Issue No. 38 | Over 20 Years of Service | 2015

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

Not Peer-Reviewed, but Viewed by Your Peers.

Demographic dividend paid to teachers

Demographic penalty dumped on doctors and general surgeons

By Dr. Chris Vinden

I had hoped that this report would have been the who's who of over utilization - a dissection of which specialties escalated billings in response to a threat of fee reductions and which ones stayed the course. Alas, the data is not available for public consumption at the time of submission, so instead, some commentary of our response to the cutbacks.

One of the radiologists in my region recently announced that he would no longer be providing a certain service, as the impact of the recent ministry cuts made it untenable. Rather than sympathy from other physicians, his protest was met with emotions more akin to derision and contempt. Radiologists have far higher professional incomes than most other physicians. The average after-expenses professional income of a radiologist is $190K higher than the average general surgeon, and at the 75th percentile, their after-expenses income is $240K more than a general surgeon.

I relay this story, not to denounce radiologists, but to emphasize the point that if you are making a lot of money, you won't get any sympathy from those that make substantially less than you do, no matter how reasonable your argument. The median household income in Ontario is $76,000 - a figure that typically includes multiple wage earners. The difference between our incomes and those of the general population are far greater than between us and radiologists. If we have no sympathy for radiologists then it is pretty safe to assume that the general public will have little sympathy for us if we talk about money. The OMA hires professional marketers and consultants to guide its public policy, and they confirm that we really can't talk about money.

So, does that mean we can't do anything to protest our situation of having unilaterally imposed fee cuts? After all, it really is about money.

My recommendation is that we talk about "value" and "fairness" rather than money, but we need to be careful. We could list a whole bunch of undervalued codes where we get paid less than I pay for a haircut (A034 comes to mind). But really, that is smoke and mirrors, microeconomics not macroeconomics, and basically, what my radiology colleague was doing. For every A034, there is a Z571 or similar overvalued code that counter balances it. Relativity has been in our court for years, and the OMA has done little to solve the problems, except massively boost the incomes of family doctors.

Perhaps, if we talk about value in macroeconomic terms, the public might understand, but it's a complicated argument, not terribly amenable to a sound bite. The Ministry of Health has imposed a system that holds physicians accountable for all increases in health care utilization. They maintain that they are flat broke and that there will be no new money.

Yet, the number of seniors, by far the largest consumers of health care, is growing enormously. Sixty-five years ago, the baby boom was just getting going and the birth rate was 4%. Since few people die before the age of 65, it simply results in a massive increase in the number of seniors - the prime health care consumers. Their numbers are expected to swell by 25% in the next 5 years and 50% in the next 10 years. There are already more seniors than those under 18.

Since our failed negotiations, two other major public service groups, secondary school teachers and hydro workers, have both successfully negotiated agreements that were far more generous than what the OMA was able to achieve.

Ontario Hydro workers have had a banner year. Electricity use in Ontario peaked 8 years ago. In fact, we are generating less electricity than we did 15 years ago. Yet, despite declining productivity and the highest cost of electricity in North America, our government gave them a 3% signing bonus, a 3% pay increase over 3 years

See "President" on page 10

INSIDE

NOTICE: OAGS 2015 MEMBERSHIP DRIVE (Jan-Dec, 2015)

Please be reminded that the OAGS is still collecting annual dues for the current calendar fiscal of 2015. The 2nd Notice invoices or receipts were mailed out in September. For more details or to pay online, please visit our website: www.oags.org/membership.html. Feel free to call our office about your status: 1-877-717-7765.

21st OAGS ANNUAL MEETING: Saturday, November 7, 2015

OAGS Board of Directors, President Dr. Chris Vinden, AGM Committee Chair Dr. Kevin Lefebvre and Section Chair Dr. Jeff Kolbasnik would like to invite all General Surgeons to this fall's 21st OAGS Annual Meeting on Saturday, November 7, 2015. **Remember, we're at a new location - Hilton Toronto Hotel - Downtown**, 145 Richmond St. West, Toronto, ON. For more details: www.oags.org. RSVP Deadline: Oct. 30th. (Note: Free annual meeting admission for curent OAGS members.)

