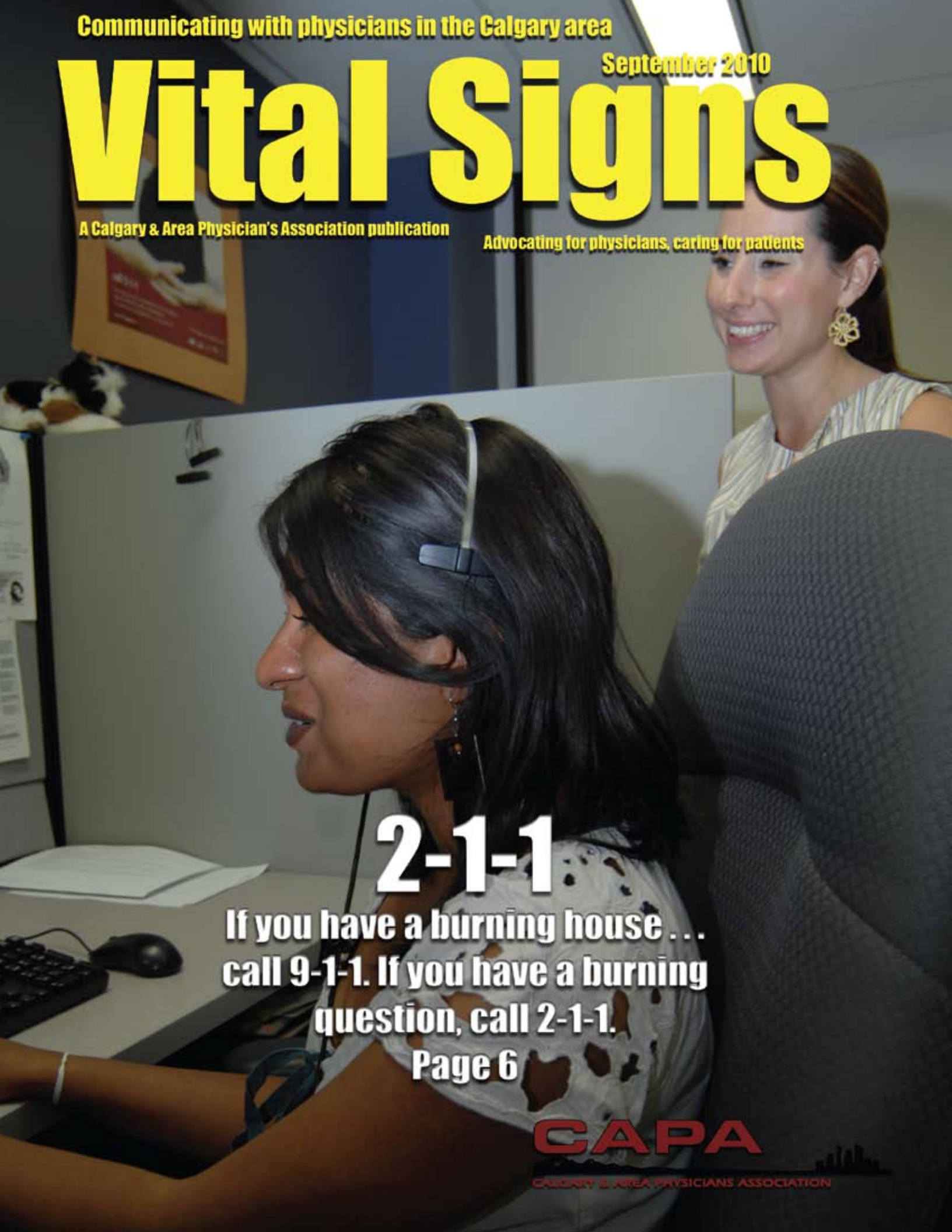
Communicating with physicians in the Calgary area

September 2010

Vital Signs

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients



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If you have a burning house . . . call 9-1-1. If you have a burning question, call 2-1-1.

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CAPA

CALGARY & AREA PHYSICIANS ASSOCIATION

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

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Vital Signs reserves the right to edit article submissions and letters to the editor.

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On the cover: Volunteer 2-1-1 call taker Danushka Galappathy (left) with Michelle Wickerson, MSW, RSW, the communications manager for the Distress Centre Calgary.
Photo by Dave Lowery

