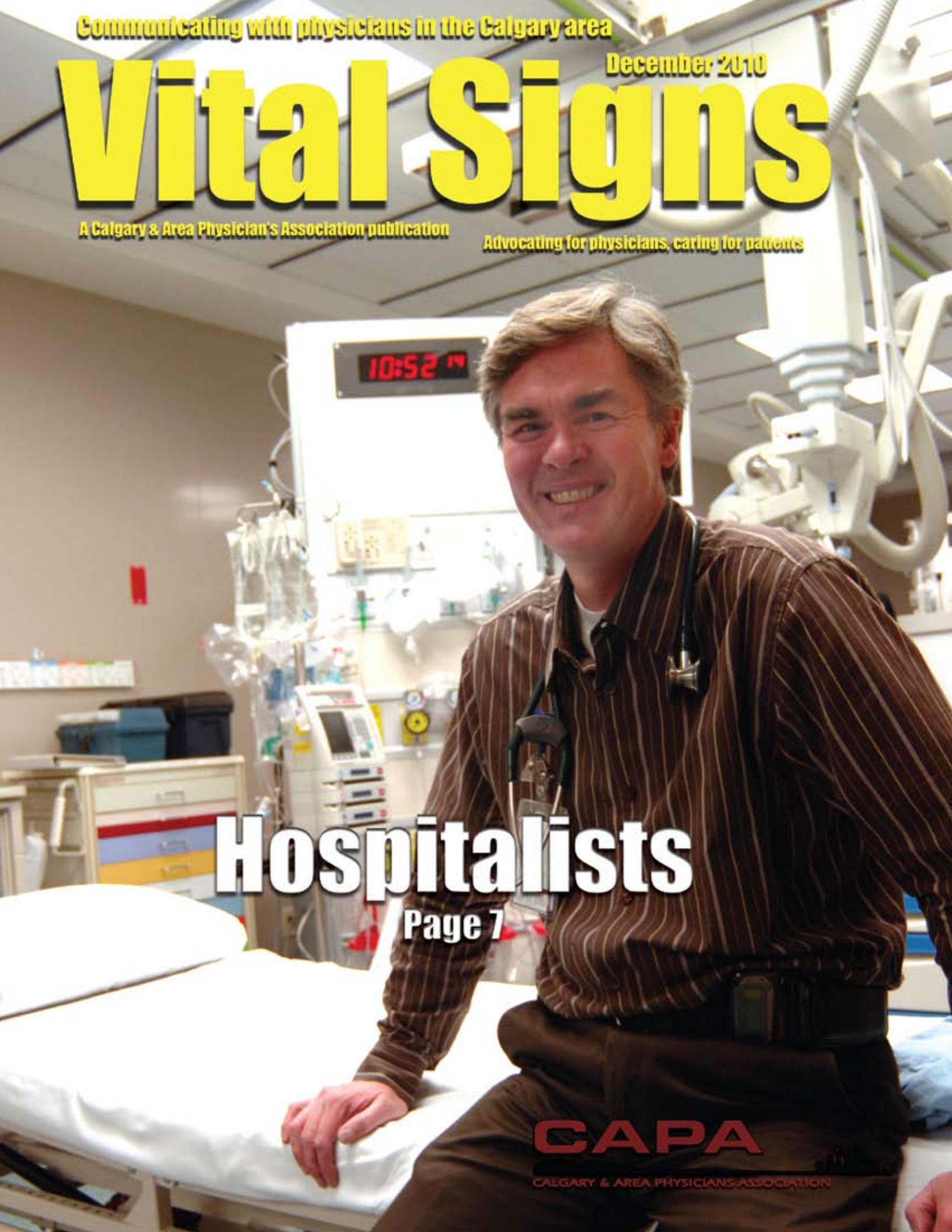
Communicating with physicians in the Calgary area

December 2010

Vital Signs

A Calgary & Area Physician's Association publication

Advocating for physicians, caring for patients



Hospitalists

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CAPA

CALGARY & AREA PHYSICIANS ASSOCIATION

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A Calgary & Area Physician's Association publication
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CAPA executive - Please feel free to contact your representative with any concerns or issues.

