1)
Founding principles of equity / fairness / respect or empathy (our social contract);

Continue to bring the conversation back to the values of empathy equity and fairness. The goal of the plethora of proposed motions is to bury these values in details and force the organization into a position of not being able to move forward. It is important to understand the why of this conversation. We've entered an age of rapid technological advancement, and change in health service delivery. Values of empathy equity and fairness have forever been enshrined in our social contract. Recent years have seen the public questioning whether that remains the case. It's important to ground the discussion in the fact that the world is changing around us, I have recently seen artificial intelligence engines that outperform radiologist in diagnostic interpretation, similar intelligence that outperforms dermatology in lesion recognition, facial recognition software that outperforms human ability to read emotion, and evidence that procedures are equally performed by technicians as physicians. In our world is becoming more broadly understood that physicians are not required for all clinical decisions in primary care. There is no shortage of allied health personnel, such as nurse practitioners or pharmacists, who are willing to step into our role and assume responsibility for the social contract. If within the organization we cannot commit to the values of empathy equity and fairness, there is simply no way the public will trust that we can embody these values in the delivery of health services. The question must be - given any imperfections in data, is the gap just - can we defend the stark differences to each other and the public?

2)
Many of the arguments are going to be emotional, the challenge is to stay out of the detail out of the emotion. It is certainly reasonable to very briefly attempt to refute any conjecture with evidence, speak plainly for or against any motion, but always reference the values of equity and fairness and the need to move forward and make progress.

3)
If the argument is to factor in a difference in complexity, speak to the evidence that complexity is as high or higher for primary care physicians. Agree that further study of this issue might be warranted but it should not preclude moving forward with the best available data currently. **See attached articles on complexity X 2.**

4)
If the argument is hours of after-hours work, point out the difference between radiology or dermatology vs general surgery. Raise the question regarding the data truly being explained by this factor? Again, agree that further study might be warranted but it shouldn't preclude us moving forward with the best available data now.

5)
If the argument is to start a specialty alliance, I might speak in favor of this motion. I would also point out what the objectives of PCA are (this comes of the PCA Charter);

1) Expand, cultivate and enhance strategic internal and external partnerships to advance Alberta's primary health care agenda and build alignment amongst groups.
2) Gain a better understanding of the different perspectives of PCA members.
3) Share data/research about primary care improvement initiatives with decision and policy makers.
4) Illuminate and analyze successful, developing and unsuccessful initiatives, services and supports impacting primary care in Alberta during regular and special meetings and other invitational opportunities as required.
5) Provide input on current and proposed policies and regulations that may affect primary care in Alberta.
6) Create a cohesive *"one voice"* approach by identifying areas where PCA members can target leadership and outreach via strategic partnerships to contribute to policy making, communication, pathways, community support and education initiatives directed at Alberta's primary care community.

I would invite specialty sections to start such an alliance, but point out that fees and income are not the focus of the primary care alliance. **See attached documents – TOR's of PCA and PCA Charter.**

6)
I would support that the RF gives direction to the board it does not "tell them what to do". This may be challenged by the floor. The goal of any board is to lead + represent and the board is trying to look at environmental signals and position the AMA favorably by dealing with an equity issue. Forward thinking is in fact good governance. If we cannot demonstrate the ability to create equity, we are ripe for someone else to do so.

7)
I would refute any attempt to impose a two thirds majority rule by again returning to the values of equity and fairness and questioning whether any organization will be able to logistically move forward productively in such an arrangement. Again, reference that the accepted democratic standard is 50% + 1, that challenging this standard would be challenging the fundamental understanding of democracy.

8)
Last segment of work is on population health given primary care and specialty ratios. Arguments may come that decreasing fees could decrease interest in specialty and therefore health outcomes. I am not sure that I can justify the argument regarding selection into a career being influenced by a modest income reduction – there is no evidence to support that. You can also point out the evidence that increasing PC ratios associated with better health outcomes. If your bold there is evidence that increasing specialty ratios increase mortality. **See the attached Starfield articles X 4.**