January 2017

ZONE MEDICAL
STAFF ASSOCIATIONS
OF ALBERTA

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

Not What I Signed Up For
Honour and Good Sense?
Vital Signs 2017
AMA President's Message
Aspirations, Hopes and Dreams for 2017…Personal and Professional
The Demise of Multi-Tasking in Dental Anesthesia
Are We Keeping Up With The Changing World?
The Amending Agreement

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BACKGROUND

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A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

January 2017

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ADVOCATING FOR PHYSICIANS, CARING FOR PATIENTS

CAMSS EXECUTIVE
President: Dr. Sharron L. Spicer – sharron.spicer@ahs.ca
President-Elect: Dr. Linda Mrkonjic – linda.mrkonjic@ahs.ca
Secretary-Treasurer: Dr. Davinder Sidhu – Davinder.Sidhu@ahs.ca

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SOUTH ZMSA EXECUTIVE
President: Dr. Fredrykka D. Rinaldi
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CONTRIBUTING WRITERS
Dr. Sharron L. Spicer
Dr. Christopher Doig
Hellmut Regehr
Dr. Padraic E. Carr
Dr. Richard Bergstrom
Dr. Lucy M. Entwistle
Dr. Mike Kalisiak
Dr. Kevin Hay

MANAGING EDITOR: Hellmut Regehr, hregehr@studiospindrift.com

EDITORIAL ADVISORY COMMITTEE:
Dr. Sharron Spicer – sharron.spicer@ahs.ca
Adrienne Wanhill – adrienne.wanhill@albertadoctors.org
Hellmut Regehr – hregehr@studiospindrift.com
Dr. Tobias Gelber – tgelber@pinchermedical.ca
Dr. Steven J. Patterson – spatterson@plcgas.net
Dr. Alayne Margaret Farries – amfarries@me.com

Calgary & Area Medical Staff Society (CAMSS)
350, 708-11 Avenue SW, Calgary, Alberta T2R 0E4

COORDINATOR: Adrienne Wanhill 403-205-2093

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 January 16, 2017.

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

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Save the Dates!

CAMSS

Council Meeting
January 11, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

Council Meeting
February 8, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

CZMSA

Executive Meeting
January 19, 2017 | WebEx

Executive Meeting
February 1, 2017 | Location TBD

Annual General Meeting
February 1, 2017 | Location TBD– 5:30-8:30 pm

EZMSA

Executive Meeting
January 19, 2017 | Misericordia – 5:00-5:30 pm

Council Meeting
January 19, 2017 | Misericordia IN-106 – 5:30-7:30 pm

Executive Meeting
February 16, 2017 | Misericordia IN-106– 5:00-5:30 pm

Council Meeting
February 16, 2017 | Misericordia IN-106 – 5:30-7:30 pm

SZMSA

Council Meeting
January 9, 2017 | Location TBD & tele/videoconference – 5:30 pm

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President's Message:

Not What I Signed Up For

Dr. Sharron L. Spicer, CAMSS President

Have you ever sat expectantly through a great vacation promotion, then at the end felt disgusted with yourself realizing you've been duped into a bogus time-share offer? Like many other physicians in Alberta – or at least 74% of 29%* – I cast my ballot in favour of the amending agreement. It seemed like the right thing to do.

I voted in good faith that "[w]e will now be assisting to moderate the rate of growth in physician expenditures… ***in collaboration with government, sharing risk and responsibility.*** The ratified amendments will bring a level of stability to the system in terms of how the ***parties will work together*** [1]"(emphasis mine). But that good feeling has been replaced by a sickly realization that I might have signed up for something I hadn't exactly expected. The government now proposes a restriction on physician billing numbers beginning in 2017 as a means to reduce healthcare costs.

Placing a Cap on Billing Numbers is Wrong in So Many Ways.

