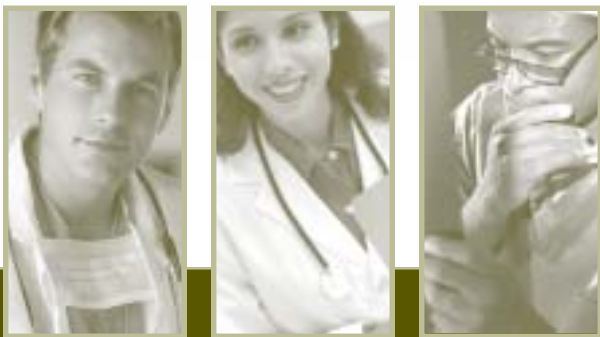


the Messenger

College of Physicians and Surgeons of Alberta

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College of
Physicians
& Surgeons
of Alberta

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Vice President - Dr. Gordon Arnett
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Registrar's Report



An unprecedented event occurred during the February meeting of Council: Councillors joined Alberta Medical Association Board Directors and Alberta Health and Wellness representatives to consider and discuss the challenges of primary care renewal/reform.

The evening was a success on a number of fronts: an enhanced collegiality among Directors and Councillors was most identifiable. Another included a broader common understanding of what comprises "primary care reform":

- integration of the delivery of first contact patient services;
- collaborative and team-based delivery models, with an emphasis on increasing and improving population health indicators;
- coordinated 24/7 access to essential services
- preventive and health promotion measures; and
- the use of medical informatics to

support electronic health records and clinical decision support systems.

General discussion surrounding challenges to the process followed - a discussion that helped the participants understand each other's roles in responding to the challenges. For the College's part, these include reviewing existing standards and direction to the profession that may constitute barriers to interprofessional collaboration, common record keeping, and shared responsibility.

This activity also contributes to achieving one of the initiatives outlined in the College's 2003 *Business Plan*, which was presented to the Council at its February meeting. Working within four key areas, the *Business Plan* outlines targets for the year. Priorities underlying the initiatives include the *Health Professions Act* regulation process, work to enhance issues of access, (through the primary care work referred to above, as an example), and other similar efforts to mitigate physician shortages. These priorities serve to emphasize what continues to be an ambitious agenda of operational issues for the College.

One of these operational issues is the provision of advice to physicians surrounding ethics, especially conflict of interest. Council assessed that the existing guidance (found in the *Conflict of Interest*, *Ownership of Medical Practice*, and *Association with Pharmaceutical Manufacturers* policies) is well-grounded, providing a good framework for advising physicians. What is lacking is awareness of the existence and content of these policies, and examples of their application in

physicians' day-to-day experiences. Starting with this issue, *The Messenger* will feature a series of articles to address this topic. As always, feedback is welcome.

A final explanatory note: included in this issue is a letter from Dr. Lindsay Crowshoe, an Aboriginal family physician, on the sensitive and tragic issue of native adolescent suicide and its linkage to prescription drugs.

This letter appears for a couple of reasons. First, it is a health problem of vexing proportion. (Coincidentally, Health Canada just released a national year-long study of the same issue, so Dr. Crowshoe's letter is timely). Second, it is in response to a request arising from a consultation with provincial and regional interests. The message to physicians is stark: the first step in mitigating the situation is awareness, for which Dr. Crowshoe's letter is an excellent beginning.

Dr. Bob Burns
Registrar

Do you have a question for your Registrar?

Would you like to get the College's perspective on a particular issue?

Mail your questions and comments to the College office or e-mail: rburns@cpsa.ab.ca

Prescribing Precautions

Cross Border Prescribing

The College continues to receive inquiries from physicians, pharmacists, lawyers, and the media about its position on Alberta physicians signing/countersigning prescriptions written by U.S. physicians for non-Canadians. The aim of this scheme is to allow dispensing by a Canadian pharmacist at a price substantially lower than the American patient would pay if dispensed by a U.S. pharmacist - that saving being further enhanced by the present value of the Canadian dollar. Payment to the Alberta physician for doing this is very substantial and thus the incentive is great when one provides the service on several hundred prescriptions at a time.

