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LETTERS

Dear colleagues,

As president of the Canadian Medical Association (CMA), and on behalf of our over 78,000 members, it is my pleasure to welcome you as you begin your career in medicine.

Your training has equipped you with the knowledge to provide high-quality, patient-centred care, but medicine also involves many other responsibilities beyond caring for patients. The issue of *New In Practice 2013* that you are reading is full of useful information about financial, legal and administrative matters that are key to your future success and security.

This guide contains important advice and suggestions, but I also encourage you to learn more about how the CMA and MD Physicians Services can help you throughout the various phases of your life and career. At the CMA, we advocate on behalf of physicians for the highest standards of health and health care, while also providing a range of services related to professional development and leadership training.

So as you embark on your exciting new career, I congratulate you for all that you have accomplished so far and I wish you the very best for a challenging and rewarding future.

Anna Reid, MD, CCFP-EM
President
Canadian Medical Association

Dear resident colleagues,

What will residency training look like in the future? Though we currently benefit from some of the best training in the world, there are many ways that the residency programs of tomorrow will be improved. One such area is the difficulty of transitioning from residency into practice. Today, residents are having trouble finding jobs in several specialties, setting up a practice for the first time, and learning the business side of medicine.

As your national voice, the Canadian Association of Internes and Residents (CAIR) is working hard to improve the resident experience. CAIR is pleased to work with the Canadian Medical Association to develop a pan-Canadian strategy on balancing residency positions with the physician job market and patient needs. This work enhances the many resources that the CMA already provides Canadian residents in facing the challenge of transitioning from residency into practice, such as this helpful guide.

Thanks to such collaborative initiatives between the CMA and CAIR, and the support of the members of both organizations, we can ensure a smoother transition to practice experience for the residents of today and of the future.

Simon Moore, MD, CCFP
President
Canadian Association of Internes and Residents
2012–2013

Dr. Alan Bates.
Psychiatry Resident and
President of the Vancouver
Street Soccer League

VANCOUVER, BC

Game Changer

When psychiatry resident Dr. Alan Bates began volunteering with the Vancouver Street Soccer League, he had no idea how big an impact the game would have on the city's homeless population. Getting together to practice and play games – sometimes in international tournaments – has been incredibly beneficial for the lives and health of the players in the nine-team league. "The returns have been striking: Reduced alcoholism and hospitalizations, players finding homes and jobs. It's amazing what a difference these games make." **DOCSFORPATIENTS.CA**

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chapter 1

evaluating practice opportunities

As medical residents, you are remunerated, or paid, as salaried employees of your hospital or medical faculty. Your salary and payment format resulted from negotiations between your provincial resident association, the ministry of health and your academic institution. The biweekly income you receive is your net take-home pay after deductions for income tax, Employment Insurance (EI), Canada Pension Plan (CPP), group benefits and any other dues you are required to pay. When you complete residency, regardless of where you decide to practise medicine, the way you are paid will change.

While self-employed physicians have been paid primarily on a fee-for-service (FFS) basis, you should know that new ways to reimburse physicians for services continue to emerge. Increasingly we hear more about alternative payment plans (APPs), individually negotiated salaries and other blended remuneration models. Understanding how you may be remunerated for the various services you provide is important as you evaluate your short- and long-term practice options.

FEE-FOR-SERVICE BILLING

FAST TRACK

- Understanding fee-for-service billing is essential for all physicians, regardless of the type of practice in which you intend to engage.

In a traditional fee-for-service system, the physician is a self-employed professional who bills for each individual service provided. The parties responsible for payment for insured services include the provincial ministries of health and Workers' Compensation Boards and federal government departments such as Veterans Affairs Canada, National Defence, Indian and Northern Affairs Canada and Public Safety Canada. For all other services not insured by the above parties the responsible party will be the patient or the requesting third party such as an insurance company.

As recently as 10 years ago, the vast majority of physicians were remunerated solely by billing for services provided. The concept of alternative payment plans first took hold in academic and institutional settings, as it became obvious that monies generated from the provision of clinical services were no longer enough to remunerate the faculty for the teaching and academic administrative services provided. Academic institutions now negotiate for a "global budget" to pay for the faculties' provision of all services.

The variety of alternative payment plans now offered to primary care doctors in some provinces has encouraged many to move away from the traditional FFS payment model. Consequently, residents often ask questions such as: Why should I learn about fee-for-service billing if I plan to work in an academic setting with an APP, or if I am a family doctor in an APP? The reality is that understanding FFS billing is essential for all physicians, regardless of their payment model, for several reasons:

- For the majority of family physicians, remuneration will still directly or indirectly depend and be accounted for by FFS billing.
- Most APPs will require shadow FFS billing for all services provided, so that the provincial Ministry of Health (MoH) can track whether there is a change, an improvement or a drop in services offered under the new payment formula. Shadow billing requires the physician to submit an invoice for all services provided as if still paid by FFS, even though there will be minimal or no remuneration for the individual service. This applies in Ontario, for example, where some family doctors work in such settings as family health networks and family health organizations. Shadow billing is also required of many specialists who work under APPs. To encourage compliance, bonuses for effective shadow billing are now being offered in some provinces. Most APPs require academic institutions to capture and submit shadow FFS billing for all services provided by faculty and residents.
- Institutions that have hired a hospitalist or government sponsored clinical associate on salary or a guaranteed hourly stipend collect data regarding the equivalent services provided under an FFS model. Failure to capture all shadow billings will result in an under-representation of services provided by both the individual physician and the overall group. This may have a significant negative impact on the group's next negotiation for an increase in global funding. Failure to track all individual clinical work may also adversely affect each physician's ability to negotiate his or her next contract renewal.

THINKSTOCK

THE ANATOMY OF A FEE-FOR-SERVICE BILL

Every clinical encounter can be broken down into essential billing components, and all appropriate components must be completed when a claim is submitted for payment. This chapter references Ontario billing code examples, *but be aware that each province has its own distinct codes.*

DIAGNOSTIC CODE: This code indicates the diagnosis for the medical assessment or procedure. Most provinces use a modified three-digit version of the International Classification of Diseases (ICD) to designate how to numerically code the diagnosis. The list of numerical diagnostic codes is provided to each physician once his or her independent billing number is assigned. Note that the codes are not always specific. When hospital medical record departments submit diagnostic coding information, they use a more specific four-digit version of the ICD.

SOME EXAMPLES OF DIAGNOSTIC CODES ARE:

- **DIABETES – 250**
- **HYPERTENSION – 410**
- **TENDONITIS – 427**
- **CONGESTIVE HEART FAILURE – 428**

SERVICE CODE: This code indicates the type and detail of service provided during the patient encounter. This service fee is for history-taking, examination, assessment, investigation plan and counseling of the patient, as well as the documentation of the encounter. Service codes are specialty-specific and are usually alphanumeric combinations.

Examples for specialists would include the service code for a consultation, repeat consultation, specific reassessment or regular office follow-up visit. The coding may be different depending on where the service was provided — in the office, for example, versus an out-patient clinic, inpatient treatment or emergency room. All physicians must learn the province-specific coding format.

Common service codes for family doctors include regular office visits, complete assessments, counseling, interviews, prenatal visits, well baby exams, house-call visits and limited consults. The place of service may require a specific code.

PROCEDURE CODES — PROFESSIONAL, TECHNICAL AND TRAY FEE: Procedures are billed in addition to the professional service fee. Minor and major procedures covered by the MoH can be billed when performed by the physician or, where permitted, by an assignee. Billing may include a specific professional component, technical component or tray fee. The technical component and tray fee can be billed by the physician if he or she provides the equipment and staff for the procedure; however, if the procedure is done in a hospital where all technical support and equipment is provided, then the physician can only bill for the professional component. Staff performing procedures on behalf of a physician must take care to include these procedural fees in the daily billing submissions; otherwise, a significant amount of income can be lost. The specific procedures covered vary by province. Procedure codes are usually alphanumeric.

Procedural fees are the bread and butter of specialists such as obstetricians, surgeons and ophthalmologists, and are especially important for anesthesiologists and radiologists, whose billing is mostly procedure-based. However, forgetting to bill for minor procedures such as urinalysis, injections, phone supervision of anticoagulation, and chemical treatment of skin lesions is very common among family physicians and results in the loss of thousands of dollars of income each year.

The following examples use *Service Codes* from the Ontario fee schedule.

EXAMPLE 1

An Ontario family doctor assesses a patient in her office for bronchitis.

Description	Code	Fee
Diagnostic code	466	
Service code for an intermediate examination	A007A	$34.70

EXAMPLE 2

A patient sees an Ontario plastic surgeon concerning a complicated finger fracture.

Description	Code	Fee
Diagnostic code	816	
Service code for a consultation	A085A	$81.10

EXAMPLE 3

An Ontario family doctor assessing a patient with rectal bleeding does a rigid sigmoidoscopy and makes a provisional diagnosis of ulcerative colitis.

Description	Code	Fee
Diagnostic code	556	
Service code for an intermediate examination	A007A	$34.70
Procedure code for sigmoidoscopy	Z535A	$36.80
Tray fee code for providing the instruments in the office	E746A	$5.85
TOTAL FEE		$77.35

EXAMPLE 4

A general surgeon sees a patient in consultation for an inguinal hernia, and performs elective surgery 12 weeks later.

Description	Code	Fee
Diagnostic code for inguinal hernia	550	
Surgical consultation code	A035	$90.30
Surgical procedure code (*The procedural fee usually includes postoperative care)	S323A	$331.80
TOTAL FEE		$422.10

EXAMPLE 5

A radiologist reviews and reports on an MRI of a patient's knee. Only the professional component of the procedure is billable (unless the radiologist provides the MRI and staff).

Description	Code	Fee
Professional procedure code for MRI	X471	$77.20

EXAMPLE 6

A family doctor on call for his group is called on a Saturday afternoon by the nurse in the emergency room to come in to evaluate a colleague's patient. An ECG and chest x-ray are ordered and turn out negative. The patient is ultimately diagnosed with non-cardiac chest pain.

Description	Code	Fee
Diagnostic code for chest pain NYD	785	
Service code for complete assessment	A003A	$77.20
Special visit premium for going to the ER on a weekend afternoon	K998	$75.00
Travel premium to ER	K963	$36.40
TOTAL FEE		$188.60

SPECIAL PREMIUM OR MODIFIER CODE: Additional fees are paid when the physician provides the service at a location other than the regular office or clinic and must travel to provide the service, and/or when the service is provided after regular work hours, or on weekends or holidays.

The terms premium or modifier may be used to describe this additional fee. In some provinces these special visit premiums are now billed as two components; a travel premium (usually a set fee) and a special visit premium which is coded and paid based on where and when the special visit is offered as well as if there is one or more patients seen during that visit. These codes are now very complicated. Your provincial medical association will offer additional resources to assist you in learning and capturing these codes.

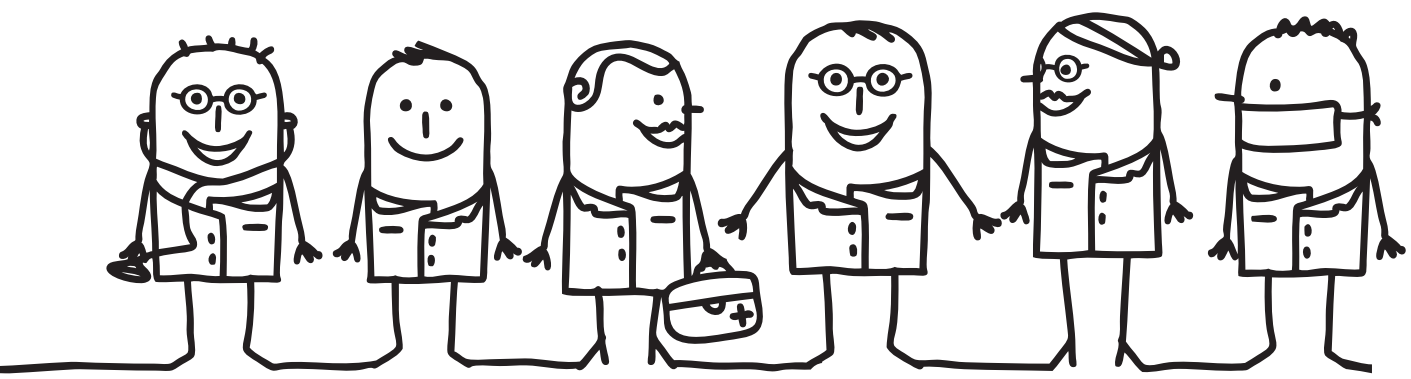
BONUSES: Bonuses are an increasingly important component for remunerating physicians for providing designated and targeted services such as complex care and evidence based management of chronic diseases such as diabetes, CHF and COPD. Financial incentives are not the same in all provinces, so you will need to verify your specific situation. These bonuses can apply in different formats.

As well, some provinces are now rewarding family doctors for encouraging patients to participate in preventative care programs such as regular PAP tests, mammograms, stool for occult blood, flu shots, etc.

BOTTOM LINE

Approach all the services you provide with the checklist of what was the diagnostic code, service code and possible procedural codes, tray fees and bonuses. By doing so you will minimize the number of services you provided but failed to bill.

Finally, stay up-to-date with your fee schedule. The services that family physicians and specialists offer are constantly evolving so new service and procedural fees will be created to pay for these services. Failure to keep up-to-date with your fee schedule will result in a significant loss of income over your career.



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ALTERNATIVE PAYMENT AND FUNDING PLANS

FAST TRACK

- Physicians engaged in an alternative payment or funding plan usually still need to submit billings as if earning income as fee-for-service.
- Be aware that there could be certain tax implications to participating in an alternative payment plan. Regardless of what your contract states, you could be assessed as an employee. Consult with an accountant who is a tax expert prior to signing any contract.

The terminology to describe alternate payment plans varies in different provinces but the principles are essentially the same. In this article we will use the terminology used in Ontario for example purposes. Alternative payment plans (APPs) address alternate methods of remunerating physicians for clinical work. Alternative funding plans (AFPs) address alternate methods of paying physicians for clinical and academic work. AFPs are typically implemented in academic centres where a significant part of the physician's work and time is not remunerated by fee-for-service payment. For instance, academic physicians often devote a lot of time to teaching, research and administration, yet none of these services or duties are billable under the fee-for-service model.

An APP or AFP is created through a mutual agreement between a group of physicians and the province or territory. The agreement is documented in a binding contract signed by the province and the physicians, often as well as the provincial medical association, and for academic positions, the university. The province/territory agrees to provide a set amount of remuneration per physician or full-time equivalent, and the physicians agree to provide set levels of clinical, teaching, research, administrative and other activities. The parties agree on a mechanism to account for these defined deliverables and compare them to budgeted amounts on a periodic basis. As part of this process, APPs and AFPs generally require physicians to submit billings as if they were earning income as fee-for-service doctors, even though their remuneration is set and guaranteed by the contract (i.e., shadow billing). Governments often compare the amount of shadow billing to the remuneration received by the same physicians to ensure that the public has received value for money.

Provincial ministries of health continue to evaluate how best to offer cost effective primary care. Provinces such as Ontario have, since 2002, been promoting APPs to encourage family physicians to form group practices offering patients easier access to comprehensive, seven-day-a-week out-patient care; in exchange, the physicians usually agree to provide a predetermined "basket" of common services. There may be additional incentives for after-hours outpatient care, home care, obstetrics, palliative care and hospital care. These models require physicians to enroll (roster) their patients into their practice and are referred to as Patient Enrolled Models (PEM). Services rendered under such APP contracts may be remunerated in several ways, including but not limited to the following

- A percentage bonus applied to the fee-for-service billing for existing comprehensive services (e.g., 10%–15% based on age), as well as performance incentives and incentives for after-hours care (additional 30%) and for meeting predetermined special service delivery targets, are components of plans such as Ontario's Family Health Group (FHG) program. This model *enhances* the traditional fee-for-service model where the physician is remunerated for seeing their patient.
- A capitation format guarantees an annual basic fee paid for each rostered patient (factoring in age and gender) for the delivery of a predetermined basket of common primary care services. For example, the annual payment for providing out-patient non-emergent primary care services for a 20-year-old male may be about $50 compared to $300 for a 75-year-old female. The physician receives this basic fee in 12 equal payments over the year, whether or not he or she has seen the patient. There are incentive bonuses for preventative care targets and for shadow billing for all services and procedures that would have been covered under fee-for-service. Services not in the basket are billed under fee-for-service. In Ontario, for example, there are two models, one is called a Family Health Network (FHN) and the other a Family Health Organization (FHO).
- The majority of provinces, like British Columbia and Alberta, have chosen to enhance the traditional fee-for-service model with percentage-based bonuses, age-based modifiers and bonuses for preventative care and chronic disease management rather than offer capitated models.
- A "blended" model is common in rural and remote areas where the population base is too small to guarantee the volume of fee-for-service billing that would generate an appropriate income for a physician. In these scenarios, the MoH guarantees the physician an annual gross income for provision of common medical services in the office. The physician must provide shadow billing records for office-based services. Fee-for-service still applies for obstetrical and emergency care, as well as medical services provided after hours or in hospital. Retention incentives and bonuses are offered annually to physicians who stay in the underserviced area. This model is common to rural areas of Ontario and Newfoundland and Labrador.

THE COMPLEXITY OF APPS AND AFPS

The contractual aspects of APPs are much more complex than traditional FFS or salary contracts. Most APPs consist of a blend of some (or all) of: fees for clinical services; population or capitation funding; time-based payments (hourly, daily or other); rewards for participation in specific clinical initiatives; bonuses for achieving specific targets in prevention or quality care; remuneration for administrative duties and costs; and financial contribution for medical information technology. In the case of AFPs for academic physicians, there may also be some (or all) of: compensation for teaching; research funding; stipends for administrative duties; and partial compensation or subsidies for staff, other health care workers, facilities or equipment. APPs targeting primary care physicians will include some or all of the following components:

FEE-FOR-SERVICE BILLING: In an APP that incorporates the FFS format, a physician is paid only if a patient is seen and a medical service is provided. Income relates directly to the

number of patients seen and the services provided for each patient. Payment as defined in the provincial FFS schedule of benefits is made directly to the physician providing specific services. This applies also to an APP with a FFS blended payment format, in which FFS billing represents only a portion of the physician's income.

SHADOW FEE-FOR-SERVICE BILLING: Physicians participating in an APP with capitation payments must also submit FFS invoices for all services provided to rostered patients. Although the physician may not receive FFS payment for these services, physicians participating in a capitation PEM may receive a percentage bonus (e.g., 15% per bill) for all shadow FFS billings they submit as an incentive to keep accurate records of all services provided. The MoH requires this information for evaluating patient access and utilization under the different APP models. If the physician provides a service to a non-rostered patient, the physician can still bill regular FFS to the MoH and be fully paid. However, there are often limits on how much FFS income a physician participating in a capitation model can receive. In addition to the FFS payment, there can also be a percentage bonus payment for qualifying medical services. For example, a 10% bonus may be paid in addition to the regular FFS fees when the physician participating in a PEM provides the service to an enrolled patient. Another example would be an additional percentage bonus for providing that service on evenings or weekends.

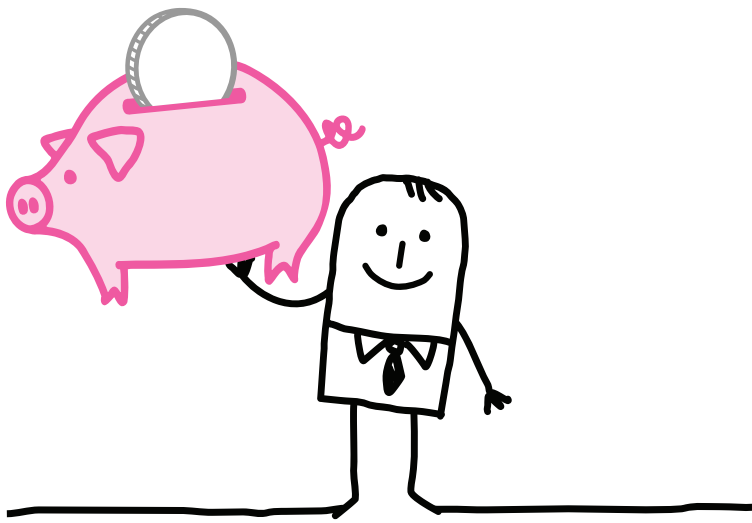
PREVENTATIVE CARE BONUS: Some provinces now offer annual bonuses when the physicians can document that they have met or exceeded certain percentage targets for preventative health care. For example, physicians who can document that they have given, or documented the receipt of the flu shot to predetermined percentages of the target population may receive a lump-sum bonus payment. Other preventative care bonuses proposed in some provinces include biennial Pap tests for women aged 35–70; biennial mammograms for women aged 50–70; colorectal screening every 30 months for patients aged 50–74; and primary childhood immunization as per the latest guidelines for children up to two years old. Many physicians fail to reap these bonuses simply because they do not have solid procedures in place to prompt, track and capture preventative care services. Setting up a good process will prompt you to initiate the service, prompt your patients to receive the service, and ensure that you track and submit all services rendered to the MoH. This will lead to a win–win situation for both you and your patients. Electronic medical records can make this process much easier.

COMPREHENSIVE CARE MANAGEMENT (CCM) FEE: This is a payment for the ongoing administrative work, medical record review and upkeep that comprehensive family doctors do in addition to seeing their patients. A monthly capitation rate is paid per rostered patient. Rates vary based on age and gender and may be in the average range of $2 per month, per patient. CCM fees are commonly seen in patient-enrolled models and apply only for enrolled (rostered) patients.

CHRONIC DISEASE MANAGEMENT FEE: Provinces such as BC, Alberta and Ontario offer physicians an annual fee for providing documented evidence-based care for patients with chronic conditions such as diabetes, congestive heart failure and COPD. These annual fees may range from $60–150 per patient.

COMPLEX CARE MANAGEMENT FEES: At least three provinces now reward family doctors for the ongoing management of patients with complex medical issues. Criteria and documentation is required to receive these incentives that are in the range of $300 per patient.

NEW PATIENT INCENTIVES: A few provinces offer a fixed bonus to physicians who accept "orphaned" patients (those who do not have a family doctor) as new patients into their practices. There are usually a limited number of new patient enrolment bonus payments per year. For example, there may be a $100–$180 (based on age) bonus for the first 60 new patients accepted per year into an existing practice. As an additional incentive, new entrant physicians may be offered these bonuses for a greater number of new patients in their first year of practice (in Ontario, this amounts to about 300 patients in the first year of practice).



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ADMINISTRATIVE FEES: These per-patient fees are paid annually to the physician or the group practice to help defray some of the administrative costs of meeting the accountability criteria required by APPs that have a capitation payment format.

SESSIONAL FEES: These fees, usually based on an hourly rate, are paid for the delivery of specific services. For example, many emergency departments now offer physicians a guaranteed sessional fee per hour for working as the doctor on duty, regardless of the number of patients seen. The physicians are obliged to shadow bill so the actual services rendered can be monitored. Failure to capture and submit all shadow billing has already led the MOH in Ontario, for example, to reassess (and sometimes reduce) the guaranteed sessional fee in some jurisdictions.

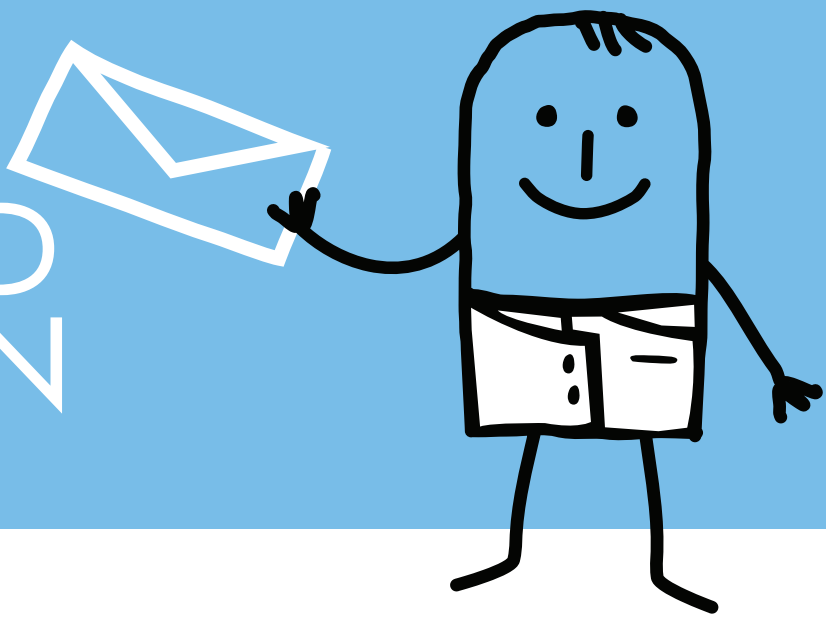
BLOCK FUNDING: Some physicians receive a guaranteed payment to provide medical services for a specific location or region for a defined interval of time. Block funding is often offered to physicians working in rural and remote areas where they would not receive adequate remuneration if they had to rely solely on FFS billings. Shadow FFS billing is required. In an APP that incorporates block funding, the physicians often also qualify for additional FFS billing and other bonuses. The block funding guarantees a monthly minimum gross income from which physicians can pay themselves and their overhead expenses.

SUMMARY

Alternate payment plans are constantly evolving and definitely vary from province to province. Up-to-date information can be obtained at your provincial-specific resident association and medical association websites. Many provincial governments are now funding recruitment agencies that help residents, new entrant doctors and doctors in practice in not only finding work but also in understanding the varied payment models. CAIR — Canadian Association of Internes and Residents — lists all of these on their website.

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

SALARIED POSITION



FAST TRACK

- An increasing number of physicians are now considering salaried positions.
- The term salary can be a misnomer so clarification is always required.
- Consult a tax expert prior to signing an agreement with any employer.

As a resident, you receive a salary negotiated by your provincial residents' association and paid by the Ministry of Health (MoH). Income tax and employee contributions for CPP, EI and other benefits are deducted at the source by the medical institution that employs you. A biweekly cheque represents your take-home income, which is guaranteed by contract. You receive standard employee benefits such as medical–dental coverage, disability coverage, paid vacation and sick leave. Your contract stipulates your basic work hours, service obligations and expectations, as well as on-call duties and practice restrictions. Regardless of the number of patients you see, the services you provide or the intensity of after-hours on-call work, your income is fixed and non-negotiable. Your professional deductions for tax purposes are very limited during residency. As well, you have minimal control over your work environment, the patients you serve, whom you work with, the clinic's policies, your holidays and your call schedule.

Once in practice, your remuneration situation will change. Most physicians in Canada are still self-employed professionals whose income is primarily generated directly or indirectly by fee-for-service billing. However, an increasing number of physicians now derive a portion or all of their income in the form of a negotiated guaranteed income. The term salary is most often used, but clarification is always required because the guaranteed 'salary' is most often a guaranteed gross income rather than a true salary format as received as a resident.

Salaried physicians are either the employees or contractors of their hospitals, regional health authority or organizations. If the physician is an actual employee, then the institution will deduct tax, CPP, EI and potential benefit contributions from the negotiated salary. If a guaranteed gross income (income tax, CPP etc, still owing) is received, then a physician is in effect a contracted physician, contracting their services for a negotiated amount of money and still considered self-employed by Canada Revenue Agency.

In either scenario, a guaranteed income, unaffected by the volume of procedures and services performed, is one of many advantages enjoyed by salaried physicians. But unlike their fee-for-service colleagues or contracted physicians who earn business income, employee-physicians can claim very few expenditures as tax deductions. A physician whose entire income is paid as salary generally cannot deduct association dues or malpractice insurance premiums. Under such circumstances, physicians should negotiate to have their employer pay these expenses.

Salaried physicians should also consider negotiating for the ability to do additional fee-for-service work to earn business income. For example, the physician could negotiate for regular time — perhaps one day a week — to work as a fee-for-service provider independent of contractual obligations to the employer. In this scenario, expenses such as malpractice insurance premiums, convention costs, automobile deductions and association dues should be tax-deductible if they were incurred to earn business income,

were reasonable in amount, and were allowed under the *Income Tax Act*. Seek the advice of an accountant who specializes in taxation before making a commitment to an employer, and have the accountant review the actual agreement. Tax planning opportunities may exist, and there may even be tax implications if your employer pays for certain benefits on your behalf (e.g., partial or complete payment of employee disability insurance premiums by the employer will make any disability benefits that may be collected taxable to the employee).

HOSPITAL-BASED ACADEMIC POSITIONS

While many physicians in academic institutions may receive 100% of their income as salary, some academic positions offer a combination of salary, contracted and fee-for-service income. Some jurisdictions have a ceiling limiting the amount of fee-for-service income each academic physician may earn and retain. Income generated by physicians in excess of the limit may be redirected, in whole or in part, to the general operations and benefit of their department. The specific arrangement can be complicated; academic physicians may need to address the issues of association or partnership arrangements, as well as the issues of "blended" income. In addition, academics often have no autonomy regarding practice management decisions, unlike their non-academic counterparts.

SUMMARY

As when evaluating any mode of practice it is essential to make an informed decision and get advice from your professional advisors. Always have your tax specialist accountant and your contract lawyer review the salary contract offered to you in detail.

ADVANTAGES OF SALARIED POSITIONS

- A secure, agreed-upon income, received every pay period
- No requirement to manage the practice
- No responsibility for overhead costs
- Benefits may include guaranteed paid vacation, CME time, sick leave, medical and dental benefits, life and disability insurance

VS

DISADVANTAGES OF SALARIED POSITIONS

- Limited ability to earn more money except by renegotiating contract, even though workload could increase without a parallel increase in earnings
- Benefits may be limited and must always be clarified in the contract
- Limited control over working environment
- Employer makes decisions about staff, working conditions, patients and overall operation of the clinic
- No guarantee of employment beyond the term of the contract
- Limited ability to claim such expenses as CMPA fees or association dues as tax deductible

It is imperative to always have your accountant and contract specialist lawyer review all contract offerings because the taxation implications can be profound.

THINKSTOCK

LOCUMS

For family physicians and now many specialists who have recently completed residency, there are many advantages to working as a locum before making a long-term practice commitment. Whether you provide short-term coverage for a vacation or long-term relief for a maternity leave or sabbatical, a locum is an excellent opportunity for you to gain experience in medical practice.

When committing to a locum opportunity, a physician essentially agrees to assume the responsibilities and practice style of the host doctor. Historically, such arrangements were informal, verbal or arranged by a handshake between the parties. Today, however, both medical practice and the business of medicine are much more complicated — and physicians have developed their own ways of doing things. There are many different approaches to matters such as scheduling appointments, billing for uninsured services, providing extended hours, accepting walk-in patients and keeping medical records. Since every physician strives to develop a style of practicing medicine that best suits his or her personality, it is no surprise that a host physician and a locum might have quite different approaches as to the provision of medical care and the management of a medical practice. This could lead to misunderstandings, making a locum experience unpleasant for both parties. This could lead to misunderstandings, making a locum experience unpleasant for both parties. The best way to ensure a positive experience for you and that you can meet the host doctor's needs and expectations is to use a "locum evaluation checklist" to evaluate the locum and to then prepare a formal, written contract that takes into account the terms of the locum and the potential contingencies — in other words, the "what ifs" that could occur.

The CMA PMC Module 11: Negotiating A Mutually Beneficial Locum Contract addresses these issues in great detail. This article captures some of the important information from that module, which you are encouraged to review.

Key areas when evaluating a locum include assessing the scope of the services offered as well as the demographics of the host doctor's practice as well as how his or her appointment schedule is managed. It is also critical to assess the comprehensiveness and ease of use of the physician's medical records. The following three lists are part of a more detailed checklist provided in Module 11.

SCOPE AND STYLE OF PRACTICE

- What are the patient demographics (e.g., pediatrics, women's health, geriatrics, adolescents)?
- Does the practice have a specialty interest or special needs population?
- Does the physician do deliveries, or shared-care obstetrics (prenatal care to 28 weeks), or perform minor surgeries? If you are expected to perform the same procedures, are you competent and comfortable in delivering these services? If not, has the host made arrangements for other colleagues to cover these tasks during the term of the locum?
- A list of procedures should be clarified in the contract.
- What are the regular office hours? Can you modify the office schedule if necessary?
- What on-call obligations are you expected to assume? Are there additional obligations related to the group's after-hours clinic, hospital, nursing home, house calls or emergency department?
- Do you have the option of not filling any of these obligations?
- Will the physician's trusted colleagues be readily available to assist you in an emergency?
- Does the host doctor follow current practice guidelines and evidence-based medicine?
- Does the doctor follow current guidelines for prescribing antibiotic, narcotic and anxiolytic medications?
- Does the host doctor have patients on long-term narcotics for non-malignant pain, and, if so, have these patients signed a contract?

THINKSTOCK

- What are the office policies for phone call prescription renewals and missed appointments?
- How does the doctor handle requests for sick notes?
- Are practice policies (e.g., missed appointments, phone consultations) clearly posted in the office? Has the doctor provided each patient with a patient information handout that explains the practice's policies? Do staff members enforce the policies?
- Is the office clean and comfortable, with up-to-date equipment?

APPOINTMENTS

- What is the average number of patients seen per day?
- Do the reception staff triage appointments?
- Is the reason for the patient visit recorded on the appointment schedule?
- Does the host doctor use 10-minute or 15-minute time slots for average patient visits?
- Are two or three time slots reserved for check-ups and counselling?
- How many periodic health examinations are scheduled each day? How much time is allocated for these appointments? When during the day are they scheduled?
- When are procedures done? How much time is allocated for procedures?

- How does the doctor fit same-day call ins into the schedule?
- How many dedicated slots are allocated and protected for same-day call ins?
- Does the doctor have clear guidelines for booking double appointments?
- Are there a reasonable number of time slots over the next two weeks for new bookings?
- Can you modify the appointment schedule if necessary?

MEDICAL CHARTS

- Are the medical records comprehensive, legible and well organized?
- Does the physician dictate or write progress notes? Do the progress notes follow the SOAP (Symptoms, Observations, Assessment and Plan) format?
- Does the physician keep up-to-date cumulative patient profiles (CPPs) and such records as cumulative medication sheets, diabetic, INR and lipid flow sheets?
- Are allergy and immunization records clearly marked?
- Do the records indicate compliance with evidence-based medicine and practice guidelines for preventative care and screening?
- Do the records indicate the physician's prescribing habits for controlled drugs, anxiolytics and antibiotics?
- Do the records raise any concerns regarding medical competence?
- Do the medical charts have year labels that will help you to determine the number of patients who have been seen within the past two years?
- If EMR, are all of the above requirements met and, if required, will you be orientated to the EMR system in advance?
- Clarification of all of the above points should be included in the locum contract as well as the following:

FEE-SHARING AGREEMENTS

One of the many points of negotiation between the host doctor and locum will be a fee-sharing agreement in which the gross fees generated and received during the locum are shared. The locum's objective is to earn a ready income stream without having to invest time, capital and ongoing commitment to generate income. The host doctor's objective is to find a competent replacement and to cover most of the overhead costs during the locum period.

While past research has indicated that the average overhead costs for a full-time GP were in the ballpark of 40% of their income, these figures are not as relevant anymore. The vast majority of GPs are now taking advantage of economies of scale by participating in group practice. The average physician's gross income is generated from several

THINKSTOCK

sources, including office work, hospital income, after-hours clinical income and third-party billings. Because overhead is still incurred on those half-days when the physician is out of office, even non-office billings help pay for overhead expenses. Since the volume of patients seen by the locum can be 75 to 80% of that seen by the host doctor, the share of fees that the host doctor receives from the locum will often not cover the proportionate overhead costs incurred during the locum. However, most host doctors understand that the discrepancy is a small price to pay for a much-deserved vacation and the reassurance that their patients are well cared for in their absence.

Most hosts are prepared to accept a fee-sharing agreement that is more attractive to the locum, and to consider a variable fee-sharing split for services rendered outside the office. For example, many locum agreements have negotiated a 70/30 split for office services, and an 80/20 split for the hospital and on-call services that are part of the host's regular work and gross income. If the locum has the opportunity to do additional shifts in the emergency department that are independent of the obligations to the host physician and do not compromise the obligation to cover for the host doctor, then the host doctor has no claim to the locum's additional income. The host would also have no claim to special incentives such as bonuses for locums in underserviced areas unless the program recommends a fee-sharing split to compliment the incentive. .

Regardless of the split, the gross income generated during the locum is what determines the net gain for both parties. The host should encourage patients to see the locum, not only to ensure their health care, but also to contribute the maximum amount to overhead costs. The result is a win–win scenario. The locum gets a ready income stream, works with different professionals in different practice settings and test drives a potential long-term practice opportunity. The host doctor gets a vacation, no crushing workload looms over his or her return to work and most overhead costs are covered. Neither party should attempt to take advantage of the other. You have a vested interest in each other's success, and you both should feel the arrangement serves you well.

GUARANTEED MINIMUM INCOME

Guaranteed minimum daily incomes are often included in government-sponsored locums or in certain circumstances (e.g., rural practices) where patient volumes are low. If the locum and host doctor have evaluated the practice opportunity thoroughly and the host ensures the locum is busy, there would be no need to negotiate such an arrangement. If in doubt, negotiate a guaranteed daily minimum income. Be sure to clarify whether the host doctor's share of the fees will be deducted before or after the daily minimum is paid to you.

WHO SHOULD DO THE BILLING?

Most provinces require billings to be submitted using the billing number of the physician who provided the service. As such, fees generated and paid by the MoH will be deposited directly into the locum physician's account, not the host physician's.

GENERALLY THERE ARE THREE OPTIONS FOR THE SUBMISSION OF BILLINGS:

- Billing is done via the host doctor's billing service/software
- The locum physician does his or her own billing
- The locum physician uses the services of a billing agent

THINKSTOCK

The last option is the best for most locums. Most agreements are well served when the locum uses a dedicated billing agent who charges a commission — usually around 3% — based on total billings collected. This agent has a vested interest in collecting all billings submitted under your number, and will know the latest changes to the fee schedule. The cost of the service is minimal and tax deductible. Every medical association should have a list of billing agents used by their members.

