September 2015

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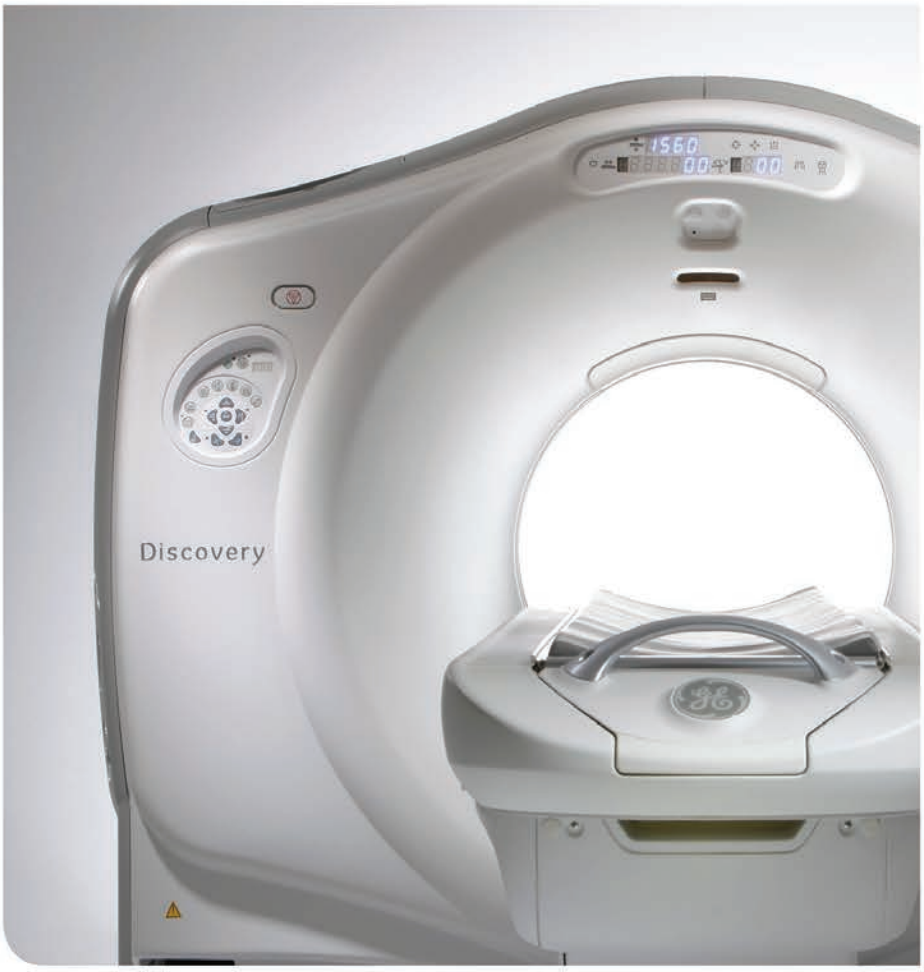
OF ALBERTA

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA



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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

September 2015

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
FOR PHYSICIANS,
CARING FOR PATIENTS

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SUBMISSIONS:
Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in Alberta. Please limit articles to 1000 words or less.

Please send any contributions to: Spindrift Design Studio Inc. Hellmut Regehr, hregehr@studiospindrift.com

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

The deadline for article submissions for the next issue of Vital Signs is September 15, 2015.

CONTRIBUTORS:
The opinions expressed in Vital Signs do not necessarily reflect the opinions or positions of CAMSS or CAMSS executive.

ADVERTISING:
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Contents:

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
September 9, 2015 | ACH 06 – 5:30-8:30 pm

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

CAMSS AGM
November 18, 2015 | Location TBA – 5:30-9:00 pm

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

CORRECTION:
In the July issue of Vital Signs Dr. Verna Yiu position was noted as a 'Medical Officer of Health', Dr. Yiu is the Chief Medical Officer, AHS.

President's Message:

Beginnings and Endings

To all things there is a beginning and an end. This is the phrase with which Dr. Steve Patterson opened his final column as President of CAMSS in the July edition of Vital Signs. It seems only fitting that I reflect also on beginnings and ends as I start my term as CAMSS President.

Dr. Sharron L. Spicer, CAMSS President

First, I want to express my gratitude to Steve Patterson, a fellow physician who would want no public praise but is ever deserving of recognition for his steadfast leadership of both the Peter Lougheed Centre MSA and CAMSS over the past several years. I am inspired by Steve's approach of working toward positive solutions to complex issues facing doctors and the entire health system. I am grateful that Steve will continue to serve as Past President to help guide the transition of leadership of CAMSS.

As I look to the year ahead of me, I reflect on the qualities of leadership that I want to personally demonstrate or improve. Leadership is a skill that many of us will spend a career lifetime trying to master. As Sheila Heen, faculty of Harvard Law School and author of Thanks for the Feedback: The Science and Art of Receiving Feedback Well, says, "Leadership is a bit like golf: an occasional good shot tricks you into thinking you're getting better at it." *(Global Leadership Summit, Chicago, August, 2015)*

Discussions about leadership are all around us. We are currently in the midst of the longest-ever federal election campaign where much of the initial focus is on the "leadership characteristics" of the party leaders, good hair seemingly among them. We look to government leaders to solve our economic woes. We see a never-ending rotation of pop psychology "leadership" titles on bookstore shelves. As I write this, I am attending a leadership summit. I'm hoping for some inspiration — admittedly, I have positive feelings and motivation from the speakers — but what is it that is so elusive about leadership that there is an entire industry built around it but it seems to remain just out of grasp?

Medicine by its very nature requires us to be leaders, a call as noble as helping the sick. "If your actions inspire others to dream more, learn more, do more, and become more, you are a leader." *(John Quincy Adams).* Along the way in our career paths, some of us take on more formal or informal leadership roles.

