Communicating with physicians in Alberta

Vital Signs

July 2011

A Calgary and Area Physician's Association pu

2011 Advocacy Award winner Dr. Rick Anderson

Page 8

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Vital Signs is published 11 times annually (not published in August) by the Calgary & Area Physician's Association (CAPA) www.capa.cc
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Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in Alberta. 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 August 15, 2011.

Contributors:
The opinions expressed in Vital Signs do not necessarily reflect the opinions or positions of the CAPA or CAPA executive.

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On the cover: Dr. Rick Anderson, former CAPA president, is presented the 2011 CAPA Advocacy Award by former CAPA president, Dr. Linda Slocombe.
Photo by Dave Lowery

PLC unit 22 rocks!

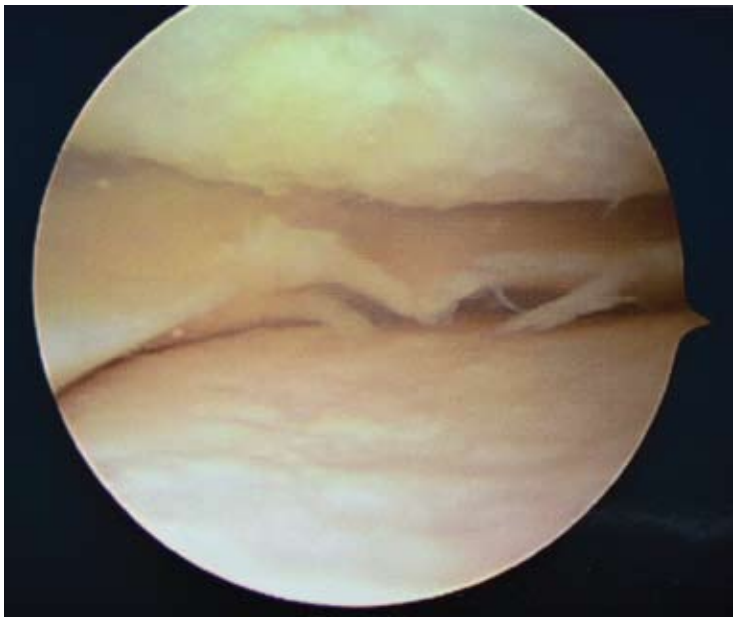
By Dave Lowery

When I first took on Vital Signs in the fall of 2002, I agreed to profile a specialty, group or individual as the main feature each month. Back then, we couldn't have foreseen the dramatic changes that were to affect healthcare in Alberta . . . and most weren't positive. Therefore, Vital Signs became the physician's uncensored voice and no subject was considered out of line. Our ambiance became more and more negative as we reported on a failing healthcare system. So it's very refreshing to throw some positives at AHS!

As a positive story, last month we featured a cover photo and small article about the 2011 graduating medical class. (And no, as a few pointed out, the front cover was not an accurate portrayal of the male and female composition in that class. Sixty percent in the U of C graduating medical class are female. While I was roving outside the convocation ceremony, those six new male doctors were the first to pose . . . it's as simple as that. When has Vital Signs been known to be politically correct? Sheesh.)

On another positive note, I recently had the privilege to access healthcare when my left knee, after complaining to me for over two years following over 25 years of running, was subject to Dr. Stewart's expert arthroscopic skills. He found, as he most accurately diagnosed, a torn meniscus and quickly snipped the superfluous meniscus out of my body during a very brief procedure while I was under a general anesthetic. I can't heap enough praise on a very polished system that confronted me. The day before, a nurse from unit 22 at the PLC called to ensure I knew my pre-operative instructions. When I called to confirm the time and place for the procedure, a very knowledgeable unit clerk was able to give me the proper information, without being put on hold and in less than a minute. Arriving at the PLC, I was immediately placed in front of an admitting clerk and, with no wait whatsoever, had my paperwork and my trendy new bracelet and headed to unit 22. Expecting a long wait at the front desk in the unit, I pulled out my book only to have to put it away within five minutes of arrival as my bed was ready. Ensconced in my very stylish blue gown, I was weighed, height measured and sent back to bed. A few chapters later, my attending nurse started an IV in my left hand with one poke. Five chapters later, I was wheeled into the surgical suite, fastened to the operating table, and then asked if I was feeling anything to which I responded "you'll have to use a lot more drugs to knock out this displaced newfie cause . . ." lights out. The next voice was a somewhat concerned nurse in recovery who asked if my pulse was always around 36-40. I reassured her that my sinus arrhythmia and bradycardia was a normal state of affairs and was soon wheeled back to my area on unit 22. Within a few hours, after the prescribed pee, my wife arrived and I was outta there. But that's not the end . . . 0900 the next morning I received a phone call from unit 22 asking how I felt and if there were any questions. Talk about customer service.