BILLING FOR NON-INSURED SERVICES

You will want to clarify the office policy regarding medical services not covered by the MoH. Some physicians are uncomfortable billing their patients for non-insured services, while others routinely bill their patients for such services. Note that billing for non-insured services can increase gross revenues by 5% to 10%. However, a locum must always exercise discretion regarding such billings. There will be unnecessary friction with patients, and you may upset staff if you require them to enforce decisions that run contrary to their usual practice.

FAIR PAYMENT SCHEDULE

Regardless of which party receives payment, the locum and the host should agree to remit the proportionate share to each other within one week of receipt of payment. Note that billing periods vary from province to province. Remittance payments are made once a month in Ontario, and every two weeks or twice monthly in most other provinces. Accordingly, it can be as much as six weeks before accounts receivable are paid. This can be a problem for graduating residents who start locums in July or August, as delays in MoH remittances could leave a locum with no income until mid-September.

BOTTOM LINE

Using a locum evaluation checklist will ensure that the locum is a good fit for you and you are a good fit to cover the host physician. A win–win scenario.

EVALUATING LONG-TERM PRACTICE OPPORTUNITIES

Choosing where and how you want to settle down and establish your long-term practice requires many questions to be answered, by yourself, your family, your peers and the people with whom you are contemplating working. The following checklist has been edited from the online CMA PMC Module 10: Evaluating Practice Opportunities: Family Medicine. For specialists a dedicated Module 13: Evaluating Practice Opportunities: Specialist is available for your review. The following checklist will serve as both a useful tool and a discussion guide for the bigger points of consideration.

THINKSTOCK

FIRST AND FOREMOST: LIFESTYLE

- ❒ Will you and your family be happy living in the community for several years?
- ❒ Is affordable, quality housing available in the community?
- ❒ Are schools and shopping, as well as recreational, cultural and religious facilities, readily available and accessible?
- ❒ Can you visit your extended family and friends easily?
- ❒ Are there employment opportunities for your significant other and family?

PROFESSIONAL CONSIDERATIONS

- ❒ Do you want to practice in an urban, a rural or a remote area?
- ❒ Will you be a traditional, comprehensive family practitioner?
- ❒ Will you do obstetrics? Will you provide hospital or nursing home care?
- ❒ Do you want your own patient roster, or do you prefer to offer shared care on a clinical team?
- ❒ Will you prefer to primarily offer periodic or sessional care?
- ❒ Do you have special interests such as sports medicine, ER, student health, industrial medicine, occupational health, or consultative work for insurance companies or Workers' Compensation Board?
- ❒ Will you work full-time or part-time?
- ❒ Do you prefer solo or group practice?
- ❒ What are your income aspirations?
- ❒ Do you prefer an associated or partnership group arrangement?
- ❒ What remuneration model do you prefer: Fee-for-service? Salary? Blended format? An alternate payment plan?
- ❒ What is your comfort level with billing for uninsured services?
- ❒ To what degree do you want management responsibilities?
- ❒ Do you want to teach?

A SALARIED POSITION

- ❒ Have you addressed what you are to give, what you are to receive, and all of the "what ifs" with your lawyer and accountant?

ASSUMING A PRACTICE AND/OR JOINING A GROUP

- ❒ Does the practice have a specialty interest or special needs population?
- ❒ Does the practice follow current guidelines and evidence-based medicine?
- ❒ What are the policies regarding antibiotic, narcotic and anxiolytic medications?
- ❒ Are patients charged for non-insured services? If so, for what services?
- ❒ What are the office policies for telephoned prescription renewals and missed appointments?
- ❒ How are requests for sick notes handled?
- ❒ Does the practice offer obstetrics or minor surgical procedures?
- ❒ What are the regular office hours?
- ❒ Is there flexibility for your schedule?
- ❒ What are the on-call obligations for the hospital, nursing home or emergency department?
- ❒ Do the doctors share the on-call obligations equally?
- ❒ What are the arrangements with your group and other physicians for after hours, weekend and holiday coverage?
- ❒ Does the practice have a comprehensive list of specialists for referrals?
- ❒ Are there teaching opportunities or obligations?
- ❒ Is the practice in an area where hospital restructuring has happened or is pending?
- ❒ If the group consists of male and female physicians, is there a "gender neutral policy" educating patients that in the event their personal physician is not available, emergency visits will be with the next available colleague, all of whom are sensitive and experienced with "women's and men's" health issues?

EVALUATING LONG-TERM PRACTICE OPPORTUNITIES

APPOINTMENT SCHEDULING

- ❒ What is the average number of patients seen per day?
- ❒ How much time is allocated for the average patient visit?
- ❒ Are time slots reserved for periodic (annual) health exams and counseling?
- ❒ How many time slots are allocated for same-day call-ins? How are these patients accommodated in the schedule?
- ❒ How many periodic health examinations are scheduled each day? How much time is allocated for these appointments? When during the day are they scheduled?
- ❒ When are procedures done? How much time is allocated for procedures?
- ❒ Does the practice offer variety (e.g., pediatrics, geriatrics, adolescents, women's health)?
- ❒ Is the reason for the patient visit recorded on the appointment schedule?
- ❒ Does the practice have an extensive list of contacts (e.g., call group members, consultants, labs, diagnostic services and pharmacies)?
- ❒ Can you customize your appointment schedule?

MEDICAL RECORDS

- ❒ Are the medical records comprehensive, well organized and legible?
- ❒ Do the physicians dictate or write progress notes?
- ❒ Are progress notes done in a SOAP (Symptoms, Observations, Assessment and Plan) format?
- ❒ Do the physicians keep up-to-date Cumulative Patient Profiles and records such as cumulative medication sheets, diabetic, INR and lipid flow sheets?
- ❒ Are allergies and immunization records clearly marked?
- ❒ Do the records indicate compliance with evidence-based practice guidelines for preventative care and screening?
- ❒ Do the records indicate the office's prescribing habits for controlled drugs, anxiolytics and antibiotics?
- ❒ Do the records raise any concerns regarding medical competence?
- ❒ Will the group members welcome standardization of medical records?
- ❒ Does the practice have, or intend to have, electronic medical records and a paperless office?

THE MEDICAL OFFICE

- ❒ Do the physicians own, lease or sublet office space?
- ❒ Which office functions are computerized? Which are still done manually?
- ❒ What communications equipment does the office use?
- ❒ Is the office accessible, modern, comfortable, clean and pleasant for patients, staff and physicians?
- ❒ Are the exam rooms and common areas designed for function and comfort?
- ❒ Is the office and medical equipment up-to-date?
- ❒ Will your personal needs for equipment and office space be met?
- ❒ What are the present and proposed staffing arrangements?
- ❒ Will you have shared or dedicated staff?
- ❒ What responsibility will you have for hiring and evaluating staff?

FINANCES AND BILLING

- ❒ Does the group have an association or partnership agreement?
- ❒ Are shared and individual expenses clearly outlined in the agreement?
- ❒ Will expenses be shared equally, or will they be proportionate to each physician's utilization?
- ❒ Have you reviewed the agreement in detail with your lawyer and accountant?
- ❒ Are you happy with the financial terms of the partnership or associateship?
- ❒ Are health, dental and/or other benefits available through the practice?
- ❒ How are the physicians remunerated: Fee-for-service? Alternate payment plan? Blended format? Salary?
- ❒ Who submits and reconciles the billings?
- ❒ Are there clear policies for the billing and collection of fees for noninsured and third-party services?
- ❒ Is there a clear policy regarding patients who have overdue accounts?
- ❒ Does the practice post its office policies and distribute patient information sheets to clearly inform patients that they will be billed directly for non-insured services?

ACCOUNTING

- ❒ Has your accountant reviewed the bookkeeping and accounting practices in detail?
- ❒ Are expense and income records readily available for your review and approval?

INSURANCE AND LEGAL ISSUES

- ❒ Do all group members have adequate professional and personal liability insurance, life insurance, office insurance, disability insurance and practice overhead insurance to cover any losses or obligations for the term of the group practice agreement?
- ❒ Has your lawyer reviewed and approved the office lease?
- ❒ Have your lawyer and accountant reviewed and verified that your best interests are covered in the association or partnership agreement?

THE BOTTOM LINE

- ❒ Do your future associates have a vested interest in your success?

For a more comprehensive review of the above topics and the rest of the topics presented in *New in Practice* visit the online CMA PMC Modules at cma.ca/pmcmodules

NEW INDICATION

ELIQUIS

is now indicated for the prevention of stroke and systemic embolism in patients with **atrial fibrillation**

ELIQUIS (apixaban) is indicated for the prevention of stroke and systemic embolism in patients with atrial fibrillation.

ELIQUIS is contraindicated in patients with clinically significant active bleeding, including gastrointestinal bleeding; lesions or conditions at increased risk of clinically significant bleeding: e.g., recent cerebral infarction (ischemic or hemorrhaghic), active peptic ulcer disease with recent bleeding, patients with spontaneous or acquired impairment of hemostasis; hepatic disease associated with coagulopathy and clinically relevant bleeding risk; concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-glycoprotein such as azole-antimycotics, e.g., ketoconazole, itraconazole, voriconazole, or posaconazole, and HIV protease inhibitors, e.g., ritonavir; concomitant treatment with any other anticoagulant, including unfractionated heparin (UFH), except at doses used to maintain a patent central venous or arterial catheter), low molecular weight heparins (LMWH), such as enoxaparin and dalteparin, heparin derivatives, such as fondaparinux, and oral anticoagulants, such as warfarin, dabigatran, rivaroxaban, except under circumstances of switching therapy to or from apixaban; hypersensitivity to apixaban or any of the ingredients in the formulation.

As with all anticoagulants, ELIQUIS should be used with caution in circumstances associated with an increased risk of bleeding. Bleeding can occur at any site during therapy with ELIQUIS. The possibility of a hemorrhage should be considered in evaluating the condition of any anticoagulated patient. An unexplained fall in hemoglobin and/or hematocrit or fall in blood pressure should prompt a search for a bleeding source. Patients at high risk of bleeding should not be prescribed ELIQUIS. **Should severe bleeding occur, treatment with ELIQUIS must be discontinued and the source of bleeding investigated promptly.** Close clinical surveillance for blood loss is recommended throughout the treatment period. This may include looking for obvious signs of bleeding, e.g. hematomas, epistaxis, or hypotension, testing for occult blood in the stool, checking serum hemoglobin for significant decrease, etc., especially if other factors/conditions that generally increase the risk of hemorrhage are also present.

As with any anticoagulant, patients on ELIQUIS who undergo surgery or invasive procedures are at increased risk for bleeding. In these circumstances, temporary discontinuation of ELIQUIS may be required. **The risk of these events is even further increased by the use of indwelling catheters or the concomitant use of drugs affecting hemostasis. Accordingly, indwelling epidural or intrathecal catheters must be removed at least 5 hours prior to the first dose of ELIQUIS. The risk may also be increased by traumatic or repeated epidural or spinal puncture. If traumatic puncture occurs, the administration of ELIQUIS should be delayed for 24 hours.**

Although ELIQUIS therapy will lead to an elevated INR, depending on the timing of the measurement, the INR is not a valid measure to assess the anticoagulant activity of ELIQUIS. The INR is only calibrated and validated for vitamin K antagonists (VKA) and should not be used for any other anticoagulant, including ELIQUIS.

Bleeding of any type was observed at a rate of 11% to 18% per year and major bleeding at a rate of 1.41% to 2.13% per year in AF patients. Concomitant aspirin use with either ELIQUIS or warfarin increased the risk of major bleeding 1.5 to 2 times when compared with those patients not treated with concomitant aspirin. ELIQUIS should be used with caution in patients treated concomitantly with antiplatelet agents. Common adverse reactions with ELIQUIS in AF clinical trials were epistaxis (1.9-6.2%), contusion (1.8-5.0%), hematoma (0.5-2.6%), hematuria (1.1-3.7%), hemorrhage (including eye [0.8-2.3%], gastrointestinal [0.9-2.1%], rectal [0.6-1.6%] and other [0.4-1.7%]) and gingival bleeding (0.7-1.2%).

In patients fulfilling at least two (2) of the following characteristics, a reduced dose of ELIQUIS 2.5 mg twice daily is recommended: age ≥ 80 years, body weight ≤ 60 kg, or serum creatinine ≥ 133 µmol/L (1.5 mg/dL). These patients have been determined to be at higher risk of bleeding. In patients with eCrCL 15-24 mL/min, no dosing recommendation can be made as clinical data are very limited. ELIQUIS is not recommended for use in patients with CrCl <15 mL/min, patients undergoing dialysis, or patients with severe hepatic impairment. ELIQUIS should be used with caution in patients with mild or moderate hepatic impairment (Child Pugh A or B). ELIQUIS should be used with caution in patients with elevated liver enzymes (ALT/AST >2 x ULN, or total bilirubin ≥1.5 x ULN) as they were excluded in clinical trials.

All temporary discontinuations should be avoided, unless medically indicated.

Eliquis™ apixaban

PAAB Member R&D
Bristol-Myers Squibb Canada, Montreal, Quebec H4S 0A4
Pfizer Canada Inc. Kirkland, Quebec H9J 2M5

Bristol-Myers Squibb Pfizer

See prescribing summary on page 97

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CANADIAN MEDICAL ASSOCIATION

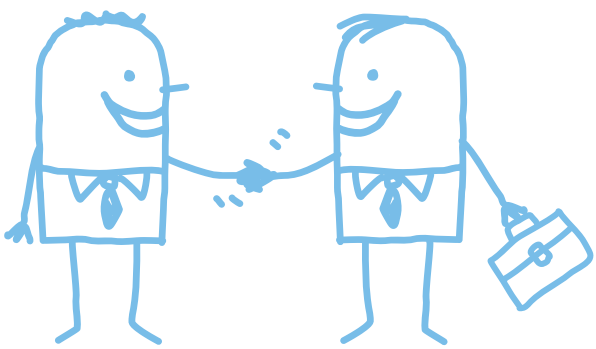
1758

chapter 2

the business side of medicine

You worked your way through med school. You learned all you could throughout residency. Most of you have expanded your clinical and professional experience by doing locums and sessional work. Now you are ready to commit to a medical practice of your own. What are your next steps?

Many graduating residents and new physicians feel concerned they won't be up to the task of running a rewarding, effective practice on their own. But don't let the administrative side of things scare you off. This guide will give you the edge on how to manage a successful practice weeks — even months — before you begin. Learn about various types of practice set-up, the costs of getting started, how to evaluate a practice, the advantages and disadvantages of renting versus owning office space, and much more. Now is the time for you to focus on what you want in a practice and learn how to get it.



TYPES OF GROUP PRACTICE

FAST TRACK

- The various types of practice set-up each have unique pros and cons. Consider carefully what you really want and need out of a practice from a personal, professional and financial perspective.
- A detailed, specific association contract or partnership agreement will help you immensely in the future, as it details how many potential issues are to be resolved within the group practice setting.

While some physicians are still choosing to run a solo practice, most today find a group practice setting to be much more efficient and cost-effective. Among other benefits, a group practice allows participants to capitalize on economies of scale and save considerably on overhead costs. If planned and negotiated properly, a well-organized group practice can have all the benefits of a solo practice.

If you're considering a solo practice, take a look at some pros and cons:

ADVANTAGES

- Experience complete autonomy-set your own rules and do things your way
- Take control of all aspects of your work environment
- Enjoy dedicated staff and resources
- Work in a possibly quieter office with fewer distractions

DISADVANTAGES

- Shoulder full responsibility for practice setup, overhead, staffing and management — all of which can be overwhelming without help
- Face greater start-up costs and ongoing overhead on your own than with a group practice
- Costs of EMR set-up and ongoing maintenance are significant when not shared
- Coverage for time out of the office when you are ill, on vacation or away at a conference is very difficult to secure
- Access is minimized to the financial benefits that many provincial Ministries of Health offer to group practices that can provide 24-hour out-patient care
- No peer support available on-site

BOTTOM LINE

In general, the disadvantages of solo practice significantly outweigh the benefits primarily due to fewer economies of scale in daily operational costs.

Assessing a potential group practice opportunity requires a detailed evaluation of the composition, philosophy and structure of the practice. Across Canada there are many different practice structures. Learning about the different models will help you evaluate the obligations, costs and benefits associated with each.

GROUP PRACTICE

A group practice is defined as two or more professionals practicing within the same office. The professionals do not have to be of the same discipline (e.g., a GP specializing in sports medicine, an orthopedic specialist and a physiotherapist sharing an office). Group practice is much more practical in Canada because of the changing medical environment and the inherent cost-efficiencies. One key advantage of a group practice is sharing the costs of office space, medical equipment, supplies and support staff. However, once a group exceeds seven or eight doctors, the economies of scale will often plateau. In this case, bigger is not always better.

There are two main types of group practice to consider: associations and partnerships. Whether you are looking at an associated or partnership group practice, make sure

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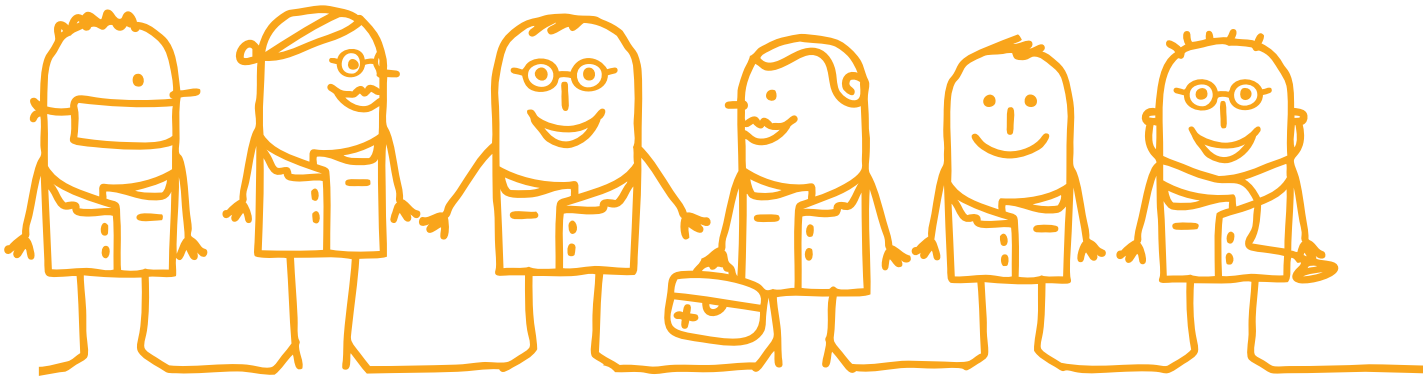


to have both your accountant and your lawyer review and update the contract agreement before you sign, to ensure your interests are protected.

ASSOCIATION

An association is an expense-sharing agreement that can range from sharing rent and waiting-room costs only to sharing everything, including staff, equipment, medical supplies and office resources. Associates do not share income, nor do they bear professional or legal responsibilities for others in the group. The degree to which expenses are shared must be clearly specified in a legally binding association agreement.

HOW IT WORKS: A group of physicians rent office space (which may or may not be in a building with other medical services) and shares clinic overhead costs and expenditures, such as administrative and medical staff salaries, computer equipment, rent, supplies, telephones and furniture.

It's easy to understand why association is a popular option. It allows physicians to enjoy most of the advantages of an individual practice, while benefiting from economies of scale, in-house coverage and collegiality. The physicians are independent and autonomous, determine their own schedules (within certain limits set by the group), share overhead with their associates, avoid professional isolation, and assist each other with administrative tasks.

An individual physician's overhead annual costs can be subdivided into three areas:

- **PERSONAL** such as association dues, CMPA and practice overhead insurance
- **SHARED ONGOING OFFICE EXPENSES** such as rent, staff salaries, office expenses and insurance
- **CAPITAL EXPENSES** such as the purchase of an EMR, major equipment or office renovations

The association agreement will specify the points above and in turn clarify each physician's responsibility. Each physician will be personally responsible to pay for their association dues as noted above.

An expense-sharing agreement formula will delineate each associate's obligation toward shared ongoing overhead costs. Most often this is proportional to the number of half days each physician works in the office. As an example, let's consider five physicians sharing an office. Two of the physicians work five half days in the office, two of them work seven half days and the final one works eight half days. This equals a total of 32 half-days worked. An agreement that assigns shared expenses based on proportionate utilization would result in two physicians paying 5/32 = 15.6%; two physicians paying 7/32 = 21.9% and one physician paying 8/32 = 25% of the shared overhead.

Capital expenses are usually shared equally, because regardless of the number of days in the office everyone needs the infrastructure and communication systems with which to work.

If you prefer exclusive use of your office, you will have to pay a higher share of overhead, since you will be paying for full-time use of the space. Even if you are away from the office several days a week, the support staff still has to answer the phone, take appointments and manage your schedule. Therefore it makes sense to share the cost of staff salaries, regardless of how many days you plan to devote to private practice. These arrangements must be worked out among the associates on a case-by-case basis, as there is no set formula. Always be sure to sign an association agreement detailing how all expenses are to be shared. The advice of an accountant and a lawyer who have experience with such agreements is invaluable here.

PARTNERSHIP

A partnership practice shares not only expenses, but also income and personal and medical liability. The contractual obligations and benefits of this complex arrangement must be evaluated closely. A formula detailing each partner's

share of income and expenditures must be specified within a legally binding partnership agreement, which is usually much more complicated than an association contract. Until recent years, the majority of group practices in Canada were associations rather than partnerships. Today, however, the popularity of alternate funding models encourages physicians to consider partnerships.

Finally, some group practice arrangements may be based on a corporate model. The discussion of this is beyond the scope of this guide, as specialized accounting and legal advice is required.

There are many factors to consider before committing to a group practice:

ADVANTAGES

- Economies of scale help reduce your expenses (e.g., office space, medical equipment, supplies and staff)
- Few or no start-up costs, if joining an existing practice
- Convenient on-site consultations on difficult cases
- If there are five or more equivalent full-time physicians, it may be more efficient and cost-effective to hire a dedicated office manager to recruit staff and run the practice
- The cost-sharing advantages of a group practice enable you to afford more sophisticated medical and computer equipment

DISADVANTAGES

- Potential reduction of autonomy
- Resources and staff must be shared
- Daily practice routines and schedules may be influenced by other physicians and staff
- Complex personnel structure means greater possibility of personality conflicts. Open, ongoing communication is essential to maintain a positive work environment
- Greater possibility for disagreement over capital purchases. What voting structure will the group use to make decisions? Majority agreement? Unanimous agreement?

KEY CONTRACT POINTS

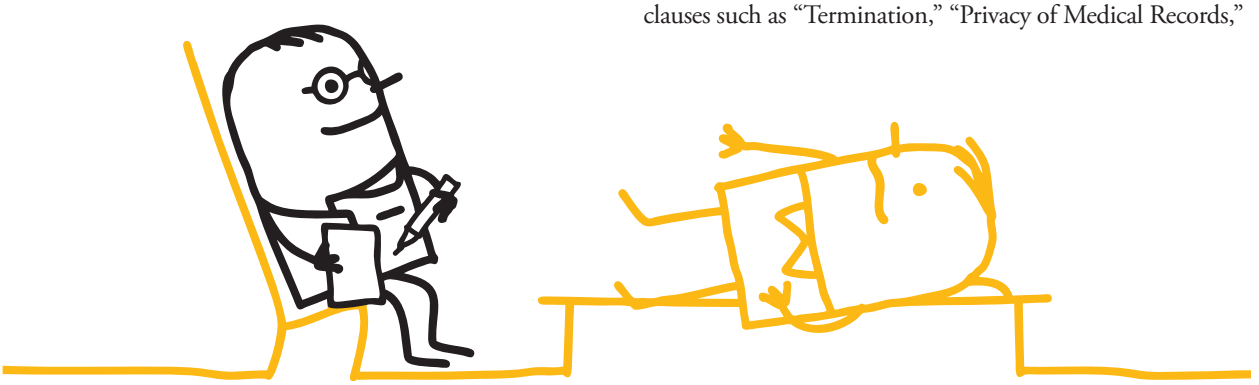
The association contract or partnership agreement is highly important to anyone planning to join or form a group practice. The document must outline both the responsibilities and the benefits for each member of the group. It must also be sufficiently detailed to address all existing issues and potential problems, and outline courses of action on the "what ifs." Ultimately, this planning will save group members time, stress and money. Some specific items a contract should address include:

TERMS OF AGREEMENT AND NOTICE OF TERMINATION: Ultimately, every contract will have to cover off and mitigate the 5D's of conflict: Departure, Disability, Death, Divorce and Disagreement. These clauses outline the length of the agreement and the procedures to be followed if a partner or associate wishes to leave the group. Also outlined are the obligations of the outgoing member. Usually, the outgoing member is responsible for paying his or her share of shared expenses for the rest of the term of the group practice contract and lease, unless the outgoing doctor can find a physician to assume these commitments.

INDIVIDUAL OBLIGATIONS: Outlines the responsibilities (clinical, on-call, financial, administrative) of each group member.

GROUP OBLIGATIONS: Specifies the benefits each member is to receive-for example, clinical coverage, expense sharing, shared staffing, administrative support.

OFFICE LEASE: Is this a sublet or new lease? Are there negotiated options to renew? How do you ensure your name is on the lease? Do you want your name on the lease? Review all lease clauses that may trigger unnecessary risks or expenses, such as "Restoration" or restrictive "Hours of Operation" clauses, or wordage that may prevent the subletting or assigning of the lease. If negotiating a new lease, your provincial or national medical association may recommend helpful lease clauses such as "Termination," "Privacy of Medical Records,"



and "Right to Audit." Have your lawyer and commercial lease advisor review the lease document to ensure you have both negotiated the best deal possible and anticipated all obligations.

BILLING AND EXPENSE RESPONSIBILITY: Who does the billing? Who is responsible for administration? How will shared expenses be allocated?

BUSINESS DECISION AUTHORITY: Outlines how decisions will be made-for example, will you abide by the results of a majority vote, or will it be two-thirds, or unanimous?

STAFFING ISSUES: When you join a group, interview all shared staff as if you were hiring them for the first time. You want to negotiate the ability to replace staff and have an equal say in performance evaluations, office policies and staffing plans.

BASIS FOR PROFIT SHARING: If in a partnership, the formula for distributing revenues among the members of a partnership must be detailed in the agreement.

INCORPORATION: Does the agreement impact the incorporation options available to you? If you think you would like to incorporate your practice in the future, consult the incorporation section of *Chapter Four: Financial Planning and Insurance* in this guide, and remember the rule of thumb: If in doubt, ask an expert.

FINANCING THE PRACTICE: The financial responsibilities of each partner or associate for expenses and capital purchases must be detailed.

LIABILITIES AND DEBT: The potential debt responsibilities, shared expenses and personal expenses assumed by each member individually, as well as the group as whole, must be defined.

INSURANCE: In the event of disability or death, how much disability, practice overhead and life insurance will each member of the association or partnership be required to have in order to cover potential financial obligations? Will members be required to insure each other?

BUY-OUTS: Can an individual member be bought out? How will the value and security of a share or "partnership interest" be calculated?

The contract points outlined above are just a few of the issues to address in the association contract or partnership agreement. It is essential to retain a lawyer experienced in contract law who has worked with physician groups in the past. You will need to work closely to anticipate all of the "what ifs" that can-and often do-occur in a group practice setting.

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

OVERHEAD

FAST TRACK

- Looking at the costs of setting up a practice can help you decide if you are ready to shoulder the costs and responsibility yourself, or if you would benefit by joining or forming a partnership.

Whether you work part- or full-time, individually or in a group, you will incur operating costs in managing your practice. These costs, or overhead, include such expenses as support staff salaries, medical supplies, rent, utilities and, in some cases, furniture. There are various options for renting an office or working in private practice, some more costly than others.

Physicians are encouraged to join or form group practices. However, understanding the potential costs of

SETTING UP YOUR OFFICE: CONTENTS, EQUIPMENT AND SUPPLIES

Area and item	Cost per unit	Total cost	Area and item	Cost per unit	Total cost
OFFICE FURNITURE			Ophthalmoscopes (2)	$225	$450
Consult Room:			Reflex hammers (2)	$5	$10
Desk	$600	$600	Tape scissors (2)	$15	$30
Swivel chair	$155	$155	Wall sphyngomanometers (2)	$185	$370
Patient chairs (2)	$266	$532	Extra cuffs *(pediatric & large)* for both rooms (4)	$60	$240
Bookshelves	$300	$300	Tuning forks (2)	$19	$38
File cabinet *(optional, lateral 5-drawer)*	$700	$700	Cupboards *[sink/base/desk, if not supplied]* (2)	$3,125	$6,250
Dictaphone system	$1,400	$1,400	**Office equipment total**		**$14,198**
Computer terminal *(see Nursing area)*	—	—	**Individual equipment:**		
Consult room total		**$3,687**	Hyfrecator (1)	$1,085	$1,085
Nursing / Reception Station:			Steam sterilizer	$4,725	$4,725
Desk	$600	$600	Adult scale, digital (1)	$400	$400
Chair	$350	$350	Baby scale, digital	$279	$279
Wall open lateral filing cabinet	$1,000	$1,000	Sigmoidoscope (1)	$700	$700
Answering machine	$200	$200	Fetal Doppler (1)	$595	$595
Refrigerator	$600	$600	Glucometer (1)	Free	Free
Base, sink and wall cabinets	$3,125	$3,125	**Individual equipment total**		**$7,784**
Requisition cabinet	$300	$300	**Subtotal B**		**$21,982**
Patient chair (for injections)	$100	$100			
Fax/modem/laser photocopier	$1,100	$1,100	**INSTRUMENTS**		
Computer and software for 3 terminals *(not EMR)*	$10,000	$10,000	Vaginal specula (16)	$26	$416
Telephone system *(5 units)* Entry level	$3,000	$3,000	Ear syringe (1)	$30	$30
Blood pressure machine	$400	$400	K-basin (2)	$4	$8
Nursing station total		**$20,775**	Scalpel handles (3)	$6	$18
Waiting Room:			Adson forceps (2)	$12	$24
Chairs (10)	$100	$1,000	Tissue forceps (2)	$14	$28
Tables (2)	$150	$300	Sponge forceps (2)	$30	$60
Magazine racks	$100	$100	Dressing forceps (2)	$8	$16
Pictures and mirrors	$600	$600	Mosquito forceps (2)	$15	$30
Coat rack	$300	$300	Ear curettes (4 sizes)	$14	$56
Bulletin board	$30	$30	2 mm punch biopsy (50)	$97	$97
Waiting room total		**$2,330**	5 mm dermal curette, disposable (50)	$147	$147
Subtotal A		**$26,792**	2 mm dermal curette, disposable (50)	$147	$147
			Needle driver (2)	$30	$60
EQUIPMENT			Nasal speculum (1)	$30	$30
Office equipment:			Nasal forceps (1)	$45	$45
Exam tables (2)	$1,480	$2,960	Metzenbaum scissors (1)	$24	$24
Swivel stools, hydraulic (2)	$155	$310	Straight iris scissors (2)	$36	$72
Footstools (2)	$30	$60	Curved iris scissors (2)	$38	$76
Utility table (1)	$150	$150	Uterine tenaculum (1)	$33	$33
Patient chairs, 2 per room (4)	$266	$1,064	Uterine sound instrument (1)	$15	$15
Magazine racks (2)	$10	$20	2-ounce glasses (2)	$6	$12
Bulletin boards (2)	$20	$40	Thermometers, digital (2)	$15	$30
Requisition racks (2)	$30	$60	Sundry glass jars, set of 5 (1)	$30	$30
Flexible gooseneck exam lights (2)	$435	$870	**Instrument total**		**$1,504**
Tape measures (2)	$5	$10	**Subtotal C**		**$1,504**
Wall transformers (2)	$408	$816			
Otoscopes (2)	$225	$450	**Total set-up costs1 [Subtotals A, B and C]**		**$50,278**

setting up and managing a solo practice will allow you to critically appraise the potential benefits of cost sharing in a group practice. Furthermore, the capital and ongoing expenses that don't have to be duplicated become more obvious when compared to the costs of a solo set-up. You can use the following case example of a solo practice set-up as a checklist and inventory of what exists and what is needed when looking at potential group practice opportunities.

In the example, the landlord provides a solo physician with leasehold improvements including painted rooms, basic electrical outlets and lighting, plumbing, a finished office washroom, and tile or carpet flooring. The physician tenant is responsible for all cabinetry and millwork to outfit all rooms except the bathroom.

This example does not address two important issues: EMR set-up and ongoing costs, and a multi-functional office communication system.

SETTING UP YOUR OFFICE: ONGOING MEDICAL AND OFFICE SUPPLIES

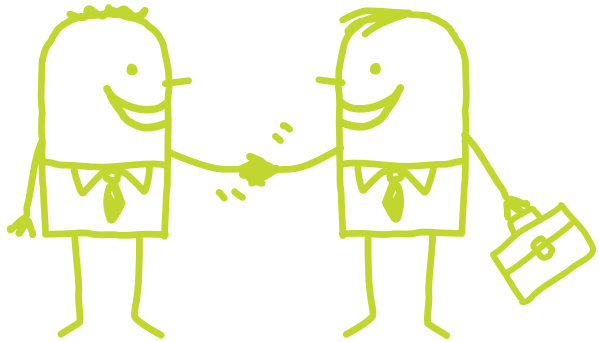
Supplies for one year	Cost per unit	Total cost
MEDICAL SUPPLIES		
Syringe 60cc *(used infrequently)*	$62 per 40	$15
Syringe 10cc *(used infrequently)*	$34 per 100	$10
Syringe 3cc, 25Gx 5/8" *(used a lot)*	$15.95 per 100	$225
Syringe 3cc, no needle	$26.50 per 200	$5
Syringe TB, 26G *(allergy)*	$4.65 per 25	$186
Scalpel blades #15	$17.95 per 100	$15
Needles #23	$6.75 per 100	$4
Needles #20	$6.75 per 100	$4
Exam table paper, 12 rolls per box	$40 per box	$240
Sutures, nylon 3.0, 4.0, 5.0, and chromic 3.0	$38 per doz.	$100
Gauze, 4x4	$5 per 100	$20
Gauze, 2x2	$3 per 100	$12
Sigmoidoscope tubes, 25 per box	$110 per box	$70
Anoscopes, 25 per box	$27 per box	$27
Sharps containers	$7	$56
Tape, bandages	$2.50 per box	$17
Reagant strips, urine GP	$30 per 100	$300
Reagant strips, urine 4MD	$15 per 50	$34
Reagant strips, blood glucose	$34.99 per 100	$35
Reagant strips, urine pregnancy	$29 per 25	$29
Lancets	$12 per 200	$6
$AgN0_3$ *[rarely used if hyfercator available]*	$18 per 100	$9
EtOH swabs	$2.50 per 200	$38
Eye patches	$8.29 per 50	$4
Gloves, vinyl *(assumes use of app. 20 per day)*	$10.50 per 50	$5
Tongue depressors	$8 per 500	$16
Cotton swabs	$1.25 per 100	$2
Personal lubricant gel	$2.30	$40
Lidocaine 1% and 2%	$4.10–6.25 ea	$20
Steroid for joint/tendon injection	$42 per vial	$210
Cervical cytobrushes, culture medium, Pap and biopsy	Free	Free
Total Medical Supplies for one year		**$1,754**
PAPER AND STATIONERY		
Paper, photocopy/fax/progress notes	$35 per box	$70
Appointment cards	$30 per 1,000	$240
Letterhead and envelopes	$100 per 1,000	$100
Pens, pencils, staples, sundry office supplies	—	$100
Window envelopes	$60 per 1,000	$60
Prescription pads	$200 per 5,000	$200
Database sheets	$40 per 1,000	$40
Files, heavy bond *(2000 in Year One — 200/yr thereafter)*	$325 per 1,000	$650

Supplies for one year	Cost per unit	Total cost
Appointment books, if not computerized	—	$30
Personal phone book	—	$20
Chart stickers, etc.	—	$40
Total paper & stationery for one year		**$1,550**
OTHER EXPENSES		
Rent, 700 sq. ft., prime location	$25 per sq. ft	$18,725
Nurse-receptionist	$23 per hour	$48,500
Accounting services	—	$1,000
Telephone, 3 lines	—	$2,200
Parking	—	$800
Subtotal other expenses		**$71,225**
Total office operating expenses for one year		**$74,529**
PROFESSIONAL DUES		
Academy of Medicine (local)	—	$120
Provincial medical association dues, incl. CMA	—	$2,000
Provincial College of Physicians and Surgeons	—	$1,000
College of Family Physicians of Canada	—	$800
Canadian Medical Protective Association	—	$7,000*
Royal College of Physicians and Surgeons of Canada	—	$890
College of Family Physicians of Canada	—	$641
National specialty societies	—	$400
Total dues		**$12,851**
INSURANCE		
Office insurance	—	$500
Practice overhead insurance	—	$700
Disability insurance	—	$2,000
Total insurance		**$3,200**
SUMMARY OF OFFICE SET-UP COSTS IN YEAR ONE**		
Initial office set-up	—	$50,278
Operating expenses for one year	—	$74,529
Professional dues	—	$12,851
Insurance	—	$3,200
Total expenses for one year		**$140,858**
IN YEAR TWO OF PRACTICE		
Overhead drops by around $45,000		$95,858
If a receptionist is hired at $18 per hour		$85,188
If rent is $15 per square foot		$78,538

(*) CMPA dues vary greatly depending on your area of practice.
Notes: Prices used in these examples may vary greatly, depending on practice set-up, rental costs, location and staffing costs. This case example was originally prepared by Dr. Tom Faloon for *CMA's Practice Management Curriculum Modules for Medical Residents*, and updated in 2012. All figures used in this example are intended for illustrative use only, and should not be relied on for formal budgeting purposes. Cost of medical supplies provided by The Stevens Company.