The College's response remains that prescribing medications based on information received either verbally or by fax, telephone, or electronic means, without an opportunity to perform a personal assessment of the patient (except when acting as part of an on-call group), does not meet an acceptable standard of care and may be considered conduct unbecoming of a medical practitioner.

Retired Physician Prescribing

The College recently received a few calls from or about retired physicians writing prescriptions.

Retired physicians should not treat themselves, family members or others. Retired physicians, by definition, are no longer actively treating patients. Retired physicians can not prescribe medications, order laboratory investigations or other treatments, as they are no longer attending to patients in person. In addition, they do not have access to the patient's medical record.

Prescribing for Self or Family Members

It is inappropriate for physicians to treat themselves or family members, including the prescribing of medication.

The Canadian Medical Association's *Code of Ethics* states that doctors should "Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment."

There are risks in treating one's self or family members:

- There is an inherent conflict of interest in doing so;
- There is no clear boundary between personal and professional roles; and
- The risk to both parties for an unexpected and unfavorable outcome is considerable.

Physicians should ensure that they and their family members have a family doctor of their own who can provide them medical care.

See *Messenger* issues 76 (February 2000) and 91 (January 2002) for other articles discussing this topic.

Past issues of *The Messenger* are available on the CPSA web site under "publications/resources - the messenger".

*Ms. Cathy McCann, Manager
Physician Prescribing Practices*

Assisted Reproductive Technologies

The Government of Canada is considering legislation (Bill C-13) to regulate assisted reproductive technologies and services.

As currently drafted, Bill C-13 states that artificial insemination must be done in an approved and accredited facility. Physicians currently providing artificial insemination services in an office-setting should notify the College.

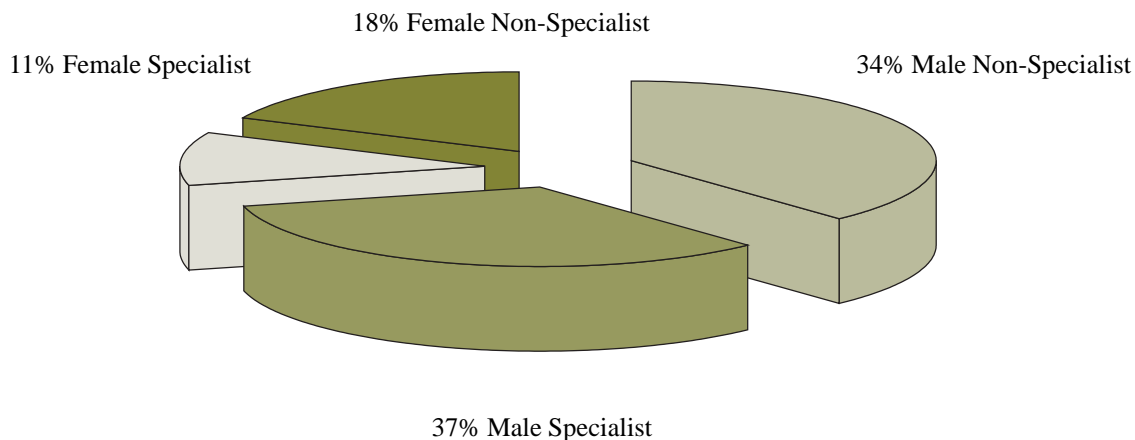
The College is also asking for your feedback on the proposed legislation as your opinions are important for this and future regulatory steps. Send comments in writing to the attention of Dr. Bryan Ward, Assistant Registrar, or e-mail bward@cpsa.ab.ca.

