Communicating with physicians in the Calgary area

# Vital Signs

January 2010

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients

## Michelle Lang
## 1975-2009

CAPA
CALGARY & AREA PHYSICIANS ASSOCIATION

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A Calgary & Area Physician's Association publication
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**CAPA executive** - ***Please feel free to contact your representative with any concerns or issues.***



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Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in the Calgary region. Please limit articles to 600 words or less.

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**On the cover: Michelle Lang.**
**Photo by Dave Lowery**

# Contents

**January 2010**

***Columns:***



***Feature:***

# Are we expendable?

**From the CAPA president**

I, for one, am very glad now that it is January and we have passed the shortest day of the year once again. It never used to be such a memorable occasion for me . . . must be a sign of getting old! 2010 is now upon us and we can look forward to new and exciting things on the horizon for healthcare in our Calgary zone. Or can we? The future is looking more and more bleak as we face daily cutbacks and looming budget cuts.

I am desperately trying to see the vision for Alberta Health Services beyond the rhetoric and the goal to save money. The vision appears to be missing.

So I looked at the platforms for healthcare online for our current government and the three opposition parties. I was expecting to see perhaps some real differences, some real changes and some real vision. There are lots of platitudes, grand statements for better healthcare for all Albertans but no real vision. "Having timely and affordable access to healthcar" as is stated in the Wildrose Alliance party's platform is not a vision. It is a reflection of the serious decline we have seen in our ability to provide medical care under the Canada Health Act. The conservative platform talks about approved funding for new hospitals in Alberta, including the South Calgary Health Campus. This was a vision but is now a constant reminder of the lack of vision. The funding has been scaled back so much we are no longer sure what we will be getting if anything. The liberal platform talks about training enough nurses, doctors and other healthcare professionals to meet Alberta's need. This is not a vision; it is a basic statement of supply and demand. The NDP platform is more a statement of what they are, not than of a future vision for healthcare. They are not apparently like the other parties who are on the side of "the for-profit healthcare insurance and drug companies."

Interestingly, in the conservative platform, they talk about waiting lists and delays in seeing a healthcare professional as due to labour shortages in the health services field. They talk about building world class facilities that attract high calibre researchers, practitioners (?code for doctors), technicians and nurses from around the world. But wait a minute, we are not able to build the south health campus as planned. What happens to our ability to attract the best in the world? What about the waiting lists and delays?

We are really talking in circles, again without any vision. Without the facilities (world class or not) that we can be proud of we will not attract ongoing recruitment that will add to the waiting lists and the delays. The wait times are not just due to labour shortages, the labour shortages are a direct result of lack of infrastructure such as OR times for surgeons or community clinics for family doctors. Short term fiscal decisions made with no vision for the future will keep us spinning, like the hamster on a wheel chasing its tail. All the international medical graduates in the world will not fix our system if we do not provide the building blocks for a functioning system.

Are there any innovative ideas to be found in the platforms? A few maybe. A provincial ombudsman for health might be a start as suggested by the Wildrose Alliance. The liberal platform talks about electing the old RHA boards. How about electing the AHS board. The NDP suggests better funding for longterm care which is laudable.

**Dr. Linda Slocombe, CAPA president**
**Phone: 403-861-8423**

The conservatives have increased the number of training spaces for physicians which was sorely needed. A colleague of mine suggested the novel concept of 24-hour patient care. It is a reality of illness that it can strike at any hour of the day and yet we pretend that patients can live with a system that runs on a five day week, nine to five schedule. Cafeterias close, ultrasound is not available, OR's close. The poor overcrowded emergency rooms are taking up the slack for a system that virtually comes to a standstill on weekends and holidays. Care around the clock, a vision or a pipedream?

A recent new "innovation" from Alberta Health Services has been the announcement of the appointments to the new health advisory councils. The board has appointed these members of the public to the councils. They will work directly with "local leaders" and will help inform decision-making processes as AHS works to meet the health service delivery needs of Albertans. Sounds like a reasonable idea. My question is 'why are there 12 councils for only five zones in what were previously nine regions?' It seems dividing up Alberta into nice little geographic pieces is not an easy task. Geography does have a way of causing problems, especially in our harsh climate.

