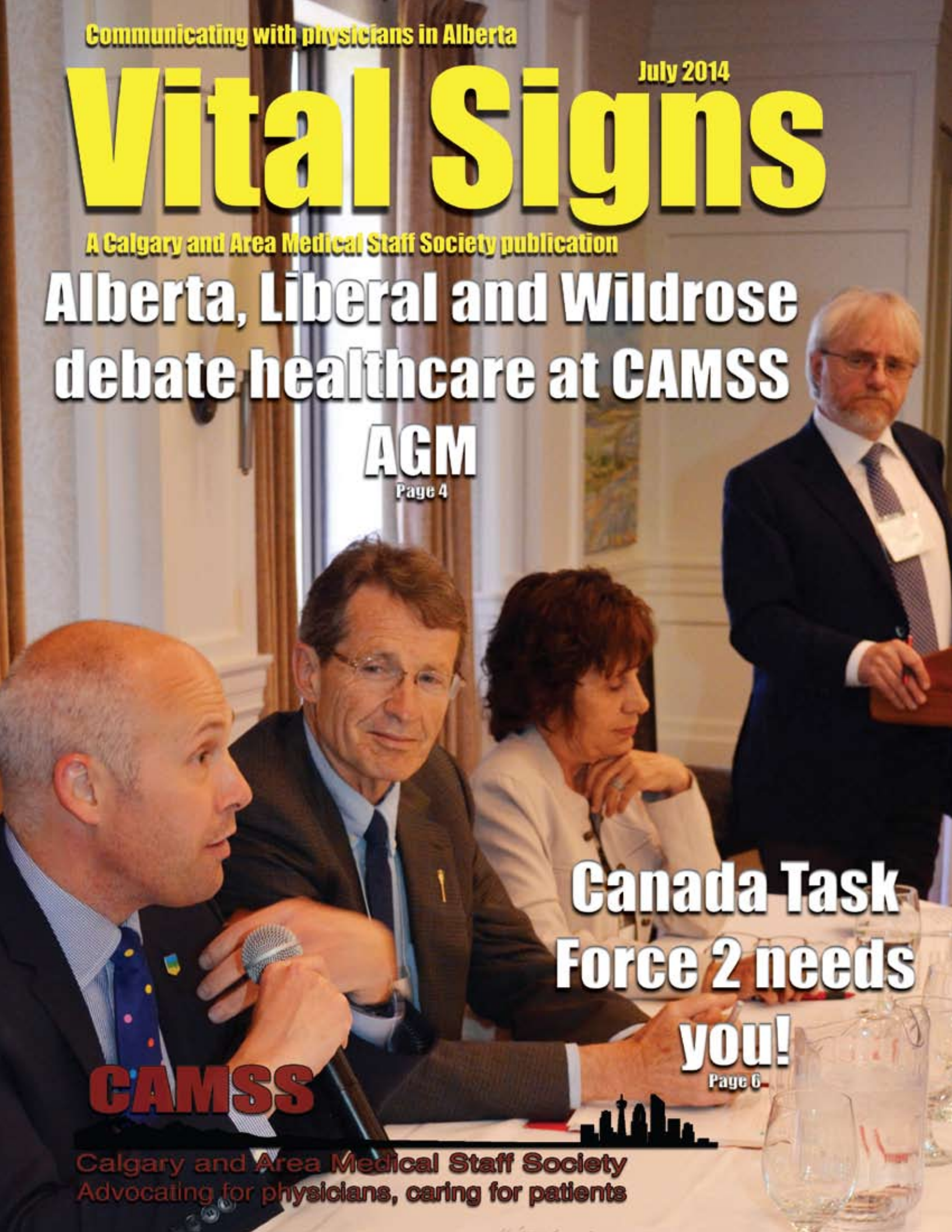
Communicating with physicians in Alberta

July 2014

Vital Signs

A Calgary and Area Medical Staff Society publication



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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.

Please send any contributions to: Dave Lowery: bethere@shaw.ca, 403-243-9498.

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Dues are due!

If you are already a member of AMA contact Audrey Harlow, administrative assistant for CAMSS and central ZMSAs:

audrey.harlow@albertadoctors.org or 403 205 2093

The cost is $150 payable by cheque to AMA, by credit card (over the phone) or by written instruction to add it to your payment plan currently in place.

In the case of CAMSS you have the option to designate a specific MSA:
Calgary Laboratory Services, Alberta Children's Hospital, Foothills Medical Centre, Peter Lougheed Medical Centre, Rockyview General Hospital

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Don't miss out on the best doctor's golf tournament of the year!

Register today for the 87th annual north/south doctors' golf tournament

When: Monday, July 28, 2014
Where: Red Deer Golf and Country Club
To register contact Jennifer McCombe at Jennifer.mccombe@albertadoctors.org or phone 780-732-3359 (Edmonton and area) or toll-free 1-800-272-9680, ext. 359.