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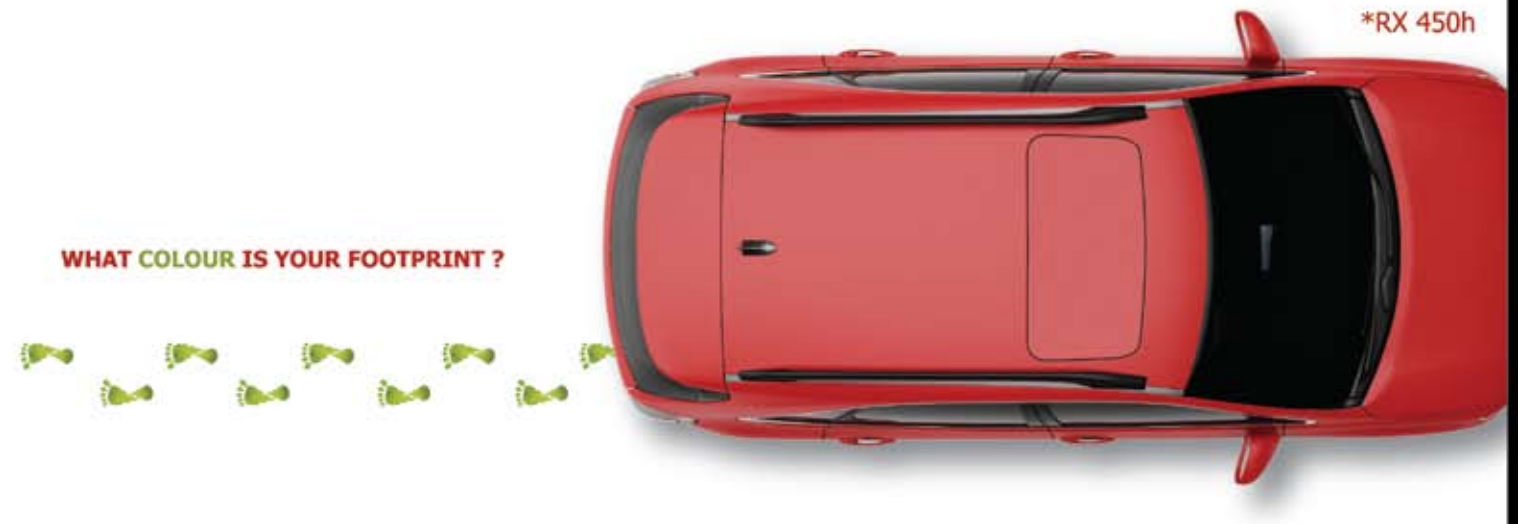

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Where are the soundbites?

From the CAPA president

It is difficult to not begin each of my reports with a mention about the weather. It is so much a part of our Canadian identity. So I will not stray from that format for this my last chance to speak to all of you in my role as CAPA president. The summer has been noteworthy for unpredictability. Should we go out the door prepared for sweltering heat or torrential rains and hail? The almost daily storm warnings became like the daily code reds at the hospital, something to be ignored and not to be taken seriously.

So it was with great excitement that I watched the national news the other day to have the anchor announce that the president of the Canadian Medical Association would be featured on the National that night to talk about the latest initiative from the CMA entitled "health care transformation in Canada." Health care in Canada is at the point where we could have daily storm warnings and watches. On any given day Canadian patients are told to wait too long for appointments with their family doctors, wait too long for appointments with specialists and wait too long for desperately needed treatments. How were the doctors of Canada going to fix this? I was worried as the news went on for almost 45 minutes before the CMA president was interviewed. What did this mean? Why put this important subject at the end of the nightly news? Unfortunately I discovered why. The president, Dr. Anne Doig, did a masterful job at discussing the document and its intent. However, no matter how hard the media tried, there was no "sound bite." The document is so politically correct that it, at times, has no meaning for the average Canadian. The problem is stated well. "The healthcare system in Canada is in urgent need of reform. Canadians wait too long for care. Care providers feel overworked and discouraged." That is putting it politely!

But then the vision gets fuzzy. Statements such as "there are numerous steps required to transform Canada's healthcare system so that it becomes highly effective and meets the needs of Canadians. A first step is to re-examine the five principles of the Canada Health Act and modernize them as they are no longer sufficient to meet current and evolving needs. Does the average Canadian, or healthcare provider for that matter, know what the five principles of the Canada Health Act are. I will remind those of you who have forgotten.

Universality, accessibility, comprehensiveness, portability and public administration.

The CMA document states that all Canadians must have timely access to an appropriate array of medically necessary services across the full continuum of care, independent of their ability to pay. All health care must be patient centred.

Lofty goals but how do we implement them. In the summary of recommended directions we had statements such as "develop a long-term health human resources plan through a national body using the best available evidence to support its deliberations."

Not too many sound bites from that.

The next day the CMA announcement and healthcare transformation plan was on page five of the daily newspaper. I was truly disheartened.

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

The media was waiting for something, perhaps controversial, stimulating, exciting or even aggressive in its content. It was not to be. The document is politically correct and, it seems, written to the politicians and not to the average patient or even doctor. The problem is that in Canada we have a minority government that is not about to tackle thorny issues such as healthcare reform.

The media was looking for an answer from the doctors of Canada. How do we transform healthcare in Canada and why? I do not believe that they got a succinct answer.

We got a summary that included 14 directions with the proviso that implementation of these recommendations will require the collaboration of all levels of government and medical and other health organizations.

Any takers?

It may come down, in my opinion, to physician accountability. Accountability is not one of the five principles of the Canada Health Act and perhaps it should be added. When I say physician accountability I am referring to the fact that we should maintain accountability for our patients care and not delegate or relegate it to the healthcare administrators or politicians, which is what we appear to be doing. We need to stand up for our patients at every opportunity even if that means being at odds with the funders of the system. The CMA has a great opportunity to energize the doctors and their patients in this country to demand better. I will continue to wait for the soundbite!