> Whether leading a small group of staff, a department, or an entire institution, it is important that leaders have a sense of what they are building.

A surprising revelation to me is the number of medical leaders who have confessed that their leadership journeys have begun almost by accident: perhaps they were asked by a department head to take on a vacant position, or they had the passion for a cause that needed a voice and ended up navigating the political system to advocate for change. For all, they describe stumbles along the way but the humility to pick up and keep going. "The irony is that we attempt to disown our difficult stories to appear more whole or acceptable, but our wholeness — even our wholeheartedness — actually depends on the integration of all of our experiences including the falls." *(Brene Brown, excerpt from Rising Strong: The Reckoning. The Rumble. The Revolution. 2015.)* At a personal level and an organizational one, there is a sense that it's not about achieving perfection but getting better as we go.

Such is my journey. My clinical pursuits opened up leadership opportunities that continue to beckon me. As a training pediatrician, I had several role models who showed unending compassion to their dying patients. Late in my residency and in my early years of practice, I felt a draw to palliative care. Thereafter I returned to train in palliative care, and as the opportunity for alternate funding positions arose, I started in a position for pediatric palliative care at Alberta Children's Hospital at a time when children's palliative care services across the country were scarce. Fast-forward ten years, and there is a new pediatric hospice, Rotary Flames House, in Calgary, and more than a dozen clinical palliative care programs for children across the country. Much of the growth happened as people at the front lines of caring for these fragile children and their families saw need for improved clinical, institutional and social approaches to their complex lives. As a junior physician in a leadership role of an emerging field, I felt unprepared for the challenges. I have spent the years since residency training learning — sometimes by trial and error, and lots of the latter — how to be more effective at leading change.

As a participant in the recent AHS Executive Education program, I can now recite the LEADS framework components: lead self, engage others, achieve results, develop coalitions, and systems transformation. Whatever the framework or the table of contents or the agenda of a leadership summit, the key factors in leadership that speak most to me are relationship, vision, and change.

I am keenly aware that leadership is relational. It is about taking time to invest in people. It involves role modelling, not only in our strengths but through our candid and open wrestling with difficulties: allocation of resources, competing priorities, and moral uncertainty. It also requires us to see our own blind spots and to seek others who complement our style.

Leadership is a catalyst for change. We don't need leadership in order to stay the same. Whether leading a small group of staff, a department, or an entire institution, it is important that leaders have a sense of what they are building. They need to have a vision for the future state and a plan of how to build it. Sometimes this means taking time away from the busy work we all face. A great learning for me in the Executive Education program is that reflective time is a component of effective leadership. We are expected to think, not just do, and sometimes quiet contemplation or brainstorming with a few other key leaders can spark new thinking.

Just as political candidates make their promises, I will make some to you. My first leadership promise is that I will fail. Well, not intentionally, hopefully not often, and I humbly hope not to your detriment. But undoubtedly I will cause confusion or hurt, whether known or unknown to me, and I humbly ask your grace to give me another chance. My second promise, though, is that I resolve to have the openness to hear from members about what needs to change, and the courage and tenacity to fight for change where it is needed.

AMA Update:
Dear Colleagues

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

Dear Alberta physician:

Your Zone Medical Staff Association (ZMSA) needs you. Join your ZMSA today!

Your ZMSA is your voice — strong and unified — with the Alberta Medical Association (AMA) and Alberta Health Services (AHS). Your ZMSA is an independent body that represents and advocates for physicians in your zone, and promotes you and your colleagues as leaders in a health care system that put Patients First®.

With the formation of AHS and creation of five AHS zones, ZMSAs are a crucial layer of representation in zone-related matters and are recognized as the representative bodies for practitioners in matters related to AHS Medical Staff Bylaws and Rules.

Your ZMSA:

- Is open to all physicians in the zone (AHS appointment not required).
- Gathers advice from zone physicians and advocates for you on local and zone issues.
- Makes medical staff appointments to bylaws-related committees.
- Obtains advice on strategic direction for policy and advocacy from the Zonal Advisory Forum.

By becoming a member, you contribute to a strong, sustained infrastructure that supports physician engagement and advocacy at the zone level.

If you practice in the Edmonton Zone or Central Zone, you can join your ZMSA by filling out Step 6 in your enclosed AMA membership form. For all other zones, contact your zone president for membership information, or contact Kirsten M. Sieben, Membership and Benefits Team Leader, AMA (780-482-0323 or email kirsten.sieben@albertadoctors.org).

For more information about ZMSAs, visit www.albertadoctors.org/leaders-partners/leaders/zmsas.

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

Federal Cowboys

Dr. Kevin Hay

This summer all three official party leaders were at the Calgary Stampede roping in some pre-election support. They had that *'city slicker'* come *'cowboy-for-a-day'* thing – which is like going to your doctor for a prostate exam to find he's wearing chaps & a 10 gallon hat. *Awkward…!*

This year Alberta bucked off its prize-winning rider of 44 years — the *Progressive Conservative* — which might be an indication we're in for a wild ride during our national 'rodeo', the Federal Election. '*Albertans have not elected more than 2 non-conservative MPs in any federal election since 1993.*'[1]

All parties are now galloping towards the tie-down competition finals slated for Monday October 19th: *Election Day!*

Federal Politics 101:

- This year, Federal Electoral Districts (i.e. seats in the House of Commons) increase from 308 to 338.
- Alberta gets an increase of 6 to 34 districts (seats) which is an increase from 9% to 10% of the total. (Map reference: see footnotes.)
- As of July 2015 there were 6 parties with seats (*Table 1) and 13 other *'Registered'* & 3 other *'Eligible'* parties with Elections Canada without seats (**Box 1.)

We have 3 official / 'recognized' parties with the required minimum of 12 seats.

