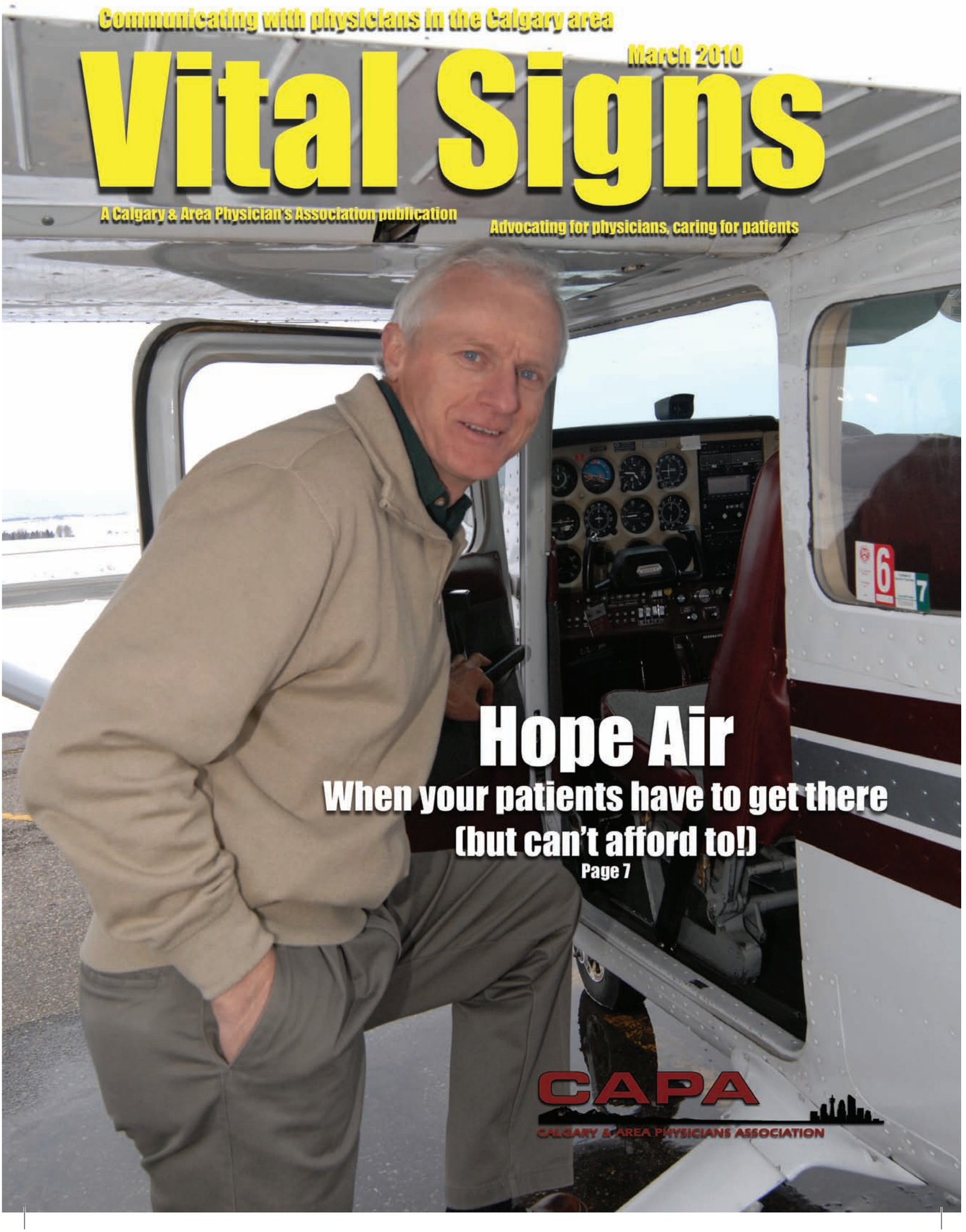
Communicating with physicians in the Calgary area

March 2010

Vital Signs

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients



Hope Air

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CAPA

CALGARY & AREA PHYSICIANS ASSOCIATION

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A Calgary & Area Physician's Association publication — Advocating for physicians. Caring for patients.

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.

Please send any contributions to:
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Vital Signs reserves the right to edit article submissions and letters to the editor.

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On the cover: Hope Air volunteer pilot and Calgary Flying Club president, Harry Range. Photo by Dave Lowery

Communication is easy . . .

but not in medicine apparently!

From the CAPA president

CAPA
CALGARY & AREA PHYSICIANS ASSOCIATION

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

I am writing this month from the beauty and serenity of Hawaii. It is a welcome respite from the cold of Calgary and the stress of working in our current healthcare environment.

We have ongoing changes, many of which appear to be just different reworkings of past models or, in other words, reinventing the wheel.