A cap seems to blame doctors for healthcare costs that are exponentially increasing. Simplistic thinking would suggest that since the physician-patient interface (clinic visits, hospital admissions, surgical procedures, ordering and interpretation of tests) generates most healthcare costs, simply cutting back on the number of available physicians will cut costs. This is nonsense. If our service delivery is in balance, then our services are driven more from the demand side of the equation (from population and patient needs) than the supply side (any perceived physician "over-supply"). In provinces where restriction of billing numbers is ongoing or considered, it is highly opposed by their provincial medical associations. "The New Brunswick Medical Society supports eliminating the cap on the issuance of Medicare billing numbers."[2] "Doctors Nova Scotia does not support restricting billing numbers as an effective recruitment and retention strategy."[2] Doctors Nova Scotia further suggests in its position statement that restricting billing numbers is a regressive, rather than progressive approach; it might produce short-term economic savings but at the risk of disenfranchising and alienating physicians, eroding their trust in the government.[2]

We know there is inequity in physician distribution across the province, with northern, rural and Aboriginal communities less well-served than urban areas. One might speculate that putting a cap on physician billing numbers in over- or sufficiently-serviced areas might lead to better distribution of physicians across the province. Unfortunately, this has not been evidenced in practice. In the 1980's and 90's, British Columbia enacted a physician supply strategy to re-direct incoming physicians to less-resourced areas by restricting billing numbers or limiting billing rates for those who entered the urban areas. Several successful court challenges followed, including *Waldman v. Medical Services Commission of British Columbia,* where the court did not find grounds that the financial disincentives would either redistribute physicians to underserviced areas or control costs by reducing overall number of physicians in the province.[3] The social experiment in B.C. did not serve to diminish their geographical inequity of physician manpower. More effective strategies to geographically reallocate physician services, suggests Doctors Nova Scotia, are alternate funding plans, robust locum plans, efforts toward distributed medical education, and regional on-call programs.[2]

Beyond being ineffective at reducing overall costs and addressing regional disparities, restriction of billing numbers unfairly burdens physicians who are transitioning from training into practice. These young physicians are typically burdened with debt and often in life stages with young families and partners fulfilling training and employment opportunities. Simply closing doors to their full integration into the healthcare system is short-sighted and does not take into account the longer-term changing demographic of our own profession. If we discourage new physicians from entering our province, we will find ourselves unable to meet our needs in decades to come. We will see a trickle-down effect in our medical schools as well; uncertain of future prospects, qualified potential students and residents may look elsewhere for their career opportunities.

It is disquieting that the government would plan to put Alberta Health Services (AHS) in a gatekeeper role for determining billing number allocation. This is a major paradigm shift — not necessarily misdirected, but certainly thrust upon the profession (especially those who are not currently affiliated with an AHS program or facility) without proper consultation. I wonder how community physicians would view the role of AHS in determining how and where they set up their private practices.

In a recent editorial of the Canadian Journal of Physician Leadership, Dr. Johny Van Aerde addresses trust in the Canadian health care system. As physicians, he notes, we have a social contract to advocate and care for patients, and the government has responsibility to create frames for providing that care to achieve best outcomes for individuals and populations within the bounds of available financial resources. The basis of effective partnership and collaboration is trust. Foundational to trust between government and physicians (or any other parties) is *contractual trust*: managing expectations, keeping agreements, encouraging mutually serving intentions, and ensuring consistency.[4] If the government unilaterally restricts billing numbers to incoming physicians, it will erode the fragile trust that catalyzed the acceptance of our amending agreement in the first place.

If I were a political cartoonist, I would depict a grinning ogre (the government) with a grip on two diminutive, squirming creatures (AMA and AHS), one in each hand as it puts forth the deal silently, covertly, and with tacit agreement from its "friends." I hope that the AMA and AHS retain the backbone to say that restricting billing numbers is not the solution to the escalating health services budget. Please reach out to your medical staff associations, AHS physician leadership, PCN medical leaders, PARA leaders and others to make it clear that physicians will be part of the solution to financial stewardship, but we will not be sold out.