- **Conservative Party of Canada:** led by Stephen Harper [age 56]
- **Liberal Party of Canada:** led by Justin Trudeau [age 43]
- **New Democratic Party of Canada:** led by Thomas Mulcair [age 60]

The 3 other parties with seats are: **Bloc Québécois, Forces et Démocratie** and the **Green Party of Canada.** (2 are registered and Force et Démocratie is 'eligible.')

Candidates have till 28th September to return Nomination Papers but the numbers of candidates for the 34 seats in Alberta as of 12th August 2015 are:[2]

- Christian Heritage: 4
- Conservative: 34
- DAPC: 4 (Democratic Advancement Party of Canada.)
- Green: 24
- Independent: 3
- Liberal: 26
- Libertarian: 16
- NDP: 21[…many NDP nominations are still in progress.]
- Pirate Party: 1
- Rhino Party: 1

All parties are now galloping towards the tie-down competition finals slated for Monday October 19th: *Election Day!*

***Figure 1:**

FEDERAL PARTY or CATEGORY *(*official or recognized bolded)*	CANADA PRE-ELECTION *(308 total seats)*	ALBERTA PRE-ELECTION *(28 seats)*
CONSERVATIVE*	**159**	**26**
LIBERAL*	**36**	**0**
NEW DEMOCRATIC*	**95**	**1**
BLOC QUÉBÉCOIS	2	0
FORCES et DÉMOCRATIE	2	0
GREEN	2	0
INDEPENDENT	8	1
VACANT	4	0

****Figure 2:**

The additional 13 'Registered' parties: no seats in the Commons.

(**bold:** *running candidates in Alberta.)*

Animal Alliance Environment Voters Party of Canada *(environmentalist, animal liberationist)*
Canadian Action Party *(populist, anti-globalization)*
Christian Heritage Party of Canada *(social conservative)*
Communist Party of Canada *(duh!)*
Libertarian Party of Canada *(individual rights, lower taxes, pro-cannabis legalization)*
Marijuana Party of Canada *(single-issue on cannabis)*
Marxist-Leninist Party of Canada *(communist, version II)*
Party for Accountability, Competency and Transparency *(direct democracy)*
Pirate Party of Canada *(copyright reform, privacy, network neutrality, open government)*
Progressive Canadian Party *(progressive conservative, Red Tory)*
Rhinoceros Party *(satirical party)*
The Bridge Party of Canada *(a new party in 2015: uncertain policies)*
United Party of Canada *(centrist)*

The 3 additional 'Eligible' parties: no seats in the Commons.

Canada Party *(populist, bank reform, direct democracy)*
Democratic Advancement Party of Canada *(populist, direct democracy)*
Seniors Party of Canada *(no web site: unknown policies)*

HEALTH PLATFORMS FOR THE 3 OFFICIAL PARTIES

(from their web sites as of 4th July)

Conservative Party of Canada.

- '*…promoting healthy living and physical activity through continued support for community-based programs like ParticipAction & Athletescan*' […their only health related comment.]

Liberal Party of Canada.

- *'Every Canadian must have access to timely, publicly funded, high-quality, universal health care, regardless of background, physical needs, geographical location, or income.'*
- '*…we believe the federal government must show leadership & work in collaboration with provincial and territorial partners to address critical health care issues like reducing wait times, & strengthening homecare, seniors care, mental health prevention and treatment, & pharmacare.'*

– Continued on page 6

– *Continued from page 5*

New Democratic Party of Canada.

- *'…access to high-quality public health care that is transferable between provinces & territories…'*
- *'…Fighting the privatization of public health care services…'*
- *'Increasing health care transfers to the provinces & territories...'*
- *'…providing incentives to recruit & train more health professionals, especially doctors & nurses.'*
- *'…reducing costs by providing funding for provincial & territorial pharmacare programs…co-ordinating the bulk purchase of pharmaceutical drugs, & less expensive generic drugs.'*
- *'Investing in not-for-profit home care for seniors & people with disabilities.'*
- *'…promoting healthy living, physical activity, & reduced tobacco use.'*
- *'Adopting a harm reduction approach to substance abuse & permitting the use of marijuana for medicinal purposes.'*
- *'Specific focus on health & safety of sex-trade workers…First Nations, Inuit & Métis peoples… reproductive health…coordinated emergency plans…pandemics, product & food security & drinking water.…'*
- *'Establishment of a Canadian Health Covenant or patient's bill of rights.'*
- *'Establishment of a national healthcare council to ensure that the Canada Health Act is enforced & the range of services extended to include home care, palliative care & prescription drugs.'*
- *'Facilitate Canadians aging in place...'*
- *'…a designated federal home care transfer to guarantee a basic level of home care services to all Canadians…'*
- *'…federal long-term care transfer to…address the shortage of quality care spaces across the country.'*

Which Leader Can Represent Canada On The World Stage?

For sure Canada has health care problems — mostly first world issues — and these shrink in importance when we see beheadings on the evening news.

Consider the crises which have affected the world over the past 10 years: the financial crash; ISIS; Russian invasion in the Ukraine; Iranian nuclear arms race; Syrian massacres and natural calamities such as an earthquake in Nepal etc.

So put the question a little differently: **Which PM candidate has the guts to handle tough international issues for Canada — Harper, Mulcair or Trudeau?**

OCTOBER 19TH: SADDLE UP & VOTE!

APPENDIX:

HEALTH PLATFORMS: for the 2 parties with seats but NO candidates in Alberta.

- **BLOC QUÉBÉCOIS:** No health policies relevant to Alberta.
- **FORCES et DÉMOCRATIE:** 'Strength & Democracy' No health policies relevant to Alberta.

HEALTH PLATFORMS: for the 6 additional parties running candidates in Alberta.