However, while I was here reading the Maui newspaper an article on electronic health records caught my eye. The US government is awarding some $750 million in grants to expand the use of electronic health records. The funds come from the economic stimulus bill passed by Congress and signed by the president last year. So here in Hawaii a non-profit is to receive $5.6 million to increase the use of EHR's in the islands. The non-profit organization is called the Hawaii Health Information Exchange Inc. and is formed by Hawaii hospitals, health insurers, physician organizations and other health care providers. The money for the exchange will allow patients to have their doctors working for different health care providers access their records.

This brought me to wondering how it is that the state of electronic health records and its relative, the electronic medical record, is so primitive in relation to all other things I seem to access on the computer.

Could the airlines survive without a very capable computer booking system?

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Small things matter!

From the CAPA president- Contd.

Could the banks survive without computers?

Could I survive, for that matter, without access to online banking?

While on vacation one googles directions for a daytrip on Maui. We ponder the origin of capers and I google it that evening. By the way, they are the unopened flower buds of a plant grown in Europe soaked in brine. Very expensive as they must be hand picked. We discuss the difference in price of gasoline in liters versus US gallons and the answer appears in seconds.

As I write this article from thousands of miles away it is very apparent that communication has become so easy and yet not in medicine.

I still cannot access a patient's electronic chart from doctors who use different vendors.

I cannot view the x-rays done at clinics in the community on the electronic network. There is no provincial system, other than Netcare, to access lab and xray results and not all Calgary doctors have access yet. Alberta Heatlh Services provides free hospital access to Up to Date, the online medical database that the "younger" doctors all use to get information on a daily basis. Looking up information in books has almost gone the way of the dodo bird. It does take up less space than books and as long as I have a computer nearby it is very handy. I have no idea where the information comes from. Mind you, it must be "correct." If nothing else it is UP TO DATE. However Up to Date is not provided by AHS to family physicians in the community for their patients. Our patients expect us to be able to access their information anywhere in the system and cannot understand why we are unable. One does have to wonder why I cannot view the hospital charts of my patients in Calgary from my office when I can see a satellite view of my house and even read the license plate numbers of the cars in the driveway.

Do we need more money to make a truly integrated electronic system work in medicine? That is probably part of the answer but also we need much more coordination, perhaps like the non-profit organization talked about here in Hawaii. Alberta Health Services may be the perfect vehicle for the creation of a fully functioning, well funded, easily accessible and truly provincial electronic health record and this could be its lasting legacy. But they must act quickly so that we do not end up with a system that is unable, or unwilling, to communicate across the miles or across the street!

My final thoughts revolve around the state of our emergency rooms and how it now compares to the state of security at our airports. I have long been disturbed by the appearance of signs in the emergency rooms stating emphatically that abuse of the staff will not be tolerated. Of course true abuse is not acceptable but I have had a lingering concern that these signs were in some way necessary to quiet those patients who become legitimately upset by the unreasonable wait times. Well that has now been confirmed. On a recent visit through security at the Vancouver airport the same sign has now appeared. Indeed to quiet those passengers who may become upset by the unreasonable searching we must endure. These signs do not show us how "unreasonable" we have become as patients or travellers but instead how "inhumane" the treatment is that we are being subjected to in the name of safety or security.

PARA
Professional Association of Residents of Alberta

What defines an exceptional residency program? Many factors are important in fostering learning, resident maturity and independent thinking. People are key; preceptors, support staff, and others all contribute to make an environment supportive and encourage each distinct team member to strive for excellence. A lot of programs have excellent staff resources and are solid programs. The difference, however, between a good program and an exceptional one are tiny; some small things make a big impact and unintentionally may deliver statements about a program's priorities and values.

Let me give you an example; as resident physicians, we often work long hours. By the evening, most of the physician staff leave the hospital and only those who are on call remain overnight. Among those remaining on service are senior residents with their junior colleagues and students; these individuals will address any emergencies that arise during the night, admit new patients, and deal with acute issues of the patients already on the service. No matter which medical or surgical service it is – it is often busy and challenging, but it gives the invaluable hands on experience. During the long night hours there may be some quiet time to rest, no matter how long it is, it matter; even 30 minutes of rest make us feel more rested and alert. I have also found that a cup of hot coffee or strong tea at 4 am in the morning often helps me to keep going and provides the little boost I need to continue assessing my patients.

They are little things: a place to rest and some hot tea when I need it. These little things can make a world of difference during a busy night on call. Unfortunately, late at night, the cafeteria is closed, and some of the junior learners on the team are not able to find an empty bed, making it difficult for them to rest between new admissions.

Sometimes in medicine, we get an extra student or resident physician scheduled on call to make sure everybody is able to the necessary exposure to procedures and protocol. It certainly helps to have extra help on busy nights; however, additional help means that call rooms are at even more of a premium. This situation occurred during one of my medicine rotations; there were not enough rooms for all the resident physicians on call. By 3 am, when we had reviewed the new patients, one of the residents did not have a call room and had to spend the remaining hours of the night on the sofa in the doctors' lounge, trying to rest between the calls from the units and interruptions from those who had need of the lounge.

I also hear about the students on other rotations who stay overnight on call, but have no call rooms to rest in, or, by the time they deal with all the acute patients' issues, all the rooms are taken by others.