**The amendments to the 2011-18 AMA Agreement were ratified by 74% of physicians, with 29% voter turnout.*

FOOTNOTES

[1] Carr PE. Ratified: AMA Amending Agreement (president's letter). Edmonton: Alberta Medical Association; 2016. Available from: https://www.albertadoctors.org/services/media-publications/presidents-letter/pl-archive/ratified-ama-amending-agreement (accessed 16 Dec. 2016).

[2] Doctors Nova Scotia. Restricted billing numbers position statement. Dartmouth:(n.d.). Available from: http://www.doctorsns.com/site/media/DoctorsNS/restricted-billing-numbers-position.pdf (accessed 16 Dec. 2016).

[3] Manfredi CP, Maioni A. Courts and health policy: Judicial policy making and publicly funded health care in Canada. Journal of Health Politics and Law. 2002 April; 27(2). Available from http://www.law.utoronto.ca/utfl_file/count/documents/chaoulli/CourtsHealthPolicy.pdf (accessed 16 Dec. 2016).

[4] Van Aerde J. Embedding trust in the Canadian health care system. Canadian Journal of Physician Leadership. 2016; 3(2). Available from http://www.physicianleaders.ca/assets/cjplvolume3_2_2016.pdf (accessed 16 Dec. 2016)

Honour and Good Sense?

Dr. Christopher Doig

I am privileged and fortunate to be a physician. Growing up, I was lucky to be bounced on the knees of many physicians whom in later years as a young physician I looked up to and admired. Not surprising, given the filial relationship, one of the most important was my dad. My dad is an international medical graduate who moved to rural Saskatchewan in the 1950's, to a community desperate for a doctor. He taught me much about the physician-patient relationship, and responsibility of a physician to the community. One of the stories I remember was the care he provided to a poor farm family. The mum would bring the family (her and the 2 children—men back then are no different than now) for medical check-ups and care. My dad was careful in ordering only tests and treatments that were necessary and affordable. When my dad knew they were coming, that morning he made sure he didn't eat breakfast. The reason? Their payment to my dad was always 2 fresh eggs. Similar to the parable of the Pauper and the penny, this was a considerable sacrifice for them: my dad knew it, and that morning his breakfast was the eggs, given for care, respectively and graciously accepted. I'm not sure how many of us today would accept a fee-for-service payment of eggs, but I hope the principle of knowing your patient, and being thoughtful in ordering tests and treatment that are 'reasonable and affordable' endures.

Since I'm waxing sentimental, I also remember growing up in Saskatchewan in the 1970's with laments from Government that Medicare was consuming a growing burden on the provincial budget and was not sustainable. Soon after my graduation, the Barer-Stoddart report was published. Although primarily focused on physician supply-stabilization policy, the report is by some attributed to at least in part blaming physicians, as the cause for rapidly escalating health care costs, and a simple solution proposed was to limit physician numbers. There were significant long-term negative effects from the report and how it was interpreted. Soon after and close to the time of my completion of specialty training, there was a plan in Alberta to restrict billing numbers for new physicians. This Government plan was far enough along to be announced at meetings, apparently with the tacit support of some parts of the profession. It was never enacted, I hope due to a clear response from within the profession. As I said, I'm lucky: if it had come about, I wouldn't be in Alberta. I hope that my contributions to patient care, research, education, and in other ways to patients, the system, and society represent a reasonable pay back from my personal opportunity at being a physician practicing in Alberta; I also doubt I am unique. I provide this anecdote juxtaposed to the following aphorisms: "Fool me once, shame on you, fool me twice, shame on me", and "Those who don't learn from history are doomed to repeat it."