THE ART OF NEGOTIATION

Creating a win–win situation



FAST TRACK

- No matter how tempted you may be to dive in and start your practice, you will benefit tremendously from taking a methodical, informed approach to your negotiations.
- The importance of seeking legal counsel prior to signing any contract cannot be stressed enough. It can save you from any awkward, potentially costly situations in the future.

The idea of negotiation can be intimidating, but keep in mind that you have honed your negotiation skills throughout medical school and residency, and even in your personal life. Whether negotiating with a program director for a desired elective or rotation, reasoning with fellow residents over call schedules, or compromising with your significant other over who should take out the garbage, you are no stranger to negotiation skills and methods. Strong negotiation skills are helpful when entering into any binding contract, whether a partnership agreement, a hospital position or a lease.

THE CHANGING ENVIRONMENT

In recent years, physicians finishing residency and fellowship programs have seen a considerable change in the number and quality of practice opportunities in Canada. Previous concerns of a shortage of physicians in Canada had prompted an increase in medical school enrollment from 1,577 in 1997/98 to 2,800 in 2011/2012.* In addition, expanding scopes of practice, issues surrounding resource planning and certain other factors have resulted in a growing risk of unemployment and underemployment for residents in an expanding number of specialties, including cardiac surgery, nephrology, neurosurgery, plastic surgery, public health and preventative medicine (community medicine), otolaryngology, radiation oncology and orthopedic surgery.† When progressing through the steps of negotiation, the prudent resident or fellow should consider these factors as they apply to their situation and their respective specialty.

CMAJ, October 18, 2011 183 (15) p.1801.
†*CMAJ*, October 4, 2011 183 (14) p.1673.

NEGOTIATION 101

There are three important stages to negotiation: preparation, bargaining and settlement.

1. PREPARATION

DO YOUR HOMEWORK — Review your goals, desires and objectives, both personal and professional. Research the market for your specialty, identifying potential opportunities, determining the gross billings or average rates of remuneration in your field, and investigating the monetary and non-monetary benefits potentially available. Learn about your negotiating partners and the opportunities you are considering, such as the number of applicants, the specific needs of the group or institution, and the positive and negative attributes of the practice in question.

IDENTIFY PRACTICE OPPORTUNITIES — There are a variety of avenues to consider when identifying and evaluating practice opportunities. You may find yourself in a position where there is no practice to join or you are simply not ready to start your career in a practice setting. Look to your colleagues (former senior residents now in practice), department heads, and program directors. Don't underestimate the power of meetings and networking with your colleagues. In addition, resources such as the MoH website, specialty/sub specialty societies, community health officers and head hunters can also help form part of your plan.

IDENTIFY AND EVALUATE YOUR NEGOTIATION POINTS: Before you leap into negotiations, set the boundaries and

frames of reference (i.e., negotiation points) with which to evaluate the opportunity. Appropriate research should give you enough knowledge to objectively position your own skills, training and abilities in relation to market rates of remuneration and the specifics of the opportunity. Try documenting the points that are important to you will help better guide your decisions. Think about remuneration, procedure time, call schedule, vacation time, CME time and money, protected research time, maternity/paternity time and other benefits that are important to you. Keep in mind not all benefits are monetary — some may define vacation time as a deal breaker and anything less than a certain number of weeks will not be accepted.

BEST ALTERNATIVE TO A NEGOTIATED AGREEMENT (BATNA: Your objective in any negotiation is to obtain the best possible deal to improve your position. Knowing and assessing your alternatives protects you from making unwanted commitments. Although the most attractive alternative may be the culmination of an existing opportunity, your best alternative to a negotiated agreement (your "BATNA") provides you with a "Plan B" and an ability to say "no" to existing negotiations, if the possibility of reaching an agreement becomes unreasonable, doubtful or detrimental to your overall position.

RESERVATION PRICE: Your reservation price is closely linked to your BATNA and represents the value below which you would accept an impasse rather than concede to the terms of an existing offer. With appropriate research and knowledge of the benefits and obligations of a particular position, you can easily have a reservation price in mind that ensures you will not settle for less. A reservation price may be monetary, such as a given level of remuneration, or non-monetary, such as number of hours per week you will work, the on-call obligations you will accept, a set number of operating room or procedure room days, or similar.

TARGET PRICE: A target price or target set of conditions describes your wish list. Setting a target price shifts the direction of negotiations from obtaining just enough, to obtaining what you truly want. If your research shows you are in a strong negotiating position (e.g., there are few or no other candidates), it may serve you well to create doubt in your counterpart's mind about the point at which you would prefer impasse. Done in a diplomatic and professional manner, this may shift negotiations back in your favour and the offer may more closely approach your target price.

IMPORTANCE OF DOCUMENTATION: Although verbal promises may be made during negotiations, the respective parties may not recall (deliberately or inadvertently) such commitments once the contract is completed. Documenting what is agreed upon during the talks will protect both parties.

Major terms and conditions should be documented within a binding contract. Verbal agreement on less critical issues should also be documented for possible future reference. Make sure to confirm verbal talks via email, and have the negotiating party confirm your interpretation of the verbal conversation. Save these emails in a confidential file for future reference. The best advice is to make sure that what has been negotiated (in writing or verbally) is reflected in the final agreement.

REMEMBER: If it isn't written in the contract, it didn't happen. To ensure your interpretation of the details of an opportunity matches the actual legal offer, all relevant contracts should be reviewed concurrently by legal counsel before the offer is accepted. This point cannot be stressed enough. Unfortunately, it is common for physicians to sign a contract without a thorough legal review beforehand, only to regret it in the long run.

2. BARGAINING

The majority of bargaining should occur before the face-to-face session. Questions and answers can be posed via email, allowing both parties time to consider answers or alternatives. Physical reactions such as flinching can also be avoided this way. Bargaining is not restricted to the actual interaction between the parties, but also involves terminology, timing and tone of discussion, among other factors. During negotiations, be aware of these dynamics to avoid pitfalls and capitalize on opportunities.

THREE TIPS FOR EFFECTIVE BARGAINING:

- Build rapport.
- Be fair and trustworthy.
- Control your emotions and reactions, both verbally and physically.

REMEMBER: Even if you fail to negotiate a position, you may encounter the other party at various times throughout your career, perhaps at meetings or while working on common projects. Establishing trust, respecting fairness and maintaining a professional demeanour can help your career in the long run.

MAKING THE FIRST OFFER: The first figures presented in a negotiation often become the baseline against which all subsequent negotiations are measured. Making the first offer depends partly on how experienced in negotiation both you and your counterpart are; inexperienced negotiators are more likely to make mistakes.

If you make the first offer, information will be your strongest asset. With good research, you should be able to estimate the BATNA of your negotiating counterpart. While your offer should be ambitious, it should also be close enough to your counterpart's BATNA to ensure he or she will be convinced that negotiation should reach a mutually agreeable conclusion.

However, making the first offer is fraught with potential pitfalls. If your demands exceed the potential offer of your counterpart, it may reflect unfavourably on you; if your initial demands are below what your counterpart was willing to offer, you may receive what you've asked for and no more.

IMPASSE: Negotiation often continues until both parties feel they cannot achieve a deal better than their BATNA, and there appears to be no bargaining room. If problem solving efforts are unsuccessful, negotiations should cease. Stopping negotiations, however, is different from walking away and abandoning the opportunity. When negotiations are stopped, an impasse has occurred. Although an impasse may be unavoidable in many circumstances, there are several strategies that can help restart talks.

- Re-examine the opportunity in terms of your and your counterpart's interests, rather than your positions.
- Make a small concession and ask your negotiating counterpart to do the same. This may form the basis for negotiations to continue. Your counterpart may not match your concession, and it may not be prudent for you to retract your offer; however, the reward of making a small concession is often worth the risk.
- Bring in a third party. A fresh perspective sometimes gets negotiations back on track.

3. SETTLEMENT

While negotiations sometimes inch to a conclusion, at other times a solution quickly emerges. Always negotiate to the end. Since wording can be ambiguous, both parties should have a shared understanding of the meaning of every provision in an agreement before anything is signed. A word of advice: approach any post-settlement adjustments with caution.

WHOSE SIGNATURE COUNTS?: All negotiations come down to whose signature counts. A physician joining an academic department or institution will have to negotiate with several groups before securing a position. In fact, several contracts may apply. It is wise to sign all contracts at the same time to eliminate loose ends. In all situations, always determine who has the authority to approve the terms and conditions of your agreement. Remember: just as you wouldn't purchase a home without having a lawyer review all documents, you should not accept a practice opportunity without reviewing the contract with a lawyer.

THINKSTOCK

In addition, all relevant contracts should be reviewed concurrently by legal counsel before an opportunity is accepted. For example, if offered a position in an association and also required to jointly sign an office lease agreement, you should review both the association and lease agreements with your legal counsel before accepting the offer; if the association agreement is for a three-year term, renewable at the option of the other associates, and the lease is for a fixed five-year term, you may find yourself in an undesirable position in years four and five if the association agreement is not renewed but you are still liable for lease payments.

FINANCIAL OBLIGATIONS IN A GROUP PRACTICE: Many new physicians join a group practice that is either an association or a partnership. Academic groups are often a hybrid of both, plus or minus a salaried component. The financial terms and obligations are usually set out in an agreement or a contract. When considering joining a group, you should review the agreement with your accountant and your lawyer and accountant to determine if the cost allocation and obligations are fair and equitable.

When considering a group practice, it is important to ask about potential liabilities within the group. If the group owns the building, is the mortgage liability shared? How does the group make decisions (e.g., simple majority or two-thirds vote)? Failing to ask the right questions may have you unknowingly assuming a share of the liability for the purchase

of an expensive piece of equipment-perhaps a purchase to which you had objected. Never assume someone else is paying the bills, and don't unknowingly assume full responsibility for the cost of operating a practice. It's in your own best interest to fully understand your potential commitment.

Your lawyer and commercial lease advisor review the lease document to ensure you have both negotiated the best deal possible and anticipated all obligations.

BILLING AND EXPENSE RESPONSIBILITY: Who does the billing? Who is responsible for administration? How will shared expenses be allocated?

BUSINESS DECISION AUTHORITY: Outlines how decisions will be made-for example, will you abide by the results of a majority vote, or will it be two-thirds, or unanimous?

STAFFING ISSUES: When you join a group, interview all shared staff as if you were hiring them for the first time. You want to negotiate the ability to replace staff and have an equal say in performance evaluations, office policies and staffing plans.

BASIS FOR PROFIT SHARING: If in a partnership, the formula for distributing revenues among the members of a partnership must be detailed in the agreement.

INCORPORATION: Does the agreement impact the incorporation options available to you? If you think you would like to incorporate your practice in the future, consult the incorporation section of *Chapter Four: Financial Planning and Insurance* in this guide, and remember the rule of thumb: If in doubt, ask an expert.

FINANCING THE PRACTICE: The financial responsibilities of each partner or associate for expenses and capital purchases must be detailed.

LIABILITIES AND DEBT: The potential debt responsibilities, shared expenses and personal expenses assumed by each member individually, as well as the group as whole, must be defined.

INSURANCE: In the event of disability or death, how much disability, practice overhead and life insurance will each member of the association or partnership be required to have in order to cover potential financial obligations? Will members be required to insure each other?

BUY-OUTS: Can an individual member be bought out? How will the value and security of a share or "partnership interest" be calculated?

The contract points outlined above are just a few of the issues to address in the association contract or partnership agreement. It is essential to retain a lawyer experienced in contract law who has worked with physician groups in the past. You will need to work closely to anticipate all of the "what ifs" that can — and often do — occur in a group practice setting.

BENEFITS — THE ICING ON YOUR CAKE

Many physicians in a fee-for-service environment assume that no additional benefits are available for their position, and that they must assume all costs related to the practice. With the shortage of physicians in Canada, however, this situation is changing. Many FFS specialists that are contacted to a hospital have negotiated a guaranteed minimum billing amount for each year of practice, reducing their risk in the event that their access to operating rooms or other resources is restricted. Some hospitals have offered financial stipends on top of FFS billings in an effort to recruit and retain physicians. Many hospitals and communities also offer financial incentives such as moving costs, signing bonuses or relocation allowances to attract family practitioners and certain specialists.

BENEFITS MAY INCLUDE:

INSURANCE: Life, medical and dental insurance may be provided by the department, hospital, health region or province or territory of your potential practice. Even if you are responsible for your Canadian Medical Protective Association (CMPA) dues, many provinces reimburse you for a portion, depending on your location and specialty. Some employers may cover the portion of CMPA dues not reimbursed by the province.

HOLIDAYS AND CONTINUING MEDICAL EDUCATION (CME): While fee-for-service physicians must arrange their own vacation time, the hospital may assist in finding locum coverage. It is essential for physicians working in a group or departmental practice to be guaranteed a certain amount of vacation (generally at least four weeks per year) as well as time for CME.

PROFESSIONAL ASSOCIATION DUES: Although membership dues for the Canadian Medical Association, specialty societies and provincial medical organizations may be tax-deductible (as either a professional due or business expense), some hospitals or health boards pay

for such necessary costs of practice.

PENSION PLANS: Most physicians are not members of registered pension plans (RPPs) and must rely on contributions to registered retirement savings plans (RRSPs) to ensure they are prepared for retirement. An employer-provided pension plan is generally a welcome benefit (the details should be reviewed by your accountant and/or lawyer). Most RPPs are generous, and the individual physician's contributions are often matched or exceeded by the hospital or health region.

CAR ALLOWANCE AND PARKING: Parking may be provided by the group, department, hospital or other institution. In addition, if you must use your own car for hospital purposes (e.g., to attend administrative meetings), a tax-free allowance may be provided.

MOVING EXPENSES: Hospitals attempting to recruit new physicians are increasingly willing to cover moving costs to entice physicians to relocate. This can amount to a considerable amount of money and should not be overlooked.

START-UP LOANS: Hospitals and other organizations sometimes offer low- or no-interest loans to help a physician set up for practice. However enticing the preferential interest rates may sound, the potential tax implications should be reviewed with your accountant.

OTHER POINTS TO CONSIDER

In addition to the traditional benefits, you should also consider the other benefits that will impact your practice life. What operating room time is available? Is a procedure room available and appropriately staffed? Is office space available? If you need support staff, will you get to select and hire the people who will be working with you? If you will be performing research, who will provide research staff and equipment? Will parental leave be available?

You should give considerable thought to all positions you are evaluating and investigate the "what ifs" of every opportunity. Don't make assumptions — ask questions instead.

IN REALITY

Assuming an existing practice will be the exception for most family doctors due to the incentives many provinces have to take on new and orphaned patients. Such bonuses are usually not offered when one assumes an existing practice. However, for many specialists assuming an existing practice can have many of the benefits mentioned above.

ASSUMING A PRACTICE

Most new physicians prefer to build their practices by accepting new patients. Generally it can take a year or two to establish a practice this way. Assuming, or taking over, a practice can eliminate the need for the three to four visits needed to establish a foundation of care for new patients. However, assuming a practice may require you to buy existing equipment from the departing doctor; you may also incur additional start-up fees if the capital expenditures of the outgoing physician's associates or partners are not fully depreciated (such costs are usually not significant and can easily be financed). What are the benefits and risks of assuming a practice?

BENEFITS

- A well-established practice with comprehensive medical records of patients who have realistic expectations of the services you can and can't offer
- An effective, efficiently-run business that is professionally and financially rewarding
- Experienced staff who already know the patients
- Consider assuming a practice if you have already given it a test-drive through a locum

RISKS

- Assuming a poorly run practice with patients who have unrealistic expectations
- Inheriting the outgoing physician's potential mistakes

RENT INDUCEMENTS

An increasing number of pharmacies and large retail stores are offering physicians, either directly or through third party developers/landlords, competitively priced clinic space adjacent or in proximity to their outlets. The retailer benefits from the easy access of the patients to their stores and/or pharmacy, and the physician benefits from potential financial incentives such as leasehold improvement allowances, below average market value rent and free parking. Some offerings may also include furnished and equipped clinic space as well as staffing and administrative support.

The potential overhead cost savings can look very attractive; however, there are specific regulatory college guidelines physicians must follow. For example, a physician must not financially benefit directly or indirectly from their patients patronizing a store or pharmacy that may have, in one way or another, subsidized their rent. The physician must not encourage or oblige their patients to use the pharmacy or lab facilities provided by the landlord. It is therefore very important to ensure that the contractual arrangement between the physician and the landlord does not compromise professional ethics and obligations. Always get advice from your provincial regulatory college and medical association, as well as your accountant and lawyer, before signing any deal that seems too good to be true.

ELECTRONIC MEDICAL RECORDS

What you need to know

You've likely heard about the benefits of using an electronic medical record (EMR). Maybe you've also heard scary tales about choosing and implementing an effective system. Is this something you can put off until you're settled in your career? Or is an EMR something you need to think about now, before committing to a practice?

Dr. Darren Larsen, a family physician located in Thornhill, Ontario, and Senior Peer Leader for Ontario's EMR funding body OntarioMD, shares his experiences with both paper and electronic medical record systems.

THE FRUSTRATIONS OF PAPER

When he began practicing medicine some 20 years ago, Dr. Larsen's record keeping was entirely paper-based. "Even our billing used cards and scheduling was done in a big multi-columned ledger," he recalls. At that time, there were few other options. Eventually, the practice moved to electronic billing, and some years after that adopted electronic scheduling. But it was just seven years ago that the team made the transition from paper to an EMR and in many ways they were considered early adopters.

In the old paper-based office, Larsen and his colleagues struggled with missing and misfiled charts and lab results, near-illegible handwriting, large and unwieldy lab reports, lack of storage and the sheer inconvenience of bringing charts home at night to complete his work. "I used to take a recycling bin of charts home every night in my car, which is really not a great practice to get into, especially with respect to privacy and security."

BENEFITS OF AN EMR

Dr. Larsen says he appreciates advantages such as:

- fewer calls from pharmacists, reduced from about four or five per day to one a week
- treating chronic care patients with more ease because he can track which tests were done, review lab work and trend them over time
- using educational tools like graphs, charts and diagrams to illustrate for his patients the actual effects of treatment
- templates to help make quick printouts during patient physical exams
- accessible information from all members of the health care team (such as nurses, dietitians)
- preventive care easily done with electronic reminders
- group care — he or another team member can quickly send a letter to all patients over age 65 reminding them to come in for annual seasonal flu shots, for example, with a simple "click, merge, print and mail".
- a valuable database that can be used for future reference to improve quality of care.

MAKING THE LEAP

With all the inconveniences, privacy and safety concerns of a paper-based office, what kept him from making the switch to EMR? "From a practical perspective, the up-front cost of purchasing an EMR was a factor in waiting as long as we did. When our practice became provincially funding-eligible, we made the move, but it took about a year," Larsen states.

The practice took a true team-based approach to making the decision, Larsen explains. "All of us, including every office staff member, went to the vendor sessions and showings. After choosing our vendor we picked a go-live date, three months out. This was an aggressive goal but we wanted to be progressive and dive in head-first."

He adds: "One of the best and worst tasks in going from paper to electronic is 'filling up' the EMR. It's tedious work, but physicians need to do this part themselves — it cannot be outsourced. Populating a Cumulative Patient Profile (CPP) sounds labour-intensive, but it actually creates an opportunity to clean up each patient's profile, and to find things you might have missed. In essence, it puts you back in touch with your practice again."

Within three months, Larsen's practice had about 80 % of his patients' clinical profiles entered into the EMR. At the six-month mark, the full patient list had been entered. Within two years, there was no more pulling of paper charts. At three years, the old archived paper charts were no longer required for anything and they were moved to storage. His office is now "paper-free."

THE EMR OUTCOME

While Larsen can't definitively say he works fewer hours (patient data still has to be entered, whether by hand or by typing), there is a sense that he's doing a better job. "The quality of my practice is improving," says Larsen. When asked whether he or his colleagues would go back to paper records, Larsen is clear. "Absolutely not. We can't imagine going back. We made an excellent choice."

And now that he has seven year of data, the practice can easily embark upon major quality improvement projects because a large amount of information is available for analysis. This is good for his patients, his practice, and meshes well with provincial quality agendas.

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

ADVICE TO RESIDENTS ABOUT EMRS

1. Examine what EMR the practice has, and really delve into how the product works. Use your time in locums to sample various products, and learn the business side of EMR including billing, reconciling and preventive care features.
2. Choose an EMR that works the way your brain works. It should feel intuitive.
3. Even if you haven't had much exposure to one, don't be scared off by an EMR. Try to shadow a physician who is using an EMR well, and observe.
4. Spend time with vendors at their booths when you attend conferences or trade shows. Try out the demo products and ask questions about their features.
5. Don't just learn how to use the EMR for recording visits but also take the time to learn its messaging, billing and referral systems.
6. Ask a lot of questions — not just of the physicians who work in the practice but also of the secretaries and nurses who use the tool every day.
7. From the beginning of using an EMR, keep your data clean. Use consisent terminoloy and location of information to make QI searches easier.

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† Refers to the drug acquisition cost; dispensing fees may vary.

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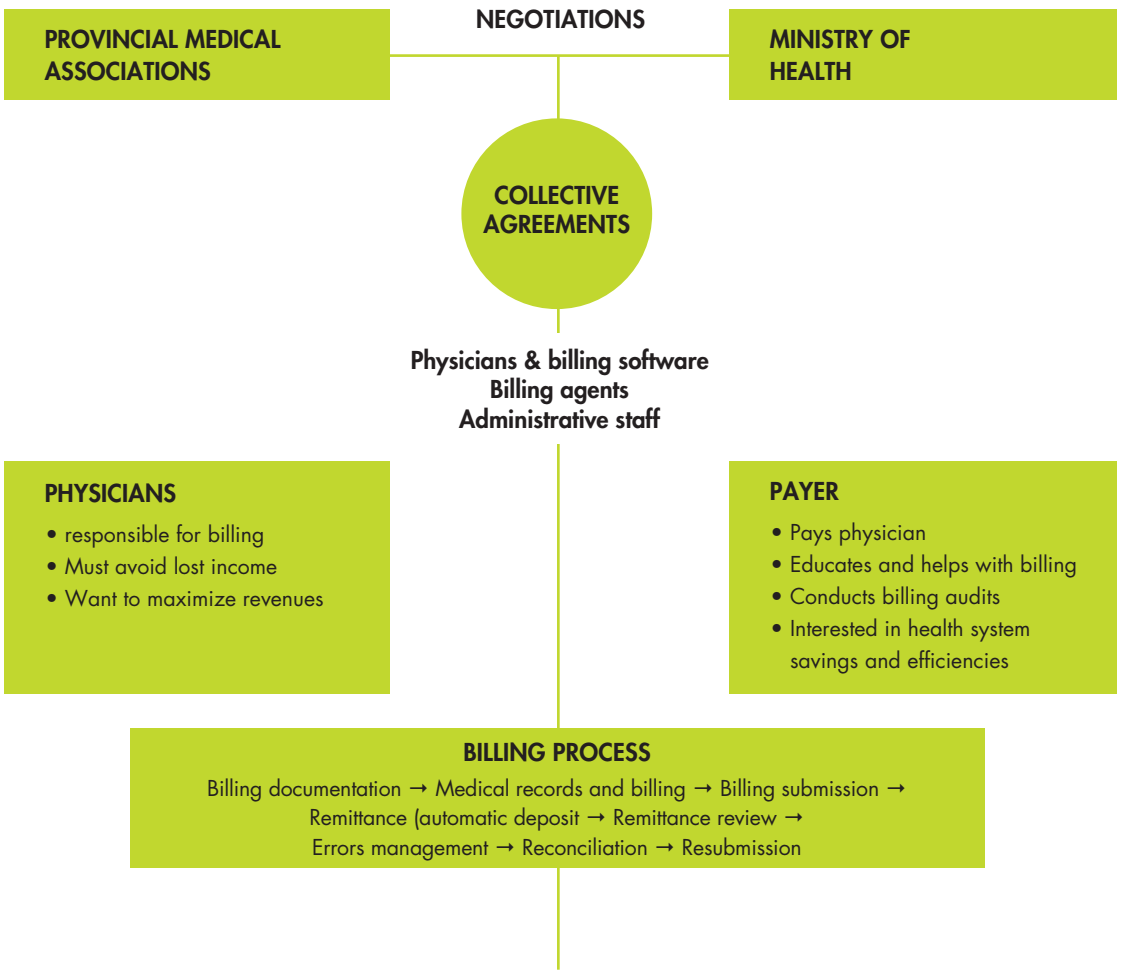
chapter 3

medical billing

Throughout your residency, you are taught to consider your patients first as your number one priority. Your working conditions as a resident have been negotiated for you and your salary is stable and consistent, allowing you to focus on perfecting your skills and knowledge without worrying about billing. But once you finish residency and start your own practice, you will be faced with a new situation: you will be responsible for "billing" the Ministry of Health (MoH), and your staff will need to submit and reconcile those billings in order for you to get paid. Every patient, service, procedure and visit has a dollar value attached to it that will need to be billed; each time you meet with a patient and with every medical service, you will have to think about your billing and income, while remaining focused on your patient's needs. Staying up-to-date with your billing schedule will be integral to your success with billing. For a complete list of provincial billing guides, visit cma.ca/provbilling.

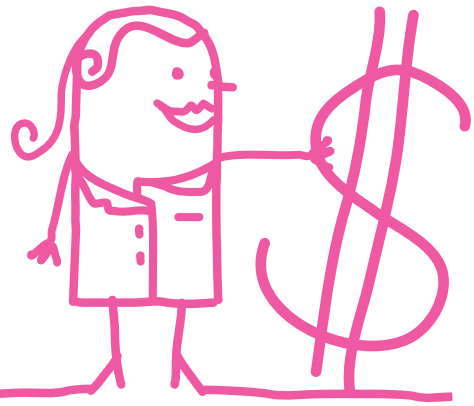
RECEIVING WHAT YOU'VE EARNED



Research by the Canadian Medical Association indicates that physicians, on average, fail to bill for at least 5% of the insured services they provide. Furthermore, physicians and their staff fail to identify, correct and resubmit approximately 3% of the bills that were initially submitted but not paid by the MoH. If a physician has a potential gross income of $300,000 of insured services, this loss would equal $24,000 a year. Imagine providing $24,000 worth of services for which you were not paid! Thus it is evident that all physicians have a vested interest in ensuring their billing practices are effective and efficient. Take these three pointers to heart: learn your specialty-specific fee schedule, stay up-to-date and take the time to carefully read the MoH bulletins, because fees and codes can, and do, change. This is your professional — and personal — livelihood at stake. Only delegate this task to someone you can trust, has a vested interest in your success and with whom you are confident you will be promptly advised of changes.

PHYSICIAN REMUNERATION

Wondering how much you will earn when in practice? Here are the latest national average gross fee-for-service salary statistics, provided by the Canadian Institute for Health Information. Remember, this is average gross income — overhead and professional expenses must be paid to realize net before tax income. Nationally, we know fee-for-service billings represent 80% of total clinical payments. These stats include only physicians who received at least $60,000 in payments. Please note that such a low baseline reduces what would be a more realistic mean or average gross billings for a full time equivalent physician.



AVERAGE GROSS FEE-FOR-SERVICE PAYMENT PER PHYSICIAN WHO RECEIVED AT LEAST $60,000 IN PAYMENTS BY PHYSICIAN SPECIALTY AND PROVINCE, 2010–2011

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
Family Medicine	**265,460**	**241,484**	**217,093**	**239,685**	**197,509**	**234,591**	**264,198**	**281,520**	**316,335**	**240,356**	**241,077**
Medical Specialties	**366,712**	**219,616**	**259,591**	**315,742**	**246,977**	**338,566**	**284,343**	**341,865**	**400,792**	**288,532**	**310,351**
Internal Medicine	459,828	273,841	263,426	430,473	288,194	409,994	305,249	431,445	487,178	383,149	371,795
Neurology	226,918	*	364,770	406,428	240,774	287,035	227,522	311,436	432,283	276,098	277,928
Psychiatry	292,300	221,581	189,787	166,077	171,142	219,462	212,951	223,843	332,906	194,696	215,434
Pediatrics	239,696	*	239,864	245,639	225,734	293,794	254,156	265,005	328,298	250,520	268,172
Dermatology	654,273	*	340,407	418,808	278,581	378,033	527,645	*	741,763	358,691	385,325
Physical Medicine	n/a	n/a	*	*	230,378	257,713	302,404	*	296,888	246,512	255,972
Anesthesia	265,419	139,764	268,796	235,112	241,585	376,750	312,839	296,300	380,875	287,857	323,975
Surgical Specialties	**442,412**	**353,363**	**373,735**	**410,792**	**345,025**	**456,273**	**416,405**	**524,776**	**572,830**	**425,836**	**432,643**
General Surgery	319,967	360,366	330,798	395,657	296,563	420,041	420,995	422,665	513,969	374,188	386,723
Thoracic/Cardiovascular Surgery	*	n/a	320,455	428,120	382,492	501,544	453,821	802,736	770,914	409,149	467,794
Urology	490,637	*	476,167	462,499	373,992	431,546	353,928	509,150	570,890	436,723	430,358
Orthopedic Surgery	492,009	*	338,000	353,904	295,196	403,732	367,576	475,965	459,951	316,340	372,742
Plastic Surgery	496,556	*	337,521	347,489	251,484	321,742	468,727	451,375	479,010	318,374	337,874
Neurosurgery	*	n/a	*	n/a	250,390	533,557	*	442,336	*	487,380	407,178
Ophthalmology	587,975	624,548	532,483	798,618	492,786	702,023	581,784	970,335	943,916	731,563	676,551
Otolaryngology	519,009	*	374,374	383,928	318,767	400,782	314,332	501,676	573,026	407,280	393,417
Obstetrics/Gynecology	375,623	194,923	282,247	261,526	363,238	434,366	388,702	444,194	491,358	345,264	401,465
Total Specialties	**397,049**	**280,181**	**328,614**	**362,796**	**278,391**	**376,394**	**325,765**	**415,374**	**460,836**	**336,139**	**351,649**
Total Physicians	**316,917**	**255,927**	**262,915**	**294,765**	**239,380**	**312,666**	**296,693**	**340,102**	**371,002**	**281,667**	**295,606**

Notes
* Data was suppressed—please see the Methodological Notes, Data Suppression section, for details.
n/a: not applicable—there were no physicians for this specialty for this province.
Based on gross payments.
Alternative forms of reimbursement, such as salary and capitation, are not included.

Source: National Physician Database, Canadian Institute for Health Information.
(Table APP–A.5 in National Physician Database 2010–2011—Payments Data)
Accessed: January 31, 2013.
https://secure.cihi.ca/estore/productFamily.htm?pf=PFC2032&lang=en&media=0

ORGANIZING YOUR BILLING

FAST TRACK

- Even if you appoint your staff or an outside company to manage your billing, you need to take ultimate responsibility for it. After all, it's your own financial future at stake.
- Taking the time to study the billing guides for your province, learning the most common codes and the rules for their use will pay off for you at the end of the day.

Before getting your professional license, you will need to decide who will manage your billing. In terms of billing itself, there are three ways the work can be accomplished:

1. do it yourself using your own billing software;
2. subcontract some or all of the work to a specialized billing agency; or
3. do what most private practices and some medical departments do — assign the task to support staff who can do it for you.

With the multitude of practice sites, it is becoming increasingly common to see physicians use more than one billing option. For example, private practice services can be billed by a medical secretary, while work done in a hospital can be billed by an agency. Which is the best option, or combination of options, for you? Deciding how to organize billing will require you to make decisions that can have a huge impact on your revenue and the time you spend on administration. Of course, you can always make changes at any time if you decide to have someone else do your billing or, conversely, if you decide to take on the responsibility yourself.

CHOOSING BILLING SOFTWARE

If you opt to tackle your own billing, you will need good billing software and plenty of time to read your collective agreements and fee schedules. There are dozens of billing programs available in each province, each claiming to be the right one for you and your associates. In actual fact, many are simply not up to the task and haven't been updated for years. They simply "maintain" their existing clientele — nothing more, nothing less. Of course, rating software is somewhat subjective; however, the reputable companies who offer the best products are easy to spot. Not only do they constantly update their software, they also have support staff available to provide assistance and respond to your questions. Good billing software should be highly effective in validating data, picking up billing errors on the fly as you enter data. Such errors include incorrect health card numbers, nonexistent codes, codes for non-billable medical procedures, incorrect hospital codes, or scheduling slots inconsistent with your method of remuneration, to name a few.

Billing software will cost you and your associates anywhere from a few hundred to a few thousand dollars per year. Since a higher price doesn't always mean a better product when it comes to software, don't base your purchase decision on price alone. By the same token, don't hesitate to pay a bit more for first-rate software; the price will be worth it in both the short and long run. Your provincial medical association should be able to advise you as to who the major billing software providers are in your area. Also billing software is completely integrated in an EMRs clinical management system, so does not have to be purchased separately.

WHO DOES THE BILLING?

The responsibility of capturing all of the billing rests on the shoulders of you and your trusted staff, and it is good practice to bill each patient as soon as you finish the chart (Darren: Is this ok?). Your staff and support team help you close the billing loop by double-checking each day that you have captured and noted the bills for all the services and procedures you performed or delegated to your nurse or technician, as well as for patients who may have been added to your list throughout the day. Your staff then submit the bills and reconcile them when they come back from the MoH, Workers' Compensation Board or private payer. They should then review with you all aged accounts receivable so resubmissions for overdue accounts can be made as soon as possible as there may be a date beyond which the bill cannot be re-submitted (six months in

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many jurisdictions). You must stay up-to-date with your fee schedule and read all fee update bulletins because fees do change, new services are often being added and some insured services are being de-listed. This can be done quickly, and the financial benefits are profound.

Delegating the task of staying up-to-date with the fee schedule to staff or a billing agent is in fact abdicating your personal responsibility. Billing should be done by you; your staff or agent is there to help you close the loop. Remember, as per our example, forgetting to bill $24,000 per year translates into $480,000 over 20 years, an amount similar to what you need for your RRSP contributions over the same time. Ask yourself: can I afford that?

ADMINISTRATIVE STAFF

Your administrative staff can be critical to your success with the billing process, but only if you adopt a team approach. As with the "do it yourself" billing method, you will require a detailed knowledge of the fee schedule and its rules. You will still be responsible for billing, but you will have the administrative support of your staff, who can submit billings on your behalf and reconcile them later in the process. Your staff will require sufficient and ongoing training and support to help you to maximize your billing potential. Keep in mind that your own financial future is on the line, so ensure your staff have the tools and training they need to help make it a success. Be aware that some hospitals or clinics will try to include a billing clause in your lease or employment contract, stating that your billing must be done by their staff. Don't limit your options by agreeing to a clause like this — it's your own financial security at stake.

BILLING AGENCIES

A billing agency is to your billing what a tax accountant is to your tax return: an expert you hire to do a job to the best of their ability and knowledge. This agent has a vested interest in collecting all billings submitted under your number, and will know the latest changes to the fee schedule. The cost of the service is minimal and tax-deductible. Every medical association should have a list of billing agents used by their members. Some agencies offer a basic service, while others will look after all your billing, from data entry to rebilling and reconciliation, ensuring the accuracy of your coding and offering advice on how to maximize your revenue. In our view, the best billing agencies are those with the most experienced managers. Despite what some salespeople may have you believe, it is impossible to acquire overnight all the expertise needed to effectively provide billing services for several physicians at a time. Again, your financial future is at stake, so your interests must come first. As such, don't feel guilty about refusing to hand your billing over to your colleague's spouse or the nurse in your department. After all, a good billing agency is a full-time endeavour. Make sure your agency has the staff required to take on your billing if the manager falls ill or goes on vacation. In the end, regardless of who enters your billing codes, you must take accountability and ownership of how your billing is managed. Stay up-to-date on billing fees, read bulletins, attend seminars and take advantage of the learning opportunities presented to you. As well, the billing agent can only work on the information you have provided to him or her, so accurate documentation and billing sheet use is necessary.

HOW THEY WORK

Billing agencies generally charge between 1.5% and 4% of your gross fees for their work. Some agencies charge a set amount per medical procedure, others have fixed hourly rates or a fixed rate per bill. All are acceptable options. Billing agencies cannot deduct their fees directly from your revenues; rather, your agency will send you a monthly or quarterly invoice that you must pay as per the agreed-upon terms and conditions, and their services are subject to GST/HST. **Your billing staff or agents will close the billing loop with the following process:**

1. They will require demographic information about the patient, their provincial health card number, the service or procedural codes, the diagnosis and the referring physician.
2. In some cases you may be required to also provide details of the institution, admission date or time a particular service was performed. Your billing agent will tell you the requirements for your field of practice.
3. The information is faxed to the agency (or picked up) based on a predetermined schedule.
4. These completed requests are then forwarded for payment to the MoH, which will pay you in the weeks to follow.
5. The agency receives a remittance statement in your name and must reconcile the amounts billed with the amounts received. In the case of an error, certain procedures must be re-billed. The reconciliation and rebilling stages are those most often botched by physicians, administrative staff and agencies, though it is easy enough to recover the amounts in question.

The lesson here? Make sure your agency doesn't just "talk the talk," but "walks the walk" too.

THE BILLING PROCESS

The following offers some helpful explanations of billing mechanics

1. BILLING DOCUMENTATION

This is the process by which the physician and staff capture and document all possible billable services for submission to the MoH. Forgetting to bill for one patient visit each regular office day in a GP's office will result in a loss of about $6,600 per year or more. Keep in mind that national surveys indicate on average physicians fail to bill for at least 5% of the services they provide, and then fail to resubmit and capture at least 3% of their unpaid claims to the MoH. This results in a loss of more than 8% of gross income and 12% of net before-tax income.