So, thank you all at unit 22. You are a classy act to follow.



Above: My torn, imminently superflous, meniscus!

Presidents, media and new acronyms

Happy summer everyone with what so far seems to be an endless groundhog day of grey November skies. Although the weather forecasts have been leaving us forlorn, the forecast for your medical staff association is hopefully somewhat sunnier. So with radiant prospects in mind, I would like to share a recap of events over the last few months.

Following our spring "election" I am happy to announce that come October 1, we will have a new president-elect, Dr. John Graham. Dr. Graham is a general surgeon and the president of the Rockyview General Hospital MSA. He was a senior resident during my year of residency in general surgery so I can attest first hand that Dr. Graham is a bastion of stability; a kind, thoughtful, and approachable physician. I am certain that he will defend the interests of patients and the medical staff with fierce determination and dignity. Welcome aboard Dr. Graham.

Brace yourselves: you are also stuck with me for another two years. Through acclamation (no one else wanted the role?) I have the honour to be your president until September 30, 2013. What adventures, twists and turns our system will have taken by then - who can tell? If we survive the rapture on October 21, 2011 (it might do wonders for waitlists) I'll also be your president as we pass through the end of the world on December 12, 2012. Comparatively, the advent of AHS might seem to be somewhat less cataclysmic, but only time will tell. Given the off chance that the world is still intact, CAPA will continue to soldier on – defending the interests of patients and physicians.

For many months your CAPA executive grappled with the provincial medical staff bylaws that came into effect at the end of February. Your executive has also completed your new MSA bylaws and await official society status acquisition. We are on target for launching our official new medical staff entity on October 1, 2011. At that time, we will say farewell to CAPA and introduce the Calgary and Area Medical Staff Society – CAMSS. This name change reflects the inclusion of dentists, oral surgeons, podiatrists and medical scientists into the medical staff of AHS.

Since February, your medical staff association has represented physicians at an alphabet soup of new acronyms including the first ZMAC, ZARC and PPEC meetings. ZMAC being the new iteration of the medical advisory board (MAB) while ZARC is the new iteration of the MAB executive. PPEC is a new provincial entity – the provincial practitioners executive committee, which oversees the function of all five provincial ZMAC councils and is advisory to the CMO. I should emphasize that the AMA does not formally represent physician interests on any of these committees – it is only your medical staff association that provides the unfettered, independent voice of physicians at these meetings. By the way, have you paid your medical staff association dues yet?

Your CAPA executive continues to represent Calgary and area physicians in the media ensuring that we have a voice on important matters. Admittedly, these media interactions can turn an otherwise sleepy week in CAPA into all out pandemonium. Moreover, media interviews can be particularly angst provoking!

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

When the media calls, the pressure of not train-wrecking the association is never far from mind. For instance, from the "did you know files" we have the Top 10 worst media disasters of 2010 courtesy of Mr. Media Training. For perspective, #10 on the list was Sarah Palin while #1 was British Petroleum's CEO, Tony Hayward. Following the explosion of the oil rig in the gulf of Mexico, the latter told reporters that the crisis was affecting his life and that "I'd like my life back" in what was described as "a stunningly tone-deaf comment that appeared to slight the deceased oil workers."

Only slightly worse than the republican senatorial candidate Christine O'Donnell (#9) who needed to take out advertisements denying that she was a witch (perhaps a clear sign that she was going to lose the election) was our local hero Dr. Steven Duckett (#8). Yes, the cookie-gate incident is now a part of "what not to do" media training everywhere.