There are more than rumors that there is a plan ready for near immediate implementation to limit physician billing numbers (practitioner ID's). This will disproportionately affect 2 groups: (1) younger physicians who are in medical school or finishing residency, and (2) international medical graduates. It is poor government policy premised on the flawed logic similar to that in the 'B-S' report. It has the potential for significant long-term negative consequences for patient care, for physicians, and for the relevancy of our professional association. I hope we are not about to be fooled by a poorly conceived idea that limiting billing numbers is a necessary and good first start.

First, is this more than a rumor? I don't know. I heard of the rumor during the vote requested by the AMA to ratify the amending agreement. After discussions with others, I was reassured reasonably that this was only a rumor. The amending agreement did discuss the role of the physician as responsible stewards in the health care system, the need for physicians to be responsible partners/stewards to re-examine costs within the system, and the need to develop a physician resource plan. However, there was no mention of anything as concrete or specific as limiting billing numbers. I would have thought, given the collaborative intent of the amending agreement, that an agreement between partners would have meant that if one party had a controversial proposition for early implementation, this would have been transparently discussed and included in the agreement. I think I was wrong to trust in this principle. Over the past 2 weeks, medical leaders in various roles in our profession have commented on Government's plan to restrict billing numbers. It's hard to know what

Can we ensure that as we seek to attract the best and the brightest to Alberta, a more bureaucratic and restrictive system will be viewed as progressive place where physicians will feel engaged as partners?

if anything has been decided apart from a date (reported as April 1, 2017)…but it's hard to imagine others knowing a firm implementation date without there being a firm plan. Some leaders in our profession, such as in the medical schools, have provided government strong advice that such a policy would have significant negative consequences. They are concerned enough to have released letters to medical students and residents.

Should physicians in practice individuals or collectively care? I think so. First, I am not opposed to physicians identified as responsible partners/stewards/leaders in the health care system helping to address the serious issue of increasing health care costs. Health care costs in Alberta, and the rest of Canada, are high. Physicians can play an important role in limiting costs: for example by not ordering unnecessary tests, unnecessary consults, or therapy that will not meaningfully change the clinical course of a patient's illness. Choosing Wisely is an excellent example of a resource that can help physicians implement best practices. There are examples of local initiatives too. For example, in Calgary Zone emergency departments physicians receive individual reports on outcomes such as readmission rates after ER discharge. In my department, we have hired physicians who are researchers focused on evidence-based care gaps: an attempt to prioritize and implement best practices, minimize practice variation, improve patient outcome, with priorities set collectively by both clinicians and patient-family representatives. (One of my department's physician researchers did all of his medical training outside of Alberta, but we were lucky enough to recruit him back 'home'). We should also examine billing practices and ensure careful scrutiny and updates to the schedule. I think all these are no different than principles I learnt many years ago.

However, I am opposed to a simplistic policy that restricts billing numbers. The basis of such a policy remains rooted in the false premise that physicians are unique 'drivers' of inappropriate costs rather than the appropriate view that physicians provide services to patients with care needs who seek and require access to our and other health care services. Physicians should limit practice variation, and should limit unnecessary costs but this is an issue about quality of care, not physician numbers. Limiting physician numbers will limit costs, but only by limiting access. This is not patient centric. Consider some examples of the implications. If you are practicing physician, and you want to expand your clinic, or change current practice (perhaps limit your time) and seek additional colleagues to work with you… should you require a government bureaucratic approval? Who would know better the needs of your patients and the services that need to be provided by you or your clinic? You in the front-line, or an official centralized far away? Would you like to be told (just as an example) "nope, you don't need another physician who does low risk obstetrics because there are midwives down the street that are not busy enough"? There is concern of a maldistribution of physicians between geographic regions. However, many people in my urban community still complain that they can't get a 'local' family doctor. What will happen if there is approval for '1' doctor in an area or for a clinic, and some of the physicians who apply are of an age where they have young families and child-rearing responsibility? Will they be disadvantaged if they can't work a traditional '1.0 FTE'? Many physician opportunities are already restricted by patient volume and possibilities for service delivery. For example, opportunities for cardiac surgery are limited by virtue of case load, current surgeons, and operating room facilities. Do we need a process that will primarily apply to community based physicians in private practice? Can we ensure that as we seek to attract the best and the brightest to Alberta, a more bureaucratic and restrictive system will be viewed as progressive place where physicians will feel engaged as partners? I would like to see as many excellent physicians as possible attracted to come work in Alberta. If we had more physicians, and less wait to see physicians… great! I want my niece, a born and bred Calgarian who happened to train in Toronto, to have the opportunity to bring her expertise back home. If she hangs her shingle and provides a good service, she'll have patients referred; if she doesn't, she won't: that is how a practice should be restricted.