Resident Rostrum

By Dr. Patrick Murphy
OAGS Resident Representative

Mental Health During Residency

I would like to begin by thanking the Ontario Association of General Surgeons board members for the opportunity to represent General Surgery residents across the province. I appreciate the opportunity and look forward to the experience and advocating for residents and General Surgeons.

After reviewing the previous Resident Rostrum columns on the job crisis and endoscopy by Dr. Kellen Kieffer and the impact of super-specialization and modern limits on resident education by Dr. Julie Ann Van Koughnett, I decided to tackle a different topic for my first column. Namely, I have decided to focus on the topic of mental health during residency. The aforementioned topics continue to remain important issues for residents, and I encourage those interested to review the 2013 National Physician Survey and the 2014 report by the Royal College of Physicians and Surgeons of Canada "The Future of General Surgery: Evolving to meet a changing practice." The two reports tackle the current status of General Surgery provincially and nationally and discuss the future of General Surgery and residency training, in particular.

"In the USA...400 physicians will take his/her own life this year...."

Physician and resident mental health is a concern that has received increasing attention in academic literature and lay media. It seems, every year an article is published about new residents committing suicide. In New York last summer, two fresh interns ended their own lives within weeks of each other. This is not a new trend. In looking back and even asking fellow colleagues, it is not a challenge to find someone touched by mental illness, either personally or through peers. Sadly, it can take the death of a fellow colleague to prompt change. Stanford, in 2010, created the "Balance of Life Program," following the suicide of a newly graduated General Surgery resident turned Vascular Fellow just four months after his fellowship began.

In the USA, approximately 400 physicians will take his or her own life this year, which amounts to two medical school classes a year. Canadian statistics are more limited, but data out of British Columbia suggests approximately 20 per 100,000 physicians will commit suicide each year, which, while lower than Americans, at 30-40 per 100,000 is nearly double that of the general population.[1,2] Perhaps an even more concerning trend is that women physicians are more likely than men to be depressed and to commit suicide. Fortunately, women surgical residents are also more likely to seek help than their male counterparts.[3,4]

Before considering why surgeons are so poor at seeking help, I believe it is important to examine potential reasons which place surgeons, and particularly surgical residents, at risk of mental health issues. Perhaps, choosing surgery as a career self-selects a subset of individuals more likely to have "Type-A" personalities and to be perfectionists. These are seemingly desirable qualities for surgeons, but may lay the ground-work for mental illness when strained. I believe environmental considerations play a larger role, ranging from a lack of sleep and stress for innumerable reasons including patient care, education, debt, hospital politics, program expectations, and lack of mental health support, among others. A recent report commissioned from the Austalasian College of Surgeons points to a more worrisome finding of emotional, physical and sexual abuse – although I would like to believe this is not a problem in Canada, perhaps naively so.[5]

Stoicism is a quality surgeons have historically taken pride in, dating back to Dr. William Osler. However, while this quality may allow us to be steady in the operating room and calm in chaotic situations, it likely limits our ability to seek help. Surgeons are less likely than other physician to seek mental health services. A multitude of reasons can offer explanation, including individual denial, perceived stigma from peers, monetary concerns, or licensing implications. The last two reasons I believe have a great impact on residents. Many residents have seemingly insurmountable debt, which can reach upwards of $300,000,. This may contribute to mental health issues, as well as act as a barrier to seeking help. To put it frankly, no disability insurance could cover living expenses and loan repayments, much less address the time away from residency and the potential effect on future employment and licensing. This leaves those struggling with mental health issues in a vicious cycle. Even if a resident or staff physician would like to get help while continuing to work, there is too little time to schedule visits with a therapist or psychiatrist. Residents who take time away during training may face difficulties when it comes time to obtain a license, as time away and declaration is required on the licensing application. Additional documentation from the CPSO is usually required, and there can be delay in obtaining an independent practice license.