The above scenarios form part of my worst nightmares in my role as CAPA president. What if it happened to me? What if I totally freeze and I'm forced to defer to a cookie? A lamb chop? My God – pork rinds! Enter media interview and the mantra begins: "do not say anything that will make the top ten list, do not say anything that will make the top ten list…" Zap! Some alien life form takes control of my brain and I blurt out something completely inappropriate! The health minister is taking babies hostage! Suddenly, those cookies of Dr. Duckett look really good. I can fully understand where he came from. Wait a second, he came from Australia…

So as we move into summer, I am hoping that all of our membership, rain or shine, will find time to spend with friends and family. Embrace this greatest of joys. The only top-ten list I'm hoping to achieve is best family vacation . . . we're going to Disneyland!

When patients become doctors

Photo and story by Dave Lowery

Merriam-Webster defines a doctor as "a learned or authoritative teacher, a person skilled or specializing in healing arts, a person who restores, repairs, or fine-tunes things." And though 'doctor' is not a noun to be casually applied, a patient defined as a doctor is not something new. In the 1998 film Patch Adams, starring Robin Williams, Williams, (as Dr. Hunter 'Patch' Adams) after being charged with practicing medicine without a license, responded, "everyone who comes to the ranch is a patient, and every person who comes to the ranch is also a doctor. Every person is in charge of taking care of someone else. That makes them doctors. Is a doctor not just someone who helps someone else?"

Robert Gibbon, 54, was most decidedly a patient three years ago. After attempting suicide, he ended up at the PLC psychiatry wing where he was treated by Dr. Lloyd Maybaum. He fully admits that initially he wasn't responding well to the intervention but, "I eventually started listening more than talking and realized I wasn't the only one with problems." The biggest factor in Gibbon's attitude change was the eventual realization that he would lose his wife, family and grand kids.

"I wanted them to have more than a picture, I wanted to see my grand kids grow up," he says. Ironically though, Gibbon now faces a terminal outcome unless lungs can be transplanted. While under psychiatric care, Gibbon was also diagnosed with pulmonary fibrosis, a condition that has led to him being hospitalized full time and close to the top of the lung transplant list. With plenty of time on his hands waiting in hospital, Gibbon thought that perhaps he could help other patients by telling them his story. So he approached Maybaum to see if he could help.

"I was taken aback when the transplant team told me that Gibbon wanted to help on our unit," Maybaum says. "He wanted to tell our patients that life *IS* worth living and that he had been in their state of mind before. I didn't originally know what he would say but he speaks from the heart. And that's what makes a big impression on our patients. He understands the approach and has been able to paraphrase his own experience and employ some of the therapeutic language and concepts we employ — but with fellow patients. What makes him particularly adept with patients is that he's not a professional and he's coming from a different angle. Additionally, he has an impact because he's facing his own mortality, has no vested interest and earnestly wants to reach out to people. Initially we had our occupational therapist debrief and chaperone him but he's been absolutely stellar giving inspiration and hope. He has more impact because he's facing his own mortality and is able to reach patients in a way that we, as caregivers can't . . . because we're not terminal (at least in the short term.) That is a very powerful message that he's providing to patients."

And though Gibbon is realistic about his medical condition, saying he's "at the end of the bad condition of my lungs — I'm either going out through the basement or north to Edmonton to get lungs" he quickly smiles and says he heard about the Tuesday night and Saturday afternoon group sessions and wanted to talk to the patients there.

"I'm more positive than I used to be, and after talking with the counselors, I went to the meeting, told them how I turned around and what I did and how I want to live."

Gibbon says the main thing to get across to patients is they have lots to lose and immediately starts to ask questions about their lives. When someone mentions grandkids, that gives him an in.

"What is your spouse going to say to those kids when they see a picture of grandma and grandpa together . . . and one of them is now gone? It's hard to get into the right mindset but I encourage them to write down the things they will lose and look at all the positives they still have."

Gibbon says most respond fairly quickly as they look at him and his positive outlook and realize he may not be here much longer . . . something he has no control over.

"Right now, I'm hoping for lungs. The glass is always half full in my life and I've learned to look at everything on the positive side. If you're depressed with life, there is always someone who can help you with the first steps. Call a friend, a neighbor, talk with them. Share a bit of what you're going through and you may find they can coach you. And if you think you have no friends, try a minister, a preacher, your doctor, a nurse or other patients. Or come to me . . . I'll help you."