As I mentioned, this is my last president's message in Vital Signs. It has been an honour to be able to serve in this capacity. CAPA has survived the healthcare transformation in the province and will continue to be strong with all five provincial zonal medical staff associations being strengthened by our model and future AMA support. A special thank you to all our members for their support and to the zonal administration for their ongoing inclusion of CAPA in the decision making processes in the zone. I want to wish Dr. Maybaum all the best in his upcoming term as president. It will be interesting times, although as I tell all my patients it is not good to be "interesting" in medicine!

Healthcare in Calgary - where are we going?

From the past president

I have to admit that I was somewhat caught off guard by the response to my last Vital Signs article, "a path not chosen." Writing that article was therapeutic for me and an important part of the process of healing and moving on, after the initial shock of my Alzheimers' disease diagnosis. I would like to thank the many people who contacted me and wished me well. It was heart warming. I would especially like to thank the Calgary and Area Physicians Association for honouring me with the Physician Advocacy Award at the spring general meeting. I believe that there are many of us who are out there, working hard, doing what we believe is the right thing to do, unsure if anyone else cares. It is nice to find out that they do care!

As a part of my retirement process I attended a number of farewell events with differing groups of people with whom I'd worked over the years. It was interesting to notice what people remembered. It wasn't primarily a great save of an ill patient that people remembered but rather small deeds, often done without a second thought that struck a human chord with a fellow worker . . . a fellow human being. I can't help but wonder if anyone at Alberta Health Services (AHS) gets it. This year Professor Ducket received tens of thousands of "bonus" money despite not meeting set targets. Alberta Health Services cancelled the annual Peter Lougheed Center (PLC) Stampede breakfast, a time honoured tradition that was a thank you to hospital staff for their hard work. Individuals within the PLC managed to salvage the event in part but not to its usual standard. Could you blame staff for saying "why should we care about what the AHS bean counters want. They clearly don't care about us!" They are foolish beyond belief if they think they don't need the goodwill of the thousands of daily workers.

Our system is full of people who are highly trained to their specific tasks. We have highly trained specialists in many areas. Calgary continues to be one of the best places in Canada for surviving a heart attack. We have CT scanners, MRI scanners, and all sorts of high end technology. What we don't have is patient centered care system. I challenge anyone to spend time with a friend going through the emergency room (ER) with anything less than a major threat to life, to say that the ER is patient centered. Overcrowding, long waits, and aggravation are the norm. Many give up and go home. The department of internal medicine's ward of the twenty first century clearly demonstrated (years ago when I was still on the medical advisory board) that infections were hugely reduced by having single bed rooms. Yet that is NOT our standard care as overcrowding pushes ill patients into close quarters. It is bad care yet it is the norm. Why do Calgarians put up with this?

It has been said that those who don't learn from history are bound to repeat it. From my view, as a city, we are paying the price for the late Bud McCaig's taking Ralph Klein at his word when Ralph promised him a new hospital in the south in exchange for blowing up the Calgary General Hospital as well as closing the Holy Cross and Grace Hospitals. Bud McCaig, who was a great supporter of the bone and joint program, is no longer with us. His name is on a tower at the Foothills Campus! Yet we are still are looking for that south hospital to open. By contrast, in that same time period, Edmonton (at the time sometimes called Redmonton) voted predominately Liberal, supporting Liberal leader Laurence Decore. No major hospitals were closed in Edmonton. There is no great centralization of services. People don't get transferred across the city because only one hospital does urology. The Klein Tories took us for granted . . . and have we paid for it. There will be an election in the near future. You will have a chance to vote for change if you believe it is needed.

Dr. D. Glenn Comm, CAPA past president

Looking into the future, the current eight year agreement between the AMA, Alberta Health and Wellness (AHW) and Alberta Health Services (AHS) ends soon. Planning for the negotiation of a new agreement is well under way. The Alberta Medical Association (AMA), which controls the physician services budget, has proven to be a good steward in the current agreement in that for the total eight year agreement we have come in under budget. The challenge will be if AHW and AHS can find a vision for the coming years that the negotiators can craft into a workable agreement.

I truly hope they will succeed, that there will be a new vision, new ways of seeing things, new ways of doing things that will be part fiscally sustainable in a new agreement. I hope it will again have the stability of being eight years long. But even more important will be vision. Vision to look at what we are doing presently, the vision and wisdom to admit what is not working and change or delete it, the vision to find better ways of working together. New technologies such as SKYPE and live internet communication could reduce the need to physically be in the doctor's office There are things like telemedicine, Skype, etc. that would allow physicians to see and diagnose some of the everyday things without going to a doctor's office. Indeed it could be argued that an infected patient should be kept away from a physician's office if the diagnosis can be made with reasonable certainty via electronic means.

I suspect the new agreement will have some elements that will be uncomfortable for some. There will be necessary changes for us as physicians to embrace new efficiencies and ways of increasing productivity. I believe we have an interesting year ahead of us. It will be fun to look back a year from now and see how wrong or right I have been . . . if there is an agreement by then! Time will tell!

Your question, comments, praise and poisoned darts will all be welcomed at: glenncomm@shaw.ca

2-1-1 for burning questions

By Dave Lowery

Launched in 2005, Calgary became the third city in Canada to offer a 211 service. A partnership between the City of Calgary, the Distress Centre and the United Way of Calgary and Area, call takers, formally known as information and referral specialists, answer calls 24 hours a day, seven days a week and help callers find appropriate services and resources. Falling under the Distress Centre's umbrella and $3.5 million budget, the call takers can access 175 languages and access databases that provide information on 4000 programs and services. And in 2009, they utilized the foreign language option 142 times while answering over 50,000 calls.