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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.

Please send any contributions to:
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Vital Signs reserves the right to edit article submissions and letters to the editor.

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Advertising:
Claims made in advertisements are not verified by CAPA and CAPA assumes no responsibility for advertising accuracy.

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On the cover: Hospitalist Dr. Han Friesen in the Rockyview's new emergency department.
Photo by Dave Lowery

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- PICK UP AND DELIVERY OF YOUR LEXUS VEHICLE
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IS 250	HS 250H	ES 350	RX 350
			
FROM $37,208	FROM $42,382	FROM $44,752	FROM $49,702
CASH PURCHASE INCENTIVE $3,500	CASH PURCHASE INCENTIVE $7,000	CASH PURCHASE INCENTIVE $3,000	CASH PURCHASE INCENTIVE $2,000
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The change we need?

From the CAPA president

This month, being the festive holiday season, I thought I'd give everyone a break and perhaps reword some holiday tunes. Given the abysmal state of the system, however, there really isn't any politically correct way to do this. Instead, let's spend some time reflecting.

Think back over the last two years and ask yourself what one word best describes what we have been through with the advent of AHS. The word that pops to my mind and perhaps most readily encapsulates the ordeal is "change."

As a psychiatrist, the word "change" brings to mind an old 'light bulb' joke. How many psychiatrists does it take to change a light bulb? The answer is one. One psychiatrist but the light bulb has to want to change. Perhaps amusing at best but the joke becomes an interesting thought exercise if we switch it around a little bit. For instance, what if we change the question to "how many physicians would it take to change the system?" Would it take only one physician and perhaps more importantly, does the system want to change?

Taking it a step further, a certain AHS executive might ask, "how many administrators would it take to change physicians?" Would it take only one administrator and moreover, do physicians want to change?

These days, change is perhaps a much-overplayed word. Say the word and I think of the United States and of President Obama. You may remember the slogans – "yes we can" and "the change we need." The majority of the American population seemed to want change when they voted for Obama. I'm not sure that they got what they wanted but Obama certainly paid a political price during the recent midterm elections. I wonder if any other political entities closer to home will soon be paying a similar price.

When we look at the changes in our own healthcare backyard, I wonder if eliminating the health regions and creating a super board were the changes that we needed. Were they the changes that we wanted? Moreover, have these changes been effective? Are we, the system or our patients, better off now than we/they were two years ago?

On October 30th I returned from a conference in California. As is my pastime I enjoy engaging cab drivers in conversation. On this instance Salil and I started to chat about health care. At some point he noted how much better our Canadian system seemed to be. I suggested to him that in some ways our system is perhaps better but in other ways not. He seemed a bit shocked by this revelation apparently thoroughly disgruntled with his own system. "What isn't better about the Canadian system," he asked. I shared with him recent news stories including the problems in our emergency departments with patients waiting up to 20 hours lined up in hallways, at times seriously deteriorating. Meanwhile, other patients simply give up the wait, choosing to leave the ER and to hope for the best. His response was one of disbelief. "This could not be because that is what happens where I come from, Eritrea a third world country. I can't believe that that would be happening to people in Canada – such a wealthy country. How can this be," he said.

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

Yes, Sal, how can this be?

Although the situation in the emergency department has been front line news since the end of October, notions of adverse patient outcomes as a result of excessive delay and waitlists is likely not news to any of us working in health care. The lack of public discourse and associated political inaction stems likely from the fact that we have all been so intimidated that few dare to speak out openly. After all, the ER story only made it to the front page of the Herald as a result of a leaked email.

