Issue No. 35 | 19 Years of Service | 2013

The Cutting Edge

A Voice for Ontario's General Surgeons
ONTARIO ASSOCIATION OF GENERAL SURGEONS
(OMA Section on General Surgery)
OAGS
Ontario Association of General Surgeons
Association des Chirurgiens Généraux de l'Ontario

MOHLTC revamps hospital funding

High volume procedures move to out-of-hospital facilities

By Dr. Chris Vinden

Dear Colleagues,

It is an honour to author my first column as President of the OAGS.

We are in a time of significant change in the practice of medicine in Ontario, as the Ministry of Health and Long Term Care is dramatically changing the funding formula for hospitals and at the same time is becoming a much more active manager. Some aspects of these policy changes are exciting, while other aspects are completely baffling.

On the positive side, the Ministry has finally figured out the basic management principle of alignment of incentives. The Quality Based Procedure (QBP) initiative is just a fancy way of saying that hospitals will be on "Fee-for-Service" rather than being on a salary (global funding) with an absent, disinterested boss. This is something that we have wanted for years. Most other countries figured this out years ago; we are the last OECD country (Organization for Economic Co-operation and Development) to do this and are at least a decade behind most other progressive nations.

Finally, the patient's interests, the surgeon's interests and the hospital's interests are aligned. We all want to get the procedure done. The only outliers in this scenario are the nurses' unions who still cling to seniority rather than merit-based models and have little interest in productivity-based pay scales or incentives. The good news is that hospitals will no longer be interested in closing operating rooms to save money, as it just means that they won't get paid. The bad news is that if they can't do the procedure for what the Ministry is willing to pay, then they won't want to be in the business at all, and you may not be doing your favourite operation.

We have a major part to play in this, as we drive a significant proportion of costs. Do you really need the convenience of the $500 laparoscopic stapler or could a reusable extra-large clip applier do the job for a couple of bucks? Is the $500 energy device really necessary? Do you really need to keep that patient in hospital an extra couple of days? Historically, these decisions had little impact on us, but now they will become important parts of whether your hospital wants to be in the business of providing a service.

The baffling part of the Ministry's new agenda is their stated desire to move some "commodity procedures" into out-of-hospital facilities. Before they have even given hospitals a chance to manage cases on a fee-for-service basis, they want to award these high volume procedures to the private sector. The most notable example is endoscopy, which is of tremendous importance to General Surgery. It is the most common procedure done in Ontario with over 600,000 per year. General Surgeons do more endoscopy cases than the total of all our other procedures combined. It forms 40% of our incomes, and in many smaller communities that figure is much higher.

All the funding for endoscopy both within hospitals and outside of hospitals will be channelled through Cancer Care Ontario. Once again, there will be a drive to lower costs, and only those institutions that aren't losing money will want to stay in the business. In this situation, however, it is not a level playing field, as the private facilities are not encumbered with union pay scales or productivity issues.

While OAGS embraces a quality agenda as well as an appropriate technical fee for out-of-hospital endoscopy, we are opposed to a shift of hospital-based volume to out-of-hospital facilities. General Surgeons are a very important cog in the complex system of a full service hospital. We strongly believe that it is in the interests of our inpatients and emergency patients as well as for overall hospital efficiency that we remain with a large footprint within the hospital system. Hospitals will still have to have endoscopy facilities for emergencies - patients with high co-morbidities as well as inpatients. It is far better that those complex cases are done within a large busy full service unit than within an inefficient,

See "President" on page 10

INSIDE

NOTICE: OAGS 2014 MEMBERSHIP DRIVE (Jan-Dec, 2014)

Please be reminded that the OAGS is beginning to collect annual dues for the new fiscal of 2014. Invoices will be enclosed in this issue. For more details or to pay online, please visit our website: www.oags.org/join.htm . For any queries, please feel free to call our office: 1-877-717-7765.

20th OAGS ANNUAL MEETING: Saturday, November 1, 2014

OAGS Board of Directors, President Dr. Chris Vinden, AGM Committee Chair Dr. Angus Maciver and Section Chair Dr. Jeff Kolbasnik would like to thank all those who attended our recent Annual Meeting and invite all General Surgeons to next year's 20th OAGS Annual Meeting on Sat., Nov.1, 2014 at the Sheraton Toronto Airport Hotel, 801 Dixon Rd. For more details: www.oags.org. (Note: Free annual meeting admission to OAGS members.)

Editorial...

By Dr. Ciaran Kealy

This incoming year marks the 20th Anniversary for the OAGS and also a changing of the guard. Most of our board have to step down at the year end, as they have served their allotted time. I personally have been involved with our organization since its inception (1995).

I believe it was in the early 90's when I attended one of the annual meetings of the OMA. I couldn't find the meeting spot but eventually ended up in a room with a number of other General Surgeons where we moaned about how hard we worked and how badly paid we were. Then, we retired to the bar and further commiserated with each other.

I subsequently ended up as Chair of the Section, a delegate to the OMA, and chaired the Section meeting the following year. I found it very interesting. Being the new Section Chair, however, I came under a certain amount of attack, as if I were responsible for our miserable circumstances. Fire has to be attacked with fire, so I managed to get most of the gripers on the executive, which turned out to be a very good move. The only problem was the OMA was, in its paternalistic fashion, pulling the strings. It was also very opposed to any section trying to hive off from the mother ship.

One of the advantages of Council was running into other Section chairs. Ted Rumball was the then Chair of Orthopaedics. The Orthopaedic Surgeons had set up their own organization and were very aggressive in promoting their own interests. Imitation is, of course, the sincerest form of flattery, so we basically plagiarised what they had done and set up the OAGS.

The OMA, which some people say is the most powerful union in the country, also has resources that an organization like the OAGS could not hope to emulate, so our new group, working cooperatively with the OMA Section, has always been able to utilize these resources. The OMA has always been very helpful to us (Section/OAGS), which we appreciate very much. As an organization, we have always had the "protection" of our membership at the forefront.

The Institute for Clinical Evaluative Sciences (ICES), which was set up around the same time as ourselves, put out a report in the late 90's that surgeons around the province had huge complications with laparoscopic cholecystectomies. This report was widely published in major national newspapers. Anyone who has ever had the misfortune of injuring a common bile duct knows how devastating this can be, not only to the patient but also the surgeon involved. It turns out, however, their statistics were all wrong. A difficult cholecystectomy requiring drainage to control bile leakage was classified as a bile duct injury.

The papers had a field day - open war on the province's General Surgeons. We took issue with this and got in touch with *The Toronto Star's* press ombudsman - a position that nobody appeared to know much about. Toronto's Dr. Bryce Taylor and the OMA looked into the cases involved and disproved the allegations. *The Toronto Star* ended up publishing a retraction - giving it the same space and prominence as the original article.

On-call has always been a contentious issue with us as well. The fact that we were expected to provide this without any compensation was a source of extreme frustration, particularly since other better paid (fill in the blank) specialties were rarely in a hospital emergency room after 4 p.m. We spearheaded paid on call and this has been a major accomplishment of our organization. We set up guidelines for on call, whereby no one can be expected to do more than 1 in 5, unless they want to.

Other guidelines have been set up with respect to resources available to us and the amount of OR time we are entitled to as well. Unfortunately, this has not worked out as it should have due to fiscal restraints, but paradoxically favoured specialties have been excluded. One has to conclude that it is important for voters to be able to walk into polling stations and see the ballot they are marking. Fortunately, our organization now has money in the bank, giving us a healthy financial cushion for the next crisis that undoubtedly will occur down the road.