CHRISTIAN HERITAGE PARTY of CANADA.

- Improve delivery of services by allowing more private delivery systems'
- '…public funding must …be enhanced…is universal access, with a single government payer.'
- 'Eliminate the use of scarce healthcare dollars for abortion.'
- 'Revamp hospital design.(…single rooms with individual toilets for all patients, ample hand-washing stations, non-porous fixtures, standardized surgical rooms and quieter floor materials.')
- 'Promote healthy lifestyle choices…end Government funding for the 'Gardasil' vaccination.'
- 'Reform the healthcare system. The CHP would scrap ill C-51.'

DEMOCRATIC ADVANCEMENT PARTY of CANADA.

- 'The DAPC will strive to make public healthcare financially viable and of high quality.'
- 'Supports…the constitutional arrangement giving the provinces jurisdiction over HC…'
- 'Supports the federal government's role …to coordinate funding of transfer payments'
- 'Defends the principles and objectives of the Canada Health Act'
- 'Supports forums for public online input on healthcare issues…accessible to all Canadians.'

GREEN PARTY of CANADA:

- Health Care & Health Promotion policies run to ~5000 words & cannot be summarized here due to length: Web links are appended.
- 'Legalize marijuana by removing marijuana from the drug schedule.' ('Ending the War on Drugs')
- 'Launch a public consultation on the decriminalization of illicit drugs, considering the current high costs of the law enforcement effort...' ('Ending the War on Drugs')

[NB: Any party considering the decriminalization of Crack & Meth' etc. is DISQUALIFIED from my vote. Decriminalization of illicit drugs is not 'Ending the War on Drugs' — it is an unconditional surrender — leaving the battle to be fought by individuals, families and the health care system.]

LIBERTARIAN PARTY of CANDADA:

- '…the federal government should leave the entirety of health care decisions to provincial & territorial governments…'
- '…would repeal the Canada Health Act to ensure that healthcare is a provincial responsibility…'
- '…allow private alternatives for care & insurance…Provinces will be free to choose the system that best fits their needs'
- '…would end the war on drugs by legalizing cannabis…' (Justice platform)
- '…and immediately decriminalizing the consumption and possession of drugs…' (Justice platform)

[NB: Any party considering the decriminalization of Crack & Meth' etc. is DISQUALIFIED from my vote.]

PIRATE PARTY of CANADA:

- '…Reduce patent terms to 5 years, and require a higher standard of originality. Eliminate patents on genes, organisms, software, and business models.'
- 'Reallocate funds saved in health care due to patent reform to public pharmaceutical research, the results of which are to be made publicly available.'

RHINOCEROS PARTY of CANADA:

- No health policies relevant to Alberta.
- [Indeed they have no policies of any relevance to most anyone …anywhere… ever!]

FOOTNOTES:

Thanks to **M. Steve Mazerolle** for reviewing the health care policies of Bloc Québécois & Forces et Démocratie.

[1] David Cournoyer: www.daveberta.ca/2015/07/calgary-stampede-alberta-politics/

[2] David Cournoyer: www.daveberta.ca/federal-election-2015/

Green Party of Canada:
www.greenparty.ca/en/policy/vision-green/people/health-care
www.greenparty.ca/en/policy/vision-green/people/health-promotion

Elections Canada MAP of New Federal Electoral Districts in Alberta:
www.redecoupage-federal-redistribution.ca/content.asp?section=ab&dir=now/reports&document=index&lang=e

Letter

The Senior Physician Self Esteem Ability to Practice versus Fitness to Practice.

Aging is part and parcel of our life cycle. It is not an illness, not a disease.

When I came to Canada in 1967 I practiced at the Harvie Clinic Orillia. Dr. Harvey aged 93 years was FIT. He had the "Ability to Practice" three hours each day. He did not have the "Ability to Practice" eight hours a day.

There are many circumstances which can impact on practice performance or "The Ability to Practice" in a fit physician.

To name just a few circumstances:

1. The newly qualified inexperienced 25 year old physician who not infrequently has to discuss with an older more experienced physician patient management.
2. A 35 year old ER physician who having completed a taxing 8 hour shift in a busy emergency department because of unforeseen circumstances is requested to work non-stop for another 8 hours.
3. The 40 year old physician mother with 3 children under 6 years of age who is running a full time family practice.
4. An experienced 75 year old solo practitioner who is still working at the same pace as when he did 30 years earlier.

What we see in common with these examples is a compromised "Ability to Practice".

The term fitness is an ambiguous term. An understanding of the term "Fitness" can range from suitability, healthy, in harmony, a good fit, fit to scream, fit for nothing. There is bias with the use of this term.

The term ability is unambiguous. It means the power to do, skill, expertness or talent.

Those physicians with a medical condition be it progressive cardiac disease, end stage COPD, multiple sclerosis, uncontrolled psychiatric disease, addiction issues, memory loss, dementia etc. are strictly speaking medically unfit. None the less a compromised ability to practice is a kinder term, has no innuendo and is more respectful than the term "Fitness to Practice".

There are physicians who have sexual perversions, have become involved in criminal activities, even murder. They may have the ability to practice but because of their criminality they are unfit to practice.

Our college has a mandate to provide physicians who are safe, knowledgeable and continue to update. Particularly now that health care has become industrialized, what with the plethora of diagnostic tools available and the thousands of drugs manufactured by the pharmaceutical industry.

I do not believe that "Our College", not "The College" wishes to retire any physician able to maintain their competence. Dr. Theman makes this very clear in his response to my letter in the Messenger of February 12th, 2015. We can be confident that our Registrar and his assistants understand physician health issues. They have a wealth of experience and are not without empathy.

I have read Dr. Ronald Witzke's response to my letter in the Messenger. Here is a fit physician who feels humiliated with twelve monthly interviews. He has no support from his younger surgical colleagues when it comes to being on call.

