A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION
February 2015

COMMUNICATING WITH PHYSICIANS IN ALBERTA

VITAL SIGNS

Are We Engaged?
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VITAL SIGNS

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CAMSS

Calgary and Area Medical Staff Society
Advocating for physicians, caring for patients

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Save the dates! CAMSS 2015 Meetings

CAMSS Council meetings may be attended via video conference from the AMA SAO Conference Room (Suite 350 708 11th Ave SW, Calgary.)

Please email camss@camss.ca to request security access to the room.

CAMSS council
February 11, 2015 | ACH 01 – 5:30-8:30 pm

CAMSS council
March 11, 2015 | ACH 07 – 5:30-8:30 pm

CAMSS council
May 13, 2015 | ACH 07 – 5:30-8:30 pm

CAMSS council
September 9, 2015 | ACH 01 – 5:30-8:30 pm

CAMSS council
December 9, 2015 | ACH 01 – 5:30-8:30 pm

CAMSS ZAF
April 8, 2015 | Room 1003, 10301 Southport Lane SW – 5:30-8:30 pm

CAMSS ZAF
October 14, 2015 | Room 1003, 10301 Southport Lane SW – 5:30-8:30 pm

CAMSS AGM
June 10, 2015 | Location TBA – 5:30-9:00 pm

CAMSS AGM
November 11, 2015 | Location TBA – 5:30-9:00 pm

President's Message Are We Engaged?

By some objective measures, physicians in this province are "poorly engaged." A recent Alberta Health Services engagement survey had a 16% response rate, down from 19% in 2012. The percentage of engaged physicians was 39%, which means that around 515 of the 8200 physicians in Alberta associated with Alberta Health Services (AHS) felt engaged. Making the assumption that engaged physicians were more likely than most to fill out the survey, the actual truth is probably less flattering.

The results of this survey should be looked at very closely. What do we mean by engagement and how is it manifested in daily practice? The most important yardstick by which to judge physician engagement is patient satisfaction. Are physicians engaged in providing care to their patients? The recent Health Quality Council survey on patient satisfaction from December 2014 demonstrated that 66% of patients rated care as 4/5 or 5/5, an improvement of 2% since 2012. The engagement survey also showed that physicians felt valued by their teams (78%), and felt that they had access to the information required to provide the best patient care (70%). Physicians also demonstrated confidence in their local medical leadership (60%).

The failure of engagement is not between physicians and their patients, or even at the local leadership level. The failure of communication lies between senior AHS staff and front-line physicians. The physicians who completed the survey were disenchanted with provincial attempts to communicate with them (only 26% were satisfied with the information they received from a provincial level and only 23% of physicians felt that Alberta Health Services inspired them to do their best work). These results clearly show a large disconnect between AHS senior management and physicians working on the front lines.

While understanding that physician input is not the only factor to be considered in the health care decision-making process, physicians on the front lines do expect to be consulted when decisions are made which affect them. When physician input *is* sought, physicians should be included in the feedback loop and kept informed about how the information they provided affected the decisions, and how and why decisions surrounding health care were made. The fastest way to discourage input is to ask for it and then to provide no evidence that it was considered.

How do we resolve the distrust between physicians and AHS leadership shown in this survey? I would like to make three suggestions. First, physicians should not confuse Alberta Health with Alberta Health Services.

While understanding that physician input is not the only factor to be considered in the health care decision-making process, physicians on the front lines do expect to be consulted when decisions are made which affect them.

Alberta Health is a political fiefdom. Alberta Health Services is a large amalgamation of hospitals, programs and care facilities thrown together by Alberta Health. AHS is struggling to establish a framework of priorities in difficult times. Second, AHS management needs to interact directly with those affected by their decisions. The personal touch works. There is more incentive to be engaged with senior leadership if you have seen senior leadership. Third, AHS leadership needs to provide clear and timely information. We as physicians dislike hearing about changes that directly affect us from the newspaper or on television. Instead of weekly infomercials, give us clear information on pending changes to how we deliver healthcare.

We do not need help engaging with our patients or at our local departmental level. We do need help to clearly communicate our concerns to AHS, and AHS needs to clearly communicate their needs to us. Only then can we resolve issues of concern to both of us. Dr. Belanger, Zone Medical Director for Calgary, suggested to CAMSS executive members, "…we are all AHS, with a common goal," but unfortunately there is still a gulf between physicians and management.

The sad irony in all this is that the AHS senior staff members I have met are hard-working, highly competent and very engaged in trying to providing the best health care for Albertans. If our senior medical leaders could convey this passion and energy for health care to physicians providing the front-line care, I believe that physician engagement numbers would improve.

The truth is that we are going to have to forge a much closer relationship. The plunging price of oil has left Alberta with a large deficit. Healthcare takes up around half of the Alberta budget and it is inevitable that we are going to face hard times. Tough decisions and greater efficiencies are going to be in our future. To avoid unnecessary and unproductive squabbles we are going to have to work together. Our patients and our future demand it.

On another topic, this is the first edition of Vital Signs with our new editorial support. I hope you like our new look. Eventually we hope to provide our magazine to all Medical Staff Association members across the province and offer theme-based articles around common issues and concerns. We welcome contributions in the form of letters and other feedback.

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

AMA update

Dear Colleagues

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

My *Vital Signs* submission this month is a reprint of a *President's Letter* that I sent on December 31. I received some very thoughtful emails in response to this letter – and many good suggestions and perspectives that I welcome.

In the first weeks of this year, talk about sustainability and Alberta's economic future have been front page news every day. That being the case, I thought I would repeat my message of December 31. Those who didn't have a chance to see it, or didn't have anything to say at the time may wish to comment now. If so, please reach me by email at the address below.

As 2014 draws to a close, I want to bring attention to what I consider the major challenge facing us in the year ahead. How do we balance quality of care, including timely access, with sustainability, including affordability and appropriate levels of human and other resources?

The new challenge is in many ways the old challenge; indeed it is an on-going challenge that faces all health care systems. Alberta is at a crossroads, however, and there is an opportunity to look anew at how care is identified, organized and delivered. Any meaningful change will require the combined efforts of all parties, including government, patients and physicians.

Government needs to do three things: be clear about the extent of the public program and what public can expect of it; establish public policy in line with those objectives; ensure that the appropriate financial resources are available.