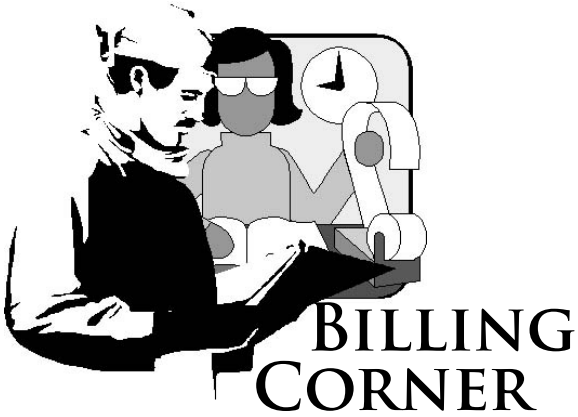
This will be my last Editorial for *The Cutting Edge*. Dr Tim Jackson will be taking over the newsletter in the new year. Many thanks to our contributors, our executive and to Lori Quilty for all their help over the years. (See p.11)

- Dr. Ciaran Kealy, OAGS board member and newsletter editor, is on staff at Health Sciences North, Sudbury. He was also the founding President of the OAGS.

Upcoming CPD Events

DATE	EVENT
Feb. 7, 2014	MAGIC Update (Multidisciplinary Annual GastroIntestinal Cancer) The Westin Prince Toronto Hotel, Toronto, ON Web: www.magicupdate.ca
Feb. 8, 2014	UofT Hand and Upper Extremity Update Eaton Chelsea, Toronto, ON Web: www.cepd.utoronto.ca/upperextremity
Feb. 15-19, 2014	16th Annual Pain Management Symposium Caesar's Palace, Las Vegas, NV Web: www.clevelandclinicmeded.com
Feb. 23-26, 2014	27th Annual Update in Emergency Medicine Whistler, Blackcomb, BC Website: www.cepd.utoronto.ca/whistler/
Feb. 26 - Mar. 1, 2014	Minimally Invasive Surgery Symposium 2014 Venetian/Palazzo Hotel, Las Vegas, NV Web: www.miss-cme.org/
Feb. 27- Mar. 1, 2014	2014 Canadian Society of Transplantation Annual Scientific Conference Le Centre Sheraton, Montréal, QC Web: www.cst-transplant.ca/AnnualConference.cfm
Mar. 28, 2014	An Overview of Evaluation and Treatment of Posterior Pelvic Floor InterContinental Hotel/BofA Conf. Ctr, Cleveland, OH Web: www.clevelandclinicmeded.com/live/courses/
April 3, 2014	44th Annual Breast Surgery Symposium Toronto Hilton, Toronto, ON Web: www.torontoaestheticmeeting.ca/
April 4-5, 2014	44th Annual Aesthetic Plastic Surgery Symposium Toronto Hilton, Toronto, ON Web: www.torontoaestheticmeeting.ca/
April 9-11, 2014	Trauma 2014: TAC Annual Scientific Meeting Centre Mont Royal, Montreal, PQ Web: www.ubccpd.ca/event/trauma-2014/
April 10-12, 2014	UofT Update in General Surgery Toronto Hilton Downtown, Toronto, ON Web: www.cepd.utoronto.ca/generalsurgery/
April 11-12, 2014	11th Biennial Canadian Ortho Foot/Ankle Symposium Eaton Chelsea, Toronto, ON Web: www.cepd.utoronto.ca/footankle/
May 24, 2014	Ambulatory Endoscopy Clinic Day Hotel Intercontinental, Toronto, ON Web: www.gutsmart.com/aecd/
May 26-27, 2014	UofT 1st Annual Canadian Burn Symposium Toronto Westin Harbour Castle, Toronto, ON Web: www.cepd.utoronto.ca/cdnburnsymposium/
Saturday Nov. 1, 2014	**20th OAGS Annual Meeting** **Sheraton Toronto Airport Hotel & Conference Ctre.** **Toronto, ON** **Web: www.oags.org ; Email: info@oags.org**

For the complete listing of CME events, check our website:
http://www.oags.org/events.htm
For a listing of national and international CME courses:
http://www.doctorsreview.com/meetings/



By Dr. Alan Lozon

For this month's *Billing Corner* column, I will be reviewing the presentations made at the recent 19th OAGS Annual Meeting.

Extra Codes For Certain Procedures:

Some surgeons are billing additional procedures when they are performing certain cases. The two examples that have come to light have been 1) an additional billing for an umbilical hernia while doing a laparoscopic cholecystectomy, and 2) billing a ventral hernia repair while doing a Hartmann's reversal. If there is an umbilical hernia present or if a stomal hernia is present, then these can be considered appropriate billings. If there is no hernia present, these should not be billed, as it would be considered fraudulent. In the situation where the hernia is present, sending the sac for pathologic confirmation would prove the hernia was present and be useful in the event of payment refusal for the additional procedure.

Number of Consults Per Year:

One of the questions that arose last year was how many consults (A035) is a surgeon allowed to bill in a year. The answer to this is quite straight forward. A surgeon can bill two A035's on a single patient in one year, provided the consults are for two completely different issues. The OHIP Schedule of Benefits (SOB-Oct2013) states as follows in the General Preamble (p.GP12):

"Consultations, except for repeat consultations (as described immediately below), are limited to one per 12 month period unless the same patient is referred to the same consultant a second time within the same 12 month period with a clearly defined unrelated diagnosis in which case the limit is increased to two per 12 month period. The amount payable for consultations in excess of these limits will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant."

So, based on this, the surgeon can bill two full consultations for two completely different diagnoses. There can only be two in a 12 month period (not in the calendar year). Any additional consultations can be billed as A036 (repeat consultation) to an unlimited number.

How To Bill Surveillance Colonoscopy:

There is no description in the Schedule of Benefits for billing surveillance colonoscopy after colon cancer resection at the 1,3,5 year intervals as recommended. For this, we (and OHIP) are advising the use of Z498 (surveillance) and have been assured it will be paid.

Billing Reviews:

It had come to our attention that some surgeons were experiencing more billing refusals and reviews than traditionally had been occurring. To this extent, I poled the membership at the last meeting to see if this was the case and how many more surgeons were involved. The results showed that 60% of surgeons had noted an increase in the number of reviews and refusal for payments. Most of these were General Surgeons (at 71%) followed by colorectal (11%) and surgical oncology (9%). Of the respondents, 49% reported to the Oshawa office.

As far as commonalities in the refusals, the only one identified was for billings that were for 2 or more codes with 55% of surgeons reporting refusals on the basis of this. Of surgeons, 37% were not able to identify any specific cause for the increased reviews or refusals.

Based on this data, the only suggestions that I have would be to ensure that if you are billing two or more codes on a patient, then be sure to have full documentation in the form of specifics in your operative notes along with supportive pathology or other documentation.

That is all for this month's *Billing Corner*. Keep the suggestions and questions coming. - Al

- Dr. Alan Lozon, OAGS Board Member and OMA Section Tariff Chair, is on staff at the Grey Bruce Health Services, Owen Sound.

