Communicating with physicians in Alberta

November 2011

Vital Signs

A Calgary and Area Medical Staff Society publication

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Advocating for physicians, caring for patients

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On the cover: Dr. Bob Rothstein, left, Johns Hopkins vice president of medical affairs in Washington, DC with Dr. Matt Poffenroth (a Calgarian), regional medical director, National Capital Region, Johns Hopkins Community Physicians.
Photo by Dave Lowery.

This is engagement?

On Monday, September 12 the province announced a five-year action plan for addictions and mental health. Certainly, such planning is a welcome prospect given that mental health desperately needs to find better coordination and efficiencies of services. That being said, there is a fundamental problem with respect to the manner in which this recent five-year action plan was developed and announced. Very simply, there appears to have been a complete lack of engagement of physicians in a plan that will radically alter the nature and means of service delivery and physician compensation.

I first became aware of this plan the morning of September 12 when the media asked me for commentary prior to the impending press conference. I wish I could have said that this plan was long anticipated but never having heard of it, I was not much help. Nevertheless, the caller kindly forwarded the documents to me.

I quickly reviewed the documents including the list of 'engaged' stakeholders hoping to see that psychiatrists or organizations representing psychiatrists had been consulted. Sadly, none were to be found. Amongst the engaged stakeholders we find Alpha House (a detox centre in Calgary), the Metis association, the Norlien foundation and various professional colleges. There were also some consumer representatives. I did find that a single primary care physician was consulted, however, psychiatrists were definitely absent from the list of engaged stakeholders.

I canvassed colleagues to see if any other psychiatrists had heard of this new plan but none were aware of it. I found this increasingly strange given AHS' professed determination to engage physicians. Thus, I forwarded the documents to members of the Alberta Psychiatric Association (APA) as well as psychiatry representatives within the Alberta Medical Association (AMA). My sense of concern increasingly gnawed as I attended the AMA representative forum, which only served to confirm my suspicions: psychiatric input was largely non-existent in the preparation of this five-year action plan. The APA was entirely unaware as were sections of psychiatry in the AMA. Dr. P.J. White, a psychiatrist and now past president of the AMA publicly declared that although the (former) health minister Gene Zwozdesky had stated that he had consulted with Dr. White this was apparently not the case. In the end, it appears that the only psychiatrist that perhaps was involved in the preparation of this plan was the AHS medical director for mental health and addiction services – hardly an impartial agent.

In the end, does it really matter that psychiatrists were not engaged in this planning? After all, a variety of health professionals and stakeholder groups, both public and private contribute to the delivery of mental health and addiction services in this province. Why then should physicians feel entitled to have a seat at the table? Well, if implemented, this five-year action plan mandates that PCNs will include addiction and mental health services within their service structure. This alone will have clear implications for PCNs perhaps further exacerbated by the fact that the plan includes an exploration of "the use of other types of providers within the primary health care environment." Finally, the documents note that remuneration strategies for physicians will be reviewed, "to explore alternative funding models for physicians and other service providers."

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

Notation in the plan indicates that new service delivery models will be created that may require the expansion / extension of alternate relationship plans (ARPs) and new health services codes. "Different funding models should be reviewed and, if appropriate, implemented. Potential areas where different funding approaches may be more effective include primary health care…"

Thus, it would seem that if implemented, this five year action plan will radically change the nature and manner in which mental health care services are delivered and may readily lead to changes in funding and compensation models for psychiatrists and primary health care providers. Therefore, one would certainly think that these would be valid reasons to engage psychiatrists and primary health care physicians. Conversely, by excluding stakeholder physicians, the tactics and strategies that AHS and AHW seem so willing to employ should cause all physicians to sit up and take notice. Psychiatrists may very well be serving as the canaries in the coal mine of future AHS/AHW tactics and changes to the health care system. Take heed my colleagues.

If we recall, a core value extolled by AHS is that of engagement. With the announcement of this plan, AHS has once again underscored that their platitudes of engagement and transparency are a sham. Informing physicians of planning arrangements or decisions after the fact is not engagement. The planning and announcement of this five-year action plan for mental health and addictions is another brutal example of the autocratic approach AHS and AHW routinely adopt.