There are no easy answers to mental health challenges in either the general population or the physician population. The recent announcement of the planned reduction to 50 residency spots in Ontario has the potential to overwhelm remaining residents with increasing service over education as well as additional time stresses. The continued OHIP cuts provide a source of financial frustrations for practising physicians. I can only hope that my colleagues and I can offer support for our peers, akin to the support we offer our patients. Our friends and partners in medicine should not have to suffer alone, or in silence.

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

McMaster University: Jennifer Li, PGY4
NOSM: Justin Poling, PGY3
Ottawa University: Nikoo Rajaee, PGY5
Queen's University: Mike Rizkalla, PGY5
University of Toronto: Debbie Li, PGY5
Western University: Mostafa El-Beheiry, PGY3

- Dr. Patrick Murphy, OAGS Resident Representative
PGY 3, General Surgery, Western University

LINKS/REFERENCES
• National Physician Health Survey – http://nationalphysiciansurvey.ca/surveys/2013-survey/
• The Future of General Surgery: Evolving to meet a changing practice – http://www.royalcollege.ca/common/documents/educational_initiatives/future_of_general_surgery_report_e.pdf
• Professionals Help Program offered by the OMA – http://php.oma.org/
1)Goldman LS, Myers MM, Dickstein LJ. The Handbook of Physician Health, American Medical Association, 2000.
2)Canadian Medical Association. Physician Health Matters: a mental health strategy for physicians in Canada, February 2010.
3)Gerada C, Jones, R. Surgeons and mental illness: a hidden problem? BMJ Careers. 2014.
4) Aminazadeh N1, Farrokhyar F, Naeeni A, Naeeni M, Reid S, Kashfi A, Kahnamoui K. Is Canadian surgical residency stressful? Can J Surg. 55(4):S145-51; 2012.
5) Royal Australasian College of Surgeons. Expert Advisory Group on discrimination, bullying and sexual harassment. Sept 8, 2015.

New Resident Representative

The Ontario Association of General Surgeons would like to welcome Patrick Murphy, PGY 3, Western University, London, ON, as our new Resident Representative, succeeding Dr. Kellen Kieffer when he graduated last summer. We look forward to working with him on resident issues for the duration of his term (~3yrs).

Murphy: *"The many stresses of our training are compounded by many challenges outside of our control and the advocacy on our behalf, while improving, continues to fall behind that of our medicine colleagues. I would like to be an advocate for General Surgical residents on a provincial level and address resident/fellow specific concerns, not only in the short term but also in the long term.."*

Guest Speakers AGM2015

Welcome to this fall's roster of topics and guest speakers:

♦ Colonoscopy: Advanced Endo Techniques

Dr. James Ellsmere, Dalhousie U., Halifax, NS

Dr. Ellsmere (MD,FRCSC) is a General and Gastrointestinal surgeon at the QEII Health Sciences Centre in Halifax, NS. He is an Assistant Professor at Dalhousie University, Director of Skills Centre for Health Sciences, Director of Advanced GI Minimally Invasive Surgery Fellowship Program, and Director of the Nova Scotia Health Authority Bariatric Surgery Program. He trained at Dalhousie, Harvard and MIT.

♦ Incidentalomas: What do I do now?!

Dr. Lloyd Mack, FHMC, Calgary, AB

Trained at UWO, Dr. Mack (MD,FRCSC,FACS) is an Associate Professor, Dept. of Oncology & Surgery as well as Program Director of the General Surgery Residency Training Program at the University of Calgary. He is on the General Surgery staff of Foothills Medical Centre and his clinical/research interest lies with peritoneal carcinomatosis, the role of synoptic operative reports and soft tissue sarcoma and related malignancies.

♦ Upper GI Endoscopy

Dr. Chris Teshima, SMH, Toronto

Dr. Teshima (MD,MSC,PhD,FRCPC) is a new member of the Therapeutic Endoscopy group at St. Michael's Hospital and Assistant Professor at UofT. His clinical interests focus on upper GI neoplasia, endoscopic mucosal resection, endoscopic therapy for pancreatic pseudocysts and walled-off necrosis, Zenkers diverticulum, small bowel endoscopy for obscure GI bleeding, and endoscopic ultrasound.