What all our politicians at present lack is a vision for how we can restore pride and common sense to our delivery of healthcare in Alberta. The vision must include a new funding model, not simply budget cuts hidden behind the veil of "finding efficiencies" in the system. One is not proud to work in a system that sees its workforce, its hospitals, its food services, its security staff, its parking lots as financial burdens. Our healthcare delivery, despite all the constraints for patients, is often world class. Why do we feel like we are not appreciated and ultimately expendable?

# An uncertain future

**From the CAPA past-president**

**Dr. D. Glenn Comm, CAPA past president**

I was a member of the Alberta Medical Association (AMA) negotiating team way back when our current tripartite agreement between the AMA, Alberta Health and Wellness and the health regions (now Alberta Health Services – AHS) was being negotiated. Most physicians know that this agreement set the stage for the development of Alberta's primary care networks (PCNs) as they are currently called. However, many don't know the premise that this funding was based on.

In AMA discussions it was estimated that about one third of the work that Alberta doctors were doing was unfunded. At the time this was about fifty dollars per Alberta patient. It was felt this amount would compensate doctors for unfunded work. However, the devil is in the details. After the agreement was signed, much happened during its implementation was certainly NOT what the AMA, at least, had envisioned. Representatives from Alberta Health and Wellness and Regional Health Area (RHA), some who were physicians in administrative roles, interpreted the agreement much differently. In the end, while we finally saw the creation of PCNs in Calgary, very little of the added funds went into physicians pockets. There WERE, programs and supports added for Calgary physicians. Yet it was a far cry from what the AMA negotiator had envisioned. Cash strapped RHAs ensured that little, if any, of these new funds ended up in physician's pockets. And Edmonton set these up way earlier than we did.

I speak about all of this because recently AHS, the current iteration of the previous RHAs, wants to have a say in the structure of regional medical organizations (RMOs). The same AHS that would forbid physicians from speaking out. As physicians, we need to be able to advocate for our patients. Physicians must be able to speak out on behalf of our patients. RMO leaders must be able to advocate for patients in their zones and to speak out about concerns for safety, care, and the impact changes made by AHS are having on our ability to do our job. To do so they must be aligned with the AMA.

As I write, some of us have been working our butts off during this holiday season to try and keep up with the fractured ankles and legs from the icy weather as well as the normal ongoing emergency cases. Extra rooms have been added and people have worked unscheduled days. What has our thanks been. Essentially a slap in the face! AHS has cancelled the free Christmas dinner that has been a thank you to staff working the holiday in past years. And to add insult to injury, the cafeterias are closed from 10 PM until 6 AM until after New Years. What's next? Are they going to cancel our stampede breakfast?

AHS may think they don't need the good will of staff. They may think they can bully and threaten and run roughshod over the nurses and medical staff in this province. If they do they are very short sighted.

In the big picture, Alberta doctors' current master agreement expires in a few years. We will need leaders from ALL involved parties to see the big picture, understand what will be needed, and who can anticipate some of the issues that time will bring. Somehow, somewhere we need to start building bridges . . . not walls, to boldly move forward . . . not retreat into the Klein years. We must to be able to come up with the good will and the wisdom to negotiate a plan that will look after Albertans health needs through the year 2020. This cannot occur in our present atmosphere. Something will have to change.

In closing, I am deeply saddened by the death of Michelle Lang, Calgary Herald reporter. She was a good friend to the Calgary medical community who took pride in accurately portraying issues facing Calgary doctors. She will be missed.

# In memoriam

**Dr. Heinz Horst Wenger**

Dr. Heinz Horst Wenger, MD, LMCC December 2, 1916 - December 11, 2009 Heinz died peacefully at the Agape Hospice in Calgary at the age of 93 with his family by his side. Heinz was born in Tilsit, Germany. He studied medicine in Colgne, Germany and graduated with his MD and PhD degrees in 1950. On immigrating to Canada in 1951, Heinz fulfilled his Canadian medical studies requirements at the University of Montreal and completed his family medicine residency program at Ottawa General. The "call of the north" took Heinz to Moose Factory, Ontario in 1953 where he met his future wife Elfriede. Together they ventured west to Calgary, where Heinz practiced family medicine for thirty-five years. Heinz was caring and passionate about his family, faith, patients, community and the pleasures of summers spent at their beloved cabin in the Kootenays. His passion lives on in all those he touched throughout his life. Heinz will be lovingly remembered by his wife of fifty-one years, Elfriede; five children Sabine (Ditmar) Stauff of Paderborn, Germany, Andre Wenger (Trudy) of Kuwait, Irene (Chris) Ouellette of Edmonton, Martin Wenger of Calgary, and Monica (Rob) Park of Three Hills; seven grandchildren: Christoph (Jen), Georg, Ulrich and Johannes Stauff and Amanda, Geoffrey and Graham Park; as well as by his great-grandchild Dominik Stauff. Heinz was predeceased by his parents Gustav and Meta, sister Erna, brother Helmut, and his first wife Dorli. The family would like to express their sincerest appreciation to Dr. Van Dyk and the staff in Unit 81 of the Foothills Hospital and especially to Rev. Doug Priestap and the rest of the compassionate and caring staff at the Agape Hospice who made his final hours dignified and peaceful.

