCHIATRY REPRESENTATIVE; B. CHOW, RESIDENT REPRESENTATIVE; N. COLLINS, GOVERNANCE CHAIR; T. ISOMURA AND I. HUSSAIN, FHA REPRESENTATIVES; A. JAGDEO, RESIDENT REPRESENTATIVE; B. KANE, NHA REPRESENTATIVE; V. KARAPAREDDY, ADDICTIONS PSYCHIATRY REPRESENTATIVE; F. MCGREGOR, ADVOCACY CHAIR; D. MILLER AND C. NORTHCOTT, VCH REPRESENTATIVES; M. RILEY, FORENSIC PSYCHIATRY REPRESENTATIVE; W. SONG, VIHA REPRESENTATIVE; S. WISEMAN, ECONOMICS CHAIR.

Over the past year the BC Psychiatric Association (BCPA) has been active on the advocacy front, led by Dr Carol-Ann Saari, with the child and youth mental health initiative. Also, Dr Saari and Dr Ram Randhawa led the revision of the BCPA bylaws, which resulted in reorganizing and redefining the role of the executives in the BCPA.

The BCPA Annual Residents Dinner was held at Seasons at the Park in March 2016, with an excellent turnout. Dr Saari gave an overview of the role of BCPA while Dr Biju Mathew talked about career opportunities.

The BCPA Education Day and AGM were held on 4 November 2016 at the Metropolitan Hotel in Vancouver. Speakers included Drs Siavash Jafari, Arun Jagdeo, Steve Wiseman, Biju Mathew, Debra Miller, Colleen Northcott, Alan Bates, and Ashok Krishnamoorthy. The topics covered were highly rated by the delegates.

Dr Mathew took over as the president and Dr Alan Bates is the president-elect. Drs Ijaz Hussain and Terry Isomura will share the position of the representative of Fraser Valley, and Dr Laura Campbell is the new psychosomatic medicine representative.

The Economics Committee led by Dr Steve Wiseman worked tirelessly to address the disparity in the MSP billing fees for psychiatrists, which are much lower than those of other specialists and GPs. There is a general dissatisfaction among the membership due to this disparity.

—Biju Mathew, MD  
President

**SECTION OF RADIOLOGY****BC RADIOLOGICAL SOCIETY**

DRS A. HARRIS, PRESIDENT; W. SIU, PAST PRESIDENT; J. DUFTON, L.S. GREEK, P. KURKJIAN, E. LEE, P. LOURENCO, M. MARTIN, S. TOLHURST, P. TREPANIER, K. SELAND, S.P. VOS, W.W. YAP, C. YONG-HING. ADMINISTRATIVE SUPPORT: MR B. RAUSCHER, MS C. RENTZ-BENNETT.

This year, Dr Alison Harris took on the role of president of the section from Dr William Siu, who remains on the executive as the past president. Executive members who have retired from the council this year are Drs Ken Wong, Pete Tonseth, and Michael Butchart. The executive thanks them for their years of dedicated service and wishes them all the best in their future endeavors. The executive council continues to be well represented by radiologists from all regions of the province along with members from the UBC Radiology Residency Program.

**CME Sessions**

The BC Radiological Society (BCRS) continues to provide valuable continuing medical education for the membership. In 2016 the BCRS held an educational day on Radiology Perils, Pitfalls, and Professional Issues, which included the first offering of a webinar. As well, the November workshop, Managing Radiological Emergencies, was sold out.

In 2017 BCRS will offer Prostate Intensive MRI Education Day on 13 May, which has both didactic and hands-on components with online case studies, and another Managing Radiological Emergencies Workshop in November.

**Sponsorships**

The Section of Radiology continues to sponsor three BCIT awards: two entrance scholarships for students in the Medical Radiography and Diagnostic Medical Sonography programs, and one First-Year Achievement Award for a student entering their second year of the Diagnostic Medical Sonography program.

**2017 Activities**

In 2017 the BCRS continues to work with its members and other stakeholders, such as the Ministry of Health, Doctors of BC, health authorities, the Medical Imaging Advisory Committee, WorkSafeBC, and the Canadian Association of Radiologists, on the following activities:

- Developing accredited CME programs for radiologists.
- Implementing the Physician Master Agreement.
- Developing a peer-reviewed quality-improvement

program for radiologists.

- Planning health human resources.
- Working on provincial e-health and advanced imaging strategies.
- Developing a modernized breast-imaging fee schedule.
- Modernizing interventional radiology fees.
- Reviewing the appropriateness and standardization of medical-imaging studies.

—Alison Harris, MD  
President

### **SECTION OF RHEUMATOLOGY BC SOCIETY OF RHEUMATOLOGISTS**

DRS J. KUR, PRESIDENT; J. WADE, TREASURER;  
D. COLLINS, ECONOMICS REPRESENTATIVE;  
M. TEO, M. UH.