I am sure most physicians support a carefully considered and thoughtful approach to physician manpower as reasonable, and appropriate as shared stewards. Physician manpower has significant long-term implications for the health system, for the profession, and most importantly for patients. This has implications for how many medical students are entered into medical school each year, and funding for the medical schools (which is in part dependent on enrolment). This has implications for how medical schools might select students (for example, if the shortfall is in rural practitioners who are generalists, can we determine selection factors more likely to result in physicians who subsequently want to work in these areas?). This has implications for how we fund training programs. Do we increase funding for rural based family medicine programs? Do we decrease the funding for some specialties that have recent reports of limited job opportunities (please! only examples!) such as neurosurgery, cardiac surgery, or orthopaedics? Do we train more generalists in mental health or family physician emergency physicians, and less psychiatrists or royal college specialty trained emergency physicians? If we have a training program that is a national leader, do we cut residency positions irrespective of the national calibre of the training? If we cut positions, do we accept training programs may lose accreditation, and as a province we will be dependent on other provinces for training some types of specialists? Is physician manpower planning considerate of major initiatives such as Precision Medicine/Health that has been proposed by the medical faculties, and is being discussed with Government? How do we integrate international trained medical graduates recognizing the increasing diversity of our communities? How do we attract the best and the brightest to residency positions if we have a reputation of severely restricting future career opportunities given that most individuals stay to work in the place they last trained? I am sure that there are many who can consider more and better examples of risks.

The few simple examples above emphasize that physician manpower planning is a complex and difficult problem with no easy or quick fix solution. A solution will require all parts of our profession and patients to have meaningful input. Despite the gravity of this

issue, there is at least the risk of momentum given budget deficits that the myopic short-term solution of limiting practitioner ID's or billing numbers will proceed.

As physicians we have a professional obligation individually and collectively to patients, and to others such as physicians in training. Our obligation is to practice medicine conscientiously, to recruit physicians when needed to help care for patients in our clinics, and communities, and to oppose ill-founded dogma such as being blamed as cost drivers. Churchill is attributed in a speech to a boy's school once saying "Never, never, in nothing great or small, large or petty, never give in except to convictions of honour and good sense." This would seem *apropos* as advice to our profession as the proposed plan is neither. I would encourage you to provide your opinion to your zone medical staff association, and to other medical leaders of our profession such as at the AMA. It is important that our profession speaks with a unified, clear, and strong voice.

Christopher Doig, MD
Calgary

Christopher Doig is a graduate of the University of Saskatchewan (trained by many IMG's). He has lived in Alberta longer than he did in Saskatchewan (but still cheers for the Riders). He is the most recent recipient of the Sir William Marsden Award in Medical Ethics (awarded by the CMA), and a recent recipient of the Distinguished Service Medal (awarded by the AMA). He practices critical care in Calgary.

AMA President's Message

Dear Colleague:

The premise of the recently ratified Amending Agreement is that physicians have a professional responsibility to serve as stewards of resources for patients. Physician can make decisions that support quality of care for our patients, while also thinking about how those quality services can be delivered in a fiscally responsible manner. I have heard from a few members who feel we should focus solely on our professional responsibility for individual patients — which is still a key role for members — and leave management of the system and funding to others. The difficulty with this view is that, by not focusing on the system, we actually lose an important opportunity to advocate and to improve care for the individual patients we serve. Providing care for patients and undertaking stewardship roles are not competing ideas but are complementary.