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There are many reasons to organize into professional corporations, often for tax-deferral opportunities. Monies to RSPs and TFSAs seem to continue to be an exception to this rule. But should doctors take a second look at this strategy?

For those already in the highest personal tax bracket, professional corp bonuses attract RSP contribution room. Their subsequent contribution to an RSP appears to be a 'tax-neutral' event, since the additional tax on the bonus is eliminated by receiving a tax deduction. So far, so good.

The crux of the problem however, is how tax has only been deferred. Worse yet, they will have created a tax-inefficient retirement income, since any growth does not 'retain its character'. What does this mean? Growth from capital gains and dividends are usually only half taxable when received, while redemptions from registered plans – however grown – are fully taxable at up to 39%. How then, could you look to reduce your tax burden and increase your retirement income? Ultimately this what really matters....your after-tax income.

What if we looked at an alternate scenario,one where money for RSPs is kept within your professional corporation? How might this improve your situation in retirement?

As a 'tax-neutral' event since no personal tax would have yet been applied, and with the same investments chosen and benefitting from tax-deferred growth, we can create an apples-to-apples comparison to view the impact taxation will have on your retirement income.

When savings are liquidated at the corporate level to fund your retirement, your savings benefit from retaining the tax-favoured status of capital gains. Moreover, half of your capital gain is not only not taxable at the corporate level, but creates a credit to your Capital Dividend Account and can be paid out as a tax-free dividend to you. Your remaining gain and original investment dollars can also be paid out as a dividend to fund your retirement, attracting the ensuing tax-preferential treatment we all know and love.

Does this mean that doctors shouldn't have RSPs? There are two salient reasons you may wish to continue to contribute a reduced amount. First, to ensure enough in your RSPs at age 65 to pay to you (and your spouse, if applicable) $2,000 per year. You'll enjoy a yearly tax savings of up to almost $1,000 through the pension tax credits generated, which you would otherwise forgo.

For a less obvious reason, we need only to look backwards to see many examples of changing tax rates. While current tax rates favour corporate holdings, all of your savings are at risk if tax rates change in the future. At least a little in each pot of Tax-Free Savings Accounts, RSPs and non-registered investments is recommended to give you the best balance going forward.

At the end of the day it is essential to coordinate your efforts through a proper financial plan, which considers your business and personal planning of cash-flow, debt management, retirement and estate planning, risk management, tax-efficiencies and family dynamics, goals and concerns. If you don't have one, get one....fast. You won't believe the impact it will have, particularly for you dual citizens or frequent enjoyers of warmer climes down South.

Markets are an uncertain beast, and taxes erode the gains made. Until a way is found to control the former, focusing on the latter is a key consideration to improve your financial success.

ADRIAN GEORGE, CFP, CH P, FCSI

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Photos by Dave Lowery

With former CEO Dr. Stephen Duckett's recent claim that AHS had "go to" people to expedite selected patients through the system, our debaters found themselves in a media scrum outside the Glencoe's ballroom.

Dr. David Swann (L) and Danielle Smith engaged in, at times, some rather spirited debate though Paul McLoughlin managed to keep both debaters, and the audience's questions, in check.

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RGH MSA annual general meeting

By Stella Gelfand, Rockyview General Hospital, medical staff association secretary

The Rockyview General Hospital Medical Staff Association held its annual general meeting on Tuesday, June 14, 2011 at Heritage Park's Town Square in the Railway Orientation Centre with the magnificent Rocky Mountains as a backdrop. The sun was shining brilliantly; it was a beautiful evening inside the fabulous Railway Orientation Centre, the venue was filled with warmth, laughter and camaraderie while outdoors revelers filled the park gleefully attending graduation dinners. Dr. John Graham, Rockyview General Hospital Medical Staff Association president skillfully hosted the evening with polish and a touch of humor.

This enchanting evening included an operatic medley performed by The Cowtown Opera Company. Singers: Barbara Thorson, Derek Johnson, Jorge Aviles & Michelle Minke. Pianist: Ron Bernie.