Earlier this year in a conversation with the president elect of the AMA he said that the greatest hazard facing the senior physician in the middle of the night is the drive to the hospital not the surgical procedure. Dr. Witzke is disillusioned with our college. Perhaps his self-esteem is likely being eroded. To practice well you need to feel good about yourself. This type of scenario I believe is being repeated time and time again with our senior physicians. An age related compromised "Ability to Practice" needs support.

Having spoken to a number of people, young and old, physicians and non-physicians and the elderly there is an impression that our seniors are not treated with the dignity and respect that should be given.

We physicians need to change this prevailing attitude. Senior physicians should be treated with kindness, dignity and respect. The term Ability to Practice is kinder than the term Fitness to Practice or Competence to Practice. A compromised Ability to Practice term is far more likely to encourage support for the senior physician that the term Fitness to Practice.

Dr. John L. Barrow

Dr. John L. Barrow is a Senior Physician. He has a special interest in issues facing senior physicians. He is past President of the Calgary Medical Society. He is in active full time practice and is involved with the teaching of medical students and international medical graduates. He has a strong commitment for safety in community practice.

On being a "Doc"

Dr. Richard Bergstrom

Dr. Richard Bergstrom,
Department of Anesthesiology,
University of Alberta

I was the recipient of a massive hug last night, and I am not a "touchy feely guy". I smiled and then thought about it, and then thought more about what we do as physicians. I was reminded of what we do; we provide care and caring.

OK, I will back track. I was on call and went in to do a heart transplant. To me this is routine work but this one was going to be tougher than many. This is because this patient had a left ventricular support device. So, first this person comes in walking and talking but has no pulse. Yes, no pulse. The device delivers laminar flow. So, how do you get an arterial line? You use ultrasound (a magnificent invention that has revolutionized healthcare and will do more of the same in the future). That is one hurdle. The other hurdle is that they all come quite anticoagulated. So, I get to put in a massive intravenous, a central line and an arterial line before they are reversed. Then we get down to the difficult part...carving out the heart and the device is the surgeon's role and mine is to manage the ensuing coagulopathy.

It all went well, a lot of powerful drugs, devices and a heck of a lot of running to the blood bank by our service attendant! I delivered this patient to the CVICU around 2300h. I then went over to help with another patient who is on ECMO (his lungs are basically shot so we have him on a portable artificial lung). After this I came back to check on my first patient and there were family members standing around this person's bedside. They all looked at me and I guess I look like a doc. I introduced myself and gave them the good part of the story....this patient basically flew off of bypass. This patient's partner then looked me in the eye, blinking to prevent tears from flowing and gave me this most magical hug. A most sincere thank-you and smiles all around.

Now, it is all about me right? Nope...not at all. I remind all patients coming for heart surgery that there is a team of about eight people in the OR with a sole focus is to provide care. But I am wrong on that when I think deeper. There are a hell of a lot more people involved.

The number of people that are needed to provide care for Albertans is vast. Sure, we as physicians are coordinators of care but we cannot do this without the array of support that plays such a vital role in the provision of care.

The network of people that deliver care is vast and spread out. You have the people in the room, the desk clerks, the blood bank people, the laboratory workers who rarely get thanked but are so incredibly necessary in providing care. The nurses, aides and respiratory therapists in ICU. The pharmacy, the cardiologists, the sonographers for echocardiograms, the transplant coordinators. Then the teams that fly all over creation to obtain organs. It is an amazing number of people who actually "touch" the patient.

Granted, this is a pretty neat event and truly life giving to many. Yet, it is just what happens in medicine. The number of people that are needed to provide care for Albertans is vast. Sure, we as physicians are coordinators of care but we cannot do this without the array of support that plays such a vital role in the provision of care.

I tell the story of one of the secretaries of one of the surgeons who we know well. She introduced herself as "I am just his secretary". I stood my ground and spoke clearly. No you are not "just" and you are not a "secretary". Somewhat aghast she looked at me quizzically. I went on to explain her role as a coordinator, organizer and facilitator for the interaction of the surgeon and his patients. I simply asked if he could do what he does without her support. She smiled gracefully and answered "no". I wanted her to understand that "just" was not the right word to describe her work. Should there be no surgeon she would not have much to do. But that is not the point. She is as valuable to the system as is the surgeon. Different jobs, different levels of complexity and risk but still valuable.

We, as physicians, have an honorable profession. We enter it via medical school, residency and then really start to learn our job. We are richly privileged to be able to help those who seek our advice and expertise. We connect with other physicians, allied health, interact (directly and indirectly) with a vast array of other people who, in a very organic fashion provide care and caring to our patient population.

It often seems to be about "us" (physicians) and it really is about the bigger "US" (the widespread fabric of individuals who in a coordinated fashion enable care to happen). As it is July and a new group of docs has finished their formal training and a new group of individuals have started same, let's show them the power of engagement, respect and coordinated care. Sure AHS keeps changing and change fatigue is all around. Sure the government can seem to have a tendency to look at budgets more than care that is needed. Sure we still need to advocate for better and timely care.

Yet, despite all these challenges we stand firm and as one when it comes to who is really important, the patient.

As this new wave of physicians and students/residents comes forward let us lead by example. To work as physicians who have the privilege of giving someone a new heart, a healthy baby, a hope for a longer life, a better life and compassionate caring. I was reminded of the power of what we do....we work for the patient....we work with each other and so many others in this world of "health care".

College of Physicians & Surgeons of Alberta

New Continuity of Care standard for physicians

The College introduced a new Continuity of Care standard* on June 11, 2015. Recognizing that no individual physician can be available to patients 24/7, the standard does expect physicians to have a system in place for after-hours triage of patients currently in their care and to receive and respond to critical test results.