#### **Labor Market Adjustment (LMA) Fee Codes**

Funding through the LMA for innovative fees codes has transformed rheumatology practice and access to care in the province. The fee codes have had their intended impact in transforming models of care, particularly as they apply to multidisciplinary nursing. With the growth of usage in these codes, along with positive recruitment and retention in BC, like many other LMA-awarded specialties, the BC Society of Rheumatologists (BCSR) has had to revise and limit these codes. We are now in the unenviable position of having to limit complex care and multidisciplinary care that has benefited many patients in the province with complex rheumatic diseases. A longer-term solution is clearly needed to address this challenge.

#### **Clinical Nursing**

As a result of the success of multidisciplinary rheumatology care in BC, the BCSR has helped foster the establishment of a Western Canada rheumatology nurses society. We look forward to partnering with the organization on future multidisciplinary CME events.

#### **Communities of Need**

Previous research has helped clearly identify the most underserved communities in the province. While there have been some improvements, Surrey, Prince George, and Kelowna remain underserved in rheumatology. BCSR is exploring ways to try and help rheumatologists who express interest in working in these communities.

#### **Billing and Audit Member Education**

The BCSR, in conjunction with the support and expertise from the Doctors of BC, held a very successful and well attended half-day billing workshop this year.

#### **Wait Times for Consults**

In an effort to improve access to rheumatologic care, the BCSR annually surveys its members to identify those physicians who may have shorter wait times for routine rheumatologic referrals. The list can be found at: <http://bcrheumatology.ca/initiatives/>. In addition, all rheumatologists prioritize referrals for inflammatory disease (rheumatoid arthritis).

The major meeting of the BCSR will occur in conjunction with the BC Rheumatology Invitational Education Series in Vancouver on 29 September 2017.

—Jason Kur, MD  
President

### **SECTION OF SURGICAL ASSISTANTS**

DRS C. COWAN, PRESIDENT; S.-Y. CHEN, P. CROW,  
D. CUTFORTH, J. HAMILTON, D. WILLIAMS.

Over the past year the executive has had several teleconferences to discuss section issues such as targeting our fee increase, and creating mission and vision statements. There are no resolutions for consideration at the Doctors of BC annual meeting.

—Cornelius Cowan, MD  
President

### **SOCIETY OF GENERAL PRACTITIONERS OF BRITISH COLUMBIA**

DRS S. GOODCHILD, CHAIR; W. AMIRALTY, PRESIDENT  
ELECT; P. ASQUITH, ECONOMICS CHAIR; K. BURNS,  
PAST PRESIDENT; E. CHANG, PRESIDENT;  
R. DOSANJH, SECRETARY; M. FAGAN, TREASURER;  
H. FOX, SNC REPRESENTATIVE; G. WATSON, GPSC  
REPRESENTATIVE. STAFF: MS S. BREWSTER,  
EXECUTIVE COORDINATOR, DR B. J. CLARKE,  
EXECUTIVE DIRECTOR.

The Society of General Practitioners (SGP) spent another busy year advocating and working for family physicians in many venues. Highlights of 2016-17 include the following.

### Governance

SGP worked with Specialists of BC and the Doctors of BC Governance Committee to propose a new structure for the Doctors of BC, consisting of a small governance board and a larger representative assembly. The proposal was approved by a referendum of the Doctors of BC membership, and SGP is now working to determine how best to meet its representative assembly responsibilities. We are also thinking ahead to how changes to the SGP structure might support alignment with the representative assembly and Divisions of Family Practice.

### Fee Codes and Tariff

The SGP Economics Committee and Board worked on fees and proposals in medical assistance in dying, telemedicine video visits, oral opioid agonist treatment, and community GP acute care hospital admission examination. SGP also cohosted a successful fall Family Medicine Conference with the BC College of Family Physicians, combining our expertise in billing education with theirs in continuing medical education. In the spring, SGP followed with its third full-day Dollars and Sense of Family Practice. In addition, several billing education webinars have been offered to chapters of the Rural and Remote Division of Family Practice.

### Health Care Transformation

- The SGP nominates three members to the GPSC and reviews GPSC initiatives and work at every board meeting.
- SGP sends representatives to the Council on Health Economics and Policy and the Overhead Committee, both of which are engaged in considering policy and the financial aspects of current and future practice.
- The SGP board is creating discussion groups on the major topics of health care transformation in alignment with the Patient Medical Home: alternative models of care delivery, compensation, quality improvement, cost-effectiveness, integration, and teamwork. This will enable the SGP and membership to be more engaged and to participate with others in Doctors of BC.

### Advocacy

SGP hosted the first Family Doctors of Canada forum, which grew from the ashes of the CMA's discontinued GP Forum. Representatives from almost all the provincial and territorial medical associations gathered in Vancouver prior to the CMA AGM to discuss national issues of importance to family physicians. A second forum meeting will take place in Quebec City at the CMA General

Council in August. The goal is to meet annually in conjunction with the CMA GC meetings.