NOTE: Please note that the opinions expressed above are those of the author and do not necessarily represent OMA or OHIP Policy. We are always looking for ideas or tips/tricks, so members are MOST encouraged to send us your questions or suggestions. Ideas can be sent via email (info@oags.org), fax or mail. Further information can be found on the MOHLTC/ Schedule of Benefits website: http://health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html.

New Editor for the Edge

After almost 20 years at the helm of the now prominent and well-anticipated publication *The Cutting Edge*, our long-standing **Chief Editor Dr. Ciaran Kealy of Sudbury** will be completing his term as board member at the end of 2013 and so too his management of our newsletter, while his source of inspiration will remain.

When he and his board founded the independent organization of the OAGS back in 1995, he had a vision of creating a vehicle to help facilitate communications with, as well as a Voice for, the General Surgeons of Ontario, hence *The Cutting Edge* - funded and brought to you solely by the OAGS and its membership.

It has since grown into a well-respected biannual. We would like to take this time to thank Dr. Kealy for taking this initiative and reaching out to his colleagues all those years ago and wish him well!

Although the respective presidents help oversee the publication as well, board member **Dr. Tim Jackson** has offered to succeed Dr. Kealy as Chief Editor. We wish him luck in continuing your Voice.

IN MEMORIAM

Dr. Raymond Rahn
Lennox and Addington County Hospital, Napanee
Passed Away on September, 2013
(OAGS Member: 2002-2010)

Note: Let us know of any other colleagues who should be remembered.
Contact OAGS: info@oags.org

The Cutting Edge newsletter is a bi-annual O.A.G.S. publication written by General Surgeons for General Surgeons. It is in its 19th year of existence. It has a circulation of over 500 General Surgeons and General Surgery Residents within the province of Ontario. Any comments related to the contents of this publication or General Surgery issues can be emailed to: info@oags.org ...or faxed to 705-745-0478.

Chief Editor: Dr. Ciaran Kealy
Editor/ Design & Layout: Lori Quilty

Resident Rostrum

By Dr. Kellen Kieffer
O.A.G.S. Resident Representative

Jobs Crisis in General Surgery

Our specialty is in the midst of a job crisis. Unemployment issues, which started as new grads not being able to secure the job they wanted, have turned into new grads not being able to secure a job at all. A recent Royal College survey quotes our unemployment rate at 16% and going up fast. This is the most important issue facing surgical residents today and an issue of utmost importance for the future of our specialty.

General Surgeons rely on hospital resources and operating room time to serve the community. As these resources remain fixed, there is only room for a finite number of General Surgeons in our province. Training more will not have any impact on wait times or patient care; it will just produce more underemployment and unemployment. We are highly trained and highly specialized, so we cannot easily be made to serve the public in other areas of medicine. There are a limited number of openings for new full-time surgeons every year - openings created when older surgeons transition out of full-time practice (to retirement or something else productive). In Ontario, this number is about 15.

"...cutting enrolment to medical schools is the first step."

Our current job crisis was completely predictable. About 20 years ago was when we started training more residents than the magic number of 15, as stated above. Initially, this was not a problem. In fact, it was a big help, as we actually had a shortage of surgeons in the mid 90's. But it didn't take long to fill the deficit, and all the while, training programs continued to grow. There is every incentive for a medical school to take on additional residents. Every resident carries with him/her government funding that goes to the training program (in addition to the resident's salary paid to the resident). Extra bodies means more hands to share the workload and cover the call schedule. More residents means more research output, bringing more prestige to the program. A larger resident contingent "buffers" against drop-outs. When union-mandated resident work-hour restrictions came into effect, however, the size of residency programs shot up even further.

Right now, there are over 50 General Surgery residents completing their 5th year in Ontario medical schools. Compare that to 15 annual retirements, and we are training over three times the number we need! As you can see with such a surplus of surgeons flooding the job market every year, our training system has quickly become unsustainable. We need to get back to a situation where we are training the number we need. That means significant cuts to residency programs. Accomplishing these cuts, however, has proven quite difficult. Though we have known about this problem for over 3 years now, relatively little has changed.

One of the major obstacles to necessary change is the **misinformation** that is circulating regarding manpower in our province. A popular myth is the idea that there is a large group of "baby boomer" surgeons delaying retirement because of the recent economic recession. On the contrary, the practising General Surgeons in Ontario comprise a very young group compared to the average physician with the largest proportion between the ages of 40-49 (data from OMA economics department). Another myth is that surgeons of the "new generation" are willing to work far fewer hours than their predecessors. Billing data demonstrates that this is false. After their first two years, new grad surgeons bill just as much (and therefore work as hard) as their older colleagues. Some advocate that the answer lies in the creation of new jobs and opening of new ORs. Unfortunately, just the opposite is occurring. As health care budgets tighten, physicians' salaries are cut (eliminating the potential to job-share) and hospitals reduce OR time.

A second major obstacle is the fact that there is no national body to provide **oversight** and manpower planning. There are multiple stakeholders involved in the allocation of residency spots. We have the medical schools that actually train the residents, the provincial Ministries of Health that fund the training, and the Royal College which provides academic oversight (accreditation, academic standards) and licensing for new graduates.

To me, there is no question that major cuts to residency programs are going to be the ultimate solution to the job crisis. Some have taken the approach of trying to "make room" for the superfluous trainees such as job sharing, on-call coverage, assisting, working exclusively in "scope shacks" or walk-in clinics, etc. To me, this is a roundabout, backwards way of approaching the problem. Why should all surgeons suffer to accommodate a surplus? Why don't we just train the correct number in the first place? When the job market is overwhelmed, there will be negative consequences even for those with gainful employment. Our negotiating power with the government will quickly erode and our income will be cut. Our perceived value in hospitals will decrease as General Surgeons become "a dime a dozen". We will be competing within our specialty for patient referrals and operating time. Eventually, we will need to start advertising.

The unemployment crisis is not something that is limited to General Surgery. Orthopedics, Ob/Gyn, Urology, Plastics... all the surgical specialties are in trouble. This has all come about through poor manpower planning. We are also admitting too many medical students in the first place. The pendulum has swung wide in the opposite direction from the physician shortage of ten years ago.

What are the next steps? We need cooperation and, more importantly, action from all stakeholders - even though this may be difficult in the short term. There is no question that cutting enrolment to medical schools is the first step. General Surgery residency programs across the country will then need to reduce their numbers by 2/3. In Ontario, we should have between 15 and 20 residents per year. For example, the University of Toronto currently admits 14 on their own. This will need to be reduced to about 5 or 6, with similar proportional reductions in other programs. The workload previously shouldered by these residents will need to pass to other healthcare professionals. This could include new staff positions (possibly acute care surgeons), surgical hospitalists, nurse practitioners or physician assistants. On a national scale, we will need to continually reassess the manpower situation and develop projections for future manpower needs. I feel that the Royal College is in the best position, as a national body, to take on a leadership role in this regard and in fact they have already made specialist unemployment a priority going forward.

The Royal College will be organizing a national summit on physician unemployment, tentatively slated for February, 2014. I hope that this will be a launching point for some real action in this matter, because it is a major issue for physicians across the board. The OAGS would welcome any discussion from its members about the job crisis going forward. But most importantly, I hope this issue stays in the forefront of everyone's mind so that it can be dealt with and the future of our specialty can be secured.