The CPSA notes such a system should start with good communication with patients about appropriate follow-up based on medical need, and may include:

- *Collaborating with colleagues in an on-call rotation (solo practice is acceptable, practice in isolation is not) or*
- *As a practice group, pursuing a formal agreement with a healthcare provider or referral service. Referral to another provider or such a service without an agreement does not absolve physicians of their responsibility to have a system in place.*

Immediately after the standard took effect, the College followed-up with a member survey to benchmark current compliance and offer individualized support to physicians challenged by the standard.

The CPSA is encouraged by the high number of physicians who report compliance with the standard. Almost 70 physicians have offered to share their processes with the College to help others develop practical solutions. The College has also responded individually to more than 40 physicians at their request.

The Continuity of Care standard and advice to the profession are available on the College website at cpsa.ab.ca. Physicians with questions should contact College Assistant Registrar Dr. Owen Heisler at owen.heisler@cpsa.ab.ca

**Formerly After-Hours Access to Care and Preventing Follow-up Care Failures*

Is the Doctor Vaccinated?

Dr. Sharron Spicer

SARS, H1N1, Ebola… these are the outbreaks of infectious diseases that garner headlines. But what of their lowly cousins such as chicken pox, mumps, measles and seasonal flu? As a health system, we need to be ready for the major epidemics when they hit, but we need to be equally prepared for the occurrences of other pathogens in our midst – some common, others we thought we could forget.

I recall as a pediatric resident being pulled into an exam room in the Emergency Department by a pediatric Infectious Diseases specialist to see a child with mumps. "The only case of mumps you may ever see in your career," I was told. While that prediction has proved correct for me, I don't have the same confidence that it still holds true for today's trainees. Just this past season, mumps caused Sidney Crosby and at least a dozen other NHL players to miss games due to illness. Considered part of an under-immunized cohort born between 1970 and 1994, this group of young adults remains at risk to contract and transmit mumps, especially if not given a second dose of vaccine in adulthood.[1] Clearly mumps is still present, not just as a childhood disease but one that is a risk to our young adult population who may need to be isolated and away from work while infected.

Our health care workforce is no less susceptible to the effects of infectious illnesses. Illness causes workers, even docs, to take time away from work when sick or caring for family members. (Or, even worse, to work when sick.) Furthermore, unlike pro sports players, we are in close contact with vulnerable patients who may have weakened immune systems and co-morbid conditions that make them much more susceptible to complications or death from infections.

We take responsibility for infection prevention on many levels: handwashing, personal protective equipment (PPE) and sterile technique are essential. Let us also consider the importance of vaccination. Just as with handwashing and PPE, our "system" needs to support vaccination through infrastructure support to meet workers' needs for information, record-keeping, prompting and providing for vaccines. This is a challenge. Even for routine childhood immunizations, there is no shared database across the province or zones. Aboriginal children have information stored in different systems than non-Aboriginal children. Vaccines administered in physicians' offices or by pharmacists might not be entered into the same database as those given by Public Health in their clinics or in school programs. Children who move will not necessarily have their vaccine records move with them. So if the challenge of accurate record-keeping is high for a somewhat captive audience of children in primary care and school settings, it is even more difficult for, let's say, physicians across the province, many of whom spent early childhood in other provinces or countries, largely prior to computerized records, who have moved as part of their education and career paths, and who may access vaccinations through various means including administration through their own clinics. Add to this that some physicians do not have their own family doctors to prompt them to have recurring vaccines — *this is where you might pause to ask yourself when you had your last tetanus shot* — and we have an occupational health challenge of immunization surveillance for physicians.

In the past influenza season, while I was ACH MSA president, we ran an influenza immunization incentive at ACH: physicians who were vaccinated in an AHS program, or in another program such as local pharmacy or clinic and then self-reported, would be eligible for a random draw for a gift certificate, and the clinic or program with the highest physician immunization rate would have a donation made in their name to the children's or health charity of their choice. The initiative had a two-fold purpose: to encourage flu shots among physicians, to be sure, but also to determine how robust the data collections systems could be in compiling the vaccination rates across a site. Sadly, the incentive was a failure — not because of lack of participation but because we didn't have systems to "talk" to one another. Quite simply, figuring out who works where and overlaying AHS- or self-reporting of flu vaccine could not be done.

In the media, vaccination rates amongst health care staff are often reported during illness outbreaks. These are usually figures of vaccines provided by AHS, with the numerator the number of vaccines given and the denominator the total staff pool. They miss counting vaccines given outside of the AHS system, and do not distinguish front-line workers from those who may have no contact with patients. Overall, they do not paint a picture of high vaccine rates — sometimes they appear to be even lower than that of the overall population. This sends a mixed message to the public who sense that health care workers themselves might be reluctant to receive the vaccines. While there may certainly be some health care workers who object to or decline vaccination for themselves, I doubt it is in the numbers suggested by the misleading reports.

Accurate vaccination rate reporting would create better public accountability and increase incentive not only to those who are part of the health system but those who may be influenced by the behaviour of its members. But another key component of vaccination records is for individual disease risk and transmission assessment. Measles, for example, is one of the most highly contagious infectious diseases, yet nearly non-contractable to or from those who are immunized.[2] As a result, during measles outbreaks such as 2014 in Alberta, health care workers, including physicians, who cannot demonstrate immunity must be off work or receive the vaccine. Think of the enormous workload for Workplace Health and Safety to determine the vaccine status of AHS staff. Then consider that WHS does not even have such records for physicians who are deemed independent contractors. *You think it was hard to remember your last tetanus vaccine? Try remembering your last measles shot, perhaps sometime back before puberty.* We require physicians and staff to work in certain ways to minimize infectious risks to patients but as a health system we have no organized systems approach to maintaining vaccine records to ensure the proper steps are taken. I think we can do better.