## Dr. Ian Martin Gunn

November 28, 1923 - November 16, 2009

Dr. Ian Martin Gunn "Gunner" of Calgary, Alberta, died peacefully on Monday, November 16, 2009. Born at the Scottish Nursing Home in Calgary on November 28, 1923, to Dr. and Mrs. (Anna) John Nisbett Gunn, he attended Earl Grey School, Central High School and the University of Alberta before joining the Royal Canadian Navy in 1945. After the war, Ian completed his studies at the University of Alberta, graduating from medical school in 1950. He undertook his medical internship in Honolulu, Hawaii and returned to Calgary to practice family medicine at the General Hospital for over forty-five years. His bedside manner was legendary as he had a way of focusing his total attention on each and every patient, regardless of the time or reason for the visit. Ian practiced medicine in a time when midnight house calls were common, and general practitioners routinely delivered babies. Over 2,500 Albertans took their first breath in Ian's hands. Ian's love for life and adventure took him to many corners of Canada and the world, but his heart was always in Alberta. It was here he met Cathy, who he married in 1954, and they began their life together. Ian was an avid outdoorsman who spent many hours with his father, sons, and friends hunting and fishing. He cherished his time duck hunting with his three sons, upland bird hunting with his friends on the Milk River Ridge, and trout fishing on the Ram River. Ian was a long-standing member of both the Calgary Golf and Country and the Glencoe Clubs. He was also an avid supporter and contributor to Ducks Unlimited and was a past member of the Kinsman Club of Calgary. He recently sponsored the creation of the Dr. Gunn Microscopy Lab at the Health Research Innovation Center in support of Kids Cancer Care. Ian was predeceased by the love of his life, Cathy (nee Morrison) (1998), his daughter Anna Elizabeth (1974), and sisters Jeanette (Motter) and Catherine. Ian is lovingly remembered by his daughter Barbara, sons John (Holly), Rob (Susan) and Murray (Sandy), thirteen loving grandchildren (Jennifer, Emily, Ian, David, Anna, Alex, Cameron, Cathy, Lindsay, Paul, Emma, Brian and Jill) and numerous nieces and nephews. Ian touched the lives of many and did everything he could for all of us. He was a remarkable husband, father, grandfather, brother, uncle, friend and physician. He always had a smile and had a knack for making everyone around him laugh and feel good; even in his later years when he was not well. We will all miss his loving spirit very much.

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# Lobbyist influence and the AHS

**From the CAPA president-elect**

**Dr. Lloyd Maybaum,**
**CAPA president-elect**
**Phone: 403-943-4904**

As a native Calgarian I have often wondered how Edmonton seems to fair so much better than Calgary in matters of provincial funding whether it be higher education, roads, infrastructure or health care. Usually, I cast these suspicions aside writing them off as the skewed perceptions of a proud Calgarian and accept that Edmontonians likely harbour the same suspicions about Calgary. However, others in Calgary have expressed similar observations and have proposed that Edmonton's success resides in its proximity to the legislative assembly. Presumably, it is much easier to meet for lunch with the elected and ministerial power players when you are just down the road vs. 300 km to the south.

In essence, the suggestion is that Edmonton's seeming success is partly a measure of effective lobbying and influence; proximity fostering greater intimacy and allowing for relationship building and the cultivation of influence. This begs the question: is influence any basis, guide or means by which health care infrastructure and funding decisions should be made? As physicians, we are continually bombarded with the importance and necessity to practice evidence-based medicine. What about legislators? Would it be too naïve to suggest that health care administrators and legislators should also practice evidence based funding and fiscal allocation?