As always, if there are any resident-related issues you would like to be brought to the OAGS or discussed here, please contact me or the OAGS at info@oags.org or contact your local OAGS Resident Liaison:

- ***McMaster University: Jennifer Li***
- ***Ottawa University: Amber Menezes***
- ***Queen's University: Mike Rizkalla***
- ***University of Toronto: Debbie Li***
- ***University of Western Ontario: Dave Paskar***

Kellen Kieffer, OAGS Resident Representative
PGY 4, General Surgery, Northern Ontario School of Medicine (NOSM).

OAGS survey questions validity of CANDI data

General Surgeons acquire more post grad training than relativity modifier dictates

By Dr. Chris Vinden

In October, we circulated a survey to members via email with regards to years of training and current work hours.

The impetus for the survey was the upcoming negotiations and the slim possibility of new money being available. The last time money was available it was doled out according to CANDI methodology (Comparison of Average Net Daily Income), a highly controversial scheme founded on the divisive and communistic principle that everyone should make the same amount of money for the same number of hours worked regardless of complexity, stress level or training required.

Some degree of reason was achieved as the final iteration of CANDI and a skills acquisition modifier was introduced to compensate for the lost opportunity costs and investments of additional training time. The lost opportunity cost modifier was 2.7% per extra year of training and the skills acquisition modifier was 4% per additional year of training for a total of 6.7% extra per additional year of training.

However, the CANDI methodology uses the minimum years of training by the Royal College of Physicians and Surgeons of Canada to determine the length of medical training for each OHIP specialty. Family Practice was assigned 2 years, and most specialists including General Surgery were assigned 5 years. Vascular Surgery and Thoracic Surgery however were assigned 7 year minimum training periods. These differences are not insignificant and would suggest that Vascular and Thoracic surgeons should make 13.4% more than General Surgeons. Paediatric General Surgeons, hepato-biliary surgeons and colorectal surgeons who have all done additional years of training are all potentially significantly disadvantaged by this.

Our recent survey was done to determine the average duration of post grad training that OAGS members have had, in our anticipation of lobbying for a fairer distribution. The results, based on a response rate of 52 out of a membership of 277 at the time, showed that the average OAGS member started their practice 7.03 years after graduating from medical school. General Surgery training averaged 5.43 years and 52% did fellowships with an average duration of 1.5 years. The totals don't add up because fellowships used to be obtained in November, five months after finishing training.

The bottom line is that most of our members have invested significantly more than 5 years in post graduate training. If new money does become available in the agreement currently being negotiated, we will lobby vigorously that the current CANDI methodology does a disservice to the majority of General Surgeons.

We acknowledge that surveys are irritating and are often imprecise, but we have few other tools to determine the needs of our membership in order to better serve you. The foundation of the CANDI methodology was a complex survey which only 6% of General Surgeons answered. Those answers suggest that we work fewer hours than most other specialists and have lower overhead costs!! Most of us would resolutely question the validity of that perspective, but those numbers are likely going to haunt us for years.

If there had been less apathy about that CANDI survey, especially by busy General Surgeons, we might not have been so disadvantaged by the results. I would strongly encourage you to put aside your understandable disdain for surveys and invest a few minutes in the surveys that we or the OMA circulate. You can't expect good governance without participating.

- Dr. Chris Vinden, OAGS President, is a General Surgeon on staff at London Health Sciences Centre - Victoria Hospital.

Results: 2013 General Surgery Profession & Training Survey

- **Date:** Circulated by email to OAGS members on Sept. 26, 2013
- **Rate of Return:** 19% (52 of 277 responses at the time)
- **Gender:** Female - 27%, Male - 73%
- **Current Average Age:** 50 yrs (32-73 yrs, min-max)
- **Year of medical school graduation:** 1988 median (1964-2007)
- **Average age upon graduation:** 25yrs (23-32 yrs, min-max)
- **Did you graduate from a Canadian medical school?** Yes - 86%, No - 14% (Other: U.K., S. Africa, Columbia, India, Central America)
- **Average length of G.S. residency:** 5.4 yrs (4-10 yrs)
- **Are you trained in a specialty other than G.S.?** Yes-19%, No-81% (Other: CritCare, Int.Med., Vasc., Thor.)
- **Average # of years in other specialty:** 1.6 yrs
- **Was your G.S. residency done at a Canadian medical school?** Yes-96%, No-4% (Other: Columbia, part of residency spent in UK or elsewhere...)
- **Did you do a fellowship after completing your surgical residency?** Yes-52%, No-48% (ie. oncology, critcare, MIS, hepatobiliary, transplant, thoracic, vascular, colorectal, plastics, OBGYN, trauma, gastrointestinal, community general surgery.)
- **Average length of fellowship training:** 1.5 yrs (3yrs max)
- **Average Age of Commencing Practice:** 33 yrs (28-41)
- **Do you practice at an academic health science centre?** Yes-28%, No-72%
- **Type of current practice:** Full Time-89% (at least 40hrs/wk), Part Time-11%
- **Average # hrs/wk spent in OR doing elective surgery:** 9hrs
- **Average # hrs/wk spent in OR doing emergency surgery:** 4hrs
- **Average # hrs/wk spent in endoscopy suite:** 7hrs (30hrs max)
- **If practice includes endoscopy, where is it practised?** hosp-based-82%, private endo only-4%, both-13%
- **Average # of endoscopy procedures/wk:** 14hrs (55 hrs max)
- **Average # of years as an independent surgeon:** 17 yrs (36max)
- **Do you experience problems finding surgical assistants?** Yes-15%, No-85%
- **If you have surgical assistant issues, who do you contact?** General Surgeon/GP: 68%, ORnurse: 20%, Other: 12% (i.e. retired general surgeons, residents/fellows, RNFA, med students, cancel OR)
- **Average age of starting a family:** 31 yrs (41max)

Other Comments:

- I felt that I needed additional ortho/plastics training before I went out into community practice, since NONE was provided during residency
- Relativity is still the main issue that needs to be addressed
- For elective surgery (our surgical assistant)...pool is small; I often rely on an elderly (>73) retired family doc for very complex cases
- If there is no assistant, I...have to cancel my list (or) beg...
- The OAGS needs to reverse its position against out-of-hospital endoscopy clinics; CCO/CPSO are moving forward and OAGS... could be left out
- More needs to be done to allow surgeons to withdraw from on-call and still be able to carry on with elective surgery in order to make a living;...ultimate retirement needs to be worked out to make room for the new and younger surgeons; we should have negotiated for a pension plan....

10th Annual OAGS International Lecture Keynote Speaker Dr. Matthew Hutter (centre - Associate Prof. in Surgery, Harvard Medical School, Boston, MA) debated with Dr. John Bohnen here on "Primary Inguinal Hernia Repair" and also spoke on "Quality Control: Own Your Data/Outcome" as well as a bqt talk.

OAGS Sponsor Chair Dr. Ian Chin (left) presents an award of appreciation to our Gold Level Exhibitor Ethicon (JJMC). We greatly appreciated having 21 exhibitors join us this year at the annual meeting. Their support has helped this respected event grow into what it is today.

Gold Sponsor Covidien receives a plaque of appreciation from OAGS Sponsor Chair Dr. Ian Chin. For more photos and information on attending next year's meeting, please visit our website: www.oags.org.

19th Annu

By Dr. Angus Maciver

The 19th OAGS Annual Meeting again exceeded expectations with consistent quality of presentations on Nov.2/2013 at the Sheraton Toronto Airport Hotel, as well as maintained an impressive attendance of 189. It becomes incumbent for us to acknowledge that our annual meeting has evolved into a key resource for Ontario General Surgeons. That said, we are also committed to correcting slight shortcomings such as registration delays and ample parking space.