Your registration fee of $275 includes one round of golf, a power cart, buffet breakfast, BBQ lunch, use of the driving range and practice facility, a fantastic souvenir and the opportunity to win great prizes.

This stroke-play tournament, co-hosted by the College of Physicians & Surgeons of Alberta, the Alberta Medical Association and the Canadian Medical Foundation, raises funds for medical student bursaries and physician health programs.

On the cover: L to R Greg Clark, Alberta Party leader, Dr. David Swann, Liberal MLA, Heather Forsyth, Wildrose MLA and Paul McLoughlin, moderator. Photo by Dave Lowery

From the CAMSS president

It was the best of times, it was the worst of times.

When I started this job and this column I wanted to avoid politics and concentrate on the day to day issues in delivering healthcare for physicians. But I challenge anyone who cares to do this job for a year and not get politically involved. AHS is huge and the job of leading it is like herding cats. I truly appreciate the job Dr. Belanger and his staff do as zone medical directors. I may not agree with everything they do but I know they wake up every morning with the goal of providing better care for Albertans. The problem is at the political level. The lack of consistent leadership and the lack of constructive communication is corrosive. The current minister treats physicians as if we are the problem, not the solution. We desperately need a change not of leaders, but a change in leadership!

To those of you who missed our June 15th AGM, it was an enlightening evening. We invited the Liberal, Alberta and Wildrose provincial parties. The Conservative party sent their regrets. We posed three questions on the role of AHS, the role of privately provided and publicly funded surgery and proposed changes in primary care. All three representatives showed their parties in a very good light. The answers were well thought out and all participants listened to each other and often agreed with each other. It was an example of what political leadership should be. Dr. David Swann from the Liberals demonstrated his depth of knowledge, and spoke in paragraphs, not in sound bites. His answers were well reasoned and informative. Greg Clark from the Alberta Party was enthusiastic, well-spoken and informed. He was able to take ideas from the other parties and add his personal experience in business to propose workable sustainable solutions for health care problems. Heather Forsyth from the Wildrose party is passionate about quality healthcare. She has a wealth of experience in politics and listens carefully to all questions. We saw engaged, passionate, knowledgeable people cooperating to create solutions. There were no Conservatives. The minister sent his regrets, and did not send another representative, thus demonstrating the value he places on engagement with physicians. Minister Horne talks of engagement but does not practice it. The current government is invested in the calculus of re-election, not healthcare. It reinforces my belief that any substantial changes in healthcare will occur because of political change. I would echo Dr. Swann's comments that we must be engaged in the political process. Apathy is not an option we can afford.

I spent the day prior to this session at a meeting of the Calgary and Area PCNs. This is a group of articulate, competent physicians trying to fashion a better and more efficient primary care system. These two meetings had a common theme. The physicians were working hard to try to improve the health care system with virtually no response or involvement from the government. The Ministry of Health seems more interested in the physician compensation committee than the other aspects of our recently negotiated agreement such as a provincial EMR or system wide efficiencies.

I will now remind you that the changes in the hospital dictation system are coming to Calgary. Transcription services are changing from a voice dictation system to a software based transcription system by Nuance(Dragon). The transition started in the north zone and progressed through central and south zones, leaving a backlog of dictations in its wake. It seems the lessons learned through the trials and tribulations of the other zones are paying off. There has been an increased awareness of the issues and the Calgary rural rollout now under way is relatively uneventful. The new system will be introduced to Calgary urban sites in mid-September. Be aware of the changes and be extra vigilant in recording your dictation numbers. While Calgary zone has been upgrading the SCM system, the Edmonton zone has purchased the Epic hospital information system and Red Deer continues on with its MediTech system. It is good to see we continue to foster diversity in our large AHS family.

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Dr. Steve Patterson, CAMSS president
Phone: 403-943-5554

I would like to elaborate on my physician sponsorship issue from the June edition of Vital Signs. In the midst of a 23 per cent unemployment rate for Alberta speciality graduates we continue to see large numbers of foreign-trained physicians entering Alberta practice. Many of these physicians are sponsored by walk-in clinics. In return for being sponsored, these physicians are expected to work in the walk-in clinics for between three to five years(see the Medicentre website for details). There is no examination process and the numbers are staggering. Over 185 physicians entered Alberta via the sponsorship route last year. In contrast, the University of Calgary took in 170 students this year . We are outsourcing our medical education and there is no check or balance to ensure the continued quality of these new physicians. There is no control on where the physicians sponsored by the walk-in clinics practice. If AHS sponsors a physician they are recruited to a geographical area of need, while walk-in clinics recruit to an urban setting for harder to fill weekend or holiday shifts. It is hard to understand why this system of recruitment is allowed to continue. It seems to fly in the face of the comprehensive care model espoused by the AMA and Alberta government. This is a new development in Alberta health care. When large corporations (Medicentres are owned by the Katz family of Rexall fame) are importing physicians for their own clinics it seems that a double standard exists. Physicians may not dispense drugs but pharmacists can dispense physicians.