As a resident representative of the Professional Association of

Continued on page 4

Calgary Medical Society gala

By Dr. Garth Wagner, CMS president

The annual president's gala 2010 was held Friday, February fifth, in the Glencoe Club ballroom. There was a champagne reception at 6:30 followed by a gourmet dinner at 7:30 with awards and door prizes presented towards the end of the banquet.

Dr. Howard Gimbel, (photo at left) a native Calgarian, received the Physician of the Year Award. The Calgary Medical Society president, Dr. Garth Wagner, presented the plaque to him. Dr. Gimbel had an impressive 11 page abbreviated curriculum vitae. He has published nine books, 109 peer-reviewed papers, 168 non-peer reviewed papers and given 1020 presentations at medical meetings, to mention only a few of his accomplishments. He has also had a long and successful ophthalmology medical practice.

Following the wonderful banquet the rest of the evening was spent visiting and dancing to the music of the band called The Real Deal. We invite you all to join us for the next president's gala that will be held about this time a year from now.

PARA - Small things matter! Contd.

Resident Physicians of Alberta (PARA), I was involved in addressing some issues related to call rooms conditions and availability. As a result of mutual efforts by PARA and AHS, the call rooms significantly improved in Rockyview General Hospital. Resident physicians no longer have to walk outside in the dark to get to the call rooms from the hospital and back. There have been ongoing efforts to improve the conditions of the existent rooms and to establish plans to increase the number of call rooms in the future to anticipation of increasing numbers of residents and medical students. These are important steps.

Is there anything that could be done in addition? I think all of us--both learners and those involved in teaching learners--should be attentive to the needs of each other. Little things like call rooms and the availability of hot drinks can totally change the experience of someone on call. These little factors can have a huge impact on how a physician or student is able to care for their patients. Allowing those servicing overnight call to care for themselves with a little nap or a drink matters and allows us to create both better working conditions and a better learning environment. Doctors who are able to care for themselves are better doctors.

CAPA notices

The FMC spring dinner 2010

Mark your calendars for Friday, April 16 2010, when the FMSA is hosting the annual Foothills spring dinner at the newly renovated Glencoe Club ballroom, 636 – 29th Avenue SW. Come and enjoy a pleasurable evening to include a cocktail reception with hors d'oeuvres, gourmet dinner, and music throughout the evening. Fantastic door prizes abound! Presentations of the FMC 2009 Outstanding Clinician Award, as well as resident scholarships in recognition for exceptional leadership

Contact Susan at 403-944-1409. Watch for further information.
Email: susan.sauve@albertahealthservices.ca
Mark the date! Organize a table! Invite your residents!

Primary care physician's association annual general meeting

When: Tuesday, March 16th, 6:30 p.m.
Where: Oslo Room, at the Red & White Club,
McMahon Stadium
(This room is on the main floor, with the entrance located to the east of the Red & White Club entrance)

- Free parking available in adjacent lots at McMahon Stadium.
- Light refreshments/supper will be available.
- $150.00 honorarium for attending the meeting.
- The annual budget will be presented, and nominations/ elections for the executive positions for the next year will take place. Other business may be conducted as necessary.

Please RSVP your attendance to Dr. Lois Torfason, at 403-242-4521 or email: lrsabuck@telus.net

Vital Signs electronic version

CAPA is excited to now offer our members the option of receiving Vital Signs via internet link rather than receiving a paper copy. Paper copies will still be available if that is what you would prefer.

If you would like to receive Vital Signs via E-mail - please E-mail your request to: Glennis.brittain@albertahealthservices.ca

"This has been a tragic mistake."

From the CAPA past president

I come from a land down under. Where beer does flow and men plunder.
Can't you hear can't you hear the thunder? You better run, you better take cover.

Dr. D. Glenn Comm, CAPA past president

I struggled for a long time to find anything positive in what I was about to write about. Finally the lyrics of my favourite Aussie band, *Men at Work*, came to mind so here I go!

Professor Stephen Duckett (from the land down under in case someone doesn't know) has a PhD. He is a PhD "doctor," NOT a physician and therefore is not bound by the Hippocratic Oath which calls on all physicians to "first do no harm." The Alberta Medical Association motto putting "patients first" is of no consequence to him either. I have difficulty understanding how ANY physician, in good conscience, could have implemented the cuts to patient care and the resulting suffering that Professor Duckett has. His actions are those of a hired gun . . . slash and burn when told to and add back when the budget gets increased.

Professor Duckett recently mourned the tragic accidental death of an Alberta Health Services (AHS) maintenance worker. As physicians, we recognize that any preventable loss of life is devastating. Yet, this was put in context when I spoke to a surgical colleague about that statement. The surgeon replied that two of his patients have died while on the waiting list for urgent surgery. And there are many patients whose conditions worsen significantly while on the waiting list for care.

One might give the professor more credibility if he made a public commitment to spend the next 20 years of his life living in the system he is creating. However I suspect that at the end of his contract (or his being terminated) he will happily leave the cold Alberta winters and head back to the "the land down under." I could be proven wrong on this, but hired guns tend not to stick around and help clean up the mess after they've rode through the frontier town and shot up the bad guys!