The day kicked off with a sparring debate around the management of appendicitis with Ori Rotstein and Sarah Jones squaring off. Marquis of Queensbury rules were followed. Audience participation was lively, and Ori managed to increase his initial support. Mike Marcaccio then gave us an extremely solid update on just about every aspect of biliary disease facing the General Surgeon, in a stepwise synopsis of Gallbladder 101. Niv Sne addressed some of our current concerns with the open abdomen in the ICU, which confronts us all. He provided a comprehensive approach and provided a useful management strategy.

Our immediate Past President/current OMA Section Chair Jeff Kolbasnik and QMP Program Manager Robert McKay updated the membership on the current CCO/CPSO quality agenda for colonoscopy in Ontario. Our members are well represented on this expert panel; we need to embrace quality and participate in driving the bus or risk being under it.

Our keynote speaker Dr. Matt Hutter of Boston, Massachusetts provided us with the necessity of "owning our own data", as quality levers evolve - emphasizing the need for us to participate in controlling this. Hutter returned to the ring with John Bohnen for what was pretty close to a "polite" UFC debate about lap versus open

An impressive attendance was drawn for this year's roster of speakers. Some of ter (Massachusetts Gen. Hosp., Boston,MA), Dr. John Bohnen (St. Michael's Hos Rotstein (St. Michael's Hospital, Toronto), Dr. Niv Sne (Hamilton General Hospi Tandan (Juravinski Hospital, Hamilton). Thanks to all who participated! (Photos

LEFT TO RIGHT: OAGS President Dr. Chris Vinden chaired the morning session. Sect chaired the Business Meeting. Board member Dr. Alan Lozon delivered Billing Corne (QMP), Dr. Michael Marcaccio (Juravinski Hosp., Hamilton) and Dr. Mehran Anvari (D

al Meeting

inguinal hernia repair. John still maintains one has to try very hard to produce a lethal outcome with open herniorraphy under local anaesthetic.

Phillip Peng provided us with a timely update in anaesthesia practice and how it can improve our post-op management with pain control. Ved Tanden, an OMA board member, brought the members up to speed about the government's agenda and how it pertains to funding allocation. Again, quality parameters, although sometimes politically driven, were presented with ample discussion from the floor.

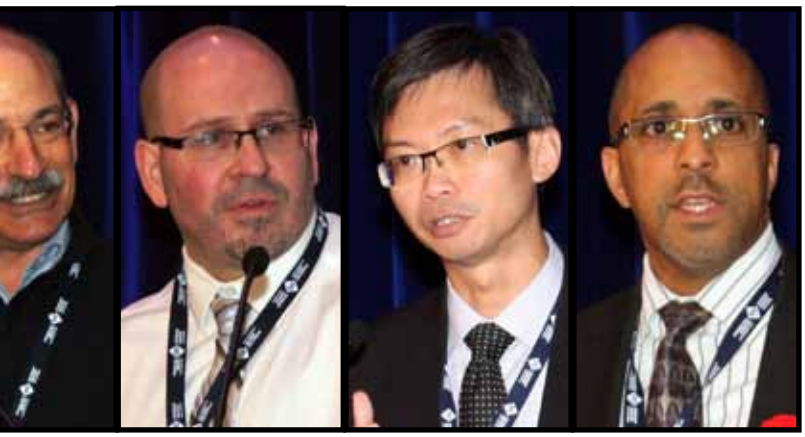
Mehran Anvari and Mike Marcaccio discussed issues of sub-specialization and on call coverage as it pertains to the provision of acute care services in the larger centres of the province. This impacts on our trainees and even those of us in smaller communities referring cases of increased complexity into our regional centres.

Al Lozon's Billing Corner interstitials provided insights throughout the day to keep us informed with tips and on track with some areas of controversy explained. OAGS Vice President Alice Wei ran the business meeting, during which we elected several new board directors to infuse new vigour (and *vigouresse)* into our organization. (See p.10) Our sincere thanks to long-serving, departing members for their commitment and dedication.

Creekside Estate wines were excellent as was the fellowship during the reception and banquet, followed by Matt Hutter's talk on "Quality, Safety, and Cost".

We will continue to do our best to build upon the progressively outstanding quality of previous years, in acquiring speakers and topics that are pertinent and engaging. We look forward to your joining us again next fall at the same venue - November 1, 2014!

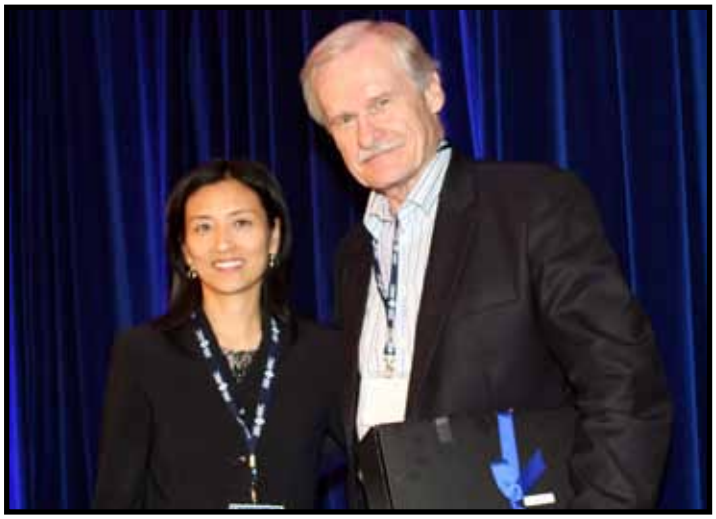
- Dr. Angus Maciver, OAGS Board Member and AGM Committee Chair, is on staff at Stratford General Hospital.



f our guest speakers were as follows (left to right): Key Speaker Dr. Matthew Hut-pital, Toronto), Dr. Sarah Jones (London Health Sciences Centre, London), Dr. Ori tal/McMaster, Hamilton), Dr. Philip Peng (UHN, Mt. Sinai Hosp., Toronto), Dr. Ved by Lisa Koski)

tion Chair Dr. Jeff Kolbasnik chaired the afternoon. OAGS Vice President Dr. Alice Wei r interstitials. The remaining guest speakers/debaters were (L-R): Mr. Robert McKay ir. & CEO, Ctr. for Surgical Invention and Innovation/ McMaster Professor, Hamilton).

Our 19th OAGS Annual Meeting was well attended again on Nov. 2, 2013. There were 189 attendees who enjoyed a day of CPD-accredited academic presentations and delicious food prepared by the Sheraton Toronto Airport Hotel. We're hoping for an even larger turnout next year on Nov.1, 2014.



OAGS Vice President and Section Vice Chair Dr. Alice Wei (left) presented Dr. Bryce Taylor (TGH Consulting General Surgeon and UofT Professor) with the OMA Section Service Award for his leadership and immense contributions to the profession on local, provincial, and national levels.

Silver exhibitor and CME Supporter MD Physician Services donated several items for our registration packages at our recent meeting. For more details and photos on our meeting, visit our website: www.oags.org.

OMA Section Submission for 2014 Contract Negotiations

To: Members of the OMA Negotiations Team
Re: Negotiations Priorities, Section on General Surgery Submission
Date: August 30, 2013

The Section on General Surgery has some general comments and then some priorities which we believe should be advanced during negotiations.