I respectfully request that AB Health and AHS cease the practice of allowing private medical facilities to recruit foreign physicians to work in urban settings in Alberta without a full study on the effects that this practice has on the health of the population and the costs of providing the care. Idealistic, dedicated, bright, and talented young Albertans are competing for tightly contested spots in Alberta medical

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By Dr. Aravind Ganesh, neurology, resident physician

Dr. Aravind Ganesh

In 2001, a young woman arrived in Ontario, one of many refugee claimants fleeing dire circumstances in Colombia. Alone, without money, unable to speak English and pregnant, she struggled day in and day out to carve out a life for herself and her unborn child. Her one assurance was that she and her child would not want for essential medical care. When it came time to give birth, she was able to rely on the Canadian health-care system to help deliver her child and welcome a new Canadian to the world.

Today, that young Colombian refugee is a successful Canadian physician. Dr. Maria Martinez-Jaraba is a resident physician specializing in public health and preventive medicine at the University of Alberta. When she shares her story, her passion for the ideals of the Canadian health-care system are evident. She also believes that if she were to start out today as she did back in 2001, she would not have made it this far. She simply didn't have the money to afford a hospital bill of several thousand dollars for her pregnancy-related medical care.

Dr. Maria Martinez-Jaraba, a former refugee, is now a resident physician in public health and preventive medicine at the University of Alberta.

In June of 2012, the Canadian government implemented significant cuts to the Interim Federal Health program[1], which resulted in many refugee claimants losing access to primary care services and medications to treat their health-care conditions. Whereas, previously, all claimants received care comparable to Canadians on social assistance including coverage of doctor's visits, basic medications, and so on, refugee claimants' access to care is now based on their classification as government-sponsored or privately-sponsored claimants, and whether they are from "safe" or "unsafe" countries (non-designated or designated countries of origin (DCOs), respectively)[2]. Claimants from non-DCOs are left on the hook for prescriptions, but can access a physician, whereas those from DCOs do not have health coverage unless they are deemed an immediate threat to public health or safety.

Among the many physicians and health-care workers concerned with this development are Dr. Martinez-Jaraba and Dr. Jessie Breton, an emergency medicine resident physician in Edmonton. "The health services not covered include what we would see as essential aspects of primary care, like treatment of diabetes or heart disease and pre-natal care for pregnant mothers," said Dr. Breton. "When people do not get such basic care, they end up presenting to the emergency department in extremis — deadly diabetic emergencies, cardiac arrests, and pregnancy complications. This also ends up costing the system — and these patients — even more." As an emergency physician, Dr. Breton is also convinced that the hierarchy instituted by the new changes is unintentionally confusing refugee claimants and the health-care staff serving them — compromising the delivery of care. Unawareness of how to access the necessary resources led some healthcare-eligible individuals to refrain from seeking medical attention all together.

Dr. Martinez-Jaraba and Dr. Jessie Breton were inspired by the work of the Canadian Doctors for Refugee Care[3] who are calling on the federal government to reverse these cuts. They first met through a public health advocacy course at the University of Alberta, led by Dr. Louis Francescutti[4]. The course had them wondering if the provincial governments could provide the needed funding for their refugee claimants, recognizing that health care falls under provincial jurisdiction. What started off as a class project for this course slowly morphed into a powerful campaign.

For Dr. Breton, this campaign was not just about defending humanitarian principles in medicine, but also about educating the public on the refugee experience: "[Canadians] were, for a long time, a shining example of giving refugees due process and appropriate care, but now we risk painting this picture of refugee claimants as nefarious folks gaming the health-care system. That is simply not what we are seeing — what we see are people struggling against the odds to create a better life for themselves in a new country while contributing to our society." One of the important points the campaign highlights is that refugees have been receiving no more coverage than those on the lowest end of our socio-economic ladder. In Alberta, these costs would add up to 2.3 million dollars or just 63 cents per Albertan per annum.

Teaming up with others who had an interest in public health, these resident physicians formed the Alberta Refugee Care Coalition[5]. They rallied together with many other frontline providers who had recognized the access challenges refugees face, and met with members of all provincial political parties, updating them on the key research emerging on this issue. In February 2014, they had an important victory when changes were made to the Alberta Adult Health Benefit plan that allowed some refugee claimants to access limited funding for medications and services. However, various access restrictions and the varying levels of assistance provided across the provinces illustrate that there is still work to be done.

To help gather hard data on the impact of the cuts to refugee health, the Canadian Doctors for Refugee Care have launched a health outcomes monitoring and evaluation system[6] (HOMES) where

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interested Canadians can document instances of refugee claimants who were unable to access the medical care they require. I strongly urge our colleagues to add their experiences to this repository. The group is also holding their third annual National Day of Action for refugee care in key cities across the country on June 16 to further promote this issue. All interested citizens are encouraged to attend.[7]

These efforts are key to ensuring that all Canadians, regardless of their country of origin, have access to the medical care they need. As Dr. Martinez-Jaraba's story shows, in doing so, we are helping to secure the future prosperity of this nation.