On a more positive note, I am keen to see what positive changes might result from the extra two billion dollars that the Alberta government added to health in the recent budget. It is interesting that suddenly orthopedic surgeons are being asked to do an additional large number of joint replacements. That is good news for Albertans on the bone and joint waiting list. But where is the extra funding to get rid of the waiting list for cancer care, vascular surgery and general surgery? One might cynically speculate that bone and joint has been chosen because it is one of the procedures measured by Health Canada for comparison across the country. We don't want the oil rich province looking bad, do we!

In the mean time, however, as I work in the Peter Lougheed Center (PLC) I cannot get any decent food between 10 PM and 7 AM. The cafeteria is closed! There is something in vending machines but it is almost unpalatable. At Foothills Hospital (FHH) on the maternity ward there are times when safety dictates that physicians stay close to the fetal monitors. The Garden Deli IS open at night at FHH, but at times is too far away for these physicians to safely leave their patients. There IS food on the unit for patients but they count the slices of bread given to patients on the maternity floor and won't share any with the hungry physicians.

Alberta Health has often says it wants evidence-based care. Perhaps it should look at the Calgary research done by Dr. Jane Lamaire that showed improved performance when busy physicians were given access to food during their daily work. Think about it! Do you really want to have your surgery done in the middle of the night by a surgeon and an anaesthesiologist who are both hypoglycaemic from being on the night-time PLC Duckett diet? Do you want the doctor watching your fetal monitor to be mentally compromised by hypoglycaemia?

I will urge my PLC anesthesiology colleagues to think long and hard before agreeing to do any extra work in hurry up manner . . . certainly not until food services return at night. We won't get any thanks for making the very people who have caused this mess look good. And where is the plan to get the waiting time for cancer surgery down? Where is the action plan to prevent vascular surgery patients from dying while on the waiting list? The fact is professor Duckett has closed, by one count, 92 days of operating rooms. I suggest we save the system the extra costs and inefficiency associated with working after hours and re-open all of those rooms during regular hours.

I would also suggest that we initiate discussions with our nursing colleagues. They, after all have "heard the thunder" of being told for the last year that they are making too much, that they aren't working enough, and that they should "watch out under" for their imminent replacement with less highly trained staff. I have my doubts that they are going to jump with joy over the Australian messiah's change of tune. If he is so flush with money and wants to get some results, perhaps we should look at our staffing numbers in the operating rooms. There have been reductions in the number of staff assigned to rooms at the PLC. This reduces efficiency as it takes a bit longer to turn around ORs between cases and has the potential to make ORs run past their scheduled finishing time.

AHS has burned up a lot of good will over the last few months. It is time that they approached us in a humble manner while trying to ask us to work even harder for their benefit. Physicians will continue to work, along with nursing staff, to do what it takes to get the job done to the best of our abilities. We do it in spite of the AHS because WE care about OUR PATIENTS. It would sure be nice to have the AHS pair anything we do with some appreciation . . . and some edible food. In the mean time, I'll wait for those in power to come to the realization of the truth in my other favourite song by *Men at Work*!

Tell us commander, what do you think?
'Cos we know that you love all that power
Is it on then, are we on the brink?
We wish you'd all throw in the towel
We'll not fade out too soon
Not in this finest hour
Whistle your favourite tune
We'll send a card and flower
Saying:
It's a mistake, it's a mistake, It's a mistake, it's a mistake

It HAS been a tragic mistake! One we will be living with for a long time.

"Foot soldiers" for healthcare

From the CAPA president-elect

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

Podiatrists rejoice!

This month I am going out on a limb. I have previously mentioned the idea that I am about to present even though the former health minister rejected it. Regardless, I propose the notion of a "health care footprint" akin to the popular notion of our collective "carbon footprint." I believe that we need to engage the population directly to play a role and assume some degree of personal responsibility for our cherished public health care system.

We should embark on a campaign emphasizing the "health care footprint" that all of us place on the health care system. In short, each and every Albertan likely makes some unhealthy decisions every day that sooner or later will result in costs to the health care system. Consequently, every Albertan can chip in to save the system financially and help to preserve public health care. It is an inclusive approach and one that can bring us all together with Dr. Duckett to develop the best, sustainable health care system in Canada if not the world. Moreover, a health care system in which we can all look upon with pride knowing that we helped to create it and more importantly, to sustain it.

I suggest a broad public relations campaign including a factual assessment of the economic picture of the health care system (escalating costs etc.). This should be paired with a message to encourage every Albertan that they have a duty to do what they can to minimize their 'footprint' on the health care system. I suggest a message to be mindful of the daily decisions that we make and to encourage a momentary pause to perhaps consider better decisions.

The campaign should include an educational message since, sometimes, we make decisions that burden the system unnecessarily. For instance, visiting the emergency department for a minor ailment or a prescription refill is far more expensive than attending a family physicians' office or a walk-in-clinic. We could do better by learning to accept that, sometimes, expensive tests or prescriptions are not always required to diagnose or treat ailments. We could do better by learning to accept that outpatient care can be just as effective as inpatient care but without the tedium of hallway waits and hospital food.

