Communicating with physicians in Alberta

November 2014

Vital Signs

A Calgary and Area Medical Staff Society publication

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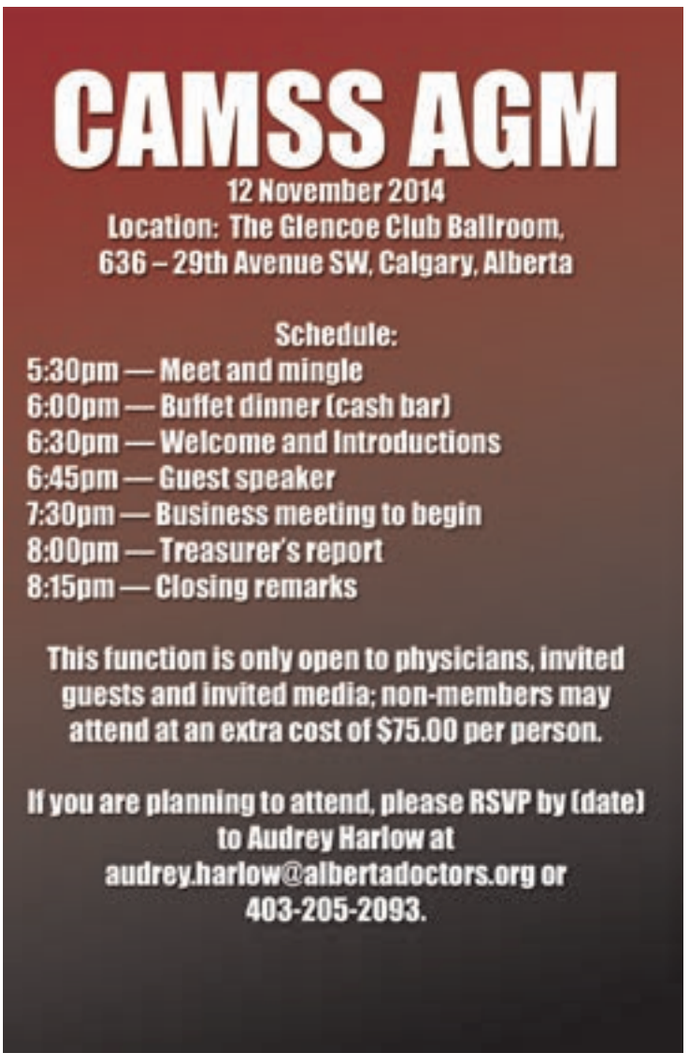

On the cover: Don't drink and dive!
Photo by David Faas, Alberta Adventure Divers.

From the CAMSS president

It's been an eventful month . . . and get the shot will ya!

It has been an eventful month in Alberta healthcare. Calgary recently hosted the AMA's representative forum. The delegates were addressed by the new AHS CEO Vickie Kaminski and by new minister of health, Stephen Mandel. I appreciated their candor but it is by their works that they should be judged. Both individuals are new to their positions and deserve some time before any conclusions are drawn. The healthcare calm during the leadership race has ended and each day brings new health-related headlines. Our hospitals are filled beyond capacity, the emergency departments are seeing huge volumes and the wait times are climbing. The lack of alternate level of care (ALC) beds has created backlogs in emergency admissions and led to the cancellation of some elective surgeries. These are chronic issues, a provincial services review from 2008 details the exact same issues. It is difficult to solve long term issues with short term directives, we await a long term plan with long term funding involving not just additional beds, but also an enhanced primary care role to keep these patients in the community.

Our system is not well but there have been successes. At a recent meeting it was brought forward that we read a lot about our shortcomings but little of our successes. The new DST (speech dictation system) has been launched in Calgary with virtually no problems. This is a major triumph for our medical records staff and the Calgary zone medical administration. The provincial influenza vaccination has begun to roll out with AHS employee vaccinations starting October 6th. The zone medical administrative committee (ZMAC) hosted a vaccination session and media event on Oct 9th encouraging all medical staff to receive their influenza vaccination this year. CAMSS is working closely with AHS and the University of Calgary to not only get "the shot" but also register with AHS to allow accurate recording of physician vaccination rates. This is important. We, as the medical staff have been subjected to many misleading statistics on our vaccination rates based on AHS employee rates, or historical guesses. Let us put the record straight and show our support. If you receive your shot in an AHS facility, no further action is needed. If you are vaccinated at a public clinic you need to sign a consent to release the information to AHS. If you are vaccinated in a pharmacy or physician's office you can fill out the "got my shot" form (from AHS website "Insite" search for "got my shot") and send the information to the address on the form. There will also be a question on influenza vaccination on the CPSA website when you renew your licence. Getting the influenza vaccination is not a guarantee you will not be sick this winter but it is the best we can do for ourselves and our patients to decrease the risk. The zone medical staff associations have purchased buttons that have been mailed out with your Doctor's Digest. The buttons prominently display "This Doc got the Shot" and are to be worn after your vaccination. As a medical staff association president I am proud to be working with the AMA, AHS and the University of Calgary to encourage physicians to show leadership and not only get the "shot" but encourage others to do so as well. The province bought two million doses for the upcoming year . . . no excuses.