I want to focus on the last point. I am not sure the public is aware of how much of the current problems are related to poor planning and how poor planning, at least partly, is related to unpredictable levels of funding. This is true in every province, but especially Alberta where government is so dependent on resource revenues. We require a public discourse on the nature of health, which requires a long-term vision and commitment in the building of infrastructure and the development of human skills. A sustainable, predictable source of revenue is required, whether that be a re-introduction of health care premiums or some other means.

I also want to mention one thing I think government has to stop doing. To be blunt, they need to get out of the delivery of care and play their part in depoliticizing the system as much as possible. In my own view, family care clinics were an example of this: ill-conceived out of political expediency, with failed implementation that lost focus. Governance matters: the public and providers should pay close attention to the report of the Alberta Health Services Official Administrator coming out early 2015.

For patients and the public in general, there are also responsibilities. Some of these are fairly obvious, such as participating in flu vaccine programs, the appropriate use of emergency rooms and doing their part to follow treatment regimes.

There are other less obvious ways that patients can participate. I want to mention one, which is the establishment of a stronger attachment between each Albertan and a primary care physician. The best evidence available — and there is a lot of it — is that strengthening these attachments pays off in terms of overall system quality and efficiency. For this to happen, Albertans will need to commit to that relationship and accept a focusing of their major entry point into the system. I understand and accept that strengthening the patient-physician relationship is a two way street: additional resources at the primary care level will be required.

This brings me to physicians. We have always seriously taken our role of delivering quality care to each patient. This needs to remain our major focus, both in our delivery of care and in advocating for the system. We must be committed to our profession and its ideals. Recently, the Section of General Practice and the Section of Rural Medicine sent out to their members the College of Physicians & Surgeons of Alberta's standards of referral and consultation. We should all pay attention to support such standards.

Finally, there is the issue of stewardship. Back of the envelope calculations vary, but up to 85 per cent of health care system resources are mobilized as the result of decisions made by physicians. There is no way around it: getting the most out of scarce health care resources will ultimately require the engagement of physicians. We need to be open to new ways of informing, incenting and making us more accountable for our decisions.

No one thing will do it — an extensive information system or simply more of what we have — and no one party can do it. If I have one wish for 2015 it's that we re-affirm and re-establish the necessary partnerships between government, the public and physicians in moving forward.

I wish all of you a Happy New Year and look forward to your comments.

Email **president@albertadoctors.org**.

Regards,
Richard G.R. Johnston,
MD, MBA, FRCPC, President

ALBERTA MEDICAL ASSOCIATION

OLD DOCTORS NEVER DIE? Or…

I'll give you my stethoscope

…when you pry it from my cold, dead hands.

Dr. Kevin Hay

A popular ballad with British soldiers during World War I was *'OLD SOLDIERS NEVER DIE'.* General Douglas MacArthur closed his 1951 retirement speech to Congress with a line from the song: *'…they just fade away.'* (MacArthur had just been fired by Harry Truman for openly criticizing his decision not to nuke Red China after their troops entered Korea to repel US soldiers near their border.)

The END-OF-WORK-LIFE debate.

Thankfully Docs don't generally retire with MacArthur levels of drama!

Work reduction and retirement planning is probably easier for office-based doctors. Doctors who share on-call duties — such as Rural Family Docs & Specialists — sometimes hit obstacles with colleagues, AHS Bylaws & the CPSA Standards of Practice while trying to reduce their work-load. It is often easier to give up completely, than to figure out a slower, kinder reduction.

This is not just important for Doctors. Patients and continuity of care are really hurt when Docs are lost at short notice. The profession is having a healthy END-OF-LIFE debate: so let's have an **END-OF-WORK-LIFE** discussion with colleagues, the Zones, AMA, CPSA & AHS…and our patients!

THE BITTER END.

Why should we care about physician work-load? The Montreal Gazette recently reported on doctor's health:

"Physician suicide rates are sobering: Despite some efforts to palliate this phenomenon, namely the creation in 1990 of the Programme d'aide aux médecins du Québec, more than 400 physicians die by suicide every year in North America. In addition, suicides are 250 to 400 per cent higher and 70 per cent higher in female and male physicians respectively, compared to the general population. This tragedy is also symptomatic of a larger phenomenon: 47 per cent of the 19,000 Québec physicians present a high level of psychological distress…"

This is not a problem just in Québec — it is the same the world over. There are many stats showing that we need to heal ourselves: mood disorders, alcoholism, drugs, and marital discord, to name but a few. Work-load is one stressor which we need to address.

PROBLEMS with ON-CALL ROSTERS.

Others can better address the many problems which creep into On-Call services.

A prevalent view is that an EQUITABLE on-call roster is an EQUAL on-call roster. Some of us older Geezers contend that after many years of service 'you've done your time' and can EQUITABLY reduce workload.

Some of the types who can survive on-call services have little forgiveness for colleagues who need to change work-load.

I have heard of some sad instances coming out of on-call disputes. One Doc who had increasing administrative and representative work (and less clinical work) was required to choose between providing full on-call service or leaving his community.

Another group of specialists insisted that an older colleague maintain full on-call duty because many of the other colleagues were getting older too. If one reduced on-call commitment the others might fall in short-order from the increased workload, like toppling dominoes!

This is similar to my own experience. I have worked in Wainwright for 27 years, through two major physician shortages and different work-load inequities. Now that three new Docs

are up and running with two more slated to arrive in 2015, I perceive it is time to cut back. My colleagues do not have the same perception and are fearful that other Docs will do the same if anyone gets to cut back their load.

This lack of flexibility (generally defaulting to 'ALL or NOTHING') in the Rules, Bylaws & Standards doesn't give many options.

OPTIONS for LIFE-AFTER-CALL.

- **RETIRE COMPLETELY.**
  So: full-time commitment to zero almost overnight? Even with three months' notice, the speed of change is unkind to patients & causes poor continuity of care.
- **DROP or DIE!**
  Many sort of expect that those who do not retire fully will push-on regardless… until they do the decent thing of collapsing at the helm or just dropping dead! (Collapsing from illness, alcoholism, divorce, whatever!) Surely we need to avoid this type of martyrdom?
- **LEAVE THE COMMUNITY.**
  Really? Even though you've made it home for many years?

  (Not an old Doc to be seen! Bet that looks good to the potential recruits checking out the community… *But perhaps they were euthanized because they felt 'tired of life'?*)
- **CHANGE PRACTICE STYLE.**
  Some colleagues respond favourably to proposed practice changes. Others take change as a personal affront or threat. Responses can include sending the 'guilty' colleague to Coventry or making sure that they have to leave the community.
- **CHANGE JOBS COMPLETELY.**
  WALMART GREETER, anyone?

