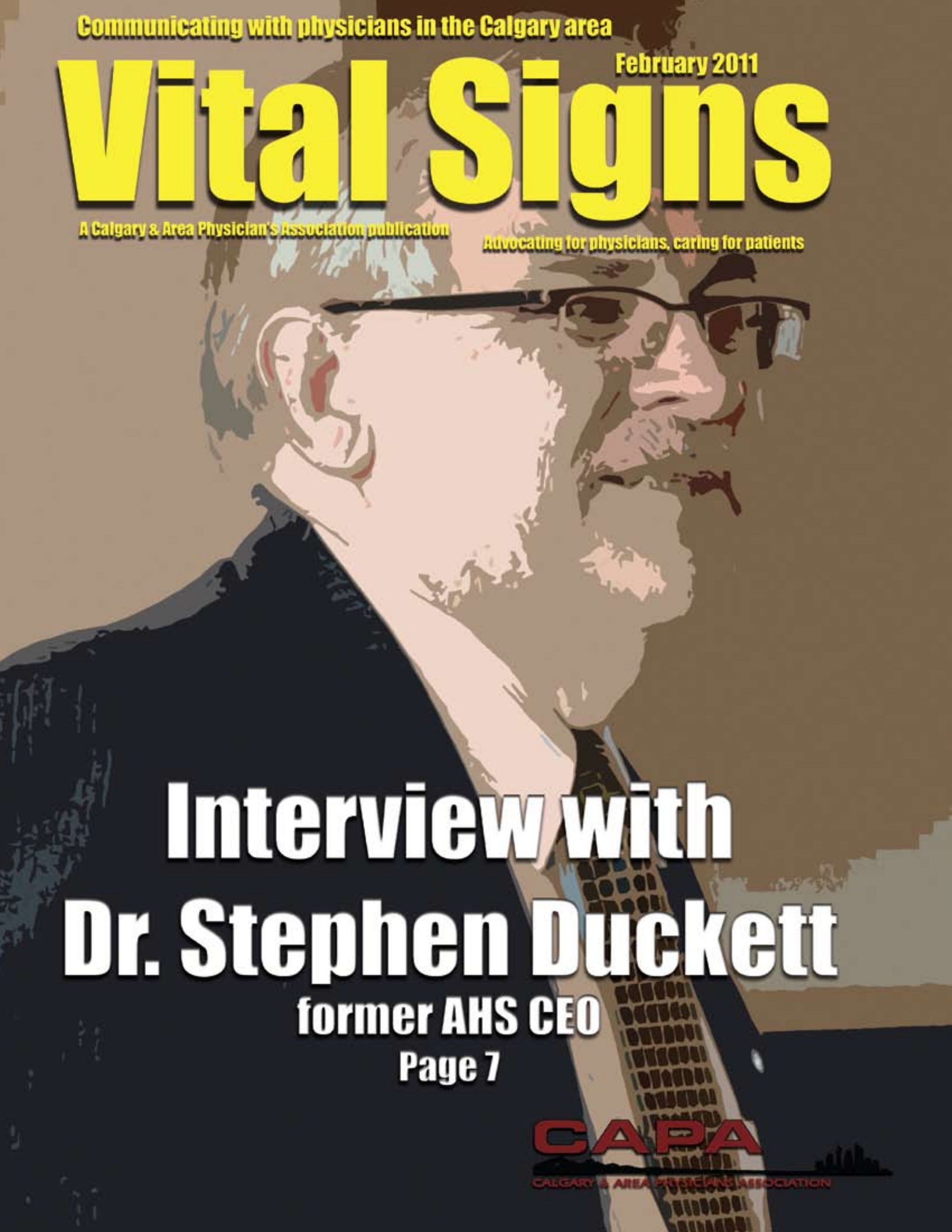
Communicating with physicians in the Calgary area

Vital Signs

February 2011

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients



Interview with Dr. Stephen Duckett

former AHS CEO

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CAPA

CALGARY & AREA PHYSICIANS ASSOCIATION

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Vital Signs is published 11 times annually (not published in August) by the Calgary & Area Physician's Association (CAPA).
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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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Vital Signs reserves the right to edit article submissions and letters to the editor.

Deadline:
The deadline for article submission to Vital Signs is the 15th day of the month for distribution the first week of the following month.
Next deadline is February 15, 2011.

Contributors:
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On the cover: Former AHS president and CEO, Dr. Stephen Duckett. Photo illustration by Dave Lowery

LEXUS
THE PURSUIT OF PERFECTION.

INTRODUCING THE CT 200h

More is better, and Lexus believes this applies to its expanding lineup of gasoline-electric hybrids.

The CT 200h brings to five the number of gas-electric hybrid models from Lexus.

The new CT 200h slots into the same category as the HS 250h, although the CT is more modestly sized and combines a sporty shape with the sort of exemplary fuel economy for which Lexus hybrids are famous.

The small Lexus is also aimed at a younger audience The CT's slinkier shape does not compromise usable cargo space and its flat-folding back seats add a level of practicality that customers will appreciate.

The CT's Lexus hybrid system consists of a 98-horsepower 1.8-litre four-cylinder gasoline engine that combines with a 60-kilowatt electric motor to produce a net total system output of 134 horses.

The good news is the CT winds up with an estimated city and highway rating well below 5.0-l/100 km making it the first luxury class vehicle to break this fuel economy barrier.

As with all Lexus hybrids, a continuously variable transmission completes the drivetrain.

The CT200h features four selectable driving modes: Normal, Eco, Sport and EV. Normal mode delivers naturally progressive power, and Eco mode further enhances fuel efficiency. For more spirited driving, sport mode modifies the hybrid system to provide more power and direct steering. Under EV mode, the CT can drive on electric power alone for shorter distances.

The CT's gauge package indicates which of the hybrid's drive systems are in operation. For example, in normal mode, the instrument cluster attains a blue hue with the hybrid power gauge situated to the left of the speedometer. Switch to sport mode and the gauges turn red and a tachometer replaces the hybrid gauge.