Overseen by Michelle Wickerson, MSW, RSW, the communications manager for the Distress Centre in Calgary, Wickerson joined the distress centre seven years ago and has been responsible for 211 for the past three years.

"To me it's one of the gateway services that provides easy access to information," Wickerson says.

With 211, 311, 411 and 911, Wickerson says, it can get pretty confusing but, if it's not an emergency (911) it's a good place to start to find ongoing support for patients. "If it's a burning house, call 911 but if it's a burning question, call 211," Wickerson says chuckling.

"In the event that there is not a service [for a person calling], that information is shared with stockholders and used for future planning. For physicians, we hope to provide peace of mind knowing they can get accurate information for patients for any issues they are facing."

Though the goal is to offer 211 across Canada eventually, to date, 211 is available in Edmonton, Toronto, Calgary and, as of January 2007, Cochrane.

What is 211? (From the 211 brochure.)

211 is a three-digit telephone number that connects callers to a full range of community, social and government services information. 211 is free, confidential and multilingual. In Calgary, certified information & referral specialists answer 211 calls 24 hours a day, seven days a week.

Why call 211?

It can be difficult and frustrating to access the wide range of resources that exist in Calgary. Sometimes, it's hard to know where to start looking, or even what's available. Talking to a trained specialist makes it easier to find information, discover options, and deal with problems. Call 211 for:

- Emotional health
- Financial issues
- Family recreation programs
- Coping with disabilities
- Death & bereavement
- Employment skills
- Citizenship
- Parenting & child care
- Support for seniors
- Sexuality
- & more . . .

Who benefits from 211?

Everyone benefits -- from individuals, families and professionals to community agencies and people facing barriers due to language, poverty or personal difficulty. Just a few examples:

- A son seeking transportation for his aging parents
- A senior seeking home care support
- A laid-off employee wanting to find out about employment insurance
- A teenager attempting to deal with school or social issues
- A family searching for child-care services in the community

How is 211 different from 311, 411 and 911?

- 211 – Information referral service for non-emergency human services in Calgary – including more than 4,000 community, social and government services.
- 311 – Customer service line for City of Calgary municipal services such as road repairs, garbage removal and building permits.
- 411 – Telephone directory listings.
- 911 – Emergency number for medical, fire and police assistance.

Service improvements at Calgary Laboratory Services

By Paula Hall, chief operating officer, CLS

In an ongoing effort to improve service at our patient service centres (PSCs), CLS will be offering two major enhancements effective September 1, 2010.

Web based patient appointment bookings:

In addition to our current patient appointment line service, CLS will offer a web based option accessible from our web site at www.calgarylabservices.com. Look for the Click2Book icon and follow the easy to use screen instructions. Using this option, patients will be able to schedule, cancel or change their own laboratory appointments at any time from the convenience of a computer with an internet connection. Recurring appointments can also be made. The system will send confirmation of the appointment(s) by email. The CLS appointment line staff will also continue to answer questions and assist with appointments by telephone.

Enhanced hours of service:

To fit the needs of patients and improve our capacity to serve demand, we are increasing morning hours for selected PSCs and opening one more site on Saturdays. CLS will open nine sites at 0630 Monday to Friday and will open Marlborough PSC on Saturdays from 0700 to 1500 hrs.

Effective September 1, 2010 new PSC hours are as follows:

Monday to Friday 0630 - 1600	Monday to Friday 0630 - 1800	Monday to Friday 0700 - 1630	Saturday 0700 - 1500	Sunday 0700 - 1500
Avenida	Beddington	Airdrie	Beddington	Market Mall
Marlborough	Glenbrook	Cochrane	Glenbrook	*South Calgary Health Centre
McKnight	Market Mall	Glenmore	Market Mall	Sunridge
Ranchlands	South Calgary Health Centre	Gulf	Marlborough	
	Sunridge	North Hill	McKnight	
		Riverbend	Ranchlands	
		Sheldon M. Chumir	Sloan Square	
		Sloane Square	South Calgary Health	
		Stadium	Sunridge	

** Also open on statutory holidays*

Early morning demand often exceeds our ability to provide timely service and we ask patients who do not require morning blood work to please make an appointment for the afternoon. To improve service time, please emphasize the importance of making an appointment to your patients. In general patients with appointments will be given priority over walk-in patients.

International medical graduates - a clarification

Last month I wrote about some of the challenges that international medical graduates (IMGs) face when they come to Alberta and work towards integrating into our medical system. I wrote the story essentially as the situation was described to me in numerous heart to heart conversations that I had, both with many unnamed IMGs and also with several immigration specialists. Much of what I wrote, therefore, was second hand information but written as though I knew it personally to be true. I failed to attribute the source of my information, giving perhaps a false impression as to my personal knowledge of licensing in Alberta and the plight of IMGs.