I suggest a frank campaign regarding the duty of every citizen to maintain their health and reduce their health care footprint by not smoking, by exercising, by working to achieve a more idealized weight, reducing drug and alcohol consumption, driving safely, developing a healthy social network, watching for household hazards, using common safety sense like wearing a helmet or life jacket where indicated. The list seems endless. It should be a broad and deliberate campaign asking every citizen to chip-in by way of healthier choices and actions.

All of us healthcare workers can also make better choices during our day-to-day operations and thereby significantly reduce the overall health care footprint. Do we really need to prescribe that expensive new medication or will an older, cheaper one suffice? Do we really need the expensive medical appliance or will a less costly one yield just as satisfactory an outcome? Does the patient really need to stay an extra day in hospital or can outpatient services now accept care? Do we really need to do that procedure or test?

If we all begin to think about the choices we make we will have an army of healthcare "foot soldiers;" people who are mindful of their present and future healthcare footprint or impact on the health care system. A successful healthcare footprint campaign should invoke self-discipline as well as a degree of camaraderie and support of one another to make better, healthier choices.

A word of caution; we will have to guard against the potential "overzealous foot soldier phenomenon." Just imagine the scenarios: "Mister, if you care about the health care system step away from the Twinkie with your hands up…" We don't want it to be too Orwellian but you get the idea.

Foot soldier "basic training" needs to happen early, in grade school. I think I was in elementary school when I first heard the "give a hoot don't pollute" message and it has stuck with me ever since. I never litter and cringe when I see someone else do it – dirty bird!

The campaign needs to be broad and sweeping encouraging everyone to become a foot soldier for healthcare. It may also help to have incentives tied to it. Perhaps those tax rebates that were once proposed for joining gyms or participating in sporting and exercise activities. Perhaps by attending some form of health education seminars Albertans could earn tax credits.

In the end, no amount of prudence will prevent all injuries or illness. No matter how much we care about our carbon footprint, some of us will still have to drive our cars. At a minimum however, a mindfulness campaign regarding our healthcare footprint should certainly help to sustain our public healthcare system now and for future generations. If we love the notion of public health care, every Albertan and every Canadian will need to pitch in by making better choices in order to sustain it. Perhaps the message should include the notion that if we aren't looking after our own health, should we really be criticizing the system?

The health care system is part of our Canadian identity. It is dear to us all. Consequently, we should engage citizens to understand why change is necessary and encourage them to play a part in reducing costs and helping to achieve sustainability. In this sense, everybody has a part to play and everybody can win. We will be able to achieve the changes needed, become fiscally sustainable whilst individuals reap the dividends of healthier lifestyles for years to come.

In Alberta we have a potential army of 3.5 million health care foot soldiers. If we all work together I am certain we can overcome any woes befalling our public health care system. So strap on your boots and of course - eat your vegetables. Any takers?

Hope Air

By Dave Lowery **When your patients have to get there (but can't afford to!)**

Established in November 1986 by Joan Rogers and Jinnie Bradshaw, CM, the registered non-profit charity was initially called the Mission Air Transportation Network and in the first three years organized 617 flights on seats donated by Canadian commercial airlines. Within 10 years, that number had risen to 20,000 clients (in Hope Air's view, their patients are clients) and was averaging 45 clients per week which ultimately resulted in 60,000 flights to date. After a name change to the current Hope Air in 1999, the volunteer pilot program was established to extend their services to communities not well covered by commercial airlines. And though Hope Air still relies on commercial airlines for the majority of their clients' travels, over 1400 missions have been completed by volunteer general aviation pilots. That translates to over 300 pilots who have volunteered their time, aircraft and expertise. One of those volunteer pilots is Harry Range, president of the Calgary Flying Club. A retired oil patch executive, Range has been flying for 12 years and signed on to volunteer with Hope Air four years ago.

"Flying was never a burning passion but it has always been of interest," Range says. "So when I got out of the oil business, I was looking forward to six months of doing nothing but my wife said it was a good time to learn to fly."

With his own Diamond DA 40 four place aircraft, Range has transported only one client but hopes to fly more.

"The concept initially attracted me and as pilots, we are always looking for excuses to go flying," he says smiling. "And Hope Air has a charitable aspect which is also attractive."

Pilot/owners are reimbursed 50 per cent of their fuel costs and a tax deductable receipt is issued for any operational costs. And though these flights are not considered medevacs, as patients need to be medically stable, Range says pilots need to be aware of a few things.

"A pilot should be prepared for nervous passengers and passengers who aren't used to flying," Range says. "Since clients need to take advantage of the charitable status, they probably haven't flown a lot so pilots need to be cool, calm and collected in case the passengers get upset. But ultimately it's a good venture and an opportunity for pilots to do something a little different and walk away feeling pretty satisfied knowing they helped out."