Positioned where your right hand rests on the centre console, Remote Touch is much like using a computer mouse. It gives you fingertip control over your Bluetooth®, cabin climate, and navigational settings and displays the information on the in-dash LCD display screen.

Other energy-efficiency helpers include available LED headlights that consume less power than standard halogen headlights, and a special amplifier for the audio system that requires less operating power. This means improved fuel economy and more power when required.

Along with the CT's sporty driving persona, Lexus engineers have ensured the car's road manners differentiate it from the rest of the pack. The chassis setup features a special front and rear damper system that's integrated with the engine mounts to help prevent chassis vibrations and road noise from entering the cabin.

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From the CAPA president

As we enter 2011 we are a step closer to the next provincial election, thus, I thought that a bit of political pot stirring might be a nice way to kick off the year. The 50th anniversary of one intriguing and remarkable political speech recently passed on January 17th. The speech was delivered by a former US General - President Dwight D. Eisenhower. Over the years, this compelling speech stands out for the prescient insights Eisenhower shared. You can find this farewell address at: www.abcnews.go.com/Archives/video/jan-17-1961-eisenhowers-farewell-address-12367106.

In short, Eisenhower warned against the undue influence of the military industrial complex. He warned against the undue influence of technology and what I believe could be construed perhaps as big-pharma and medical equipment manufacturers. He provided an environmentalist message and a warning against falling into a culture of fear and hate. Given the war in Iraq, the current state of healthcare north and south of the border and indeed, the increasing culture of fear and hate, one wonders if anybody took heed of Eisenhower's warnings.

Focusing on health care and the enormity of the health care budget one ponders what is really happening to all of those funds. One wonders if, in part, the challenge that we are facing is something akin to a healthcare industrial complex and perhaps a degree of misplaced power and influence. It seems that anything labeled medical comes with an enormous premium. This, to say nothing of the influence of pharmaceutical and equipment manufacturers for which one need only check the lobbyist registries.

A year ago, on these pages, I railed against the notion of lobbying and influence in health care decision making. I previously suggested that the allocation of health care operational and infrastructure funding should be based on evidence and actuarial need. Subsequently, I was invited to a well-heeled event in which I was schooled unto the merits of lobbying and the realities of decision making. Specifically, the concept of evidenced based decision making would mean very different things to a physician compared to a politician.

A politician is apparently persuaded by evidence that will reveal the path towards maximizing the chances for reelection. Quite clearly, a politician uses a different reference point than physicians. Consequently, the interpretation of the evidence by a politician might have very little to do with the best interests of the patient or of the health care system. The event was eyebrow raising and I received the message loud and clear – don't speak out against lobbying.

In 2008 I spoke out against cuts to mental health infrastructure at South Campus. The entire wing was deemed expendable. My advocacy unwittingly caused enormous upheaval but appeared to culminate in a budgetary announcement on August 29th, 2008 by the then parliamentary assistant to Health Minister Ron Liepert. The assistant, Dr. Raj Sherman, told the media that at 16 years of age he deliberately stepped in front of oncoming traffic presumably in a self-harming attempt. This admission was incredibly courageous and certainly compelling while the government announced 50 million dollars to be earmarked for children's mental health.

In retrospect, I now wonder if this funding announcement materialized in an effort to quell the dissent and outrage felt by mental health workers. I can't help but think that, time and again, governments collect political capital and kudos for announcements of monetary influx but rarely deliver on their promises. Quell, quiet and placate dissent. Chum the waters with hope yet don't actually deliver anything. Often times it seems that these budgetary announcements entirely relate to managing perceptions and dissent. Perception, as we know, seems to be what matters, reality not so much.

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

What was the reality of the 50 million dollars for children's mental health? As far as I can tell, they never saw any of it. Moreover, in my current state of disillusionment, I am not holding my breath to see if the recently announced funds for cancer care, obstetrics and vascular surgery come to fruition. Most governments rely on the fact that voters have short memories so, to test the hypothesis that announced funds are seldom delivered, we'll keep monthly track of some of these announcements here in Vital Signs.

They say that politics is a blood sport. A physician generally isn't afraid of blood but a physician that is also a politician is bound, particularly if they are a member of a political party and must tow the party line. If the party line mandates a course of action focusing on ensuring an electoral win over and above decisions made in the best interest of the patient or the health care system that physician/politician will be in a moral bind. Moreover, consider the ethical conundrum if the party line has been corrupted by undue influence as perhaps Eisenhower once warned? Do you stick to the Hippocratic oath or remain loyal to the party whip? I would argue that if you remain a practicing physician then the Hippocratic oath must trump all decisions and the adopted political stance must always relate to the benefit of the patient. Notions of re-election must always take a back seat to the Hippocratic agenda. In this regard, I tip my hat to Dr. Sherman for recently speaking out regarding the emergency room crisis.

In closing, might I suggest that with the coming election we unite in the kindred fellowship of medicine. That we carry ourselves as physicians first and foremost, leaving our political ideologies in the distance. We become split based upon political and ideological lines at our own peril and I state this with particular importance as it relates to the public/private debate. Respect and dignity are in order. Let the politicians engage in the disgraceful and often schoolchild misbehaviour that we so often see on display in the legislature. Over the coming months lets continue to pull together and unite. After all, we are physicians, members of the noble profession.

From the past president

I have to admit that I have missed my monthly musings on the pages of Vital Signs.

It is somewhat cathartic to be able to vent about the latest hot button issue in healthcare.

There have been almost too many of late to know where to start.