Are we better off as a result of these changes and the advent of AHS? Are our patients better off? Is our morale any better? Perhaps I'd better stop asking questions since if I proceed any further I might be at risk of causing mass depression. Maybe we aren't entirely better off yet but I do hope that once this behemoth known as AHS gets up to speed some real helpful changes will be forthcoming. Thinking about it, things better start to happen soon since I certainly wouldn't want to think that real beneficial change and problem solving only materialize after the issue lands on the front pages of the Calgary Herald. If that is the case, the new year might see all of us standing in a new line - a line to talk to reporters. Physicians would have much to say to reporters about the state of health care unlike a certain AHS economist who deferred comment in favour of his cookie.

Watching the cookie video, the arrogance of Marie Antoinette came to mind. My two year-old might think that a cookie was more important than talking to people, but my nine year-old astutely pointed out that the behaviour was unacceptable. "Those reporters were asking serious questions about serious problems in health care," yet our appointed leader attempted to brush them aside like so many crumbs. Sigh.

Once again, one doesn't know whether to laugh or to cry. Given the season, lets try to laugh, to unwind and to spend some time with loved ones. Happy holidays everyone and let's be careful out there.

May I see the doctor in charge, please?

By Dr. Lloyd Maybaum, CAPA president

Editorial

By virtue of education, training and responsibility, physicians and surgeons are the natural leaders in health care. Thirty years ago and before that, the system generally reflected this truth. Somewhere since then, things have gone awfully awry.

Over the years, our influence has waned. It seems hard to say exactly how it happened but perhaps pundits and special interests increasingly desired power and seemingly complained that MDs had too much power and influence. Perhaps our elected representatives wanted greater transparency and accountability – a rich irony given the painful lack of both commodities in our current system. Regardless of how it happened, the steady erosion of physician-managed health care has gradually unfolded. Sad, though, since back in the day we had a healthcare system that actually worked. For instance, there were no waitlists or 20-hour delays in emergency hoping to see a doctor. This was in part because doctors could admit directly to the hospital and bypass the emergency all together. Of course, back then we always had some empty beds. Today's health care rationing has handily done away with these "quaint" practices by ensuring that we never have empty beds.

Back in the day when doctors were in charge, if patients had to wait in emergency for even a modicum of time, heads would roll. This is presently not the case due to the steady and fervent erosion of physicians' power and influence. Our system has seemingly gone to hell in a hand basket and the only time that heads roll is when news of the sorry state of the system breaks out into the headlines. Even then, the only things that seem to roll are eyeballs.

Massive changes are increasingly playing a role in provinces across the country and countries across the globe. For instance, Ontario is laughably undergoing a process of regionalization. I shudder - don't they realize that Alberta tried this already and it didn't seem to work.

If we want to see some real ingenuity we perhaps need to look across the pond. In the UK for instance, a white paper was published in July 2010 entitled "Equity and Excellence: Liberating the NHS." This paper, signed by the British prime minister, deputy prime minister and secretary of state for health, proposes returning power to family physicians.

The opening salvo notes; "Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients. Of course, our massive deficit and growing debt means there are some difficult decisions to make. The NHS is not immune from those challenges. But far from that being reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation." Moreover, they note that doctors must be able to use their professional judgment about what is right for their patients.

Perhaps the white paper doesn't represent real ingenuity but instead reflects the blatantly obvious lessons that have been forgotten over the last 30 years. I would suggest that excluding physicians from the decision-making process, particularly at the local level, is responsible for the majority of the erosion and deterioration of our health care system. The UK seems to have woken up to this reality.

The white paper proposes that England's 29,000 family doctors take charge of the majority of the National Health Service's 110 billion pound budget in a massive shake-up. Currently, managers of local health authorities, known as primary care trusts (PCTs), are responsible for 80 per cent of the NHS budget. These funds pay for GPs and dentists and the cost of treatment at hospitals and clinics. These managers are now viewed as an unnecessary layer of bureaucracy that prevents patients from getting the best care. By putting GPs in charge of the PCT budgets, it is hoped that patient outcomes will improve and money will be saved.