♦ Difficult Hernias

Dr. Lloyd Smith, NYGH, Toronto

Dr. Smith (MD, FRCSC) is the Chief of Surgery and Surgical Program Medical Director at North York General Hospital. He is also an Associate Professor in the Department of Surgery at University of Toronto. His clinical interests lie in minimally invasive surgery including gastrointestinal and solid organ surgery, and abdominal wall reconstruction including laparoscopic and open hernia repairs.

♦ Panel Discussion: Anorectal Disease

Dr. Marcus J. Burnstein, SMH, Toronto

Dr. Burnstein (MD, MSc, FRCSC) is an Associate Professor of Surgery at the University of Toronto and has a broad practice in diseases of the colon, rectum and anus at St. Michael's Hospital. A past Program Director for the UofT Residency programs in Colorectal Surgery/General Surgery, he is also past Chairman of the Royal College Specialty Committee for Colorectal Surgery, Past-President of the Canadian Society of Colon and Rectal Surgeons, and numerous other positions.

Dr. Stan Feinberg, NYGH, Toronto

Dr. Feinberg (MD, FRCSC, FACS) is an Assistant Professor, Department of Surgery at UofT as well as Associate Program Director of General Surgery. His clinical practice is devoted to colorectal surgery at North York General Hospital, where he is also the Medical Director, Ambulatory & Cancer Care Program. He is the Colorectal Cancer Surgical Lead for Central LHIN and serves on the RCPSC Exam Board for General Surgery/ Colon & Rectal Surgery.

OAGS International Key Speaker

Dr. Sarah McLaughlin, MD, FACS

Sarah McLaughlin is an Associate Professor of Surgery at the Mayo Clinic in Jacksonville Florida. She completed her General Surgery residency training at the Mayo Clinic, Florida and then a Breast Surgical Oncology fellowship at Memorial Sloan Kettering Cancer Center. She has an active breast surgery clinical practice and is an NIH funded investigator with a specific focus in issues affecting survivorship, especially lymphedema diagnosis and treatment. She serves on several national committees interested in the education of breast surgeons and surgical fellows, including The American Society of Breast Surgeons CME Committee, the Society of Surgical Oncology Training Committee. The Mayo Clinic has recognized Dr. McLaughlin as a Mayo Clinic Foundation Scholar, Outstanding Course Director, Faculty Teacher of the Year, and Outstanding CME Faculty.

♦ Talk #1: "Evolving Role of Managing the Axilla". ♦ Talk #2: "High Risk Lesions and Their Management". ♦ Banquet Talk: The Angelina Jolie Effect

♦ Surgical Error & Judgement

Dr. Carol-Anne Moulton, UHN, Toronto

Dr. Moulton (MB,BS,FRACS,MEd,PhD) is an Associate Professor, Dept. of Surgery at UofT and Staff Surgeon with the Division of General Surgery, UHN. Currently, the O.R. Medical Director of Toronto General Hospital and Wilson Centre Scientist, her research program focuses on understanding the complexity of surgical judgment, the development of surgical expertise, and underlying causes of surgeon error.

♦ Panel Discussion: 4 Pearls - Surgery on Obese Patients

Dr. Dennis Hong, St. Joseph's HC, Hamilton

♦ Pearl #1: How to Make a Stoma

Dr. Hong (MD,MSc,FRCSC,FACS), an Assistant Professor of General Surgery at McMaster University, is a General Surgeon at St. Joseph's Healthcare, Hamilton. Dr. Hong specializes in Minimally Invasive and Bariatric Surgery. Highly skilled in minimal access surgical techniques, Dr. Hong regularly performs a variety of laparoscopic procedures; 75% of his practice is focused on bariatric surgery.