2002 Physician Resource Statistics

Changes in Physician Workforce:

	2002	2001	2000	1999	1998
Increases					
New Registrants					
University of Alberta	60	80	52	103	83
University of Calgary	36	37	34	51	38
Other Canadian Universities	148	162	135	132	119
USA	3	4	1	1	3
Other	131	106	121	99	129
Restored to Register	51	46	51	49	71
Returned to Province	30	24	40	51	75
Total	459	459	434	486	518
Decreases					
Left Alberta	-91	-103	-114	-90	-152
Retired	-29	-31	-35	-28	-37
Voluntary Erasure	-23	-50	-32	-37	-21
Removed from the Register	-56	-49	-45	-77	-102
Deceased	-11	-13	-14	-7	-12
Total	-210	-246	-240	-239	-324
Net change during each year	249	213	194	247	194

Workforce Breakdown:



continued on page 6

Registration Information:

	2002	2001	2000	1999	1998
Type of Registration					
Full Register	5,196	5,012	4,876	4,769	4,609
Special Register	488	431	365	297	223
Temporary Register	4	7	4	2	19
Courtesy Register	1	1	2	3	3
Total	5,689	5,451	5,247	5,071	4,854
Sex					
Female	1,649	1,541	1,457	1,372	1,298
Male	4,040	3,910	3,790	3,699	3,556
Specialist/Non-Specialist					
Specialist	2,807	2,667	2,547	2,450	2,322
Non-Specialist	2,882	2,784	2,700	2,621	2,532
Location					
RHA 1 Chinook	229	228	233	225	211
RHA 2 Palliser	109	114	117	112	111
RHA 3 Headwaters	112	105	108	104	90
RHA 4 Calgary	2,147	2,058	1,941	1,859	1,773
RHA 5 Health Region 5	44	39	42	39	41
RHA 6 David Thompson	266	259	255	247	227
RHA 7 East Central	99	94	93	95	88
RHA 8 Westview	83	86	74	77	79
RHA 9 Crossroads	49	46	45	43	43
RHA 10 Capital	2,185	2,061	1,984	1,935	1,877
RHA 11 Aspen	61	60	58	54	54
RHA 12 Lakeland	99	97	102	96	91
RHA 13 Mistahia	93	91	91	88	86
RHA 14 Peace	21	21	19	18	15
RHA 15 Keeweenok Lakes	21	23	22	19	19
RHA 16 Northern Lights	47	46	42	33	36
RHA 17 Northwestern	13	13	13	12	13
Location Unknown	11	10	8	15	N/A
Other Registrants					
Full Register, out of province	442	464	453	470	572
Educational Register	1,455	1,399	1,319	1,299	1,306
Total	1,897	1,863	1,772	1,769	2,358
Grand Total, All Registrants	7,586	7,314	7,019	6,840	7,212
Retired					
Retired, in Alberta	453	454	462	449	361
Retired, out of province	115	96	88	146	119
Total Retired	568	550	550	595	480

Medical Leadership Opportunity

The Federation of Medical Licensing Authorities of Canada (FMLAC) is looking for a new Executive Director.

As CEO, the Executive Director provides leadership, direction and guidance to the elected President, Executive Committee and Board of Directors on FMLAC issues, strategies and operational policies.

This is a permanent part-time (0.6 FTE) position, much of which time would be spent at the FMLAC offices in Ottawa.

Preferred qualifications include:

- experience as a senior officer in a Canadian or provincial medical organization, preferably in a medical licensing authority;
- experience in hospital administration, business administration or equivalent; and

- preference will be given to a physician licensed in one of the provinces or territories.

For further information, contact the FMLAC Director of Administration & Services at (613) 738-0372 or e-mail ssmith@fmlac.com.

Applications close April 15, 2003.

Update Your CPSA Records

Finding a physician who is accepting new patients is not an easy task for the public, especially residents new to Alberta.

The difficulty of this task is compounded when information on the College's web site is not up to date.

Physicians are responsible for informing the College when there is a

change to their practice information (including address, telephone, fax, and status for accepting new patients, etc.).

Changes are immediately recorded in the College's database, and this information is transferred to the web site regularly.

Although the College facilitates the collection of physician information via the annual "Registration Information Form", accuracy of our database throughout the

remainder of the year depends on physicians notifying us of changes.

To update your records, contact Karen Graves at kgraves@cpsa.ab.ca; (780) 970-6216 or 1-800-320-8624.

Letter to the Editor

Prescription Drug Abuse & Suicide in the Aboriginal Community

The College received this article in follow-up to a conversation between College and Calgary Health Region officials. Dr. Lindsay Crowshoe is a general practitioner and an assistant professor at the University of Calgary. His article is being printed as a letter to the editor to call this important topic to the attention of the profession.