The SGP also works with many external organizations, such as the BCCFP, Child Health BC, the BC Immunization Committee, BC College of Pharmacists, as well as internal groups, such as the GPSC, the Health Data Collaborative, and the Data Stewardship Committee.

—Ernie Chang, MD  
President

### SPECIALISTS OF BC (FORMERLY SOCIETY OF SPECIALIST PHYSICIANS AND SURGEONS OF BC)

DRS J. FALCONER, PRESIDENT; L. OPPEL, CHAIR OF COUNCIL; D. KENDLER, SECRETARY-TREASURER. MEMBERS-AT-LARGE: DRS M. BAKER, T. SMITH, D. WICKHAM. COUNCIL OF SPECIALISTS: DRS W. ABELSON, D. ANDERSON, E. AYMONG, B. BLUMENAUER, R. CLEVE, S. COMEAU, M. DAHL, D. DHANDA, M. DICKESON, D. FERRIS, M. FISHMAN, P. GAJECKI, G. GANZ, D. HAUGHTON, O. HREBICEK, H. KANJI, K. KAZEMI, D.S.H. KIM, J. KUR, O. NAZIF, A. POYNTER, K. SHIH, D. STARK, E. TUYP, N. VAN LAEKEN, D. WATERMAN, I. WATERS, E. WEISS, K. WING, S. WISEMAN, K. WONG, P. YENSON.

The Specialists of BC continues to be reinvigorated with the name change last year that reflects our new direction. We have worked tirelessly to ensure specialists' voices are heard.

The Doctors of BC convened a new Overhead Committee, and the Specialists of BC has a parallel working group. We believe we have the makings of the best overhead study yet, and encourage you to participate if randomly selected. We sorely need current, accurate data for allocations and benefits.

The modified average net daily income (MANDI) formula created some years ago to compare doctors' incomes is no longer working well. A Doctors of BC working group is developing a formula with the same acronym but a new name, modified annual net doctor income, which we feel will be better—stay tuned.

Doctors of BC recently made a massive governance change. At the Specialists of BC, we are working to transition to this new way of doing business and to ensure that the specialists in our province achieve equity on the new Representative Assembly and the smaller Doctors of BC Board.

The Specialist Services Committee (SSC) administers the fixed-fund labor market adjustment award as well as other SSC fee codes. They have been victims of their own

success and are running out of money to pay for the increasing uptake of these codes. The Specialists of BC and the sections affected are looking to avoid any proration of fees or reduction of these important services. We have regular meetings with key Doctors of BC department heads, and I now sit on the SSC as a guest.

For 2017 we have halved our dues as an enticement to join. We want as many specialists on board as possible to support our role as the representative body of all specialists in BC.

Finally, I want to highlight the creation of two positions on the executive committee. The executive delegates will assist with projects and perspective, and become a valuable part of our succession planning. Drs Barbara Blumenauer and Tommy Gerschman will be the first to fill these roles, beginning in April.

Thanks to our executive director, Ms Andrea Elvidge, our council, and the specialists who support our work through their dues.

—John Falconer, MD  
President

# ANNUAL REPORTS OF EXTERNAL COMMITTEES AND AFFILIATED ORGANIZATIONS

## **ADVISORY COMMITTEE ON DIAGNOSTIC FACILITIES**

MS T. BRAIDWOOD-LONEY, CHAIR; DR I. ALLAN, DR J. BUSSER, MS A. CAPRON, MS R. HENNEBERRY, DR A. HOFFMAN, MS K. MCEWEN, DR G. SCHESKE, DR M. WONG. STAFF: MR W. TURNQUIST.

The mandate of the Advisory Committee on Diagnostics Facilities (ACDF) is to “provide advice and assistance to the Medical Services Commission (MSC) with respect to diagnostic services and diagnostic facilities and to consider certain applications.” Public and privately owned outpatient facilities that bill, or wish to bill, the Medical Services Plan (MSP) fall under the responsibility of the ACDF.

Throughout the year the committee receives and assesses applications for new, expanded, or relocated outpatient diagnostic services facilities. The primary role of the ACDF is to approve or recommend denial of applications based on MSC-approved policies and guidelines. Applications that are recommended for denial are forwarded to the MSC to confirm or overturn the denial.

The committee meets quarterly throughout the year. For the 2016 calendar year and up to March 2017, 55 applications were reviewed for diagnostic imaging, polysomnography, pulmonary function, electoneurodiagnostics, and clinical laboratory facilities. Recommendations were made to the MSC for each application, which included acceptance, acceptance with conditions, or denial/rejection.

During the year, the committee was apprised of and updated on the following major issues that had been assessed in detail:

- The ultrasound stakeholder policy review.
- The ACDF public preference policy.
- The foreign ownership policy.
- A revised layout for the ACDF mapping tool.

The significant issues from the past year include the following.