To add insult to injury, six weeks after the press conference announcing the new five-year action plan for mental health and addictions, psychiatrists continue to be left in the shadows. We have not been emailed, directly informed or otherwise engaged with respect to this plan either by AHS or even by our department. It is beginning to appear that physicians, psychiatrists in particular, are deliberately being excluded and marginalized in this process. In the end I'd like to say that I am outraged but very simply, I am bitterly not surprised.

American healthcare - Are we that different?

By Dave Lowery

E.W. Paul Luxford

December 26, 1926 - September 26, 2011. Major (ret) R.C.D.C.mil, D.D.S., M.S., F.R.C.D.(C), Dip A.B.O.M.S., F.I.C.D.

Elmer William Paul passed away peacefully surrounded by family on Monday, September 26, 2011. He led a wonderful and full life packed into his 84 years. A much loved member in the community, he will be missed by many. Paul was born on 26 December, 1926 in Windsor, Ontario and some of his kindergarten buddies are still his friends to this day. He graduated with a D.D.S. from U of T where he joined the Beta Theta Pi Fraternity and made many more friends that endured through his life. He also met his wife and best friend, Nancy Sootheran to whom he was married for 42 years until her death in 1995. He went on to complete post graduate degrees and residencies in Rochester, NY and Boston before moving out to Calgary to be a pioneer in his chosen specialty, oral and maxilla-facial surgery. He established a thriving practice and was on the rolls of all the Southern Alberta Hospitals. Always one to give back to the community, he was heavily involved in the ongoing teaching and education of those in his specialty both as a sessional lecturer at the faculty of dentistry U of A and with the Royal College exam process. He is past president of the Calgary and District Dental Society, charter president of the Alberta Society of Oral and Maxillofacial Surgeons and past president of the Canadian Society; charter fellow, examiner and member of council of the Royal College of Dentists of Canada; past representative to the American Council of Oral and Maxillofacial Surgeons. His honours include fellowship in the International College of Dentists and life fellowships in the Alberta, Canadian and American Professional Societies. An avid skier and outdoorsman, Paul loved Calgary and the mountains. On one such ski adventure, he tore his achilles tendon and learned to play the clarinet during his recovery, subsequently playing his favorite jazz with a band made up of dental colleagues called the "Holy Molars." He is also one of the few people on earth to "get" cryptic crosswords. After retirement, he travelled extensively and formed a love hate relationship with golf. A devoted Calgary fan, he was a long-standing volunteer to the Calgary Stampede and, for the past 18 years, he has been a member of the Rotary Club of Calgary. An organization he not only enjoyed immensely but was so proud to be part of their good works. He will be especially missed by his four children and grandson; Lee (Robert Pelzer), Stuart, David, Heather and Leo Luxford, as well as by his older sister Mary Jane Watson and her family and by his dear friend Catherine Evamy and her family.

Dr. Joseph Kereszturi

July 30, 1923 - September 29, 2011

Dr. Joseph Kereszturi, beloved partner of Gizella Davis of Calgary, died on Thursday, September 29, 2011 at the age of 88 years. Joseph was born in Hungary and immigrated to Canada with no English. With a great deal of hard work he became a respected and successful radiologist. Joseph, the love of Gizella's life for thirty-four years, will also be dearly missed by his family and by all those that had the privilege in knowing him.

On a recent trip south of the border, Vital Signs sat down with two physicians who have practiced in the American system but now find themselves in administration most of the time. The first, originally from Chicago, Dr. Robert Rothstein, 62, was the director of the Washington, DC Suburban Hospital emergency department (ED) for 20 years before accepting a position as Johns Hopkins vice president of medical affairs in 2010. Next month we'll feature the interview with Dr. Matt Poffenroth, 42, a Calgarian though his post secondary education was all completed in the U.S. Poffenroth is currently the regional medical director, National Capital Region, Johns Hopkins Community Physicians.

Vital Signs: About how long does it take for patients to be seen in your ED currently?

Rothstein: Though this isn't necessarily typical, the average wait time at the Suburban Hospital is under 30 minutes though that is reduced to almost immediately if you arrive by ambulance. The door to doctor time is about 24 minutes.

Vital Signs: Has that changed in the past few years?

Rothstein: It is getting longer. Over the last several years people have begun to use the ED as primary care because people can't get in to see primary care doctors. One big difference is that the uninsured use the ED predominantly and most of those people are there for minor things. If you were to look at the acuity of emergency patients in our hospital, we have a very acute population. We admit about 30 per cent from the ED and about 75 per cent of our patient population comes through the ED.