So instead I want to let you in on my latest interesting readings that have led me to question a lot of things that we take for granted in medicine, in particular, medical research and the placebo effect. My recent journey began by picking up a book at the McGill Bookstore. Each time I visit I enjoy my morning in the bookstore looking for new finds. This time I was enticed by one called "Trick or Treatment, Alternative Medicine on Trial." One of the authors, Dr. Edzard Ernst, is the first professor of complimentary medicine in the world. Each chapter begins with the history of an alternative medicine treatment and methodically looks at all the evidence to decide if the treatment has any merit. The chapters included acupuncture, homeopathy, chiropractic treatment, and herbal medicine to name a few. I was spellbound by the fascinating history of each and then anxious to hear whether there was any merit. It talked a lot about rigorous randomized clinical trials, the Cochrane collaboration and the placebo effect. I do not want to spoil the book but lets just say that with the example of homeopathy there is no scientific evidence to base their cure claims. A conclusion in the book is that "alternative medicine is not so much about the treatments but about the therapeutic relationship." Also "that many alternative practitioners develop an excellent relationship with their patients which helps to maximize the placebo effect of an otherwise useless treatment." How does this relate to the current healthcare environment in Canada? A clear message was that mainstream medical doctors need to spend more time with their patients in order to develop better doctor-patient relationships. The average consultation time in some countries is seven minutes! Sound familiar! However this would take a different funding model then the one we have now. So alternative medicine will continue to benefit our patients via the placebo effect and in most cases without being evidence based. Our patients need our time, not just our efficiency in dealing with their issues.

The next reading was an article in Atlantic magazine about the world of medical research and about Dr. John Ioannidis who is one of the world's foremost experts on the credibility of medical research. His studies have led him to the uncomfortable conclusion that many of our medical publications are misleading, exaggerated or often flat out wrong. He believes 90 per cent of studies are flawed or biased, and riddled with conflict of interest. He believes the obsession with winning funding has gone a long way toward weakening the reliability of medical research. The facts are that around 80 per cent of non-randomized trials turn out to be wrong and around 25 per cent of randomized trials turn out to be wrong. What is the poor practitioner to do? As a busy doctor, we are trained to order tests and often treat our patients with whatever drugs or other treatments might help to fix their abnormal results. We are not trained, nor do we have the luxury of time, to go back and look at the research papers that helped make these drugs the standard of care. On careful examination of the papers, according to Dr. Ioannidis, you often find the drugs did not work any better than placebo. There is that word placebo again. I was getting very distressed now as not only could I not believe most alternative medicine claims but also not many mainstream medicine ones either.

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

The coup de grace was the next book I read for further punishment. It was entitled "White Coat, Black Hat – Adventures on the dark side of medicine" by Carl Elliott. I must have been feeling especially cynical that day in Montreal. This book explores the world of pharmaceutical companies and medical research. I was appalled at what I read. For many years, I did not worry about the drug reps bringing lunch, the free samples in the cupboard, the CME dinners with the leading experts. I was educated and surely able to know if I was being manipulated. What I read in this book was shocking; or maybe I am just naive. Examples were ghost writers who essentially write up studies for publication in leading journals and biased studies with no room for adverse or negative results. One of the most striking conclusions was this, that "the pharmaceutical industry controls the scientific evidence upon which medical practice is based." So what possible harm could my free lunch have? I was beginning to connect the dots. We base our daily interactions with patients on what we believe is scientific evidence. Where is the science? Is it drug company sponsored? Is it manipulated to suppress negative results? Is it just the placebo effect? Dr. Ioannidis states that "being wrong in science is fine and that only a small percentage of medical research is ever likely to lead to major improvements."

If you are feeling downhearted by now, so was I. However there is some hope. Remember there is still the Cochrane Collaboration. My big discovery was the online journal called PLoS Medicine, the Public Library of Science. A peer reviewed, open access journal that publishes all results, good and bad if the science is there. And guess who is on the editorial board. Dr. John Ioannidis and Dr. Edzard Ernst to name a few. I am now looking at this site and am at least a little more educated about some of the pitfalls of our modern day medical research. I am again reminded that there is no such thing as a free lunch, even in medicine.

My one burning question from these two books is this; what the heck is the placebo effect? It works for alternative medicine, it works for drug companies, it works for you and me in our office with our patients. Perhaps it has something to do with neuroplasticity but that is for another article.

Back to the suggestion box

Editorial

By Dr. Lloyd Maybaum

After a patient arrives on my unit one of the first things that we need to sort out are the medications that the patient was taking prior to coming to hospital. Sadly, patients often do not recall the exact medications they are supposed to be taking or when they last took them. Was it the blue one or the white one? Yesterday or last week? What is the white one? How many times per day? Sorting this out usually means checking databases and rummaging through pill bottles that are sometimes years out of date mixed with others that were filled just the other day. At times this causes some degree of trepidation as we enter the orders into the computer hoping that we are entering the patient's most recent medication cocktail correctly. On just such an occasion, another idea struck me.

Sorting through the bags of pill bottles that accompanied one particularly well-known patient, I entered the hospital orders allowing for medication dispensing from the pharmacy. Despite the bags of pills that the patient brought to hospital, the hospital pharmacy would provide fresh new pills at the hospital's expense. This centralized dispensing process is important for safety reasons, however, why does the hospital, and therefore the taxpayer, pay for these medications when the patient was clearly capable of paying for their own before they came to hospital?

In an ideal world, prescriptions would be paid for by the health care system as they are in Britain's NHS - not that the NHS is the ideal system. This brings me to my latest suggestion, taking into consideration the way our system currently functions. Perhaps AHS should charge patients for the cost of their medications while they are in hospital. Now before anyone starts jumping up and down and calling me names hear me out. First of all, if patients were covering the costs of their medication before coming into hospital and will have to somehow cover the costs once they leave hospital, why can't they pay for the cost of their medications while in hospital?

Many Albertans have coverage for their medications via Blue Cross or private insurance plans so why couldn't the system attempt to retrieve some of these costs by charging medication and dispensing fees to the very same insurers that cover patients as an outpatient?

We already appear to have the infrastructure in place to allow this fiscal recovery practice to initiate. For instance, in hospital we have an electronic medical record, Sunrise Clinibase, in which all dispensed medications are recorded. It shouldn't take much of an effort to either electronically submit or to print out a pharmaceutical report at the end of the admission and to submit it to the patients' insurer or to the patients themselves.