Each year the CAMSS hosts two zone advisory forums. These forums include representatives from the CPSA, AHS the AMA and citizen advisory groups. We have hosted previous forums on the Choosing Wisely Campaign and a vigorous forum on medical manpower based on the 2011 royal college report. The focus of the most recent forum was a one year review of the continuity of care report. Much of the discussion focused on transitions in care and care pathways. These pathways are becoming a necessity as some of the specialities such as gastroenterology are overwhelmed with referrals. I would like to applaud Dr. Sargious and Dr. Elford for their efforts in trying to create these pathways in Calgary. In addition the electronic referral form has been initiated for some orthopedic procedures. However, the current form is cumbersome and difficult to use, leading to limited uptake. This is a problem, as the e-referral project has a limited timeline and budget. Without continued funding and support and further physician input to streamline the process, the project will end with a whimper. Our patients deserve better.

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

The CAMSS annual general meeting is being held November 12 at the Glencoe Club. Please note this on your calendar now. The new AMA president, Dr. Rick Johnston is the featured guest. Alberta Premier Jim Prentice has also been invited, and we are awaiting his response. This meeting will be your opportunity to learn about the most recent updates from the physician compensation committee and other AMA/AHS initiatives. These meetings are also your chance to talk to the CAMSS executives and provide your input. As the president I represent approximately four thousand physicians in Calgary and the surrounding area. Without feedback it is difficult to represent you well. Please RSVP and come out to our November AGM.

Remember — you get the representation you deserve.

Record attendance at the PCN physician leads forum

By Alexis D. Caddy, manager, communications, primary care networks program management office

The primary care network (PCN) physician leads forum took place on October 3-4 in Calgary. The 180 participants included stakeholders across primary care and all but two of the 42 PCNs were represented. This is the best attendance of any forum held to date, signalling growing and enthusiastic interest in the evolution of primary care.

Attendees participated in some great discussions and brainstormed practical solutions for addressing some of the PCN evolution strategies.

Some of the highlights of the sessions held at the forum include:

- Medical home assessment sessions examined the value of the medical home assessment tool to assess current strengths and gaps, identify areas of focused improvement, and examined the strategies and lessons learned that can be put into place from practices who piloted this tool.
- Laying the foundation for quality improvement presentation described the skills, tools and resources needed to lead quality improvement efforts in PCNs and member clinics.
- Building relationships: panel session reviewed the fundamentals of getting started with the panel identification process.
- Leadership sessions: Two concurrent practical leadership sessions were presented — strategic planning and coaching your team for maximum effectiveness. A practical approach and various tools were shared to implement these ideas.
- Tying it together: leveraging the medical home assessment for action session identified leading strategies to support member practices and how to implement a clinical improvement project with panel as a foundation.
- Measurement and evaluation presentation linked potential performance indicators to provincial evaluation objects. It also addressed some myths around data collection.

According to a survey distributed to delegates, 90 per cent of respondents agreed or strongly agreed that the program areas discussed at the forum were appropriate.

Family physicians are embracing the future of patient-centric comprehensive primary care within a medical home and ultimately within the greater context of the health home as articulated in the primary health care strategy for Alberta.

We look forward to the next opportunity to learn and lead at the 2015 spring physician leads forum which takes place March 6-7 in Edmonton.

Above: Dr. Brad Bahler at the podium.

Below: Dr. Phillip van der Merwe at the podium.

By Dave Lowery

David Patrick Sartorelli was born on August 19, 1957 and died on August 30, 2014 after a cardiac arrest at the Foothills Medical Centre. It was ironic because Sartorelli was an advanced cardiac life support instructor (ACLS) for the past 20 years and trained hundreds of physicians, nurses and paramedics.