HOW DO WE AVOID CHERRY-PICKERS?

A real fear is that some Docs will cherry-pick the easy work & leave the drudgery for others to do. It happens! One advantage is that out-of-hours work is currently well remunerated, which helps on-call work to be covered.

We need to talk about developing new rules, but there are some precedents. The Alberta Medical Association's Physician Locum Services® provides weekend locum coverage for senior physicians (Over 54 years old: some conditions may apply!)

Perhaps after 20 years of service a Doc can automatically get off night and weekend call? Or, after 25 years of service they get the option to quit taking call altogether? Okay, if not then, when?

WORKFORCE PLANNING.

Many of these problems recur because of poor work-force planning over the last 25 years. This is one of the things which has been hobbled by the repeated administrative changes made in Alberta with Regionalization, re-Regionalization, Zonification and Centralization. (There were 2 'point in time' work-force reviews in 2000 & 2006 which did change Medical School enrollment, but no system-wide changes were implemented.)

If there was a functional human-resource plan for each program, the administration could recruit more consistently over time. An idea would be to space recruits as evenly as possible between ~30 & 55 years of age. So, simplistically, a department of ~15 staff members would need one new recruit approximately every 2 years and could accommodate—and expect!—a Doc to reduce work-load in the same time frame.

Alberta needs a nimble long-term staffing plan which is what Dr. Rollie Nichol, Associate Chief Medical Officer AHS, is promoting through the Specialist Forecasting Tool, which will become operational in all zones this year.

"…our patients need to be cared for regardless of our relative success (or failure) in recruiting to meet any plan. Our plan for providing care must be nimble and flexible enough to provide the care with the existing workforce. Manpower planning consists of supply forecasting, demand forecasting, comparing reality to scenarios, and a pragmatic time-framed recruitment plan."

I hope this Forecasting Tool will be helpful for rural family physician workforce planning also. In rural areas an important planning aspect will be to get groups of Doctors working together in larger hubs to provide extended services and to get more bodies taking call in the one location.

Dr. Kevin Hay, outgoing President of the Central Zone Medial Staff Association

WHAT DOES IT MEAN TO BE COLLEGIAL?

There is still the culture in medicine that everyone must *'SOLDIER ON!'* Medicine is very different now when we can actively treat almost every condition. Workloads are enormous and many doctors are simply doing too much.

Being human we like to see 'equality' … though defining that equality is difficult. Curiously, we can be very kind to our patients at the same time as being less than collegial with our fellow Doctors.

What does it mean to be collegial? A nice definition from the net is *'marked by camaraderie among colleagues.'* Many perceive collegiality along the lines of treating colleagues like brothers and sisters. Sure, *we fight with family!* BUT… we also come back later to talk!

As André vanZyl, incoming CZMSA president, says: *"Forcing physicians to work beyond their realistic duties, ability and availability will be counterproductive."* We should be slow to chop a Doc who has given many years of solid service to a community. Being collegial is good for the individual, the profession and for our patients.

If Harry Truman knew the last line of 'OLD SOLDIERS NEVER DIE' he might have been quick to use it back against MacArthur. Perhaps it is a telling response all around?

"Old soldiers never die — young ones wish they would…"

Letters

Dear [Editor],

I wish to offer a different perspective to Dr. Lloyd Maubaum's article entitled "'H' is for hospital", published as the December 2014 Guest Editorial. As an emergency physician at the Royal Alexandra Hospital in Edmonton and the Director of the Addiction Recovery and Community Health (ARCH) Team, I have the privilege of working with patients with substance use disorders on a daily basis. Dr. Maubaum's editorial portrays patients with substance use issues as having control over their disease, as having a choice between using substances and paying for their medications. Addiction is not a choice; it is a chronic disease of brain reward, motivation, memory and related circuitry. It is manifested by a consistent inability to abstain and a significant impairment in behavioral control.[1] Expecting patients with a substance use disorder to just stop using is akin to telling a diabetic patient to just start producing insulin. Addiction is not a choice and it is not about choice.

The emergency department is one of the few remaining social safety nets. We are open 24/7 and offer a safe refuge to all comers who walk through the door. Many of our patients need not only medical stabilization, but also social stabilization; this is a role we should embrace and not shun. If our goal in health care truly is to improve health, then we cannot overlook the importance of the social determinants of health and the need to address these in the acute care setting. The world's largest trial of housing first (the At Home/Chez Soi study conducted in five Canadian cities[2]), has clearly shown that a housing first approach can end homelessness, improve quality of life, and reduce the problems associated with substance use. It can also result in considerable cost savings, particularly in very high-cost individuals, by reducing hospitalizations, ED visits and justice related costs. Indeed, the hospital is not a hotel, but we cannot ignore the critical role that stable housing plays in improving or maintaining health. Linking patients to local housing first initiatives and viewing a period of hospitalization as an opportunity to help with social (and not just medical) stabilization just makes sense.

Finally, I wish to point out that about 20% of Albertans experience an addiction or mental health problem each year. In 2012, only 50% of individuals with an addiction or mental health issue felt that they were able to access enough treatment for their condition. In addition, the vast majority of the funds that we spent on these issues were for inpatient, residential or crisis services; only 0.1% of funds were spent on health promotion and disease prevention.[3] It should be no surprise that without adequate access to treatment and virtually no efforts being made at prevention, that these patients find their way to the ED.

I agree that there is a challenge before us. But the challenge is not to defend the current health care system. The challenge is to advocate for our patients on a daily basis, provide evidence-informed care, and to continually strive to improve the service that we provide so that our patients, and we, can be healthy.

Respectfully submitted,
Kathryn Dong *MD, MSc, FRCP*
Associate Clinical Professor, Department of Emergency Medicine, University of Alberta Director, Inner City Health and Wellness Program, Royal Alexandra Hospital

FOOTNOTES:

[1] http://www.asam.org/for-the-public/definition-of-addiction

[2] http://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi- final-report

[3] http://www.health.alberta.ca/documents/GAP-MAP-Report-2014.pdf

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Dear Lloyd,

I would like to commend you for your article and response in bringing up the conversation about malingering patients and medical stewardship. It's a controversial one and your response was very well articulated. As soon as I read the responses to your original post I had the words "Straw Man" in mind. I do not think we encounter this as much as hospitalists but it has been an issue.