AHS WHS is currently overhauling its staff vaccination registry. It supports such a registry for physicians as well but does not have the manpower or mandate to create it. The AMA has a start on demographic data for physicians but does not collect or share health information of doctors. AHS Medical Affairs works to integrate physicians in the workplace of AHS and has begun work with WHS to determine the feasibility of the two linking databases to allow better surveillance of physician immunizations for public and workplace health. CAMSS supports this endeavour and requests input from physicians regarding concerns of privacy, confidentiality, or other issues. Here is an issue where a systems approach can have a direct impact on our most vulnerable patients by ensuring that our physicians are not needlessly putting them at risk from infectious illnesses.

FOOTNOTES

[1] Ottawa Citizen, December 27, 2014; **www.ottawacitizen.com/news/national/the-nhl-mumps-outbreak-shows-importance-of-herd-immunity**

[2] **www.phac-aspc.gc.ca/publicat/cig-gci/p04-meas-roug-eng.php)**

Dr. Borys Hoshowsky,
President, RGH MSA

Welcome Back

Dr. Borys Hoshowsky

Dear Colleagues,

I wish to personally welcome everyone back and hope you have all enjoyed the summer.

I am very pleased to be taking on the position as President of the Rockyview General Hospital Medical Staff Association for the next 2 years. Other executive changes are Dr. James Janzen who is taking on the role of Vice President, Dr. David Kent who has elected to remain on board as a Member at Large and we welcome Dr. Stan Mayer who has offered to fill the role as a Member at Large as well. We look forward to working together as your new executive.

I would like to extend sincere thank you's for outstanding work; to Dr. David Kent as President over the last 3 years, to the past executive and to our administrative assistant Stella Gelfand.

As in the past, the executive will bring forward more pertinent topics and guest speakers, which we are hoping will provide for some interesting presentations and discussions.

We will be starting our term with special guest speakers from the College of Physicians and Surgeons of Alberta; Dr. Owen Heisler, Assistant Registrar and Dr. James Stone, Council President. I have personally known Dr. Heisler for over 30 years; he has always been a strong advocate for our profession and is passionate about patient care. Together they will be discussing "After Hour Care and Call Responsibilities and the Proposed Guidelines". I truly hope that many of you will be able to attend this presentation which will take place on September 8, 2015 at 6:00 p.m. at Rockyview in Fisher Hall. We look forward to your feedback.

Rockyview General Hospital Medical Staff Association members please arrive promptly at 5:30 p.m. for a delicious dinner and please let your colleagues know that non-members are very welcome to attend the meeting which commences at 6:00 p.m.

Please RSVP to **stella.gelfand@albertahealthservices.ca**

I would be remiss not to mention the importance of increasing our membership! Dues are collected via the AMA renewal/membership process. Members with an email address on file are sent an email in September advising them they can pay on-line. Members without an email address on file are sent the renewal/membership forms in the mail. When you renew your AMA membership, please remember to renew your Medical Staff Association membership as well by placing your checkmark on the box indicating that you designate the Rockyview General Hospital as your Association. If you aren't a member of the Rockyview General Hospital Medical Staff Association please consider it and contact me as I would be pleased to discuss with you the benefits of membership.

Sincerely,
Borys Hoshowsky, MD, FRCSC
President, Rockyview General Hospital Medical Staff Association

Your ZMSA Membership

The ZMSA is your vehicle for direct participation in the planning and delivery of healthcare in Alberta.

It's that time of year again… time to renew your ZMSA membership!! The ZMSA annual membership process is conducted through AMA just like last year. If you have an email address on file you will receive an email in September from Kirsten Sieben of AMA Membership Services providing you a link to complete your renewal.

If instead, you receive a paper copy of the membership forms by post, it's because we do not have an email address on file for you. You can call Audrey Harlow at 403-205-2093 to provide an email address if you wish to switch to the online registration method.

Your zone membership options will default to whatever you selected (or didn't) last year. You can remove, add or make changes as you wish.

Your ZMSA Membership provides you with many opportunities:

- get accurate information as ZMSA executive are in direct contact with the AHS and AMA on a weekly basis.
- learn about emerging issues
- provide direct input and feedback on healthcare issues
- build professional relationships outside of your own circle of influence
- dialogue about and examine healthcare issues in a frank, constructive ways
- receive Vital Signs.

Dr. Steve Patterson,
CAMSS Past-President

My Reflections on the AMA Representative Forum

Dr. Steve Patterson

I have attended the last 3 Representative Forums as a delegate from the Calgary and Area Medical Staff Society (CAMSS). I would like to provide my reflections on this event.

The Alberta Medical Association has established a Representative Forum of physicians to guide its policies and actions. The Forum is composed of elected members from the five zones in Alberta, representatives from the medical and surgical specialities, and AMA board members. There are two Representative Forums each year, held in conjunction with section meetings, on a Friday and Saturday in March and September. The meetings alternate between Calgary and Edmonton.

RF – 2015 *(Total delegates: 136)*	GP	Specialist	Vacancy
Board (AMA & CMA)	7	8	0
Section Representatives	18	37	3
Regional Representatives (i/c PCN)	27	21	3
Total	**52**	**66**	**6**
Others: 12 (Deans of Medical schools, PAIRA representatives, Speaker and deputy Speakers)			

Each meeting is composed of a Report from the Board, which provides the delegates with updates on the resolutions passed at the previous meeting as well as issues facing the profession, and a report from the Physician Compensation Committee. Keynote speakers also present, and the speakers are often members of the government or Alberta Health Services. The most dynamic part of the meeting occurs during "members' hours", when delegates are asked to debate and vote on resolutions from the floor. These resolutions range from very specific comments on current issues to broader concerns around physician manpower, service delivery and government initiatives. The range of issues and the breadth of knowledge demonstrated by the members are both very impressive.