- Moratoriums were established for both ultrasound and polysomnography, and the ASDF reviewed a number of applications requesting exception to the moratorium. In the case of nuchal translucency scans, which are an important obstetrical management tool, the committee was briefed in depth.
- The committee heard presentations on the ultrasound sonographer shortage and how it would impact planning for expanded or new ultrasound facilities across the province. As well, detailed ultrasound policy recommendations were approved by the MSC,

and included prerequisites for privately owned facilities to receive approval to bill the MSP for outpatient diagnostic ultrasound services.

Recommendations for removing the restriction for noncardiac Doppler studies only for public hospital facilities were made and there was discussion about further work needing to be undertaken to determine if the option to remove echocardiography restriction from the current public hospital facilities only was necessary.

- The MSC delegated authority to the chair of the ACDF to approve or deny applications for electroneural diagnostic testing and pulmonary function testing and private facilities.
- The committee reviewed draft guidelines for chronic obstructive pulmonary disease.

In the current year, ongoing diagnostic services policy review and stakeholder discussions are or will be taking place in the following areas:

- Polysomnography catchment area.
- Pulmonary function testing review in private facilities (to be undertaken by Ministry of Health physician Dr Vicki Forstner).

—Alan G.D. Hoffman, MD, PhD, FRCPC, FCCP  
Doctors of BC representative

## **BRITISH COLUMBIA INJURY PREVENTION ALLIANCE**

MR D. DUNNE, CHAIR; DR R. MEHIN. STAFF: MS B. HODGSON, MS K. SAUNDERS, MS H. THI, MS D. VICCARS, MR J. WONG.

The British Columbia Injury Prevention Alliance (BCIPA) is an independent strategic alliance of organizations supporting injury prevention priorities and activities across British Columbia. Its mandate is to provide a forum for organizations and leaders involved in injury prevention to:

- Advise and assist one another with research, strategies, policies, and programs that member organizations are undertaking.
- Identify and promote injury prevention priorities where evidence supports that progress can be made in injury reduction.
- Coordinate and collaborate with member organizations on activities addressing significant injury issues.
- Provide collaborative leadership thinking and action on injury prevention.

The BCIPA held two meetings in 2016 and one in early 2017. In addition to roundtable discussions reviewing the injury prevention activities of each organization, each meeting had a theme:

- May 2016: Risky Play. This meeting included presentations from the BC Injury Research and Prevention Unit, North Vancouver Recreation and Culture Commission, Vancouver Coastal Health, and Island Health. Topics discussed included evidence supporting particular playground designs; and playground design, licensing, and legislation in North Vancouver, Vancouver Island, and Vancouver.
- September 2016: Alcohol and Injuries. This meeting included presentations from the Centre for Addictions Research BC and the BC Ministry of Health. Topics discussed included risk factors and population health approaches to addressing alcohol and injuries.
- January 2017: Injuries and Social Marketing. This meeting included presentations from WorkSafeBC, The Community Against Preventable Injuries, and Vancouver Coastal Health. Topics discussed included social marketing campaigns on workplace, sport, and alcohol safety.

—Ramin Mehin, MD  
Doctors of BC representative

## **BRITISH COLUMBIA MEDICAL QUALITY INITIATIVE (MEDICAL QUALITY OVERSIGHT COMMITTEE)**

DR M. WALE, CHAIR (MINISTRY OF HEALTH/ISLAND HEALTH). DOCTORS OF BC: DRS P. BARNSDALE, S. BUGIS, L. HALPARIN, B. HEFFORD.

The BC Medical Quality Initiative (BCMQUI) addresses quality assurance activities that began in response to the Cochrane reports of 2011. It also addresses the importance of quality improvement activities as part of lifelong learning that maintains competency and standard of practice.

The Medical Quality Oversight Committee (MQOC) is a Ministry of Health committee that oversees the BCMQUI working groups: Quality Assurance, Physician Quality Improvement, and Multidisciplinary Quality Improvement. The MQOC has broad membership from the Ministry of Health, health authorities, the College of Physicians and Surgeons of BC, the BC Patient Safety and Quality Council, UBC, and Doctors of BC. The Ministry of Health is working on a framework document on quality that will help support quality

improvement activities.

A Privileging Dictionary Advisory Committee has been formed to consider revisions and additions to the privileging dictionaries and to evaluate the new privileging process. BCMQUI has requested two physician representatives from the Doctors of BC: one family physician and one specialist. The Doctors of BC Board has approved that request and the nominations process is now underway. (Please go to the website [bcmqi.ca](http://bcmqi.ca) for further details about BCMQUI and its activities.)