Born in Toronto, at the age of six Sartorelli's father, a Loblaws manager, packed up his wife and 11 children into a school bus and headed to Calgary. In 1977, he met his best friend and future wife, Sherry, at Camp Horizon and they were married on September 23, 1978. Daughter Jennifer came along shortly after followed by her brother Matthew in 1981.

Sartorelli started his medical career in housekeeping at the old General hospital but soon became interested in a nursing attendant program after a teaching coordinator recognized his aptitude. As an attendant, he continued to work on 3W, the neuro unit at the General but, with his interaction with paramedics and discussions with nursing attendant colleague and close friend, Derek Smith, now an emergency physician at the children's hospital, Sartorelli applied and was accepted to the 1980-1982 SAIT paramedic program.

Dave was the best medic I ever worked beside. I loved seeing him in the ER, sharing stories and talking about our lives. A great friend. ***DNA Cebuliak MD***

Though Sartorelli initially found the paramedic program to be academically challenging, he was voted the most improved student and following graduation from the paramedic program, Sartorelli was hired by the Calgary Fire Department Ambulance Service and continued working for them in its present form under Alberta Health Services, Emergency Medical Services. He quickly gained a reputation for avidly enjoying his chosen career.

"I think it was his passion for helping people that drove him," Sherry Sartorelli says. "He had a year older brother who ended up on Edmonton streets as a drug user. I think the 20 years he spent in

He was an exceptional human being, quick to share where he and Sherry had been on vacation and to say how much his grandchildren brought him joy. He always shared a little bit of himself whether it was a story of a patient, family or his teaching and to also listen to your story. David had a big heart and was a pilgrim of humankind. May all be well with David's family. ***Jane Clarkson MD***

downtown Calgary as a paramedic was Dave trying to help people like his [deceased] brother. He didn't care if you had a million dollars or a quarter in your pocket, he would treat you the same way."

About 20 years ago, Sartorelli began teaching ACLS which perfectly suited his love for teaching displayed earlier in his career as a paramedic preceptor with Calgary EMS.

"He felt so honoured to teach ACLS to all the physicians, nurses and paramedics," Sherry says. "He got a kick out of it and also loved teaching new paramedics later in life with Professional Medical Associates."

Sartorelli's passion for teaching appears to have been handed down to his son, Matthew, 33 a high school teacher in Calgary. But that's not all that Matthew is grateful to his father for.

"The biggest thing I took away from my dad was the value of a hard days work and if you are going to do something, do it right," Matthew says. "As I got a little older I recognized that in my own career. My dad felt a commitment to go to work and serve Calgarians, whether they were downtrodden or rich people living on the hill and he instilled in me the importance of treating everyone with the same dignity and respect. For me it's my students . . . for my dad it was his patients. It didn't matter who he had to talk to — above himself on the totem pole if necessary. If he thought something was

We are very saddened to learn of Dave's passing and send our thoughts as you struggle with your sudden loss. He is greatly missed by all you knew him in so many sectors of his life, work and community. Take care of yourselves. ***Greg and Linda Powell***

wrong, if it wasn't good for the patients or the people at EMS, he had no problem communicating that message. For dad, it was all about the people."

Jeannie Earle is one of David's seven sisters and a critical care nurse. She was in the code room with Dave at the end.

"I think Dave's mentorship was a big element of who he was especially with his peers coming up through the ranks," Earle says. "Dave had struggled himself when he was going though the program and turned that into guiding and showing new people the way. Consistently, former students and colleagues told me 'I didn't think I could make it through, but Dave knew I could.'"

Earle was able to make it to the hospital when she heard Dave had been taken there on the night of August 30. And though, for some, seeing a loved one in their last moments would be very difficult, Earle is glad she was there for her brother.

"I was with him at his head helping him through that journey," she says. "I really felt it was a privilege and I carried on what Dave would have wanted. To be able to comfort him, support him, that was what Dave always wanted from his students for patients and if anyone ever deserved to have that passionate comfort and support, it was Dave. I felt I was able to give back to him by being there in the end. I think we all want to know at the end that if we're dying, everything that can be done will be done. And that we don't have a period of suffering. Since I was there, I know he didn't suffer and everything was done right. Everybody did what they were supposed to and did it well. For me it has helped. Support your patients, assess their needs and meet their needs if you can possibly do it and if you can give them that little bit of extra, why wouldn't you. That's what Dave stood for."

Sartorelli was awarded the Alberta College of Paramedics Award of Excellence & Exemplary Service Medal in May 2013.