It's important to remember that there is a big picture. We will achieve more in the short term if we remember to keep thinking about how we can best serve patient care in a long-term, sustainable fashion.

Schedule of Medical Benefits (SOMB) Rules Savings Initiative.

Under the Amending Agreement, timelines are short for the SOMB Rules Savings Initiative. We have had a strong response from individual physicians and sections, with many suggestions for modernizing the SOMB by eliminating some things that are of limited value for patients, and streamlining rules to coincide with best practices.

Some members and sections have been understandably concerned with the speed and scope of changes, and our committees have done their best to answer those concerns. I want to applaud them for their work. A lot of information was given over a short time span; I know this has been a bit overwhelming for some members. This has not been an easy process, but few things of value are. If physicians are unable to complete this work, then who will?

Accountability is a related matter. We have asked all sections to contribute to the savings initiatives by submitting suggestions. When all the decisions are made, however, we recognize that the impact will still vary across the sections and may have an impact on equity. Accordingly, the Board will make it a priority to seek opportunities in the Reconciliation Process and future allocations to recognize the degree that sections have been impacted and their contributions. We will work through the Representative Forum and with sections to develop a process to achieve this goal. At our December meeting, the Board explored a number of options and I will have more information to share with members on that front.

Physician Resource Planning Committee (PRPC)

Developing a needs-based physician resource plan is one of the most important goals of the Amending Agreement. Physician supply levels have grown faster than that of the population, yet still there are wait times and pockets of needs. The plan will use the best evidence currently available to determine the optimal supply, mix and distribution of physicians.

I have heard concerns from members who are uneasy, fearing that conditions may be placed on billing numbers in the near future. I can assure you that no decisions have been made regarding any tools that may eventually be applied to manage physician supply.

Any decisions will need to consider the evolving needs-based plan to be developed by the PRPC. Entering this process with preconceived solutions to problems that haven't been quantified would not be in keeping with the spirit of the Agreement, and is not our intent.

Going Forward

We have begun hard and not always comfortable work. I want to thank the sections and individual members of the AMA who have extended great efforts so far. The Board's and my priority is to keep you informed about activities and also the context surrounding them. We need to look for the big picture to succeed.

Yours truly,

Padraic E. Carr, BMedSc, MD, FRCPC, DABPN
President

An Open Letter to the Auditor General of Alberta

Dear Auditor General….

"The growing problem of construction fraud is not a myth or the product of hype — it's happening and the stakes are high. The question is, what can your company do about it?" (A white paper by Grant Thornton February 2013)

Dear Auditor General (AG): I have a confession to make. For the past 10-years I have had something gnawing away at me but sadly, I have never had the courage to say anything. It is hard to describe but the feeling that I need to share with you is that sick kind of feeling that there is something wrong with the system. I just can't seem to shake this feeling which seems to flare over and over again. I am therefore going to share it with you.

Auditor General, it is a sickly feeling that seems to flare during certain discussions regarding the facts and figures of construction costs and what we can and cannot build with what seem to be budgets that are generous and appropriate.

This feeling first appeared when the South Campus Hospital was under construction. If you recall the initial 2005 construction budget was $550 million but by 2008 the costs had spiraled to $1.7 billion. The steadily increasing budget was eventually capped at $1.4 billion, however, I was struck that something seemed odd when it was explained to me, "of course it's going to cost 1.7 billion, heck just building the foundation and underground parking cost $250 million." Did I hear that correct? Digging a large hole in bald-ass prairie and pouring concrete foundations/underground parking cost $250 million. Excuse me? My sense at that time was that Albertans were not getting good value for their tax dollars. To this day I cannot comprehend how building South Campus went from $550 million to $1.4 billion especially since we didn't get the full-build given that the mental health and women's health wings were scrapped in order to keep the cost under $1.4 billion.