It has been a frustrating time for all involved in hospital care in Calgary this winter. At our hospital, we have had as many as 30-40 patients waiting for inpatient beds, for periods as long as 48 hours. This is certainly not the fault of patients or their caregivers, nor health care workers in and out of the hospital, nor is it really the fault of seasonal influenza which is an annually predictable event. It is instead a result of poor health care resource planning; a legacy of misguided approaches of years gone by — disappointingly, the press seems less impressed with this issue as the years go by. I do not ascribe this situation to the fault of malingering patients. It is hard to imagine many patients actually wanting to stay in the hospital hallways or 2 or 3 to a room designed for one. That said, malingerers exist. Their occupancy of inpatient beds on medical services to my estimation is very low but not zero; it may be overestimated due to the frustration involved from time to time. I am not able to comment on its existence in the psychiatric domain but I can imagine it may be higher and would defer to your experience with these patients. On the other hand there is a real and ongoing serious issue of malingering in the outpatient setting for the purposes of drug redirection and insurance fraud. This needs to be discussed more openly in the medical community.

It is appropriate to have a conversation about medical stewardship in a safe way without raising straw men and laying blame. Doctors and patients are all human; we should still advocate for the health of our patients in a responsible manner.

Sincerely,
Dr. Simon Dawes

Dear Dr. Dong,

I want to thank you for your interest in my article and the courtesy of your letter to the editor. Before I respond specifically to your letter I would first direct you to my rather lengthy response to prior letters as found in the January issue of Vital Signs (2015).

I again emphasize that in my article, I was referring to MALINGERING patients ONLY and not the scores of woefully homeless and disenfranchised. I fully appreciate why the latter individuals may present to the ER and how they suffer due to the painful lack of community based resources and supports. Dr. Dong, we share the same values of caring and compassion as we similarly work with the downtrodden, hopeless and helpless. Naturally, where else are they to turn but to the hospital? I thank you for facilitating further discussion specifically regarding the social determinates of health and the inadequacy of funding for community based housing, health promotion and disease prevention.

I also work on the front lines of health care with individuals that struggle with addiction related disorders. I have done so for many years and it is apparent that there is a degree of controversy between proponents of a purely medical model of addictions and those that tend to view addictions as more behavioural (think 12-step related programs). Others perhaps favour a model combining both schools of thought.

I must caution that it is best to eschew attribution. Nowhere in my article did I suggest or state that patients choose to become addicted. While I fully agree that addictions are a disease, I struggle with your diabetic analogy. The analogy of berating a diabetic patient to simply start producing more insulin is naturally absurd. Let me posit that the better and more accurate analogy is to note that diabetes is a disease but that the diabetic patient has the choice to follow the recommended diet/treatment, or not. Having the disease is not a choice. Aspects of how one manages their disease, is another matter. By your description Dr. Dong, "Addiction is not a choice and it is not about choice," making an addicted patient seemingly an automaton, robotically devoid of choice, reason or any volition, helpless to do anything but to pursue their favoured substance of abuse. It would seem apparent to me that addicted patients are not automatons.

Every day I have patients that are sometimes capable of making very healthy choices (paying for their medications or even for basic nutrition) and other days are woefully relapsing. Sometimes they manage to pick up the phone and call their sponsor. Other days they simply pick up the bottle or the crack pipe. It is generally the accumulation of negative consequences, over time, that increasingly leans the addicted individual towards calling their sponsor rather than pursuing their preferred substance.

I would like to conclude by emphasizing, once again, that in my article, I was only referring to MALINGERING patients. It is great to see your passion, Dr. Dong!

Lloyd Maybaum

PLC Medical Staff Association Update

The 29th Annual PLC/CGH Dinner and Awards night was held on Saturday, January 17th, 2015 at the Petroleum Club, and was another great success this year with over hundred guests attending the gala event!

Invited guests included residents from Obstetrics and Gynecology, Psychiatry and Orthopedic Surgery; past PLC/CGH MSA presidents – Ron Cusano and Glenn Comm.

Physician of Merit awards 2014 were presented to Dr. Tim Prieur by Dr. Elizabeth Mackay; Dr. Kevin Hildebrand by Dr. John Donaghy; and the newly created award Clinical Teaching to Dr. Iain Russell by Dr. John Donaghy. The PLC Resident of the Year Award 2014 was presented to Dr. David Weatherby in the Orthopedic Surgery program by Dr. Iain Russell. A surprise award, Exemplary Service Award, was presented to Dr. Elizabeth Mackay by Dr. Steve Patterson in recognition of Elizabeth going beyond and above the call of duty at the Peter Lougheed, for both patients and colleagues. A special thank you was made to Sally Knight for arranging another wonderful event!

Dr. Arlie Fawcett announced that the PLC/CGH MSA has newly designed lapel pins for both male and female medical staff, and are available this evening. Physicians working previously at the Calgary General Hospital were also given a CGH MSA ball cap from the previous years. She also announced that PLC/CGH MSA are working with AHS on new name tags for physicians and will include the PLC/CGH MSA logo. These name tags will replace the AHS lanyards, and hopefully will be available in the next couple of weeks.

The evening was enjoyed by all!
Sally Knight

About Becoming Dead

Dr. David Kent

Dr. David Kent, Rockyview General Hospital Medical Staff Association President

End of Life issues have become a widespread topic in the media in recent years, and physicians are rarely heard from. Medicine is progressing in the areas of hospice and palliative care, but the real controversy is in the Right to Die conversation, and physician assisted suicide (PAS).

Suicide has not been illegal in Canada since 1974, but aiding it is. This paradox — it's illegal to counsel an act which is legal — persists to protect the vulnerable. Canada moving slowly isn't really a virtue, but we can learn from American states and European countries that are accumulating decades of experience with Right to Die legislation.

Oregon legalized PAS in 1997, forced by a court decision, as later happened in Montana and New Mexico. Washington State brought it in after it was one of the items on a multi-issue public referendum, but Vermont made history bringing it in through normal democratic legislative procedure: a bill proposed, debated, and passed.

Half a dozen European countries allow some type of assisted suicide. The Netherlands are notable in that since 2002 children over 12 could be considered, and for a year now Belgium has had no age restrictions. Switzerland allows some organizations such as Dignitas and Exit to operate for a fee, and there are international clients.