This is the first president's letter of my term. I am writing today about things you have likely read or heard in recent media reports. The capacity of the health care system — in particular, insufficient capacity — has received significant attention. It will likely also be a prominent part of commentary around the by-elections taking place this month.

The basic challenge is all too familiar to physicians and patients. Our acute care hospitals are often operating above their rated bed capacity, causing problems throughout the health care system. Waits in emergency rooms grow longer; needed surgeries are delayed. In calling attention to the issue, the Alberta Medical Association (AMA) section of emergency medicine has stated that it believes the system is close to collapse. The problem is real, but what are the causes?

One possibility is simply that of acute care shortages. Reports from the Canadian Institute for Health Information (CIHI) suggest otherwise. In 2011, Alberta's provincial government health expenditures were $696 more per person than the Canadian average ($4,486 vs. $3,790). Almost all of this difference was due to expenditures on hospitals. In Alberta, those expenditures were $2,066 vs. $1,538 for the rest of Canada. Perhaps hospital systems in Canada are generally underfunded, but it seems difficult, at least in relative terms, to argue that acute care resource shortages in Alberta are the main problem.

Another possibility is that we rely too much on hospitals — which are expensive — to meet our medical and social needs. Recently we have heard about two major challenges. First is the problem of individuals being forced to wait in acute care beds for appropriate placement in long-term or other care facilities. The second arises from individuals with complex chronic conditions who show up in hospital too often and remain too long because they do not receive the support they need in the community.

Continuing care and other supports

The government has recently committed to reviewing the numbers of beds for continuing care. Getting the numbers right will help, but we also need to bring a broader perspective to this issue. This means addressing factors such as:

- Opportunities through other kinds of assistance such as home care and day programs that help people stay in their homes and communities.
- Improving access to acute care and other beds, but considered in a broad perspective including geographic distribution (keeping families together) and the economic barriers individuals face to obtain the right accommodations.
- The contributions of families, which are largely unmeasured, are a major source of support for many of our frail and elderly. They should be recognized and considered.

In general, we require better information and must broaden the debate about the access to continuing care, services and programs. Until we get the full picture, our policies and solutions will continue to be sub-optimal and will fail to deliver what is required.

The Canadian Medical Association has called for a national strategy on seniors' care, an element of which is access to the right care in the right place and includes concepts such as "aging in place." The AMA supports the development of such a strategy and will work with such organizations as the Alberta College of Family Physicians, which is bringing together several stakeholders interested in seniors' care.

By Richard G.R. Johnston, MD, MBA, FRCPC, AMA president

Chronic disease management

A recent report from the province's auditor general pointed to another challenge — that is a lack of support in the community for Albertans with chronic conditions. This results in patients ending up in hospitals too often and for too long.

To get the most out of our acute care resources, we must invest more in the community with a medical home for every Albertan. To do this we need several things, some of which I have recently discussed in the media. These are:

- Stepping up the implementation of primary care networks (PCNs) — fully implementing what has been termed PCN evolution to the medical home.
- Finding ways to use payments for physicians and other providers as incentives to support the best care right across the system.
- Improving and enhancing our information systems so that they can measure and record the patient's entire journey, avoiding gaps along the way.

Concluding comments

To put all this another way, I believe we must view our relatively high acute care costs as an opportunity to make our system more sustainable. More importantly, we must make it more sensitive to the needs of Albertans.

The problems that exist in health care today have developed over many years. It is naïve to think that they can be corrected in a short time. However, endless debate is not helpful. We need to move quickly and implement the ideas that have been already developed to address the wide range of challenges we face.In particular, we can begin to promote and support better care in the community through the medical home model for complex patients, avoiding the deterioration that result in emergency room visits and hospital admissions. We can also deliver secure messaging systems to allow doctors to communicate more effectively and provide advice and feedback, especially during transitions of care between facilities and the community. These improvements can be implemented quickly as first steps.

For this letter and those that will follow, I look forward to any comments and ideas you may wish to share.

Email: president@albertadoctors.org.

Come up for air some time . . . healthcare lessons from scuba diving

I love to hate those articles endorsing some meaningful life lesson through vague comparisons with a favourite activity. As if life's hard knocks do not teach enough, we must absorb the distilled wisdom from some self-proclaimed oracle. (. . . and there is plenty of distilled wisdom in Bushmills!)