Dr. Amy Neville, OCH, Ottawa

♦ Pearl #2: Wound Closure on the Obese

Dr. Neville (MDCM, MSc (Epi), FRCSC) currently practices general, minimally invasive and bariatric surgery at The Ottawa Hospital- Civic Campus in Ottawa, ON. She is an assistant professor of surgery at the University of Ottawa, co-director of the UofO Bariatric Surgery Fellowship program, and Medical Director of The Ottawa Hospital Regional Bariatric Centre of Excellence. She trained at McGill.

Dr. Todd Penner, TWH-UHN, Toronto

♦ Pearl #3: Bowel Preparation

Dr. Penner (MD, FRCSC) is a minimally invasive surgeon who has practiced at the Toronto Western Hospital starting since 2003. Areas of expertise include laparoscopic bariatric surgery, solid organ, foregut and colorectal surgery. Dr. Penner is involved with teaching MIS to surgical residents, fellows and practicing surgeons.

Dr. Ken Reed, GGH, Guelph

♦ Pearl #4: Affect on Surgical Decision Making

Dr. Reed (MD, FRCSC), staff General Surgeon at Guelph General Hospital, has been involved with Weight Loss Surgery since 1994. He established a programmatic approach at the GGH and introduced laparoscopic gastric bypass to the Guelph program. GGH was designated a Bariatric Surgery Ctr. by the Ontario Bariatric Network, while Dr. Reed is the chair of its Advisory Board's Surgical Task Force.

21ST OAGS Annual Meeting

Ontario association of General Surgeons

(OMA Section on General Surgery)

♦ Annual Meeting Special Guest

Dr. Chris de Gara, MB, MS, FACS, FRCS
President of
Canadian Association of General Surgeons
"CAGS Listening & Advocacy Tour"

Date & Venue:

Sat., Nov.7, 2015 - Hilton Toronto Downtown
(RSVP Deadline - Oct.30)

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)

♦ Billing Corner Interstitials

Dr. Alan Lozon, GBHS, Owen Sound

Dr. Lozon will lead the usual Billing Corner interstitials with the interactive option for attendees to test their savvy with question and answer key pad response.

♦ NSQIP Update

Dr. Tim Jackson, TWH-UHN, Toronto

Dr. Jackson will review the latest information regarding Ontario's version of the National Surgical Quality Improvement Program (NSQIP).

♦ The Clawback: OMA Negotiations & Relativity

Dr. Chris Vinden, OAGS President; Dr. Jeff Kolbasnik, Section Chair

Drs. Vinden and Kolbasnik will deliver an update on the state of OMA/MOHLTC contract negotiations and the implications of the current non-negotiated, gov't imposed 1.3% fee reduction that became effective as of October 1, 2015.

Program: www.oags.org/OAGS_program2015_web.pdf
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Opinion: How to Hire a General Surgeon

Trial Locums for New Recruits: A New Way to Hire

By Dr. Ravinder Singh

In an environment of abundantly trained General Surgeons, the challenge I and my service faced was who to choose to fill a spot at our hospital as a General Surgeon.

Traditionally, hospitals have hired those they know or have trained, but how could a hospital hire based on traditional practices when there was limited exposure to general surgery residents and little local interest due to the fact we were in Northern Ontario?

Combining intelligence with the physician recruiter at the hospital (Kristen Vaughan), a process was developed to hire for a general surgery spot at our hospital in 2013. Due to the lack of residents rotating through our hospital, we required applicants to do a locum at our hospital for a minimum period of time (1 week). The locum included doing on call work, and if a long term locum, elective time was given. As the Head of Service, I offered my elective time for 3 months for candidates to utilize. I felt all aspects of practice should be assessed and not just on call services.

For the position offered, there were several applicants similar to what had been seen provincially for job postings. In order to be eligible for a locum, the candidate's curriculum vitae was reviewed, along with references. Candidates had to have (or be in process of having) Royal College certification and have a valid license from the College of Physicians and Surgeons of Ontario (or be in the application process).

The locum was a tool to assess the candidate's knowledge, skill and professionalism. As the Head of General Surgery, I preformed surgical assist call to fulfill a supportive and assessment role. This was combined with feedback from colleagues from different services (e.g. anesthesia, emergency medicine, etc.) and allied healthcare workers (e.g. nurses, clerks, OT/PT) using formal feedback tools (Review, Recognition and Development form, and 360 review).