If we look at the manner in which health care dollars have historically been allocated, what logic or parameters served as the foundation for past decisions? What proportion of decisions was based upon the rigor of evidence of actuarial need versus political influence and the 'scrum' of advocacy? I would like to suggest that influence and lobbying seems to have played a significant role. Let me explain with an excellent example from my experience in mental health and addictions (MH&A).

I refer to developments in 2008 in which MH&A was suddenly informed that the planned mental health pavilion at South Campus was to be put on hold. The ensuing crisis lead to an urgent meeting at Fort Calgary on July 21, 2008. It was during this meeting that AHS members of the board and senior executive told us that mental health does not lobby enough. An AHS executive specifically told us that we do not carry enough influence and that we must learn to lobby better. After the howls and catcalls died down we realized the truth had been spoken. We were flatly told that decisions are not based solely upon evidence and rationale but perhaps largely upon the lobby and influence. Painfully, we were told that we do not lobby well and perhaps insightfully we realized at least one reason why mental health had been coined the "orphan of medicare."

Given the above admission, if lobbying and influence have played a significant role in health care in the past, a particularly worrisome thought is that it continues to steer decisions currently being made by AHS. In this regard, we should consider that there are currently 45 registered lobbyists working on health and wellness in this province. According to the new provincial lobbyist registry, this does not include other lobbyists that do not meet the 100-hour minimum of face-to-face contact time with decision makers – a number needed in order to be officially titled a "lobbyist." Needless to say, lobbying and influence appears alive and well in the experiment known as AHS.

Weaving the notion of the lobbying influence with our past discussion of the lack of transparency in AHS and the culture of fear in health care, who would even know if lobbying were playing a significant role? Who would speak out even if they knew undue influence were at play? Some of us fear that with the lack of transparency anything could be happening.

I do not know to what extent health care dollars are dolled out based upon influence but I do know that with the advent of AHS we are standing at a moment of fortuitous change. A moment in which all things can change including what appears to be, at times, the inequitable distribution of health care resources. I argue that for the new AHS to succeed, health care fiscal allocation must be based upon the evidence of need and prioritized accordingly. Decisions based upon empire building, geographic accident and/or satisfying different spheres of influence will be detrimental to the AHS and all Alberta tax payers.

My interests as a physician are in guiding and stewarding a health care system that is balanced, equitable and accountable to the taxpayer. A system in which "patients first" is a motto and a reality. It bears mentioning that if the AHS executive and board intend to run provincial healthcare akin to a private corporation then our shareholders in this corporation are the Alberta taxpayer all of whom are potential patients.

On a personal basis I am entirely indebted to the Alberta taxpayer who invested in the majority of my education including my medical degree. Moreover, is it not the duty of every physician to ensure that the taxpayer gets the very best return on their investment? In this regard, the taxpayer deserves a system that relies upon actuarial need and factual evidence when health care funding decisions are made.

Lobbying, influence and empire building do not place the greater needs of our patients and/or the taxpayer first. Yielding to lobbyists and influence places the wants of special interest groups first and foremost. The taxpayer deserves better. The taxpayer and our patients deserve and need an evidence-based system.

## Propaganda and transparency, December Vital Signs

I would like to take this opportunity to follow-up on some of the concerns that were expressed in the December issue of Vital Signs, specifically with respect to potential changes to the addiction and mental health budget for the Calgary zone and the AHS code of conduct.

**Addiction & mental health budget:**

To be clear, no decisions have been made with respect to the addiction and mental health budget in Calgary.

As many of you know, the budget constraints facing AHS are significant, a $1.3 billion deficit to be exact. As a result, we are working to streamline operations to be more efficient, but also to be focused on ensuring quality care is provided where and when it best meets patient needs.

The first AHS budget strategy was to identify "back office" savings and other opportunities within administration (for example management positions, finance, procurement, IT, etc.). Although successful in achieving considerable savings, this approach is not sufficient to close our substantial budgetary gap. So, we must now look for efficiencies in the delivery of clinical services while, at the same time, minimizing any impact on patient care and access. All portfolios have been asked to identify potential means to achieve efficiencies. Each proposed strategy will be reviewed with respect to its feasibility and impact on patients. In the coming months, I plan to meet with clinical departments in Calgary, including the department of psychiatry, to discuss how we best meet the goals of quality and access, as well as sustainability.