TO AVOID ERRORS AND OMISSIONS:

- Use a billing day-sheet listing patients seen, including a column for billing codes. This is an invaluable tool for physicians even if an EMR is used. Have this prepared daily by your staff for your completion. It is essential at the end of each day for the doctor, nurse and reception/billing clerk to capture (especially those delegated services provided by your nurse or technician), review and reconcile all services, and cross-reference them with the appointment schedule and names of any patients granted last-minute appointments.
- Combine billing with medical record documentation. With electronic medical record systems, you and your staff can document bills at the same time that your patient's medical records are completed. At the end of the day, cross reference with your billing day-sheet.
- Consider a program for your smartphone or tablet designed to capture all services you deliver when you are out of the office such as when you are on call or at the hospital.

2. MEDICAL RECORDS AND BILLING

Your medical records must stand alone, without your interpretation, to justify the bills you submit to the health plan insurer. At any time the MoH can request copies of the clinical records that correspond to the bills you submit. Be honest and accountable. A good practice is to document billing codes in your progress notes.

3. BILLING SUBMISSION

Most physicians should submit billings daily, or at least three times a week. Some specialists, such as surgeons, tend to submit billings weekly. Once you and your staff have accounted for all of the appropriate billing codes

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for every patient, submit the bills to the MoH. In most provinces and territories, this is done by electronic data transfer (EDT) either web based or over a modem. Electronic submission allows the MoH to review all submissions and quickly verify which, if any, are not accepted. Thus the next time your staff go online, they can check which bills from the last submission were not accepted, pull the charts, correct the errors that the MoH has identified with explanatory codes, and then resubmit the corrected bill so you are paid within the same billing period. This reconciliation, or comparison, is important to ensure you receive remuneration for all services provided.

4. REMITTANCE

This is the process wherein the MoH or other responsible payer remits payment to you. MoH payments are generally made by automatic deposit into your designated bank account. However, you will receive an electronic remittance advice document that you must reconcile.

5. REMITTANCE REVIEW AND RECONCILIATION

Your computerized billing program will automatically reconcile or compare your billing submissions with the corresponding remittance records from the MoH. Pay careful attention to what isn't paid, and why. Failure to correct unpaid remittances before their stale date may result in lost income for work you have performed and procedures for which you are legally responsible.

6. BILLING PERIOD

Depending on the province, the MoH pays physicians either once or twice monthly. Billings you submit for services rendered up until the cut off date of any billing period will generally be paid within one or two billing cycles. This means that your accounts receivable (monies owed to you) can sometimes take four to six weeks to be settled.

7. SUBMISSION TIME LIMITS

In most provinces, physicians have to submit a bill for services rendered within three to six months of performing the service. Those who fail to do so will not be paid. This omission commonly happens when a physician fails to record and hand over to the billing staff the record of services performed outside the office (e.g., when on call). Many physicians scribble patient information from the hospital visit on a card, and then forget to empty their purses or wallets until it is too late to submit the bill.

8. RECIPROCAL BILLING

What if the patient is from another province? In such cases it is essential to have the patient present their valid provincial health card, and verify the party responsible for payment. All provinces and territories except Quebec have a reciprocal agreement, so you can use your billing program to submit the bill to your provincial MoH using the patient's provincial health card number. You will be paid according to the fees of your province, not those of the patient's home province.

IF YOU WORK OUTSIDE QUEBEC AND TREAT A RESIDENT OF QUEBEC, YOU HAVE THE FOLLOWING OPTIONS:

- Bill these patients directly. Give the patient a receipt and record of services provided, and he or she can submit for reimbursement from the Régie de l'assurance maladie du Quebec (RAMQ). You can give these patients a specific form that you can download from the RAMQ; the Application for Reimbursement — Health care services insured outside Quebec is available in English and French. The patient can complete this form without the assistance of your office staff. This is the billing option most physicians use. You have the option to charge using the RAMQ, MoH or provincial medical association fee schedule amounts. Remember, though, that if you are charging above RAMQ rates, patients will only be reimbursed the amount paid for the equivalent service in Quebec.
- Submit an Out of Province Claim Form to the RAMQ for reimbursement. This form will need to be signed by the patient and sent to the RAMQ by your office. You will need to record the patient's health card number and give details of the services provided. The RAMQ will pay you directly by cheque. This is not an ideal situation, as it creates extra paperwork for your staff and can result in significant payment delays.
- Register with the RAMQ and obtain a billing number so you can submit accounts directly to the Quebec MoH, which will remit payment to you. This option is most often exercised by physicians who work near the provincial border and see a significant number of patients from Quebec. Note that physicians pay annual federation dues to provide this convenience for patients.

Quebec physicians seeing out-of-province patients face the same scenario and will most likely exercise option A.

UNINSURED SERVICES

FAST TRACK

Uninsured services can add up to a significant amount of the services you provide. Not charging for them can have a negative impact on your bottom line.

Many physicians feel uncomfortable billing for uninsured (or delisted) services. After all, what's one doctor's note here, or one phone prescription renewal there? They may not seem significant on a one-off basis, but the reality is that these "small" uninsured services can represent a significant amount of the daily activity in your practice. In many cases, physicians are not remunerated for this work. Meanwhile, the costs of maintaining a practice continue to rise.

Bear in mind that your signature represents a professional opinion or endorsement; because you are accountable and liable for anything you sign, your signature is of value.

POINT-OF-SERVICE BILLING

Point-of-service or "as needed" billing means your patients will pay for only those services used at the time that they use them. The upside of this approach is that you will receive payment at the time of service, without any accounts receivable. Offering patients the option of paying by debit or credit makes point of service billing very efficient and effective.

BLOCK-FEE BILLING

Block-fee billing is the term used for bundling a number of uninsured services together and offering one set price for the use of any of those services within a one-year period. This reduces the daily workload on your staff and cuts down on having to ask patients for money (you will only need to ask them once per year, rather than with every service performed), and reduces the need for cash on your premises. There are companies that can manage uninsured service billing on your behalf, taking on the financial and administrative burden. However, you must ensure you are dealing with a reputable company that values privacy and operates with integrity.

Is it worth it? Many physicians feel guilty asking their patients for money. Studies show that usually only about 30% of patients agree to enroll in a block fee program (block fees can never be mandatory or seen as coercive and every College agrees that patients must have the option to opt in or out of pay-for-service). But consider the work that other health-related professionals perform. Dentists, chiropractors and massage therapists have charged patients directly for their services for years. Physicians need to examine the benefits of billing for uninsured services. If you could generate an extra (for example) $18,000 per year by billing for uninsured services, you would be in a position to reinvest that money into your practice. Perhaps it could help you to pay for an EMR system, pay your staff more or to upgrade some equipment. Keep in mind that the salary stats presented at the beginning of this chapter do not reflect money physicians earned with uninsured services.

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chapter 4

financial planning and insurance

A successful, secure financial future requires careful consideration of many aspects of financial planning and management: finance, taxation, law, insurance, will and estate planning, investments and retirement.

This chapter gives you the strategies, tools and guidance you need to get on the road to financial success.

You've likely already received many brochures, emails or even personal phone calls and visits from investment advisors and financial planners from various organizations. Faced with a flurry of banking products, interest rates, tax issues, investment returns and insurance options, you may be confused and want to avoid making decisions. But equipped with a basic knowledge and understanding of financial planning, as well as the right experts on your team, you can make the right choices. You'll identify potential conflicts of interest, and learn that returns seeming too good to be true are just that. And most importantly, by taking an interest in and keeping tabs on your finances, you'll be in charge of your own financial future.

You may already be looking to choose partners to help you manage your finances. These may include financial planners, accountants, banking representatives, investment advisors and insurance brokers. When choosing experts to manage your financial assets, it's important to select carefully. Look for credible companies with a solid history. Ask questions about the products they offer, any fees, how they are compensated and how they track the monthly progress of your portfolios. Also ask your friends, family and colleagues to tell you about their experiences, opinions and referrals.

The information provided in this chapter is current as of January 31, 2013. It does not replace the tax/legal advice given by a professional advisor. You are strongly encouraged to seek your own professional guidance when implementing any tax or estate planning strategy.

ELIMINATING DEBT AND STUDENT LOANS

FAST TRACK

- Know your options and create a plan to meet your specific goals: repaying debt doesn't have to be your sole financial focus.
- Look into a tax-free savings account — a savings option that can benefit everyone.
- Talk to an expert to find the right balance between your current and future financial goals.

Repaying student loan debt is a topic that raises a lot of questions and concerns for medical residents—and for good reason. The number of young doctors with significant student loan debt has grown considerably in recent years, as has the size of the average student's debt upon graduation. This is no surprise, considering how easy it is to get sizable credit from financial institutions to finance a medical education, as well as the limited financial planning education medical students receive in university. Once you've graduated, planning for the repayment of your debt requires particular care and daily discipline to achieve financial health.

DURING RESIDENCY

Residency is the best time to develop a debt repayment plan and to consider loan consolidation — a process in which multiple loans are combined and re-established as one loan. Once you start earning a salary, you'll no longer be eligible for government loan and grant programs. Depending on the repayment terms of your original loan(s), you may have a grace period during which you don't have to make interest or principal payments; however, your debt may start to accumulate interest as soon as you are officially no longer a student.

While the convenience of consolidating debt is certainly

tempting, you'll need to determine if this is the best decision for you. There are many factors to look at, and the arguments for and against debt consolidation vary greatly by province and territory and in each individual situation. Working with a certified financial advisor will help you make the best choice.

Regardless of the financial institution you used for your student loan, it's important to make regular payments to your debt in order to keep control of your financial situation. If you fail to make regular minimum payments, additional interest charges will be added to what you owe and the size of your debt will grow quickly.

Once you create an overall debt repayment plan, you will be able to estimate when you will be debt-free. But if you aren't as far ahead as you'd like at the end of your first year of residency, don't be dismayed. In many cases, if you're disciplined with regular payments, you'll end up getting a handle on your loan and required payments within the first three years of your residency.

Then, once you start seeing extra cash over time, you'll have more choices. You can use all or part of any cash surplus to help pay down your debt more quickly: taking action to reduce your balance early in your repayment schedule will lower the total amounts you pay.

However, it still makes sense to consider all your options for any surplus cash. For instance, if you take advantage of the tax savings available when you contribute to a registered retirement savings plan (RRSP — provided you have available RRSP contribution room), not only will you be able to start a retirement nest egg with those contributions, you will also receive a tax deduction, which will reduce your overall tax bill. And if you receive a refund as a result, it can then be applied directly to the balance of your line of credit — allowing you to use money that would otherwise simply be remitted in taxes.

Keep in mind that you also have the option to defer claiming any RRSP contributions on your tax return until a time when you may be earning a higher income and may be in a higher tax bracket, giving you a greater tax deduction on any contributed dollars.

IN PRACTICE

Just as residency is the best time to start paying off your debt, it is also a good time to develop or update an overall financial plan. Ideally, by the time you start practising medicine, you will also have a good start on building a personalized financial plan.

As you move forward, you will need to continue to repay your debts while keeping in mind the tax and investment opportunities now available to you. Seeking help from professionals who can direct you in the various financial choices you will have is strongly recommended, whether you are a self-employed worker or a salaried physician.

It's also important to periodically update your plan to pay off your debt. How much of your pay cheque or billings should you allocate to your outstanding debt? Should you set aside money for tax instalment payments? If so, how much? How much should you ensure is available for living expenses?

If you have a large line of credit balance, some people think it is best to deposit all incoming money into your line of credit account to minimize the interest you pay. Others prefer to make a regular payment of a defined amount. You should choose the approach that works best for you.

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A SIMPLE PLAN FOR YOUR YEARLY FINANCIAL PLANNING

Since applying and monitoring a debt repayment strategy can be a considerable challenge, you may be drawn to a system that makes it easy to track your financial situation.

Here's one way to keep your financial affairs simple: first, at the start of the new year, after estimating last year's billed revenues, you will know how much you can contribute to your RRSP (the amount will be based on last year's earned income), and approximately how much you will need to pay in tax instalments in the current year (this amount will be based on last year's tax owing). (You may want to speak to your accountant to help calculate your instalment payments.)

Once you know how much you can contribute to an RRSP and how much you will owe in instalment payments, you can set up a system that automatically transfers designated amounts to specific accounts (such as contributions to an RRSP and a tax-free savings account or TFSA, transfers to a chequing account for automatic tax instalment payment withdrawals, etc.). This is also the time for you to consider carefully the pros and cons of using your line of credit as your main account to conduct your daily or regular transactions.

It is also a good idea to set money aside in a daily high-interest account or money market fund between tax instalment due dates. This way, you'll generate interest on the amounts due. If every account has its own purpose, it is easier to track your financial situation at any time. If you apply a systematic approach to meeting your financial commitments, including debt repayment, you'll see your overall picture improve surprisingly quickly.

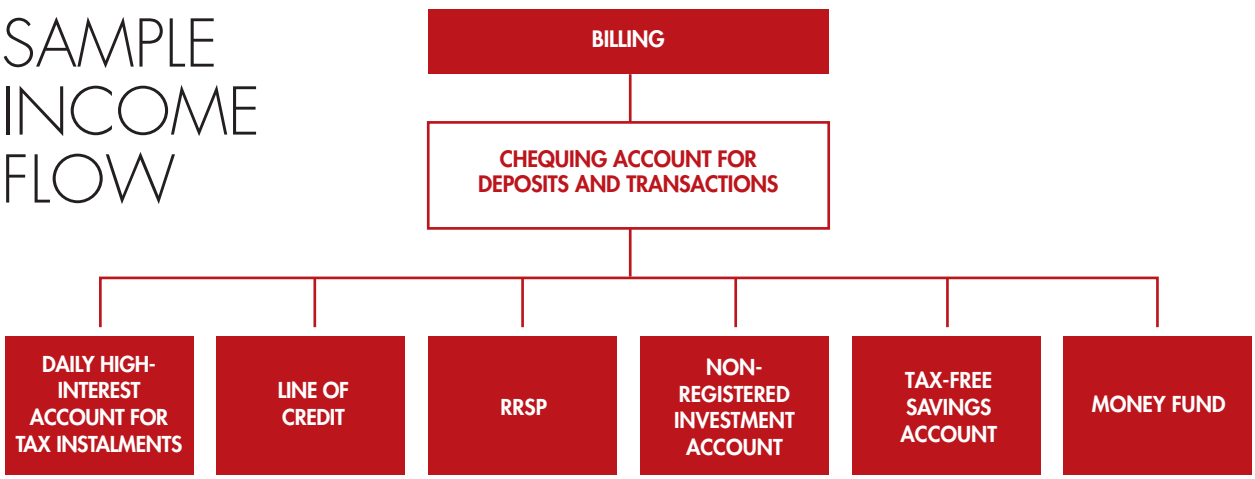
SHOULD YOU OPEN A TFSA?

The easy answer is "yes." The benefits of a tax-free savings account make it an attractive option for most Canadians, regardless of stage of life:

- Investment income, including capital gains, earned in your TFSA is not taxed, even when withdrawn.
- The annual contribution limit is indexed to inflation in $500 increments, so the limit for 2013 is $5,500.
- Unused TFSA contribution room is carried forward and accumulates for future years.
- Choose from a wide range of investment options such as mutual funds, stocks, guaranteed investment certificates (GICs) and bonds. You have the flexibility to withdraw funds at any time.
- Withdrawals in the previous year are added to the contribution room for the current year.
- Neither income earned nor withdrawals affect federal income benefits or credits.
- Unused contribution room carries forward.
- You can invest in virtually any investment opportunity you are used to leveraging for your RRSP.
- Contributions can be made by one spouse to the other spouse's TFSA without tax attribution and transferred upon death to the surviving spouse.

For residents and new physicians, a TFSA is a good place to store cash that might otherwise be absorbed into lifestyle. Ask a certified financial planner how you can take advantage of a TFSA.

SAMPLE INCOME FLOW



STARTING A FAMILY — PARENTAL BENEFITS

There are major differences in the benefits available to residents, general practitioners and specialists who wish to become parents. The birth or adoption of a child requires careful financial planning, because the disruption of work before and after the birth or adoption can result in a significant decrease in income.

If you are thinking about starting a family, it is important to realize that self-employed physicians who become parents typically do not have the same benefits as salaried workers, who may have insurance plans that allow them to take an extended period of time away from work while retaining a monthly cash flow. However, recent changes to the federal Employment Insurance (EI) rules in Canada now permit self-employed Canadians to participate in the EI program. The benefits of this option should be considered for self-employed physicians who are not incorporated.

Most provincial medical associations have negotiated parental leave insurance with their respective Ministries of Health to support physicians financially when they adjust their practice if they become parents. The table below shows how much you are eligible to receive during that time.

FINANCIAL FAMILY PLANNING TIP

Physicians thinking about starting a family should review their financial plans to ensure they have a solid foundation of financial security in place. Here are a few questions to consider:

- If your income changes when you become a parent, will you be able to manage your debt, cash flow and savings, or do you need to make adjustments?
- Do you have sufficient emergency funds set aside?
- Have you reviewed your income and asset protection in the event of your death, disability or illness?
- Since your income may be lower during this time, have you considered incorporation as a potential means to increase your cash flow and minimize your taxes? Have you sought expert incorporation advice?
- Have you reviewed your tax deferral strategies?

Once you are a parent, there are lots of new things to consider. One of these is planning for your child's post-secondary education. If you are in a position to start saving a little extra for a child's post-secondary education, talk to your financial advisor about opening a registered education savings plan (RESP).

The sooner you can start applying for and investing the federal Canada Education Savings Grant money (and any similar provincial grants), which forms part of an RESP, the sooner these funds and your child's overall education savings can start growing.

A certified financial advisor can also help you plan how to allocate your savings among your registered retirement savings plan (RRSP) contributions, a tax-free savings account (TFSA), and saving within an RESP for a child or children.

WEEKLY PARENTAL & MATERNITY BENEFITS FOR NON-SALARIED PHYSICIANS, PER PROVINCE

Province	Maternity benefits	Total maternity benefits	Parental benefits	Total parental benefits	Additional billing allowed?
Alberta	—	—	$1,000 (17 weeks)	$17,000†	No
British Columbia	50% of weekly income, up to max $1,000 per week (17 weeks)	$17,000	$1,000 (17 weeks)	$17,000	No
Manitoba	-	-	60%, up to $1,200 (17 weeks)	$20,400	$1,000 per week
New Brunswick	-	-	$800 (17 weeks)	$13,600	$1,200 per week
Newfoundland	-	-	-	-	-
Nova Scotia	-	-	$50%, up to $700 (17 weeks)	$11,900	$250 per week
Ontario	50%, up to $1,000 (9 weeks)	$9,000	50%, up to $1,000 (8 weeks)	$8,000	$1,000 per week
Prince Edward Island	-	-	60%, up to $1,200 (17 weeks)	$20,400	$1,000 per week
Quebec (GPs)	67%, up to $1,500 (12 weeks)*	$18,000	-	-	No
Quebec (specialists)	67%, up to $2,400 (12 weeks)**	$28,800	-	-	No
Saskatchewan	-	-	50%, up to $1,300 (20 weeks)	$26,000	$2,000 per week

* Plus 33% of gross revenues, up to a maximum of $665 per week ($7,980) for office overhead.
**Plus 33% of gross revenues, up to a maximum of $1,000 per week ($12,000) for office overhead.
† If two physician parents, then both quality for full amount
These benefits are current as of January 15, 2012.

TAX BASICS

FAST TRACK

- Hiring a tax specialist can be worth the additional cost, compared with doing your taxes yourself, because over the long term, this choice can save you significant time, money — and hassle.
- In Canada, federal and provincial income tax is calculated on the overall amount of taxable income you earn each year.
- If a taxpayer is self-employed, his or her income is taxed by the province in which it is earned, whether or not the taxpayer is living in that province. Therefore, in some cases a taxpayer may have to pay tax in more than one province.

TAX STATUS: EMPLOYED OR SELF-EMPLOYED?

In Canada, the tax system is based on "self-assessment," which means taxpayers themselves calculate the taxes they owe — and those amounts are verified by the Canada Revenue Agency through a review and audit process.

For salaried employees, calculations by the taxpayer on the yearly tax return are usually minimal, as your employer deducts taxes directly from your earnings every pay period. This is the case for salaried physicians who are employed by the government, including residents and general practitioners who are paid flat rates.

In contrast, self-employed people can generally deduct, from their gross income, all business-related expenses incurred to earn that income. This includes most physicians who opt for fee-for-service arrangements, alternative payment plans and by-the-hour payment. The list of potential tax deductions is extensive, but deductions should generally be assessed by a tax specialist on a case-by-case basis, as there are limitations and special rules for specific cases.

If you are self-employed, you will be held personally responsible for reporting your professional income to the tax authorities. To help you with this, your provincial Ministry of Health will send you an annual statement of your professional earnings. This information will also be shared with the federal and provincial or territorial governments in your jurisdiction to minimize tax fraud and potential oversights.

The Ministry of Health does not deduct the taxes you may owe from your income; instead, you will receive all professional earnings in full, barring a few very specific deductions such as union dues. You are therefore responsible for paying all tax owing each year. Fulfilling this responsibility may require you to make quarterly instalment payments to the Canada Revenue Agency that are approximately equal, in total, to the amount of tax you are estimated to owe at the end of the year.

OTHER TAX CALCULATIONS

In addition to your professional income, all other earnings and revenues are generally taxable. (Other earnings might include government benefits, such as employment insurance payments, and investment income.)

Certain types of income are treated differently for tax purposes. For example, only half of your capital gains — which are calculated by determining the increase in the value of capital property such as investments or real estate (excluding your principal residence) from the date it was acquired to the date it was sold or otherwise disposed of — are included in your income in the year of disposition, while the other half is not subject to any tax.

As you progress in your professional practice, it can be useful to have a basic understanding of the various tax deductions and tax credits for which you may be eligible. These include tax deductions for eligible registered retirement savings plan (RRSP) contributions, and tax credits for eligible charitable donations and for tuition and education amounts, for example.

Your situation may grow in complexity from year to year. As a result, it is strongly recommended to have a tax specialist prepare your tax return, as numerous elements of the Canadian tax system can have a significant impact on the calculation of your taxable income — especially for self-employed physicians.

— *For a free resource on taxes, download* **Tax Tips for the Physician and Physician in Training**, 2012 edition *at cma.ca/pmc.*

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MORE ON INSTALMENT PAYMENTS:

A year-by-year overview

To ensure you avoid a potentially serious financial pitfall, it can be helpful to understand how tax instalment payments work before you start your practice. Here is a review of the basics.

TAX INSTALMENTS: THE BASICS

Many physicians need to make quarterly instalment payments to the government to cover their estimated tax liability each year.

- Once you are in practice, as a self-employed individual (or even if you have certain other forms of income, such as income from a business income or rental property), you will be responsible for declaring your income and paying the taxes owed each year.
- This is different from your residency or if you are a salaried physician without other self-employment income. In these cases, your employer withholds the tax amounts you are estimated to owe, and remits them on your behalf to the appropriate tax authorities.

In addition, if you decide to incorporate your professional practice, you may also be required to submit quarterly tax instalments for your corporation.

HOW DO YOU KNOW HOW MUCH TO REMIT EACH QUARTER? When you file your tax return each year, your tax advisor will help you calculate the amount of total tax you should have paid during the year and the quarterly instalments you will owe for the coming year. (We provide a detailed walk-through of your first four years in practice, below.)

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If your quarterly instalments represent more than what you are estimated to owe, and your calculations are verified by the tax authorities, the government will refund the overpayment to you. Conversely, if you have not paid enough, you will have to pay the difference no later than April 30 of the following year.

WHEN DO YOU PAY? It is important to note that self-employed people (including physicians) are allowed to file the tax return for the previous year on June 15 of the following year (instead of the usual April 30 deadline). However, any taxes owing must still be paid by April 30 — otherwise, interest charges begin accruing immediately on the balance you owe.

It's important to understand how the system of tax instalments works before you begin your practice. Knowing what's coming will help you plan how much money to put aside, to avoid unanticipated tax bills. Failing to make payments on time can have serious consequences, including high interest charges, compounding daily.

In summary, it is important to address a system for estimating and paying your tax liabilities when you start your practice. Even if you are not required to make regular instalment payments in the first year of practice, you will owe unpaid taxes when you file your return for that first year — and it will be much easier to get through this adjustment period and avoid accumulating debt if you have planned ahead.

MAKING TAX INSTALMENTS: HOW IT WORKS

YEAR 1: For self-employed physicians, the amount of income tax you owe each year is calculated based on the information in your income tax return from the previous year. However, in your first year of self-employment, you have no income tax return with self-employment income upon which to base the tax instalments for the current year, as you have not previously filed a return as a self-employed person.

Therefore, doctors are generally not required to make instalment payments in their first year of practice. This means, however, that you may have a large amount payable when you file your tax return for your first year of practice. If you have not set aside a portion of your earnings in a savings account to cover your taxes from the first month of your practice, you may need to borrow the funds, potentially thousands of dollars, to cover the difference.

YEAR 2: Instalment payments are due March 15, June 15, September 15 and December 15 of each year. As noted above, at the end of your first year of self-employment, the amount of tax you need to pay in quarterly instalments should be set out by the federal government on the assessment notice you receive in response to your filed tax return.

Typically, the amount of the required instalment payments is based on the taxes you paid on self-employment income over the last two years. The practice of using two years of self-employment income to calculate instalment payments can mean your minimum required payments will be lower than your total tax bill for the year. It may also mean, in year two, that you are required to make only the final two instalments rather than all four instalments for the year, and you will need to pay the difference when you file your annual tax return. So, in your second year of practice, it can make sense to set a portion of your gross earnings aside in a savings account (perhaps a tax-free savings account, or TFSA) in order to be able to make this potentially large payment of tax by April 30 of the next year.

Note, as well, that tax instalments are based on an estimate of your tax owing based on the amount of self-employment income and the tax you paid on that income in previous years. If your self-employment situation changes — if you earn less or more than in a previous year — the instalments will not have been adjusted to take this fluctuation into account.

Taxpayers have the option of estimating their instalment payments based on their prior-year net tax owing, or based on their estimate of tax owing for the current year. If you have had a change in circumstances such that you expect to earn less taxable income in any given year, speak to a professional tax advisor for further information on how to reduce your instalment payments accordingly.

YEAR 3: In your third year of practice, the government will mail you instalment reminder notices indicating the amounts you owe. In this year, these amounts will have been determined based on the income you declared in your two most recent tax returns. Accordingly, instalment payments for 2013 will be based on your 2012 and 2011 net tax owing.

YEAR 4: In the fourth year of your practice, your instalment payments will probably stabilize. As in previous years, the government will mail you quarterly notices indicating the instalment amounts you owe. These sums are determined based on the income you declared in your two most recent tax returns. Instalments for 2014 will be based on your 2013 and 2012 net tax owing.

INVESTING BASICS

FAST TRACK

- A total wealth management plan, including a well-diversified portfolio, is key in helping you to achieve your financial goals in all market conditions.
- Work with a financial advisor to identify your financial goals, your risk tolerance and risk capacity. Your advisor will develop a comprehensive plan for your financial future, and review it with you regularly.

Depending on your financial goals, time horizon, risk tolerance and capacity for risk, a variety of investment products may be suitable for you. The range of available products includes individual stocks and bonds, as well as equity-based, fixed-income and balanced mutual funds.

Generally speaking, the investment returns for each of these products are proportional to the underlying risks they represent: a lower-risk investment will provide relatively lower returns with less volatility (or fluctuations in value over time), while a higher-risk investment may provide relatively higher returns, typically with greater accompanying volatility.

Investment products can be categorized into broad *asset classes*, or groups of securities that exhibit similar characteristics, behave similarly in financial markets, and are subject to the same laws and regulations. The three main asset classes are cash and cash equivalents, fixed-income securities (bonds) and equities (stocks). We'll take a closer look at each of these categories.

CASH AND CASH EQUIVALENTS

This category includes short-term, generally safe investments that provide liquidity, or quick access to your money. Cash can be held in a bank account, while "cash equivalents" include Canada Savings Bonds, treasury bills and money market mutual funds. Cash and cash equivalents produce gains in the form of interest.

The expected returns for cash and cash equivalents are low compared with other alternatives. In addition, some of these options have non-redeemable terms to maturity, which means that you cannot access your money during the defined non-redeemable period.

FIXED-INCOME SECURITIES

"Fixed income" is used to refer to investments for which the borrower, or issuer, is obliged to make payments of a fixed amount on a fixed schedule. Typically, fixed-income securities are composed of institutional debt, and provide gains in the form of interest.

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A fixed-income investment tends to offer higher returns than cash and cash equivalents, but its value may fluctuate between the date of purchase and maturity. In addition, as with cash equivalents, some of these investments also have non-redeemable terms to maturity, which means that you cannot access your money during the defined non-redeemable period.

EQUITIES

In contrast with fixed-income securities, which represent debt, equities, or stocks, represent an ownership interest in a company.

Equity investments can generate returns for investors in two ways: first, if the value of the equity (whether an individual share or a unit in an equity mutual fund) increases, which is called a "capital gain", and second, if the mutual fund or company pays a dividend. Neither outcome is guaranteed, however, and the value of equities can go up or down, depending on various factors.

Compared with fixed-income investments, equities historically have provided higher returns over time. However, investors are also exposed to a higher risk of losing a portion, or all, of their invested funds. As an owner (or equity investor), you are closely tied to the company's performance; as a lender (or fixed-income investor), you are taking less risk. The expected returns on these two types of investment reflect this difference.

INVESTMENT FUNDS

How can you invest in these broad asset classes? One common way is by using investment funds that may contain assets from different asset classes. When investors purchase investment fund units, they are pooling their money with other investors — gaining exposure to a wide selection of investments, managed by a professional investment manager, at relatively low cost.

Examples of investment funds include mutual funds, pooled funds, segregated funds and exchange-traded funds. These funds may invest in specific assets, such as varying kinds of bonds or stocks from specific industries or geographical areas, or blend stock and bond investments into a "balanced" fund.

When you invest in an investment fund, you may receive returns when the fund units distribute gains, and when the units appreciate in value. Neither form of gain is guaranteed, however, and investors are exposed to the risk of losses in value.

DIVERSIFICATION

Ensuring that your investment portfolio includes a diversified mix of assets can help you to achieve your goals. Diversification consists of choosing securities with different risk and return characteristics, so that they will respond differently to the same market conditions. This process reduces the overall level of risk to which your portfolio is exposed, and increases the probability of achieving your financial goals within the time horizon you have established.

Diversification is put into practice through "asset allocation", the process of allocating your available funds across asset classes. An effective asset allocation for achieving a retirement goal in 30 years may be very different from the asset allocation required to help save money to buy a new house in eight years. That's why teaming with the right financial advisor is such an important component of a successful wealth management plan.

INVESTING COSTS

When you are considering an investment decision, you should be aware of the investing costs you may face.

For example, when you purchase investment funds, you will be exposed to several costs, including costs to pay the fund manager, costs to buy and sell holdings in the fund, and costs to assume the administration of the funds. These costs, which are generally expressed as a "management expense ratio" charged on each unit of the fund you own, will be deducted from any gains you receive on the fund units you hold.

In addition, if you are working with a financial advisor to purchase investment fund units, there may be up-front costs to purchase units of a mutual fund, or fees that must be paid if you sell the fund units before a defined period of time has passed (typically five years or more). Alternatively, there are also costs to purchase and sell individual stocks and bonds, typically in the form of commissions on their purchase and sale.

When you are making your investment plans, it is important to understand and plan for the costs you may face. Make sure you ask questions and get them answered before you proceed!

CHOOSING YOUR FINANCIAL ADVISOR

How can a financial advisor help? Advisors typically have tools that can help to identify your risk tolerance and capacity, and can suggest an asset allocation that will help you to meet your objectives. Your advisor will construct a portfolio for you, taking into account the tax treatment of the various types of investment gains (including interest, dividends and capital gains) you may receive.

INCORPORATION

Thinking about incorporating? Consider it carefully!

FAST TRACK

Incorporating your medical practice can offer two tax opportunities that can accelerate your progress toward achieving your financial goals:

- an increased capacity to save money through tax deferral and lower tax rates on corporate income, and
- additional enhancements to available tax-deferral strategies through effective investment and withdrawal planning.

You might have heard that incorporating your medical practice can lead to big tax savings over time. And while the opportunity to save money is certainly attractive, it's always prudent to analyze your personal financial situation and consider the risks and rewards before committing to a course of action.

It's also important to work with a financial advisor who keeps abreast of the shifting tax and legal conditions that may affect your corporation, to ensure that you remain compliant with relevant tax laws and take advantage of new opportunities that may arise.

In this section, we'll review the main advantages and possible disadvantages of incorporating, and we'll also provide some summary information on the tax implications of incorporating. We'll close with two examples, which provide more detail and scenarios comparing incorporated and non-incorporated physicians.

WHAT IS INCORPORATION?

When you incorporate, you create a new legal entity: the corporation. The new corporation becomes the owner of your medical practice, while the shares of the corporation are owned by the physician and, under certain circumstances, his or her family members. The incorporating physician typically also becomes an employee, director and officer of the corporation.

When your medical practice earns income through a corporation, how that income is taxed depends on both the specific type of corporation and the kind of income generated within it. Most incorporated medical practices will

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be established as *Canadian-controlled private corporations* (CCPCs), earning *active business income* — which means they are generally eligible for reduced tax rates on that income (typically, income from your work as a physician is considered "active business income").

For 2013, this "small business tax rate reduction" results in a tax rate of about 15% on the first $500,000 of income. Investment income, in contrast, is not "active business income" and therefore is not eligible for the small business tax rate.

(Note that there are provincial small business deduction limits as well, which may vary from the $500,000 federal limit. The small business tax rate varies by province.)

POTENTIAL ADVANTAGES OF INCORPORATING

TAX DEFERRAL

Perhaps the most significant potential benefit of incorporation is the ability to defer tax on income earned within the corporation. Tax deferral allows you to invest (and grow) money that would otherwise be paid in taxes.

As noted above, incorporating generally allows a physician to pay the lower small business corporate tax rate on up to the first $500,000 of active business income earned within the corporation (with the exceptions of Manitoba and Nova Scotia, where the upper limit is $400,000). The tax rate on this first portion of income varies from province to province, but the combined federal and provincial rate is generally about 15% (see table on page 64 with combined corporate tax rates for 2013). This means that once the medical practice has deducted all of its eligible expenses, any income remaining in the corporation is taxed at a lower rate than it would be if it were instead earned by, and taxed in, the hands of an individual (see table on page 64 with combined personal marginal tax rates for 2013).

It is worth noting that it is the corporation, and not the individual physician, that benefits from the reduced rate. For the physician to receive income personally, the corporation must pay him or her — via a salary, bonuses or dividends. It is important to note that the tax treatment of dividend, salary and bonuses income will vary. Dividend income, in particular, is eligible for a federal "dividend tax credit", which taxes this income favourably compared to salary income.

As an officer of the corporation, the physician ultimately makes the decision about how (and when) remuneration is paid from the corporation. Detailed examples comparing various forms of compensation are provided on page 67.

RETIREMENT INCOME FOR THE INCORPORATED PHYSICIAN

If a physician receives compensation in the form of dividends only, this income is not "pensionable income" for the purposes of making CPP/QPP contributions, meaning no CPP/QPP contributions are payable on this income.

While this situation could be viewed as providing an advantage during the physician's working years, it also means that the physician does not receive CPP/QPP income in retirement.

In addition, when a physician receives dividend income only, this income does not create RRSP room for the physician.

In general terms, it is important to understand that the tax-deferral benefits of incorporation are only possible when earnings from the medical practice are retained within the corporation. Thus, if all funds are simply flowed through the corporation to the physician and none are retained in the corporation, the tax paid by the physician will be comparable to simply earning the income directly as a self-employed practitioner, without involving the complexities of a corporation.

INCOME SPLITTING

"Income splitting" is the practice of sharing or "splitting" taxable income between taxpayers, so that a lower overall rate of tax is paid than would be the case if the income were not shared or split.

In the case of an incorporated medical practice, income earned by the practice may be paid out in the form of dividends to the corporation's shareholders. If your family members are shareholders of your professional corporation, tax savings can be achieved if the income is "split" between the physician and family members as it flows out to those members who are taxed at a lower marginal rate than the physician's rate.

There are a couple of caveats, however, regarding the use of income splitting as a tax-minimizing strategy. If you have minor children as shareholders, income splitting is limited as a result of the attribution or "kiddie tax" rules of the *Income Tax Act.* Under these rules, certain types of income received by minor children (including dividends paid from private corporations) are taxed at the highest marginal rates, without the basic personal exemption that would ordinarily be available. The tax implications of the attribution rules should be discussed with a tax advisor.

In addition to potentially paying dividend income to family members, incorporated physicians can also pay "reasonable" salaries to family members for services they perform — which means the amount must be comparable to what you would pay to an arm's-length person for similar services.

In contrast to salaries, however, the payment of a dividend does not need to conform to a "reasonableness" test.

TAX SAVINGS

In the most general terms, and as we have outlined, tax savings are accomplished through a professional corporation when funds are retained within the corporation and taxed at lower corporate rates rather than being withdrawn and taxed at a high personal rate as shown in the table on page 66. Instead, the retained funds are withdrawn when a lower personal tax rate applies.

In a typical scenario, funds are retained in the corporation during the physician's working years (when they would otherwise be subject to high marginal tax rates, if earned directly by the physician), and withdrawn after the physician has retired from active practice, when total taxable income — and thus marginal tax rates — are lower.

In addition, tax-saving opportunities may be achieved by integrating your corporation within your estate plan. Generally speaking, the disposition of your corporate assets is addressed through your will. In Ontario, the shares of your professional corporation can be flowed through a second will that deals specifically and solely with corporate assets. This second will is generally not subject to probate, or any probate fees or related taxes that would otherwise be applicable in Ontario.