I know that some people will balk at this idea, however, we must remember that we are already paying for services such as ambulances or option items such as those fancy coloured fiberglass casts instead of the typical plaster casts. Back when private rooms were actually an option, if you had Blue Cross coverage this insurance would pay the extra fee associated with a private room.

I realize that not everyone can afford their medications. In my line of work I principally work with the homeless and disenfranchised, however, welfare and AISH would also be able to cover the costs of inpatient administered medications just like they do for disadvantaged patients when they are outpatients. For the working poor we have to consider that they must have been able to afford their medications as an outpatient. If this is not the case, then perhaps this is one of the reasons why they ended up admitted to hospital. Consequently, the hospital social work department could perhaps find assistance for these patients to cover the cost of the inpatient medications but also the costs of ongoing coverage as an outpatient.

Continued on page 11

Attention: Primary Care Physician Association (PCPA) members

A motion was moved by the PCPA representative and passed by the CAPA executive last evening to dissolve the Primary Care Physicians Association and place marooned PCPA funds into the general CAPA account to be used to continue to advocate on behalf of physicians.

Historically, PCPA has been a very difficult organization to attract community physicians to serve. As there has not been a president serving PCPA for the past year, it was concluded that the community physicians are best served now by the Primary Care Networks. CAPA will be inviting a representative from that group to attend the executive meetings.

If you have any issues or concerns with this motion please submit them in writing to the CAPA office via email to glennis.brittain@albertahealthservices.ca

If you would like to speak to me personally about the funds please send me an email at Lloyd.maybaum@albertahealthservices.ca.The deadline to reply with your suggestions is February 1, 2011

Thank you
Dr. Lloyd Maybaum, president CAPA

Interview: Former president and CEO, Dr. Stephen Duckett

By Dave Lowery

On November 24, 2010, Dr. Stephen Duckett was terminated after only 20 months as the president and CEO of Alberta Health Services following a controversial response to media questions. Though he has spoken since that time in the form of a speech to senior AHS management, Duckett has chosen not to respond to questions until now.

Vital Signs: What was your biggest challenge?

Duckett: I think there was basically a two-fold challenge when I started; creating AHS and facing a significant budget challenge.

Vital Signs: How do you think you performed in solving that challenge?

Duckett: Overall I'm quite pleased with the progress we made.

Vital Signs: What was your greatest success?

Duckett: I think ending the 'medical arms race' between Edmonton and Calgary. One of the weaknesses of healthcare in Alberta was that we had what I call 'Noah's ark planning.' Everything had to be done two by two. Whatever Edmonton had Calgary had to have and vice versa which was bad for the province. One of the positive things that creating AHS allowed was permission to work collaboratively and cooperatively across the province.

Vital Signs: What was your biggest failure?

Duckett: I think the failure to recognize the resistance to change. Alberta had a reputation as a can-do province and open to change but I struck significant resistance to change throughout the province. Everyone wanted change except when it affected him or her. The other point is that, in Australia, I had an enormous reservoir of public trust and goodwill given what I had done over the previous decades. I came here with none of that and I underestimated the implications.

Vital Signs: What advice or suggestions do you have for all Albertans; what can each and every Albertan do to help with the system?

Duckett: I think it links back to the previous point about change. There is a degree of complacency in the province about the health care system. Yet Albertans live, on average, a shorter period than people in other Canadian provinces, though our health system costs more. We're paying more and getting less. This means we can't keep doing things the way we've always done them. There needs to be some understanding and acceptance of that.

Vital Signs: How can we make Albertans more receptive to change?

Duckett: One of my strategies was to be open and up front and talk to Albertans about these issues. That didn't always get through. To some

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extent the media like to characterize issues in terms of individuals or conflict and deemphasize the issues or problems we were struggling with and that was not good. I would like to see more open discussion and debate.

Vital Signs: What would be the most important thing(s) physicians can do to help the system or to not hinder the system?

Duckett: I think more of what they are doing already. My experience, by and large, is that physicians embraced the idea of working collaboratively across the province. They embraced the idea of benchmarking with one another and learned from this how to improve the system. There are any number of examples of physicians and clinicians who really accepted the challenge of trying to do things differently and looking at new ideas and ways to improve services. That was really heartening and one of the joys of the job.

Vital Signs: If you could do one thing over again - what would it be?

Duckett: I think in terms of the way I approached the repositioning of mental health services in Edmonton I could have handled it better. What we did was try to look at repositioning mental health services and maybe I took on too much and should have concentrated narrowly on one aspect of that or had a better formulated plan before we started. We started by saying 'this is the broad general direction we want to go' and then consulted. People didn't want to consult; they didn't agree with the proposed broad general direction so the response was let's not even talk about it. That change management wasn't successful in the short term and that's one of the things I could have done better.

Vital Signs: What surprised you the most during your time at AHS?

Duckett: The degree of xenophobia in the Alberta population. There was a lot of resistance to someone from outside. Within AHS people were very supportive, one of the most supportive organizations in which I've ever worked. But if you look at the Calgary Herald, to take a local example, and the comments that were made on healthcare stories, there were a huge number of comments saying 'it's terrible to have an Australian' and 'send him back to Australia . . . or New Zealand.' Sometimes they got that wrong! Even in today's Edmonton Journal there's a letter that refers to 'the door slamming behind' me as I leave. There was an unwillingness to be open to new people and ideas and that really surprised me. That wasn't my perception of what Alberta or Canada was about.

Vital Signs: Do you regret the cookie comment?

Continued on page 9

By Dr. Patrick J. (P.J.) White, president, Alberta Medical Association

Given publishing deadlines, you may have received a President's Letter from me updating you on the status of negotiations with Alberta Health Services (AHS) and Alberta Health and Wellness (AHW) since this was written.

It is, however, important to remind ourselves of the focus, scope and importance of negotiations 2011 – not only for physicians, but also for our patients and the future of Alberta's publicly funded health care system.