The confusion surrounding budget "targets" for addiction and mental health programs in Calgary is unfortunate. It resulted from initial discussions around possible savings, and was not intended as a given or an announcement.

**AHS code of conduct:**

The original code of conduct came into effect on April 1, 2009. At the time the original code was written, AHS was in transition and many essential corporate policies had not yet been implemented. Therefore some were partially inserted into the original code because they did not have a "home" elsewhere. After it was issued, feedback from staff, similar to Dr. Maybaum's concerns, indicated that the code was overly prescriptive and too focused on details and rules about what people should not do.

AHS listened to the feedback and has redrafted the code which was circulated widely in October for further input from staff, physicians, and external stakeholders. The new code of conduct will come into effect on January 1, 2010, and addresses the concerns that had been raised about the original code. The principles of the revised code serve solely as a foundation to guide our interactions in respect to being open and honest, ethical and professional, respectful, fair, compassionate and dignified, respecting confidentiality and privacy, and taking responsibility for our own actions.

I encourage you to take a look at the new code, available on the AHS external website (www.albertahealthservices.ca) by searching 'code of conduct.'

**Dr. François Bélanger M.D., FRCPC, zone medical director, Calgary zone**

## Smoke and Mirrors

Strange that some AHS managers sent out emails announcing the 12 per cent cut (19.5 million dollars) to addictions and mental health. Only weeks after protest was made did Dr. Belanger indicate that the "prorated goal" of 12 per cent wasn't meant as a given or an announcement. In response to his explanation one of his managers emailed me and simply wrote three words; "smoke and mirrors." Three words that perhaps speak volumes.

The explanation regarding the revised code of conduct will do little to assuage the primary problem of fear and intimidation throughout the spectrum of health care workers. Once we have seen the savage bull tear someone apart, no matter how it has been tamed, we will always be watchful for a sudden change in temperament and a future goring. Actions, ultimately will speak louder than the prose of a revised, gentler, more virtuous code. AHS could perhaps start with some meaningful transparency.

**Dr. Lloyd Maybaum**

## Primary care still rocks

Health care systems with a strong primary care foundation have the lowest cost and the best quality of patient care. This fact is well-established; thanks to Dr. Doig for recognizing this in his remarks. The previous CHR specifically chose a primary care strategy many years ago, and it is essential that the new AHS administration maintain this focus. Any other strategy cannot be as effective for either cost or quality.

Consider a local example. The Crowfoot Village Family Practice changed its patient care model in 1999, incorporating increased RN and allied health staff along with a patient-based funding model that allows flexible service provision for improved access. The Health Quality Council of Alberta generated 2008 utilization data which shows that the original cohort of 10,600 Crowfoot patients are 13 per cent less likely to access the emergency department, and a whopping 17 per cent less likely to be admitted to hospital relative to other patients in the Calgary region. These results were confirmed by independent AHS data which shows the same benefit relative to other patients living in the same geographic area (ie. it is not a socioeconomic effect).

Imagine the tremendous burden taken off the acute care sector if these changes could be made for all Calgary patients. What if we could achieve an 85 per cent hospital bed usage rate instead of the current 102 per cent?

Our community family practices are now connected by the strong infrastructure of our Primary Care Networks. In our Calgary Foothills PCN, registered nursing and allied health staff provide direct patient services with physicians in our community practices, and a liaison nurse visits each physician regularly to ensure they are informed and connected. Quality initiatives such as the hypertension initiative, the chronic disease management program, and an unattached patient clinic are making a measurable difference. The primary care networks are a powerful tool for engaging family physicians and supporting progressive practice change.

We ask AHS to declare and support a primary care strategy and to include us meaningfully as they go forward. Family physicians are experts in high-volume, efficient care, and are the foundation of a successful health care system.