The Negotiations Team should be cognizant that the Section on General Surgery suffered a disproportionate decrease in fees and income during the most recent contract. We are an approximately average income specialty in the OMA **relativity calculations**, and while our decreases weren't as significant as those of some of the high earning specialties, we had a significant decrease in Year 1 and then a cumulative 7.9% decrease in Year 2. Some of the calculated decrease may not have materialized, as it was attributed to a change in colonoscopy practice patterns which have not been fully realized, but our members have commented that they have noted an obvious decrease in their earnings. We expect this disproportionate impact on our specialty in the last agreement to be mitigated in this one.

General Surgeons have also suffered recently as a result of **limited job opportunities and decreases in available resources** at the hospital level. Many of our members, particularly newer graduates, are unemployed or underemployed. Furthermore, many hospitals are in deficit situations and thus are not only not hiring additional physicians, but have also decreased access to OR and endoscopy resources for their current staff. Many General Surgeons have suffered decreases in access for non-emergent surgical and endoscopy cases, thus impacting income and clinical practice. We expect these issues to be considerations during negotiations.

We also expect to have more input during negotiations as specific issues, which significantly impact our Section rather than the profession as a whole, arise. For example, the decrease in the **laparoscopy premium** imposed by the Ministry in the last agreement was erroneously backed by the argument that advances in technology have made these procedures quicker and easier. While advances in technology may have increased productivity for ophthalmologists and radiologists, laparoscopic procedures take longer and are more difficult than the corresponding open procedures. We hope that our Section's input on such specific issues would be helpful to the Negotiating Team.

We also believe we need to develop an early understanding of the opportunities in this agreement for **further investments**, rather than simply cuts, and the degree to which the Ministry would consider re-allocation of money within a specialty to achieve better intra-sectional relativity. We have significant needs in our specialty, and if the only way to fund them is to re-allocate money from relatively well-paid codes to those that are significantly undervalued, we would welcome that opportunity. Our fear in presenting such suggestions is that the Ministry, and perhaps even our own Negotiating Team, would implement the cuts in fees without the corresponding re-investments.

Our specific recommendations for investments mirror those in our submission to the last Negotiating Team, and I gather you have access to that. We believe **fee increases and premiums** should be considered for **emergency care** in daytime hours and for surgical care for **medically complex patients**. We believe further **unbundling of surgical codes** should occur, with an ultimate goal of complete unbundling. There are specific General Surgery fee codes which are significantly undervalued, and we can discuss appropriate allocation of additional funds to such codes as the opportunity arises.

We would be happy to discuss these issues with you further and to participate in the negotiations process if possible.

Sincerely,
Jeff Kolbasnik, Chair, OMA Section on General Surgery

Below is an excerpt of the submission letter addressed to the OMA Negotiations Team for the previous contract negotiations (2012) outlining the proposed concerns of the Section on General Surgery.

"1)<u>Hospital-Based Resource Issues</u> – Access to OR and endoscopy resources has not kept pace with increasing patient demand and in many hospitals has contracted. This has caused tremendous difficulty for surgeons to manage the clinical needs of their patients. Strategies must be implemented to ensure adequate resource access. These resource issues include access to outpatient services and also inpatient care, which includes access to ward and ICU beds.

2)<u>Unbundling of Surgical Codes</u> – We believe surgical fees should be completely unbundled by allowing billing for inpatient care for all elements of the patient's in-hospital stay. We believe the current restrictions are historical and should no longer apply (they reflect past practice where patients were admitted for several days pre-operative for a work-up which is now achieved on an outpatient basis and for a prolonged but no longer considered medically necessary post-op stay). If unbundling is to be achieved in a step-wise fashion, we recommend the following priorities: **(a) Allowing billing for the two pre-operative days** – There is complete in-patient care for these patients, identical to that for any patient not undergoing subsequent surgery. We believe this billing should be per the MRP codes (C122 and C123) if applicable, and that the MRP premium E083 should be allowable as well. **(b) Decreasing the prohibition for post-op billing from 2 weeks to 1 week** – Almost all patients with a routine post-op stay, including those having Whipple's procedures, esophagectomies, liver resections, etc., are discharged within one week. If the post-op stay is beyond one week, it is typically because of post-operative complications or general patient medical issues which require prolonged stay (beyond that for a typical procedure), and surgeons should be compensated for such inpatient care. Also, patients having emergency surgery have much longer stays than those requiring identical elective care (eg. elective versus emergent bowel resection). **(c) Allow billings for the first post-op week** – Again, we believe all facets of inpatient care should be compensated. Currently, the first two post-op days are billable but at lower rates than C122 and C123.

3)<u>Increases to After-Hours Premiums for Surgical Procedures</u> – In the past few years, premiums for after-hours visits have significantly increased, including with the introduction of travel premiums. Even the call-in fee for surgical assistants has increased. It is time the premiums for after-hours surgical care be increased. We thus recommend increases to the E409A and E410A codes.

4)<u>Premium for Emergency Daytime Surgical Cases</u> – Emergency cases may be performed during daytime hours, but these carry added difficulty and burdens for surgeons. Other clinical services are often re-scheduled (eg. office patients), and organizing and attending such surgeries can take a prolonged time. We recommend a premium (eg. 25%) for emergency surgery performed during daytime hours. We believe an additional premium for sacrifice of office hours should also be developed. Restrictions such as patient presenting to ER within the preceding 24 hours are reasonable.

5)<u>ASA-Based Premiums for Surgical Cases (a la anesthesia)</u> – We note the premiums available to anesthetists for ASA 3 and 4 patients. We believe these premiums should be available to surgeons as well. These cases are often prolonged (anesthetists collect time units for these prolonged cases, while surgeons lose opportunity to perform other income-generating clinical care), and the intra-op surgical care and the post-op management of such patients are more difficult as well.

6)<u>MRP Premiums for Consult for Emergency Outpatient Surgical Cases</u> – Surgeons are participating in attempts to use hospital resources more efficiently. Some have started performing emergency appendectomy and cholecystectomy on an outpatient basis (ie. discharging patients same day as surgery). However, as a result, they cannot bill the E082 premium for the consult. We propose that this premium apply for consults performed on the same day as emergency surgery, even if the patient does not require admission to hospital. Restriction to cases performed under general anesthesia should apply."
- Jeff Kolbasnik, OMA Section Chair on General Surgery

20TH OAGS Annual Meeting

Ontario association of General Surgeons

(OMA Section on General Surgery)

Sheraton Toronto Airport Hotel
801 Dixon Rd., Toronto, ON
Saturday, November 1
2014

ACCOMMODATION

A limited block of rooms is being held at the **Sheraton Toronto Airport Hotel, 801 Dixon Rd., Toronto** at a group rate of **$119 CDN** plus taxes per single/double room. The deadline is **Oct. 1st** or until the block fills. **REBATE:** Those listed under the **"OAGS Annual Meeting"** block will also be given an OAGS post-meeting rebate of $30/rm/night - a great deal at $89/night! (Note: Rebates will be mailed out AFTER the meeting by the OAGS - not the hotel.)

To Make Your Own Reservations: *(OAGS is not responsible for your hotel reservation/cancellation)*

- Call the Sheraton Toronto Airport Hotel directly at 1-866-932-7058 / 416-675-6100.
- Online: Visit www.oags.org/agm.htm to be linked directly to the hotel.