Some have corny jokes such as 'why do old musicians never die — they just decompose!' Many purport to be a guide for life through a handful of simplistic rules. For example, veteran rock climber Matthew Childs has nine 'rules of rock climbing' in an online TED lecture. These rockin' rules include:

No. 1: Don't let go! A truism for climbing & life if I've ever heard one! But his last rule reads: No. 9: Know how to let go! Really?! No bloody contradiction here? To be fair he focuses number nine on the exact moment you are really and truly going to fall. Then he says you should 'fall properly' to cause the least amount of injury. Fair enough. Ever wonder why there are so few veteran rock climbers? Gravity's a bitch!

There are seven rules of scuba diving — which should make religious, numerology-inclined divers happy 'cause they can relate to the Wiccan heptogram (the seven pointed faery star) Judaism's seven pillars of wisdom, Islam's seven heavens and Christianity's seven cardinal virtues — though the Irish probably get more use out of the seven deadly sins. In truth, it's seven to keep it short! Anyway this article is not life lessons — it parallels health-care: big difference.

No. 1: First, save yourself.

No this does not mean you can let your buddy drown. Many rookie divers depend on their buddy or dive-master to save them from whatever problems occur. Though it is fine to need help and everyone will need it sometime, it is even better to fix problems yourself. That means you are not taking up resources. With experience over time you can then assist someone else because you are in control.

Number one is an easy comparison to health care! First, fix your own problems: plan to come up for air and get some rest, manage personal difficulties (. . . maybe rule number four?) improve communication skills and even learn to say you're sorry: Then care for your buddy, the patient.

No.2: You can quit a dive! or alternatively, come up for air — sometime.

A nasty dogma in North American culture is 'quitting is for losers.' Taking a break is seen as a weakness, a character flaw. Bring that dogma to diving and people die when pushing beyond their personal limits and training. Divers should leave their ego at the water's edge. You can't dive deeper and longer than everyone else, all the time. You can always dive another day. Falstaff in Shakespeare's Henry IV says it well:

"The better part of valor is discretion, in the which better part I have sav'd my life."

Similarly, in health care, we need breaks. Dedication is good, but few of us are martyrs. Quitting — as in 'I need a break today / this week / this month' — is what we must do to replenish peace-of-mind, our focus and spirit — our empathy.

No 3: Be prepared or at least keep calm and carry on.

Being prepared includes good training, well maintained equipment, adequate surface support, enough emergency equipment and an appropriate dive-plan. We also need to be ready for the unexpected — gear fails, conditions change, people fatigue, weather worsens — in other words, shit happens and panic doesn't help. So transition to rule number one or number two, calmly.

This correlates easily to health care. The only difference is that little can prepare workers for unrelenting changes such as those occurring in Alberta over the past 25 years. Some workers got fired after each re-organization; others became shell-shocked survivors and defaulted to a continuous number two or got really stuck in rule number four.

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

No. 4: No booze or drugs.

A bad mix for both diving and healthcare. (Caveat: Rule number four absolutely excludes all reference to Bushmills.)

No. 5: Don't swim against the tide.

It is very tiring for divers to swim against a current in full gear. Often it is best to go with the flow and exit somewhere else. For many healthcare workers this principle means putting their family's well-being first and not challenging authority unnecessarily. Good examples of what happens to those swimming against a political tide include the AHS board and top management who were fired for their efforts. Sir Thomas More had many noble principles and was executed for his fixed position. He said about public service:

"You must not abandon the ship in a storm because you cannot control the winds. What you cannot turn to good, you must at least make as little bad as you can."

No 6: Deeper is not always better.

Many divers are proud of their deepest dive. The challenge to go deeper provides great examples of fatal stupidity. After two divers died off the UK coast, the headline read: *"Divers doomed by stupidity. Inquiry told of insufficient air in scuba tanks for attempts at personal bests off Mull."*

These guys attempted a dive which was simply beyond physiology, physics and even logic. The 'plan' was to dive to 70 metres / 230 feet while breathing air. That is approximately seven atmospheric pressures. One can guestimate their nitrogen narcosis at 230 ft. to drinking about 5 martinis / 15 oz. of hard liquor! Oxygen toxicity, which causes seizures, is calculated to happen somewhere below 180 ft. In addition, they did not even have enough gas in their tanks to compete such a dive because each breath at 230 ft. depth takes out the volume of approximately seven breaths at the surface. Darwin would be proud.

The simple analogy for most of us is to do only that which we are appropriately trained for. The trickier question is about overarching healthcare decision making. What happens if the person who has complete power over health care makes a decision which flies in the face of logic?

And my truism for diving and health care:

No 7: Don't piss off the fish with big teeth!

Editorial: A prescription for change

A political prescription for Alberta physicians: It's about the patients.