I believe that much of the heartfelt angst that many IMGs experience came through in that article. Unfortunately, I also believe I was unsuccessful in capturing the whole story, moved as I was by their situation, and this was brought home to me by a letter from the registrar of The College of Physicians and Surgeons of Alberta (CPSA), Dr. Trevor Theman.

In his letter Dr. Theman pointed out a number of deficiencies in that article. During the article's writing I did not speak to anyone in his office; doing so would have helped me round out the story. Upon receipt of his letter I followed up with him personally and spoke to him at length in order to bring greater clarity to the situation. The following is my clarification and expansion, thanks to Dr. Theman's assistance, to my earlier article.

Approximately 30 per cent of physicians working in Alberta are IMGs, and in the last few years the proportion of new registrants who are IMGs has increased to 40 per cent. There are a number of IMGs working in the acute care system under supervision as clinical assistants, and there are others who are in the midst of postgraduate training through the Alberta IMG (AIMG) training program.

In addition to these many that have been licensed, there remain many who are not. In my most recent conversation with the Alberta International Medical Graduates Association, they estimated the number of unlicensed IMGs in Alberta at around 600.

There are many contributing factors as to why there are so many unlicensed IMGs in Alberta. One is due to an apparent disconnect at the federal level between what is needed to immigrate to Canada, and what is needed to practice medicine. For example, some time ago the Medical College of Canada set up the evaluating exam as a screening tool at the request of the federal government, yet federal immigration rules don't make having passed it a requirement for immigration.

The crux of the issue for IMGs is that they need to demonstrate training equivalent to their Canadian counterparts. In Alberta it is the CPSA's responsibility to ensure that this is accomplished. Canada and the US have common accreditation standards, and so their training regimes may be considered interchangeable, but beyond those boundaries all applicants must be scrutinized to ensure they measure up to the same criteria. The reality is that post graduate requirements for practice differ in different countries. For example, not all countries in the world recognize family medicine as a specialty that requires two years of post graduate training the way that Canada does. Similarly, all post graduate training in Canada is accredited, but this is not always the case with training received elsewhere.

Dr. Joseph Tucker, faculty of medicine, University of Calgary

Many of the IMGs who come to Alberta will end up not meeting the standards for practice here, but some eventually do. As I mentioned in the previous article, the process of assessing their current level and providing any training which is lacking can be time consuming. This can unfortunately lead to the degradation of an IMGs skills. As well, Dr. Theman tells me that it is statistically significantly less likely for a person who has been out of practice for some years to successfully make it through the entire licensing process compared to someone fresh out of training.

The CPSA tries to make licensing determinations as efficiently as possible so that those who should be registered are and those who shouldn't be aren't. The goal is also to make applicants aware of whether or not they will meet standards as quickly as possible so that if not they can at least move on with their lives and careers. Dr. Theman admits that like many others, the CPSA struggles with resource limitations while trying to get the job done.

IMG applicants eligible for the provisional register still require an assessment. For this sponsorship is required. When there is a need for a certain specialist and a sponsor steps forward, the individual's assessment and residency process can be advanced. More sponsorships of IMGs could therefore enhance the registration throughput.

Perhaps the primary bottleneck for IMGs occurs at this assessment stage. According to Dr. Theman, it may take three months to a year to perform an assessment depending on the candidate's type and scope of practice. In Manitoba, the College of Physicians and Surgeons of Manitoba, the provincial government and the medical school collaborated to come up with the CAPE assessment to address their own assessment bottleneck concerns. CAPE is open to IMGs with at least one year of postgraduate training who come to Manitoba seeking licensing. It has its own drawbacks however, including a high failure rate and a high per candidate cost.

A secondary bottleneck is that the number of residency positions available to IMGs is not unlimited. While "more spaces" seems like an obvious place to start, there are limits as to how many more could be created given the human resource requirements to educate and evaluate additional Individuals. Residencies of shorter duration are another possible solution that has been contemplated, but at present the system is not set up to accept them.

At the end of the day it is in everybody's best interests to support the efficient assessment and integration of IMGs into our medical system. Indeed, by the numbers of IMGs currently working in Alberta and the numbers who are being registered each year, the CPSA and other important players are accommodating a significant number of IMGs already. If additional resources were available they could doubtless be put to good use in increasing IMG registration throughput by expediting assessments and funding additional residency positions each year.

An IMG's perspective on the journey towards medical practice in Canada

By Dr. Florence Obianyor, family medicine

The experience of international medical graduates (IMGs) no longer makes news for good reason. Now more than ever, there are opportunities for IMGs to become fully licensed physicians in Canada. In fact, I am training to become one myself. In recent years, the Alberta government has significantly increased investment into utilizing the skills of the IMGs living in this province; and rightly so, there are many individuals living and working in Alberta who have the potential to serve as competent and productive health-care providers. This investment is good news, and it means that we are heading in the right direction, but there is still more work to be done!

Some of this work includes achieving a better understanding of the IMG perspective. When people come to learn that I am an IMG, I am often asked: why do IMGs leave an established medical career or the potential for one for the elusive chance of one in Canada – why would they risk the known for the unknown? IMGs immigrate for the same reason anyone else does: to seek a better life for themselves and for their families; the desire to experience a different way of life – a way of life that allows access to an excellent social infrastructure and better educational opportunities for their children. These reasons are a few of many cited by IMGs.