The evening was highlighted with Physician Recognition Awards, very important presenters to our very impressive physicians as Rockyview General Hospital physicians were recognized for their outstanding skills and leadership that have guided their department/ division throughout the past year:

Department of emergency medicine

Dr. Pauline Head, medical director Calgary sexual assault response team (CSART) - Award recipient. Dr. John Graham - Award presenter.

Department of emergency medicine

Dr. Stuart Turner – Award recipient, Dr. John Graham - Award presenter.

Department of family medicine

Dr. Patricia Bryden, women's health program – Award recipient, Dr. Deborah Hitchcock - Award presenter.

Department of medicine

Dr. Willis Tsai, respirology division – Award recipient, Dr. Robert Herman – Award presenter.

Department of psychiatry

Dr. Madan Suparna – Award recipient, Dr. Jenny Mew – Award presenter.

Department of obstetrics & gynecology

Dr. Sheila Watson – Award recipient, Dr. Jaelene Mannerfeldt – Award presenter.

If you missed the RGM MSA AGM this year, you won't want to miss next year's AGM, mark your calendar for June 12, 2012. Here are some words of praise received:

- Stella . . . once again, phenomenal night! Best wishes to the Cowtown Opera, they were fantastic! John Graham was pretty good too! Thank you for doing this for us. Jeff S.
- This was the best ever RGH MSA AGM.
- This is one evening we will not forget! It was a really great event. The food was exceptional.
- The venue was bright and the food delicious.
- I enjoyed visiting with my peers in a dynamic atmosphere while being (at times hilariously) entertained and listening to the music. I am planning to attend next year and will spread the word.
- Congratulations on a splendid evening - you did an impressive job!
- Thank you for organizing this event, and to the RGH MSA, for what was an absolutely wonderful AGM this year.
- Stella was asked, "had you heard the Cowtown Opera Company perform before you organized this event?" My reply was no, but Barbara Thorson always comes through with the best entertainment that Calgary has to offer!

Upcoming RGH MSA meetings: September 13, 2011, December 13, 2011, March 13, 2012, June 12, 2012 (AGM)

L to R: Dr. John Graham, RGH MSA president, Dr. Jenny Mew, Dr. Suparna Madan, Dr. Sheila Watson, Dr. Jaelene Mannerfeldt, Dr. Stuart Turner, Dr. Pauline Head, Dr. Deborah Hitchcock, Dr. Patricia Bryden. Inset photos: Left, Dr. Willis Tsai, right, Dr. Robert Herman.

Be careful what you wish for.

One of the current activities in Alberta today stems from the desire by both the medical school faculties of both the University of Alberta (U of A) and the University of Calgary (U of C) to have an academic alternative relationship plan (ARP). These plans would be similar to the many alternate funding programs (AFPs) currently existing in Alberta except that these programs would be directed to members of the respective faculties of medicine in our province.

In going in this direction, many of the doctors involved with academic medicine hope to make the separation of clinical and research commitments (and the funding thereof) easier and simpler. I sat on the committee that dealt with ARPs for a few years after the start of the last eight-year agreement and am reasonably comfortable that there are, for the most part, the needed checks and balances in place. I can believe this because of the GREAT staff within the Alberta Medical Association (AMA) who do the lion's share of the grunt work when putting these agreements into action.

I have a few concerns about the potential impact going in this direction might have on individual physicians. My main concern is that this could result in a power shift in the direction of academia at the expense of the common worker who is the backbone of our increasingly fragile system. I would hate to see a time come when a well qualified, badly needed physician within an academic department, might NOT be able to work in our region because they don't fit into the departmental ARP/AFP human resources plan. A bigger concern is that these agreements are one-way streets. In the academic plans, if you are part of the group providing a designated service and, for whatever reason, you are no longer happy with your situation, I wonder if there will be any options for you other than to move elsewhere?

Changing gears! I believe that being physicians makes us innately want to succeed and do well at every task we choose to tackle. Unfortunately, some individuals who move into administrative roles seem to forget that they were doctors first, before they were administrators. Many of the problems that the Alberta government has tried to avoid dealing with, by denying the need for an independent enquiry into physician intimidation, were results of the actions/views of administrator MDs versus other clinical MDs.