More recently, I was involved in discussions regarding the modification of a small existing space in one of our emergency departments. The plan was to convert the space into a tight but functional 10 bed brief stay mini-unit. Capital planning was naturally involved and there was a budget of approximately $4.5 million to renovate the existing space into something functional as an inpatient unit. We would need to add some walls, doors, a couple washrooms and also enhance some security details. All told, the renovation, I would estimate, involved maybe 5,000 square feet and seemed quite doable. Sadly, we were informed that $4.5 million wasn't enough to renovate this existing space. The capital planning person began to explain that the cost of simply painting the walls (not the ceiling, not the floor, just the walls) was estimated at $500,000. That is a five with five zero's after it. I nearly fell out of my seat. I clarified with the capital planning person that it was actually going to cost $500,000 simply to paint this small space. They looked at me deadpan and confirmed that indeed, this was the actual number. Naturally, the rest of us around the table laughed and even joked that we would do it for 1/10 the price. They stood their ground and informed us that it took 'special handling' to paint inside a hospital. This seemed odd since we at the PLC have a unionized team of maintenance repair/painters that run around the hospital patching and repairing/painting walls and such work does not seem to require any 'special handling'. The feeling flared again.

Not long ago a colleague complained that they were once planning to modify an outpatient unit so that they could provide depot injections for patients. The privacy needed for such procedures would require an additional internal, non-load bearing wall to enclose a small injection room. The team managed to raise $150,000 for this 'renovation' only to be informed that the addition of the wall would cost $250,000. In the end, the wall was never built and the clinic was unable to provide depot injections. Maybe I am somewhat naïve but how on earth could it cost $250,000 to add a wall to an outpatient clinic? The feeling flared.

This feeling became a torrent when, more recently, I heard the astronomical budget to renovate existing high observation rooms at one of our hospitals. These are not surgical suites. These are simply small, approximately 10' by 15' secure rooms for patients to sleep and dwell in. There is no fancy equipment other than tamper proof toilets, (well, tamper proof everything) but how on earth could this cost so much?

I snapped. I had to contact the Auditor General. I had to write an article. I informed one of our managers regarding my concerns and my intentions to perhaps write to the AG. His initial concern was that I was going to get people into trouble and so he was going to immediately give his superiors the heads-up that 'Maybaum' was going to the AG or perhaps writing another article.

Please allow me to suggest that in this time of economic downturn we should be looking to save every nickel and dime. I had hoped that the manager I had approached would have been more supportive and willing to question construction costs as it seems appropriate, if not mandated, by our present economic environment. It is not my desire to get anyone into trouble but it is a thread, that if pulled, might lead to nothing, conversely, might lead to a land where 'thar be dragons'.

Worried that my sickly feeling might be completely off of the mark, I decided to do a little research to determine if there was any information regarding what seem to be excessive hospital construction costs in Canada. I was taken aback by some of the headlines that were all too easy to find and all of which, make for fascinating reading:

- "Fraud, kickbacks and collusion alleged in Ottawa Hospital construction lawsuit" (http://ottawaconstructionnews.com February 15, 2016);
- "Hospital employee at centre of allegations went on Baltic cruise with contractor" (Ottawa Citizen January 8, 2016);
- "Quebec construction industry a 'clandestine universe' of collusion, kickbacks: report" (The National Post September 15, 2011);
- "Bureaucrat tells Quebec corruption inquiry he accepted $600,000 in kickbacks" (http://montreal.ctvnews.ca October 18, 2012);
- "Two whistleblowers' takes on the Charbonneau commission" (The Montreal Gazette November 25, 2015);
- "Corruption in Quebec construction industry 'far more widespread' than originally believed, report says" (The Star November 24, 2015);
- Inquiry in Canada hears that P3 infrastructure hospital project is "biggest corruption fraud" in Canadian history (http://www.antimoneylaunderinglaw.com June 1, 2014).