And helping out is what Hope Air's executive director Doug Keller-Hobson, 54, hopes many more people will do.

Though originally from Calgary, Keller-Hobson says his family gradually migrated back to the Ottawa area when his father "dropped the oil exploration stuff" and oversaw polar continental projects for the federal department of Energy, Mines and Resources. After graduating from the University of Ottawa Law School, Keller-Hobson pursued executive-entrepreneurial opportunities in North America, Europe, the Middle East, Caribbean and the Far East before joining Hope Air's board of directors in 2003. As executive director since 2005, Keller-Hobson remains passionate about his organization.

"In 2003 I was at a stage in life where I was exiting some projects and wanted to give back to the community," he says. "Hope Air appealed because, quite simply, every day you're helping people. It also allows me to use my business skills to implement ideas from the

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Pilot volunteers

Hope Air requires the following minimum experience:
(1) hold a valid Canadian private, commercial, or airline transport pilot licence; and
(2) have 500 hours, total time; 400 hours, PIC; 50 hours in make and model;
(3) and 30 hours during the past 12 months.

Patient referrals to Hope Air

Hope Air is not an air ambulance. Rather, it provides flights on both commercial airlines and in private planes from rural/remote locations to larger cities and inter city. The following will be considered by Hope Air when reviewing flight requests:
• Flying in Canada for an approved medical appointment (meaning the client's provincial health plan covers the treatment they are going for)
• Financial need.

How quickly can Hope Air respond to a client's need?

Very quickly! Hope Air wants to help as many fellow Canadians as possible so we do everything we can to get clients to their appointments when they need to go. Advance notice ensures that we are able to get in touch with the client's doctors to confirm all appointments and medical clearance to fly in a timely manner, but we recognize that sometimes appointments get scheduled at the last minute. Just call us and we will do everything we can to help you.

What can staff & volunteers do to help clients get Hope Air's assistance?

(1) Spread the word - let people know that Hope Air is a resource they can call.
(2) Put up the posters and make the Hope Air brochures readily available.
(3) When a client calls, inquire of them whether they might need to consider flight assistance - then refer them to the Hope Air website or phone:

1-877-346-4673 - www.hopeair.org

(4) Contact Hope Air if you have any questions or are running low on Hope Air materials.

Who do I call if I need more information to help a client?

Sandrine Levrier, flights manager
416-233-5663 ext 225
1-877-346-4673
slevrier@hopeair.org

AIMGA's observership program now under way

By Dr. Shahnaz Sadiq, president AIMGA

The Alberta International Medical Graduates Association (AIMGA) is a provincial non-profit organization that represents internationally educated physicians. The association's goal is the recognition of skills and experience gained outside Canada, without compromising current Canadian medical ideals or standards.

While trying to integrate into the Canadian health system, international medical graduates encounter many challenges, including development of appropriate communications skills, adaptation to the Canadian medical system and successfully completing Medical Council of Canada (MCC) examinations.

AIMGA recently launched an observership program to address some of these challenges, thanks to a Citizenship and Immigration Canada grant. This pilot project gives international medical graduates (IMGs) the chance to observe, gain experience and get feedback from licensed Alberta physicians in a Canadian medical setting. The program also gives the internationally trained physicians the opportunity to obtain reference letters from local physicians to submit with their applications for residency positions. We hope to provide eligible participants with two or three observership opportunities during the course of the program.

Through this program participants become familiar with standards of medical practice and unique aspects of the physician's role in Canada. They also have the opportunity to improve their communication skills and learn about the roles of other health professionals in multi-disciplinary health care teams.

These internationally trained physicians have backgrounds and experience in a range of medical fields, including family medicine, obstetrics and gynecology, pediatrics, surgery, ophthalmology, internal medicine, neurology, pathology and psychiatry. Many speak more than one language in addition to English.

The program is exclusively for permanent residents, landed immigrants and refugees in Alberta. To be considered, international medical graduates must have passed the Medical Council of Canada Evaluating Examination (MCCEE) as well as an English language proficiency exam. The program gives priority to those who have passed Medical Council of Canada Qualifying Examination Part 1 (MCCQE1).

More than forty internationally trained physicians from all over the province are waiting to be placed in community practices or hospital settings. We have been contacting physicians since early October. So far, many have expressed interest and willingness to participate but we need many more. Observerships can be as short as five hours a week for a one-month period but most physicians have agreed to longer periods and more hours. Physicians and observers mutually agree to arrange their own flexible schedules for the observership period.

AIMGA provides guidelines for the preceptors and ongoing support to international medical graduates. Preceptors provide feedback to the IMGs at the end of their observership which the observer then sends to the AIMGA office.

International medical graduates who have completed observerships to date tell us how much they have benefitted from the experience. "My first observership in Canada helped me learn the colloquial language associated with medical issues and being part of a busy family practice gave me a feel for how people talk to each other and work together here," said Alejandra Ugarte-Torres, a program participant. "This has helped me enormously."