Dr. D. Glenn Comm, CAPA past president glenncomm@shaw.ca

During my time as Calgary and Area Physicians Association president, I was involved in trying to sort out several miscarriages of justice (in my opinion). I was not able to help many to any great extent. The playing field is uphill in the direction of the administrators at the top of the food chain. In truth, a few of the situations were personality mismatches where there was a square peg trying to fit into a round hole, but an unfortunate number were doc vs. doc!

I know this is not a cheery picture. The Alberta Medical Association board called for a public enquiry into physician intimidation. This followed days of discussion in the Alberta Legislature. Unfortunately the Health Quality Assurance Council investigation, without the powers it needs to get to the bottom of these issues, will likely be no more than a whitewash. I would love for them to prove me wrong.

In the last session of the legislature, the Alberta government seemed to be using a head-in-the-sand, ostrich approach to dealing with all the healthcare issues that dominated the headlines. They must be eagerly awaiting the end of the last legislative session so they can go back to doing what they do best . . . slapping constituents on the back as they take pictures of babies at barbeques . . . anything to bury any memory of the physician intimidation storm that dominated the last session. I suspect, however, that most physicians will remember. These issues simply cannot be buried and forgotten. Have a safe and happy summer. The struggles will resume in September.

As always your comment, criticism, praise and poisoned darts are all welcomed at glenncomm@shaw.ca

In memoriam

Dr. Anthony Paul Melgrave

November 16, 1926 - May 23, 2011 We sadly announce the passing of Dr. Anthony Paul Melgrave, who died peacefully at the Peter Lougheed Hospital on May 23, 2011 at the age of 84. Dr. Anthony was born and raised in London, England. After serving a tour of duty in the British Military, he pursued a career in medicine as an anaesthesiologist. Dr. Anthony worked firstly in the U.S., then in Saskatchewan, before putting down permanent roots in Calgary, AB in the mid 1950's. He pursued his career diligently until retiring in 1986. Outside of work Tony was a strong lover and supporter of the performing arts, gardening, travelling and his model railway. Tony is survived by his son Ben, his dear friend Judy, and other close friends and supporters he met through out his life.

Dr. James Richard Stuart, MD, PhD

Jim Stuart, beloved husband of Betty Stuart, died peacefully June 1, 2011, aged 87. Dearly loved father of Helen (Eugene) Greschner, Frances (Brent) MacLean and Diana Stuart (Rob Milner), Jim is also survived by five grandchildren: Chris (Jeannine) Greschner, Lauren Greschner, Jill Greschner, Conor (Sam) MacLean, Kyle (Lindsay) MacLean and one great-granddaughter, Aida Greschner. Jim obtained his MD (1945) and PhD in biochemistry (1957) from McGill. After a brief time at UBC Vancouver (1959-1961), Jim served as pathologist at the Queen Elizabeth Hospital in Montreal and in 1967, Jim and Betty moved their family to Calgary, finally settling in their rural Okotoks/Black Diamond area home in 1972. During these years and until his retirement, Jim was first, a pathologist at the Foothills Hospital and later, the director of pathology at the Calgary General Hospital as well as being involved in private medical laboratories. Jim embraced his mountain-view home and wholeheartedly enjoyed many years being close to his family. He will be deeply missed. The family would like to extend sincere thanks to everyone who provided excellent care: Dr. F. Byam, Oilfields Hospital, Vulcan Extendicare and Rising Sun Care Centre. Heartfelt thanks to Cecilia and Kirstie Vaile for their invaluable support to Jim and our family.

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By Patrick J. (P.J.) White, MB, BCh, MRCPsych, president, Alberta Medical Association

The AMA released the study June 15. The evaluation can be accessed through a link in the June 15 President's Letter. Go to www.albertadoctors.org and look under Publications/President's Letters.

- Independent, third-party evaluation trumpets PCNs' successes.
- PCNs are the model to move to a strategy of primary health care from primary medical care.

An independent, third-party evaluation commissioned by the Alberta Medical Association (AMA), Alberta Health Services (AHS) and the Alberta government's department of health and wellness makes an exceptionally strong case for primary care networks (PCNs) as the building blocks and pillars for the future of primary care in Alberta.