QUICK PROS AND CONS OF INCORPORATION

PROS	CONS
✓ Small business income tax rate up to $500,000 (depending on your province) of annual taxable practice income in the corporation	✗ Investment income earned by your corporation doesn't benefit from reduced tax rates.
✓ Deferred payment of personal tax by leaving money in the professional corporation.	✗ The corporation must file its own tax returns and make instalment payments.
✓ May offer opportunities for income splitting.	✗ The attribution rules in the *Income Tax Act* attribution rules are complex and could mitigate income-splitting opportunities.
✓ Payment of a regular salary from your corporation can make personal budgeting easier.	✗ Incorporation adds another layer of complexity to your day-to-day affairs.
✓ Incorporated physicians can draw a mix of dividend income and salary — to maximize tax-planning opportunities.	✗ Dividend income does not qualify as earned income for the purposes of generating RRSP contribution room and does not provide an opportunity to contribute to the CPP/QPP.
✓ If applicable in your province, corporate shares can be dispersed after death by way of a second will that is not subject to probate.	

COMBINED FEDERAL/PROVINCIAL TOP PERSONAL MARGINAL TAX RATES FOR 2013

Province/territory	Capital gains	Eligible dividends	Non-eligible dividends	Other income
British Columbia	21.85%	25.78%	33.71%	43.70%
Alberta	19.50%	19.29%	27.71%	39.00%
Saskatchewan	22.00%	24.81%	33.33%	44.00%
Manitoba	23.20%	32.26%	39.15%	46.40%
Ontario	24.76%	33.85%	36.47%	49.53%
Quebec	24.99%	35.22%	38.54%	49.97%
New Brunswick	21.65%	22.47%	30.83%	43.30%
Nova Scotia	25.00%	36.06%	36.21%	50.00%
Prince Edward Island	23.69%	28.70%	41.17%	47.37%
Newfoundland and Labrador	21.15%	22.47%	29.96%	42.30%
Nunavut	20.25%	27.56%	28.96%	40.50%
Northwest Territories	21.53%	22.81%	29.65%	43.05%
Yukon	21.20%	15.93%	30.40%	42.40%

Note: This information is current as of December 31, 2012, but may be based on proposed legislation (which has not yet become law), and is subject to change pursuant to legislation introduced after this date.

COMBINED CORPORATE FEDERAL/PROVINCIAL TAX RATES FOR 2013

Province/territory	Small business tax rate	General tax rate	Investment tax rate (for CCPCs)	Provincial small business income threshold
British Columbia*	13.50%	25.00%	44.67%	$500,000
Alberta	14.00%	25.00 %	44.67%	$500,000
Saskatchewan	13.00%	27.00%	46.67%	$500,000
Manitoba	11.00%	27.00%	46.67%	$400,000
Ontario	15.50%	26.50%	46.17%	$500,000
Quebec	19.00%	26.90%	46.57%	$500,000
New Brunswick	15.50%	25.00%	44.67%	$500,000
Nova Scotia	14.50%	31.00%	50.67%	$400,000
Prince Edward Island	12.00%	31.00%	50.67%	$500,000
Newfoundland and Labrador	15.00%	29.00%	48.67%	$500,000
Nunavut	15.00%	27.00%	46.67%	$500,000
Northwest Territories	15.00%	26.50%	46.17%	$500,000
Yukon	15.00%	30.00%	49.67%	$500,000

* The 2012–13 budget proposes a temporary increase in the general corporate income tax rate, to 11% from 10%, effective April 1, 2014; this proposed increase is subject to re-evaluation in the 2013–14 budget.
Note: This information applies to CCPCs and is current as of December 31,2012, but may be based on proposed legislation (which has not yet become law), and is subject to changes pursuant to legislation introduced after this date.

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POTENTIAL DISADVANTAGES OF INCORPORATING

INCREASED COSTS AND COMPLEXITIES

Incorporating can be both complex and costly. The costs associated with incorporation include initial setup costs, ongoing legal and accounting fees, and may also include payroll taxes. When you are contemplating incorporating, it is important to assess whether these increased costs might eliminate the financial advantages of incorporating.

In addition, there are also additional planning costs and expenses associated with incorporation, such as setting up family trusts or revising wills to reflect the new corporate structure.

Finally, every corporation must ensure that records and books are kept up to date and that taxes are paid. These ongoing tasks include making regular corporate tax instalments, filing annual corporate tax returns, establishing and maintaining separate bank accounts and recording directors' resolutions.

OTHER CONSIDERATIONS

TAX DEDUCTIONS

You may have heard that, if you become incorporated, certain personal expenses will be deductible to the corporation — this is generally not true, however.

If personal expenses — such as automobile costs — are paid by the corporation, they cannot also be deducted by the corporation from taxable income.

Instead, in this case, the shareholder for whom the cost was incurred will be deemed to have received a taxable benefit for the personal use of the vehicle — meaning the expense will be taxed twice: once at the corporate level, and then again in the hands of the recipient of the taxable benefit.

In general, for an expense to be deductible from the income of a corporation, it must be incurred for the purpose of earning income, and must be a reasonable amount under the circumstances.

Making certain payments at the corporate level may, however, provide tax advantages. For example, as tax rates are generally lower in the corporation than for the physician personally, debt repayments for the medical practice can be made more efficiently within the corporation — as they require a lower level of gross earnings when paid from within the corporation than if they were paid at the personal level, due to lower tax rates in the corporation.

Holding a permanent life insurance policy within the corporation is another example of possible tax advantages, compared with holding the policy personally. In addition to taking advantage of the greater tax efficiency of funds in the corporation (as described above with respect to debt repayment), permanent life insurance can also help to defer taxes on corporate investments during the insured physician's lifetime. Then, upon the death of the insured physician, the

death benefit from the permanent insurance policy will be paid to the corporation, as the owner of the policy.

Finally, a large portion, or perhaps all, of the death benefit can be paid out, in turn, as a tax-free capital dividend to the physician's estate or the surviving shareholders, depending on the circumstances.

IN SUMMARY: Paying permanent life insurance premiums tax efficiently within the corporation, sheltering investment dollars held in the policy inside the corporation, and paying out the death benefit on a tax-free basis to the insured physician's estate or surviving shareholders are all potential benefits of holding a permanent life insurance policy within the corporation.

LIMITED LIABILITY

The rules of incorporation for physicians provide that a physician remain personally liable for all medical acts that he or she has performed while incorporated. However, the corporate structure can nevertheless provide a source of limited liability in situations that do not involve the physician's medical practice — for example, if a person trips and falls in the physician's office and sues for personal injury.

EMPLOYEE LIFE AND HEALTH TRUSTS

A physician can further reduce his or her corporate tax bill by using the corporation to fund what is known as a personal health services plan, or employee life and health trust.

This type of plan, if properly structured, effectively converts uninsured medical expenses to tax-deductible expenses for the corporation, instead of a tax-creditable expense for the shareholder (which would be the case if the medical expense were to be paid and claimed personally).

An employee life and health trust can be complex, and must be set up correctly to maximize its benefits. To ensure that you benefit from a personal health services plan, consult a financial advisor who is knowledgeable about the options available in your province.

LIFETIME PERSONAL CAPITAL GAINS EXEMPTION

Every individual can potentially benefit from a lifetime capital gains exemption. This exemption can be used to shelter gains of up to $750,000 arising from the disposition (including the sale) of shares of your corporation — provided those shares are qualified small business shares at the time of the disposition.

Typically, few physicians are able to benefit from this exemption, as it is unusual to find a buyer for a medical practice. However, it is important to be aware of the rules for qualifying, as tax planning to take advantage of the exemption will generally be required well in advance of any sale of an incorporated medical practice.

To qualify for the exemption, all or substantially all (90% or more) of the corporation's assets must be used in an active business in Canada at the time of the disposition. Excess cash and investments held inside the corporation do not qualify for the exemption. Ensuring that the shares of your corporation continue to qualify for the capital gains exemption requires attention over time.

As this lifetime capital gains exemption has significant potential tax benefits, you and your team of professional advisors should be aware of the complex rules in place for your shares to qualify. In general, any tax planning will generally be required well in advance of any disposition or sale.

CONCLUSION

Based on this review of potential advantages and disadvantages, it should be clear that incorporating often makes the most sense for those who are able to retain significant funds within the corporation.

In addition, it can also make sense in situations where income splitting with family members is a possibility. Other potential benefits of incorporating include more efficient business debt repayment and access to the lifetime capital gains exemption.

It can be difficult to predict the value of the benefits associated with incorporation over the long term, however — the physician's circumstances can change, as can tax laws, which might eliminate or diminish the tax advantages of incorporation that are available today, or, conversely, could make incorporation even more beneficial. In considering and timing your decision, multiple scenarios should be assessed with the assistance of knowledgeable advisors.

ILLUSTRATIVE COMBINED FEDERAL AND PROVINCIAL TAX RATES	
PERSONAL TAX RATES	
First $45,000	24%
• Over $45,000 up to $90,000	34%
• Over $90,000 up to $135,000	40%
• Over $135,000	44%
• Non-eligible dividend tax credit (% of taxable dividends)	18%
Basic personal amount (tax credit)	$2,500
CORPORATE RATES	
• First $500,000	15%
• Over $500,000	28%

INCORPORATION EXAMPLE 1: PHYSICIAN WITH SALARY AND/OR DIVIDEND INCOME

	Unincorporated physician	Corporation: No deferral	Corporation: Deferral
Income (after expenses)	$250,000	$250,000	$250,000
Incorporation costs (deductible)	-	**($2,000)**	**($2,000)**
Salary		**($135,000)**	**($135,000)**
Net taxable income	$250,000	$113,000	$113,000
Personal income	$250,000	$135,000	$135,000
Taxes — personal	($92,200)	($41,600)	($41,600)
Net after-tax salary	$157,800	$93,400	$93,400
Corporate net income		$113,000	$113,000
Taxes — corporation		**($16,950)**	**($16,950)**
Available for deferral		$96,050	$96,050
Total after-tax funds (personal plus corporate)		$189,450	$189,450
Non-eligible dividend income		$96,050	
Personal tax on dividend income		**($31,216)**	
Net salary and dividend income		$158,234	

Consider the example of Julie, whose medical practice earns $250,000 after expenses. As a self-employed individual, she reports this income on her personal tax return, and pays about $92,000 in personal tax on it. If Julie were to incorporate her practice, the corporation would earn the revenue, rather than Julie personally, and Julie would be compensated by the corporation in the form of salary, dividends or a mix of both.

In the example above, Julie incorporates and pays herself a salary of $135,000 to meet her lifestyle needs. This also creates the maximum RRSP contribution room for the following year. If she leaves all of the remaining funds in the corporation, she can benefit from deferring tax on $97,750 of retained earnings (as illustrated in the "Corporation — Deferral" column).

If all of the earnings are withdrawn from the corporation, however, then no deferral of tax is available (as illustrated in the "Corporation — No Deferral" column).

In this example, if Julie does not need additional funds beyond what she is withdrawing in salary, then, by leaving the retained earnings in the corporation, she is deferring personal tax totalling almost $32,000, which she would otherwise have to pay on the dividends received from the corporation.

INCORPORATION EXAMPLE 2: INCOME SPLITTING VIA DIVIDEND INCOME*

	Unincorporated physician	Corporation Year 1	Corporation Year 2+
Income (after expenses)	$250,000	$250,000	$250,000
Incorporation costs (deductible)		**($4,000)**	**($2,000)**
Net income	$250,000	$246,000	$248,000
Tax owing	($92,200)	($36,900)	($37,200)
Available cash (after tax, before dividend distribution)	$157,800	$209,100	$210,800
Non-eligible dividend: Paul	n/a	$104,550	$105,400
Non-eligible dividend: Diane	n/a	$104,550	$105,400
Tax owing: Paul	n/a	**($16,351)**	**($16,585)**
Tax owing: Diane	n/a	**($16,351)**	**($16,585)**
Net after-tax cash	$157,800	$176,398	$177,630

Now we'll take a look at Paul's situation. Paul lives in a province in which spouses can be shareholders of the physician's professional corporation. In this example, Paul earns $250,000 after eligible expenses. As a self-employed individual, he pays $92,200 in taxes, leaving him with $157,800 in after-tax income.

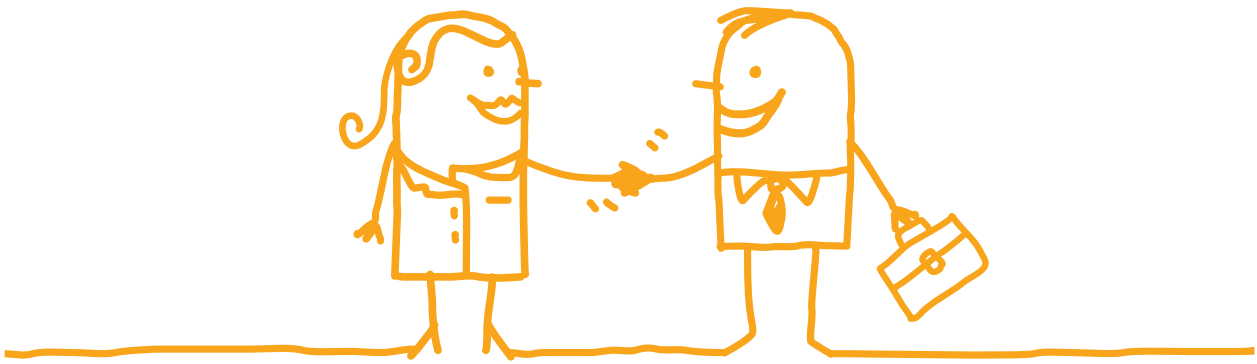
If Paul incorporates his practice, the corporation earns the revenues from his medical practice, which are then paid out to Paul and his wife, Diane, as dividends.

If Paul leaves funds in the corporation, as shown in the table above, he can benefit from a tax deferral on $209,100 of retained earnings.

Conversely, if all funds flow out to him and his wife, the couple will have a combined $176,398 in after-tax income in the year of incorporation, and no funds are retained and no tax is deferred. (Note that this example assumes that Diane and Paul have no sources of income other than dividends from Paul's incorporated medical practice.) In addition, as all of their income is in the form of dividends, they would not generate any RRSP contribution room, nor would they have any CPP premiums payable — or future CPP benefits.

In Paul's situation, there may be a measureable benefit to incorporate. For Paul and Diane, the tax savings arising as a result of the graduated tax rate system in Canada, as well as the dividend tax credit, mean that Paul and Diane may be better off financially if they incorporate.

* This example uses federal 2013 tax year calculations for dividend income. Provincial taxes may arise in these examples, but are not considered.



Note: These two examples use the generic tax rates (shown on the previous page) in the computation of personal and corporate taxes owing in each scenario. These rates are intended to approximate average tax rates for Canada, but these examples are provided for illustrative purposes only. Actual tax amounts will vary by province and by income amounts.

IS IT BETTER TO RENT OR BUY A HOME?

FAST TRACK

- If you're comparing home ownership and renting, be careful not to go on numbers alone: there are pros and cons to both options.
- If you decide to buy a home, make sure you consider protecting yourself and your family from some of the financial risks of home ownership. You can purchase insurance to help cover your mortgage payments in the event of disability or critical illness, or to pay the mortgage off in full in the event of your death.

A great debate among young professionals is the rationale for home ownership. Is it better to jump into the real estate market early, or are you further ahead financially if you rent for longer?

It can be confusing to work through both options and make the decision that you feel will set you on the path to financial success in the future. Part of the reason for this confusion is that comparing home ownership and renting is not an "apples to apples" comparison. Here are some of the factors you should consider to help you make the choice that's right for you.

ARE YOU STAYING PUT FOR THE LONG HAUL?

One of the most important things residents should consider when contemplating the purchase of a home is whether they plan to stay in the same city for a number of years. While housing prices generally rise over time, making housing a reasonable financial bet, prices can be volatile in the short term. Couple that with the high transaction costs of buying and selling a home, and if you are planning to buy and then sell a home in the short term, you could end up losing money. Instead, a home should be viewed as a longer-term investment, with a minimum of five years as a good rule of thumb.

ARE YOU PREPARED FOR THE UNEXPECTED?

When committing to a mortgage payment, you must consider your ability to make the payments in even the worst–case scenario. This means contemplating whether you could manage financially if you or your partner became ill or disabled, and considering whether you are going to take parental leave, to give two examples. Here's why: the maximum debt load you are comfortable repaying may be quite different if you're accustomed to two incomes, but they suddenly become one. You can mitigate some of the risk presented by unforeseen circumstances by purchasing insurance to cover the mortgage payment if you become disabled or critically ill, or to cover the entire amount in the event of your death.

In making your decision, avoid relying too heavily on the prospect of your home appreciating quickly in value. While the possibility does exist that a property will appreciate in value over a few years, this is by no means guaranteed. In fact, home prices sometimes drop in the short term — and in some instances take many years to return to previous levels. Accordingly, you should be wary of any plan to quickly "flip" a home in a brief period of a year or so and make a substantial profit.

COST COMPARISON

While you are new in practice and renting, you might think of your monthly rental payments as "giving away" your money to someone else—your landlord. On the other hand, mortgage interest, house insurance, land transfer taxes, property taxes, condo fees, and legal and other selling fees can all reflect "lost" money from home ownership in exactly the same way that rent is "lost" money. Consider the example below:

Let's say you are renting, with a monthly cost of $1,200, and you are contemplating buying a resale condo at a cost of $225,000, with a mortgage amortized over 25 years.

Your costs to rent can be estimated at $1,200 multiplied by 60 months (or five years), for a total of $72,000 (assuming no increases in rent over those five years).

If you buy the condo, let's assume a 5% down payment totalling $11,250, plus the mortgage insurance fee of 2.75%, or $5,878, for a mortgage amount of about $219,628.

Here's what the total cost of ownership might look like over the first five years, given these assumptions:

Mortgage interest cost for five years, assuming monthly payments	$51,400
Land transfer tax	$0
Property taxes	$16,000
Legal fees for house purchase	$1000
Condo fees for five years	$12,000
Total cost for five years	**$80,400**

Note about land transfer tax: Generally, if you are involved in a purchase of property in most provinces, you must pay land transfer tax on the transfer. First-time home buyers may be eligible for a full or partial refund. Property in the City of Toronto may be subject to a separate land transfer tax (in addition to the Ontario land transfer tax). In this scenario, we are assuming the land transfer tax has been fully refunded.

The difference? Using these scenarios, buying would cost $80,400 over five years, whereas renting would cost $72,000. And this comparison does not include other costs associated with home ownership, such as moving and maintenance (more on these below).

So, although buying can mean building financial equity in a property you own, you may decide buying now — while you are new in practice — isn't the right choice for you. If that's the case, one benefit of waiting is that you can carefully plan the purchase of a house, and build it into your financial plan for the next few years.

For instance, by investing the difference you might have spent on a condo (in our example, above) in a registered retirement savings plan (RRSP), together with other contributions, after five years you would be able to withdraw up to $25,000 from your RRSP through the federal Home Buyers' Plan (provided certain criteria are met). This amount, combined with whatever you have invested in a tax-free savings account (TFSA), can provide you with a nice down payment that you've been able to save in a tax-efficient way.

If you follow this path, you may find yourself with the home you want, in the area where you will be practising over the longer term, without making purchasing decisions under the pressures of an uncertain future.

THE HIDDEN COSTS OF HOUSING

Keep in mind that there are many extra costs involved in buying a house. Some of these are one-off costs, such as moving costs and buying appliances; others, such as maintenance costs, property taxes and property insurance, will be ongoing monthly expenses. Mortgage loan insurance (through the Canadian Mortgage and Housing Corporation, or CMHC) will also apply if your initial down payment is less than 20% of the total purchase price. This fee will range up to 2.9% of the amount of your mortgage, and may be added to your mortgage amount.

MARKET CONSIDERATIONS

Finally, you should also consider the economic climate when making a decision to purchase a home. In some regions, housing markets are expected to cool slightly, and price growth is expected to hold steady or even decline marginally. At the same time, although interest rates are expected to rise, they are expected to remain low in historical terms over the near future. All in all, it's important to plan for uncertainties and to keep in mind that the both the Canadian real estate market and the interest rate environment are unpredictable, so professional advice can be important in helping you move forward with a decision.

RENT OR BUY? UNDERSTANDING YOUR OPTIONS

Weed through the fees, taxes and monthly payments. Check out the online calculator tool at **https://mdm.ca/tools/calculators/rent-vs-buy.asp**.

PROTECTING YOUR LIFESTYLE

FAST TRACK

- Three main types of insurance can help secure quality of life for you and your loved ones: disability insurance, life insurance and critical illness insurance.
- Permanent life insurance can also play an important role in your financial planning by helping you diversify your assets, as the money held within a permanent life insurance policy accumulates on a tax-advantaged basis.

Have you ever contemplated what would happen to your family's finances if an accident, illness or death interrupted your career? While it's not pleasant to think about, the risk is real. However, many of these risks can be managed with an effective strategy, using insurance products as risk management tools.

There are three main types of insurance to consider adding to your personal risk management strategy when you start your practice. The benefits from these distinct types of coverage can:

- provide an income if a disability prevents you from working, whether over the short or long term,
- replace your future income and leave a tax-free inheritance for your family in the event of your death, and
- provide a significant tax-free lump sum if you are diagnosed with a serious illness.

DISABILITY INSURANCE

Given that your financial well-being can depend significantly on your ability to earn an income, disability insurance is likely the most important coverage all physicians should get, starting when they are new in practice. In fact, it is statistically more likely that you will become disabled during your working years than it is that you will die prematurely.

Disability income insurance provides you with replacement income if you are unable to practise medicine as a result of an accident or illness (even a temporary illness, such as a depressive episode, or recovery from surgery). This form of insurance can allow you to maintain your lifestyle by helping to cover your living expenses and by allowing you to keep making payments on student or other loans—or even contribute to a registered retirement savings plan (RRSP) or tax-free savings account (TFSA).

The amount of income you need to replace in the event of a disability should be based on your net income after professional expenses, but before taxes (disability benefits are not taxable, as long as the premiums are paid personally).

If you are purchasing disability insurance at the outset of your career, it is recommended that you choose an option that provides indexation of the benefits to inflation.

It is also important to choose a coverage option that pays an income benefit if you are no longer able to practise medicine (called "own occupation" insurance, as it protects you in the event you are unable to work at your chosen profession) even if you are able to perform other jobs. Other types of disability insurance coverage only pay an income benefit if you are unable to perform any job. Physician-surgeons, in particular, need coverage that recognizes them as disabled if they lose the use of a hand or one finger.

Other key provisions of a disability income insurance policy include a guaranteed insurability benefit and coverage for partial, residual and total disability, as well as the elimination period. Here is more on each of these elements of a disability insurance plan:

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GUARANTEED INSURABILITY BENEFIT

The guaranteed insurability benefit allows you to increase the amount of your insurance without having to provide medical proof of insurability. If you select this option, you will be able to increase your disability insurance coverage over time, so that it keeps pace with your rising income level.

In contrast to individual disability insurance plans, group disability plans typically do not allow for an increase in coverage without a medical examination. However, provincial and territorial medical association disability plans all include a guaranteed insurability benefit as part of their insurance offering to students and to residents in most cases; thus, your disability benefits under your provincial and territorial medical association coverage will grow along with your career.

PARTIAL, RESIDUAL AND TOTAL DISABILITY

Another important element is the definition of "disability." Coverage can include partial, residual and total disability. Partial disability occurs when an individual becomes partially disabled but can continue in the same functions in a reduced capacity—for example, for two or three days per week. Residual disability occurs when a disabled individual can still work but will earn less because of reduced productivity. Finally, total disability means the individual is unable to work at all.

ELIMINATION PERIOD

The elimination period is the time between the onset of a disability and the point at which you are eligible for benefits — think of it as a deductible period for your disability insurance policy.

Residents who have just started to practise medicine should give some careful consideration to choosing the right elimination period to meet their personal needs. If you have a heavy student debt load, and possibly a mortgage and family in the picture, will you have enough savings to cover all of your expenses for 30, 60 or 120 days, all of which are common elimination periods? Discussing your specific situation with your insurance and financial advisors is essential when making this decision.

BUSINESS OVERHEAD INSURANCE

This form of insurance operates hand in hand with your personal disability insurance, but whereas disability insurance is structured to help pay for personal expenses, business overhead insurance covers your business expenses if you are unable to work.

What kind of expenses does it cover? For example, if you practise out of an office with a receptionist and use electronic medical records, you will have ongoing business expenses (salary, electronic records billing) whether you are working and earning income or not.

If you become disabled and cannot work for a period of time, overhead insurance can provide your business with monthly payments that can be used to cover your monthly business expenses. These payments can provide a financial bridge until you are able to return to work, or until you are able to unwind any business contracts and financial obligations.

LIFE INSURANCE

Life insurance provides your beneficiaries with a tax-free payment, called a death benefit, which they can use to pay both immediate expenses such as funeral costs, legal fees, estate liquidation and taxes, as well as your debts—such as your mortgage, business loans and the balance of your student loans.

The proceeds from the life insurance policy can also maintain or supplement your family's lifestyle by generating income that can cover any long-term expenses you may have in place, or replace your future income.

When you are selecting life insurance coverage, it is important to accurately assess your insurance needs and your financial goals, and choose coverage that meets them.

There are two types of life insurance: *permanent* and *temporary* (also called "term" life insurance). Over your lifetime, your may have either or both types of life insurance. That's because some planning needs may be short-term or temporary in nature, while others will involve meeting long-term planning needs.

Permanent insurance can take two forms, known as whole life and universal life. Just like you may have both permanent and temporary insurance over your lifetime, you may also have one or several different permanent insurance policies, depending on your situation.

How do you know how much insurance to purchase? One way is to add up your total debts (credit line, student loans, mortgage, personal loans and any others) and any expenses that would arise from your death (such as funeral expenses, legal and accounting fees and the costs of estate administration). Next, you should consider your long-term needs and any future financial goals. For example, consider your loved ones and how much income they would need to maintain their current and future lifestyle (that is, how much income they would need and for how long, including expenses such as university education for children).

Then, you would purchase coverage to clear your debts and provide sufficient resources to help meet your dependents' lifestyle goals.

The coverage needed to pay off debts may be temporary, but the costs of future income replacement are more permanent and also tend to increase over time, because of inflation and the rising value of your income and financial net worth.

Similarly, as your net worth increases in value, you may need permanent life coverage to ensure that your estate will have enough liquidity to pay future capital gains tax and other costs that may arise upon death, such as restructuring or winding up a professional corporation. In addition, new needs may surface as you age, as grandchildren enter the picture, as you purchase recreational properties, as you decide to incorporate significant charitable gifts into your estate plan, and more.

One advantage of permanent life insurance is that it can combine a flexible permanent *life insurance contract* with a tax-advantaged *investment component*.

Each kind of permanent life policy can contain these two components, but treats them differently. Whole life policies integrate the insurance and investment components, while universal life policies "unbundle" them. What this means is that the owner of a universal life policy can manage the investments held within the policy's investment account directly. At death, certain universal life policies will pay out the balance in this investment account tax-free in addition to the death benefit (although certain conditions may apply). This option can be valuable if you want a "hands-on" approach to your investments and are willing to live with a bit more investment risk.

In contrast, if you prefer a more "hands-off" approach to investing and want to trade in a bit of return potential in exchange for added safety of your investments, whole life insurance may be best.

With both types of permanent life insurance, while you are living, you can often also access the values inside your policy in a tax-efficient manner if you have a need for cash. Finally, a mix of temporary and permanent coverage, meeting different needs, may be consolidated to reduce your insurance costs. To get the mix that's right for you, you should consult with a certified financial advisor who can help you choose from the many insurance options.

CRITICAL ILLNESS INSURANCE

If you are diagnosed with a critical illness, there may be significant financial implications: aside from the costs of care and treatment, recovery costs can include losses to personal wages and savings plans, and you may need additional child care.

The role of critical illness insurance is to protect your and your family from the stress of managing your household finances during this difficult time by providing a financial safety net.

Critical illness insurance works by providing a lump-sum payment if you are diagnosed with one of the conditions covered by your policy. These policies generally cover cancer, heart attacks, strokes and up to 25 other "catastrophic" illnesses as long as you survive for a minimum period — usually 30 days, though for some illnesses, the survival period is 90 days.

The tax-free lump-sum benefit you receive will help finance your recovery, so you don't have to change your lifestyle. You can use the money as you please to pay your mortgage, pay down debt, pay for child care, adapt your home to suit your condition, make home-care arrangements, seek alternative medical care or even take a vacation to recover from the stress of your illness.

INSURANCE TAILORED TO YOUR NEEDS

Many provincial and territorial medical associations offer insurance solutions developed exclusively for physicians. These products have been designed specifically to add value and benefit the unique needs of physicians like you from the start of medical school — and to grow with your career as you embark on your practice. Some independent insurance brokers also offer individual disability insurance products on a "volume" basis, which allows for some customization to medical students and residents.

Whatever options you choose, you should consider working with a certified insurance advisor to ensure you understand the benefits and costs of the options available to you. In particular, provincial and territorial medical association plan ownership structures benefit physicians by providing cost-effective protection that grows with your career. Individual insurance, when added to this base, can top up your foundational insurance protection and provide further tailoring to your needs.

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PROFESSIONAL LIABILITY PROTECTION

Professional liability protection provides residents with assistance in the event of medico–legal difficulty. Most health care institutions require physicians and other regulated health care providers to provide evidence of such protection. The Canadian Medical Protective Association (CMPA) provides residents and licensed physicians with medico–legal advice and assistance and, where required, pays compensation to those patients proven to have been harmed by negligent medical care. The CMPA also provides education aimed at helping physicians manage medico–legal risk in their practice and enhancing patient safety. See the CMPA website for articles and eLearning activities.

The CMPA offers a unique, occurrence-based protection, which means members are eligible for assistance regardless of when a legal claim is made, provided they were members at the time the care in question was provided. The CMPA also protects retired members and the estates of deceased members. Because the CMPA is not an insurance company, it does not charge premiums for its service. Physicians pay a membership fee to the Association based on the type of medicine and the region in which they practice. Members can contact the CMPA's medical officers for advice on a broad spectrum of medico–legal difficulties arising from their professional work in Canada, including:

- Civil legal action arising from a member's professional work
- Regulatory authority (College) complaints and investigations
- Coroners' inquests or other fatality inquiries

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CMPA FEE SCHEDULE FOR 2012

Description (type of work code)	Fees Ontario	Fees rest of Canada[5]
Allergy (40)	$696	$1,152
Anesthesia (90)	$4,896	$3,552
Assistance at Surgery — no other professional work (33)	$336	$888
Cardiac Surgery (91)	$4,896	$4,788
Cardiology (70)	$1,428	$1,728
Chronic Pain Management without general or spinal anesthesia (38)	$696	$1,152
Clinical Associates — on a medical service (31)	$336	$888
Clinical Associates — on a surgical service (32)	$336	$888
Clinical Fellow — no moonlighting (13)	$300	$888
Clinical Immunology (42)	$696	$1,152
Community Medicine (Public Health) (28)	$396	$1,152
Dermatology (44)	$900	$1,728
Diagnostic Imaging (45)	$900	$2,544
Emergency Medicine/Emergentology (82)	$1,500	$3,552
Endocrinology (46)	$696	$1,152
Family Medicine or General Practice (35)[1]	$648	$1,152
Family Medicine or General Practice (73)[2]	$648	$2,544
Family Medicine or General Practice (79)[3]	$1,200	$2,616
Family Medicine or General Practice (78)[4]	$1,200	$4,788
Gastroenterology (47)	$900	$2,544
General Surgery (83)	$3,492	$10,800
Genetics (48)	$336	$888
Gynecologic Surgery without labour and delivery (84)	$3,492	$3,552
Hematology (50)	$900	$2,544

- Billing audits or inquiries
- Hospital privilege matters
- Criminal proceedings arising from a member's professional work
- Some general contract and research contract matters
- Privacy legislation breaches and privacy complaints
- Human rights complaints

DID YOU KNOW?

If you will be treating non-resident patients either regularly or occasionally, you may also need to supplement your medical malpractice protection with special non-resident coverage. For example, a renowned Canadian plastic surgeon's foreign patients regularly travel to Canada; if a patient later feels aggrieved, the surgeon runs the risk of having a lawsuit brought against him or her from the patient's home country. Regular medical malpractice protection may not suffice in this case. The same risk exists for family physicians and other specialists who may treat non-resident patients. No successful physician has the kind of time it takes to find and consult lawyers in foreign countries, or to travel extensively to participate in depositions and court-related activities — let alone any desire to place personal assets at the disposal of lawyers and legal systems. Talking to an insurance expert is the best way to protect yourself.

TAX TREATMENT OF CMPA MEMBERSHIP DUES

The annual membership fee paid to the CMPA (less any rebate from a provincial reimbursement or other program) is deductible as an expense against business income earned as a self-employed medical practitioner. However, the rules for a salaried physician (such as a resident or salaried Fellow) are slightly more complex. Be sure to discuss the deductibility of CMPA membership dues with your tax advisor.

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

CMPA FEE SCHEDULE FOR 2012 (CONT'D)

Description (type of work code)	Fees Ontario	Fees rest of Canada[5]
Administrative Medicine — no clinical contact (20)	$336	$888
Infectious Diseases (52)	$336	$888
Intensive/Critical Care (53)	$696	$1,152
Internal Medicine (54)	$900	$2,544
Medical Biochemistry (24)	$336	$888
Medical Microbiology (25)	$336	$888
Medical Oncology (59)	$696	$1,152
Missionary or Charitable Work Abroad excluding the USA (8)	$300	$336
Neonatology (66)	$900	$3,552
Nephrology (55)	$696	$1,152
Neurology (56)	$900	$4,788
Neurosurgery (92)	$4,896	$23,256
Nuclear Medicine (58)	$336	$888
Obstetrical/Infertility practice without labour, delivery and/or surgery (39)	$696	$1,152
Obstetrics with or without Gynecology (93)	$4,896	$14,292
Occupational Medicine (51)	$696	$1,152
Ophthalmology (60)	$900	$3,552
Orthopedic Surgery (94)	$4,896	$10,800
Otolaryngology (77)	$1,500	$3,939
Pathology — Anatomic (21)	$396	$2,544
Pathology — General (22)	$396	$2,544
Pathology — Hematological (23)	$336	$888
Pathology — Neurological (26)	$336	$888
Pediatrics (61)	$900	$3,552
Pediatric Surgery (85)	$3,492	$3,936
Physical Medicine and Rehabilitation/Physiatry (27)	$336	$888
Plastic Surgery (86)	$3,492	$7,248
Psychiatry and/or Addiction Medicine (36)	$648	$1,152
Radiation Oncology (65)	$696	$1,152
Respiratory Medicine (62)	$900	$1,728
Rheumatology (63)	$900	$2,544
Sport Medicine (64)	$696	$1,152
Surgical Consultations/Office Surgical Practice (37)	$648	$1,728
Teaching/Research Work Abroad excluding the USA (9)	$300	$336
Thoracic Surgery (87)	$3,492	$4,788
Trainees — no moonlighting (12)	$300	$1,152
Trainees — with moonlighting (14)	$300	$1,152
Urology (88)	$3,492	$3,552
Vascular Surgery (89)	$3,492	$4,788

1. Excluding anesthesia, obstetrics (labour and delivery), shifts in the emergency department, and surgery.

2. Primary professional work in family medicine including shifts in the emergency department. If working primarily in the emergency department, choose code 82.

3. Including anesthesia and surgery. Also includes shifts in the emergency department.

4. Including obstetrics (labour and delivery). Also includes anesthesia, surgery and shifts in the emergency department.

5. Excluding Quebec.

chapter 5

medical law

Two key medico-legal issues new physicians should keep top of mind are those of informed consent and disclosure of adverse events. Taking the time to obtain informed consent from a patient prior to treatment has shown to be "good medicine" indeed. Patients need to know the nature of the proposed investigation or treatment and its anticipated outcome, as well as the significant risks involved and any reasonable alternatives to the treatment. In the event the treatment does not go as anticipated and the patient experiences an adverse clinical outcome, it is important for the physician to discuss the unanticipated outcome with the patient or, with the patient's permission, the family.

The following Canadian Medical Protective Association (CMPA) publications are available online at cmpa-acpm.ca or in print by request:

1. *Consent: A Guide for Canadian Physicians.* Kenneth G. Evans, BSc, BEd, LLB
2. *Communicating with your patient about harm: Disclosure of adverse events.* Ottawa, ON: Canadian Medical Protective Association; 2008.

THE BASICS OF INFORMED CONSENT

1 Tell the patient the diagnosis. If there is some uncertainty about the diagnosis, mention this uncertainty, the reason for it and what is being considered.

2 Disclose to the patient the nature of the proposed treatment and its gravity, as well as any material and special risks relating to the treatment in question. Even if a risk is a mere possibility that ordinarily might not be disclosed, if its occurrence carries serious consequences — paralysis or death, for example — it must be regarded as a material risk requiring disclosure.

3 Be aware of Telehealth encounters. Telehealth can present a unique set of circumstances that may be novel to both the patient and the healthcare providers. In such circumstances an explicit consent process may be prudent. Areas a physician might consider addressing in the consent process would include the limitations of this assessment modality; alternative assessment options; roles and accountabilities of the participants; ongoing care responsibilities; and the capabilities and limitations of the technology, including backup plans in the event of a technology failure.

4 Answer any specific questions posed by the patient. The patient must always be given the opportunity to ask questions about the risks involved in the proposed treatment.