**Peggy Aufricht, family physician, Crowfoot Village Family Practice**

On Wednesday, December 30 at about 4:50 p.m. I was initially notified by CAPA's secretary that Michelle Lang had been killed in Afghanistan. My disbelief turned to an agonizing realization when I opened the Calgary Herald webpage which confirmed, what I hoped was, a truly horrible rumour. You would think, with my background as a paramedic and journalist, that I would be able to control my feelings. Not so much. I felt like someone had ripped my heart out. Michelle was a true friend to CAPA, an amazing journalist and a gem as a person. I had known her for about five years as she was on the medical beat and we frequently exchanged story ideas, both for her Herald assignments and my contributions to Vital Signs. She called frequently looking for physician comments and background information. I'm always one to say that out of every negative comes a positive but I'm at a loss on this one. I don't think I will ever, adequately, write about or express what I feel has happened to Michelle. Personally, I'm starting to feel an anger rising about the utter waste of a life. She was simply a storyteller who shouldn't have had to make the ultimate sacrifice in the pursuit of a story. Initially I was terrified that the E-mail she had sent me shortly before she left should be taken literally. "It's where they send reporters who've been bad. ;-) Anyway, I am going for six weeks for Canwest. I know it's hard to believe, but as a reporter it's considered an awesome assignment. At least, that's what I'm telling myself."

But after speaking with, after we both cried first, her close friend, colleague and social issues reporter, Colette Derworiz, Colette made me understand that Michelle's E-mail was simply her quick wit, she had followed her heart and went overseas with eyes fully open. Michelle even went so far as to go on a long hike with Colette to ensure the boots she had for the trip wouldn't cause blisters. Simply, Michelle knew there were more stories to write and she wanted to write them.

So on that note, what follows is what your CAPA presidents, past, current and future wrote about her.

*Dave Lowery*

### Dr. Linda Slocombe, CAPA president

As the current CAPA president, it has been a very difficult day for myself and our CAPA executive members and staff. We are all reeling from the news of the untimely death, at such a young age, of the Calgary Herald health reporter Michelle Lang. She was a trusted professional in her career here in Calgary as a journalist.

I remember beginning my term as president being very naive to the workings of the local media and also quite scared that I would be misquoted or "used" by the media. My first contact was with Michelle who immediately made me feel comfortable and reassured by her obvious knowledge, compassion and expertise.

She upheld the highest of work ethics. I was never misquoted or my words used out of context. For a novice such as myself this was a great relief. I learned a lot about journalists dealing with Michelle and gained a great deal of respect for her personally and professionally. It is indeed a very sad day and we have lost a real friend.

Our thoughts and prayers are with all her family and friends as we approach this New Year having to deal with such a tragic loss.

### Dr. Glenn Comm, CAPA past president

The City of Calgary, and the Calgary medical community, has suffered a great loss with the untimely death of Calgary Herald reporter Michelle Lange.

I met Michelle during my term on the CAPA executive when Dr. Michael Giuffre, Vital Signs editor Dave Lowery, and I set up a media liaison group in an effort to achieve better communications with Calgary media. It did not take long for good, trusting relationships to be built. She asked probing questions but was always fair in her coverage. A friendship developed between us during my two year CAPA presidency. She would call often to ask if I could speak about a given issue. There were times I could help her out, times I couldn't, and times I was able to suggest someone else who might be able to help her. I was never quoted out of context, our exchanges were friendly and I considered her a personal friend as well as a friend of Calgary physicians.

In my opinion, Michelle's most important contribution to Calgary doctors was her Calgary Herald story which she noticed from the February 2007 Vital Signs, "Family medicine in crisis" issue. Her article, detailing the financial struggles of Calgary family physicians, gained nation wide exposure and resulted in positive change. For this we are indebted to her.

There is nothing I can say that will assuage the pain of Michelle's family, fiancé and friends. My heartfelt condolences go out to them. Calgary doctors will remember her fair approach and her caring about the issues.

### Dr. Michael Giuffre, CAPA past president

More than four years ago, I met Michelle Lang, then a health reporter for the Calgary Herald. She introduced herself to me following one of the Calgary Health Region board meetings. Her pleasant demeanor was evident immediately as was her keen insightful questions that consistently brought depth to her health care reporting. I can recall thinking that she was such a breath of fresh air in her approach and style in getting to the crux of the health care issues. Her reports then are the same health care issues today. Back then the issues seemed so daunting to those past administrators "in charge" of those of us caught in the "sweeping health care reforms" that were

forced upon us in the quest to provide quality and timely health care. I was then president of the medical staff association of the Alberta Children's hospital and became president of the Calgary Heath Region Medical Staff Association that soon changed its name to CAPA with the regionalization of care.

Michelle was astute in her ability to get to the source of a story. She maintained her contacts and frequently engaged with those that had a perspective needed to balance her stories. Whether it was the KCl IV medication error that caused death or a story that covered the construction of a new Alberta Children's hospital that offered less than 20 new beds for three quarters of a billion dollars spent, her stories contained accurate facts and both sides.