Dr. Michael Giuffre, MD MBA AMA and CAMSS past president

I feel that somehow, most would think I am qualified and perhaps even justified, in writing an opinion piece on the politics of health care delivery in Alberta. My most recent eight-year stint with the Alberta Medical Association has ended, and this was preceded by previous positions within the medical staff associations of the Alberta Children's Hospital, the Calgary Regional Medical Staff Association (CRMSA), Calgary and Area Physician's Association (CAPA) that became Calgary and Area Medical Staff Society (CAMSS) with regionalization, as well as the Calgary Medical Society (CMS).

They don't teach politics in medical school or residency, but after 20 years of representing our profession and patients in various stakeholder capacities in the public healthcare system, I firmly believe we should make political training mandatory curricula. Most physicians I know would far prefer to leave the politics to the politicians, but in our current health care system, where political considerations take precedence over medical outcomes, a basic political understanding and aptitude seems essential.

After all, ignoring politics doesn't free you from its grip. Case in point: Alberta's healthcare system changes over the past 20 years.

As physicians, we have had to participate, either actively or passively, in Alberta's tortuous health delivery journey. This has largely been a forced journey, as we have had no choice but to respond to a wide assortment of decisions and changes made by various political and medical leaders over these twenty years.

These political health care decisions, seemingly made with voters in mind, yet ignoring patients (though they are one in the same), has left health care personnel, including all the members of our healthcare teams, exposed to turbulence, instability and uncertainty that continue to this day.

These ill-advised decisions scatter the landscape; the list is long, but this article is short. The intent is not to chronicle them all, rather point out some for context, mainly as a cautionary voice of concern, and also directed toward the newest set of enthusiasts that are bent on finding the next fix to our broken, expensive, healthcare delivery system in Alberta.

Without circumspect and learning's from the past, and the ability to share pain as a form of catharsis, we cannot even hope for an improved value for dollars spent on healthcare in Alberta. We all know that close to 50 per cent of Alberta's annual provincial budget is spent on health care and that 2014 evaluations give healthcare less than favorable ratings. Translated this means that today, a health care dollar spent in Alberta, does NOT translate to maximal value for the patients we care for. It seems as we spend more and more, we achieve poor ratings on patient care.

Context is always important, so let me continue to outline relevant background. In Alberta, we actually spend $18-20 billion a year on health care. The annual AHS budget is in the order of $15-16 billion. For comparison, the physician services budget that is used to pay physicians annually, and managed by the Alberta Medical Association (AMA), is in the order of $4 billion.

Most health care delivered in Alberta is still done in the community by individual medical practices, with only about 10 per cent of overall care provided within our institutions or hospitals. You wouldn't know, from looking at just health care spending that roughly 80 per cent of all health care dollars spent in Alberta are under the direction of AHS. Yet, most care in Alberta is delivered directly in the community, and not in an AHS facility.

How did this happen? Let's briefly travel back into the years that immediately followed regionalization. In the good old days, there were two meaningful styles of CEOs, representing the two big regions, Calgary and Edmonton. They dominated the political health care arena, with little if any significant or directional involvement of Alberta Health, other than paying the bills.

. . . roughly 80 per cent of all health care dollars spent in Alberta are under the direction of AHS. Yet, most care in Alberta is delivered directly in the community, and not in an AHS facility.

The management styles of the two CEOs were indeed vastly different. One was a style that was top-down, demanding to know and manage every decision, and every expense down to a paperclip. That style we could deem to be the bureaucratic or a closely governed approach. The other CEO was the ultimate in contrast, with a plan of an autonomous, progressive, team-based system approach, with localized, bottom-up decision-making, and implementation. Jack Davis was not appreciated by the powers of the day and that era came with a crash landing.

When the political winds changed in 2008, a new premier, a new health minister, and a majority government became the flavor of the month, The past health care decisions in the south of the province reflecting autonomy in governance and management, were no longer considered wholesome or desirable traits by politicians, even if they did appear to improve delivery. In fact, this type of common sense decision-making with grass roots physician involvement was to be permanently stamped out, and is gone to this day.

The big move to a single health care region for all of Alberta occurred in a backdrop of no significant planning and certainly without the perceived need of any change management. Health care workers, including physicians, were unceremoniously joined together. We were all now joined as a one happy messy disjointed single region, for the sole benefit of economies of scale.

Continued on page 10

Of course, now this single region decision necessitated a deluge of executive compensation packages. These packages would continue to abound for more than a decade, until the next series after series of ongoing changes, and the next round of severance packages.