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schools, while foreign-trained graduates who are often unfamiliar with the language, culture and medical conditions in this province are gaining access to the province with ease. It seems that we are experimenting with an open chequebook for the benefit of a few clinic owners and corporations.

I would like to take this opportunity to remind members that our annual renewal is coming up this fall included in the AMA renewal package. Please take a moment to ensure that you have renewed your membership in your medical staff association (MSA). In the case of Calgary physicians if you have a hospital affiliation please check the appropriate box. This is how your hospital's MSA is funded for the coming year.

Canada Task Force 2 needs you!

Photo and story by Dave Lowery

Still not widely known but an agency that was key in Alberta emergencies such as southern Alberta's flood last year and the Slave Lake Fire in 2011, Canada Task Force 2 (CANTF2) is based in Calgary and is an 'all-hazards' disaster response team with a diverse capacity to respond to a variety of man-made and natural disasters.

The team is composed of over 100 rescue specialists, doctors, paramedics, structural engineers, communications specialists, canine & technical searchers, logistics specialists and command staff, who volunteer their time to train and prepare so that they can respond as a highly specialized team, capable of handling a wide variety of demanding disaster and rescue situations.

Within six hours of being called, CANTF2's mandate is to respond with up to 70 specialized team members, via ground or air, and to operate 24 hours a day for up to 14 days with specialized equipment which allows them to be fully self-sustained.

CANTF2 is also one of only four nationally recognized heavy urban search and rescue (HUSAR) teams in Canada. The additional three teams are located in Vancouver (Can-TF1), Toronto (Can-TF3), and Manitoba (Can-TF4). Collectively, these four teams lead Canada's emergency response initiative in urban search and rescue (USAR).

Dr. Kevin Hanrahan, an emergency physician practicing in Calgary, is the CANTF2 logistics section chief and assistant medical director who has volunteered for 12 years. And though, he says, there are currently five physicians on the roster who have agreed to help if another disaster occurs, CANTF2 could use more.

"I do believe another physician or two would not hurt us," he said via email. "The volunteer commitment is five hours/month or 15 hours/quarter. The volunteer hours are not paid but if we are deployed there is competitive remuneration. As well there is an arrangement for money to be paid to encourage last minute shift coverage as we need to deploy rapidly and would not have time to try and barter shift coverage."

If any physician is interested in volunteering, please go to the CANTF2 website (http://www.cantf2.com/) where there is more information and contact details.

Emergency requests for team deployment and/or equipment: Call the provincial operations centre (POC): 1-866-618-2362 (24 hrs)

Dr. Kevin Hanrahan (right) speaks to new recruits during a boot camp held in early June.

Straw man

There is an issue that has been irking me for some time now. The pangs flare every time I hear discussion regarding the discontinuation of pharmacy inducements such as Airmiles or Aeroplan when all the time a much larger issue is being overlooked. The latter is an issue that I am quite certain the general population is largely unaware of but that I first wrote about on the pages of Vital Signs in June 2012. The article was entitled 'Bitter pill: prescribing conflict of interest'.

This month I would like to reexamine the issue of pharmacists and the apparent conflict of interest in their ability to both prescribe and dispense medications. We will also look at some of the arguments posed by the College of Pharmacists with respect to their decision to abolish the use of patient rewards programs (inducements) such as Airmiles or Aeroplan for drugs and blood products. The discussion becomes even more intriguing when we consider that some (not all) pharmacists stand to benefit from professional allowances (kick-backs) or inducements from the pharmaceutical industry when they hit sales targets for certain medications.

I realize that this topic is controversial and I must stress that not all pharmacists stand to benefit from volume sales rebates. For instance, our AHS pharmacists do not face this moral quandary. It is likely that owner operator pharmacists would face the greatest ethical challenge in this regard. However, when a pharmacist, any pharmacist, can both prescribe and dispense, can they ever truly be at arms length and respect the purity of the pharmacist/patient relationship? If we examine the arguments used by the College of Pharmacists to substantiate the discontinuation of inducement programs (Airmiles, Aeroplan etc.) it would appear that the same arguments should hold true with respect to the matter of dual agency – both prescribing and dispensing – but also calls into question the entire practice of accepting rebates for volume sales of certain medications.

On the Alberta College of Pharmacists website (https://pharmacists.ab.ca) we find the following statements:

1) It is not acceptable for pharmacists and pharmacy technicians to offer individuals inducements conditional on them being provided drugs, blood products or professional services. Despite this statement, we also discover in the website FAQ section that Co-ops are still allowed to provide patronage refunds on purchased pharmaceuticals AND discounting of professional or dispensing fees is still allowed. Thus, if inducements are unacceptable then wouldn't a patronage (Co-op) refund be an inducement? Wouldn't a discounted dispensing fee be an inducement? Moreover, if a pharmacist in any manner stands to benefit from volume sales incentives from the pharmaceutical industry then wouldn't this pharmacist inducement also and perhaps even more-so, be unacceptable?