Michelle's approach was congenial, friendly, thorough and completely professional. Her personality and flair for her profession was evident in her daily efforts, the small stories and the headline stories. She often stole the front page with her coverage. I can recall meetings with Jack Davis and the editorial board of the Herald, trying to get the, then, CHR less aggressive headlines that did not always match the insightful reporting of Michelle Lang. Her articles and coverage were sound, and not one ever seemed critical. They did act to promote change, they did break the code of silence, and they did uncover stories that needed to be told.

My impression was that Michelle felt that she was part of the health care team. She was able to give health care information, report advances and errors, throw out the bricks and bats with a flair towards acknowledgement and information dissemination to the general public. Her notion was that the status quo was often hidden and unacceptable. She could see that patient care was not optimal and that the health care system was too often failing in its quest to provide safe, quality and timely health care. She was a driving force to recognize that the system was not at all perfect and in fact quite the opposite. She could report on the standouts in physician and nursing care that were working well within the system and those that were not. She wanted those in charge to be accountable within health care administration and for those in health care politics.

Michelle approached me, Dave Lowery (editor of Vital Signs) and Dr. Glenn Comm, while we were on the executive of CAPA, and wanted changes in the way health care information was received by herself and her colleagues on health care stories in the region. What used to happen was the public relations people in the CHR would release a story to the radio, print and TV media, with very little depth, no contact individuals and little background information to accompany the story. Michelle found this unacceptable, in spite of pleas to the CHR. Michelle helped lead the way for a media liaison council being formed with CAPA, improved access to the Vital Signs by the media, and improved media relations particularly with CAPA.

She improved the "voice" of physicians being heard. She was a soldier, before heading to Afghanistan, but in the health care field trying to make a difference She was trying to point out the need for change, trying to make the world aware of the impact on patients when care was inadequate and when the regional health care system failed. She could differentiate between capital costs in the system and the lack of operating costs. She could translate, for the public, the toll of the long wait lists and the line ups in emergency to the patients. She could relate and report on the doctors and nurses going full-tilt and burning out in a system that just couldn't provide the needed access.

Michelle seemed to grasp a healthcare system that was gobbling up more and more money as it failed to provide world class timely safe health care. She reported all the administrative shuffles; new administrative pyramids, new health care leaders with new titles, changes in the political reigns and she reported salaries and settlements. With all of this, perhaps Michelle noted, that over the many years on the health care beat, that the health care issues, oddly, remained the same. Perhaps it was the redundancy of these same health care issues that contributed to her growing restlessness, trying to make change that was effective in health care delivery. Perhaps, if she would have stayed on our health care beat, she would have seen us through our latest set of changes, with one region, with a single health board, with an Australian economist leader, and another set of under-funded healthcare needs.

I know for sure that Michelle will indeed be missed. I know she was a breath of fresh air. I know that her experience and expertise will not be replaced easily. I think she had our respect because she loved what she did and did it well. From her new resting place I hope she will watch over us and guide us in our ongoing health care quests, as I know she would like to see effective change that truly makes a difference to patient care. We will miss Michelle and we all send our condolences to her family, friends, colleagues and fiancé. She will truly be missed. She has left her mark on our health care world.

### Dr. Lloyd Maybaum, CAPA president-elect

My first meaningful telephone contact with Michelle occurred on December 3 as she sought some details on an emerging story. As such, I was likely one of the last health care workers to speak with her. As we chatted she mentioned that she would be going to Afghanistan and became somewhat emotional. It struck me what a compassionate, decent and 'real' human being Michelle was. Moreover, what an incredibly brave individual she was; obviously somewhat apprehensive as her departure loomed yet overcoming any fears she might have.

From what I know of Michelle everyone at CAPA always found her to be professional and thorough. She was fair and could be trusted to report an accurate story. Her diligence and insightful reporting was appreciated by CAPA as she delivered a balanced message regarding issues of importance to physicians and health care workers in the Calgary area. I sense that she was a good soul and to many of us, a friend. She obviously will be deeply missed. For me, that conversation will be playing in my head for some time. Michelle, I hope that you are at peace. You clearly were loved and will not be forgotten.