PCNs "generated considerable benefits to patients with respect to improved access, management of patients with complex or chronic medical conditions, coordination of care and support for the development and expansion of multi-disciplinary teams," states the evaluation by Malatest Program Evaluation & Market Research, provided April 29 to all three parties.

All three parties now are reviewing the evaluation. The AMA has provided it to the board of directors and to the executive of the PCN physician leads.

Alberta Health and Wellness (AHW) and AHS have already identified what they regard as shortcomings, and the AMA is assessing their concerns. In the coming days, I will distribute an AHS-AHW letter and a copy of the Malatest evaluation itself.

The development of multi-disciplinary health care teams is just one of many successes reported in the Malatest evaluation: "443 full-time equivalent non-physician health care providers are now working with family physicians in the 29 PCNs." Today, Alberta has 40 PCNs.

PCN family physicians have long lobbied for an increase in the $50 per-patient funding, which has been frozen since the PCNs began. This would allow PCNs to employ even more allied health care professionals, which would result in bigger and more robust multi-disciplinary teams.

Among the "key, important results" from the evaluation, which took nearly three years to complete, are:

1. A marked increase in the number of Albertans attached to a family physician.
2. PCN physicians have more time to spend with patients.
3. Increased patient access to primary care was a priority for almost all PCNs.
4. Improved access to primary care, including some specialized services within the primary care setting.
5. PCNs developed linkages within AHS and external agencies and providers, most notably 100 per cent with home care; 90 per cent with community mental health and community health services; and 84 per cent with public health, hospitals, emergency departments and physician specialists.
6. Expanding multi-disciplinary teams has been a key priority for most PCNs.
7. Multi-disciplinary teams continue to be well-functioning units within PCNs.
8. Members of multi-disciplinary teams work to their full scope of practice in PCNs.
9. Less utilization of emergency rooms by PCN patients.
10. Targeting complex patients and/or patients with chronic disease was a priority in most PCNs.
11. Increased access to chronic disease management.
12. Informing patients of after-hours care alternatives.
13. 92 per cent of PCNs implemented or expanded one or more health promotion/prevention programs and services.
14. PCN physicians (compared with non-PCN physicians) more commonly screened for smoking (93 per cent vs. 77 per cent), tetanus/diphtheria immunization (59 per cent vs. 33 per cent), clinical breast exam (99 per cent vs. 84 per cent), mammography (96 per cent vs. 85 per cent) and bone density (63 per cent vs. 44 per cent).
15. PCN patients report greater satisfaction with regard to wait times.
16. 96 per cent of PCN physicians have changed how they practise.
17. PCNs have contributed to the retention of family physicians.

The AMA had previously informed the government on the evolution and successes of the primary care networks, including: a presentation to many members of the PC caucus; a meeting PCN physician leads had with Jay Ramotar, the deputy minister of health and wellness; and a letter to all MLAs that was signed or supported by all PCN physician leads.

And, I highlighted the Malatest evaluation when I met April 8 with Premier Ed Stelmach and Health and Wellness Minister Gene Zwozdesky.

Last year, when meeting with the Calgary and Area Physicians' Association, the minister made the following commitment in writing: "PCN's are great and PCN's will be here next year, and for as long as I can help them be here." The minister's commitment is the obvious focal point if the government goes ahead with a task force on primary care. Building on the success of the PCNs should overarch all deliberations; there is no need to reinvent the wheel.

The AMA and AHS have identified PCNs as the foundation for both primary medical and primary health care in Alberta. PCNs have earned the trust of Albertans and they deserve the support of the government.

The evidence clearly shows there is no reason to radically change direction.

1. The independent, third-party evaluation commissioned by the Alberta Medical Association, Alberta Health Services and Alberta Health and Wellness.
2. The primary care strategy of Alberta Health Services is built upon PCNs.
3. Qualitative evaluation and anecdotal evidence – including what MLAs have heard from their constituents.

The investment in primary care networks has provided remarkable benefits and outstanding returns. At the same time we must be open to improvements and innovations. Our discussion paper, AMA vision for primary and chronic care, demonstrates the commitment of physicians to do exactly this.

PCNs, a made-in-Alberta initiative, are a major success story! They have changed the face of primary medicine. The opportunity now is to have PCNs change the face of primary health care. Let's build upon what we've already achieved!

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

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