At their fall 2010 meeting, representative forum (RF) delegates endorsed the AMA's approach to create Value for Patients™ by identifying four key system objectives:

1. Access
2. Quality
3. Productivity
4. Sustainability

The eight-year trilateral master agreement expires March 31. While AHW will continue to pay through the schedule of medical benefits, everything is up for discussion from representation recognition to programs under the master agreement, e.g., primary care initiative, physician office system program (posp), retention benefit, business costs program, continuing medical education (CME) reimbursement, etc.

The 2003-2011 trilateral master agreement was ground-breaking by its inclusion of some very important features. It:

a. Defined the relationships between the three parties, a relationship that was unprecedented in Alberta and, indeed, within Canada. Physicians had a recognized role in shaping health care, from the planning stages to the delivery of care, e.g., primary care networks (PCNs).

b. Recognized the right of the AMA to be the sole and exclusive representative of the physicians of Alberta with respect to all matters within the agreement including budgets, programs and services.

c. Established a structure to address issues through a hierarchy of committees with representatives from all three parties. This provided a new mechanism to address and resolve problems; it also improved communication channels and provided a structure for addressing issues as they arose.

In summary, the trilateral agreement was about much more than important financial agreements, programs and benefits. It defined relationships, recognized the AMA as the physicians' representative and provided a structure to address issues in a more timely way.

AMA's primary and chronic care strategy

Government's Becoming the Best: Alberta's 5-Year Health Action Plan 2010-2015 contains perhaps the strongest endorsement we've seen recently as to the role of physicians:

- "Primary health care refers to the care a patient receives from a doctor or a health-care team when first entering the health-care system."
- "A PCN is a formal arrangement between groups of family physicians and Alberta Health Services. The new organization formed by this legal partnership is a primary care network that works to co-ordinate primary care services for patients in a specific geographic area."

Our discussion paper, AMA Vision for Primary and Chronic Care, was developed by the leadership of the sections of general practice and rural medicine and the PCN leads, and with participation from the Alberta College of Family Physicians (ACFP).

Putting people first – recommendations for an Alberta Health Act, released last fall by MLA Fred Horne, who is parliamentary assistant to Health and Wellness Minister Gene Zowzdesky, notes: "We heard that the Alberta government should ensure every Albertan has access to a primary care team, including a family physician." His report also called for a health charter that "should specifically commit that all Albertans have access to primary care services through primary care teams."

The AMA's discussion paper offers realistic options and concrete ideas that complement a number of the 15 recommendations that Mr. Horne put forth. We hope the government will realize the synergy possible between the ideas presented in Mr. Horne's report, the government's own five-year plan and the AMA's vision for primary and chronic care.

Medical staff bylaws

The amalgamation of nine regional health authorities into one authority under Alberta Health Services in May 2009 precipitated the need to develop a single set of provincial medical staff bylaws to replace the existing ones.

Last October, physicians with AHS appointments voted to accept the new provincial bylaws.

The minister has final decision-making and approval authority for the bylaws. Assuming he approves them, it is anticipated the bylaws will be implemented March 1.

Once the new bylaws are in place, Calgary and Area Physicians Association (CAPA) and other regional medical organizations will disappear. Replacing them will be zone medical staff associations (ZMSAs) in each of the five zones.

ZMSAs will interface with both the AMA and AHS. The AMA is contributing significant funding and staff support to the ZMSAs, including administrative support similar to that currently given to AMA sections.

The ZMSA concept is still being fully fleshed out, but one of the expected activities of each ZMSA will be to hold elections for zonal reps to the AMA's Representative Forum and to appoint representatives to the AMA's Council of Zonal Leaders.

(This article is based on a January 22 presentation to the Alberta section of rural medicine.)

CAPA appreciates the funding support from AMA to help with their monthly submission publishing costs.

Duckett: Yes. But I have to say it's a mixed blessing. This job that I had was draining me. I've looked at photos of myself when I was first appointed and compared those to photos taken more recently and you can see the visible change in my health during the period I was president and CEO. It was a pretty brutal way of slowing down but it's a better way than having a heart attack. I'm no longer subject to the same vilification. A benefit is I have more time with the family, so it's not a totally bad thing.

Vital Signs: Was the cookie incident simply your way of saying 'I've had enough.'

Duckett: As I said, I regretted the comment and I didn't plan that sort of comment but it's not necessarily a bad thing for me personally. I also regret the missed opportunities to lead the change necessary to improve health services in Alberta.

Vital Signs: What's in your future?

Duckett: At the moment we're still puzzling about that. I don't want to make decisions quickly. The family, at the moment, would prefer to stay in Edmonton for a couple of years. I've had a job offer back in Australia, but I don't know if I'll accept it. If I stay here, I would like to get back to writing, as I didn't have any time to write about the health care system reform when I was president and CEO.

Seeking part time family physicians for urban Aboriginal Health Centre

Join a newly established, team based model that concentrates on delivering high quality care for the specific needs of the urban Aboriginal population of Calgary. The Elbow River Healing Lodge (ERHL) is a publically funded Alberta Health Services program located within the Calgary downtown Sheldon Chumir facility.

- The centre houses core services including laboratory, diagnostic imaging, pharmacy and urgent care as well as other key diverse services such as public health and mental health that offers the opportunity for multi-service collaborations
- The ERHL's in-house team includes clerical, nursing, pharmacy, behavioural therapy, advocacy and research
- The ERHL is based on a philosophy of considering and addressing the broader determinants of health and strives to innovate primary health service to achieve this
- Remuneration is sessional

Contact Dr. Lynden (Lindsay) Crowshoe (lynden.crowshoe@albertahealthservices.ca) 403-955-6600 for more details

Family physician needed

Lynnwood Medical Clinic, in Southeast Calgary, is looking for a part or full time family physician to start on or after June 1, 2011. Great colleagues, staff and location. Newly renovated clinic with electronic medical records. Part of the Mosaic Primary Care Network with a chronic disease nurse, behavior health consultant and shared mental health program.