—S.P. Bugis, MD  
Doctors of BC representative

## **DATA STEWARDSHIP COMMITTEE**

MR W. MACDONALD, CHAIR; DR E. CHANG, PUBLIC MEMBER (DOCTORS OF BC), MS T. COLLINS, MINISTRY OF HEALTH REP, MS M. DE VERA, PHARMACEUTICAL REP, MS O. DJURDJEV, HEALTH AUTHORITY REP, MR A. ELDERFIELD, CHIEF DATA STEWARD, MS E. ELLIOT, PUBLIC MEMBER, MS T. HAGKULL, PUBLIC MEMBER, MR G. KEIRSTEAD, PUBLIC MEMBER, MS M. KOEHOORN, HEALTH RESEARCH, MR C. LENCAR, MINISTRY OF HEALTH, MR R. NAKAGAWA, COLLEGE OF PHARMACISTS, MR D. NAM, PUBLIC MEMBER.

The Data Stewardship Committee (DSC) is a legislated committee in the sense that its creation is part of BC legislation, the e-Health Act, which specifies its composition and its duties.

The secretariat of the committee is Mr Cornel Lencar, senior health data request officer in the Ministry of Health, and committee members come from the colleges, universities, Ministry of Health, the legal profession, and members of the general public. I am the only practising physician and represent Doctors of BC, at the pleasure of the Crown.

The mandate of the DSC is to review and authorize all research projects that intend to use the data that are the responsibility of the DSC. The Provider Registry and the Patient Registry are the two registries named in eHealth Information Banks (eHIBs) in the e-Health Act. Research requests for PharmaNet data and Provincial Laboratory Information Services data have also, through their legislation, been assigned to the DSC.

Applications for research grants from BC, across Canada, and elsewhere (within various regulatory frameworks) are reviewed by the Data Stewardship Secretariat, and then discussed and approved, or held for further clarification, or rarely, rejected by the Data Stewardship

Committee itself, which meets once a month.

All data accessed are to de-identified data only, which are often aggregated, but frequently are required at the patient level. In all cases, the applicants are required to demonstrate their diligence for security and privacy. Applicants who can ensure they have a secure research environment (SRE) are more likely to be approved.

All applications are confidential, and neither the applicants nor the subject matter can be disclosed. Many applications are collaborative efforts of researchers/doctors from across Canada, and a significant number of projects come from graduate students. All are in the area of health care—clinical or systems research, and the presence of a physician with clinical knowledge is valuable in the review process, even though the mandate of the DSC is on the privacy and security aspects, rather than the research content.

I contributed to the overall discussion by inquiring about the policy framework for the use of data from multiple administrative sources for clinical treatment and proactive health delivery. The present DSC mandate is only for retrospective research. The general feedback was that in order to accomplish this some modifications to legislation would be needed, and new governance structures would need to be introduced.

—Ernie Chang, MD

Doctors of BC representative

### **DRIVER FITNESS ADVISORY GROUP**

MR S. ROBERTS, CHAIR; DRS I. BEKKER, I. GILLESPIE.  
STAFF: MS S. SHORE, MS D. VICCARS.

The Driver Fitness Advisory Group (DFAG) was formed in 2005 on the initiative of the Superintendent of Motor Vehicles. It is an external committee comprising representatives from RoadSafetyBC and the health professions who may be required to report concerns that arise under Section (230) – Report of medical condition or impairment of the Motor Vehicle Act. Initially, the three professions were physicians, psychologists, and optometrists. In 2010 occupational therapists and nurse practitioners were added under the Motor Vehicle Amendment Act. The respective colleges are also invited to send representatives, as the topics often relate to professional responsibility issues. Doctors of BC representatives include a specialist and a general practitioner.

The mandate of the committee is to be advisory—a focus group of health care professionals that discusses current policy and possible revisions, all from the

perspective of the clinicians' experience with driver fitness issues.

Road safety falls under the mandate of the Emergency and Public Safety Committee (EPSC), a subcommittee of the Council on Health Promotion. Updates from DFAG are a standing item on the EMSC agenda.

Since the reporting deadline for the 2015 annual general meeting, DFAG held meetings on 15 June and 27 September 2016, and 10 January 2017 and focused on several issues:

- The group addressed concerns raised by the Society of General Practitioners about the usability of the CCMTA Medical Standards for Drivers (CCMTA Guide). RoadSafetyBC worked with DFAG representatives to divide the guide into 30 sections, each available online.
- The group discussed the slow processing of urgent evaluations of unfit drivers. RoadSafetyBC worked with DFAG representatives to rewrite the Report of a Condition Affecting Fitness and Ability to Drive form. This form is expected to be released for use in spring 2017 with a number of improvements requested by physicians.
- RoadSafetyBC continued to bring proposed changes to the CCMTA Guide to the group for review.
- RoadSafetyBC identified that current resources required to administer age-based driver fitness reporting is preventing the timely review of urgent medical reports of unfit drivers. RoadSafetyBC is consulting DFAG to consider options for addressing this issue in 2017.