In my mind, Britain is years ahead of Canada when it comes to health care innovation and experimentation. In other words, where we are in Canadian health care, the UK has already been there, done that. They now seem to be bailing on the cadres of middle management in their system and placing their faith, once again, in doctors. In my opinion, they have seen the light.

Many years ago, when the health care system actually functioned well, physicians ran hospitals, ran the boards and essentially made all of the key decisions. These days, if we are kept in the loop at all it is simply to be informed of the decisions made by others or perhaps to provide 'input.' We have no actual authority or influence over the final decisions. We are now worker bees and essentially have none of the influence and decision making authority that we once had when Tommy Douglas first introduced universal health care in the 1960's.

On the bright side, due to the incredible marginalization of physicians, at least we shouldn't be blamed for the problems currently plaguing the system. If we are to be blamed for anything, it is perhaps for not speaking out often enough or loud enough.

Our elected representatives need to recognize that physicians are not the problem. We are the solution. Give us back a real voice, real influence and substantive decision-making authority and we'll show you how to fix the system. It is time for government officials to wake up and take note.

Rationing acute care is not a solution to our health care woes

By Carolyn Lane

I know I risk accusations of being too simplistic, but hear me out nonetheless.

I have lived through several transformations of our health care system; some major such as the restructuring of health regions up and down in numbers (including the formation of our current megaregion) and some less noticeable such as the shift of urban family physicians out of the acute care setting. I confess I consider myself a major instigator in some of the activities, most notably the provision of family medicine obstetrics in a low risk maternity setting. Some changes have been for the better, but many of the changes have resulted in one clear reality. Health care is being rationed.

Now, one could make an argument for the rationing of health care. Designation of medically necessary services and non-insured services is a good example of health care rationing. This should ensure Albertans have access to all medically necessary services and that market forces take care of non-insured services. (What is designated as medically necessary is a whole different debate we have been assiduously avoiding for decades.) However, in Alberta, our health care rationing is occurring at many levels and appears to occur as a series of budget cutting measures; fewer acute care beds, fewer long term care beds, reduced operating room access and many other activities. When health care rationing is done in this manner and not as a carefully designed process to provide the most cost effective and cost efficient care for all Albertans, then chaos ensues.

I read with dismay reports such as the sorry state of vascular surgery in the city of Calgary (Vital Signs, October 2010) and the experiences of many unfortunate Albertans in our emergency departments. All the more troubling is the multitude of similar stories out there: operative procedures rescheduled repetitively, patients housed in broom closets as 'temporary' beds, waitlists for diagnostic testing, Albertans unable to find a primary care provider, 'bed-blockers', transfers between sites, cities, provinces and even out of Canada for lack of resources of one kind or another. All these stories have one thing in common; our health care rationing is costing us a lot of money, time, resources and suffering.

What if we didn't make people who required a long term care bed wait to access that bed? Well, those in an acute care bed would vacate it earlier, receive less expensive care in a more appropriate setting and free up space for those who require an acute care bed. Those in the community would be able to transition to long term care at the right time, they would be at less risk of injury or medication error while remaining too long in the community (resulting in fewer acute care admissions) and their family members would be able to continue their full time day to day activities without interrupting their lives to become untrained long term care providers for aging parents and others, resulting in a better level of productivity for the province.

What if all Albertans had access to a primary care physician or physician-led team? Among other things, access to primary care results in more timely intervention for significant medical illness, better utilization of health promotion strategies, appropriate use of specialist services for consultant care instead of primary care, a reduction in need for emergency department services when used for primary care or when preventable and treatable illness left unattended becomes an emergency.

Carolyn Lane, MD, CCFP, FCFP, assistant clinical professor, department of family medicine, faculty of medicine, University of Calgary

What if there were enough acute care beds in the system to accommodate those in need? Then, people would receive acute care in the most appropriate setting in a more timely manner, there would be less backup in the emergency department, there would be fewer transportation costs shifting patients around the system, complications and suffering would both be reduced resulting in a reduced length of stay in the system and all this would result in a reduction in health care costs.