To meet our goal of placing at least twenty international medical graduates, two to three times each, over the next eight months we will need more participating physicians as well as physicians who are willing to act as preceptors for several consecutive observerships. We hope to expand our roster of preceptors and matches by developing a targeted outreach strategy.

How you can help

If you are a physician or know of one whom you think may be interested in volunteering as a preceptor in the observership program, please contact Barbara Schleifer at the AIMGA office by phone or e-mail. (403-520-7730; aimga.obs@shaw.ca)

Hope Air - Contd.

kitchen table to the board table and it has been a lot of fun."

Though not a pilot, he did take lessons as a teen but never had enough interest to commit to the full training program.

"But I've logged enough hours in airplanes to know what they're about," he says laughing.

And though Hope Air is considered a success from all angles, Keller-Hobson says there are two challenges that remain constant.

"One is fundraising; like all charities," he says, "and 90 per cent of donations go directly to the mission so overhead is very small. But even with donated airline seats there are airport authority fees and taxes that have to be paid. We don't pass any costs on to the client. The second challenge is to build awareness of our organization. We don't want to be a best-kept secret so we need people to know we're here to help and make the medical profession aware of us."

Keller-Hobson says he hopes to involve both federal and provincial governments to expand the program.

"We don't need free universal travel but our most vulnerable population do need help. We know that if a client cannot afford to get to an appointment, they will postpone or cancel what might be a life saving appointment or procedure," he says. "The cost of an airline ticket is a small element to help them get back on their feet. The airlines are great donors of empty space but they can only donate so much. We need to involve the government more and develop a very public private partnership. Instead of 2500 flights a year, I hope we are doing 5-6000 per year within five years."

"Ultimately, we live in a big country and there are a lot of barriers to healthcare," Keller-Hobson says. "We are trying to get the government to see that distance is a significant barrier. The difficulty some people face is that we have a great health system, which we adore, but it starts at the front door of the hospital. And sometimes how you get to the front door is up to you. We would welcome physicians to spread the word about us and if they see fit to support Hope Air, we would be more than thrilled."

Another unsatisfied customer . . .

Like CAPA, the Alberta Union of Provincial Employees has been dealing with a number of issues under the Alberta Health Services board since the restructuring began.

I'm writing at this time to highlight one issue that our members are seriously concerned about. You may be aware of changes announced on November 17th to reduce protective services staff in our hospitals. AHS is moving to a hybrid model in Alberta that will reduce the overall number of security staff, contract out a portion of the remaining employees and centralize dispatch services in Edmonton. In addition, rural health facilities in the central and southern regions, like Ponoka and Claresholm, will lose all dedicated security staff, to be serviced instead by Edmonton dispatch, and an AHS roving peace officer. These changes are to be implemented as of April 1, 2010.

Our members, who have been working in the Calgary area prior to 2007, remember working with contracted security guards, and tell us that staff turnover was high, and that there were many issues with employees who were less committed to providing quality security service.

Over recent years we have seen increased reports of assaults on the job against our members in health services. Combine this with the increase in population in Alberta, and you could make the case that we need more security officers at this time, not less.

AUPE has welcomed the delay or reversal of past decisions made under AHS such as the proposed closure of adult psychiatry at Alberta Hospital Edmonton, and the 300 acute care beds that were slated to close in the Edmonton and Calgary regions.

The fight to save Alberta Hospital, Edmonton was made possible in no small part by the vocal physicians at AHE who spoke up about the issue. We hope that with a new health minister, and the support of affected professionals such as those in CAPA, that we may be able to reverse the decision to reduce security services in our hospitals.

As you are well aware, there has been a chill created by the code of conduct; and some of our members are reluctant to speak publicly about these issues. If your members agree with our concerns, I encourage them to speak out. We have created a link on our website at http://www.aupe.org labeled SOS - save our services to write to your MLA. Some of our members are also scheduling meetings with their MLAs in the hopes of generating positive pressure.

AUPE thanks you for any support your organization or members are able to provide. We welcome the opportunity to work together on other issues of common concern.

Guy Smith, president, Alberta Union of Provincial Employees

Medicine is a 24/7 profession? Really . . .

I was quite intrigued by Linda's [Slocombe] comments regarding the "novel concept of 24 hour patient care."

I qualified in medicine in 1953 from the Royal London Hospital and our teachers impressed upon us that practicing medicine was a 24-hour 7-days a week profession.

I came to Calgary in1958 and started at The Colonel Belcher hospital. In 1959 I opened my own practice and was available to my patients 24 hours a day. Subsequently I joined Dr. Naylor and we set up a clinic in Calgary. One member of the clinic was always on call after normal office hours, weekdays, weekends, holidays including Christmas. No patient was left without a doctor to see, often at his or her homes.

Donald A Potts M.D.

Or is part-time medicine okay too?

I read with great interest the courageous article by Jillian Schwarz "the part time stigma" Vital Signs January, 2010.

Having emigrated from the UK in the 1950s, with very young children, my first part time job was with the City of Calgary health department, as it was then called, during which time we adopted three more children.