However, what is even more appalling is that we, the health care providers, were duped or lost in this profound provincial health care shuffle. Only one particular style of CEO management has prevailed for the now massive single region, called AHS or Alberta Health Services. This has turned out to be the bureaucratic style.

Our health care system would grow and expand, to become a quagmire of bureaucratization that continued to stifle even the strongest of heart and even those with a sense of determination. Our most recent former health minister prided himself as hands-on, intrinsically knowing, single-handedly, what was best for all of us and made it so.

Ignoring any acceptable form of governance model, we became horned *[Editor – get it!?]* into a new model of healthcare that drove all power to AH. With the ministry of health now becoming the sole decision maker for all things capital or operational, puppeteering the enormous AHS machine and its associated hierarchy.

Shenanigans such as firing of the AHS board and reassigning the past 180 vice-presidents of AHS, so they could be placed further down from the AHS command center, has done did little to garner perception of AHS system competence. Physician engagement remains at all time lows, with 24-28 per cent of physicians rating themselves as engaged, merely reflecting an ongoing disconnect of doctors within the AHS system of care. Incidentally, and for comparison, AMA has an engagement rating of 96 per cent for Alberta's physicians.

At the AMA representative forum (RF) held just last month, I had to hold my nose and bite my tongue, as I heard from the latest well intentioned AHS leader say, stay tuned, for the next new and better way of doing business for AHS.

Most disturbing, is that AHS sees an expanding role for itself into primary care and the community, because there is no way for the, health care system to work until this part of health care runs better. They feel the path to running better is to put delivery decisions in their hands, one step removed from patients, their physicians and health care teams.

In Alberta, we spend more on hospital and institutional care than almost any other province.

The notion that the least efficient and least effective part of health care feels it needs to have more control in governing the most efficient and effective part of health care should be disturbing to patients and taxpayers (one in the same).

Further we heard that AHS needs to get doctors involved and engaged to get the AHS health care system to work and that this will happen via the new fangled strategic clinical networks (SCN) — a series of AHS, top down, specialty care network systems, in a dozen or so major areas of medicine and surgery, all mysteriously commencing at once.

Our new health minister, too, wants to fix the Alberta's health care and publicly stated that AHS is "the single biggest problem that the minister and the new premier has."

Startling, and yet we now have the expansionist leaders of AHS saying they want to add-on and cover off primary care and health care in the community.

I don't have the answers to the new ministers quandary. I do know a fact that is most concerning for health care providers. In Alberta, we spend more on hospital and institutional care than almost any other province. It turns out that hospital and institutional care is the most expensive, the most demanding of health care providers and, most importantly, least productive for patient outcomes.

One would think that moving care from the hospitals back to the community, in every situation that is safe and reasonable, with appropriate community based support services, would be an ideal path to travel for the new minister and his new AHS.

It may also seem logical to some, including the new minister, that expanding is the last thing that should be on an AHS agenda. Rather, it should be significant contraction, with streamlined efficiency in a single core competency that is vital but currently NOT happening. Core competency of running each and every hospital and institute, in our province, at peak performance in every way required, to provide safe, timely, quality for acute and surgical care. This is not rocket science, it is about core competencies, and in my view, AHS has lost its way completely.

What happened to the days of putting the patient first? Of bringing the system to the patient instead of forcing a patient to navigate a complex AHS system of care?

We need to get back to the basics. A bold minister and premier would perform a cost cutting contraction of the AHS budget. The ministry for once, should give meaningful direction to AHS to focus on its single core competency — hospital care excellence — and move all other funds out of AHS control and purview.

These moved funds would be reallocated to deliver care where we live, in our communities, and should be preventative in nature, comprehensive and non-institutional. This would become a well-supported, non-AHS, true health care system that actually works, and does everything it can to prevent the need for hospitalization. It would become excellent at keeping patients out of hospital once they have been discharged from hospital treatment, expanding the concept of the medical home that the AMA and other primary care doctors have been trying to promote for years.

I don't think the enemy is AHS or its administration. In fact they are hard working and as frustrated as you and I. They have simply been taken down the wrong path and no matter how they tweak or revamp, we end up spending more and getting less. Not because those involved are not trying, but because they have been told what system is best for them, by a set of politicians, that are well meaning, but directing a path without the knowledge or even a compass.

As a profession, doctors are naïve about politics and politicians. We focus on patients, and are often in the role as the leaders of our health team. We want the system to work and in fact need the system to work for our patients to achieve world-class care.