Vital Signs: Do you provide any services to uninsured patients?

Rothstein: We don't pay much attention to insurance in terms of providing care. In this area, about 20 per cent are uninsured. However, an important thing to point out is that at the original Johns Hopkins hospital in east Baltimore, the payer mix is probably the opposite and 15 per cent of ED patients are HIV positive.

Vital Signs: How will Obama's suggested health reforms improve the health of the population?

Rothstein: Ideally, universal healthcare would make a difference. That assumes that primary doctors are available to service the population but I'm not terribly optimistic that is possible. You would hope that support of primary care incentives would improve.

Vital Signs: What would you like to see reformed in American healthcare?

Rothstein: We don't have enough primary care doctors. Massachusetts passed state health care reform where everyone had to have insurance. Wait times for primary care went from three weeks to four months. We have a lot of issues. We spend an awful lot of money on the last few months in life. If we could have the political gumption to make cigarette smoking illegal, we could make the system pay for itself. But there is also a fear of malpractice that drives up costs. Our challenge here is figuring out how to ration the resources.

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Adrian M. George CFP, Ch P, FCSI
Director, Advanced Planning

If this headline grabbed your attention, imagine how it would impact your patients coping with a lifetime disability and the financial strain that disability can cause. For families requiring a care-giving parent or spouse to reduce or stop working due to a disability, the resulting day-to-day financial struggles can be overwhelming. And the thought of providing for their families when they are no longer able to is one of the single biggest concerns for the disabled, adding more anxiety to an already stressful situation.

Why Living Assistance Programs for Those with Disabilities Are Rarely Enough

In Alberta, programs such as AISH can provide up to $1,188 per month in living assistance payments for the severely disabled. As an income-tested benefit, however payments are reduced and eventually eliminated past monthly earnings of $2,137 (for a single) or $2,925 (for families). If an individual has out-of-pocket special treatment needs – even just the need to give the caregiver a break – these living assistance payments are quickly spent.

Enter RDSPs, Savings Plans with Government Matching

The Canadian government offers a matching program for contributions to Registered Disability Savings Plans (RDSPs). Families earning an annual income of less than $83,088 can contribute just $1,500 to an RDSP each year to receive $3,500 in grants. If annual household income is less than $41,544, up to an additional $1,000 can be received, to a lifetime maximum of $70,000. When combined with up to $200,000 in allowable contributions – and when you consider the tax-deferred growth of an RDSP – the financial impact can be significant.

The Alberta government has fully exempted the RDSP as income and assets when determining eligibility for AISH (and other provincial assistance programs), so planning for the future will not harm the present.

It is crucial to discuss RDSPs with your patients – especially those with disabled children – as early as possible. To qualify to contribute, the individual must be 49 years of age or under, a Canadian resident with a Social Insurance Number and eligible for the Disability Tax Credit (DTC).

How to Secure the Financial Future of Adult-Dependent Children

For adult-dependent children, parents should consider setting up income-splitting strategies or using assets to pay the child $400 per month, which is exempted from AISH income calculations. (Additional income in the AISH recipient's hands is also exempted, but on a diminishing basis.) While family and testamentary trusts can certainly play a role, life insurance on the parents is absolutely critical to both fund a potential trust need as well as provide the assets toward the purchase of a prescribed annuity for their child. Such annuity payments are guaranteed for the child's life – mostly tax-free – and do not require a health test, unless applying for impaired annuity due to a shortened life expectancy.

Properly funding an RDSP has two tangible and lasting benefits: it reduces the future need for then-elderly parents to provide assistance from their fixed retirement income, and it allows the deferral of an annuity purchase on their child's behalf. Annuity payments increase significantly with age, and the RDSP bridges the gap between costs of care coming from the parents' assets (or estate) and the disabled individual becoming old enough to receive a higher mortality credit for their lifetime payments.

> RDSPS PROVIDE RETIREMENT INCOME FOR THOSE WITH LIFETIME DISABILITIES.

The next time you are working with an affected family, have one more arrow in your specialist-quiver by encouraging them to speak with a financial specialist who understands RDSPs. Certified Financial Planners can be found in your area by clicking on the "Find A CFP Professional" link located at www.fpsc.ca, with additional RDSP information located at www.disabilitysavings.gc.ca.