During my own journey through residency, I have often discovered that many people are misinformed about what an IMG must accomplish in order to practice medicine. For example, I have often heard people comment on how an IMG spends six years learning what a Canadian medical graduate learns in three or four years. This understanding is a misconception. To clarify, an IMG will often spend the first three years of a six year program studying pre-clinical sciences with the last three years being spent studying clinical sciences. These three years are not dissimilar to what a Canadian medical graduate studies in their pre-medical years.

I was educated under a six year medical degree model. Not having a non-medical degree upon entering the Canadian work force proved to be a challenge. I quickly discovered that an international medical degree was not as competitive as a Canadian research degree; this reality became clear as I was often overlooked in favour of other Canadian-trained candidates for research-oriented jobs. Regardless, this tough luck was for the best as it enabled me to re-align with my initial goal, which was getting accepted into a Canadian residency program and practice medicine in Canada.

Another challenging question I have heard in response to concerns about IMGs who are unable to obtain a Canadian residency spot is "why don't they go back and work at home?" They don't because they are home. IMGs are Canadian and they see themselves that way. When I go back to visit the country of my birth I am now the foreigner, and I must take all the precautions that most other foreigners must take. From both a cultural and biological perspective, I have become a visitor to my birth country. I have even lost my immunity to malaria! For better or for worse, Canada is my home.

PARA
Professional Association of Residents of Alberta

Last spring, I visited Nigeria and I marvelled at the advancing careers of my old friends and classmates; many were already staff physicians now enjoying the benefits of a well-established career. Nevertheless, I am not envious; I'd rather be where I am, in Canada! It's a dream I am living today, and I am most grateful to the system that has allowed me to get this far. I am one of the lucky ones and I know it.

Canada is an amazing place to call home; however, the country faces cultural and organizational handicaps that make it challenging for bright, talented internationally-trained professionals to succeed. These barriers can be as simple as the cultural meanings associated with body language. No one ever thinks to teach body language, and it can come as a nasty shock when colleagues and mentors interpret that language in an unintended way.

IMGs are not just facing the rigors of residency and their postgraduate medical education. Often, they are also training in this "new" language, a different social and medical culture, with new, often unspoken expectations. It is a challenging experience. Many effective international businesses and organizations recognize that their employees can be more productive with training in this new 'cultural language.' This type of training could be successfully applied to IMGs preparing for residency. Such a proactive initiative would make for a better experience and learning for us, our peers, and our mentors.

This country's triumph was built by the international citizens who chose to call Canada home. Thus, I encourage my fellow resident physicians, be they born here or abroad, to get involved in the system in which they work. Being involved can mean many different things. A good starting place for resident physicians is PARA, where issues influencing residency as well as the Alberta health system are discussed in-depth. It is an opportunity that has eased my integration into the Canadian system. I feel fortunate to be involved in PARA, last year through my role as a PARA board member and, this year, as a member of the executive. Being active in my community for me is a not just a means of learning, it is an opportunity for me to give back and have a say in shaping the system of which I am a part.

By Dr. Christopher J. (Chip) Doig, president, Alberta Medical Association

As you read this, the proverbial "dog days of summer" may be behind us, but they certainly did not stifle your association's energy and focus.

The Alberta health care system will face a major retooling in the year ahead from a conflux of activities and projects. The success of these projects will require a strong and dynamic relationship between the Alberta Medical Association (AMA), Alberta Health Services (AHS), and Alberta Health and Wellness (AHW) to ensure the provision of timely and quality care in our province.

- Zone medical associations that will be resourced through the AMA with funding and staff support
- A single set of province-wide medical staff bylaws to be voted upon this fall
- Separate, but complementary, initiatives for primary care by both the AMA and AHS
- AHS' introduction of clinical networks
- Uncertainty about the relationship between AHS and the faculties of medicine at the University of Calgary and the University of Alberta, and the potential impact on academic medicine including an academic alternate relationship plan (AARP)
- Challenges with the pace and extent of integration of health care computerization: electronic medical records (EMRs) in physician offices and the provincial electronic health record (EHR) in hospitals and AHS facilities
- Alberta Health Services' desire to employ its own EMR(s) within its facilities, and the need for all EMRs to conform to a common set of provincial standards and requirements
- Formal commencement of negotiations 2011 after the AMA's representative forum meets September 24-25 in Edmonton (the eight-year trilateral agreement between the AMA, AHS and AHW expires March 31, 2011)
- A legislative framework for health care with an Alberta Health Act to be introduced at the fall sitting of the Alberta Legislature
- The beginnings of an election mentality among all political parties and the media, given the premier's support for a traditional four-year electoral cycle, i.e., March 2012

Understanding the dynamics of each is only the beginning. The real value comes from a realistic assessment of the quantitative and qualitative information available, the conflux of these activities, projects and relationships, and their potential for integration where the outcome exceeds the sum of the individual parts.

The AMA has always prided itself on being holistic, comprehensive, thorough and evidence-based in its decision-making. This attitude was definitely apparent when the board of directors met in July.

ALBERTA MEDICAL ASSOCIATION

Zone medical associations

The five zone medical associations (ZMAs) reflect the AMA's structural response to the establishment of a single health authority, Alberta Health Services, and its formation of five zones.