2) Inducements cloud decisions that should be based solely on the best healthcare. Providing inducements in conjunction with drugs, blood products or a professional service is disruptive to:

a. Impartial decision making by pharmacists

b. The coordination and continuity of care

c. The effective operation of health teams and Alberta's health system

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

In this instance it is hard to imagine how a pharmacist would benefit when a patient collects a few Airmiles on a prescription or how such a program would undermine the impartial decision-making by pharmacists. After all, it is the pharmacy owners (corporate head office) that establish and direct inducement programs not the front line retail pharmacist.

Conversely, it is quite easy to see how a pharmacist might benefit from a dual agency role, prescribing and dispensing and subsequently collecting a dispensing fee and possible volume rebates. It is also easy to see how pharmacist decision-making under such conditions may become less than impartial. We need to remember that, after all, physicians are barred from any dual agency role for the very simple reason that it places them, us, in a conflict of interest. Why are pharmacists any different?

3) The College of Pharmacy website identifies systemic concerns with inducements (Airmiles) as they relate to drugs and professional services including:

a. Calls into question the integrity of the pharmacy profession

b. Disrupts relationships between patients, pharmacists and other health team members

c. Disrupts coordination and continuity of care

d. Potential to negatively impact treatment goals and health outcomes

The above, I feel, identifies the straw man that the College of Pharmacists is attacking. They are pushing the morale sanctity of the profession higher by tackling the ethics of patient inducements when the real Achilles heal dragging down the integrity of the pharmacy profession is the problem of dual agency and volume sales kickbacks.

These latter issues are, I feel, the core problems that the College of Pharmacists should be tackling particularly when we note the following on their website; ***"eliminating inducements for drugs, blood products and professional services is about ensuring a practice environment where pharmacists practice on the basis of highest ethical standards applicable to health professionals and outside influences, real and***

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Rockyview Medical Staff Association AGM

Article and photos by Stella Gelfand, Rockyview Medical Staff Association,

In our own back yard in Calgary, a scenic ten minute walk from "the Rock," a village lays atop a hill and bordering a reservoir. This village and its exhibits represent the challenges, lives and victories experienced by generations responsible for the settlement of Western Canada.

This magical place is Heritage Park's Town Square and Historical Village and prominently situated in the town square is the railway orientation centre, where, on Tuesday evening, June 3, 2014 the Rockyview Medical Staff Association AGM took place. A night where our own history is being made; and the sentiments, repeated year after year, are that Rockyview General Hospital is a special place for doctors to work at and along side each other, a place patients ask of their doctors to come to, a place to celebrate this family.

With a mix of joy, camaraderie, appreciation and maybe a tear or two this Rockyview family gathered to break bread, be entertained and celebrate. The sun was in our hearts and smiles lit up until the very end. From the windows, we observed and enjoyed other victors; groups of happy families, friends and graduates meandering to attend their own celebrations in the village.

Chairing the event, dressed in western garb and donning a cowboy hat, Dr. David Kent, the Rockyview Medical Staff Association president rose to the occasion by spreading warmth and humour.

Special guests in attendance included, from the College of Physicians and Surgeons of Alberta, councillors, Dr. Randall Sargeant, Dr. Keith Brownell (& RGH MSA member) and Kate Wood.

Our featured guest speaker Dr. Sandie Black, a veterinarian at the Calgary Zoo Animal Health Centre since 1989 presented us with a vets eye view that both moved us and gave us a rekindled appreciation of the zoo, its caregivers and its inhabitants. Dr. Sandie's view included a power point presentation that we will not soon forget as she filled our hearts with sad and happy stories, medical stories and personal stories. We were all enthralled by Dr. Sandie's presentation, her work, her experience and expertise. One story with a slide that she showed us was an x-ray of a gorilla and she recalled that when she was presenting this at FMC to attendees at a grand round, she was able to fool them; they didn't realize the x-ray was of that of a gorilla; they thought it was a human. We could have listened to Dr. Sandie's stories for hours and we especially laud and thank her and all the zoo staff for their work during the June 2013 flood.

Dr. Sandie Black, Calgary zoo veterinarian.

Following this presentation was the culmination of every Rockyview Medical Staff Association AGM, the Rockyview General Hospital Physician Recognition Awards. We call this portion of the evening "very important presenters to our very impressive physicians." This year we were touched with 10 departmental awards given by Rockyview physician leaders to their outstanding colleagues. Descriptions and biographies of each awe-inspiring recipient's highly regarded contributions past and present overwhelmed us and this list is as follows:

Department of anesthesia, clinical site chief, Dr. Christopher Sims presented the award to **Dr. Udell Larsen.**

Department of emergency medicine, site chief, Dr. Nancy Zuzic presented the award to **Dr. Laurie-Ann Baker.**

Department of family medicine/hospitalist program leader, Dr. Thomas Tam presented the award to **Dr. Britt Simmons.**

Department of family medicine/medical newborn care site chief, Dr. Nicola Chappell presented the award to **Dr. Glenda MacLean**.