The real value of the Representative Forum is as a venue and occasion to bring together so many motivated physicians. The RFs have acted as a tonic to recharge my enthusiasm and energy for physician engagement and to provide a sounding board for ideas. It is always informative to talk with the other Medical Staff Presidents at one of the many meetings scheduled around the RF. It is hard to accurately relay the enthusiasm, the exchange of ideas and the many viewpoints represented at RF. RF has also provided opportunities to question the Minister of Health, and the CEO of Alberta Health Services as well as others involved in health care. The RFs have given all participants a broader view of the many issues around providing healthcare in Alberta and of the challenges face by individual physicians.

We are well represented and well led by the AMA, and our Representative Forum plays a crucial role in providing an interface between the leaders of the AMA and all practicing physicians. I would encourage all physicians to participate in the Representative Forums if they have the chance. I would also encourage physicians who have issues they would like brought forward at RF to contact their regional or sectional representatives. It is after all our representative forum and we all have a stake in our association. Thank you for letting me serve as president of CAMSS and for allowing me to provide a voice at our forum.

CALGARY INTERNATIONAL FILMFESTIVAL SEPT 23 - OCT 4, 2015

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
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CARING FOR PATIENTS

The ACH Medical Staff and CAMSS are pleased to sponsor a night at the Calgary International Film Festival. The Calgary International Film Festival brings films and film makers from around the world to Calgary for a series of showings over 2 weeks. We are sponsoring the event and have secured a number of tickets to the 7:00 p.m. showing of 3 films at Eau Claire Cinema on October 2nd. We will be meeting at the Garage Bar in Eau Claire Market at 5:30 p.m. for a preview of the films and a presentation by the film festival staff and potentially some of the actors and directors in the films will be present as well. This is a great event and a chance to enjoy an evening out with your partners and friends. The film titles will be released in the beginning of September so stay tuned. Tickets are limited and will be available at $10/ person through the CAMSS executive, Sharron Spicer, Steve Patterson, Charlene Hunter or Warren Yunker.

"Today it is the largest film festival between the Rockies and the Great Lakes, and has been named "one of the top 25 film festivals in the world worth your entry fee" by MovieMaker Magazine."

We Want You To Get Involved

We have an awesome opportunity for you! Vital Signs exists to represent and advocate on matters pertinent to medical staff and patient care at the zone and provincial levels. We do this by publishing articles written by medical professionals that have a knowledge and a caring for their profession and their patients. Professionals like you.

Everyone Wants to be a Writer

Deep down we know everyone wants to writer, now is your chance. You have passion, knowledge and a perspective that is all your own. We want you to share that passion with Vital Signs readers. If you have a topic or interest that fits into the Vital Signs mandate we are asking you to consider submitting an article. Some topics include, but are not limited too, medical marijuana, assisted suicide, communicating with patients and their families, working smarter, funding issues, workplace issues, work-life balance, working with new technology and of course, the many aspects of patient care.

The Benefits of Being Involved

Your participation in Vital Signs educates, enlightens and encourages colleagues, it also benefits you in many ways. Satisfaction for a job well done, connection with new people and the excitement of a new experience. Make a difference, be part of a group of doers and grow in ways you never expected.

Upcoming issue themes you might want consider participating in.

2015 October issue – **End of Life**

2015 November issue – **Advocacy**

2015 December issue – **Physician Engagement**

2016 January issue – **Technology**

Editorial Guidelines

CONTENT:

1. Content submitted to Vital Signs should represent and advocate on matters pertinent to medical staff and patient care at the zone and provincial levels, such as:
   - Quality and safe patient care
   - Service planning and delivery
   - Practitioner workforce planning
   - Inter-disciplinary patient care
   - Workplace and wellness
   - Medical Staff bylaws and rules
2. Content submitted should be original and is published at the discretion of the Editorial Committee. Content should reflect the goals of the ZMSAs and be respectful and constructive.
3. Content with commercial interests will only be accepted as paid advertisements. The following may be submitted for possible inclusion as paid advertising in Vital Signs:
   - Third-party sales/product and promotional offers
   - Private/for-profit conferences or seminars
   - Job ads
   - Want ads

FORMATTING:

1. Articles submitted should be no more than 1000 words in length and in MS Word format with sources cited and trademarks and copyrights honoured.
2. Please observe writing conventions:
   - Be brief, but engaging. Limit unnecessary words and adopt plain language where possible.
   - Use action words and make it clear how this information will directly benefit the reader.
3. Graphics are welcome. Please provide logos in .eps format if available; jpegs should be at least 300 x 300 to allow for cropping. Images should be supplied at 300dpi at original size. Stock photos may be provided at the discretion of the managing editor.
4. Articles are approved and may be edited by the Editorial Committee prior to being published.

Please send submissions and inquiries to: Hellmut Regehr, Vital Signs Managing Editor at hregehr@studiospindrift.com

2015 CAMSS Physician Advocacy Award

ATTENTION:
Calgary and Area Physicians

Who deserves to be recognized for exemplifying the spirit behind the CAMSS mission statement: "Advocating for physicians caring for patients"? Soon the CAMSS executive we will be accepting nominations for the 2015 CAMSS Physician Advocacy Award.

Presentation to the award winner will be made at the CAMSS Annual General Meeting at the Glencoe Club on November 18, 2015.

Nominations will be accepted until midnight November 9, 2015 and the CAMSS executive will select the award recipient from the nominations received.

Previous Award recipients are:

Dr. Lloyd Maybaum: 2014 | Dr. Martin Labrie: 2013 | Dr. Phillip der Merwe: 2012
Dr. Rick Anderson: 2011 | Dr. Glenn Comm: 2010

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