Candidates were then offered a formal interview after reviewing their locum experience. The interview was a chance to assess the candidate's ability to deal with certain scenarios (e.g. dealing with conflict, thoughts about quality and quality initiatives, etc.). Most candidates had the academic ability and training based on their CV, but this way of interviewing was a tool to assess the candidate's experience and ways of responding to scenarios encountered in the workplace.

After interviewing of candidates as the Head of Service, I touched based again with the references of each candidate. A package was then compiled for each candidate including the CV, references, feedback forms, and interview results. These packages were given to each of my General Surgery colleagues. After a time period to review, all General Surgeons met along with the physician recruiter and a non-General Surgeon (in this case an anesthetist) to rank the candidates. The reason for the non-General Surgeon to be present was to ensure there was no bias in the decision that was being made by the service of General Surgery. The position was then offered based on ranking.

What did we learn from this experience? The most important aspect was actually having candidates as locums. This provided a realistic assessment of candidates and actually helped keep things objective instead of choosing based on subjective opinions. In fact, this process changed our outlook in picking a candidate several times until we all met as a service and discussed the candidates. The style of interviewing assessed the candidate's abilities to fulfill CanMeds roles like Leader, Scholar, Professional, Collaborator, etc.

The success of this process was in the candidate we chose. Furthermore, other services and departments have adopted this process and have had continued success.

- Dr. Ravinder Singh, OAGS Board Member-at-Large, is on staff at North Bay Regional Health Centre as Chief of Surgery and Head of Service for General Surgery. He is also NOSM Site Director for the General Surgery Residency Program.

The Quality Management Partnership Needs Your Input

In 2013, the Ministry of Health asked Cancer Care Ontario (CCO) to partner with the College of Physicians and Surgeons of Ontario (CPSO) to create provincial quality management programs for mammography, colonoscopy and pathology.

The **Quality Management Partnership (the Partnership)** has worked in close collaboration with clinical experts, system partners and other relevant stakeholders to design quality management programs for each of the three service areas. Implementation activities are currently underway.

As part of the Partnership's early work for the colonoscopy quality management program, a Clinical Working Group, led by Dr. David Morgan, drafted the following tools and guidelines:

- Bowel preparation dosing reference tool
- Guidelines for endoscopy reports for referring physicians
- Guidelines for patient discharge information
- Pre and post-procedure check list tool

These tools/guidelines will be piloted and evaluated in clinical settings across Ontario during October and November, 2015 to gather stakeholder opinions about their completeness and usefulness. Information gathered from providers will guide necessary revisions and/or adjustments to the tools/guidelines. It will also help the Partnership to tailor design implementation and dissemination efforts.

Quality Management Partnership

Active recruitment for the pilot and evaluation is underway, so please check your email for an invitation to participate which will include a letter from Dr. Morgan, frequently asked questions (FAQs) about the evaluation and an informational backgrounder on these early quality initiatives.

For more information or to indicate your interest in participating, contact Yasser Ismail (Evaluation Specialist) directly by email (yismail@cpso.on.ca) or (416) 967-2600 ext. 598.

2015 Awards

OMA
ONTARIO MEDICAL ASSOCIATION

Congratulations
to
Dr. Angus Maciver, Stratford
2015 OMA Life Membership Award

General Surgeon Dr. Angus Maciver of Stratford (left) receives the OMA Life Membership Award during 2015 Spring Council from then OMA President Dr. Ved Tanden

Dr. Robin McLeod, Toronto
2015 OMA Section Service Award

Join us in congratulating Dr. Robin McLeod as we present this year's OMA Section Service Award during the 21st OAGS Annual Meeting on Saturday, November 7, 2015 at the Hilton Toronto Hotel (downtown).

Attention: If you know of someone who should be considered for these awards next year, let us know. The Section/OAGS boards will review the candidates and submit the final paperwork to the OMA within the next month. Email your suggestions to info@oags.org BEFORE Nov. 13, 2015.