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Bridging the patient/doctor divide

By Drs. Mark Ballard & Vera Krejcik, internal medicine resident physicians

When Mark asked me to collaborate on an article about my recent surgery, I felt it was a good opportunity to tell a story that only a few of my colleagues knew. I had kept my grave diagnosis secret for a year, telling only those who needed to know; I found the secrecy very isolating. After we had "won the war," as my surgeon says, I had made my way through so many wards in the hospital, met so many allied health professionals and patients that I had a story to tell. The following article includes both my and Mark's reflections on our experiences on different sides of the patient/doctor divide.

Left: Dr. Mark Ballard.

Right: Dr. Vera Krejcik.

Throughout a doctor's career - as a student, a resident, and then a physician – we should never be complacent about how well we deliver care; within every experience, there are lessons to be learned. As physicians, we need to look for these lessons in each patient encounter. My recent experience caring for one of my colleagues on a neurosurgery rotation allowed for just such a reflection.

Neurosurgery is a rigorous and demanding rotation. I was exposed to a world where work started at 6am and ended at 8pm. A patient on this service often faces a grim prognosis; an irremovable brain tumour with a life expectancy of one year is not uncommon. I discovered that this context can sometimes make it very challenging to really connect with patients.

When one of my former medical students, Dr. Vera Krejcik, came in for an elective removal of an arteriovenous malformation (AVM), the harsh realities of neurosurgery hit close to home. The AVM itself was quite large – a spetzler-martin grade III – and required twelve hours to resect. She was going through something more traumatic and dangerous than most people ever experience and there was little I could do to help. I was worried about her and upset that I had missed the only opportunity there was to wish her well before the surgery began. All I could do was to pray.

The surgery was successful. Post-surgery, Dr. Krejcik had minimal left-sided movement that was believed would improve with time; however, seven days later, nursing noted that she was becoming less responsive; the surgical site had re-bled, which was now causing her brain to herniate – Vera was dying. She was rushed back to the surgical suite with the resident physician beginning the process of opening the old surgical site even before she was in the operating room. The primary surgeon raced to assist and the bleeding was controlled, but at a price: Vera was still unresponsive; some of her cranial nerves were affected; and she had persistent hemiparesis. The whole situation shook me and I wondered if I would ever be able to talk to the friend I had known again. Teary-eyed, I met Vera's family for the first time and wished them the best, and then encouraged her to "heal well."

It has now been four months since the surgery Vera has recovered the majority of her cranial nerve functions. She is able to walk and is starting to move her hand and arm. Her family and medical team are working hard with the goal of full recovery. While talking to her recently, I asked Vera to expand on her experiences as a patient. Her perspective has given us both insight into the patient/physician relationship and allowed each of us an opportunity to reflect on how crucial care through effective communication is. I asked her to expand on how we as doctors can communicate more effectively with our patients.

What was the most frustrating experience you encountered as a patient?

I found being talked about in the ICU very frustrating. It was a terrifying time and I both wanted and needed someone to actively involve me in my care. My family and I felt very much on display and isolated during rounds when I was discussed from behind glass with members of the care team looking in.

How did your relationship with your doctors contribute to your experience?

I only felt safe when physicians spoke directly to me. I was so desperate for a human connection at one point in the ICU that I asked every member of the team to "pinky swear" to me that I wouldn't die. It sounds so silly, but when my surgeon did so, I felt significantly safer, more confident, and less anxious.

There was a period in the ICU where I had become quite agitated and delirious. I was desperate for the attending physician to talk to me, but he felt that being alone would allow me to calm down. This circumstance was extremely isolating and increased my agitation; a physician's explanation would have helped me to feel less scared and lost.

Based on your own experience, how do you think patients' experiences could be improved?

As physicians, we need to know our audience. Some patients, like me, want to know everything about their condition; some would prefer to know much less. All patients want to hear from their physician. Taking the time to show results and make the patient an active member of the care team can be extremely therapeutic; it also helps patients feel that their caregivers are invested in their care.

Anything else you would like to comment on?

We are with our patients during some of the most profoundly difficult times in their lives. Never underestimate how much they appreciate the face-time and explanations we give them. This time is critical as it allows patients to feel as though their physician is truly interested in them as people and in their well-being, not just in their illness.