PARKING

Parking will be free for those attending the meeting, courtesy of the OAGS. Members should provide necessary vehicle details in advance or upon arrival at the OAGS registration desk before 10am. DO NOT pay the parking meter. *(Be sure to arrive early to avoid delays.)*

MEMBERSHIP DUES

OAGS 2014 annual membership dues (Jan-Dec) include benefits such as free admission to the upcoming 20th OAGS Annual Meeting. For more details, visit: www.oags.org/join.htm .

RSVP & PAYMENT

How to RSVP to the OAGS Office:

- **Phone:** 1-877-717-7765 / 705-745-5621 **Email:** info@oags.org
- **Online: https://www.surveymonkey.com/s/HJ3JQT9**

How to Pay: (2 methods)

- **Cheque** - Make payable to "OAGS" and send via post...or
- **PayPal** - Major credit cards accepted online only: www.oags.org/join.htm .

Registration Deadline:

Oct. 1st, 2014

Target Audience:

Active & Inactive
General Surgeons
General Surgery Fellows,
Residents, Med Students

CME Accreditation:

This event is seeking accreditation by the Canadian Association of General Surgeons as a group learning activity as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada.
(1 credit/ 1 hr attended)

Admission Fees (day only):

- **FREE** - Current OAGS Member
- **$450** - Non-OAGS Member
Gen Surgeon (active/inactive/O-P)
- **$ 30** - Non-OAGS Member
Gen Surgery Resident/Fellow
- **FREE** - Medical Student

Wine/Banquet Fee:

- **$50** - Member & Non-Member

NOTE: Refunds will not be issued for cancellations after the deadline.

Toll Free: 1-877-717-7765
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Web: www.oags.org

OAGS
Ontario Association of General Surgeons
Association des Chirurgiens Généraux de l'Ontario

OMA Section Election 2013-14

Please note that the OMA facilitates the elections of all individual sections. Although the OAGS and OMA Section on General Surgery executives are separate entities and hold their elections at different times, the two bodies continue to work together as one unit in an effort to represent all General Surgeons throughout Ontario.

Dr. Jeff Kolbasnik, Chair

OMA Section Election Report: The final day of the Section Election for 2013 was set for December 16, 2013 - several weeks following the 19th OAGS Annual Meeting. Initial notification and a call for nominations was disseminated 2 months before the election date by the OMA. Because there were no new nominations, the roster of Section executive candidates that was submitted was acclaimed on November 4, 2013. Terms will end in December, 2014. The current Section Executive will set the date for the next Section Election next fall. The Section will notify the OMA (and in turn the Section membership) two months in advance of the intended election date, and nominations will be invited amongst the membership at that time as well.

The current **Section Executive** began their 1-year terms as of Dec.16, 2013:

1) Chair - Dr. Jeff Kolbasnik, Milton
2) Vice Chair - Dr. Chris Vinden, London
3) Secretary - Dr. Alice Wei, Toronto
4) Tariff Chair - Dr. Alan Lozon, Owen Sound
5) Member-at-Large - Dr. Frank Baillie, Toronto
6) Member-at-Large - Dr. Harshad Telang, Thunder Bay
(Note: As Past Chair, Dr. Angus Maciver was automatically acclaimed as well.)

The following were also acclaimed for 1-year terms as **OMA Council Delegates and Alternates**:

1) Delegate - Dr. Jeff Kolbasnik
2) Delegate - Dr. Chris Vinden
- **Alternate** - Dr. Frank Baillie
- **Alternate** - Dr. Alan Lozon
- **Alternate** - Dr. Angus Maciver
- **Alternate** - Dr. Alice Wei

For more details: www.oags.org/election.htm

President... continued from p.1

poorly staffed remnant left behind. I encourage you to advocate for this.

I would strongly recommend that you become actively involved in your hospital decision making process by whatever means possible. QBP means that we should no longer be on an adversarial basis with hospital managers. Your ideas about improving efficiency and reducing turnover time that used to fall on deaf or obstructive ears should be met with enthusiasm. Hospitals and surgeons that work together will be successful - those that don't, risk major consequences. The managers, nurses, and pretty well every other hospital employee will want to keep their jobs, and they can only do that if you can work with them to do the procedures quickly, safely and within budget while still maintaining quality.

Things are changing, and we will have to change with them. There are more positives about the changes than negatives. Embrace the changes and become actively involved. The status quo will leave you far behind.

- Dr. Chris Vinden, OAGS President, is a General Surgeon on staff at London Health Sciences Centre - Victoria Hospital.

2014: New OAGS Board

Dr. Chris Vinden, President

The Ontario Association of General Surgeons (OAGS) held its board election during the 19th OAGS Annual Meeting recently on Nov. 2, 2013.

As it was a staggered year, only half of the 14 board members were up for re-election. There were several vacancies this year, as some members completed their terms. We'd like to thank Drs. Suru Chande, Dr. Ian Chin, Dr. Dennis Desai and founding OAGS Past President Dr. Ciaran Kealy for their long time dedication and service to the OAGS. (see p.11)

Drs. Frank Baillie, Tim Jackson and Chris Vinden ran for re-election along with an impressive number of 6 new nominees, which necessitated a private vote. As a result of the vote, the following seven candidates were elected: **Drs. Frank Baillie, Tim Jackson, Kevin Lefebvre, Jennifer Macmillan, Lynn Mikula, Chris Vinden, and Joel Weaver.** (The other 7 board members will be up for re-election at the annual meeting next fall.)

We'd like to take this opportunity to thank all the election candidates for participating recently and encourage those and any other members to run again in the future; your interest was greatly appreciated!

It is during the next board meeting in the new year during which the directors elect/appoint the officers from the slate of board members; committees will be chosen at that time as well. Until then, the committees and officers will remain the same with the exception of Treasurer. During a recent online vote, the majority of directors voted in favour of Dr. Harshad Telang, Thunder Bay to succeed Dr. Dennis Desai as Treasurer.

As of January 1st, 2014, the OAGS Board will look like this:

1. **President: Dr. Chris Vinden, London**
2. **Immediate Past President: Dr. Jeff Kolbasnik, Milton**
3. **Vice President: Dr. Alice Wei, Toronto**
4. **Treasurer/Secretary: Dr. Harshad Telang, Thunder Bay**
5. **Member-at-Large: Dr. Frank Baillie, Toronto**
6. **Member-at-Large: Dr. Timothy Jackson, Toronto**
7. **Member-at-Large: Dr. Kevin Lefebvre, Stratford**
8. **Member-at-Large: Dr. Alan Lozon, Owen Sound**
9. **Member-at-Large: Dr. Angus Maciver, Stratford**
10. **Member-at-Large: Dr. Jennifer Macmillan, Huntsville**
11. **Member-at-Large: Dr. Lynn Mikula, Peterborough**
12. **Member-at-Large: Dr. Eric Touzin, Sioux Lookout**
13. **Member-at-Large: Dr. Joel Weaver, Ottawa**
14. **Member-at-Large: Dr. Peter Willard, Welland**

New Board Members (L-R): *Dr. Kevin Lefebvre of Stratford, Dr. Jennifer Macmillan of Huntsville, Dr. Lynn Mikula of Peterborough, and Dr. Joel Weaver of Ottawa.*

Thank You!