Due to some much needed whistle blowing in the public health service, which I could not have risked if I had been the sole bread winner and for which I was both applauded and condemned, depending on one's point of view, I ended up as chairperson of the Calgary board of health in the 1970s. During this time I was also occupational health physician at Foothills hospital, also a part time job where I made excellent professional contacts which stood me in very good stead when I finally took on a solo full time family practice in the 1980s which I still enjoy. I have had a very interesting and varied career while being wife and mother and part time doctor with a lot of community involvement and contributed to society in a way which I could not still be doing at my age if I had been practicing clinical medicine 70 hours a week for the past 55 or more years.

The moral of all this? Do not denigrate part time women physicians. We are capable of a tremendous contribution to society over a lifetime of medicine.

Dr. Nancy Maguire, MBBS, FCFP. (Recipient of the Outstanding Family Physician Award, Calgary, 2009.)

In memoriam

Hossein (Dr. Joe) Moghadam

December 7, 1924 - February 3, 2010

Beloved husband of fifty-five years of Hilda Moghadam of Calgary, died on Wednesday, February 3, 2010 at the age of 85 years. Hossein is survived by his sons, Brian (Gayle Hunter), Kenneth (Andrea) and Michael (Esther); his grandchildren, Megan, Rachel, Matthew, Jeffrey and Katie; his sisters Mehry and Fatima and his brother Hassan all of the USA as well as numerous cousins, nieces and nephews in the USA, Europe, Australia and Iran. In accordance with his wishes he will be cremated and his ashes will be scattered over one of his favourite spots in his beloved Canadian Rockies. The family would like to thank Dr. Johan Conradie for his compassionate care, the wonderful and caring doctors, nurses and staff of Unit 73 at the Rockyview Hospital and the many friends and colleagues of Hossein and Hilda for their love and support.

Standardizing the academic alternate relationship plan

Many of you have heard about the initiative by the University of Alberta (U of A) faculty of medicine and dentistry and the University of Calgary (U of C) faculty of medicine to develop a provincial, faculty-wide academic alternate relationship plan (AARP).

The proposal results, in part, from both Alberta Health Services (AHS) and Alberta Health and Wellness (AHW) wanting a greater degree of standardization in AARPs and faculty concern over declining access to AARPs in recent years by new department applicants.

The Alberta Medical Association (AMA) is supporting the two faculties in their request to AHW and Alberta Advanced Education and Technology for funding to support the development of a proposal.

Communication between both faculties and the AMA has been excellent. For example, both deans, Dr. Phillip Baker (Alberta) and Dr. Thomas Feasby (Calgary), recently met with the board of directors.

Current AARPs involve only certain departments in each faculty, and the details of each are generally independent. The common element is that each AARP funds physician remuneration for clinical, teaching, research and leadership components for full-time faculty within the given department.

- Funding for the clinical component comes from the physician services budget within the trilateral master agreement between AMA, AHW and AHS.
- Funding for the teaching, research and leadership components comes from various sources including AHW, AHS, the university and others.

Academic physicians in departments that do not have an AARP usually bill fee-for-service for their clinical services, but are remunerated from other sources for their non-clinical work.

The process to establish existing AARPs ensured that physicians who were directly impacted were:

- Engaged in the AARP discussions and decision-making
- Provided with a clear understanding of the terms and conditions of the AARP so that they could make an informed decision regarding their individual participation
- Had a process for determining whether or not the physicians would participate

The AMA will emphasize the challenge and the necessity that this same process and understanding remain as the discussions evolve for a faculty-wide AARP.

A key concern is that a number of alternate relationship plan (ARP) principles, which the AMA has enunciated since the initial days of ARP development, must continue to apply. For example, physician involvement in an ARP must be voluntary and the terms and conditions for doing so must be clearly understood.

ALBERTA MEDICAL ASSOCIATION

Other ARP principles promoted by the AMA include:

- Provisions for clinical independence
- Fairness and equity on remuneration, including increases for clinical services tied to generally negotiated fee increases, as well as access to AMA benefit programs
- Requirement for AMA representation

The current trilateral master agreement has a process for reviewing ARPs; it requires the AMA, AHS and AHW to jointly approve any new ARP. This process enables the AMA to insist on the principles above as a condition of approval of all ARPs including AARPs.

Continuance of funding – not only for existing AARPs but also all other ARPs – is imperative. (Fee-for-service is not subject to the same uncertainty.) The AMA has written AHW to stress the need to fund both existing AARPs and ARPs beyond the March 31, 2011 expiration date of the current eight-year trilateral master agreement.

The master agreement also serves as an umbrella over most physician compensation in Alberta. The physician services budget (PSB) has funding for both fee-for-service and ARPs, including the clinical component of AARPs.

The PSB allows for a wide range of payment options for physicians, and it is important this continue into the future.

In the upcoming negotiations 2011 the Alberta Medical Association will support an agreement with a single physician services budget that incorporates all clinical payments to physicians, but with different options, including AARPs, for physicians to suit their specific circumstances.

To comment or for more information,
email: ronald.kustra@albertadoctors.org

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

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