—Ian Bekker, MD

—Ian Gillespie, MD

Doctors of BC representatives

### **INFORMATION PRIVACY AND SECURITY STANDING COMMITTEE**

The Information Privacy and Security Standing Committee (IPSSC) is a new subcommittee of the Ministry of Health IM/IT Standing Committee (IMITSC). The Doctors of BC has representation on the IMITSC as well. The mandate of the IPSSC is to promote and govern health information and privacy across the BC health sector and report to the IMITSC. Doctors of BC was invited to put a representative on this committee, and in September 2016, the Board decided to do this on a 1-year trial basis.

Having a Doctors of BC representative on this

committee meets the association's strategic objective to engage with government on the development and implementation of policies and programs that promote the best standard of health care.

The immediate agenda of this committee is to advise on the creation of new health information privacy legislation. This new legislation is proposed to replace several older existing acts, with the purpose of enabling efficient sharing of information in a modern provincial health care system while protecting patient privacy.

—Eugene Leduc, MD  
Doctors of BC representative

### **MD ADMISSIONS SELECTION SUBCOMMITTEE**

The MD Admissions Selection Subcommittee is a subcommittee of the MD Undergraduate Education Committee (MDUEC). Its purpose is to consider and select applicants for interview offer and ultimately admission to the MD undergraduate program in accordance with UBC and Faculty of Medicine policies and social responsibility mandate.

This subcommittee has three types of members: ex officio, elected, and appointed. Doctors of BC is included under the appointed category, and I am entering my third year in this role. The committee meets in person once per year to review applicant files in detail and make decisions about admission. Throughout the year there are brief meetings for planning and discussion of any policy change.

Significant changes in the past year include introducing a new MCAT and removing basic sciences as a mandatory requirement. This latter decision was made to remove the obstacle some excellent candidates might have to applying due to the lack of one particular course. It also encourages applications from a wide range of individuals. There was much discussion about this topic, and ultimately it was agreed that the MCAT requires basic science knowledge regardless of what specific course was taken by the student. These courses continue to be “recommended.”

The admissions process is an impressive undertaking. First, the written applications are screened, and from those some applicants are invited to an interview. Applicants are then assessed based on their academics, nonacademics, MCAT score, and interview score (itself a rigorously tested process). Final decisions are made in April and the successful applicants are notified shortly after. For the 2016 admission year, there were 2124 applicants (1467 from BC) and ultimately 288

seats assigned.

The process is impressively thorough, with serious consideration given to the many qualified applicants. It is an honor to sit on the committee as the Doctors of BC representative, providing my perspective as a community physician.

—Lilah Rossi, MD  
Doctors of BC representative

### **MD UNDERGRADUATE ADMISSIONS POLICY ADVISORY COMMITTEE**

This is a subcommittee of the MD Undergraduate Admissions Committee that considers the evolution of policies affecting admissions and recommends the criteria, policies, and procedures for the admission of applicants to the MD Undergraduate Program. The committee also evaluates how these changes affect those selected in medical school as well as the quality and distribution of physicians produced in keeping with the Faculty of Medicine's social responsibility mandate.

Three years ago, I was on a working committee to re-examine the nonacademic qualifications for admission to UBC. These qualifications were initiated last year, and this year they were evaluated in terms of how they affected the selection and distribution of the medical class. There is also an increased awareness of the Policy Advisory Committee about the medical needs throughout the province for First Nations and rural areas, and how the distributed program addresses these needs. There has been a yearly increase in the number of spots for First Nations applicants. These changes reflect the supply needs and interests of practising physicians of BC and future health care.

In our early fall meeting, we review how recent changes are reflected in the medical students accepted and consider new initiatives to further the goals of diversity and social accountability. The second meeting brings three associated committees together (policy, selection, and northern rural) for information and discussion. The March meeting considers changing demographics, and then the late May meeting reviews how the present application process proceeded. Admissions is a crucial part of deciding who will be our future doctors and provide health care in BC and I appreciate being part of the process.

—Mary Johnston, MD  
Doctors of BC representative



## PROVINCIAL ROAD SAFETY STEERING COMMITTEE

MR S. MACLEOD, CHAIR; DR D. BUTCHER. STAFF: MS B. HODGSON, MS K. SAUNDERS, MS H. THI, MS D. VICCAR, MR J. WONG.

The Provincial Road Safety Strategy Steering Committee oversees the implementation of the report *BC Road Safety Strategy: 2015 and Beyond*. The purpose of the strategy is to:

- Work toward zero deaths and serious injuries from road traffic in BC.
- Promote road safety.
- Increase efficiencies within the road safety community.
- Facilitate the creation of improved information and tools to support road safety.

The Steering Committee reports to the Minister of Justice and has representation from a broad range of stakeholder organizations. The committee produces an annual report on the progress of road safety outcomes, delivers the BC Road Safety Strategy, and develops 5-year succession plans to the 2015 strategy. Doctors of BC is kept informed of and provides input to the discussions of the Steering Committee through the Emergency and Public Safety Committee.