The **Ontario Association of General Surgeons (OAGS)** would like to take this opportunity to thank several important board members who will have completed their terms at the end of December, 2013. They've played an integral part in the success of the organization over the years, and we'll always be indebted to their time, efforts and dedication to the cause.

Back in 1995 before the OAGS existed, General Surgeons and the Section felt they were largely overshadowed by other OMA sections, particularly during tariff and contract negotiations. It was finally felt that General Surgeons needed to create their own voice independent of the OMA in order to make a difference and to be free to approach/lobby other groups that could help improve the working conditions of the General Surgeon in Ontario.

Dr. Ciaran Kealy

Section Chair on General Surgery at the time, **Dr. Ciaran Kealy of Sudbury,** rallied together like-minded colleagues for the board and the OAGS was born. Together, they surveyed the specialty and started working on critical issues of concern. Armed with their own data, they took it to the OMA to strengthen their arguments. Over the years, the OAGS has worked in tandem with the Section on General Surgery to champion paid call, to tackle tariff matters, to defend media allegations of bile duct injuries of epic proportions throughout the province (which incidentally garnered a rare retraction from *The Toronto Star*), to promote initiatives with other groups such as guidelines or a patient's informational packet on breast cancer with ICES, and much more. Dr. Kealy served as OMA Section Chair (1991-97), OAGS President (1995-1998) and continued as board member and Editor of the ever popular newsletter *The Cutting Edge*.

Dr. Suru Chande

Dr. Suru Chande of Winchester/Ottawa was also part of the original board since 1996. He served as our first Sponsor Chair (1996-2011) and Treasurer (2006-2011). He was integral in lining up financial support from sponsors and annual meeting exhibitors over the years which helped the event grow and excel to what is now considered one of the better General Surgery CPD-accredited meetings today in Ontario.

Dr. Ian Chin

Dr. Ian Chin of Oshawa didn't hesitate in getting involved right after his residency. He joined the board in 2001, during which time he served as Secretary (2005-2008) and soon succeeded Dr. Chande as Sponsor Chair (2011-2013). Dr. Chin's vision not only helped bring in revenue from the online job listing page but also expanded the exhibiting opportunities during the annual meeting to where it is today.

Dr. Dennis Desai

Dr. Dennis Desai of Ottawa joined the OAGS in 2005 and served as Treasurer since 2011. Inheriting a stable treasury and supported by growing sponsorship/membership, Dr. Desai endeavoured to successfully streamline the finances to ensure even further fiscal efficiency and growth. He also took a keen interest in updating our bylaws. Many thanks!

Locum & Job Listings

The O.A.G.S. does not offer a job placement program. We provide space in our newsletter/website for both those who are seeking and/or institutions/communities that are offering a General Surgery position in the province of Ontario. Rates can be found on our website: **www.oags.org**

All candidates should be eligible for licensure in Ontario and have obtained or be eligible to obtain RCPSC specialty qualifications. Surgical credentials can be confirmed by calling the Royal College directly: 1-800-461-9598 ext.478.

ONLINE VACANCIES & LOCUMS:

- Advanced Multi-Specialty Walk-In Clinic (Mississauga)
- Bluewater Health (Sarnia)
- Royal Victoria Regional Health Care Centre (Barrie)

For more details on the above, please visit our website at: www.oags.org/joblisting.htm

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Download a form: www.oags.org/joblisting.htm
Other websites with job placement programs: www.hfojobs.ca

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Board Member/Officer/Reps*	OAGS Position	Board Member/Officer/Reps*	OAGS Position
Dr. Chris Vinden (London)	President	Dr. Timothy Jackson (Toronto)	Member-at-Large
Dr. Jeff Kolbasnik (Milton)	Past President/Section Chair	Dr. Ciaran Kealy (Sudbury) *	Member-at-Large
Dr. Alice Wei (Toronto)	Vice President	Dr. Alan Lozon (Owen Sound)	Member-at-Large
Dr. Dennis Desai (Ottawa) *	Treasurer	Dr. Angus Maciver (Stratford)	Member-at-Large
Dr. Harshad Telang (North Bay)	Secretary	Dr. Eric Touzin (Sioux Lookout)	Member-at-Large
Dr. Frank Baillie (Hamilton)	Member-at-Large	Dr. Peter Willard (Welland)	Member-at-Large
Dr. Suru Chande (Winchester) *	Member-at-Large	Dr. Kellen Kieffer (NOSM)	Resident Representative
Dr. Ian Chin (Oshawa) *	Member-at-Large	** Incoming Successors: Drs. K.Lefebvre, J.Macmillan, L.Mikula, J.Weaver*	

COMMITTEES	COMMITTEE CHAIR & MEMBERS
Economics & Tariff (MSPC)	C. Vinden (Chair). Alts: Section Chair (J.Kolbasnik), T.Jackson, A.Lozon, A.Maciver, H.Telang, E.Touzin.
General Surgery Resources (Manpower)	C. Vinden (Chair), J. Kolbasnik, E. Touzin. (Res. Consultant: K. Kieffer)
Membership	F. Baillie, I. Chin, A. Wei (Res. Consultant: K. Kieffer)
Bylaws	D. Desai (Chair), C. Kealy, A. Maciver
Nominating	C. Kealy, C. Kolbasnik, A. Maciver (Past OAGS Presidents)
Political Activity	A. Maciver (Chair), C. Kealy, J. Kolbasnik, A. Lozon, C. Vinden
(Ad hoc) CAGS	C. Maciver (Chair), C. Vinden (Alt.), J. Kolbasnik, A. Wei
(Ad hoc) Cancer Care Ontario	C. Vinden (Chair), J. Kolbasnik, A. Lozon, A. Maciver, A. Wei
(Ad hoc) CPSO	President (C. Vinden) (Chair), Section Chair (J. Kolbasnik), S. Chande, A. Maciver
(Ad hoc) Newsletter	C. Kealy (Managing Editor), President (C. Vinden)
(Ad hoc) OMA	Section Delegates: J. Jolbasnik, C. Vinden (Alts: F. Baille, A. Lozon, A. Maciver, A. Wei)
(Ad hoc) On-Call	J. Kolbasnik, A. Lozon, H. Telang, E. Touzin, C. Vinden, P. Willard
(Ad hoc) Peer Support	Board-at-Large
(Ad hoc) Program & Education (i.e.AGM)	A. Maciver (Chair), S. Chande, I. Chin, D. Desai, C. Kealy, J. Kolbasnik, C. Vinden
(Ad hoc) Sponsorship / Exhibiting	I. Chin (Chair), S. Chande, J. Kolbasnik, C. Vinden

EDITOR'S NOTE: *This is the 35th issue of The Cutting Edge and my final issue as Editor. None of our work would be possible without your support. Your board members are hard-working active general surgeons, like yourselves, who are interested in improving both our working conditions and our quality of life. Although we would like to send this newsletter to every general surgeon in the province, The Cutting Edge is mailed exclusively to paid-up members due to the cost factor. If you have not yet renewed your membership, we encourage you to do so. Remember, it is* ***the OAGS that brings to you the annual meeting, CPD accreditation, this newsletter, the website, job posting, Billing Corner, CPD listing, email/fax communications, and more****. We get very little funding from the OMA as the Section on General Surgery, and your financial support is essential to the survival of the OAGS. Thank you. - Dr. Ciaran Kealy, Editor*

Our recent Annual Meeting of 2013 was funded by the following sponsors. Their support is greatly appreciated. Thank you.

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