Contact: Dr. Joan Meldrum or Dr. Mark Sosnowski
Telephone 403 279 3311 or tnt.lynnwood@shaw.ca

Medical office space will be available March 2011

Superb location on the banks of the Bow River with stunning views of the river and local parks. The office is within a few minutes' drive to the Foothills Medical Center, Health Sciences Center, The Alberta Children's Hospital and The University of Calgary as well as being on a major bus route.

This office space is suitable for psychiatrists (child and adult), psychotherapists, psychologists and some paediatric sub-specialties. The premises have recently been renovated.

For further information please contact:
Gillian (business manager) at 403-571-5160 or BRPC@telus.net
or
Dr. Jennifer Fisher at Jennifer.fisher@albertahealthservices.ca

Oasis MEDICAL CENTRE

The Oasis Medical Centre in Airdrie and Calgary is looking to recruit new physicians full-time/part time.

Please contact our clinic manager for future details at ph(403)945-8216 or email frances@oasismedicalclinic.ca

Calgary Medical Society

The Calgary Medical Society president and executive invite you to attend the Annual President's Gala 2011 Friday the 11th of February at the ballroom of the Glencoe Club 636 - 29 Ave. SW Calgary Champagne Reception - 6:30 Dinner and Awards - 7:30 Followed by an evening of dancing to THE REAL DEAL.

RSVP by the 4th of February by phone - 403-875-3706 or email: cmscalgary@shaw.ca

Medical clinic in High River

Space available for two or three physicians, specialist or GP. This clinic is already occupied by two female OB/GYN's. Terms flexible, from rent only to complete office set up and clinic management.

Level 1 hospital, three minutes from the clinic, Calgary city limit, 25 minutes drive.

Contact : David Baker: 403-262-2222; Cell: 403-660-8551
mdbaker@shaw.ca

A pirate revisited

From the past president

Six years ago, in a cozy little inn in Palm Springs I celebrated my 50th birthday and wrote an article entitled "a pirate looks at fifty." Six years later I have returned to the same inn. It is a home away from home where my wife and I relax. Yet, a copy of Al Gore's "An Inconvenient Truth" that was on a discount rack at a bookstore where I stocked up for reading material for the trip has left me disheartened. I KNOW there is much truth in what the former vice president of the USA spoke of in his book as I have seen the changes in my lifetime. I am disheartened to see the ravaging of our beautiful planet earth that has occurred over the last several decades. I am also very concerned about what sort of world my 17 year-old daughter, who wants to go into medicine, will face 20 years from now. I am NOT going to rehash Mr. Gore's book but highly recommend that anyone who is concerned about where our planet is going read it for themselves.

I found positives in looking at what 2011 will bring for Alberta's doctors. For one, it will see the new provincial medical staff structures come into being. This will actually be negative for the Calgary zone, where in the past there have been substantial dues paid, funding a well integrated medical structure that has been able advocate strongly and effectively for Calgary and area physicians.

It is my understanding that "Vital Signs" magazine will morph into becoming a provincial magazine. This should be a benefit for its ability to raise funds and sell advertising, yet the most positive factor will, I believe, be the access to the power of the pen and press that doctors outside of the Calgary region have not had the benefits of to any major degree.

Dr. D. Glenn Comm, CAPA past president

There will be a LOT of change happening. There is a new master agreement between the AMA, Alberta Health and Wellness as well as Alberta Health Services that is under negotiation. This will most likely be a long drawn out process as it is quite complicated and covers a broad territory. Whether the Alberta government's need for a "win" in healthcare will positively influence the outcome of these negotiations remains to be seen.

Throughout this all, it will be important for us all to adhere to our medical association motto, "patients first." It is the care we provide to

our patients on a daily basis that give us legitimacy and believability when we speak out, on behalf of Albertan's, about issues within healthcare that concern us. When we frame our concerns about the effects of changes upon the care of our patients, it positions us as champions for our patients care. This patient trust is something we must never take for granted.

I don't pretend to have crystal ball to see how the system will look in 12 months. I DO know, however, that we will not go wrong by putting patients first, no matter what curveballs get thrown our way over the coming months.

So we face times of uncertainty. Yet by doing what we do best, taking care of patients, we will continue to retain the trust of our patients, the people who matter the most!

So while I'm NOT sure what I can do about melting icecaps that could threaten to raise ocean water levels, I DO know that by staying our course in medicine we will be doing the best we can for our patients, the system, and our longterm prospects!

Fiscally, how much might this suggestion save the system? According to the Institute of Health Economics, the total number of hospital beds in Alberta, in 2007, was 10,273. I attempted to elucidate the average daily cost of inpatient administered pharmaceuticals in the province but was unsuccessful. Thus, for the sake of example, if we arbitrarily say the average (mean) daily cost for pharmaceuticals is $10 per inpatient, we would save the system almost 37 million dollars before any dispensing fees were applied. In reality, I would suspect that the daily cost of inpatient pharmaceuticals is likely significantly more than $10 per day.

One positive aspect of this suggestion is that the act of charging patients for their medications should not contravene the Canada Health Act. Moreover, we should be able to easily implement such a program with current information technology. Many questions remain such as what to do with extremely expensive short term use medications while in hospital and perhaps those medications not typically a part of the hospital formulary. Finally, will people be able to calmly and rationally consider this suggestion? I welcome any of your thoughts on this idea and certainly would welcome any fresh ideas. Vital Signs is waiting to put them into print!

CAPA AGM expressions of interest

Wednesday, June 8

Dr. David Swann is confirmed. Representatives from the premier's office and Wildrose Alliance have also been invited.

Please send RSVPs to Glennis Brittain so we can determine the size of venue to reserve for this year's AGM.
Call 403-943-1270 or
email: glennisbrittain@albertahealthservices.ca

One mouthpiece and 42 cartridges = pharmaceutical waste

By Lloyd Maybaum

By now, most of us in healthcare are aware of the need to curtail costs, live within budgets and find new efficiencies. One of the areas in which considerable 'fat' could likely be trimmed is that of pharmaceuticals. Judging from what our pharmacy friends tell me there is considerable pharmaceutical waste in our health care system. In this regard, I have a specific pet peeve that I would like to share with you.