Vera's perspective has brought home to me how necessary it is for us as health-care professionals to do what we can to empower our patients and involve them in their own care. Part of caring for them is taking the time to make them feel secure; sometimes a "pinky swear" is all it takes to make a patient feel safer and less afraid.

A bloody mess

My article this month is a first for me. I received a request, from colleagues, that I expose a situation that occurred recently at the Peter Lougheed Center. An unknown number of people may have been exposed to blood products that could have tainted food. I quote the individual who initially exposed the problem:

Friday September 30th

"At around 13:OO I was finishing my lunch break in the staff lounge. Having just used the communal knife to cut my kiwi, I walked over to the sink to give it a rinse. When I looked in the sink there was an inch or more of a pale red fluid filling the sink. When I looked closer I noticed what appeared to be a blood clot near the drain. I proceeded to sniff the sink to verify what I was seeing and I almost vomited at the smell of blood and sewage. I explained to the staff in the room what I had noticed and I observed the sink empty. In a few minutes as I stood in shock as to what I should do about the problem the sink refilled to a higher level with the same fluid. I immediately left the lounge in search of management who could further investigate the problem. On my way to the offices I looked into the soiled utility across the hall from the staff lounge and I noticed that one of our new Neptune arthroscopic suction devices running a wash cycle. With my background in power engineering, I figured out fairly quickly that the wash and drain cycle of the two tanks on the Neptune had overcome the gravity drain causing the backup into the lounge sink. While I continued to look for management someone else called maintenance and occupational health and safety (OH&S) regarding the issue.

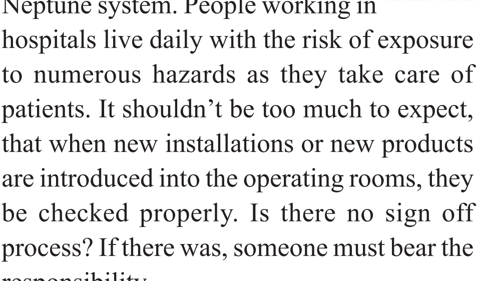
Initially maintenance told me that my view of what happened was not possible until they themselves tried to back up the drain with success. They proceeded to clean the drain and stated that a rag was stuck in the drain. I'm not sure of the validity of that statement.

I had placed a sign up covering the taps stating that the sink was unserviceable and that people should be aware of the problem. While I was away for a few minutes, someone removed my sign and replaced it with a piece of paper towel taped to the faucet stating "do not use." The rational had been removed. This annoyed me greatly since someone was not taking this seriously enough. I proceeded to take a large biohazard bag out of room five and draped the entire sink with a message stating that people might have been exposed to biohazard over the last six months (this figure may be erroneous as it was someone's guess as to when the Neptune's arrived). Thankfully this remained in place from Friday until the following Monday.

In the hours that followed I spoke to a number of nurses who remember seeing "the soup" or "the cranberry juice" in the sink but had not recognized what was happening. We can only assume the time frame dates back as far as the instillation of the Neptune cleaning station (I'm unaware of this exact date).

Since the Friday incident OH&S has become involved and today we were provided access to a lab tech in the recovery room who was taking blood from interested staff. I am unaware of what communications may have happened regarding staff such as residents who should be notified.

Thanks for your time, (Signature)"



I am quite upset by the lack of diligence by those who installed the Neptune system. People working in hospitals live daily with the risk of exposure to numerous hazards as they take care of patients. It shouldn't be too much to expect, that when new installations or new products are introduced into the operating rooms, they be checked properly. Is there no sign off process? If there was, someone must bear the responsibility.

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

I have had the opportunity go get an update. Someone within the system did some investigating and then reported to the nurses. The nurse I spoke with said it had been helpful. Still, most nurses are looking forward to the future new construction which will put the lounge far away from the site of this disaster.

However, I wonder what the reaction to something similar happening in Southport or another Alberta Health Services administrative building. I suspect the response might have been a bit stronger. But then, so long as Dr. Duckett's famous cookie wasn't damaged, maybe no-one would have cared!

As ever, your comments, questions, praise and poisoned darts are all welcomed at glenncomm@shaw.ca

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Calgary family physician, Dr. Linda M. Slocombe, became AMA president on September 24. Following are excerpts from Dr. Slocombe's October 13 AMA President's Letter .