Dr. David Kent, Dr. Christopher Sims, Dr. Udell Larsen, Dr. Nancy Zuzic, Dr. Laurie-Ann Baker, Dr. Thomas Tam, Dr. Britt Simmons, Dr. Nicola Chappell, Dr. Glenda MacLean, Dr. Stefan Mustata, Dr. Khan Ali, Dr. Sachin Pendharkar, Dr. Viviana Chang, Dr. Jaelene Mannerfeldt, Dr. John Tuttle, Dr. Kent Sargeant. Absent from photo: Dr. Andrew Pattullo, Dr. Willis Tsai

Department of medicine/division of infectious diseases, department of medicine site chief, Dr. Stefan Mustata presented the award to **Dr. Andrew Pattullo.**

Department of medicine/division of general internal medicine, department of medicine site chief, Dr. Stefan Mustata presented the award to **Dr. Khan Ali.**

Department of medicine/section of respirology Dr. David Kent, RGH MSA president presented on behalf of the department of medicine/division of respirology site coordinator, Dr. Willis Tsai, to **Dr. Sachin Pendharkar.**

Department of obstetrics & gynecology site chief, Dr. Viviana Chang presented the award to **Dr. Jaelene Mannerfeldt.**

Department of pathology and laboratory medicine site chief, Dr. Kelly Guggisberg presented the award to **Dr. Asli Yilmaz.**

Department of psychiatry site leader, Dr. John Tuttle and Dr. Kent Sargeant presented a posthumous award to **Dr. Patrick Conway.**

With appreciation to all who attended in support of the Rockyview Medical Staff Association, it is you that makes this night memorable!

Dr. Kelly Guggisberg presenting the award to Dr. Asli Yilmaz.

Upcoming 2014 Rockyview General Hospital Medical Staff association meetings: September 9 (guest speaker: AHS archivist, Dennis Slater, Topic: "Rockyview General Hospital then and now") & December 9.

Letters

Walk-in clinics shouldn't be deciding what physicians we need and where they practice.

Physician resource planning continues to lose ground in Alberta and one symptom is reflected in the article by Dave Lowery and Steve Patterson. The physician sponsorship program needs leadership to ensure that Alberta's needs, paid for by the public purse, provides safe, accountable care to all citizens. With walk-in clinics deciding what physicians we need and where they will practice (mostly urban), we are losing equitable access and quality control. Doctors who are not part of a larger organization are not subject to medical staff by-laws, may have no collegial oversight and support, and are exempt from continuing medical education.

The College of Physicians and Surgeons have been involved in the past in both certifying and locating physicians with provisional licenses. Their role should continue to ensure qualifications but it is clearly time for AHS to bring these independent physicians under their administrative support and oversight.

Dr. David Swann, MLA Calgary-Mountain View, critic for aboriginal relations, agriculture and rural development, health, and human services

From the past president - Continued.

perceived, are removed from patient professional relationships." Adopting the dual role of prescriber and dispenser is a real influence on the professional relationship and all the more so when there are sales volume inducements offered to pharmacist owner/operators. Moreover, if a pharmacist in any way benefits directly or indirectly from those volume sales kickbacks or inducements this will affect the professional relationship. This is far more of an ethical dilemma than anything posed by Airmiles or Aeroplan type patient inducements. The general public doesn't hear anything about the problem of dual agency or rebates. They're busy setting their hair on fire about the prospect of losing out on points.

In the end, will the College of Pharmacists ever muster the courage to address the fundamental issue of dual agency and volume sales rebates? I might anticipate the president of the Alberta Pharmacists Association to take issue with this article but I welcome the debate and the opportunity to bring this issue into the public mainstream. Alas, they will probably be most happy with little to no debate swirling around this article. I once again invite feedback, pleasant or poisonous on this, or any of my articles.

The survivor's guide to burnout . . .

I'm almost a crisp; and this time it's not from being abandoned on the open seas after a scuba-dive.

We are fried by chronic manpower shortages & 25 years of provincial health care change. Those administrative changes are coming ever faster as the health care we deliver seems to get ever smaller.

The original hospital boards became 15 regional health authorities which were reduced to nine regional health authorities then reorganized into five zones and modified to two main zones & three 'sorta other zones — some zones are more equal than others — to the final pièce de résistance of centralized administration & governance from Alberta Health & the minister of health.

Maybe there's relief on the horizon: Perhaps the feds will take over? The Wildrose Party appears to be a contender but their suggestion of returning to hospital boards is quite scary because all that hard-earned experience was lost years ago after the boards were dissolved.