Some of the lessons for Canada are reassuring, others instructive. In all jurisdictions, only about 10 per cent of serious, reasonable candidates go through with it. Oregon averages about 38 assisted deaths a year by take-home prescription, and one interesting point in their growing data base is that the majority were satisfied with the palliative or hospice care they received, but still opted to choose their exit... answering the criticism that no one would chose suicide if end-of-life care was adequate.

Another reassuring point from Oregon is that the profile of patients is not changing much, easing fears of the 'slippery slope' argument that penny-pinching healthcare administrators would push expensive, chronic care patients to the cup of hemlock.

In all countries, a large number of legitimate enquirers who didn't take the option felt comforted knowing they had another choice if their end-of-life situation became intolerable.

All jurisdictions seem to have the predictable reasonable safeguards in place, such as defining the terminal condition, good end-of-life care offered, the requests being

More and more governments are starting to hear the debates, and none of those that have established the right to choose has reversed their decision.

voluntary and repeated and made in clear mind, clearance by other doctors and parents where applicable, and so forth. However, a few troubling controversies have come to light.

In Europe where the numbers have grown by about 200 per year for a dozen years, there has been criticism of a few cases. One case involved deaf twins aged 45 who were now going blind and couldn't tolerate the loss of independence. Another, a woman in her 60's with relentless depression. Yet another case involved a trans gender whose multiple re-assignment surgeries were fraught with complications and were basically a dismal failure.

Overwhelmingly, the terminal population prizes having the option of choosing their time and place of death, and this practice will spread. More and more governments are starting to hear the debates, and none of those that have established the right to choose has reversed their decision.

However, the subject of End of Life care is much broader than assisted suicide of course, and I've skewed the topic with my paragraphs above.

For the related topics we are fortunate to have lined up Eric Wasylenko MD, BSc, MHSc (bioethics), Palliative Care Physician, Clinical Ethicist as a guest speaker at the Rockyview General Hospital Medical Staff Association Meeting on March 10, 2015 in RGH Fisher Hall.

Dr. Wasylenko's topic, "Becoming Dead - Medicine, Mercy and Humility" will introduce us to the important terminology, and then share his extensive, pragmatic knowledge from his years working in this area. Find out what he means when he says that he never withdraws care. We are all looking forward to hearing him, and I'm sure the discussion after will be lively.

We expect a larger turn out with this interesting speaker; RGH members please arrive by 5:30 p.m. and RSVP by February 24 to stella.gelfand@albertahealthservices.ca so that we have enough delicious Chinese food to go around.

We welcome and encourage the attendance of Medical Staff from other hospital sites! Please email Stella and arrive after 6:30 p.m. so that we can clean up the dinner and attend to local business first.

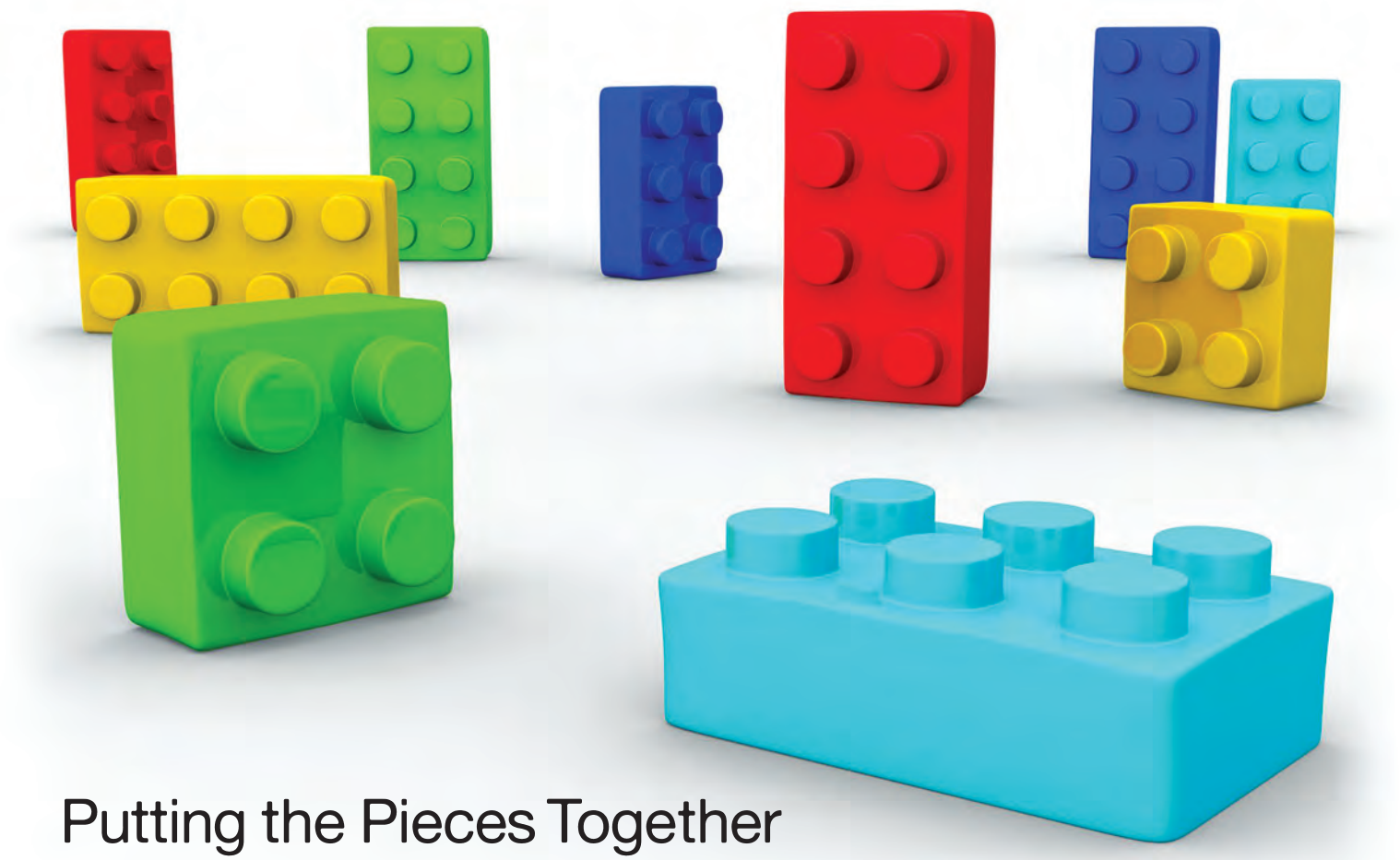
Rockyview General Hospital Medical Staff Association Meeting

March 10, 2015, RGH Fisher Hall at 6:30 pm

Becoming Dead – Medicine, Mercy and Humility

Eric Wasylenko MD, BSc, MHSc (bioethics), Palliative Care Physician, Clinical Ethicist

This talk and discussion will focus on the practice of medicine around the events that lead people to become dead. It will explore some of the language, techniques and experiences physicians commonly encounter, such as; depending on the patient, alternately striving to keep some people alive; assisting optimal living during the inexorable approach of death for others; mercifully attempting to reduce suffering and perhaps even promote benefits in being dead. The talk will also challenge some of our potential assumptions about what some have called the 'medicalization of death', and will ask participants to consider the tension between medicine's deployment of science's rational tools and the mystical nature of the beings we try to serve.