Prescription Drug Abuse and Suicide in the Aboriginal Community: The Physician's Contribution?

Prescription drug misuse, abuse or diversion is not well documented in the addictions literature but is recognized as a problem with significant consequences for all communities in Canada and is viewed as one of the important indicators of social distress in the Aboriginal community.

Suicide is another indicator of social distress in the Aboriginal community and has strong association with addictions. Suicide is the second most common cause of death in Aboriginal people after motor vehicle accidents. Across Canada, the suicide rate in Aboriginal people is approximately three times higher than in non-Aboriginal Canadians and up to seven times higher than in non-Aboriginal adolescents.

In Alberta, the trend is similar. From 1983 to 1999 there were approximately 475 suicide deaths in registered First Nations.

For males the predominant methods are hanging followed by firearms, but for females 25 years and older the predominant method is drug overdose. The current inequities in the social and economic environment as well unresolved grief and loss from tragic historical events are all underlying causes.

“To prescribe ethically we need knowledge and enhanced skills specific to the Aboriginal health situation.”

Understanding historical and cultural determinants of Aboriginal health is key to understanding a cycle of loss, social distress, substance abuse and suicide.

Historically important events and policies such as the Epidemics, Treaties, *Indian Act* and Residential School System have had tremendous adverse impacts and resulted in abrupt social change and stress. Historical documents or “Winter Count” of the Black Foot tribes (pictograms drawn on a Buffalo hide representing important yearly events) give clues to the personal and community experience due to the stress of rapid social change. Interestingly, pictograms from a Piikani Winter Count dating from the 1700’s only began to document suicide in 1822 when an individual hanged himself. We do not know the true reason this individual committed

suicide but we can make some inferences based on events occurring at the time, including, losses of community, family and friends due to repeated epidemics of infectious diseases and increased inter-tribal warfare over land and resources. The most likely causative factor was the ‘Whiskey Trade’ where alcohol became the currency for buffalo hides, which initiated tragic socio-economic changes and undermined the integrity of communities, families, and individuals. Likely, this individual’s personal, social and cultural protective factors had been overwhelmed.

Central nervous system agents are the most commonly prescribed class of drugs to Alberta First Nations clients. Codeine containing analgesics and benzodiazepines account for the majority of medications prescribed and have a significantly dangerous relationship to abuse, dependency and intentional and non-intentional injuries. A national Aboriginal profile of medication use and misuse is unknown, however, in Calgary, Alberta, 48 per cent of Aboriginal clients accessing addiction treatment reported using prescription medication inappropriately. Sedatives/relaxant followed by opioids/analgesics were the most common classes of medications that were inappropriately used.

Physicians in Alberta have prescribed 122 kilograms of codeine in 81,167 prescriptions to registered Aboriginal

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patients during a six-month block in 2002. Tylenol # 3 seems to be a readily available drug from physicians and is often used to address problems of pain post-injury and chronic non-cancer pain in patients. This mild narcotic is also used recreationally to create a “buzz”. This medication is often one of the many substances ingested to achieve suicide and adds acetaminophen induced hepato-toxicity to acute intoxication. The cycle of drug misuse is driven by a combination of availability, lack of access to adjunctive therapies, unresolved situational crises, as well as an altered community threshold around the perceived need for pain medications.

Benzodiazepines also have a risk for misuse, dependency and tolerance but also cause depressive symptoms, and there are reports of increased suicidal tendencies.

Benzodiazepines are used on the street to enhance the action of other substances and are a dangerous addition to poly-drug misuse. One out of every ten Canadians uses a benzodiazepine at least once a year and Canadians were prescribed 48 DDD (defined daily dose) per 1000 adult inhabitants per day. Physicians prescribed 297 DDD/1000/day to Alberta registered First Nations patients, which is six times the Canadian rate.

A full description of why physicians prescribe six times more benzodiazepines to Alberta registered First Nations patients is beyond the scope of this article but is extremely important. Likely, Aboriginal patients request benzodiazepines for situational anxiety arising from chronic stress and unresolved crises. Physicians need to be aware that benzodiazepines have a substantial adverse profile, particularly in the vulnerable Aboriginal population, and

that perhaps the underlying causes of stress and crises also need to be addressed.