The Steering Committee has endorsed a “safe systems” approach to road safety. They have created five working committees, each of which is given the task of developing initiatives to support road safety in BC. The Steering Committee is currently re-examining the governance of the BC Road Safety Strategy and is developing a Road Safety Secretariat to support and coordinate the work of the committees.

The Steering Committee has also endorsed the development of a branded initiative, Vision Zero. The logo for this initiative was launched at the BC Road Safety Strategy Conference in December 2016, and now the committee is overseeing the development of a toolkit for user groups to participate in road safety initiatives and activities toward the goal of zero road-user deaths.

The conference featured speakers who outlined initiatives and research related to road safety. Topics included cannabis and prescription drug impaired road users, and training on installing and using infant and child safety seats. A proposal is under consideration for developing a best practices guide using a public health approach to promote safe behaviors by all road users.

The committee continues to support the development of a Road Safety Research Institute.

—David Butcher, MD  
Doctors of BC representative

## PROVINCIAL SURGICAL EXECUTIVE COMMITTEE

MS M. COPE, CO-CHAIR; DR A. HAMILTON, CO-CHAIR; DRS S. BUGIS, M. STANGER. OTHER MEMBERS OF THE COMMITTEE INCLUDE THE SURGICAL AND ADMINISTRATIVE LEADS FOR EACH HEALTH AUTHORITY, MINISTRY OFFICIALS, AND MEMBERS OF THE PUBLIC.

The Provincial Surgical Executive Committee (PSEC) is a Ministry of Health committee whose mandate is to provide strategic oversight for the planning of surgical services across BC, although it recognizes that it does not have resources to provide what is needed to the six health authorities who are responsible for putting the strategy into action. This committee replaced the Provincial Surgical Advisory Committee about 2 1/2 years ago.

In 2015 the focus was on addressing surgical waitlist issues. The health authorities used additional funding from the Ministry of Health that was specifically targeted to increase capacity. Each health authority reported back to the Ministry of Health and to the PSEC about those activities.

The PSEC has been working on an overall surgical strategy that includes addressing access, surgical growth and demand, health human resources, pathways (e.g., ERAS), performance indicators, funding formulas, surgical oncology, and information technology. In June 2016 the Ministry of Health asked that the implementation of the surgical strategy be accelerated. Eleven early-adopter sites have now been chosen, but it has been a challenge getting input from the practising surgeons and other providers to the implementation group. We are awaiting results of the implementation to find out what has been learned so far at the 11 sites.

—S.P. Bugis, MD  
Doctors of BC representative

## RESIDENT DOCTORS OF BC

DR D. KIM, REPRESENTATIVE

This year Resident Doctors of BC focused on two strategic priorities: increased member engagement and improved stakeholder collaboration. We started the year with several distributed training site visits and the annual Fireworks Social, which is a cocktail reception held in conjunction with the Celebration of Lights fireworks festival. Residents showed their support for the LGBTQ community by marching in the Vancouver Pride Parade alongside the UBC Faculty of Medicine. In the fall, several

of our past presidents and board members joined us for a formal dinner to celebrate the 2015 Awards of Excellence winners: Drs Megan Ho, Jagdeep Ubhi, and Andrew Campbell.

Resident Awareness Week (RAW) was, as usual, a big focus for the association over the winter. The BC government proclaimed 6-10 February 2017 as Resident Awareness Week, which was celebrated jointly with the other provincial resident associations and our local stakeholder organizations. Residents reached out to the public through booths at several community centres around BC to spread awareness about their role in the health care system. Multiple articles were published internally and externally, including profiles of a few residents based in distributed sites. We also conducted an extensive social media campaign and ran our Humans of Residency project for the third time.

In response to letters sent during RAW, two board members had the opportunity to hold individual discussions with three MLAs in Victoria. Considerable time was spent with the Minister of Advanced Education; as a physician, he understands the particularities of medical education. These meetings have strengthened our relationship with provincial politicians. We also had success in developing our relationship with the Ministry of Health through the creation of a joint task force with resident and ministry representatives to facilitate resident input and collaborate on health care policies and initiatives.

We recently held our annual tax clinic and workshop in collaboration with Financial Literacy Council and Employee Family Assistance Program. The parenting workshop was held at the end of April. We are looking forward to our annual orientation event in June; our keynote speaker this year will be Dr Julielynn Wong, a Board-certified public health and preventive medicine physician who is internationally recognized for her contributions to digital health and medical technology.

Finally, there were substantial internal changes with association staffing this past year; most notably, Ms Pria Sandhu left her role after almost 10 years as the executive director, and we welcomed Mr Harry Gray as the new executive director to lead Resident Doctors of BC. Mr Gray has a background in health care, education, and labor relations, which made him an excellent fit for the role, and we are excited to see how he will grow the organization.