Putting the Pieces Together
LEGO®-style

Dr. Sharron Spicer

Dr. Sharron Spicer, MD, FRCPC
Children's Hospice and Palliative Care Service. Physician Lead for Safety and Chair of the Alberta Children's Hospital Quality Assurance Committee. President, ACH Medical Staff Association and President Elect, Calgary and Area Medical Staff Association

Let's replay a story from the not-so-distant history books. The 1990s saw a major shift in the industry. No longer time for innovation, it was instead time for tight fiscal control and top-down management. Enter the new CEO: "He comes in and… does things by the books. He lays people off, he streamlines some things, he globalizes. He's basically going by the turnaround book, but it doesn't work."[1] You think I'm talking about AHS? Wrong. It's the story of LEGO®. This profitable toymaker grew from humble beginnings to global dominance, then teetered on the edge of bankruptcy. A first attempt at turnaround – described above – failed. The toy making company nearly fell apart brick-by-brick but was pulled back from the brink with a different way of thinking by Jørgen Knudstorp , hired as LEGO® CEO in 2004.

LEGO® — Danish for "play well" and Latin for "to assemble" — started as the family business of carpenter Ole Kirk Kristiansen in Denmark in 1916. Over three generations of family leadership, it moved from cottage industry to high-tech mass production and world-wide distribution. Then came the overindulgent 1980s with an explosion of LEGO® amusement parks and merchandise. Its brand power was compelling, but sales were not. Competing products, high-tech gadgets and a sagging economy brought the company down. In 1999 Poul Ploughman, a turnaround expert, was brought in from outside the Kristiansen family. Despite his tight control from the Boardroom, the company continued to choke on its growing complexity. In 2004, Ploughman was fired and Knudstorp, a young, forward-thinking leader, was promoted from director of strategic operations to LEGO® CEO. Knudstorp is credited with saving the company. Three key factors shaped his success: clarifying core business, controlling complexity, and engaging the community.[2]

Clarifying core business

Knudstorp explains that the LEGO® company had diversified almost to the point of destruction. "Most companies don't die from starvation, they die from indigestion."[3] Having moved away from its innovative

Then, to steal a line from the LEGO® movie, which can only truly be appreciated if you can actually hum it to its soundtrack tune, "Everything is awesome. Everything is cool when you're part of a team. Everything is awesome, when we're living our dream."[10]

product of little plastic blocks, its niche had blended with the other big names of its time. Knudstorp and his colleagues had to redefine its purpose. They reviewed its heritage and looked to its future, covering the period of handcrafted wooden products to mass-produced plastics and then to the digital age. What they discovered was that the essence of LEGO® — its building blocks, so to speak — was to be its saving feature. Clarifying its core business allowed the company to create the foundation for better leadership.

Controlling Complexity

Once LEGO® defined its true essence it had the flexibility to take on a looser structure. It relaxed its top-down management style and pushed decisions down the hierarchy as much as possible. It became less risk-averse and more driven by opportunities, collaborative networks, efficiency and calculated risks.[4] Innovation remained important but, unlike in the no-holds barred approach of the 1980's, this time creativity was channeled within bounds set by market research and user feedback. "Putting parameters on how people innovate had the paradoxical effect of making them better at it."[5] The company reduced complexity by using standardized parts and processes. It began to implement tighter quality control. It started to train the management team in formal decision-making models. In a candid interview, Knudstorp muses, "The other thing that has inspired me is my wife is a GP, medical doctor, and she's often looked at me and she's said, 'Explain this to me. So you had worked for the company three, four years, and you became the CEO. I'm a medical doctor. I get to go to school for nearly 10 years, spend 7-8 years working, training and working, to just become a bloody GP.' Becoming a medical doctor, like an airline pilot you have to fly thousands of hours to maintain your license and certificate, but people become managers overnight. Where's their practice? They are not practitioners. Where is the practice of leadership?"[6] (Really, I'm not making this up.) Knudstorp doesn't directly answer the question posed by his wife — deftly negotiating the marital dynamic, I suspect — but gives examples of engaging with employees at all levels of the organization and encouraging the creative drivers. He refers to the job of the CEO as the "Chief Disorganizing Officer" whose job it is to question the status quo and always look for innovative ways to change.[7] What's more, the company accepted and responded to criticism, both from within and without. The Harvard Business School interview noted that "LEGO® executives were unusually supportive about the case-writing process. They wanted the story to be told truthfully."

Engaging Community

Admit it, we've all stretched out on the floor with our own kids (or borrowed some) for a lazy afternoon of building LEGO®. Having the kids there is just an excuse for us grown-ups to put together a race car or a boat or the best condo tower you can imagine. That's the beauty of LEGO®. Even with kits to build any Star Wars ship or LEGO Friends® beach house, the essence of using LEGO® is still the desire to create something new. And creating is what LEGO® fans around the world do! Knudstorp capitalized on this voluntary labour by seeking contributions about product design from fans. "One of the insights Jørgen had when he became CEO was that he needed to reconnect with the community, one of the most powerful assets the company had."[8] Not only did this result in ideas for products, it engaged the public by giving them a role in the company — unpaid and uncited, but recognized nonetheless. Says Knudstrop, "We never take customers' enthusiasm for granted. We reward them by showing that we listen to and care about their feedback."[9] He calls this the avenue to the truth. In essence, LEGO® acknowledges that its success is ultimately judged by its consumers.