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It is time for doctors to engage our patients, individually and through the AMA, to include them in the conversations that set health care delivery expectations and the actual implementation of all aspects of the health care system.

As a profession, we must be given back our voice, not just within AHS, but also in the wider health care system. The government has tried to pit elements of our profession against each other to their advantage. The illusions that doctors are heard through the College of Physicians and Surgeons or AHS, is simply used against us.

Many of our patients continue to look to us, as medical experts, for more than just advice on their own health. They look to us as the most credible source of information about the health care system and how to make the system better. Yet we have had no collective voice.

We do need to engage our patients in this discussion and get them involved. We need to talk to them about their needs and desires from the health care system, and we need to involve them in discussions about proposals coming forward. Only by listening will we be an effective voice on their behalf.

My closing advice to our profession is to get involved in your section in the AMA, and encourage your section to move towards a sense of readiness, that engages your colleagues and your patients.

Our physician agreement with AMA and AH has not progressed all that quickly. We still do not have an EMR/EHR integrated system that works for doctors and patients or a provincial framework for electronic health care provision. AH and AHS have not widely embraced the concept of system wide efficiencies nor capitalized on choosing wisely. There are too many stakeholders playing the game of primary care reform without a clearly endorsed plan accepted and implemented. We are being effectively bureaucratized in our failing health care system.

We are being effectively bureaucratized in our failing health care system.

A general election is only 18 months away and we do not want to hear of a new health care direction without representation from both a strong united physician voice and our patients' voices at the table.

Actively support our provincial medical association, the AMA, and speak with one voice on behalf of the profession and in pursuit of excellence in health care. Use the position we have negotiated with our agreement to influence the system positively, but without playing politics and political favorites.

Be a credible voice for our patients — we engage them and welcome them to the dialog.

We have a long journey ahead but as a profession, we MUST lead the way. Get engaged and lead the way doctor!

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By Dr. Scott McLeod, University of Alberta, pediatrics resident physician

Managing the distribution of physician resources is crucial to providing the best possible health care to Canada's population. The availability of family physicians and other specialists is often a limiting factor to providing this care. For the most part, tertiary care is provided in major city centres and is dependent on smaller numbers of specialists and subspecialty resources and nursing expertise. Canadians living outside of these centres often face extended travel for their medical and surgical care. Even in cities, timely access to necessary surgical procedures or medical care is challenged by the large number of patients needing care and the systemic factors limiting space or personnel available. In today's health care system, the recruitment of appropriate numbers of family physicians, other specialists, and subspecialists in order to meet the needs of the Canadian population is of great importance. For this reason it is prudent for governing bodies to inform current and future trainees about current fluctuations in the medical workforce and the predicted future needs of the population so that future physicians can make informed decisions about their career choices and career practise location.

Currently, efforts are underway at multiple levels to improve physician workforce planning in Canada, however, it is a complex problem. The Royal College of Physicians and Surgeons of Canada recently held the first national physician employment summit in Ottawa to address the work which needs to be done to match highly trained physicians with patient needs. Prior to this summit, in fall 2013, a study was released assessing the number of physicians in each discipline of medicine, the geographic areas where physicians are practising, and the factors behind unemployed specialists in the country. Interesting results from this study included that up to 16 per cent of new specialist and subspecialist physicians reported difficulty in finding work and 31 per cent of those surveyed pursued additional training in order to improve employability. Many areas were discovered with unemployment or underemployment

Ultimately, in this era of long wait times, budget limitations, and patient struggles to find primary care physicians, our health care system needs to maximize the efficiency and effectiveness of all health professionals. The specialty societies, the College of Family Physicians, and university medical schools all have a role to play in ensuring that medical specialties are not subject to boom and bust employment cycles. Being able to highlight areas of need would not only improve health care provision but reduce the disappointment and frustration currently being experienced by resident physicians struggling to find employment.

One example of an initiative in pediatrics is a study examining the number of medical trainees in various pediatric subspecialties, and then projecting the need for their services based in part on the number of doctors retiring over the next five years at each of the 16 academic hospitals across Canada. Although there are difficulties in every study of this nature, because they cannot necessarily control for events which may change the population of a location and cannot always accurately address migration of physicians from foreign countries, they provide useful information to trainees that improve job prospects.

PARA
Professional Association of Resident Physicians of Alberta

Dr. Scott McLeod

There is still a long way to go in addressing physician workforce planning; however, recent developments indicate that more information will be made available to trainees and current practitioners to assist with career decision-making, as well as to ensure the well being of Canadians by providing adequate access to health care.

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