These same classes of drugs are also diverted by drug seeking clients to sell on the street. In Vancouver, Tylenol #3 and Valium 10 mg were the index drugs of abuse for sale. The street value of a single Tylenol #3 in the Aboriginal community in which I work is 50 cents, whereas in the nearby urban community the price was approximately two dollars. Economics theory tells us that the price of a commodity is regulated by factors such as supply and demand, and so a logical explanation for the low street value is a large supply.

“Prescription drugs are freely available because they are ‘free’ and physicians seem to readily prescribe.”

Physicians prescribe large volumes of these medications and obviously a large proportion arrives on the street, and therefore a large proportion of individuals requesting these medications are malingering. Are physicians so easily fooled or are there other explanations?

As an Aboriginal person and physician, I find prescription drug abuse troubling. I am troubled with the volume of Aboriginal patients who request narcotics, benzodiazepines, and muscle relaxants for acute and chronic musculo-skeletal pain post injury. I am troubled when these same people arrive to the emergency room after they have over-dosed on ‘cocktails’ of prescription medications and alcohol. I am troubled by conversations with on-reserve nurses about the empty vials of medications

that are ‘strewn about the floor’ in the houses that they visit. Prescriptions drugs are freely available because they are ‘free’ (prescriptions for registered Aboriginal people are paid for by First Nations and Inuit Health Branch) and physicians seem to readily prescribe.

So, what is the solution? It is not simple. The cycles that lead to addictions and suicide need to be dismantled and Aboriginal communities need to heal, develop capacity and reconnect.

Aboriginal communities desperately need a well-defined collaborative cross-sectoral approach from policy to providers that offers appropriate and integrated services. At the end of the day, we still must make a decision to prescribe but we must realize that our prescribing habits influence the pattern of medication use and misuse. To prescribe ethically we need knowledge and enhanced skills specific to the Aboriginal health situation. Effective appropriate alternate therapies for pain and situational crises must be available.

To make a fundamental difference, physicians need to start impacting the root determinants of health, through primary care strategies such as multi-disciplinary teams and alternative payment programs. We as physicians need to be part of the solution not the problem.

I thank Dr. Margaret Clarke and Dr. Jim Dickinson for their assistance and editing.

*Dr. Lindsay Crowshoe
Calgary*

A referenced version of this article is available on the College’s web site www.cpsa.ab.ca.

2003 Medical Directory

A copy of the College's 2003 Medical Directory is being mailed out to all physicians with this issue of *The Messenger*. (Physicians receiving *The Messenger* electronically will also receive a hard copy of the directory by mail.)

Physicians who do not receive this one complimentary copy of the Directory should contact Ms. Karen Graves at (780) 970-6216, 1-800-561-3899 ext. 216, or kgraves@cpsa.ab.ca.

If physicians require additional copies, or if other parties are interested in obtaining the 2003 Medical Directory, it may be purchased based on the following rates.

- Picked up personally: \$53.50
- Shipped within Canada: \$58.85
- Shipped outside of Canada:
 - USA \$57.40
 - Overseas \$72.40

The above rates, where applicable, include shipping/handling charges and GST.

To place an order, complete the Medical Directory Order Form available on our web

site (http://www.cpsa.ab.ca/findaphysician/purchase_md.asp) or submit the form located in the back of the Medical Directory. Pre-payment is required by cheque, VISA or MasterCard prior to shipping any directories.

The College's Medical Directory is also available on-line at www.cpsa.ab.ca. It's Information at your fingertips!

PAR Program Update

Some recent news regarding the Physician Achievement Review (PAR) Program:

- Dr. Chuck Harley, an Internist from Edmonton, has been appointed as the new Chair of the Physician Performance Committee (PPC). Dr. Harley replaces Dr. Bill Hall of Calgary, who had been Chair of PPC since its inception.

- The first groups of medical specialists are currently undergoing PAR review. However, physician reports for

these specialists will be delayed somewhat until adequate numbers of physicians' data can be collected to calculate group norms. Within medical specialists, three sub-groups are being considered: pediatrics and its sub-specialties, psychiatrists, and all other medical specialists/sub-specialists.