Readership Feedback

If you would like to comment on the editorial/articles/columns within this issue or any other matter, write to us: info@oags.org .
Visit our site for more information: www.oags.org
Remember: Only OAGS members receive The Cutting Edge

The Cutting Edge newsletter is a bi-annual OAGS publication written by General Surgeons for General Surgeons. It is in its 21st 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. Timothy Jackson
Assistant Editor/ Design & Layout: Lori Quilty

PRESIDENT ...continued from Pg.1

and then stock worth 2.7% of their salary as stock every year over 12 years. Seventy-seven per cent of Hydro workers already make over $100,000 per year. So, our flat broke government that can't afford to fund basic healthcare can somehow find the cash to handsomely pay an industry that is already a massive outlier in its cost structure.

High school teachers arrived back from their summer vacations to a nice 1% lump sum signing bonus, as well as a .5% pay increase this year and another 1% in 2016. In addition, they got another PD day (now up to 7, which will force countless other workers to stay home and look after their kids) and also won improvements to their benefits package, allowing them to take sick leave for medical and dental appointments. Some teachers got an increase in allowable sick days from 60 to 120!!! And this is all despite declining student enrolment. The number of students is expected to drop by 6% over the next 5 years and won't be back to 2014 levels until 2029!

Basically, the savings of taxpayers' conservation efforts have been handed to Hydro workers, the demographic dividend of a declining birth rate has been handed to teachers rather than taxpayers, and the demographic penalty of looking after a burgeoning senior population has been handed to physicians. It is poor governance, plain and simple - unfair, illogical and rather nasty.

So, here are the sound bites:

- Electricity use is declining and hydro workers productivity is tanking, yet Wynne gives them a huge raise with your money.
- High School enrolment is dropping, yet Wynne gives teachers a raise with your money.
- The number of seniors with health care needs is skyrocketing, yet Wynne cuts doctors' pay.

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...Unreasonable. Unfair. Poor Value. Bad Governance.
I think politicians need a gentle reminder that most seniors vote.

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

DYNAMIC ...continued from Pg.4

Solo vs. Integrated Group Practice

Overall, I enjoy my practice much more now than as a solo practitioner. As a group, patient care is more efficient; mentoring is easier; teaching is better; research is great; operating is more fun; discussion around patient care is improved; my lifestyle is better; and clinic is actually a lot of fun! Complications still hurt, but when I have had a colleague participate in a case, it gives me just a little bit of solace when I wonder whether someone else would have done something differently. Most importantly, I believe patient care has improved. Our patients appear to enjoy the quicker access (wait times have gone down); our outcomes and processes continue to improve, and patients have embraced the concept of having multiple expert opinions and involvement in their cases. They routinely acknowledge the excellence of the team and its concept.

Finally, there is a significant amount of pride that comes with being part of a group that you believe in. There is also a pride that comes with being part of a legacy (just like the pride I have in graduating from Western General Surgery), and hopefully this group will continue long after I retire. When I do retire, I know my patients will be taken care of seamlessly. The tradition of excellence will continue. And, hopefully, I will have played a meaningful role in the legacy of The Ottawa Hospital Colorectal Group and the care of colorectal patients.

- Dr. Husein Moloo is on staff at The Ottawa Hospital, Department of General Surgery. He is also Associate Professor at the University of Ottawa.

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Association des Chirurgiens Généraux de l'Ontario

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(Ad hoc) Newsletter	T. Jackson (Managing Editor), President (C. Vinden), J.Kolbasnik
(Ad hoc) OMA	Section Delegates: J. Kolbasnik, C. Vinden (Alts: F. Baille, T. Jackson, A. Lozon, A. Wei)
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EDITOR'S NOTE: *This is the 38th issue of The Cutting Edge and my first 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 & accreditation, this newsletter, the website, job posting, Billing Corner, CPD listing, monthly email updates, CJS, 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. Tim Jackson, Managing Editor*

Our upcoming 2015 Annual Meeting will be funded by the following sponsors. Their support is greatly appreciated. Thank you.

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