—David Kim, MD  
Representative

## UBC FACULTY OF MEDICINE EXECUTIVE COMMITTEE

The primary functions of this committee are to advise faculty on academic matters, carry out faculty business between full faculty meetings, and obtain faculty approval for its actions. The committee meets six times per year, and at the time of writing had met in September and November 2016 and January 2017.

Highlights from the meetings include:

- A clinical faculty mentoring program is being developed in direct response to a survey done by the Doctors of BC in 2015.
- CACMS has granted continued accreditation status to the undergraduate MD program.
- The Faculty of Medicine has developed a new strategic plan, Building the Future. Its four transformative goals are education, research, organization, and partnerships. An implementation framework has been presented to the full faculty, and the plan is available on the UBC Faculty of Medicine website.
- An Office of Education Innovation is being established.
- The faculty executive has approved the establishment of a School of Biomedical Engineering and a Biomedical Engineering program and curriculum to be jointly taught by both the Faculties of Medicine and Applied Science.
- The faculty executive has approved the establishment of the Master of Global Surgical Care program and associated curriculum.

—Darlene Hammell, MD  
Doctors of BC representative

## UBC MEDICAL UNDERGRADUATE SOCIETY

D. LU, PRESIDENT; MR K. SHIH, VP EXTERNAL SR;  
MS L. KIM, VP EXTERNAL JR.

The 2016-17 academic year was a busy one for the Medical Undergraduate Society (MUS), working on several internal and external initiatives. The focus this year included greater integration with our partner organizations, better student engagement with the organization as a whole, and developing and implementing the MUS Strategic Plan 2017-20.

The Division of External Affairs, including the VPs External and Global Health, AMS representative, and Director of Sponsorship and Donors, has been focused on fostering relationships with our many external

partners. Highlights include participating in Provincial Lobby Day at the BC Legislative Assembly in collaboration with the Political Advocacy Committee, centralizing and enforcing access and sponsorship of medical students from third parties, and organizing a very well received multidisciplinary Global Health Conference. The MUS was also represented at the CMA General Council by eight UBC students, three of whom were on the Doctors of BC Caucus.

The Division of Internal Affairs, including the VP Internal, clubs' representative, and sports representative facilitated the day-to-day operations of the vibrant MUS clubs program, which consists of more than 80 clubs and interest groups. As well, they were active in the organization of the 2017 Ice Bowl, an annual hockey tournament that brings together medical students from BC to Manitoba.

The Division of Academic Affairs participated in the development of the new medical school curriculum, with focus on the clinical clerkship for upcoming years. This marks the first year of the Medical Education Committee (MEC), a very successful initiative by the MUS and interested students to coordinate the efforts of the many students that sit on academic committees across each of the years and sites. The MEC continues to make refinements as it moves forward to ensure that medical students are well represented in the decisions that affect their education.

This year was marked by the tragic passing of Laura Taylor, a third-year medical student suffering from mental illness. Her death shook the entire student body and medical students across the country. In her honor, her family, the Mental Illness Network for Destigmatization, and the MUS collaborated to create the Laura Taylor Award to identify and celebrate students in each year who go above and beyond in reaching out to their fellow students and creating a sense of community in their class.

The newly elected MUS council will continue with the projects set out this past year, implementing the items laid out in the new strategic plan.

—Kingsley Shih  
VP External Sr


## **UBC NORTHERN MEDICAL PROGRAM ADMISSIONS SUBCOMMITTEE**

DR B. FLEMING, CHAIR; DR S. BREARS, DR M. CURRY, DR T. FRASER, MS K. GUNN, MS L. HELVQUIST, DR C. HOLMES, DR M. HYSLOP, DR A. JONES, DR P. KINDLER, DR T. LARSEN SOLES, DR G. PAYNE, MR T. PFANNER, DR P. RUBEN, DR B. SIMPSON, DR D. SPOONER, MS L. TAMBLYN, DR M. WATT, DR P. WINWOOD.

The Northern and Rural Admissions Subcommittee is a standing subcommittee of the Admissions Selection Committee of the UBC Faculty of Medicine MD Undergraduate Program. Its mandate is to help select students for the Northern Medical Program and a designated number of rural positions in the Southern Medical Program of the UBC Faculty of Medicine. Its primary objective is to select students in accordance with UBC and Faculty of Medicine policies to address the social accountability mandate of the university. The committee has delegated authority and acts on behalf of the MD Undergraduate Education Committee.

The committee meets three times annually. This year's meetings were 12 October 2016 and 18 January 2017 by videoconference, and 28–29 March 2017 in Vancouver. I serve as the Doctors of BC representative and am funded through REAP. The specific details of the committee meetings are confidential and each member of the committee must sign a waiver annually for continued participation. A term is 3 years and individuals may be reappointed once. This is my sixth year and final term on this committee.

—Trina Larsen Soles, MD  
Doctors of BC representative



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115-1665 West Broadway, Vancouver, BC Canada V6J 5A4  
604 736-5551 • Fax 604 638-2917  
1 800 665-2262  
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