In this letter:

- Constitutional changes to more effectively represent broad needs of AMA members
- Zone delegates to represent their unique issues
- ARP physicians to discuss changes proposed by AHW

Representative forum changes to better represent physicians

Geographical representation at the Alberta Medical Association's (AMA's) representative forum (RF) is being changed to reflect:

- Alberta Health Services (AHS) restructuring from nine regions to five zones
- Zone medical staff associations (ZMSAs) replacing regional medical organizations
- The growth of primary care networks (PCNs)

The constitutional amendments, which were approved at the September 24 annual general meeting, are intended to balance geographic representation, reflect new governance structures including the zone advisory forums (ZAFs), and represent current health care delivery mechanisms in the form of PCNs.

RF representation for sections will not change. The net change in the number of RF delegates, due to these changes, will be plus one.

A number of factors provided the impetus to introduce these changes including:

1 The 2009 AHS change from nine regions to five zones and the introduction of ZMSAs in place of regional medical organizations (RMOs).

Some things won't change.

- The RF will continue to represent physicians within the same geographic regional boundaries as were in place prior to the establishment of AHS zones. This will ensure that physicians from all parts of the province are appropriately represented. For example, zone 5 in the north will have delegates from the previous regions 7, 8 and 9.
- The number of delegates per region, within the zone, remains the same.
- Current regional delegates will complete their terms. Vacancies will be filled via regular election processes.
- All AMA members will continue to be eligible to run as regional delegates to the RF.
- All AMA members will continue to vote to select their regional RF delegates.

Some things will change.

- Zone presidents from the ZMSAs in each of the five zones will become RF delegates, providing liaison between the ZMSAs and the AMA at RF. These delegates will be well informed and able to represent their unique zonal issues and needs. The previous regions were represented at RF by their RMO presidents. Therefore, the delegate count will be reduced by four with the five ZMSA presidents replacing the former nine RMO presidents.
- Being familiar with zonal issues, each ZMSA will be asked to prepare a slate of RF candidates to represent the zone geographically. This list will go out to physicians in each region within a zone, along with the AMA's call for RF nominations. Physicians will be encouraged to add additional names to the candidate list.

- For example, the ZMSA in zone 1 will create a list of RF nominees from the previous regions 1 and 2.
- AMA's call for nominations to all physicians in zone 1 will include the ZMSA list of candidates and invite further nominations of physicians from regions 1 and 2.
- The combined ZMSA and physician nominations will be listed on the ballot for each of regions 1 and 2.
- Zone 1 AMA members will then vote for RF delegates within their individual regions.

2 The need to provide appropriate RF representation for primary care physicians in primary care networks.

Some things won't change.

- The section of general practice will continue to represent primary care physicians across Alberta with the same number of RF delegates.
- The section of rural medicine RF representation will also remain the same.

Some things will change.

- Over 80 per cent of primary care physicians now practise in PCNs. The AMA supports the PCN physician leads executive, which meets regularly to discuss primary care network issues. Just as academic physicians are represented at RF, there will now be a PCN representative from each zone on RF.
- It is hoped that the PCN representative on the AHS zonal advisory forum will be the representative to RF as this physician will be well informed on regional PCN issues; however, this is not a requirement.
- Having PCN zonal representatives at RF will add five delegates to the RF delegate count.

We believe that the geographical and practice-related amendments to the RF membership will serve to more effectively represent members' needs and local issues.

ARP physicians to discuss changes proposed by AHW

With the absence of an overall master agreement, one of the challenges that has arisen relates to clinical alternate relationship plans (ARPs) and the terms and conditions under which they will continue. Government has been using ministerial orders to extend the clinical ARPs. The AMA has concurred with this approach on the understanding that the current terms and conditions would simply continue.

Recently, however, Alberta Health and Wellness (AHW) indicated it wanted to use the ministerial orders to make changes to the ARPs. Both the ARP leadership and the AMA objected. We appreciate that AHW has agreed to extend the ARPs until December 31 while it meets with physician representatives.

In parallel, the AMA has established a five-member ad hoc working group with physicians representing a broad spectrum of ARPs across Alberta. This working group will provide guidance, will be linked in to a provincial discussion with government, and will report back to ARPs on progress.

As I go through the next year as your AMA president, I look forward to open communication with you that includes not only my emails to you, but also your emails sharing your views, opinions, concerns and suggestions with me.

I look forward to working with you and for you!

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

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