What if there was enough operating room time and the most appropriate equipment to provide timely access for both urgent and elective procedures? As those awaiting surgery require medical resources to help endure the wait (pharmacotherapy, physiotherapy, acute care beds, and temporizing procedures) interim health care needs would be reduced. Complication rates would also be reduced. Cancellations of procedures due to 'bumping' would be rare resulting in more efficient use of physician and staff time as well as being less disruptive and distressing to patients. Albertans would lose less time from work and once again, the productivity in Alberta would be enhanced.

All this brings me to my simplistic conclusion. We should not be rationing our health care resources through a rationing of infrastructure and operational funding. There should be surplus capacity in the system to accommodate the ebb and flow of need. Alberta's population including our human health resources are our most valuable assets and we should be doing everything we can to ensure we do not waste those resources. Care that is designed to be the timeliest, most efficient and evidenced-based care will result in the most appropriate use of our health care providers' skills and time while resulting in the healthiest and most productive population in Canada. Now that is a transformation I would truly love to be a part of.

By Dave Lowery

You are sick. You go to the emergency department. Eventually an emergency physician examines you, determines your diagnosis, and asks who your family doctor is. Since your family doctor has admitting privileges at the hospital you are currently in, you are admitted. Within a day or two your family doctor visits and manages your care. Though that sometimes still happens, chances are greater now that your care, while in hospital, will be managed by a hospitalist – not your family doctor. Hospitalists generally specialize in internal medicine, family practice or pediatrics and about 10 years ago, they began to appear in Calgary at all sites. At that time, on average, hospitalists saw roughly 20-40 patients per day at each site. But that number has grown significantly to around 200 patients per day, or up to 600 patients in Calgary. Dr. Han Friesen, 48, was there at the beginning and has spent his career at the Rockyview with a few sojourns out to the Calgary General hospital, Peter Lougheed Centre and Holy Cross. Friesen obtained his family medicine specialty at the University of Calgary and was attracted to institutional work.

"I like having a lot of colleagues," Friesen says. "And it's wonderful to have lots of investigative tools at your fingertips."

Friesen says hospitalists are somewhat a victim of their own success as the number of patients they manage has increased exponentially.

"In the past 10 years, our volume has increased about eight times," he says. "Each week I'm personally on call for 15-20 hours and patient care consumes another 20-30 hours. The biggest change has been the sheer volume but the second factor that has become obvious is that the acuity of patients has gone up. We take care of very sick patients now and specialists take care of even sicker patients."

Friesen says the combination of medical care advances and the congested system can sometimes lead to very frail patients arriving at the hospital.

"Most patients used to have one main diagnosis but now it's not uncommon to see one patient with three severe and complicated diagnoses," he says. "I would have to say that once you are in the system, it works reasonably well. But the infrastructure has not kept up with the demand, which far outstrips our available bed numbers. Most of the time we don't have major problems doing our jobs but we are seeing a large load of elderly frail folks who probably don't need the acute setting."

He says there are not enough out-of-hospital spaces for the ill elderly to be taken care of.

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"The south hospital is not as necessary as a hospital as much as it could be a long term care facility," Friesen says. "What we really need are more assisted living facilities. That would make a great difference to the need for acute beds. We can't get people in because we can't get people out. It's not an emergency department problem. Our long-term care facilities have not kept pace in our city. Pretty well everyone agrees that is the cause but it's a very challenging problem to fix. Once a decision is made to build another hospital, you have to see it through to the end but by the time it's done it may not be needed anymore. In this city of a million people I'm not sure we really need another hospital on top of the three major hospitals we already have. Right now we really need a few more nursing homes."

And though family medicine has had troubles attracting new physicians in the past five years, Friesen says the hospitalist option seems to be gaining ground as a viable family medicine option.