When it comes to smoking, we should all be counseling our patients to reduce or discontinue their habit. Anything that we can do in this regard will aid the long-term health of the patient and the health care system in general. Regardless of our efforts however, some people will continue to smoke. On the mental health unit where I work patients are typically not allowed off unit for smoking privileges for the first day or two. In the interim, they are usually offered a variety of smoking replacement options including Nicorette gum, Nicorette inhalers or Habitrol patches.

Providing smoking replacement options are necessary in an inpatient setting. This is especially the case for those patients that are unable to leave hospital property to smoke. I do, however, have a specific problem with the manufacturers of Nicorette inhalers. That would be McNeil Consumer Healthcare, a division of Johnson and Johnson.

When Nicorette inhalers are ordered for the patient the smallest package available comes with 42 cartridges and one mouthpiece. The hospital cost for this box of goodies is $31.50. Over the course of the admission it is common for the patient to use only a few of the 42 supplied inhaler cartridges before they bound off for a real smoke.

Here's the issue: The inhaler cartridges are useless without the supplied mouthpiece. The mouthpiece is simply two pieces of plastic into which the cartridge is inserted. I am told by the hospital pharmacy that the manufacturer does not sell mouthpieces separately. Thus, if the patient loses the mouthpiece or chews it to oblivion the unit is forced to call up another box of inhalers for $31.50. Moreover, out of the original 42 cartridges it is common to have almost 40 cartridges remaining in the box once the patient has stopped nicotine replacement. One would think that these left over cartridges could be reused for the next patient but, sadly, this is not the case. Without a fresh mouthpiece for a new patient the left over cartridges become marooned space junk. I am told that they are returned to pharmacy and are subsequently discarded.

In my opinion, the above scenario represents a colossal waste of taxpayer money. Obviously, the manufacturer of Nicorette inhalers has a vested interest in not providing spare mouthpieces or mouthpieces that can be purchased separately. Thus, if you damage or lose the mouthpiece you'll have to pony up for another entire box of inhalers. This problem happens on my unit repeatedly, virtually every day and every week of the year. Imagine the waste when we consider that this problem likely occurs on every unit and in every hospital in Alberta.

One could easily anticipate the counter argument. Perhaps out of the $31.50 cost of the box, $31 is the cost of the mouthpiece. Looking closely at the mouthpiece it is a very simple two-piece plastic tube, which likely would cost pennies to mass-produce. Thus, I cannot help but think that it is a strategic profitability decision to not supply separate mouthpieces. Consequently, I would suggest that it is time for AHS and our public health care system to fight back.

Perhaps AHS should initiate a boycott of Nicorette inhalers until such time that either the manufacturer offers spare mouthpieces or perhaps some generic firm initiates a separate supply. There are other replacement options available but perhaps, while we're at it, we should look for a generic alternative to Nicorette gum. These may seem like unreasonable requests, however, we all know the large numbers of samples pharmaceutical sales reps will eagerly drop off at physicians offices in order to promote their latest and greatest medications. How difficult would it be for McNeil Consumer Healthcare to provide Alberta hospitals with a steady supply of spare Nicorette mouthpieces

and thereby perform a corporate good deed by supporting our public health care system?

In my opinion, AHS and other health authorities need to get tough and fight back over structured pharmaceutical waste. Thus, if anyone has more examples of pharmaceutical waste or inefficiencies in general, Vital Signs would love to hear about it. So, dear pharmacy industry – put that in your pipe and smoke it!

Do you have a pet peeve? A practice or object that annoys you? Or perhaps you have a better way to do something or save money by doing something a different way? If so, we would like to hear about it. Please send in your pet peeves to Dave Lowery, Vital Signs editor: bethere@shaw.ca

From the barber's chair

"Stick with what you know" was the gist of my young barber Z's take on the latest furor in health care over ERs. More precisely he said he doesn't believe what he reads – "seeing is believing" for him. His scissors danced a hair's breadth from my scalp as he digressed from the business at hand. I thought of the red–striped barber's pole performing its optical illusion outside his shop. A few hundred years ago he might be doing my bloodletting too. And I thought about what he said.

What I know – what I know I know – I've come by doing general practice in Calgary for 35 years, including until recently, acute hospital care and ER visits. Added to this are countless stories of patients, in my office after an acute, sometimes life–threatening illness landed them in hospital under other physicians' care. And because all of us start as someone's children and eventually, as the table turns, inherit frail, elderly parents, I've added that agonizing, personal experience too, from the other side of the patient chart.

And that's it – no political experience, not an economist, doubt there's an administrative bone in my body. But I know that the dire warnings of an imminent "collapse" of our ERs and characterizations of our "crumbling" system are not so. They simply fly in the face of both my experience and that of so many of my patients who have been seriously ill and received the timely, skillful care they needed. Nor do they do justice to the smart, dedicated people working there or the enormous resources we spend on health care in our province. It seems like a moment for a cheap, time–honored remedy – a brown paper bag and a few slow, deep breaths – and then to emphasize three things we will always need:

1. Advocacy. Not only the poor, but the sick we will always have with us. Their weak cries need amplification by family, friends, physicians, interest groups, even plucky politicians who still know how to speak their language. The message may get distorted and hard to listen to but they guarantee the vital human element that makes our society a humane one. God bless them.

2. Patience. Because "everyone you meet is fighting a great battle." This seems especially true in health care these days. The battle is to make it better and it takes its share of casualties. A colleague with that strange gift (curse?) for administration once rightly described health care to me as a complex business. We can act as if it were not.

3. Confidence. I've rubbed shoulders with plenty of ER docs over the years. They're cut from a cloth well suited to the work – equal parts cool, compassion and competence (think Clint crossed with Oprah, who cut their teeth on chaos). They are not alone in representing perhaps the strongest argument in the ongoing debate about health care – the kind of people working in it.