For over a year the AMA has been supporting the council of presidents in the development of the medical staff bylaws and in determining how Alberta physicians could best be organized at the regional and local levels, including the medical staff association. The AMA's 2010-11 operating budget (October 1, 2010 – September 30, 2011) allocates $700,000 for ZMA representation.

Primary and chronic care

The board supported a working draft of the AMA's "strategic plan for primary and chronic care," developed with leadership from the section of general practice, PCN leads and the section of rural medicine.

In addition to these three principals, the general practice representative (GPR) working group has representatives from the Alberta College of Family Physicians, two members of the AMA's negotiating committee, the co-chairs of the former comprehensive family practice strategy steering committee and AMA Executive Director Michael A. Gormley.

As discussed in my July 13 president's letter, the AMA's approach to primary and chronic care is being built around the "medical home" concept developed by the College of Family Physicians of Canada.

Academic medicine

As a result of a joint proposal from the two faculties of medicine to develop a province-wide academic alternate relationship plan (AARP), the AMA has identified several other options for cooperation and collaboration. The board of directors has agreed on an engagement strategy that broadens the AMA's connections with academic physicians beyond an AARP.

Physician office system program

When it was introduced about a decade ago the physician office system program (POSP) catapulted Alberta to North American leader as far as computerizing physician offices. This, however, no longer is the case.

As a result, under the title of "towards EMR clarity for physicians" the board has discussed the implications of how Alberta Health Services EMR(s) might be made available to AHS-based physicians and the need for physicians to be fully engaged in strategies, plans, and associated terms and condition.

Continued on page 12

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

Right care for all of Alberta

Mr. Zwozdeski, the minister for health, has announced a $1.25B capital development program for health facilities located outside Calgary and Edmonton, that is to say for rural health care. His colleague, Mr. Danyluk, minister for infrastructure was reported to have said, "we are focused on building the right facilities, in the right part of the province, that meet community health care needs now and into the future."

Certainly the logistics of medical care delivery sometimes differ between rural and metropolitan areas, but dichotomous thinking about rural and metropolitan care is unfortunate and biologically inappropriate. Albertans have the same illnesses, the same concerns and the same needs for medical care wherever they reside. This is probably the fundamental premise for the current Alberta Health Services managerial system.

I want to repeat my opinions of March 2009 that urban medical care would benefit from inclusive thinking about the systems that are associated with the "rural" mindset. What is right for rural Alberta is not inherently wrong for urban and metropolitan communities in Alberta:

Reprinted from March 2009 Vital Signs

In praise of rural practice – a model for the future

Having regularly travelled from the city to a small community hospital for the last several years, I have come to appreciate and greatly respect the work of rural physicians.

Alberta's demographics necessitate health care provision for dispersed small communities and this is the basis of rural practice. Although patients will always have to travel to regional centres for highly specialized services, these do not address the bulk of common medical needs for most of the population. Rural practice is a cohesive model of health care continuity, currently at increased risk of being portrayed as outdated and inefficient. Rural physicians have to multi-task more than most of us. They do regular office practice, hospital visits, minor procedures and emergency care, across the range from pediatrics to long-term care of the elderly and from mundane to acute life saving. They are more likely than city physicians to care for entire families, and to know the social dynamics that impact the health of their patients. They are recognized in their local communities, and I observe that rural patients know and respect their physician to a greater extent than is often the case with urban patients. Rural family physicians are visible and welcome in their hospital. Unlike the large city hospitals, patients can identify with their personal physician and do not suffer bewilderment and loss of confidence generated by a parade of medical strangers.

Enactment of Alberta Health Services as a monolithic administrative structure is imminent. AHS has the premise that improved efficiencies and cost-effectiveness will flow from an integrated and over-arching management system. The philosophy is both simple and uncertain - large is probably better than small. History teaches us that that the varieties of monolithic empire that have been built by assimilation and aggregation will eventually suffer overburden, and devolve into smaller more autonomous units. Ebb and flow of human organizations is as inevitable as the rhythm of the oceans. An occasional tsunami may drown the minor players and smaller entities. In other countries and in other provinces, many small and rural hospitals have suffered the indignity of being branded as inefficient outliers, in prelude to closure. The chain of new rural community hospitals conceived in the era of Premier Getty has been cast in that light from time to time. It would be a real loss if ascendancy of a centralized large AHS was to squelch remote small units, and with them the culture of rural practice.

Alberta Health and Wellness has recently unveiled its latest long-term plan entitled Vision 2020, which places patients at the centre of a sustainable system. Rural medical practice in smaller communities already fulfils three of its five goals:

- *Providing the right service, in the right place, and at the right time*
- *Enhancing access to high quality services in rural areas*
- *Improving co-ordination of care and delivery of care*

Rural medical practice is a model of comprehensive care for the future. In anticipation of the next restructuring, now is the time to think about how to transpose its values and rebuild small efficient medical units integrated with community "cottage hospitals" in the larger population centres.

Ray Lewkonia

Our patients – and we, their physicians – expect, and deserve, an effective e-health system with functional EMRs and EHRs, timely results of laboratory and diagnostic testing, and a person's pharmaceutical history. Our patients – and we, their physicians – also expect, and deserve, absolute respect for the privacy and confidentiality of their personal health information.