"Our experience with residents suggests that we won't have nearly as much difficulty as some other programs might," he says. "There is an increased interest in family medicine because it's an issue of lifestyle and cost. Additionally, the family medicine option is a relatively short training period in an era of very high educational costs. It's become more attractive because you can get out and work earlier. It's become more obvious that the family medicine option is attracting more medical students due to the hospitalist position. We're young. We're a very new part of the system and we're doing work not done before. It's different than it used to be; there's been rapid growth and lots of opportunity. The landscape really changed and the need for hospitalists grew very fast. We became desperately needed as full service family medicine rapidly lost practitioners for a variety of reasons. But that created a need for hospitalists."

The new south hospital. Is it needed?

By Dr. Patrick J. (P.J.) White, president, Alberta Medical Association

Dr. Raj Sherman

Dr. Raj Sherman – MLA (Edmonton-Meadowlark) and the only physician in the 68-member government caucus – ignited a political firestorm recently when his email to Premier Ed Stelmach, a number of PC MLAs and numerous other recipients became public.

Dr. Sherman has been, and continues to be, a tremendous advocate for patients: as an emergency physician, as the former president of the section of emergency medicine, as a first-term MLA and as the parliamentary assistant to the Health and Wellness Minister Gene Zwozdesky and his predecessor, Ron Liepert.

Patients and the medical profession in Alberta – family physicians and general practitioners, specialists and sub-specialists, medical residents and medical students – share the frustrations and concerns that prompted Dr. Sherman to take his own government and Alberta Health Services (AHS) to task.

As physicians, we want a health care system that puts Patients First®, where there is timely access to quality care. That, after all, is governments' social contract with Canadians.

Actions NOW for a 21st century health care system

Transformation of the health care system requires the focus be Patients First®. Last week I wrote a letter to each MLA that offered actions the government and Alberta Health Services can, and should, start planning for now even if they won't immediately fix the current problems.

We need to pursue a number of ideas if Albertans are to have a health care system that is effective and sustainable for the 21st century. For example:

1. Primary care networks – which are led by family physicians – are popular with patients, but we need more of them and we need to support the current ones better so that their primary care teams can do more. Having physicians leading the teams is important to avoid fragmentation of care.

2. A second area is developing an electronic health care system.

a. Medicare should make telephone advice from doctors available. It would be much more convenient for some patients.

b. The same holds true for using the Internet to provide care for some patients. (The telephone was patented 144 years ago. We can't afford to wait another 144 years to begin using the Internet in the year 2154.)

c. Every Albertan should have her/his electronic health record.

d. We need to continue computerizing physician offices.

Transformation also requires a change in the culture of Alberta Health Services. AHS' own research shows dismal levels of physician engagement.

ALBERTA MEDICAL ASSOCIATION

This dismal situation is repeated at the broader provincial level in AHS' failure to truly engage the medical profession through its professional association, the Alberta Medical Association. (Some AHS officials, in a disparaging way, describe your association as just a union).

Another cultural change that is required, by both the Alberta government and Alberta Health Services, is to truly value partnerships with the Alberta Medical Association and with others.

Other elements for this transformation identified in my October 29 President's Letter included:

- Having a personal family doctor for every Albertan by developing "incentives to increase attachment to physicians through value-added services."
- Enhancing patient-centred teams by abolishing the antiquated "white of the eyes" rule that prohibits physicians from billing for services provided by other health care providers, like lawyers/paralegals and dentists/dental hygienists.

In addition to primary care payment reform and innovation, the Alberta Medical Association is pursuing options and ideas such as:

- Specialists' linkages to primary care
- Electronic communications between specialists, patients and primary care physicians
- The important role of academic medicine
- Academic alternate relationship plans
- Physician contributions in the clinical networks being developed by Alberta Health Services

Emergency departments

As physicians, we know that the situation in emergency departments, although serious and even dire at times, is a symptom of a health care system in distress: they are a highly visible focal point for lapses and shortcomings beyond the ER walls. Moreover, solutions also exist beyond the ER walls.

The delivery of health care in Alberta can continue to lurch from crisis to crisis to crisis, along with a superficial diagnosis and a patchwork of short-term "solutions."