So what can we do to survive? I have found the answer to ALL of our health-care problems and appended it to the end of this article. Made'ya look? The answer for me personally is that beach in Fiji — oh yeah! Grab a bag, throw in those gaudy Hawaiian shirts, add the scuba gear & set sail for the southern seas. Memo to self: don't forget the wife. That is my escape.

In reality, I do not know what is burning your butt, nor how you will survive it, so right now you might be tempted to move on to one of those other well-crafted articles in this excellent edition of Vital Signs — HANG ON! The trick is to find your own personal solution.

First thing — if things are that bad from marital discord, booze, drugs, whatever, PLEASE GET HELP.

Resources include:

- AMA's physician and family support program: 1-877-767-4637
- Alcoholics anonymous: www.aa.org
- Narcotics anonymous: www.na.org
- Alberta mental health line: 1-877-303-2642.

If things are not so bad, consider some personal suggestions in no particular order:

- Breathe…
- Have a pint with an old friend.
- Get fitter! Walk, cycle, or that sport you used to do. You could coach or referee!
- Eat better — that includes getting home in time for supper.
- Make daily family-time. Take holidays . . . Fiji is great!
- Get a doctor . . . and that check-up!
- Resume your long lost hobby — Be honest, you do not have to play well to enjoy an instrument!
- Heck: even do some charity-work! Some people really are having a worse day than you.
- Religious? Go to church.
- Not religious? Go to the church bake-sale — The pie is heavenly.

Dr. Kevin Hay, president of the central zone medical staff association

Add some professional ideas:

- Introduce yourself to patients. Sit down with them. Hold their hand.
- Yes, you too can eat lunch.
- Be collegial: that includes other professions.
- Get involved with the AMA & your zone medical staff association.
- Look & act professionally - this morning's hissy fit doesn't cut it.
- Do some medical research.
- Get your influenza shot this year.

Another way is to imitate your role model. The one I would choose is the great Irish hero Sir Ernest Shackleton. (Yup, IRISH! Born in County Kildare & till 10 years of age he lived in Ireland.)

August 1914 — the day Germany declared war on Russia — 28 men set off for Antarctica on the ship Endurance. The ship was trapped in the polar ice 18 Jan 1915 and after unbelievable challenges, including an 800 mile trip in a lifeboat & a trek across 32 miles of uncharted South Georgia mountains, all souls were saved ~19 months later.

They were all being severely rationed during their long time as castaways, but Shackleton gave his one biscuit allowance to an ailing Frank Wild, who wrote in his diary: "All the money that was ever minted would not have bought that biscuit and the remembrance of that sacrifice will never leave me." Another time Shackleton gave his mittens to the photographer, Frank Hurley. He suffered frostbitten fingers as a result. That is a real man — Irishman to boot! *[So let me guess Kevin, you must be from . . . oh, Ireland? Editor]*

http://en.wikipedia.org/wiki/Ernest_Shackleton

On a slightly less heroic basis I look to some of our colleagues for inspiration. Characters well known to CAMSS are Steve Patterson & Lloyd Maybaum who diligently write articles for Vital Signs, attend numerous god-awful meetings and keep rallying the troops. I do not know how they maintain their enthusiasm — but they do. They are like many others docs throughout the province.

Maybe this is the real survivor's guide: stick together!

"The ultimate answer to life, the universe and everything is . . . 42!"
Douglas Adams, The Hitchhiker's Guide to the Galaxy

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As we all know, multidisciplinary teams are essential to the future of health care delivery. The Alberta Medical Association (AMA) business plan recognizes this.

Under our system partnership and leadership key result area, we have a priority activity to "work with Alberta Health and other provider groups to support teams." Strategic clinical networks, alternative relationship plans and primary care network evolution all require successful team approaches.

The way teams function will be affected by roles and responsibilities of health professions involved.

Because we all recognize the value of collaboration and cooperation, for a number of years the professions of medicine, nursing and pharmacy have come together to sponsor a tri-professional conference. The organizations involved are:

- AMA.
- College of Physicians & Surgeons of Alberta (CPSA).
- College & Association of Registered Nurses of Alberta (CARNA).
- Alberta College of Pharmacists (ACP).
- Alberta Pharmacists' Association (RxA).

Three conferences have been held since 2007. They focused on providing education and information, while building on emerging expertise around inter-professional collaboration.

We know from daily experience that there are many great examples of effective inter-professional teams. We are making progress, without a doubt. At the same time, some fundamental issues remain.

That's why we decided to bypass the format of previous years for the 2014 event (held May 22-23 in Edmonton). Instead of members at large, we invited only the governing boards and councils of the five organizations.

The objective was to work with a facilitator to have a candid, focused conversation about changes in health care delivery that have strained our inter-professional relationships. The hope was to identify how we can tackle those issues together.

For example, how do we address the impact of ongoing changes to scopes of practice? Our business plan calls on the AMA to develop a strategy "ensuring quality and collaboration."

When government has reviewed proposals to change various professional scopes over the years, there has been detailed discussion and debate about what changes can be accommodated safely. There is a need, however, to think more broadly.