Health care transformation

The AMA has prepared for the August 22-25 general council of the Canadian Medical Association (CMA). In early August CMA released its latest policy document, "Health Care Transformation in Canada: Change that Works. Care that Lasts." It defines five pillars fir specific action:

- Building a culture of patient-centred care
- Incentives for enhancing access and improving quality of care
- Enhancing patient access along the continuum of care
- Helping providers help patients
- Building accountability/responsibility at all levels

On the provincial scene, the AMA met with MLA Fred Horne and his advisory committee regarding the forthcoming Alberta Health Act. We highlighted the importance of medicare's social contract with Canadians and their physicians, the need for oversight on scopes of practice, and formal recognition of the AMA within the new legislative framework.

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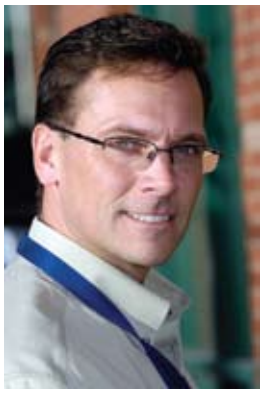
From the CAPA president-elect



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

What I am about to present is an idea that I have hesitantly sat upon for the last eight months. Colleagues have noted that the idea has merit but suggested that I might need a flack jacket if I ever proposed it publicly. Well, the time has come.

We are all aware of the long wait lists for procedures, investigations and treatment. Much has been debated about the pros and cons of publicly-funded private health care and its ability to solve the waitlist dilemma. Perhaps no topic has been more controversial than the notion of queue jumping. Queue jumping or "jumping" is perhaps seen as the most unsavory if not unwelcome aspect of private care.

Some may bristle with the notion of wealthy people jumping the queue but we need a reality check. It would seem that the wealthy are essentially already jumping the queue by having their procedures performed in the USA or elsewhere. Take the case of Newfoundland's premier, Danny Williams, who in February chose to undergo heart surgery in Florida. The concern is that sometimes individuals pay huge dollars (i.e. profits) to out-of-province hospitals and organizations in order to jump the queue. My argument is to keep these profits in Alberta and use them to pay for our public health care services.

If jumping is already occurring in the context of the current health system, then could we somehow learn to embrace the notion of jumping and simultaneously allow all Albertans to benefit? Perhaps we could let anybody in our current system jump to the front of the line for hip surgery, cataract surgery or whatever else might present with a waitlist. I say this with one major caveat – jumpers would have to pay perhaps five times the actual cost of the intervention. For example, if the total cost to the health care system (i.e. the taxpayer) for one cataract surgery is $2k, then jumping to the front of the line would cost that individual perhaps $10k.

When a jumper pays five times the cost for cataract surgery, all derived profits would be retained within the cataract system to pay for four other people waiting in the queue. This is a sort of Robin Hood approach except that the jumpers are voluntarily helping to pay for those marooned in the queue. Profits would help underwrite more equipment, nurses, technical staff and physicians. More operating rooms could be opened which would also cut faster into the waitlists. Performance incentives could be offered to physicians capable of ramping up their practices to meet the increased demand. Eventually, the more queue jumpers we have in this model the faster the waitlists would shrink and disappear.

This proposal would seem to benefit most everyone. The jumpers would likely be happy because they not only had their personal medical needs met, but they also voluntarily helped the system and others less fortunate. The taxpayer would benefit and I am certain that we would all be happy to see the end of waitlists.

Thinking about the model, the only unhappy people might be those profit-minded individuals wishing to embrace the private provision of health care services. Profits from the queue jumpers in my model would benefit the public system and would not benefit private individuals or shareholders. In my model, the ultimate beneficiary from the jumpers is other less fortunate patients and the Alberta taxpayer.

An actuarial would have to look at this model but it seems that the more jumpers we have the more supercharged the system would become and the faster waitlists would be eliminated. The rate-limiting steps would be the speed with which procedures and investigations could be performed, staff availability and the number of people interested in paying to queue jump. In order to allow more people to become jumpers limited tax credits or tax deductions could perhaps be offered. In addition, insurance companies could offer plans to cover jumping expenses. In the end, if the model fails then we are really no farther ahead or behind.

Eventually, as waitlists subside, the amount paid to jump the queue would likely have to be reduced as waitlists are eliminated and the system is balanced. Once balanced, we could invite Canadians from other provinces to have their procedures performed in Alberta where there are no wait times. Such patients would have to pay perhaps two or three times the Alberta cost of the actual procedure so that ongoing profits could continue to supercharge our Alberta health care system.

If this plan were successful, other provinces may catch on and initiate their own queue jumping program. If Alberta were to strike first we would have a head start on reducing our waitlists and therefore be in a position to undercut other provinces. In essence, provinces might compete with each other for jumpers.

This is a seemingly simple solution to the problem of waitlists and funding in our current health care system. Some effort to find acceptance of a queue jumping model such as this may be required but it seems possible that if we allow paid jumping to occur, everyone would eventually win. Think about it. Lets try to keep those health care dollars in Alberta and put them to work for Albertans. I'm prepared to take the flack for making this suggestion. Is anybody willing to consider it? Would the premier or health minister be willing to risk trying something different?

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