Or, as the Alberta Medical Association advocates, the province can – and should – implement actions that will not only deal with the present but will also ensure Albertans have a health care system that is effective and sustainable for the 21st century.

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

CAPA classified

2010 FMC Outstanding Clinician Nominations

Nominations are being accepted for the 2010 Outstanding Clinician Award for FMC primary site physicians. Please forward your nominations noting the following information.

Nominations should be made in a letter addressed to:

Clinician award nomination committee

c/o the Medical Staff Office, Room 154J, Doctors' Lounge, FMC

Please include the following:

- Name and department of the nominee
- How you feel the nominee has met the selection criteria
- Name of person or persons nominating the individual
- CV of the nominee if possible

The deadline for nominations is Friday, January 28, 2011

For more information and nominating criteria, please contact Susan Sauvé in the FMC medical staff office at 403-944-1409 or email: susan.sauve@albertahealthservices.ca

Family physician needed

Lynnwood Medical Clinic, in Southeast Calgary, is looking for a part or full time family physician to start on or after June 1, 2011. Great colleagues, staff and location. Newly renovated clinic with electronic medical records. Part of the Mosaic Primary Care Network with a chronic disease nurse, behavior health consultant and shared mental health program.

Contact: Dr. Joan Meldrum or Dr. Mark Sosnowski
Telephone 403 279 3311 or tnt.lynnwood@shaw.ca

In memoriam

Dr. Robert Douglas Wickson

February 25, 1947 - October 9, 2010. We lost our beloved husband and father suddenly while visiting our son Michael in Yellowknife. He is survived by his wife Jane, daughter Jennifer, sons Steven, Kenneth, and Michael (Amber), his brothers Ron (Diane) and Dave (Jacqui) and many nieces, nephews and cousins. We will always cherish the memories of his love and care for his family, friends and patients.

Times of change

From the past president

As Calgary and Area Physicians Association (CAPA) president, Lloyd Maybaum pointed out at the last ever general meeting of the CAPA, these are times of change. Musically put, "the times, they are a changing" a la Bob Dylan.

Dr. D. Glenn Comm, CAPA past president

The coming year will bring about wholesale changes in the structure for medical staff representation in our province. The good news is that all doctors, province wide, will be included as members. They will have the opportunity to get involved and to have their say in some of the areas of the province where such activities have not been supported by prior AHS administration. The Alberta Medical Association (AMA), recognizing the value that it brought over the years, is considering the expansion of Vital Signs to a province-wide newsletter which many of us have dreamed it could become. I hope this happens so in those areas of the province where doctor's voices have been stifled these doctors will be then be able to publically address their concerns through writing about their issues in Vital Signs. This will be a very positive step for most of the province.

For years at the AMA representative forums some of the same issues from the same areas of the province have been on the agendas for years with no seeming change. I hope that doctors caught in those binds will be empowered to go public with their concerns.

The dichotomy is that for Calgary, it is a step backwards. The funding levels that CAPA has been accustomed to operating on will NOT be in place. One of the secrets of our success was that the mandatory dues structure that has been in place has allowed CAPA to pay doctors who take on medical staff association roles without a huge financial hit. I am concerned that this will not be so in the "new reality."

CAPA has raised awareness and been an agent of change for many years. Two examples are issues in family medicine and vascular surgery (which is ongoing). It was able to do so, in a large part, due to the mandatory membership fee structure. The new fee structure will NOT replace the budget that has kept CAPA running for the last number of years. The structure that replaces CAPA in the Calgary area will be allowed, if it chooses, to ask for additional dues above what is automatically paid on member's behalf through the new structure. IF the new executive for the Calgary area decide that additional funding is needed I would urge you all to support those needs with your votes and funding.

I have seen, close up and personally, the mindset of SOME, not all, AHS administrators. Some are great, others I am reluctant to turn my back on. As we advocate for physicians and care for patients we also need to unite as a profession. As one of the American revolutionary leaders is quoted to have said, "we must all hang together or we will surely hang separately." (For any hyper sensitive AHS officials this IS a figure of speech).