Challenges that have appeared on the front lines are not so much about what a profession does. Often they are more about the way scope changes affect relationships between providers and continuity of care.

When new activities by one profession bump into existing practice patterns of another, fragmented or duplicated care may result. When changing a scope of practice, we need a plan to take this into account. We need to know in advance how the change will affect patient care and the other professions.

The health professionals around the conference table agreed on these points. We acknowledged that we can expect expanding scopes of practice to continue as technology, knowledge, skills and information grow. I can also say emphatically that we all want to do what is best for patients. It makes sense to collaborate so that we can provide guidance on future changes.

Therefore, our conversation at the event was about things like:

- Working together to identify what we need from each other to provide more effective continuity of care.
- The need to meet together as a group regularly.
- Advocating as a group to influence government, policy, etc.

By Allan S. Garbutt, PhD, MD, CCFP AMA president

It was a good beginning. I was encouraged by the common desire to put patients at the center of moving forward as professions. The five executive leads of the partner organizations will be meeting to discuss how we may continue to work together to promote, support and demonstrate collaboration.

Supporting refugees in our province

In June 2012, the federal government implemented cuts to its Interim Federal Health Program (IFHP) that applies to refugees, refugee claimants and certain other non-citizens.

1. All refugees (excluding government-assisted refugees) lost access to medication coverage and vision and dental care through IFHP.
2. People from designated countries of origin no longer have health coverage including for urgent or essential care except for #3 below.
3. All refugees are covered for the following conditions (including medications):

- Issues of public health concern: These are infections that are on the Public Health Agency of Canada notifiable diseases list and involve human-to-human transmission (note this does not include common infections such as pneumonias, pyelonephritis, etc., or even conditions such as malaria).
- Issues of public security concerns: This is defined as psychotic conditions where a person has been identified as being a danger to others (but does not include suicidal intent).

(Source: http://www.doctorsforrefugeecare.ca/the-issue.html)

At the 2012 Canadian Medical Association General Council in Yellowknife, delegates passed a resolution that called for the reversal of the changes to the IFHP so that consultation and measurement of the potential impact on affected populations could be properly assessed. Unfortunately, our plea went unheard.

Today is the third National Day of Action organized by Canadian Doctors for Refugee Care. Events and activities are going on across the country to mark the concerns of physicians, other health professionals and many others about the treatment of these vulnerable individuals.

I wanted to take the opportunity to echo the concerns that the Alberta

Continued on page 14

Medical Association has expressed since 2012.

1. Relying on emergency departments to provide care to refugees means longer waiting times for everyone and the use of expensive facilities.
2. Care that is provided earlier, when it is needed, has a better chance of preventing deterioration of the long-term health of refugees.
3. Long-term health problems cost much more to treat, so the costs to Canadian taxpayers might exceed the so-called savings from the current cuts.

If we needed any validation of these concerns, then you only have to read a May 15 Toronto Star story that reported on a study showing "admission rates for refugee children at SickKids Hospital doubled after Ottawa cut its health care coverage for asylum seekers."

The article goes on to say:

"Before the cuts were made, in June 2012, only 6.4 per cent of refugee patients appearing in the emergency room of the Hospital for Sick Children actually had to be admitted. Six months later, that rate had jumped to 12 per cent, said the study published in the May issue of the Public Library of Science Journal."

The cuts to refugee care make no sense from a humanitarian, clinical or fiscal point of view. The SickKids article pointed out that "prior to the cuts … 46 per cent of the total emergency room bills were paid by the IFHP. However, after the cuts, the government reimbursed only seven per cent of the medical costs to the hospital. The unpaid bills were absorbed in SickKids' budget . . . Refugee children would have had nowhere to turn if not for the hospital's no-turn-away policy."

Here in Alberta, our provincial government formed a number of working groups in 2013 to address the challenge of the funding cuts. This province has done more than many of our neighbors and should be commended:

- Alberta Works has filled some of the coverage lost for medications. Privately sponsored refugees and refugee claimants are eligible to apply for the Alberta Adult Health Benefit and Child Health Benefit.
- The Alberta Adult Health Benefit covers medications for low-income adults who have ongoing prescription needs.
- The Alberta Child Health Benefit provides medications to all children living in low-income families.

Yet, still there has been no move to cover those refugee claimants from designated countries of origin for basic, chronic or preventive health services.

Alberta physicians have contributed to the national movement against the cuts. Physicians like Calgary's Dr. Annalee Coakley and Edmonton's Dr. Jessica M. Breton have led events, given media interviews and lobbied tirelessly to change the federal attitude.

Medical students at the University of Calgary are collecting signatures on a petition and circulating posters and other information about the problem. I'm sure many more of you have quietly advocated when sick refugees presented in your practice and there may be other structured activities of which I am unaware.

If you have a chance to lend support or encourage your Member of Parliament and the federal government to do the right thing, please do so.

Your comments are always welcome.
president@albertadoctors.org.

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