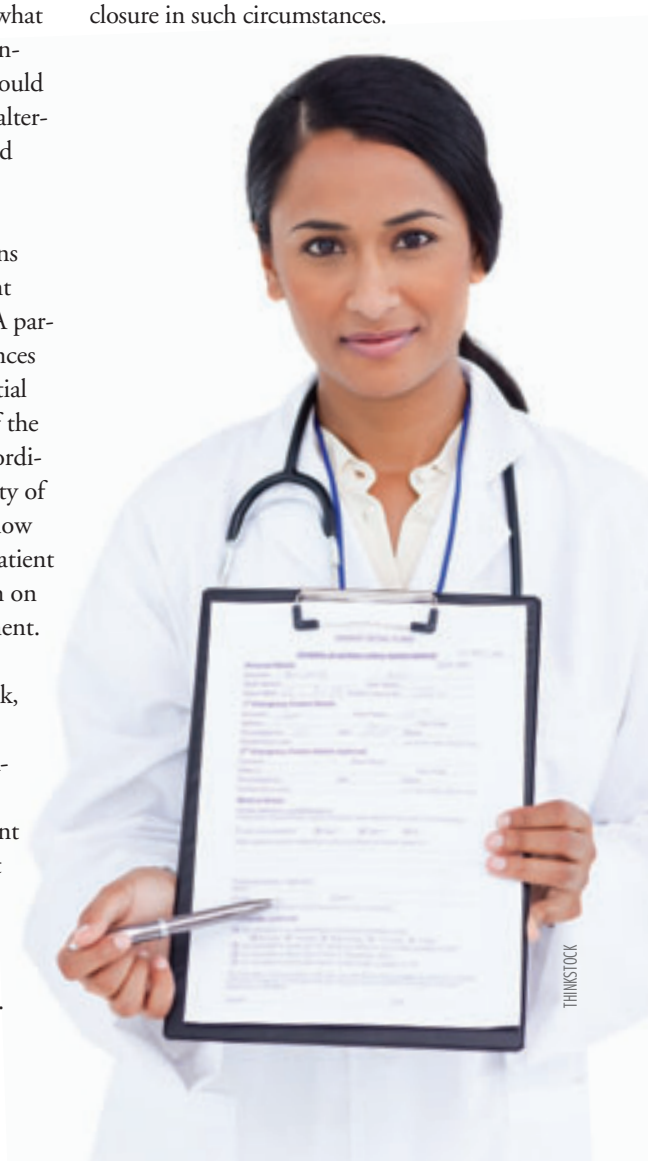
5 Inform the patient about the consequences of leaving the ailment untreated. Although there should be no coercion by frightening patients who refuse treatment, you have an obligation to inform patients about the potential consequences of their refusal.

6 Inform the patient about reasonable alternative forms of treatment and their risks and benefits. There is no obligation to discuss what might be clearly regarded as unconventional therapy, but patients should be made aware of other accepted alternatives and why the recommended therapy has been offered.

7 Be alert to a patient's concerns about the proposed treatment and address them appropriately. A particular patient's special circumstances might require disclosure of potential (although uncommon) hazards of the treatment when these might not ordinarily be seen as material. The duty of disclosure extends to what you know (or should know) the particular patient would deem relevant to a decision on whether or not to undergo treatment.

8 Do not fall into the "don't ask, don't tell" trap. Although a patient may wave aside all explanations, ask no questions, and be prepared to submit to the treatment whatever the risks may be without any explanatory discussion, you must continue to exercise your obligation to provide sufficient information for informed consent.

9 Pay special attention in obtaining consent for optional or cosmetic procedures. When obtaining consent for cosmetic surgical procedures, or for any type of medical or surgical work that may be less than entirely necessary to the physical health of the patient, you must take care in fully explaining the risks and anticipated results. As in experimental research situations, courts may impose a higher standard of disclosure in such circumstances.



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10 Do not guarantee results. Encouragement about optimistic prospects for the results of treatment should not allow for misinterpretation by the patient that results are guaranteed.

11 Who else is caring for the patient? Where part or all of the treatment is to be delegated, patients need to know that others will be involved in their care. Consent explanations should include such information.

12 Write it down! A written note documenting the consent discussion can later serve as important confirmation that a patient was appropriately informed, particularly if the note refers to any special points that may have been raised in the discussion.

The Canadian Medical Protective Association posts a number of risk management resources on its website. The CMPA's current online medico-legal resources include articles on documentation and consent. For more information, please feel free to visit the Association's website at www.cmpa-acpm.ca.

Alternatively, member physicians can also contact the CMPA at 1 (800) 267-6522. If members do so, they will be placed in contact with a medical officer who can provide them with confidential medico-legal advice.

EMERGENCY TREATMENT

The general rule that consent must be obtained before treatment is administered comes with an important exception: in cases of medical emergency when the patient (or substitute decision-maker) is unable to consent, a physician has the duty to do what is immediately necessary in the interests of the patient, without consent. For the physician to declare any clinical situation an emergency for which consent is not required, there must be demonstrable severe suffering or an imminent threat to the life or health of the patient. It cannot be a question of preference or convenience for the health care provider; there must be a clear and certain need to proceed at the time. Further, in medical emergency situations, treatments should be limited to those necessary to prevent prolonged suffering or to deal with imminent threats to life, limb or health.

Even when the patient is unable to communicate in medical emergency situations, his or her known wishes must be respected. Before proceeding, the physician will want to be satisfied there has been no past indication, by way of an advance directive or otherwise, that the patient does not want the proposed treatment. Further, as soon as the patient is able to make decisions and regains the ability to give consent, a proper and informed consent must then be obtained for additional treatment. In some provinces, legislation permits the designation of a substitute decision-maker to provide or refuse consent on behalf of the incapacitated patient. If the substitute decision-maker is immediately available, emergency treatment should proceed only with the consent of that individual.

In urgent situations, it may be necessary or appropriate to initiate emergency treatment while steps are taken to obtain the informed consent of the patient or the substitute decision-maker, or to determine the availability of advance directives. However, the instructions as to whether to proceed or not must be obtained as quickly as practicably possible.

When an emergency dictates the need to proceed without valid consent from the patient or the substitute decision-maker, a contemporaneous record (at the time) should be made explaining the circumstances that forced the physician's hand. If the circumstances are such that the degree of urgency might be questioned at a later date, arranging a second medical opinion would be prudent if possible.

THE BOTTOM LINE

When the patient (or substitute decision-maker) is unable to consent and there is demonstrable severe suffering or an imminent threat to the life or health of the patient, a physician has the duty to do what appears immediately necessary without consent. Emergency treatments should be limited to those necessary to prevent prolonged suffering or to deal with imminent threats to life, limb or health. Even when the patient is unable to communicate, his/her known wishes of must be respected.

THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION

The Canadian Medical Protective Association (CMPA) is a not-for-profit, physician-owned medical liability protection organization providing education, advice and legal assistance to physicians in Canada. The CMPA also assists physicians in identifying and managing risk in promoting safer medical care. Any physician licensed to practice in Canada (including medical residents) is eligible for CMPA membership. The CMPA's membership fees are based on specialty or type of work; they are also calculated on a regional basis. There are three fee regions in Canada: Ontario, Québec and rest of Canada. CMPA fees are paid by members directly to the Association. In all provinces and territories, the government provides a reimbursement program to physicians for their liability protection fees.

DISCLOSING ADVERSE EVENTS TO PATIENTS

ADVERSE EVENTS AND LITIGATION

Patients and families litigate for a variety of reasons. While financial need is certainly a factor, disappointment and anger over poor clinical outcomes or unfulfilled expectations also play significant roles. Surprise at unanticipated outcomes or the incidental discovery of important undisclosed details in and around an adverse event are also strong motivators. Patients and families sometimes state that litigation is an attempt to find out what happened after other attempts at communication and inquiry have not successfully answered their questions. Litigation may also be an attempt to change the system so that similar events do not recur.

There is some evidence to suggest that physicians who have a good bedside manner and a caring attitude, and who support their patients through an adverse event, may be less likely to be sued.

Physicians react to unexpected complications and poor clinical outcomes for their patients in a variety of ways. Most want to understand what went wrong. Moreover, most physicians experience a great sense of personal responsibility and are self-critical when an adverse event affects a patient. There is sometimes a tendency to attribute the cause of the harm to others before all of the contributing circumstances and facts are even known. All physicians are motivated to prevent, to the extent possible, the adverse event from happening again.

WHAT IS AN ADVERSE EVENT?

Adverse clinical outcomes are not usually caused by negligence or fault. In fact, most adverse events — events that result in unintended harm to the patient and that are related to the care and/or services provided to the patient, rather than to the patient's underlying medical condition — are an inevitable part of clinical practice, even with the best of care. In the courts, the medical standard of care to determine a physician's negligence or fault is not one of perfection, but rather the standard of care that might reasonably have been applied by a colleague in similar circumstances. The courts rely heavily upon the testimony of other physicians working in a similar specialty in the same kind of practice to help establish the applicable standard of care.

The term "adverse event" refers to harm from healthcare delivery. Adverse events therefore include harm

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related to the risks inherent in investigations and treatments but also harm from system failures or issues in provider performance, some of which are medical errors. The WHO uses a different terminology focused on "patient safety incidents" and this is being introduced to Canada. Whatever the terminology used, many of those charged with improving patient safety dislike the term "medical error" because it carries a sense of blame or fault that may be inappropriate, especially when it is used before all the circumstances and facts about a case are known.

DISCLOSURE OF ADVERSE EVENTS TO PATIENTS

It is an ethical, a professional and a legal obligation to disclose to patients the occurrence and nature of adverse outcomes as soon as is reasonable to do so. Ideally, the communication of adverse events should be done in a gentle, non-rushed manner in a private setting. It is important to formulate a plan of communication prior to approaching the patient and/or family. But remember: Prior to communicating directly with patients who have commenced legal action against them, members should consult the CMPA and/or legal counsel.

TIPS FOR DEALING WITH ADVERSE EVENTS

1 Deal with any emergencies and immediate health concerns.

2 Residents involved in an adverse event should report it to their supervising physicians and are encouraged to be present to observe the disclosure discussion as a learning experience. If time allows, CMPA members may wish to seek telephone advice from the association prior to communicating with the patient, family or hospital involved.

3 Give your patient factual clinical information about what has happened and the clinical nature of his/her condition as it now exists. Avoid speculation about what may have happened if a different course of action had been followed. Avoid attribution of blame, particularly concerning the care provided by others.

4 Provide recommendations to deal with the medical condition as it now exists, including alternate treatments and the risks and benefits of any other investigations and treatments. This is an informed consent discussion on how to move forward. Answer your patient's questions about the proposed treatments.

5 Maintain close communication with your patient and the family (with the patient's consent) about the ongoing clinical condition and any further plans for treatment.

6 Facilitate any necessary treatments and consultations.

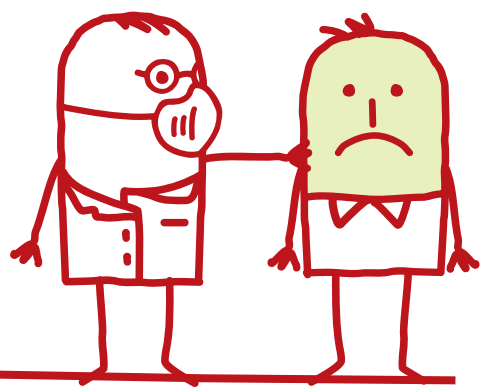
7 Transfer the care to another physician if your patient requests or prefers it, or if the condition requires care that you cannot provide.

8 Express your feelings of empathy, sorrow and concern as appropriate. Sharing your sincere regret about what has happened, or wishes that the event had not occurred, is an entirely acceptable and desirable response. Sometimes, if the outcome is indisputably due to your improper care, you may acknowledge your responsibility.

9 Inform your patient about any process through which the incident may be investigated, but be aware that there may be limitations on what information may be made available from further analysis.

10 Document your care and the discussions that occurred in a factual way after the adverse event. Never alter the record or change what had been written previously in any way.

11 Call the CMPA if you are concerned about potential medico-legal problems as a result of the incident.



TORONTO, ON

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You could be forgiven for mistaking Dr. Mike Evans' video *23 ½ Hours* for Internet entertainment. But look beyond the 'cool factor' and lightning fast hand-animation, and what you find is a powerful new approach to health education. With over 5 million hits and global media attention, Dr. Evans is connecting with people in an exciting new way. Find out more about how doctors like Mike Evans are making health care better. **DOCSFORPATIENTS.CA**

Dr. Mike Evans.
Physician.
Storyteller.

Photo: Sugino Studio Creative: Scott Thornley + Company STCworks.ca

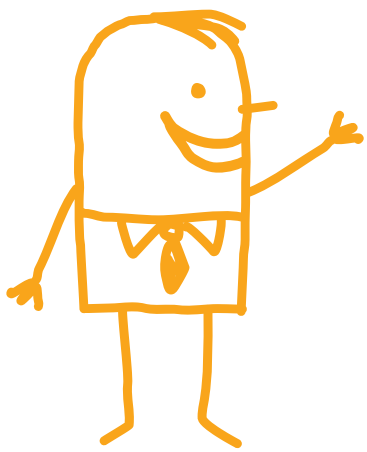
Canada's Doctors.
Innovating for Patients.

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

chapter 6

so... you're finishing residency

The finish line is in sight and you're excited to start your own practice, but this next stage can leave you more confused than you were on your first day in med school. Which applications do you have to complete and when? Are you sure you have all the certifications you need? How much is all of this going to cost? Will someone please just tell you what to do?! This final chapter will help you with the administrative side of transitioning from residency to medicine.



FINAL STEPS

Between exam prep, increased clinical duties, research requirements, and other academic and clinical responsibilities, senior residents have very limited time and resources. The key to avoiding costly delays in beginning your practice is careful planning to ensure you satisfy all administrative and legal requirements. Although the demands of each situation are unique, the following points should be addressed before you can begin your medical practice.

HOSPITAL PRIVILEGES

Most graduating residents will require hospital privileges. Filling out an Application for Hospital Privileges can be time-consuming and usually requires significant documentation, including photocopies of medical license(s), malpractice insurance certificates, records of immunizations, Curriculum Vitae, Certificates of Good Standing, etc. A fee (about $100 to $150) may be charged and the receipt should be retained for tax purposes. The accreditations committee of many hospitals only meets on a periodic basis. Try to have your completed application submitted and approved prior to their planned meeting to avoid unnecessary delays in granting your hospital privileges.

Today, many hospitals require verification that there are no criminal convictions against the applicant on the national police databank, so a Certificate of Adult Criminal Convictions is requested. This will require completion of an application at the local police department and will take several days to one week of processing time. The cost is nominal ($25 to $50, plus applicable taxes). Keep your receipt for tax purposes.

FELLOWSHIP IN THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

As a resident enrolled in one of the 66 recognized specialty and subspecialty disciplines, you are invited to become a Resident Member of the Royal College of Physicians and Surgeons of Canada (Royal College) (email membership@royalcollege.ca). Residents sit their respective Certification Examination in their final year of training, and must apply one year in advance to confirm their eligibility to write the Certification Examination. Residents are encouraged to visit the Royal College website (www.rcpsc.medical.org) to obtain up-to-date information on the application process, credentials and examination dates, or via email at info@royalcollege.ca.

Successful completion of the examination, which may include both written and oral examinations, means that you are certified to practise in your particular specialty or sub-speciality. You are then invited to become a Fellow of the Royal College, which allows you to use the prestigious designation of FRCSC or FRCPC, the symbol of your high-quality training and commitment to lifelong learning. Receipts for examination fees as well as membership should be kept for tax purposes.

MAINTENANCE OF CERTIFICATION (MOC) — ROYAL COLLEGE

Fellows of the Royal College are required to participate in the Maintenance of Certification (MOC) program, which demonstrates their ongoing commitment to continuing professional development and provides patients, employers, medical regulatory authorities and peers with evidence of continued competency. The Royal College works with medical regulatory authorities to keep the MOC program aligned with physician revalidation requirements. For more information, visit www.rcpsc.medical.org.

The MOC program reflects the Royal College's commitment to lifelong learning as a professional obligation throughout a Fellow's career. Participation in the program enables Fellows to identify gaps between actual and optimal

performance, participate in educational activities and document the impact of learning on practice.

The MOC program is based on a five-year cycle, with the first cycle beginning on January 1 of the year following admission to Fellowship. Fellows complete a minimum of 40 credits in each year of a cycle by participating in continuing professional development activities and reporting the outcomes of those activities, and 400 credits during the span of a cycle. Fellows are asked to self-report completed learning activities on or before January 31 of each year using MAINPORT at www.mainport.org.

CERTIFICATION IN THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC)

When entering a Family Medicine residency program in Canada, trainees are automatically registered as "resident" members of the CFPC. In their final year of training, residents sit the Certification Examination in Family Medicine. Following successful completion of the exam, the program director notifies the CFPC of the physician's success at the end of residency and the candidate is moved from resident to certified status. At that point, the physician is entitled to use the designation Certificant of the College of Family Physicians. Following your certification, the CFPC will automatically notify the provincial chapter of CFPC, as well as the College of Physicians and Surgeons of the province or territory of your practice.

MAINPRO — CME REQUIREMENTS FOR CFPC MEMBERS

All CFPC members who are in full- or part-time practice are required to participate in the College's Continuing Medical Education (CME) program, referred to as Mainpro®. Both certificant and noncertificant members are required to submit a total of 250 credits every five years. The five-year cycle begins on January 1 following attainment of certification or membership. Residents, however, may carry forward a maximum of 30 Mainpro-M1 and five Mainpro-C credits into their first Maintenance of Certification five-year cycle. For further details, visit the CFPC website at www.cfpc.ca

LICENSURE IN YOUR PROVINCE/TERRITORY

Upon successful completion of either the FRCPC or CCFP exams, the respective national authority will communicate your success to the provincial or territorial authority where you will ultimately practise. Nevertheless, a complete application for membership to that provincial or territorial college must be made prior to beginning practice, with the understanding that your subsequent exam success will be transmitted at a later date. The application can be time-consuming and is not free. Hospital privileges are generally dependent upon successful admission to membership in the College of Physicians and Surgeons of your province or territory of practice. Applications for registration in the provincial or territorial College are generally assessed in the order received, with the peak period running from March to July. As such, it is advisable to contact your college in a timely fashion. For example, contact the college in April if you intend to begin practice in June or July, to ensure that all required documentation will have been provided and that approval may be granted prior to the intended date of practice.

PROVINCIAL/TERRITORIAL MEDICAL ASSOCIATION MEMBERSHIP

Membership in your respective provincial/territorial medical association is generally a requirement to practise medicine in that jurisdiction. Although this application may sometimes be made subsequent to initiation of practice, it is wise to plan and budget for this requirement. While fees vary among jurisdictions, annual dues are often pro-rated for those practicing for only a portion of the year, and discounts are sometimes available for physicians in their first and even their second year of practice. The graduating resident should contact his or her medical association to obtain the necessary application documents and enquire as to availability of discounts. Remember to keep your receipts for tax purposes.

MALPRACTICE INSURANCE

It is imperative that your malpractice insurance is in force on the date you begin your medical practice. Fortunately, many residents have a portion or all of their Canadian Medical Protective Association (CMPA) dues paid by their employers. Upon graduation, however, the medical practitioner must arrange his or her own malpractice coverage. Prior to graduation, the senior resident should contact the CMPA (1-800-267-6522) to ensure that a successful transition will be arranged and coverage will be in force upon beginning practice. The Ministries of Health of several provinces offer partial reimbursement of CMPA dues, depending on the jurisdiction and specialty of the practitioner. In addition, funding arrangements may be in place to allow minimal disruption of cash flow for the physician — a significant benefit for those in their first year of practice. Residents should contact their provincial

medical association or Ministry of Health regarding the availability of such benefits.

For those physicians who during their practice find themselves treating non-residents in non-emergent conditions, obtaining malpractice insurance for non-residents in addition to CMPA coverage, may be considered.

OBTAINING A BILLING NUMBER

Unlike the guarantee of employment income during residency, the vast majority of new family physicians and specialists will earn business income (i.e., fee-for-service). To be able to bill for services provided, a new practitioner must obtain a billing number from his or her province's Ministry of Health in a timely fashion. However, eligibility for a fee-for-service billing number is generally contingent on successful registration with the College of Physicians and Surgeons of that province or territory, as indicated above. Without an approved billing number, you may not be able to bill for services provided or the revenue from such billing may be delayed, reducing your needed cash flow. Applying for a billing number early will minimize the usual administrative delay before the first payment arrives.

COMMUNICATION WITH YOUR MEDICAL SCHOOL AND PROVINCIAL RCPS/CFP

Generally, applications for hospital privileges or membership to your provincial College of Family Physicians or College of Physicians and Surgeons require a record of good standing from your medical school and/or the appropriate regulatory body of any province where you practised medicine during your training. Although some provinces and territories may issue a Certificate of Standing without charge, most will require a small fee ($25 to $100, plus other applicable fees). Once again, keep these receipts for tax time.

CHANGE OF ADDRESS

As you begin professional life as a qualified specialist or family practitioner, don't forget to send your forwarding address and contact number to all pertinent individuals and organizations to ensure that no important documentation is lost or misdirected. Your program director, departmental secretary, provincial residency association and financial institutions, as well as the payroll department of your hospital, student accounts of your university and the Canada Revenue Agency, should receive your forwarding address and contact numbers. Consider having Canada Post forward your mail to your new address. This inexpensive (e.g., $37.50 plus taxes for six months) and convenient service can be accessed online at canadapost.com.

MOVING COSTS

Those residents relocating more than 40 km to a new site of employment or practice may be able to deduct certain moving costs not reimbursed by a potential employer against income from the new location. This may include travel costs, transportation costs for belongings, and meals during travel, as well as lodging for a reasonable period while you are waiting for your new residence (usually up to 15 days). The costs of selling a former residence, including advertising, notary or legal fees, real estate commissions and mortgage penalties (i.e., if the mortgage was paid off before maturity) are also eligible. Individuals have the choice of calculating certain travel costs for the purpose of moving expense deduction based on either a detailed or a simplified method (e.g., gas receipts for travel versus a set cost per km rate). For more information, consult your financial advisor or go to cra-arc.gc.ca and search for "moving expenses."

TAKE ADVANTAGE OF THE BENEFITS OF BEING A STUDENT

One of the last things residents may do before completing residency is avail themselves of student rates when booking travel and accommodations to the designated site of their certifying exams. Residents are eligible for an International Student Identity Card (ISIC) and can book travel through TravelCuts, a travel agency with offices on most campuses. ISIC membership provides the convenience of a travel agency and generates considerable benefits and savings on both travel arrangements and accommodation. In addition, membership provides increased flexibility with regard to advanced purchase requirements and allows increased leniency in making changes to existing airline reservations. Membership is inexpensive and can be obtained at a TravelCuts office or at travelcuts.com. Furthermore, students attending a Canadian Federation of Students (CFS) member school, such as the University of Toronto, may be entitled to free membership. In addition, the prudent resident may wish to renew subscription to select journals to get preferential student rates.

— This article was originally published by Dr. Brian E. Cummings for the CMA Practice Management Curriculum for Medical Residents.

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

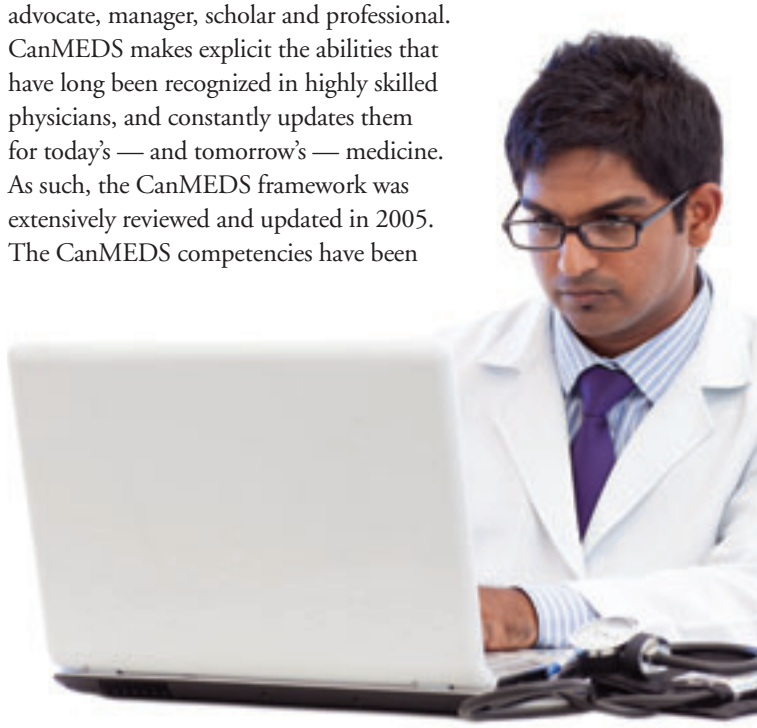
You will connect with the Royal College when you start the application process to take your specialty certification exam. Many residents think the Royal College is a licensing or disciplinary body; however, that is not the case. The Royal College is the national, not-for-profit organization responsible for overseeing the medical education of specialists in Canada (approximately 60 specialty disciplines in 2012). The Royal College advances the highest standards and quality of health care and contributes to the improved health of Canadians on behalf of over 44,000 members. The Royal College supports its members by encouraging lifelong learning and performance assessment from residency to retirement; influencing health policy development and contributing to health system renewal; and providing funds for awards, grants, fellowships, visiting professorships, clinical traineeships, continuing medical education and medical research.

While your relationship with the Royal College will encompass much more than just the exams over the course of your professional life, the exams are likely your primary concern at this point in your career. The Royal College develops and administers certification exams to over 2,900 candidates annually. Exams for specialties take place in the spring, subspecialty examinations in the fall. The organization's ability to deliver certification exams is largely dependent upon the contribution and dedication of over 1,800 Fellows. These volunteer medical specialists and other professionals offer their time, energy and wide-ranging skills, providing invaluable expertise, experience and perspectives to ensure high standards are reflected in the certification exams.

When you complete the postgraduate residency education requirements and pass the exams, you are granted Royal College certification — evidence that you have met a single national standard for competency in specialty medicine. You will then be invited to join the Royal College and become a Fellow, earning the right to use the professional designation of FRCPC for physicians and FRCSC for surgeons. This professional designation signifies to patients, peers and regulatory authorities that you have met the high standards for specialty training and are committed to lifelong learning.

THE MAJOR FUNCTIONS OF THE ROYAL COLLEGE ARE TO:

SET STANDARDS IN POSTGRADUATE MEDICAL EDUCATION: The Royal College sets the requirements for specialty postgraduate medical education over 60 areas of medical, surgical and laboratory medicine. As a leader in specialty medicine, the Royal College responds to and helps shape the medical education environment so that future medical specialists are competent and equipped to better meet the health needs of society. You are no doubt familiar with the Royal College's CanMEDS Physician Competency Framework, which is organized around seven roles: medical expert (central role), communicator, collaborator, health advocate, manager, scholar and professional. CanMEDS makes explicit the abilities that have long been recognized in highly skilled physicians, and constantly updates them for today's — and tomorrow's — medicine. As such, the CanMEDS framework was extensively reviewed and updated in 2005. The CanMEDS competencies have been



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integrated into the Royal College's accreditation standards, objectives of training, final in-training evaluations and exam blueprints, as well as the Maintenance of Certification program.

ASSESS AND ACCREDIT RESIDENCY PROGRAMS: The Royal College accredits the specialty residency program, which involves regular reviews of the training programs and resources of over 750 specialty residency programs in 17 faculties of medicine to ensure they continue to meet the standards set by the Royal College.

ASSESS TRAINING AND CREDENTIALS OF RESIDENTS: The Royal College assesses the training and credentials of approximately 2,000 residents annually to determine their eligibility to write the Royal College certification exams.

PROMOTE SCHOLARSHIP AND INNOVATION: Each year, the Royal College distributes more than $1 million through its awards, grants, fellowships and visiting professorships.

SUPPORT PROFESSIONAL DEVELOPMENT AND LIFELONG LEARNING: The Royal College maintains high standards in continuing professional development through its Maintenance of Certification (MOC) program, which is mandatory for Fellows and also leveraged by other health care professionals. The MOC Program offers a framework that promotes the enhancement of practice-based learning and specialty-specific knowledge, skills, attitudes, performance and, ultimately, health outcomes. The Royal College's innovative online tool and features within MAINPORT (royalcollege.ca) help Fellows plan learning activities, track total learning hours, and document learning outcomes and specific learning activities in a simple and convenient way.

INFLUENCE HEALTH POLICY: The Royal College contributes to shaping key issues in specialty medicine and health care by engaging governments, partners and stakeholders in dialogues on patient safety, timely access to quality care, physician health and well-being, and health human resources. Work in this area includes conducting health policy analyses and research, and advocating with external stakeholders including federal, provincial and territorial governments and other medical organizations for sound health policy to meet societal health needs.

COMMUNICATE WITH MEMBERS: To recruit, retain and serve its members, the Royal College implements activities to better understand the needs and interests of its current and prospective members, conditions and trends in the environments in which they work, and whether its products and services address those needs and conditions. To this end, the Royal College regularly conducts surveys of current and prospective members.

REGISTERING FOR A ROYAL COLLEGE CERTIFICATION EXAM

As a resident in one of the accredited specialty residency programs of the Royal College of Physicians and Surgeons of Canada, you are progressing toward the Royal College examinations and certification in your specialty.

Please note, above all, that neither the Royal College nor your university can initiate the assessment process for a resident. It is your responsibility, as a resident, to establish and maintain your professional relationship with the Royal College.

Residents who wish to take the specialty certification examination of the Royal College must first have their residency training assessed by the Royal College to ensure that the specialty specific training requirements have been met in a program that is recognized and approved by the Royal College. Applicants must contact the Credentials Unit one year before they wish to write the examination and apply for a Preliminary Assessment of Training. You are encouraged to apply well in advance of the application deadlines to avoid late penalty fees.

THERE ARE TWO EXAMINATION PERIODS

SPRING FOR PRIMARY SPECIALTIES. The assessment deadline is April 30, one year before you wish to take the examination (for example: for example, April 30, 2013 for the examinations of 2014); examination registration deadline is February 1 of the year you write the examination.

FALL FOR SUBSPECIALTIES. The assessment deadline is August 31, one year before you wish to take the examination (for example: August 31, 2013 for examinations in fall 2014); examination registration deadline is May 15 of the year you write the examination.

PRELIMINARY ASSESSMENT OF TRAINING

The Application for Preliminary Assessment of Training is not intended for applicants who have completed their postgraduate training outside of Canada or the United States. Please visit the Royal College website for alternate routes to certification for International Medical Graduates for additional information.

Complete and submit the Application for Preliminary Assessment of Training before April 30, one year before you wish to take the certification exams. Attach the appropriate application fee to your application, payable by credit card. Credit card authorization forms are included with the application package. As of January 1, 2013, the following fees apply:

PRELIMINARY ASSESSMENT OF TRAINING . . . . . .$620.00 Cdn

EVALUATION OF AN ADDITIONAL SPECIALTY . . . .$315.00 Cdn

SURCHARGE FOR ASSESSMENT OF U.S. TRAINING . . . . . .$340.00 Cdn

Submit the application form, supporting documents and application fee by the deadline of April 30, 2013, in consideration for the examinations in the spring of 2014.

BY FAX:
613-730-3707

BY MAIL:
Royal College of Physicians
and Surgeons of Canada,
Credentials Unit,
774 Echo Drive,
Ottawa, ON K1S 5N8, Canada

The application process for a Preliminary Assessment of Training may take up to six–eight months to be completed. Applicants will receive a ruling letter outlining the decision for their examination eligibility by December. Following the receipt of the ruling letter, the deadline to register for the spring 2013 examinations will be February 1, 2013.

For further information on how to apply, please visit the Credentials and Examinations web page at royalcollege.ca. Questions about applying for assessment can be addressed to the Credentials Unit of the Royal College by email at credentials@royalcollege.ca or by telephone at 1-800-668-3740.

SURGICAL FOUNDATIONS EXAMINATION

All applicants in the following surgical specialties must successfully complete the Surgical Foundations examination to obtain eligibility for the final examinations in their surgical specialty: Cardiac Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery and Urology.

Applicants to the Surgical Foundations examination must also complete and submit an Application for Preliminary Assessment of Training as well as the fee of $620 by the deadline of April 30, 2013 for examinations in the spring of 2014.

If you have already been assessed for the Royal College's Surgical Foundations examinations (surgical specialties only), you are not required to complete another Application for Preliminary Assessment of Training, but you must contact the Credentials Unit in writing at credentials@royalcollege.ca by April 30 of the year before you intend to take your final surgical specialty examination in order to continue the assessment of your final years of training. When contacting the Credentials Unit, please provide the following information: your full name, your surgical specialty, the year you intend to take the final surgical examination, dates and rotations of your final years of residency training, proposed end of training date, and name and contact details for your program director.

EXAMINATION REGISTRATION

Following the receipt of the assessment ruling letter from the Royal College Credentials Unit, you will be sent (via email) a notice of registration by the Exam Administration unit to complete and submit the exam registration forms and payment to the Royal College, before February 1 (specialty exams) or May 15 (subspecialty exams) of the examination year.

Registration is not considered complete unless the examination fee is submitted with the registration forms. Submit a cheque or money order for the appropriate exam fee (Canadian dollars) with your registration forms. Payment by credit card is acceptable only if a credit card authorization form is completed.

Note that there is no opportunity for late registration. If you miss the exam registration deadline, you will be required to wait until the following year to take the examination.

PRINCIPLES OF SURGERY:.....$700 Cdn

COMPREHENSIVE.....$3,725 Cdn

OBJECTIVE EXAMINATION (ALL SPECIALTIES) WRITTEN ONLY.....$1,850 Cdn

(some fall subspecialties)

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

It is an exciting time for you, the resident, as you near the completion of your medical school education and training and you prepare to enter practice. For family physicians, the College of Family Physicians of Canada (CFPC) will continue to be your professional home. The following information provides you with a brief overview of the College programs and services that are in place to support you throughout your career as a family physician.

ABOUT THE CFPC

Founded in 1954, the CFPC now represents more than 28,000 members across the country. It is the professional organization responsible for establishing standards for the training, certification, and lifelong education of family physicians, and for advocating on behalf of family physicians and the specialty of family medicine. The CFPC also accredits postgraduate family medicine training in Canada's 17 medical schools.

CFPC members belong to the national college as well as to their provincial chapters. Many members serve on national or provincial committees and CFPC Sections, which support the development and advancement of family medicine policy, programs, education, research and advocacy initiatives. For further information on the CFPC, please visit www.cfpc.ca.

CFPC MEMBERSHIP

Upon successful completion of the Certification Examination in Family Medicine, residents become Active Members of the CFPC and the provincial Chapter of the College in their home province. Benefits of CFPC membership include the following:

- Potential to earn and use special designations: MCFP (Member of the College of Family Physicians of Canada), CCFP (Certification from the College of Family Physicians of Canada), and FCFP (Fellowship in the College of Family Physicians of Canada) — symbols of excellence in family medicine that are recognized worldwide
- Access to MAINPRO® (Maintenance of Proficiency) programs such as Self Learning™, which support continuing professional development (CPD)
- Preferential rates for provincial annual scientific assemblies and for Family Medicine Forum (FMF) —Canada's pre-

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miere family medicine conference — and for provincial annual scientific assemblies
- A complimentary subscription to *Canadian Family Physician* (CFP), an internationally recognized, peer-reviewed medical journal entirely devoted to the specialty of family medicine
- Access to the Section of Teachers, Section of Researchers, and the newly established Section of Family Physicians with Special Interests or Focused Practices (SIFP)
- Advocacy and policy development initiatives; the college is at the table to represent the interests of family physician members across Canada with governments, other health care organizations and key decision-makers
- Access to the services of the Canadian Library of Family Medicine
- Eligibility for grants, scholarships and awards through the CFPC Honours and Awards Program and the Research and Education Foundation
- Opportunities to be involved in the family medicine community in Canada.

INFORMATION FOR MEDICAL STUDENTS

Medical students enrolled in Canadian university faculty of medicine programs can enjoy membership with the CFPC at no charge.

Student members are welcome to join a Family Medicine Interest Group (FMIG) at their home medical school. These groups are designed to raise the awareness of and exposure to family medicine during the undergraduate medical school years, offer information about postgraduate training and practice in family medicine, and provide opportunities for networking among students across the country. Learn more about FMIGs at www.cfpc.ca/FMIGs.aspx.

The CFPC's Section of Medical Students (SOMS) links the college with medical students in each university across Canada. Representatives on the SOMS Council come from FMIGs at each medical school. The Section sends two representatives to the Board of Directors of the college, where they represent the views and interests of students in the development of college policies and positions. Learn more at www.cfpc.ca/SOMS.

Student members receive free online access to CPD programs of the College, access to research services from the Canadian Library of Family Medicine and a number of other benefits.

INFORMATION FOR RESIDENTS

All first-year family medicine residents automatically become members of the College and the CFPC's Section of Residents. The Council of the Section of Residents (the governing body of the Section) is composed of R1 and R2 representatives elected by their peers from each family medicine program. Resident members of the CFPC are also automatically enrolled in Self Learning Interactive, our online CPD program, for the duration of their studies, free of charge.

The council's mandate is to serve as a strong voice for family medicine residents. They offer a resident perspective on issues facing the CFPC and family medicine, provide input related to family medicine training in Canada, and participate in the development of CFPC initiatives and policies through representation on the CFPC Board of Directors and key college committees.

NEW CERTIFICATION EXAMINATION IN FAMILY MEDICINE

In collaboration with the Medical Council of Canada (MCC), the CFPC looks forward to implementing the new Certification Examination in Family Medicine in the spring of 2013. When meeting all other requirements of both organizations, candidates who are successful on this exam will be granted Certification in Family Medicine from the CFPC (CCFP) and the Licentiate of the Medical Council of Canada (LMCC).

The new examination responds to many requests from family medicine candidates to decrease the burden related to cost, travel, time, and the stress of preparing for and taking these two separate examinations. The exam also provides an excellent opportunity for the CFPC and MCC to share resources and work to achieve maximum efficiency.

Important information about the new exam and how to prepare for it is located on the CFPC website at www.cfpc.ca/FMExam/ and in the Q&A document.

For further information, please contact the CFPC at 2013CCFPexam@cfpc.ca or (905) 629-0900.

MAINPRO®

Mainpro (Maintenance of Proficiency) is an education program designed to support the continuing professional development of CFPC members. Participation in Mainpro is required for active members for maintenance of their college membership, Certification and Fellowship.