Lessons for Alberta Health Services

It seems almost a sport in Alberta to take shots at leaders in our health system or political office — but it's hard to resist calling down the likes of Stephen Duckett or Alison Redford. With Vickie Kaminski now head of AHS, let's see if we can build upon the lessons imparted from LEGO®. First, AHS needs to *define its purpose*. It needs to know what its core business is and what it is not. If it's clear to AHS what AHS does, then it can let the decision-making trickle down to the front line staff at the community or unit level. Then AHS can *control its complexity* through its management: using evaluation and quality improvement techniques, encouraging innovation, and developing leadership capacity. Finally, AHS needs to *engage its community* of staff and the citizens. Like LEGO®, AHS needs to value its consumers and let them shape its direction. Then, to steal a line from the LEGO® movie, which can only truly be appreciated if you can actually hum it to its soundtrack tune, "Everything is awesome. Everything is cool when you're part of a team. Everything is awesome, when we're living our dream."[10]

FOOTNOTES:

[1] Harvard Business School Cases: LEGO, Stefan H. Thomke (March 2013)

[2] Harvard Business School Cases: LEGO, Stefan H. Thomke (March 2013)

[3] Interview by Adam Burns for Meet the Boss (April 2010)

[4] Lego CEO Jørgen Vig Knudstorp on leading through survival and growth, Harvard Business Review, Andrew O'Connell (January 2009)

[5] Harvard Business School Cases: LEGO, Stefan H. Thomke (March 2013)

[6] Interview by Adam Burns for Meet the Boss (April 2010)

[7] Interview by Adam Burns for Meet the Boss (April 2010)

[8] Harvard Business School Cases: LEGO, Stefan H. Thomke (March 2013)

[9] Lego CEO Jørgen Vig Knudstorp on leading through survival and growth, Harvard Business Review, Andrew O'Connell (January 2009)

[10] "Everything is Awesome" The Lego Movie, produced and arranged by Shawn Patterson, performed by Joshua Bartholomew and Lisa Harriton under the name Jo Li (January 2014)

Forcing the Flu Shot

Adria Laycraft

Medical practitioners recommend the flu shot. Health advisory boards work hard to convince people that the vaccine is safe and important. So when statistics reveal healthcare workers are lax about getting the shot, Alberta authorities start talking about making it mandatory.

The objective is to protect both the workers and the public, and the goal is always to increase vaccination rates among physicians. While the arguments for and against the vaccine both have merit, the flu shot continues to save lives… and that makes it vital for healthcare practitioners.

Unfortunately many practitioners are opposed to a compulsory program even when they support vaccines in general. A position statement issued by the Canadian Federation of Nurses Unions from two years ago stated they do not support any program or policy that requires mandatory immunization.

"While CFNU does strongly support increasing overall immunization rates in health care workers, we argue that this should be achieved by increasing awareness, education and access to immunization, not by mandating it. The role of the employer to support access and education is critical, particularly as the evidence regarding immunization efficiency remains up for debate."[1]

While the vaccine does protect others around you from getting the flu, there is some evidence that forcing medical staff to get the shot doesn't seem to help the numbers. The Cochrane Database of Systematic Reviews reported that, "Evidence of vaccination had 'no measurable benefit on flu rates or the number of related complications of long-term-care residents'" and therefore, "given the limited effectiveness of the annual flu shot and the lack of evidence showing that mandatory campaigns can reduce transmission rates, health-care workers should retain the ability to choose."[2] Furthermore, many maintain that prevention methods such as hygiene and sick leave are far more effective.

Unfortunately it's been shown that when employees are only recommended to get the shot, less than half do. When BC mandated it, nearly 80% of workers were vaccinated, and some doctors think that's the way it has to be to protect patients.

Despite objections from the healthcare community, the province of B.C. and hospitals like St. Michael's, Mount Sinai and Sunnybrook in Toronto have adopted a mandatory immunization policy. Dr. Douglas Sinclair, the chief medical officer of St. Michael's Hospital in Toronto, told CTV News the decision will save lives. "There is lots of literature on this," said Sinclair. "When it came down to making the decision, the evidence seemed to be there."

In the face of all this debate, a symposium was held last June at the University of Calgary Faculty of Medicine to discuss how best to protect patients and healthcare workers. They proposed that, "A robust healthcare worker influenza vaccination policy and program in Alberta would increase patient and healthcare worker protection against influenza disease and death, and reduce pressure on Alberta's healthcare system."[3]

Dr. Talbot, Alberta's Chief Medical Officer of Health, said that he strongly supported improving healthcare worker vaccination rates. He asked those healthcare workers attending the symposium to consider three questions. First, how many people in their personal and work life do they come into contact with every day who could be asymptomatic or symptomatic carriers? Secondly, how many degrees of separation are there between them and a grandparent, pregnant woman, a diabetic, or a person on chemo for breast cancer? And third, "If you thought you had been responsible for a person's hospitalization or death, how much would you give to reconsider your original vaccination decision?"[4]

At the Symposium there was a lot of discussion around the idea of mandatory choice. While sounding like mutually exclusive ideas, mandatory choice provides a compromise between mandatory immunization and freedom of choice. Health care workers would have the option of receiving the vaccine or using personal protective equipment throughout the flu season. After small group discussion, most attendees at the Symposium opted for some form of mandatory choice.

There are hospital units in Calgary with outbreak precautions already in place. In a memo from Dr. Peter Jamieson, Medical Director of the FMC, staff was advised that "any physician, including consultants and students/residents, who have patient contact on an outbreak unit must be able to demonstrate vaccination — or alternatively must be on antiviral prophylaxis."

Since the goal is to increase vaccination rates overall, the question still remains why medical personnel would be against receiving a flu shot. Unfortunately there are some urban myths around vaccinations with just enough truth in them to frighten people, making them reluctant to inject their body with the vaccine ingredients. One expert that once supported mandatory vaccination is Dr. Michael Gardam, director of infection prevention and control at the University Health Network in Toronto. He feels that if someone is opposed to putting vaccine ingredients in their body, they have the right to say no without it affecting their employment status.

Flu shots do contain mercury; however it is not the type of mercury that stays in the body. The Public Health Agency of Canada explains, "Ethyl mercury is eliminated from the body rapidly and does not accumulate, even in premature infants. This is in contrast to methyl mercury which is found in many foodstuffs, especially fish — and which remains in the body longer and can accumulate."[5]

A Globe and Mail article stated, "Public-health officials may feel the need to use scare tactics and fear to counter the persistent anti-vaccination movement, which erroneously attributes a host of health problems to vaccines and has scared many away from getting them. But heavy-handed messages can undermine the very important goals of public-health campaigns around the flu."