- The PPC, augmented by its two subcommittees, held a retreat March 3-4, 2003. Under discussion were mechanisms for the ongoing evaluation and improvement of the PAR Program, and identification of aspects of the program

which should receive additional emphasis for 2003.

- To the end of December 2002, 2,652 physicians had completed PAR reviews of their practices. This represents over 83% of all eligible family/general practitioners and surgical specialists.

*Mr. John Swiniarski
Assistant Registrar*

Conflict of Interest

As the practice of medicine evolves, physicians increasingly find themselves working in multiple roles. These roles may include that of a “traditional” medical practice, multidisciplinary teams, administrative roles with regional health authorities or private organizations and research.

This complex medical ecosystem may lead us into situations of conflict of interest, that is, where our primary duty to the well-being of the patient may be unduly influenced by competing interests.

These conflicts of interest may be obvious or may be extremely subtle, but we have a responsibility to recognize them and to resolve them. The acid test of conflict

resolution rests in the first principle of the CMA’s *Code of Ethics* which states “consider first the well-being of the patient”.

The College will, over the next several issues of *The Messenger*, provide you with a detailed review of some of the more commonly occurring situations in which conflict of interest might arise. We hope that these articles will stimulate discussion between you and your colleagues, and we would, of course, welcome any feedback (including suggestions of other areas of conflict of interest that you believe need to be addressed through articles such as these).

Council has addressed the issue of conflict of interest in the past and physicians are encouraged to review the following policies/articles which are available on the CPSA web site (www.cpsa.ab.ca under

complaint advice and policies and guidelines):

- Conflict of Interest policy
- CMA’s Code of Ethics
- Don’t Treat Family Members
- Don’t Treat (or Investigate) Yourself
- Employing Patients and Relatives
- Ethics of Accepting Gifts
- Informed Choice
- Informed Choice - A Case in Point
- Physicians Reporting Physicians
- Who Can Give Consent

Dr. Paul Flynnne
Assistant Registrar

Kudos to Diagnostic Laboratories

Congratulations to Alberta’s Diagnostic Laboratories

Since 1965, the College has monitored the performance of diagnostic medical laboratories through its Laboratory Proficiency Testing Program (LPTP). This includes a review throughout the year of over 12,500 results in five disciplines,

including chemistry, cytology, hematology, microbiology and transfusion medicine, for over 150 laboratories.

Recently, on a cross-Canada survey, Alberta laboratories achieved a remarkable 100 per cent success rate on identifying a bacterial organism and performing antibiotic susceptibility testing - an

accomplishment never before achieved by any another province. Congratulations.

Complete details of the LPTP are available in the annual *Statement of Activities*. Copies of this publication are available by contacting Ms. Liz Melnyk at (780) 970-6208; 1-800-561-3899 ext. 208; lmelnyk@cpsa.ab.ca.

Methadone Workshop

Opiate Dependence and Methadone Maintenance Treatment Workshop - Calgary, Alberta.

The Addictions Task Group of the Non Prescription Needle Use Consortium is hosting a full day workshop for physicians, pharmacists and allied professionals with an interest in providing treatment for those suffering from opiate addiction.

Special Guest Speaker:

Dr. John Chappel, MD, Professor Emeritus of Psychiatry, University of Nevada School of Medicine; Medical Director, American Therapeutics Association

Other Presenters:

Dr. Ian M. Postnikoff (Psychiatry and Addictions); and Dr. Sarz Maxwell (Program Coordinator, Center for Addictive Problems, Chicago Illinois)

May 25th, 2003
8:00 am - 5:00 pm
Cost: \$100.00
Location: TBA

Continuing Medical Education credits are available for physicians through the University of Nevada. The workshop is recognized by the College of Physicians and Surgeons of Alberta.

For more information or to register contact Rose Dehod: Tel: (780) 990-0326,
Fax: (780) 990-1236, or E-mail: rose.dehod@altapharm.org.

the Messenger

College of Physicians and Surgeons of Alberta



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