# The part-time stigma

**By Dr. Jillian Schwartz - PGY 2 - family medicine**

**A perspective from a thirty-something female resident**

Consider the following true scenario: a medical student on her anaesthesia rotation strikes up a conversation with the surgeon across the drape. When she tells him that she is interested in obstetrics and gynaecology, he disparagingly replies: "Well, that will make a nice part-time job for you, won't it?" She is speechless. What can she say? Ironically, in this particular circumstance, the surgeon was talking to a woman who had always planned to work a traditional full-time schedule. Nevertheless, in that moment she found herself subject to a criticism that is faced by a growing number of physicians; that part-time choices show lack of commitment and contribute to the doctor shortage.

Hearing this anecdote prompted me to investigate some of the debates about part-time work, female physicians, and the doctor shortage. My quick Google search turned up a number of recent articles, both academic and non-academic, around the work-hours issue. One can always count on the Internet for sensationalism. I certainly discovered plenty of hostile message boards with blatantly sexist "get back in the kitchen" comments but these comments were far from the mainstream sentiment. The most widely quoted article that came up in my search was written by Dr. Brian McKinstry in April 2008's edition of the British Medical Journal (BMJ).[i] McKinstry argued that society needs to ensure an equal number of men and women enter medical schools to meet future health-care demands because women simply work fewer hours over the course of their careers. In the same issue, Dr. Jane Dacre [ii] argued the counterpoint: if women are the most capable candidates for medical school entrance, then they should be admitted and no limitations should be implemented based on gender. Instead, she argued that more should be done to encourage women to take on leadership roles given that there are still few women in these positions.

All of this research has made me sit back and think: am I doing something detrimental to my profession or my society by choosing to work part-time hours? Following much reflection on my priorities, I took the unusual step this year of requesting a part-time residency arrangement. I will be working sequences of two blocks in training followed by one block free of duties until I complete my program, about six months later than I would have otherwise. Will I continue to work part-time after I complete my residency? Most likely. Is this choice wrong? I don't think so.

In all this discourse, there exists the implied assertion, shared by a number of my colleagues, that I should not have entered the medical profession unless I was willing to put the rest of my life's aspirations aside. This perspective saddens me, because I have much to offer the profession, even working only a portion of the "full-time" hours resident physicians often work—an average of 75 hours per week (before studying).

True, I will serve fewer patients in my career, but I believe I will serve them better and I will serve them longer. I know I am fallible and I have limits; the responsible solution for me is to pace myself throughout my career. If I decide to have a family, I accept that my net contribution to society working part-time as a physician serving patients and part-time within the home will equal or exceed even the hardest working physician. My role in society will be different, not reduced.

I do not argue that this is the path for everyone. Those individuals in medicine who are keen to put their passion and talents exclusively into their careers should be acknowledged, validated, and celebrated on their own terms. In turn, those who chose to direct those same passions and talents into more than just their careers should also be acknowledged, validated, and celebrated. Neither women nor men in medicine should be lumped together as a homogeneous entity around their opinions on these issues. We are a widely disparate group of people with diverse interests and priorities that do not fall easily along gender lines.

In terms of the doctor shortage, it is too simplistic to blame it on part-timers, as there are a multitude of reasons that we do not have enough doctors to go around. For example, the historic cut back in the training of medical professionals is a significant contributor to this shortage. Whether we approve or not, the trend in medicine is toward alternative ways of practicing. Collectively, the profession will need to find ways to allow for part-time employment. It will do us no good to disparage colleagues who make different choices or to lament the "good old days." It is time to reshape our ideas about medical practice.

In the end, I agree with both Dr. Dacre and Dr. McKinstry. Dr. Dacre is right that we need to be more flexible in the way we practice medicine. On-site childcare, easily accessible part-time training and practice options would go a long way in this respect. We must also ensure equal numbers of men and women in the profession, as Dr. McKinstry argues. However, the reason for this is not only to ensure adequate human resources, but also to ensure diverse perspectives that reflect the population that we serve. A completely feminized version of medicine would have its own limitations.

Overall, this discussion does not need be one of "either, or." With a bit of out-of-the-box thinking, we should be able to provide career flexibility for those who seek it, all the while valuing the many physicians who want nothing more than to dedicate the entirety of their lives to their job. There is room for us all in medicine.


i. *McKinstry, Dr. Brian. "Are there too many female medical graduates? Yes." British Medical Journal: 2008 (336), 748.*

*ii. Dacre, Dr. Jane. "Are there too many female medical graduates? No." British Medical Journal: 2008 (336), 749.*

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