As always, your comments question, praise and poisoned darts (no gallows please) are welcomed at glenncomm@shaw.ca

Capital regional medical staff association update

by Dr. Richard Bergstrom, president

The have's and have not's

I had the most wonderful experience the other day. My patient had rheumatic fever as a child and now, significantly later in life, needed a double or triple valve replacement. Her age, in addition to her medications, increased the risks. Meeting with her family I witnessed the love her family showed though the intense care and the tenacious guardians. Our patient population is just getting more complex. Ask our OB-GYN friends, our pediatricians, our internists, our family practitioners, our mental health colleagues, our cardiologists, our diagnostic imaging partners, geriatricians, damn near everyone (I could mention all physician groups but it would be rather boring, no offence to those not mentioned)! It is just getting more challenging. I am not complaining about the difficulty but I am just making note of it. The surgery was challenging, the anesthetic same. I came to see her the next day and she was awake, extubated and looking good. Her family was so deeply thankful. They spoke to the great health care system we have. I then told them the truth.

I thanked them for their sincerity and noted it is a privilege and a pleasure to provide care. I also told them how appreciative I was for the kind comments (who cannot smile when a sincere, as opposed to insincere, thank you is voiced). I told them that it is not uncommon that once in the system (and you in ER know that getting into ER does not mean getting into the system, in your world it is getting OUT that is important) you do get good care. I noted that there are those who do not get timely assessment or care. It is their world that physicians worry about. I told them about the times their mother had been in with congestive heart failure and asked them if they had to endure that and not the definitive surgery she needed, how would they feel. They looked at me with deep appreciation for not being in a situation where crisis care was all they could hope for. They understood what others feel.

There have been some good letters in the Edmonton Journal recently. Cheers to the ER docs who wrote such a wonderful letter. It was clear and thoughtful, not just angry emotion and threats. I would laud them for their work, not just their words. They have documented, measured, the problem as we would a fever. They did not just think the patient was warm. They did not just say "it is pervasive." They had facts and facts speak. The letter by the intensivists from the nuns spoke to a greater need, that is, for all of us to be the change we want to see (stealing from Gandhi). They, who work in the super intense world of ICU, reflected on health and good health. Great for them to make these comments as they also realize the need for their patients and the support needed to provide better health tomorrow. Dr. Armstrong's letter was powerful. The idea of Alberta being a world leader in advancing care through research (not just publishing research, he spoke well about how research needs to change care through discovery, education and implementation) being potentially destroyed, not just threatened. This would have an enormous impact on who we are and what we do (I am not speaking from the university, I am speaking from the voice of physicians who continually improve care and share new knowledge).

Now the responses were interesting. The minister of health and wellness speaking to making change is great and how his heart is in the right place. Yet there are people who need help now. Five years for a solution is too long for so many, they will not get the care that is both needed and available. Dr. Duckett supports the idea of wellness, but what about those who are waiting in long lines for care (ask your corner family practitioner if it is easy to get a timely referral…but stand back… they might tell you the truth). He spoke of Oliver Twist and asking for "more." I find that comment offensive. We are not asking for more - we are asking for better and we are asking for enough. His job as CEO is to engage the workforce. Can you find me engaged workers? To ignore Peter to praise Paul is wrong, just wrong. He should ask the physician workforce for forgiveness with such a comment.

We do need to support wellness, mostly in ourselves. But tell me who can change their genes? You might be able to outwardly change your sex but not your genes or the fact that we are all aging. The system, that includes us, needs to adapt and that means change. Yet, I would challenge a system where radical and ill thought changes continue to be paraded as great. I would challenge a system where front line workers are not engaged. I would challenge a system where those who are on the outside are not treated with the same focus as those on the inside. Where is the accountability of which they sing?

Those who "have," have it very good. We are mostly concerned about those who "have not." It is as simple as that.

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