Each of the ingredients have been proven to be safe over seven decades of use, and the benefits from avoiding both contracting and spreading the flu seem to outweigh the risks. However, as with other decisions affecting an individual's body — even when it affects the lives of others — most healthcare workers still argue it should remain their choice. For either vaccination numbers to go up or the immunization to be accepted as mandatory, it seems that more research is required to show actual results backing the program.

Unfortunately it's been shown that when employees are only recommended to get the shot, less than half do. When BC mandated it, nearly 80% of workers were vaccinated, and some doctors think that's the way it has to be to protect patients.

FOOTNOTES:

[1] Position Statement on Mandatory Immunization, Canadian Federation of Nurses Unions (2012)

[2] Roger E. Thomas, Tom Jefferson and Toby J. Lasserson, Cochrane Database of Systematic Reviews (July 2013)

[3] SYMPOSIUM ON INFLUENZA IMMUNIZATION IN THE HEALTHCARE WORKPLACE, from the report of Conference Proceedings at the University of Calgary Faculty of Medicine, prepared by Juliet Guichon, Ian Mitchell, and Margaret Russell (June 11, 2014)

[4] Position Statement on Mandatory Immunization, Canadian Federation of Nurses Unions (2012)

[5] Public Health Agency of Canada (January 2014)

College of Physicians & Surgeons of Alberta

CPSA consulting on three standards of practice

Deadline for feedback is March 12, 2015.

The College of Physicians & Surgeons of Alberta is seeking feedback on draft revisions to three standards of practice related to Physician-Patient Relationship. The standards represent the minimum expectations for Alberta physicians.

- *After-Hours Access to Care (revision)*
- *Episodic Care (revision)*
- *Establishing the Physician Patient Relationship in Office Based Settings (revision)*

To review the draft documents and comment online, go to **http://bit.ly/CPSAconsultation**.

You can also:

- Email your comments to **consultation@cpsa.ab.ca** with subject Consultation 007, or
- Mail your comments to: **Consultation 007**, College of Physicians & Surgeons of Alberta, 2700-10020 100 Street NW, Edmonton, AB T5J 0N3

After the consultation period ends on March 12, 2015, feedback will be compiled and presented to Council. Approved standards will be posted at **http://bit.ly/CPSAStandards** and announced in The Messenger newsletter.

We value your feedback as it assists College Council in striking the appropriate balance between serving public needs and setting reasonable expectations for physicians.

For more information, contact **sarah.thomas@cpsa.ab.ca**

Dr. Corinne McKernan

Our Community Lost a Talented Physician and a Wonderful Human Being on December 21, 2014.

Dr. Corinne McKernan graduated from the Faculty of Medicine from the University of Alberta in 1986. Her father is Dr. Andrew Krebes, a local ophthalmologist for many years. Corinne interned for a year at the Holy Cross Hospital and then for a year in New Zealand. She returned to Alberta to work as a family physician in Fort MacLeod from 1991 to 2002. She returned to Calgary in 2002 to join the Rockyview General Hospital as a Hospitalist where her energy and zest for adventure became evident to those around her. She also worked at the Regional Community Transition Program and Geriatric Mental Health Rehabilitation and Recovery Unit at Glenmore Park Carewest. Corinne was an avid cyclist and had participated in the Trans Rockies Challenge mountain bike race placing 4th. She was a caring physician and developed many friendships with those around her. Our community lost a talented physician and a wonderful human being on December 21, 2014. She is survived by a son Mitchell (age 20) and a daughter Kaitlin (age 18) who are attending university in Victoria and by her parents and two brothers.

From Dr. Thomas Tam
Rockyview General Hospital, Hospitalist Program Site Leader

Photo taken by Dr. Hans Berkhout at Nose Hill Park

CALLING FOR NOMINATIONS - Foothills Medical Centre

Nominations are being accepted for the 2014 Outstanding Clinician Award for Foothills Medical Centre Primary Site Physicians. Please note the following information and the criteria required.

Nominations should be made in a letter addressed to:

CLINICIAN AWARD NOMINATION COMMITTEE
c/o The Medical Staff Office, Room 154T
Doctors' Lounge, Foothills Medical Centre

Please include the following:

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

THE DEADLINE FOR NOMINATIONS IS FRIDAY, FEBRUARY 27, 2015

THE RECIPIENT OF THE AWARD LAST YEAR (2013) WAS

DR. STEPHEN WATSON
DEPT OF FAMILY MEDICINE

Previous recipients of the award are:

Dr. R.E. Hatfield 1991
Dr. N.B. Hershfield 1992
Dr. G.N.F. Hughes 1993
Dr. J.A. Williams 1994
Dr. E.A. Flagler 1995
Dr. P. Davis Elliott 1996
Dr. J. Dean Sandham 1998
Dr. Jane B. Lemaire 1999
Dr. Stephen K. Field 2000
Dr. John B. Kortbeek 2001
Dr. Keith Brownell 2002
Dr. Martin J. Labrie 2003
Dr. Harvey Rabin 2004
Dr. Ronald Hons 2005
Dr. Lorne Price 2006
Dr. David P. Archer 2007
Dr. Andre Ferland 2008
Dr. Elizabeth McRae 2009
Dr. Paul Beck 2010
Dr. Ahsan Chaudhry 2011
Dr. Robert L. Cowie 2012
Dr. Stephen Watson 2013

CRITERIA

The nominated physician would normally have met many or all of the following:

- Provided exemplary health care: compassionate, advanced and effective.
- Promoted an atmosphere of respect and dignity in all individual relationships with patient and staff.
- Assisted with nurturing the staff to achieve their best.
- Promoted the development of outstanding students for health professions of the future.
- Contributed to innovative research evaluation and continuous improvement of hospital activities.
- Instrumental in sharing expertise and resources within our organization and with the communities we serve.
- Would normally have served the institution for ten years or longer and have been principally associated with the Foothills Hospital.
- Would have promoted safety and environmental responsibility both in the hospital and outside its confines.
- Would be recognized by the individual's peers as a dedicated physician.
- May have received peer or community recognition of contributions outside of the Foothills Hospital, which reflect on the hospital in a positive way.
- May have made an especially significant contribution to departmental, divisional or hospital life.

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

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