I've seen and I believe. Thanks Z.

Dr. Bruce Jespersen

Appropriate referral?

I wanted to bring up a recent situation and wondered if anyone else has some thoughts.

I saw a patient recently with gout. As I've seen lots as a family doctor, I put the patient on an NSAID and adding in a small dose of prednisone and discussed starting Allopurinol when it settled.

The patient had an appointment at the specialty clinic at the Foothills and saw a nurse practitioner. She, for some reason, thought that this patient needed to see a rheumatologist STAT. So somehow he was seen within a few days!

The rheumatologist confirmed the diagnosis, agreed with my treatment and suggested a daily dose of colchichine if needed.

So a few issues. Firstly, why can a NP be getting specialist appointments so fast for something like gout? I personally thought it a waste of resources. If I sent every patient with bad gout to the rheumatologist, they would be a bit sick of me.

Second, why wasn't I consulted about the referral? I thought a phone call would be in order, at least. I'm sure I could have prevented an expensive referral and left the spot for someone else.

Thanks for your forum.

Dr. Joan Knight

Not rationing, but careful use of resources.

In the December edition of Vital signs, Carolyn Lane wrote an argument that rationing acute care is not a good solution to health care problems. She is right. Restricting senior bed spaces causes back-up in acute care. The details of each individual patient are often complex, so that central, top-down rules and guidelines are seldom able to include all circumstances.

However, each of us, in our clinical care, needs to be better aware of the resources that we command. Each day in practice, any of us can easily commit the health care system to spend several times our own personal income. But that money must come from somewhere; taxes — from our patients and ourselves. In a publically funded system, each of us has a dual role, to do our best for the patient in front of us but also to use resources wisely. The funds used for minimal benefit today will not be available for something important tomorrow.

Family medicine residents in my clinic come to Calgary from all across Canada and overseas, and it is interesting to hear their reflections on how we do medicine in Alberta, compared to what they learned in their medical school. Many mention that, as clinical clerks in many other provinces, they were enjoined to only order the tests that are needed. Yet here, this is seldom discussed. In hospital rotations they commonly order sets of tests to be done every day for long periods. They are encouraged to order extra tests in case the results are useful. In the community, family physicians regularly order many tests for healthy young people on their annual physical. Screening PSA tests are ordered for patients even in their 80s. When do we really need BUN as well as creatinine? It seems that almost any patient who goes to emergency with even the most trivial, anxiety-magnified chest wall pain gets referred to cardiology for further investigation, and once there, few get away without the full set EKG, exercise stress test and thallium. Many also get an echocardiogam. Clinical assessment is no longer good enough for many conditions. No carpal tunnel operation can be performed without electrophysiology. Examples are legion across all specialties.

In the January edition, Dr. Chin wrote about the exponential rise in vitamin D testing despite our not fully understanding what this test means either in terms of physiology or of disease. The number of tests being done might be warranted if we had an epidemic of disease caused by vitamin D deficiency but the effects of extra vitamin D are marginal at best, except in a few rare situations. Worse, many practitioners, including various specialists my patients attend, appear to think that vitamin D metabolism is like that of iron; take a measure, fill them up with high-dose supplement and measure again to see that the patient is replete. Unfortunately vitamin D does not work that way. It is a hormone in itself and is tightly controlled by the body. Some patients seem to run at levels lower than the normal range and can only be raised above that by extraordinary means.

In many places where I have practiced, radiologists take a serious educational role advising appropriate testing and recommending against tests that will not solve the clinical problem. They would not accept a request unless the reason for ordering the x-ray was specified. Yet here they often do and we seldom receive feedback that a test is inappropriate. I am sure my residents and I are not so good that we always order appropriately.

Although both medical schools in Alberta have a policy of focusing on generic drugs, this is not enforced. It seems the majority of doctors think and communicate in terms of trade names and do not even know the generics. Dependence on trade names makes doctors susceptible to prescribing the most recent and expensive drugs in a setting where it is difficult to learn the relative costs. Some specialists seem to take pleasure in recommending patients start on the latest and most intellectually interesting (and advertised) drug. The trouble is that once the samples are finished, the patient cannot afford them. Even if they could, often they should not. While it may be educational for doctors to learn about the side effects of a new drug, most patients prefer that we let someone else do this exploration. Everyone needs a copy of "Rx files" one of the best products to come out of Saskatchewan. This not only compares drugs for their properties, but also gives their prices.

The growth of hospitalists has been a major change in recent years and they substitute for the now rare general internists. This gives the increasing number of specialists the opportunity to become super-specialists. Perhaps the New Zealand coinage of "partialist" is a better word. Each one restricts themselves to their own very narrow field so that patients are on the receiving end of multiple cross-referrals. The most extreme was my patient who had four different cardiologists; an electrophysiologist who only looked after the pacemaker, a valve person who listened to the replaced aortic valve intermittently, a stenter who followed up his installations and a cardiac failure specialist. Although I presume each had been trained as a general cardiologist before specializing (partialising?) they never presumed to offer advice in the other's territory let alone the endocrinologist and nephrologist. So the patient came to me with contradictory advice from all six and I had to help him make choices. All this cost a great deal with minimal enhancement of the patient's quality of life.

Other doctors seem to like seeing patients repeatedly at frequent intervals to follow-up. This applies to both specialists and general practitioners. We do not need to generate work, though I recognize that seeing a repeat patient is often easier and effectively pays better than seeing a new one. But more likely doctors do this because they have got into the habit of doing it; the family physician who sees patients every month or two to check their BP or their diabetes, the specialist who continues follow-up every six months forever though there is no change

We must look carefully at what we do and think hard about how to reduce cost and create better value for our patients and the system. If we do this consistently, we will actually produce better care, cause less harm and leave more resources available for those who are currently missing out. But our system could help with better feedback.

Dr. Jim Dickinson MBBS CCFP, UCMC Central Clinic

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