There are three categories of Mainpro credits: Mainpro-M1, Mainpro-M2, and Mainpro-C. All members are assigned to a five-year Mainpro cycle, during which participants must report a total of 250 credits to maintain their membership (MCFP) and certification (CCFP) designations. At least half of these credits (125) must be Mainpro-M1 or Mainpro-C credits.

Mainpro-M1 credits are linked to structured learning programs, events, or activities that focus on enhancing knowledge and skills integral to family medicine. Examples include accredited conferences, courses and workshops; accredited hospital/clinical rounds and journal clubs; interactive, Internet-based continuing medical education (CME); Self Learning; and more.

Mainpro-M2 credits are linked to self-directed, unstructured CPD/CME activities (e.g., journal reading, teaching, podcasts), as well as non-CFPC-accredited live events (e.g., American Medical Association accredited programs).

Mainpro-C credits are linked to activities that promote performance/quality improvement and include a self-reflective component. Examples include practice audits and practice-based small-group learning. For each Mainpro-C credit earned, the CFPC provides a bonus Mainpro-M1 credit. Mainpro-C credits are required for members wishing to earn Fellowship in the College.

Starting in 2013, participants must earn and report a minimum of 25 Mainpro credits each year. This year also marks the end of paper-based reporting; starting in 2013, all Mainpro participants must report their CPD activities online. Visit www.cfpc.ca/ReportCredits/ to learn more.

Participation in Mainpro is optional for resident members; however, it is encouraged to allow residents to become familiar with the Mainpro reporting system and structure, and to ease the transition from resident to active membership. As an added incentive, up to 30 Mainpro-M1, and five Mainpro-C credits earned and reported during residency will be automatically carried forward to each physician's Mainpro cycle as an Active CFPC member. For more information, visit www.cfpc.ca/Mainpro_Residents.

SELF LEARNING™

Self Learning is a CME program of the College that allows physicians to evaluate their knowledge of topics in the current medical literature. Each issue contains multiple choice questions based on peer-reviewed medical journals plus Short Answer Management Problems (SAMPs) that explore topics in greater depth. Self Learning provides your entire annual requirement for Mainpro-M1 credits.

To learn more please contact: slinfo@cfpc.ca

FAMILY MEDICINE FORUM (FMF)

FMF is the premier family medicine conference in Canada and is a great venue for academic learning, earning Mainpro credits and networking with colleagues from across the country. The three-day event includes presentations and workshops from leaders in family medicine and is attended each year by 4,000 to 5,000 family physicians, residents, medical students and other health care professionals.

FMF 2013 VANCOUVER, BRITISH COLUMBIA NOVEMBER 7 TO 9, 2013

Registrants can choose from more than 200 sessions covering a wide variety of clinical, teaching, and research presentations, as well as workshops, networking events, computer learning sessions, the exhibit hall and satellite symposia.

An FMF app is available for smart phones and tablets to help organize your schedule and submit Mainpro credits. *FMF Today*, the online FMF newsletter, provides daily updates, articles and videos. For more information, visit the FMF website at http://fmf.cfpc.ca/

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HONOURS & AWARDS

Through the CFPC's Research and Education Foundation, the Honours and Awards Program offers grants, scholarships, and awards to recognize and support family physicians, family medicine residents, and medical students committed to education, research, and excellence in family medicine practice.

For more information on the CFPC's Honours and Awards Program and submission deadlines, please visit www.cfpc.ca/aboutus/awards.

PATIENT'S MEDICAL HOME

In September 2011, the CFPC released the Patient's Medical Home position paper. Since then, we have gained a significant amount of attention from health care providers, policy-makers, and federal, provincial, and territorial governments.

Patients' Medical Homes are patient centred and are focused on meeting the health and wellness needs of each patient. They also strive to provide enhanced opportunities for patients to participate in their own care as well as in the decisions related to the delivery of services in the practice. With a team of health professionals, nurses and others working together — physically or virtually — with the patient's family physician, Canadians will benefit from timely access to comprehensive, continuing, coordinated care centred on their needs. The CFPC's vision is that every person in Canada living in a rural, suburban or urban community will have the opportunity to be part of a family practice that serves as their personal medical home.

The CFPC continues to produce "Best Advice" papers and other tools to assist family practices as they move toward achieving the goals and recommendations of the Patient's Medical Home.

We invite you to read the full document at www.cfpc.ca/A_Vision_for_Canada.

TRIPLE C

You might be aware of the CFPC's efforts to advance postgraduate family medicine education in Canada through the Triple C Competency-based Curriculum (Triple C).

The goal of Triple C is to ensure that all family medicine residents achieve readiness to begin the practice of comprehensive family medicine in any community in Canada. This renewed curriculum enhances what is taught, how it is taught and how learners are assessed.

THE TRIPLE C COMPETENCY-BASED CURRICULUM IS BASED ON THREE MAIN COMPONENTS:

1. Comprehensive care
2. Continuity of education and patient care
3. Centred in family medicine

Learn more about Triple C at www.cfpc.ca/Triple_C/ or email triplec@cfpc.ca.

SECTION OF FAMILY PHYSICIANS WITH SPECIAL INTERESTS OR FOCUSED PRACTICES

The CFPC has recently introduced an opportunity for members to network with colleagues who have similar practice interests. The new Section of Family Physicians with Special Interests or Focused Practices (SIFP) is comprised of a number of programs, each of which will address a particular area of special interest of our members.

Family physicians with special interests are those who blend one or more clinical interests into their comprehensive, broad-scope family practices, usually committing up to a maximum of 20% of their time in each of these areas.

Members interested in one or more special interest area will benefit from networking opportunities, College advocacy and policy initiatives, and programs related to lifelong learning (CME/CPD) needs. College members can find a list of the SIFP programs at www.cfpc.ca/sifp. Members interested in being linked to one or more SIFP program can do so by sending an email to sifp@cfpc.ca.

The CFPC remains committed to maintaining continuing comprehensive care as the hallmark of being a family physician, and it encourages family physicians with special interests to incorporate them into practices that offer their patients the broad spectrum of services that define family medicine.

For further information on SIFP and SIFP programs, please visit www.cfpc.ca/sifp.

CFPC VALUES ITS MEMBERS

The CFPC is dedicated to serving its members throughout their careers. We work to provide the best possible programs and services while advocating on behalf of College members for the provision of quality health care for all Canadians.

Congratulations on starting your career in family medicine. We look forward to welcoming you as a member of the CFPC!

CFPC'S FIRST FIVE YEARS IN FAMILY PRACTICE COMMITTEE

The First Five concept was developed in 2008 by the Associates in Training Committee of the Royal College of General Practitioners in the United Kingdom. The aim is to address concerns from trainees who, at the end of their training program, experience an "off-the-cliff" feeling where suddenly they are out on their own as independent practitioners in the vast and ever changing world of family practice — sound familiar?

THE FIRST FIVE CONCEPT IS BASED ON FIVE MAIN PILLARS

1. Connecting with the college: promoting a sense of belonging
2. Facilitating networks: encouraging peer support and mentoring
3. Supporting revalidation
4. Career mentorship
5. Continuing professional development

The CFPC recognizes the unique interests and challenges for new family physicians and is therefore pleased to support the new First Five Years in Family Practice Committee (FFYFP). The group has been actively developing practical resources to help support new family doctors. What follows are a few highlights.

AS A NEW FAMILY PHYSICIAN, LET US KNOW WHAT YOU NEED TO HELP SUPPORT YOUR CAREER

In 2010, we asked about the residency training experience, and how prepared new family physicians felt for the challenge of practice. We responded to the results of that survey with the development of our website (http://cfpc.ca/firstfiveyears), which focused on practice management resources.

In early 2013, FFYFP will launch its second needs assessment survey to take the pulse of what new family doctors need. We will be asking about mentorship programs, research and teaching opportunities, and the challenges of starting up a practice. We hope you have a few minutes to complete the online survey and provide your valuable input. Watch your email this spring for the survey link and further information.

GREAT PRACTICE MANAGEMENT RESOURCES

Clinical and practice management resources include the CFPC's Primary Care Toolkit; Patient Education Guide; Quality in Family Practice Book of Tools; Starting Your Practice Website; continuing professional development; information about your CFPC membership; and resources on communication, leadership, and work-life balance.

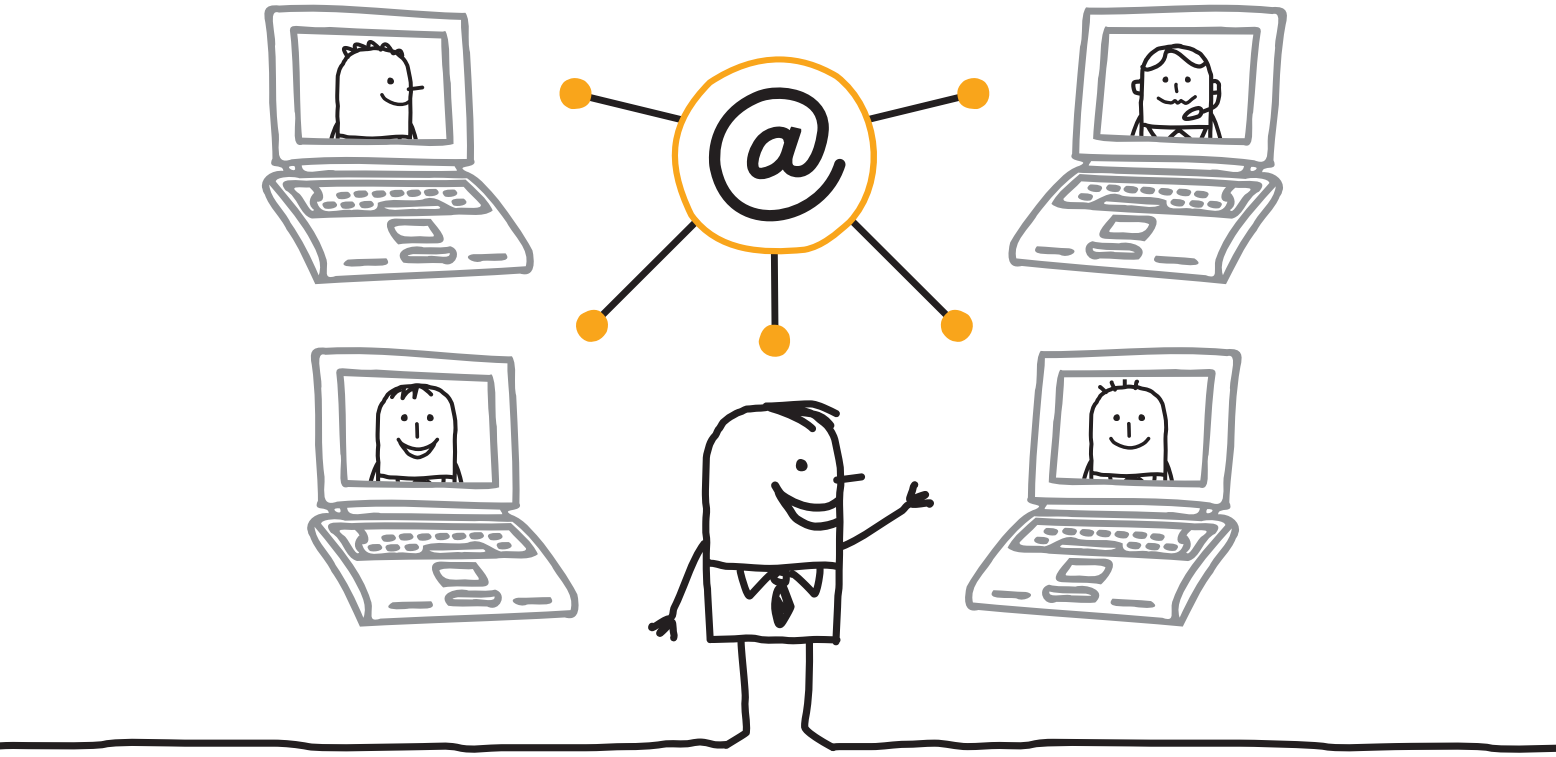
Province-specific resources are also available to provide easy access to information on a variety of topics:

- Getting a billing number
- CFPC Chapters
- College of Physicians and Surgeons contact info
- Insurance coverage, locum info
- Canadian Medical Protective Association
- Rural practice info
- Contact information for many other services

PROVINCIAL LINKS TO PRACTICE MANAGEMENT RESOURCES

Find us on Facebook, email and the FFYFP website. We hope to hear from you!

FACEBOOK: www.facebook.com/groups/FirstFiveYearsinPractice.Canada/
WEBSITE: www.cfpc.ca/firstfiveyears
EMAIL: firstfiveyearscanada@cfpc.ca



YOUR PROFESSIONAL ADVISORY TEAM

Throughout this guide you have seen repeated reminders of the importance of consulting an expert on many of the legal, insurance, financial and taxation-related topics covered. But if you have not yet built a strong, reliable advisory team around you, where should you begin?

Your professional advisory team should be an integral part of your practice and will include a financial advisor, an accountant, an insurance advisor, a lawyer and a banking partner.

FINANCIAL ADVISOR

In many ways, the financial advisor is the "quarterback" of your advisory team. This professional should be much more than just an investment advisor to consult when you have disposable income to invest. In fact, a qualified financial advisor is even more valuable to you when you are in debt. He or she will work with you to address several essential financial matters:

- **CASH FLOW AND BUDGET** — Understanding your cash flow is the cornerstone to your present and future financial health. A cash flow statement is needed to develop a reasonable budget. Your financial advisor can show you how to assess your cash flow and prepare an effective and efficient budget.
- **NET WORTH STATEMENT** — Most residents carry significant debt and therefore feel a net worth statement is of no value, since it is depressingly negative and in the "red." Not so! Your net worth statement becomes a benchmark for future comparison and is essential for effective financial planning.
- **DEBT STATUS** — In 2006, a study by the Canadian Association of Internes and Residents (CAIR) reported that the interest obligations on this debt can be significant. For physicians considering the purchase of a home soon after completing residency, the subsequent debt load can easily exceed $300,000. By analyzing your debt status, a financial advisor can recommend measures to efficiently reduce your debt load obligations. This will include weighing the pros and cons of consolidating student loans and other debts, such as credit cards carrying high interest rates and attempting to minimize interest rates.
- **PERSONAL LINE OF CREDIT AND INTEREST RATES** — Your financial advisor will also help you negotiate with your banker for the best interest rates on your

personal line of credit during medical school or residency. A concise and well-organized cash flow statement, net worth statement and business plan will be of great assistance when you are negotiating with any financial institution. On completing residency, you will have to renegotiate your personal line of credit.

- **INSURANCE PLANNING** — Insurance will be a cornerstone of your financial plan, now and in the future. It's an important discussion early in your career, especially if you have debt, family or financial obligations, particularly when interest rates are generally favourable. Your financial advisor can conduct an unbiased review of your present and potential future liabilities to help you plan and act on your insurance needs as well as identify potential providers, e.g., disability insurance through your resident association and/or your provincial/territorial medical association.
- **INCORPORATION PLANNING** — The decision on whether or not to incorporate your medical practice is an important one involving a number of factors. A qualified financial advisor can help explain the pros and cons of incorporation, as well as referring you to tax and legal experts, as needed. In addition, a qualified financial planner can help with developing a comprehensive wealth management strategy should you decide to incorporate.
- **FINANCIAL PLAN AND INVESTMENT STRATEGY** — Once your financial advisor has gathered and analyzed all the above information, he or she can help you develop a financial plan and investment strategy that addresses your short-, intermediate- and long-term goals.

ACCOUNTANT

It is never too early to talk to an accountant. Accountants can provide advice on the tax deductions and credits that you can claim now, as well as the expenditures made during medical school and residency that may be carried forward and deducted once you enter practice. Setting up personal and professional financial books and bank accounts before you start practice will save you a lot of time and money in the long run.

For those residents and practicing physicians who will be working on a fee-for-service basis, earning more than $100,000 per year and/or considering incorporation, they would greatly benefit from the services of a qualified accountant.

INSURANCE ADVISOR

It's a common mistake for medical trainees to initially underinsure themselves, wrongly assuming they can defer buying insurance until they are earning more money in practice. All residents should have a detailed, objective review of their insurance needs to ensure they obtain the appropriate coverage. This will include an evaluation of different insurance packages, including:

- **Disability insurance** for income replacement. This should be re-evaluated annually during your residency.
- **Life insurance.** In addition to protecting your family income, life insurance is also about covering debt so your survivors are not left with this potentially large expense. You may not be as insurable tomorrow as you are today. Your health, good lifestyle and youth allow you to buy insurance at preferential rates.
- **Critical illness insurance**
- **Property insurance** for your home/apartment and personal goods
- **Automobile insurance**
- **Professional liability insurance**
- **Extended health and dental insurance**

LAWYER

Physicians' exposure to lawyers during medical training is often restricted to malpractice issues. However, legal issues touch every aspect of a physician's personal and professional life. It is extremely important to seek professional legal advice before signing any contract. Remember, it's much cheaper to consult with a lawyer up front than it is to pay for a lawsuit later. In addition to contracts, legal advice should be sought for:

- Wills
- Powers of Attorney for personal care and property, granting authority for another person to act on your behalf
- Personal and professional contracts
- Home purchase agreements
- Creditor protection
- Incorporation

BANKING PARTNER

The terms of your banking package and services are extremely important to all medical students and residents as the costs can be quite significant over the long term. Before approaching a banking partner for services, review the cost of banking fees and credit options (e.g., consolidating your student loans), with your financial advisor. Your objective will be to obtain low monthly fees and competitive rates for your personal and professional lines of credit. Even a reduction of 0.25% in one's interest rate on their line of credit could make a big difference over five years. Your financial advisor will be of great assistance to you as you prepare for your negotiation with a financial institution.

SOCIAL MEDIA GUIDELINES

These guidelines have been developed to help provide guidance to residents and others who choose to use social media. While developed in 2011, the document provide principles and advice that remains current. The full document can be accessed at cma.ca/social media

IMPORTANT NOTE: For Canadian physicians, regulations and guidelines from provincial regulatory authorities or employers take precedence over any of the guidance provided here by the CMA. Certain regulatory authorities such as the College of Physicians and Surgeons of British Columbia and the College of Physicians and Surgeons of New Brunswick have issued guidelines or statements with respect to social media.[1]

SOCIAL MEDIA: WHAT DOES IT MEAN?

To many people, social media are just the names of well-known online products — Facebook, YouTube and Twitter. But in the broader sense, social media can be defined as a set of web-based and mobile technologies that allow people to monitor, create, share or manipulate text, audio, photos or video, with others. This information can be shared unidirectionally (e.g., posting text to one's own blog) or multidirectionally (e.g., contributing to a discussion on an online forum). Social media places particular emphasis on interactive, user-driven communication.

SOCIAL MEDIA AND PATIENTS

There is currently widespread discussion among health care professionals, academics, social media observers and the public about how social media can and should be used in health care. The evidence base is currently lacking on whether the use of social media can improve patient outcomes.[2] But it is undeniable that the internet and social media platforms have become an integral part of how patients and members of the public seek information about health and increase the sense of engagement patients have in their own care. Through a variety of websites and fuelled by the growing availability of electronic patient health records, patients are increasingly sharing information with other patients about their health conditions and their health care providers.

RISKS AND BENEFITS

For physicians, social media provide a unique set of opportunities and challenges. There is growing debate about whether the medical profession should play a role in using social media to communicate more effectively with individual patients and the patient community at large. The reality is that individual doctors and medical organizations have to consciously decide if, why and how to use the various social media platforms. While use of social media could potentially increase the exposure of physicians to disciplinary and medico-legal issues, those physicians who choose to use social media can help shape how these tools can improve health care in the future.

Social media pose a challenge for physicians (and other professionals) in terms of separating one's personal and professional lives. While such a separation is a fundamental tenet of the medical profession, social media blur such boundaries in ways that can enrich communications, but can also put physicians at risk. It is an entirely new environment that medical professionalism has not yet satisfactorily addressed.

When communicating through social media, physicians must remember they remain governed by the same ethical and professional standards that have always applied and that are paramount.

As recent findings show, Canadian physicians believe social media present a variety of professional and legal risks, and they are uncertain of the potential benefits of these new forms of communication and interaction.[3]

KEY ISSUES

PATIENT CONFIDENTIALITY

- The privacy and security of individual patient information is paramount and should never be shared beyond the circle of care. This principle is also enshrined in CMA policy.[4] In communicating with an individual patient in other than a face-to-face environment, a secure electronic communication platform must be used.[5] Identifiable patient information, including images, should never be posted online.
- When using social media, physicians should endeavour to use the most stringent security and privacy settings available for the particular platform.
- Social networking sites cannot guarantee confidentiality. Anything written on a social networking site can theoretically be accessed and made public.

PROFESSIONALISM

- Having an online profile or identifiable presence on social media can have the same degree of positive or negative impact on a physician's social reputation as being active in any other public venue.
- The most effective use of social media often involves communicating information that is both personal and professional. However, physicians must retain the appropriate boundaries of the patient–physician relationship when dealing with patients.

ONLINE COMMUNICATION ISSUES

- Electronic communications are not anonymous and are always stored in some form. As such, it is possible to trace the author of a comment even if posted anonymously.
- Once their material is published online, authors of comments on social media sites no longer control how and where the information is disseminated.
- Postings to social media sites are subject to the same laws of copyright, libel and defamation as written or verbal communications.

POTENTIAL BENEFITS

- Social media can enhance the role of traditional media in delivering important public health messages.
- Use of social media can provide patients and the public with quicker and easier access to medical expertise, often in a way that is more current.
- Posting (with copyright permission) evidence-based medical information on social media sites can improve the quality of health information made available to the public

RULES OF ENGAGEMENT

The following should be kept in mind when using social media.

- **Understand the technology and your audience:** The many social media platforms work in different ways and often have different goals. Some social networking sites, for example Facebook, are intended for use by everyone, but you set your own network of people you know. Others, like Twitter, are designed for interacting with people you might not know at all. And others still, such as Asklepios, are intended for peer-to-peer interaction between Canadian physicians only. It is necessary to have a good understanding of how they work and who your intended audience will be.

- **Be transparent:** Identify clearly who you are and any potential conflicts of interest you may have in association with information you are providing. Being transparent encourages more honest interaction with others and a more productive outcome. If you are discussing medical or health issues, it is probably beneficial to identify yourself as a physician.
When participating on a social networking site such as Facebook, you should avoid communicating personal or private information with patients. It is possible to establish a professional page, where you can post information about your practice and general health information and links.

- **Respect others:** If you are posting information created by somebody else, proper permission should be obtained and acknowledgement given. Most social media sites have their own sets of rules, guidelines and etiquette, and these should be followed. Always respect the principle of patient confidentiality.

- **Focus on areas of expertise:** As a physician you can often bring most value to a forum or conversation by discussing issues on which you have a particular expertise. Sharing this information — as long as it does not contravene individual patient confidentiality — will likely to be viewed favourably by other participants.
You should anticipate that the information you provide on social media may be challenged by both other physicians and non-physicians. Remember to keep the tenor of the debate at a civilized level and do not be unnecessarily offended if your viewpoint is rejected.
If you choose to use your own website to communicate to a non-medical audience about medical or health issues, you should include a terms of use agreement to advise users that information is intended for Canadian residents and that individual health queries will not be addressed.[6]

REFERENCES

1. College of Physicians and Surgeons of British Columbia Social Media and Online Networking Forums (www.cpsbc.ca/files/u6/Social-Media-and-Online-Networking-Forums.pdf) ; College of Physicians and Surgeons of New Brunswick Facebook Guidelines (www.cpsnb.org/english/Guidelines/Facebook.htm)
2. However, numerous research studies are showing that social media tools and resources are being used to provide patients with health information and attempt to change health-related behaviours. See, for example, the abstracts of presentations from the four Med 2.0: Social Media and Web 2.0 in Health conferences (www.medicine20congress.com/ocs/index.php/med/med2011), or papers published in the *Journal of Medical Internet Research* (www.jmir.org/)
3. Social media use by physicians (www.cma.ca/advocacy/social-media-use-physicians)
4. CMA Health Information Privacy Code (www.cma.ca/index.php?ci_id=53584&la_id=1)
5. *CMA Physician Guidelines for Online Communications with Patients* (http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD05-03.pdf)
6. *Health promotion: CMPA will assist* (www.cmpa-acpm.ca/cmpapd04/docs/member_assistance/more/com_is0890-e.cfm)

Share your thoughts with us and your colleagues at facebook.com/MDPhysicianServices

Eliquis™ apixaban

Tablets 2.5 mg and 5 mg

PRESCRIBING SUMMARY

PATIENT SELECTION CRITERIA

THERAPEUTIC CLASSIFICATION

Anticoagulant

INDICATIONS AND CLINICAL USE

ELIQUIS (apixaban) is indicated for the prevention of venous thromboembolic events (VTE) in adult patients who have undergone elective knee or hip replacement surgery and for the prevention of stroke and systemic embolism in patients with atrial fibrillation.

Pregnant Women: There are no data from the use of apixaban in pregnant women. Animal studies do not indicate direct or indirect harmful effects with respect to reproductive toxicity. Apixaban is not recommended during pregnancy.

Nursing Women: It is unknown whether apixaban or its metabolites are excreted in human milk. Available data in animals have shown excretion of apixaban in milk. In rats, this resulted in high milk-to-maternal plasma ratios (apixaban AUC ~30, C_{max} ~8).

A risk to newborns and infants cannot be excluded. A decision must be made to either discontinue breastfeeding or to discontinue/abstain from ELIQUIS therapy.

Hip Fracture Surgery Patients: Apixaban has not been studied in clinical trials in patients undergoing hip fracture surgery to evaluate efficacy and safety in these patients. Therefore, ELIQUIS is not recommended in these patients.

Pediatrics (<18 years of age): The efficacy and safety of ELIQUIS in children have not been studied. No data are available.

Geriatrics (≥65 years of age): *Prevention of VTE following elective hip or knee replacement surgery:* No dose adjustment is necessary in elderly patients. Of the total number of patients in clinical studies of apixaban in VTE prevention following major orthopedic surgery (N=5924), 50% were 65 and older, while 16% were 75 and older. *Stroke Prevention in Patients with Atrial Fibrillation (SPAF):* No dose adjustment is necessary in elderly patients, unless the criteria for dose reduction are met (see DOSAGE and ADMINISTRATION). Of the total number of patients in the ARISTOTLE and AVERROES studies, about 69% were 65 and older and about 32% were 75 and older in these trials.

CONTRAINDICATIONS

ELIQUIS is contraindicated in patients with clinically significant active bleeding, including gastrointestinal bleeding; lesions or conditions at increased risk of clinically significant bleeding: e.g., recent cerebral infarction (ischemic or hemorrhagic), active peptic ulcer disease with recent bleeding, patients with spontaneous or acquired impairment of hemostasis; hepatic disease associated with coagulopathy and clinically relevant bleeding risk; concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-glycoprotein such as azole-antimycotics, e.g., ketoconazole, itraconazole, voriconazole, or posaconazole, and HIV protease inhibitors, e.g., ritonavir (see WARNINGS AND PRECAUTIONS, Drug Interactions, and DRUG INTERACTIONS, Inhibitors of both CYP3A4 and P-gp); concomitant treatment with any other anticoagulant, including unfractionated heparin (UFH), except at doses used to maintain a patent central venous or arterial catheter, low molecular weight heparins (LMWH), such as enoxaparin and dalteparin, heparin derivatives, such as fondaparinux, and oral anticoagulants, such as warfarin, dabigatran, rivaroxaban, except under circumstances of switching therapy to or from apixaban; hypersensitivity to apixaban or any of the ingredients in the formulation (see DOSAGE FORMS, COMPOSITION AND PACKAGING in the Product Monograph).

SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Bleeding: As with all anticoagulants, ELIQUIS should be used with caution in circumstances associated with an increased risk of bleeding. Bleeding can occur at any site during therapy with ELIQUIS. The possibility of a hemorrhage should be considered in evaluating the condition of any anticoagulated patient. An unexplained fall in hemoglobin and/or hematocrit or fall in blood pressure should prompt a search for a bleeding source. Patients at high risk of bleeding should not be prescribed ELIQUIS (see CONTRAINDICATIONS). **Should severe bleeding occur, treatment with ELIQUIS must be discontinued and the source of bleeding investigated promptly**. Close clinical surveillance for blood loss is recommended throughout the treatment period. This may include looking for obvious signs of bleeding, e.g. hematomas, epistaxis, or hypotension, testing for occult blood in the stool, checking serum hemoglobin for significant decrease, etc., especially if other factors/conditions that generally increase the risk of hemorrhage are also present. Some examples of these risk factors/conditions are included in Table 1, below.

Table 1 – Factors which Increase Hemorrhagic Risk

FACTORS INCREASING APIXABAN PLASMA LEVELS
Severe renal impairment (CrCl <30 mL/min)
Concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-gp
PHARMACODYNAMIC INTERACTIONS
NSAID
Platelet aggregation inhibitors, including ASA, clopidogrel, prasugrel, ticagrelor
DISEASES/PROCEDURES WITH SPECIAL HEMORRHAGIC RISKS
Congenital or acquired coagulation disorders
Thrombocytopenia or functional platelet defects
Uncontrolled severe arterial hypertension
Active ulcerative gastrointestinal disease
Recent gastrointestinal bleeding
Recent intracranial hemorrhage
Intraspinal or intracerebral vascular abnormalities
Recent brain, spinal or ophthalmological surgery
Bronchiectasis or history of pulmonary bleeding
OTHERS
Age >75 years

Concomitant use of ELIQUIS with drugs affecting hemostasis increases the risk of bleeding. Care should be taken if patients are treated concomitantly with drugs affecting hemostasis such as non-steroidal anti-inflammatory drugs (NSAID), acetylsalicylic acid (ASA), and other anti-platelet agents (see DRUG INTERACTIONS). In patients with atrial fibrillation and having a condition that warrants single or dual antiplatelet therapy, a careful assessment of the potential benefits against the potential risks should be made before combining this therapy with ELIQUIS. Concomitant use of ASA or dual antiplatelet therapy increases the risk for major bleeding with either ELIQUIS or warfarin in patients with atrial fibrillation (see also DRUG INTERACTIONS). In high-risk patients following acute coronary thrombosis, apixaban 5 mg bid, as an adjunct to standard anti-platelet treatment, has lead to significantly increased bleeding (see ACTION AND CLINICAL PHARMACOLOGY, Post-acute coronary syndrome patients in the Product Monograph). The antiplatelet agents, prasugrel and ticagrelor, have not been studied with ELIQUIS, and are not recommended as concomitant therapy. The use of thrombolytics should generally be avoided during acute myocardial infarction (AMI) or acute stroke in patients treated with apixaban, due to expected increased risk of major bleeding.

Cardiovascular: *Patients with Valvular Disease*: Safety and efficacy of ELIQUIS have not been studied in patients with prosthetic heart valves or those with hemodynamically significant rheumatic heart disease, especially mitral stenosis. There are no data to support that ELIQUIS 5 mg twice daily or 2.5 mg twice daily provides adequate anticoagulation in patients with prosthetic heart valves, with or without atrial fibrillation. Therefore, the use of ELIQUIS is not recommended in this setting. Of note, in the pivotal ARISTOTLE trial, that evaluated ELIQUIS in the prevention of stroke in atrial fibrillation when compared to warfarin, 18% of patients had other valvular disease, including aortic stenosis, aortic regurgitation, and/or mitral regurgitation. In the AVERROES trial, that also evaluated ELIQUIS in patients with atrial fibrillation but when compared to ASA, 23% had other valvular disease of a similar nature to that described just above in the ARISTOTLE trial.

Drug Interactions: *Inhibitors of Both CYP3A4 and P-glycoprotein (P-gp):* Co-administration of apixaban with ketoconazole (400 mg q.d.), a strong inhibitor of CYP3A4 and P-gp, led to a 2-fold increase in mean apixaban AUC and a 1.6-fold increase in apixaban C_{max}. Therefore, the use of ELIQUIS is contraindicated in patients receiving concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-gp, such as azole-antimycotics (e.g., ketoconazole, itraconazole, voriconazole and posaconazole), and HIV protease inhibitors (e.g., ritonavir) (see CONTRAINDICATIONS). These drug products may increase apixaban exposure by two-fold (see DRUG INTERACTIONS, Inhibitors of Both CYP3A4 and P-gp).

Inducers of Both CYP3A4 and P-gp: The concomitant use of ELIQUIS with strong inducers of CYP3A4 and P-gp (e.g., rifampin, phenytoin, carbamazepine, phenobarbital or St. John's Wort) reduces apixaban exposure. Combined use of ELIQUIS with strong inducers should generally be avoided since efficacy of ELIQUIS may be compromised (see DRUG INTERACTIONS, Inducers of Both CYP3A4 and P-gp). Paradoxically, increased bleeding has been noted in patients with atrial fibrillation taking concomitant inducers with either apixaban or warfarin (see DRUG INTERACTIONS, Inducers of Both CYP3A4 and P-gp, Table 7 in the Supplemental Product Information).

Hepatic/Biliary/Pancreatic: *Hepatic Impairment*: ELIQUIS is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk (see CONTRAINDICATIONS). ELIQUIS is not recommended in patients with severe hepatic impairment (see ACTION AND CLINICAL PHARMACOLOGY, Hepatic Impairment in the Product Monograph). ELIQUIS should be used with caution in patients with mild or moderate hepatic impairment (Child Pugh A or B) (see DOSAGE AND ADMINISTRATION, Hepatic Impairment). Patients with elevated liver enzymes (ALT/AST >2 x ULN, or total bilirubin ≥1.5 x ULN) were excluded in clinical trials. Therefore, ELIQUIS should be used with caution in these patients.

Peri-Operative/Procedural Considerations: As with any anticoagulant, patients on ELIQUIS who undergo surgery or invasive procedures are at increased risk for bleeding. In these circumstances, temporary discontinuation of ELIQUIS may be required.

Pre-Operative Phase: If an invasive procedure or surgical intervention is required, ELIQUIS should be stopped at least 24 hours before the intervention, if possible, due to increased risk of bleeding, and based on clinical judgment of the physician. If the procedure cannot be delayed, the increased risk of bleeding should be assessed against the urgency of the intervention. Although there are limited data, in patients at higher risk of bleeding or in major surgery where complete hemostasis may

be required, consider stopping ELIQUIS at least 48 hours before surgery, depending on clinical circumstances.

Peri-Operative Spinal/Epidural Anesthesia, Lumbar Puncture: When neuraxial (epidural/spinal) anesthesia or spinal puncture is performed, patients treated with antithrombotics for prevention of thromboembolic complications are at risk for developing an epidural or spinal hematoma that may result in long-term neurological injury or permanent paralysis. **The risk of these events is even further increased by the use of indwelling catheters or the concomitant use of drugs affecting hemostasis. Accordingly, indwelling epidural or intrathecal catheters must be removed at least 5 hours prior to the first dose of ELIQUIS. The risk may also be increased by traumatic or repeated epidural or spinal puncture. If traumatic puncture occurs, the administration of ELIQUIS should be delayed for 24 hours.** Patients who have undergone epidural puncture and who are receiving ELIQUIS should be frequently monitored for signs and symptoms of neurological impairment (e.g., numbness or weakness of the legs, bowel or bladder dysfunction). If neurological deficits are noted, urgent diagnosis and treatment is necessary. The physician should consider the potential benefit versus the risk before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis and use ELIQUIS only when the benefits clearly outweigh the possible risks. An epidural catheter should not be withdrawn earlier than 24 hours after the last administration of ELIQUIS.

Post-Procedural Period: ELIQUIS should be restarted following an invasive procedure or surgical intervention as soon as adequate hemostasis has been established and the clinical situation allows, in order to avoid unnecessary increased risk of thrombosis.

Renal Impairment: Determine estimated creatinine clearance (eCrCl) in all patients before instituting ELIQUIS (see DOSAGE AND ADMINISTRATION). ELIQUIS is not recommended in patients with creatinine clearance <15 mL/min, or in those undergoing dialysis (see DOSAGE AND ADMINISTRATION, Renal Impairment, and ACTION AND CLINICAL PHARMACOLOGY, Renal Impairment in the Product Monograph). *Stroke Prevention in Patients with Atrial Fibrillation:* No dose adjustment is necessary in patients with mild or moderate renal impairment, or in those with eCrCL 25-30 mL/min. However, patients with serum creatinine ≥133 micromol/L (1.5 mg/dL) who are also ≥80 years or whose body weight ≤60 kg, should receive a reduced dose of apixaban 2.5 mg twice daily (see DOSAGE AND ADMINISTRATION). In patients with eCrCL 15-24 mL/min, no dosing recommendation can be made as clinical data are very limited.

Monitoring and Laboratory Tests: The pharmacodynamic effects of apixaban are reflective of the mechanism of action, namely Factor-Xa (FXa) inhibition. As a result of FXa inhibition, apixaban prolongs clotting tests such as prothrombin time (PT), and activated partial thromboplastin time (aPTT). Due to their lack of sensitivity, PT or aPTT are not recommended to assess the pharmacodynamic effects of apixaban. **Although ELIQUIS therapy will lead to an elevated INR, depending on the timing of the measurement** (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph), **the INR is not a valid measure to assess the anticoagulant activity of ELIQUIS (see also DOSAGE AND ADMINISTRATION, Switching from ELIQUIS to VKA, Considerations for INR Monitoring of VKA Activity during Concomitant ELIQUIS Therapy). The INR is only calibrated and validated for vitamin K antagonists (VKA) and should not be used for any other anticoagulant, including ELIQUIS.** Apixaban demonstrates anti-FXa activity as evident by reduction in Factor-Xa enzyme activity in the Rotachrom® Heparin Anti-Xa assay. Anti-FXa activity exhibits a close direct linear relationship with apixaban plasma concentration, reaching maximum values at the time of apixaban peak plasma concentrations. The relationship between apixaban plasma concentration and anti-FXa activity is linear over a wide dose range of apixaban, and precision of the Rotachrom assay is well within acceptable limits for use in a clinical laboratory. The dose- and concentration-related changes observed following apixaban administration are more pronounced, and less variable, for anti-FXa activity compared to that seen with standard clotting tests, such as PT and aPTT (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph). Although there is no need to monitor anticoagulation effect of ELIQUIS during routine clinical practice, in certain infrequent situations such as overdosage, acute bleeding, urgent surgery, in cases of suspected non-compliance, or in other unusual circumstances, assessment of the anticoagulant effect of apixaban may be appropriate. Accordingly, the Rotachrom anti-FXa assay may be useful to inform clinical decisions in these circumstances. See ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics, for predicted steady-state peak and trough anti-FXa activity in different indications and for different doses of apixaban.

ADVERSE REACTIONS

(see Supplemental Product Information and Product Monograph for full listing)

Prevention of VTE following Elective Hip or Knee Replacement Surgery: The safety of ELIQUIS (apixaban) 2.5 mg twice daily has been evaluated in one Phase II and three Phase III studies (ADVANCE 1, 2 and 3) including 5,924 patients exposed to apixaban after undergoing major orthopedic surgery of the lower limbs (elective hip replacement or elective knee replacement) and treated for up to 38 days.

Stroke Prevention in Patients with Atrial Fibrillation (SPAF): The safety of ELIQUIS has been evaluated in the ARISTOTLE and AVERROES studies, including 11,284 patients exposed to apixaban 5 mg twice daily, and 602 patients exposed to apixaban 2.5 mg twice daily. The duration of apixaban exposure was ≥12 months for 9,375 patients, and ≥24 months for 3,369 patients in the two studies. In ARISTOTLE, 9,088 patients were exposed to apixaban over a mean duration of 89.2 weeks, and 9,052 to dose-adjusted warfarin (INR 2.0 to 3.0) over a mean duration of 87.5 weeks. In AVERROES, 2,798 patients were exposed to apixaban, and 2,780 to ASA, over a mean duration of approximately 59 weeks in both treatment groups. The overall discontinuation rate due to adverse reactions was 1.8% for apixaban and 2.6% for warfarin in the ARISTOTLE study, and 1.5% for apixaban and 1.3% for ASA in the AVERROES study.

Bleeding: Bleeding is the most relevant adverse reaction of ELIQUIS. Bleeding of any type was observed in approximately 12% of patients treated with ELIQUIS short-term following hip replacement surgery and about 6% following knee replacement surgery. In long-term treatment in patients having atrial fibrillation, bleeding of any type of severity occurred at a rate of 18% per year for patients exposed to ELIQUIS in the ARISTOTLE trial, and 11% per year in the AVERROES trial. Major or severe bleeding may occur and, regardless of location, may lead to disabling, life-threatening or even fatal outcomes.

Prevention of VTE following Elective Hip or Knee Replacement Surgery: In all Phase III studies, bleeding was assessed beginning with the first dose of double-blind study drug. In studies that compared apixaban to the 40 mg once daily dose of enoxaparin, the first dose of either enoxaparin or injectable placebo was given 9 to 15 hours before surgery. Bleeding during the treatment period for these studies includes events that occurred before the first dose of apixaban, which was given 12-24 hours after surgery. Bleeding during the post-surgery treatment period only included events occurring after the first dose of study drug after surgery. Over half the occurrences of major bleeding in the apixaban group in these two studies occurred prior to the first dose of apixaban. For the study that compared apixaban with enoxaparin given every 12 hours, the first dose of both oral and injectable study drugs was 12-24 hours after surgery. For this study, the treatment period and post-surgery treatment period are identical.

Table 2 shows the bleeding results from the treatment period and the post-surgery treatment period.

Table 2 - Bleeding in Patients Undergoing Elective Hip or Knee Replacement Surgery

BLEEDING ENDPOINT[a]	ADVANCE-3 Hip replacement surgery		ADVANCE-2 Knee replacement surgery		ADVANCE-1 Knee replacement surgery	
	Apixaban 2.5 mg po bid 35±3 days	Enoxaparin 40 mg sc qd 35±3 days	Apixaban 2.5 mg po bid 12±2 days	Enoxaparin 40 mg sc qd 12±2 days	Apixaban 2.5 mg po bid 12±2 days	Enoxaparin 30 mg sc q12h 12±2 days
	First dose 12 to 24 hours post-surgery	First dose 9 to 15 hours prior to surgery	First dose 12 to 24 hours post-surgery	First dose 9 to 15 hours prior to surgery	First dose 12 to 24 hours post-surgery	First dose 12 to 24 hours post-surgery
All treated	n=2673	n=2659	n=1501	n=1508	n=1596	n=1588
TREATMENT PERIOD[b]						
Major	22 (0.8%)	18 (0.7%)	9 (0.6%)	14 (0.9%)	11 (0.7%)	22 (1.4%)
Fatal	0	0	0	0	0	1 (<0.1%)
Major +CRNM	129 (4.8%)	134 (5.0%)	53 (3.5%)	72 (4.8%)	46 (2.9%)	68 (4.3%)
All	313 (11.7%)	334 (12.6%)	104 (6.9%)	126 (8.4%)	85 (5.3%)	108 (6.8%)
POST-SURGERY TREATMENT PERIOD						
Major	9 (0.3%)	11 (0.4%)	4 (0.3%)	9 (0.6%)	11 (0.7%)	22 (1.4%)
Fatal	0	0	0	0	0	1 (<0.1%)
Major +CRNM	96 (3.6%)	115 (4.3%)	41 (2.7%)	56 (3.7%)	46 (2.9%)	68 (4.3%)
All	261 (9.8%)	293 (11.0%)	89 (5.9%)	103 (6.8%)	85 (5.3%)	108 (6.8%)

[a]All bleeding criteria included surgical site bleeding.
[b]Includes bleeding events which occurred before the first dose of apixaban.

Stroke Prevention in Patients with Atrial Fibrillation (SPAF): Bleeding events observed in patients with atrial fibrillation are presented below in Tables 3 and 4.

Table 3 – Bleeding Events* in the ARISTOTLE Study

	Apixaban	Warfarin	Hazard Ratio	*p*-value
	N=9088	N=9052	(95% CI)	
	n (%/year)	n (%/year)		
Major*	327 (2.13)	462 (3.09)	0.69 (0.60, 0.80)	<0.0001
Fatal	10 (0.06)	37 (0.24)		
Intracranial	52 (0.33)	122 (0.80)		
Major + CRNM**	613 (4.07)	877 (6.01)	0.68 (0.61, 0.75)	<0.0001
All	2356 (18.1)	3060 (25.8)	0.71 (0.68, 0.75)	<0.0001

Events for each endpoint were counted once per subject but subjects may have contributed events to more than one endpoint
* Dataset includes events occurring on-treatment plus the following two days
** Clinically relevant non-major (CRNM) bleeding.

Treatment discontinuation due to bleeding-related adverse reactions occurred in 1.7% and 2.5% of patients treated with apixaban and warfarin, respectively.

The incidence of major gastrointestinal bleeds, including upper GI, lower GI, and rectal bleeding, was reported at 0.8% per year with apixaban, and 0.9% per year with warfarin. In the ARISTOTLE study, concomitant aspirin use with either apixaban or warfarin increased the risk of major bleeding 1.5 to 2 times when compared with those patients not treated with concomitant aspirin. ELIQUIS, like other anticoagulants, should be used with caution in patients treated concomitantly with antiplatelet agents.

Table 4 – Bleeding Events* in the AVERROES Study

	Apixaban	Aspirin	Hazard Ratio vs. Aspirin	*p*-value
	N=2798	N=2780	(95% CI)	
	n (%/year)	n (%/year)		
Major*	45 (1.41)	29 (0.92)	1.54 (0.96, 2.45)	0.0716
Fatal	5 (0.16)	5 (0.16)		
Intracranial	11 (0.34)	11 (0.35)		
Major + CRNM**	140 (4.46)	101 (3.24)	1.38 (1.07, 1.78)	0.0144
All	325 (10.85)	250 (8.32)	1.30 (1.10, 1.53)	0.0017

Events for each endpoint were counted once per subject but subjects may have contributed events to more than one endpoint.
* Dataset includes events occurring on-treatment, plus the following two days for patients that did not enter open-label extension
** Clinically relevant non-major (CRNM) bleeding

Treatment discontinuation due to bleeding-related adverse events occurred in 1.5% and 1.3% of patients treated with apixaban and ASA, respectively.

Prevention of VTE following Elective Hip or Knee Replacement Surgery: In total, 11% of the patients treated with apixaban 2.5 mg twice daily experienced adverse reactions. Adverse reactions occurring in ≥1% of patients undergoing hip or knee replacement surgery in the one Phase II study and the three Phase III studies are listed in Table 5.

Table 5: Adverse Reactions Occurring in ≥1% of Patients in Either Group Undergoing Hip or Knee Replacement Surgery

	Apixaban 2.5 mg BID PO n=5924 (%)	Enoxaparin 40 mg SC OD or 30 mg SC q12h n=5904
GASTROINTESTINAL DISORDERS		
Nausea	153 (2.6)	159 (2.7)
BLOOD AND LYMPHATIC SYSTEM DISORDERS		
Anemia (including post-operative and hemorrhagic anemia, and respective laboratory parameters)	153 (2.6)	178 (3.0)
VASCULAR DISORDERS		
Hemorrhage (including hematoma, and vaginal and urethral hemorrhage)	67 (1.1)	81 (1.4)
INJURY, POISONING AND PROCEDURAL COMPLICATIONS		
Contusion	83 (1.4)	115 (1.9)
Post procedural hemorrhage (including post procedural hematoma, wound hemorrhage, vessel puncture site hematoma and catheter site hemorrhage)	54 (0.9)	60 (1.0)
HEPATOBILIARY DISORDERS		
Transaminases increased (including alanine aminotransferase increased and alanine aminotransferase abnormal)	50 (0.8)	71 (1.2)
Aspartate aminotransferase increased	47 (0.8)	69 (1.2)
Gamma-glutamyltransferase increased	38 (0.6)	65 (1.1)

Stroke Prevention in Patients with Atrial Fibrillation (SPAF)

Common adverse reactions in patients with atrial fibrillation are shown in Table 6, below.

Table 6 – Adverse Reactions Occurring in ≥1% of Patients with Atrial Fibrillation in the ARISTOTLE and AVERROES Studies

	ARISTOTLE		AVERROES	
	Apixaban N=9088 n (%)	Warfarin N=9052 n (%)	Apixaban N=2798 n (%)	ASA N=2780 n (%)
EYE DISORDERS				
Eye hemorrhage (including conjunctival hemorrhage	211 (2.3)	326 (3.6)	22 (0.8)	11 (0.4)
GASTROINTESTINAL DISORDERS				
Gastrointestinal hemorrhage (including hematemesis and melena)	194 (2.1)	190 (2.1)	24 (0.9)	23(0.8)
Rectal hemorrhage	141 (1.6)	156 (1.7)	17 (0.6)	6 (0.2)
Gingival bleeding	113 (1.2)	223 (2.5)	19 (0.7)	9 (0.3)
INJURY, POISONING, AND PROCEDURAL COMPLICATIONS				
Contusion	456 (5.0)	745 (8.2)	49 (1.8)	61 (2.2)
RENAL AND URINARY DISORDERS				
Hematuria	340 (3.7)	409 (4.5)	31 (1.1)	17 (0.6)
RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS				
Epistaxis	560 (6.2)	685 (7.6)	54 (1.9)	52 (1.9)
VASCULAR DISORDERS				
Other hemorrhage	150 (1.7)	188 (2.1)	10 (0.4)	5 (0.2)
Hematoma	233 (2.6)	439 (4.8)	15 (0.5)	24 (0.9)

Reporting Suspected Side Effects

To monitor drug safety, Health Canada through the Canada Vigilance Program collects information on serious and unexpected side effects of drugs. You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:
Report online at www.healthcanada.gc.ca/medeffect
Call toll-free at 1-866-234-2345

Complete a Canada Vigilance Reporting Form and:
Fax toll-free to 1-866-678-6789, or
Mail to: Canada Vigilance Program
Health Canada
Postal Locator 0701C
Ottawa, ON K1A 0K9

DRUG INTERACTIONS

(see Table 7 in the Supplemental Product Information and Product Monograph for full listing).

CYP Inhibition: ELIQUIS does not inhibit CYP3A4 or any other major CYP isoenzymes. In vitro apixaban studies showed no inhibitory effect on the activity of CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2D6 or CYP3A4 (IC50 >45 µM) and weak inhibitory effect on the activity of CYP2C19 (IC50 >20 µM) at concentrations that are significantly greater than peak plasma concentrations observed in patients.

CYP Induction: ELIQUIS does not induce CYP3A4 or any other major CYP isoenzymes. Apixaban did not induce CYP1A2, CYP2B6, CYP3A4/5 at a concentration up to 20 µM.

P-gp Inhibition: ELIQUIS does not inhibit P-gp based on *in vitro* data.

DRUG-DRUG INTERACTIONS

Apixaban is metabolized mainly via CYP3A4/5 with minor contributions from CYP1A2, 2C8, 2C9, 2C19, and 2J2. Apixaban is a substrate of transport proteins, P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP).

Inhibitors of Both CYP3A4 and P-gp: Co-administration of apixaban with ketoconazole 400 mg q.d., a strong inhibitor of both CYP3A4 and P-gp, led to a 2-fold increase in apixaban mean AUC and a 1.6-fold increase in apixaban C_{max}. The use of ELIQUIS is contraindicated in patients receiving concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-gp, such as azole-antimycotics (e.g., ketoconazole, itraconazole, voriconazole, or posaconazole), and HIV protease inhibitors (e.g., ritonavir) (see CONTRAINDICATIONS, and WARNINGS AND PRECAUTIONS, Inhibitors of Both CYP3A4 and P-gp). Active substances moderately inhibiting the apixaban elimination pathways, CYP3A4 and/or P-gp, are expected to increase apixaban plasma concentrations to a lesser extent. Diltiazem 360 mg q.d. led to a 1.4 and 1.3-fold increase in mean apixaban AUC and C_{max}, respectively. Naproxen (500 mg), an inhibitor of P-gp, led to a 1.5 and 1.6-fold increase in mean apixaban AUC and C_{max}, respectively. No dose adjustment for apixaban is required when co-administered with less potent inhibitors of CYP3A4 and/or P-gp (see WARNINGS AND PRECAUTIONS, Bleeding, and DOSAGE AND ADMINISTRATION, Interaction with CYP3A4 and P-gp).

Inducers of Both CYP3A4 and P-gp: Co-administration of apixaban with rifampicin 600 mg q.d., a strong inducer of both CYP3A4 and P-gp, led to an approximate 54% and 42% decrease in mean apixaban AUC and C_{max}, respectively. The concomitant use of apixaban with other strong inducers of both CYP3A4 and P-gp (e.g., phenytoin, carbamazepine, phenobarbital or St. John's Wort) may also lead to reduced apixaban plasma concentrations and should generally be avoided (see WARNINGS AND PRECAUTIONS, Inducers of Both CYP3A4 and P-gp, and DOSAGE AND ADMINISTRATION, Interaction with CYP3A4 and P-gp). Increased stroke rates, and paradoxically, increased major bleeding have been noted in patients with atrial fibrillation taking these drugs with either apixaban or warfarin.

Drug Products Affecting Hemostasis: The concomitant use of ELIQUIS with drugs affecting hemostasis, including antiplatelet agents increases the risk of bleeding (see WARNINGS AND PRECAUTIONS, Bleeding). Care is to be taken if patients are treated concomitantly with drug products affecting hemostasis such as non-steroidal anti-inflammatory drugs (NSAID), including acetylsalicylic acid (ASA). If concomitant antiplatelet therapy is contemplated, a careful assessment of the potential risks should be made against potential benefits, weighing risk of increased bleeding against expected benefit. In clinical trials conducted in patients with atrial fibrillation, the addition of ASA or dual antiplatelet therapy to apixaban did not decrease the incidence of stroke but increased the incidence of major bleeding (see ADVERSE REACTIONS, Bleeding, Stroke Prevention in Patients with Atrial Fibrillation, and DOSAGE AND ADMINISTRATION, Concomitant Use of Antiplatelet Agents). For concomitant treatment with any other anticoagulant, see CONTRAINDICATIONS.

Drug-Food Interactions: ELIQUIS can be taken with or without food (see DOSAGE AND ADMINISTRATION, and ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics, Absorption in the Product Monograph).

Drug-Herb Interactions: The concomitant use of ELIQUIS with strong inducers of both CYP3A4 and P-gp inducers (e.g. St. John's Wort) may lead to reduced apixaban plasma concentrations. Combined use with strong inducers of both CYP3A4 and P-gp should generally be avoided, since efficacy of ELIQUIS may be compromised (see WARNINGS AND PRECAUTIONS, Inducers of Both CYP3A4 and P-gp).

Drug-Laboratory Interactions: Clotting tests, e.g., PT (including INR), and aPTT, are affected as may be expected by the mechanism of action of apixaban (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph). Changes observed in these clotting tests at the expected therapeutic dose are relatively small, subject to noteworthy variability, and are not useful for assessing the anticoagulant effect of apixaban (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests).

ADMINISTRATION

ELIQUIS can be taken with or without food. **ELIQUIS should be taken regularly, as prescribed, to ensure optimal effectiveness. All temporary discontinuations should be avoided, unless medically indicated.**

Determine estimated creatinine clearance (eCrCl) in all patients before instituting ELIQUIS, and monitor renal function during ELIQUIS treatment, as clinically appropriate. Determination of renal function by eCrCL should occur at least once per year, and especially during circumstances when renal function may be expected to be compromised, i.e., acute myocardial infarction (AMI), acute decompensated heart failure (AHF), increased use of diuretics, dehydration, hypovolemia, etc. Clinically relevant deterioration of renal function may require dosage adjustment or discontinuation of ELIQUIS (see below, Renal Impairment).

Glomerular filtration rate may be estimated by calculating eCrCl, using the Cockroft-Gault formula: eCrCl (mL/min)=

in males:

$$\frac{(140\text{-age})\ (\text{years}) \times \text{weight (kg)} \times 1.23}{\text{serum creatinine } (\mu\text{mol/L})}$$

or,

$$\frac{(140\text{-age})\ (\text{yrs}) \times \text{weight (kg)}}{72 \times \text{serum creatinine (mg/100 mL)}}$$

in females:

$$\frac{(140\text{-age})\ (\text{years}) \times \text{weight (kg)} \times 1.04}{\text{serum creatinine } (\mu\text{mol/L})}$$

or,

$$\frac{(140\text{-age})\ (\text{yrs}) \times \text{weight (kg)} \times 0.85}{72 \times \text{serum creatinine (mg/100 mL)}}$$

RECOMMENDED DOSE AND DOSAGE ADJUSTMENT

Prevention of VTE following Elective Hip or Knee Replacement Surgery: The recommended dose of ELIQUIS is 2.5 mg twice daily. The initial dose should be taken 12 to 24 hours after surgery, and after hemostasis has been obtained. In patients undergoing hip replacement surgery, the recommended duration of treatment is 32 to 38 days. In patients undergoing knee replacement surgery, the recommended duration of treatment is 10 to 14 days.

Stroke Prevention in Patients with Atrial Fibrillation: The recommended dose of ELIQUIS is 5 mg taken orally twice daily. In patients fulfilling at least two (2) of the following characteristics, a reduced dose of ELIQUIS 2.5 mg twice daily is recommended: age ≥80 years, body weight ≤60 kg, or serum creatinine ≥133 micromole/L (1.5 mg/dL). These patients have been determined to be at higher risk of bleeding.

SPECIAL POPULATIONS

Renal Impairment: *Prevention of VTE following Elective Hip or Knee Replacement Surgery:* No dose adjustment is necessary in patients with mild or moderate renal impairment (eCrCl ≥30 mL/min) (see ACTION AND CLINICAL PHARMACOLOGY, Renal Impairment in the Product Monograph). Limited clinical data in patients with severe renal impairment (eCrCl 15-29 mL/min) indicate that apixaban plasma concentrations are increased. Therefore, apixaban is to be used with caution in these patients because of potentially higher bleeding risk. Because there is very limited clinical experience in patients with creatinine clearance <15 ml/min, and there are no data in patients undergoing dialysis, apixaban is not recommended in these patients (see WARNINGS AND PRECAUTIONS, Renal Impairment, and ACTION AND CLINICAL PHARMACOLOGY, Renal Impairment in the Product Monograph).

Stroke Prevention in Patients with Atrial Fibrillation: No dose adjustment is necessary in patients with mild or moderate renal impairment, or in those with eCrCL 25-30 mL/min. However, patients with serum creatinine ≥133 micromol/L (1.5 mg/dL) who are also ≥80 years or whose body weight ≤60 kg, should receive a dose of apixaban 2.5 mg twice daily. In patients with eCrCL 15-24 mL/min, no dosing recommendation can be made as clinical data are very limited. Because there are no data in patients with creatinine clearance <15 mL/min, or in those undergoing dialysis, apixaban is not recommended in these patients (see ACTION AND CLINICAL PHARMACOLOGY, Renal Impairment in the Product Monograph).

Hepatic Impairment: ELIQUIS is contraindicated in patients with hepatic disease associated with coagulopathy and clinically relevant bleeding risk (see CONTRAINDICATIONS). ELIQUIS is not recommended in patients with severe hepatic impairment (see WARNINGS AND PRECAUTIONS, Hepatic Impairment, and ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics in the Product Monograph). ELIQUIS should be used with caution in patients with mild or moderate hepatic impairment (Child Pugh A or B). No dose adjustment is required in patients with mild or moderate hepatic impairment (see WARNINGS AND PRECAUTIONS, Hepatic Impairment, and ACTION AND CLINICAL PHARMACOLOGY, Hepatic Impairment in the Product Monograph). Patients with elevated liver enzymes (ALT/AST >2 x ULN, or total bilirubin ≥1.5 x ULN) were excluded in clinical trials. Therefore, ELIQUIS should be used with caution in these patients.

Concomitant Use of Antiplatelet Agents: The concomitant use of ELIQUIS with antiplatelet agents increases the risk of bleeding (see WARNINGS AND PRECAUTIONS, Bleeding). If concomitant antiplatelet therapy is contemplated for indications related to coronary artery disease, a careful assessment of the potential risks should be made against potential benefits, weighing risk of increased bleeding against expected benefit (see ADVERSE REACTIONS, Bleeding, Stroke Prevention in Patients with Atrial Fibrillation, and DRUG INTERACTIONS, Drug Products Affecting Hemostasis).

Concomitant Use with CYP3A4 and P-gp Inhibitors/ Inducers: *Inhibitors of Both CYP3A4 and P-gp:* The use of ELIQUIS is contraindicated in patients receiving concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-gp, such as azole-antimycotics (e.g., ketoconazole, itraconazole, voriconazole, or posaconazole), and HIV protease inhibitors (e.g., ritonavir) (see CONTRAINDICATIONS, and WARNINGS AND PRECAUTIONS, Inhibitors of Both CYP3A4 and P-gp). Drugs moderately inhibiting the apixaban elimination pathways, CYP3A4 and/or P-gp, would be expected to increase apixaban plasma concentrations to a lesser extent. For example, concomitant administration of diltiazem led to a 40% increase in apixaban AUC, while naproxen, an inhibitor of P-gp, led to a 50% increase in apixaban AUC (see DRUG INTERACTIONS, Table 7 in the Supplemental Product Information). No dose adjustment for apixaban is required when co-administered with less potent inhibitors of CYP3A4 and/or P-gp, (see WARNINGS AND PRECAUTIONS, Bleeding).

Inducers of Both CYP3A4 and P-gp: Co-administration of apixaban with rifampicin, a strong inducer of **both** CYP3A4 and P-gp, led to an approximate 54% decrease in apixaban AUC. The concomitant use of apixaban with other strong inducers of both CYP3A4 and P-gp (e.g., phenytoin, carbamazepine, phenobarbital or St. John's Wort) may also lead to reduced apixaban plasma concentrations. Combined use of ELIQUIS with strong inducers should generally be avoided since efficacy of ELIQUIS may be compromised (see WARNINGS AND PRECAUTIONS, Inducers of Both CYP3A4 and P-gp).

Body Weight: *Prevention of VTE following Elective Hip or Knee Replacement Surgery:* No dose adjustment required.

Stroke Prevention in Patients with Atrial Fibrillation: No dose adjustment is generally required. However, patients with body weight ≤60 kg, and having age ≥80 years or with serum creatinine ≥133 micromole/L (1.5 mg/dL), should receive a reduced dose of apixaban 2.5 mg twice daily.

Gender: No dose adjustment required.

Ethnicity: No dose adjustment required.

Pediatrics (<18 years of age): No data are available in respect of the safety and effectiveness of ELIQUIS in children. Use of ELIQUIS is not recommended in children.

Geriatrics (≥65 years of age): *Prevention of VTE following Elective Hip or Knee Replacement Surgery:* No dose adjustment required (see WARNINGS AND PRECAUTIONS, Geriatrics, and ACTION AND CLINICAL PHARMACOLOGY, Geriatrics). *Stroke Prevention in Patients with Atrial Fibrillation:* No dose adjustment is generally required. However, patients with age ≥80 years, and having body weight ≤60 kg or with serum creatinine ≥133 micromole/L (1.5 mg/dL), should receive a reduced dose of apixaban 2.5 mg twice daily.

Cardioversion: Patients can be maintained on ELIQUIS while being cardioverted (see ACTION AND CLINICAL PHARMACOLOGY, Cardioversion in the Product Monograph).

Switching from or to parenteral anticoagulants: In general, switching treatment from parenteral anticoagulants to ELIQUIS (or vice versa) can be done at the next scheduled dose.

Switching from vitamin K antagonists (VKA) to ELIQUIS: When switching patients from a VKA, such as warfarin, to ELIQUIS, discontinue warfarin or other VKA therapy, and start ELIQUIS when the international normalized ration (INR) is below 2.0.

Switching from ELIQUIS to VKA: As with any short-acting anticoagulant, there is a potential for inadequate anticoagulation when transitioning from ELIQUIS to a VKA. It is important to maintain an adequate level of anticoagulation when transitioning patients from one anticoagulant to another. ELIQUIS should be continued concurrently with the VKA until the INR is ≥2.0. For the first 2 days of the conversion period, the VKA can be given in the usual starting doses without INR testing (see Considerations for INR Monitoring of VKA Activity during Concomitant ELIQUIS Therapy). Thereafter, while on concomitant therapy, the INR should be tested just prior to the next dose of ELIQUIS, as appropriate. ELIQUIS can be discontinued once the INR is >2.0. Once ELIQUIS is discontinued, INR testing may be done at least 12 hours after the last dose of ELIQUIS, and should then reliably reflect the anticoagulant effect of the VKA.

Considerations for INR Monitoring of VKA Activity during Concomitant ELIQUIS Therapy: In general, after starting VKA therapy, the initial anticoagulant effect is not readily apparent for at least 2 days, while the full therapeutic effect is achieved in 5-7 days. Consequently, INR monitoring in the first 2 days after starting a VKA is rarely necessary. Likewise, the INR may remain increased for a number of days after stopping VKA therapy. Although ELIQUIS therapy will lead to an elevated INR, depending on the timing of the measurement (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph), the INR is not a valid measure to assess the anticoagulant activity of ELIQUIS. The INR is only calibrated and validated for VKA and should not be used for any other anticoagulant, including ELIQUIS. When switching patients from ELIQUIS to a VKA, the INR should only be used to assess the anticoagulant effect of the VKA, and not that of ELIQUIS. Therefore, while patients are concurrently receiving ELIQUIS and VKA therapy, if the INR is to be tested, it should not be before 12 hours after the previous dose of ELIQUIS, and should be just prior to the next dose of ELIQUIS, since at this time the remaining ELIQUIS concentration in the circulation is too low to have a clinically important effect on the INR. If INR testing is done earlier than just prior to the next dose of ELIQUIS, the reported INR will not reflect the anticoagulation effect of the VKA only, because ELIQUIS use may also affect the INR, leading to aberrant readings (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph).

Missed Dose: If a dose is missed, the patient should take ELIQUIS immediately and then continue with twice daily administration as before. A double dose should not be taken to make up for a missed tablet.

OVERDOSAGE

For management of a suspected drug overdose, contact your regional Poison Control Centre.

Overdose of ELIQUIS (apixaban) may lead to hemorrhagic complications, due to its pharmacologic properties. A specific antidote for ELIQUIS is not available. In healthy subjects, administration of activated charcoal 2 and 6 hours after ingestion of a 20-mg dose of apixaban reduced mean apixaban AUC by 50% and 27%, respectively, and had no impact on C_{max}. Mean half-life of apixaban decreased from 13.4 hours when apixaban was administered alone to 5.3 hours and 4.9 hours, respectively, when activated charcoal was administered 2 and 6 hours after apixaban. Thus, administration of activated charcoal may be useful to reduce absorption and systemic exposure of apixaban in the management of overdose or accidental ingestion. Hemodialysis decreased apixaban AUC by 14% in subjects with end stage renal disease, when a single dose of apixaban 5 mg was administered orally. Apixaban protein binding has been shown to be over 90% in subjects with end-stage renal disease. Therefore, hemodialysis is unlikely to be an effective means of managing apixaban overdose (see ACTION AND CLINICAL PHARMACOLOGY, Renal Impairment in the Product Monograph).

Management of Bleeding: In the event of hemorrhagic complications in a patient receiving ELIQUIS, treatment must be discontinued, and the source of bleeding investigated. Appropriate standard treatment, e.g. surgical hemostasis as indicated and blood volume replacement, should be undertaken. In addition, consideration may be given to the use of fresh whole blood or the transfusion of fresh frozen plasma. If bleeding cannot be controlled by the above measures, consider administration of one of the following procoagulants: activated prothrombin complex concentrate (APCC), e.g., FEIBA; prothrombin complex concentrate (PCC); recombinant Factor-VIIa (rFVIIa). However, there is currently only very limited experience with the use of these products in individuals receiving ELIQUIS. Protamine sulfate and vitamin K are not expected to affect the anticoagulant activity of ELIQUIS. There is no experience with antifibrinolytic agents (tranexamic acid, aminocaproic acid) in individuals receiving ELIQUIS. There is neither scientific rationale for benefit or experience with the systemic hemostatics, e.g., desmopressin and aprotinin in individuals receiving ELIQUIS. The Rotachrom anti-FXa assay may be useful to confirm excess apixaban exposure and help to inform clinical decisions in circumstances of clinical overdose (see ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph). INR should **NOT** be used to assess the anticoagulant effect of ELIQUIS (see WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests, and ACTION AND CLINICAL PHARMACOLOGY, Pharmacodynamics in the Product Monograph).

SUPPLEMENTAL PRODUCT INFORMATION

ADVERSE REACTIONS

Prevention of VTE following Elective Hip or Knee Replacement Surgery

Less common adverse reactions observed in clinical trials in apixaban-treated patients undergoing hip or knee replacement surgery occurring at a frequency of ≥0.1% to <1% were: blood and lymphatic system disorders: thrombocytopenia; gastrointestinal disorders: gastrointestinal hemorrhage, including hematemesis, melena, and hematochezia; hepatobiliary disorders: liver function test abnormal, serum alkaline phosphatase increased, serum bilirubin increased; injury, poisoning and procedural complications: wound secretion, incision site hemorrhage or hematoma, operative hemorrhage; renal and urinary disorders: hematuria; respiratory, thoracic and mediastinal disorders: epistaxis;

vascular disorders: hypotension. Less common adverse reactions observed in clinical trials in apixaban-treated patients undergoing hip or knee replacement surgery occurring at a frequency of <0.1% were: gingival bleeding, hemoptysis, drug hypersensitivity, muscle hemorrhage, ocular hemorrhage (including conjunctival hemorrhage), rectal hemorrhage.

Stroke Prevention in Patients with Atrial Fibrillation (SPAF)

Less common adverse reactions observed in the ARISTOTLE and AVERROES studies in apixaban-treated patients occurring at a frequency of ≥0.1% to <1% were: immune system disorders: Drug hypersensitivity, such as skin rash, anaphylactic reactions; nervous system disorders: Intracranial hemorrhage, intraspinal hemorrhage or hematoma, subdural hemorrhage, subarachnoid hemorrhage; vascular disorders: Intra-abdominal hemorrhage; respiratory, thoracic and mediastinal disorders: hemoptysis; gastrointestinal disorders: hemorrhoidal hemorrhage, hematochezia, retroperitoneal hemorrhage (<0.1%); reproductive system and breast disorders: abnormal vaginal hemorrhage, hematuria; injury, poisoning and procedural complications: post-procedural hemorrhage, traumatic hemorrhage, incision site hemorrhage; investigations: occult blood positive.

DRUG INTERACTIONS

Table 7 – Summary of Drug-Drug Interactions

Proper Name	Reference	Effect	Clinical Comment
Ketoconazole	CT	Co-administration of apixaban with ketoconazole (400 mg once a day), a strong inhibitor of both CYP3A4 and P-gp, led to a 2-fold increase in mean apixaban AUC and a 1.6 fold increase in mean apixaban C_{max}.	The use of ELIQUIS is contraindicated in patients receiving concomitant systemic treatment with strong inhibitors of **both** CYP3A4 and P-gp, such as ketoconazole, itraconazole, voriconazole, posaconazole and ritonavir (see CONTRAINDICATIONS).
Diltiazem	CT	Diltiazem (360 mg once a day), considered a moderate CYP3A4 and a weak P-gp inhibitor, led to a 1.4 fold increase in mean apixaban AUC and a 1.3 fold increase in C_{max}. Other moderate inhibitors of CYP3A4 and/or P-gp, such as amiodarone and dronedarone, are expected to have similar effect.	No dose adjustment for apixaban is required. Use with caution.
Naproxen	CT	A single dose of naproxen 500 mg, an inhibitor of P-gp but not an inhibitor of CYP3A4, led to a 1.5-fold and 1.6-fold increase in mean apixaban AUC and C_{max}, respectively. A corresponding 63% increase in mean anti-Xa activity at 3 hours post-dose was observed when apixaban was co-administered with naproxen. Apixaban had no effect on naproxen AUC or C_{max}. No changes were observed in the usual effect of naproxen on (arachidonic acid-induced) platelet aggregation.	No dose adjustment for either agent is required. Use with caution.
Rifampin	CT	Co-administration of apixaban with rifampin, a strong inducer of both CYP3A4 and P-gp, rifampin, led to an approximate 54% and 42% decrease in mean apixaban AUC and C_{max}, respectively.	Combined use with strong inducers of both CYP3A4 and P-gp should generally be avoided, since efficacy of ELIQUIS may be compromised (see WARNINGS AND PRECAUTIONS, Inducers of Both CYP3A4 and P-gp.
Enoxaparin	CT	Enoxaparin had no effect on the pharmacokinetics of apixaban. After combined administration of enoxaparin (40 mg single dose) with apixaban (5 mg single dose), an additive effect on anti-Factor-Xa activity was observed.	Concomitant use of apixaban with enoxaparin is contraindicated (see CONTRAINDICATIONS).
Acetylsalicyclic acid (ASA)	CT	Pharmacokinetic interactions were not evident when apixaban was co-administered with acetylsalicylic acid 325 mg once a day.	No dose adjustment for either agent is required, but bleeding risk is increased (see WARNINGS AND PRECAUTIONS, Bleeding, and ADVERSE REACTIONS, Bleeding, SPAF). Assess bleeding risk before co-administration, and use with caution, if deemed necessary.
Clopidogrel	CT	Pharmacokinetic interactions were not evident when apixaban was co-administered with clopidogrel 75 OD or with the combination of clopidogrel 75 mg and acetylsalic acid 162 mg OD.	Concomitant use of ASA or dual antiplatelet therapy increases the risk for major bleeding with either ELIQUIS or warfarin in patients with atrial fibrillation (see WARNINGS AND PRECAUTIONS, Bleeding, and ADVERSE REACTIONS, Bleeding, SPAF).
Atenolol	CT	Co-administration of a single dose of apixaban (10 mg) and atenolol (100 mg), a common beta-blocker, did not alter the pharmacokinetics of atenolol or have a clinically relevant effect on apixaban pharmacokinetics. Following administration of the two drugs together, mean apixaban AUC and C_{max} were 15% and 18% lower than when administered alone.	No dose adjustment for either agent is required.
Famotidine		The administration of apixaban 10 mg with famotidine 40 mg had no effect on apixaban AUC or C_{max}.	No dose adjustment for apixaban is required when co-administered with famotidine. These data indicate that apixaban pharmacokinetics are not likely to be altered by changes in gastric pH or co-administration with other organic cation transport inhibitors.
Digoxin	CT	Co-administration of apixaban (20 mg once a day) and digoxin (0.25 mg once a day), a P-gp substrate, did not affect digoxin AUC or C_{max}.	No dose adjustment for digoxin is required. Apixaban does not inhibit P-gp mediated substrate transport.
Prasugrel	CT	When prasugrel 10 mg qd was co-administered with apixaban 5 mg bid, there was no impact on steady-state apixaban AUC or C_{max}. No clinically meaningful effect of apixaban co-administration on the PK of prasugrel's active metabolite was detected.	No clinically relevant PK interaction (see WARNINGS AND PRECAUTIONS, Bleeding).
Charcoal (activated)	CT	Administration of activated charcoal (50 g charcoal and 96 g sorbitol in 240 ml of water) 2 hours and 6 hours after apixaban 20 mg, resulted in a mean 50% and 27% decrease in apixaban AUC, respectively.	May be useful in overdosage or accidental ingestion (see OVERDOSAGE).

Legend: CT = Clinical Trial

For a copy of the Product Monograph, please contact: Pfizer Canada Medical Information at 1-800-463-6001 or visit www.pfizer.ca or by contacting Bristol-Myers Squibb Canada at 1-866-463-6267 or visit www.bmscanada.ca.

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