These are truly breathtaking headlines underscoring that there is clearly Canadian precedent for public infrastructure construction cost issues. I also came across one final paper that I believe everyone should read but particularly anyone undertaking a construction project;

- "Construction Fraud in Canada — Understand it, prevent it, detect it" (A white paper by Grant Thornton February 2013).

A highlight quotation from the above article includes, "The growing problem of construction fraud is not a myth or the product of hype — it's happening and the stakes are high. The question is, what can your company do about it?"

To be fair, reviewing the above articles and most of the headlines that I discovered, related to the situation in Quebec. One might want to pause and consider, however; our province was run by a PC dynasty that ruled for 43 years. One might worry or imagine that some degree of a 'clandestine universe of collusion and kickbacks' might have developed at some point over that 43 year dynasty.

Let me underscore that I am not saying that corruption in the construction industry did or has ever crept into hospital infrastructure capital planning in this province. Myself and many others that I have spoken to, however, struggle to comprehend what appear to be outlandish construction costs. Our most recent AMA past-president, Dr. Carl Nohr, drilled into us that physicians have a duty to be "stewards of the system." Consequently, I see calling into question construction costs as a fulfillment of this duty. While unable to comprehend some of the reported infrastructure costs, I find myself disconcerted when I hear that these otherworldly numbers are seemingly preventing us from obtaining the critical hospital infrastructure that we Albertans and patients, desperately need.

We now have a new government in the form of the NDP that might very well be interested in pulling the thread and to begin questioning construction costs. In this time of economic downturn someone needs to say something. Maybe I am just painfully naïve and do not understand the nuances of construction in a hospital setting but in my mind, someone needs to ask questions.

I will conclude by asking you, the Auditor General, is this something that Albertans should be worried about? Does someone need to take a good hard look at the processes of competitive bidding and the procurement/awarding of health care related construction contracts in this province? Some of us would really like the sickly feeling to go away.

With kindest regards,

A physician and concerned citizen.
Lloyd Maybaum

Aspirations, Hopes and Dreams for 2017… Personal and Professional

Dr. Richard Bergstrom

Dr. Richard Bergstrom

As I write this article, I am sitting in the airport lounge at Heathrow, coming back from a pre-Christmas vacation in London. My wife and I have just finished our usual December London trip; theatre, music and some great friends make for a great break. Of course the fact that we are in London, a city with such a great heritage and now great food makes it easy to boast!

It is times like these that I both look forward and back, to what I hope to experience and what that of which I am appreciative. I have, over the years, taken for granted where I live, what I do and the safety of my life, my family and the security that I experience. I need to remember that every day. Being reflective gives one both a sense of appreciation and an ability to look forward.

Being in my sixtieth year, I have had a lengthy experience both in life and in healthcare. I was born in Edmonton, am the fourth of four children growing up in the sixties. This meant it was a time of great social change. When I was young there were boys and girls entrances to school. You grew up in an arena where you had strong social rules and roles. Rules were those of strict social order; children were children and had no opinion, you did what you were told. School, at least from grades one to six were based on listening to the teacher and doing what she said (rarely would you see a man teaching in elementary school). Boys played hockey, girls would figure skate for winter sports. No one went on a winter vacation. Well, not in any middle class neighbourhood. Hair was short on boys, long on girls. Catholics never mingled with Protestants and we all went to church. There was the token Chinese kid in your class, they were "immigrants" without the understanding that you and your family were immigrants not so long ago. We lived near a creek and would play there without supervision. In the spring, almost every year, one child would drown with the run off from snow melt and playing in the water. You heard about children who would have died having their tonsils out. You heard of the child down the street who had the dreaded word "leukemia" and you knew they were going to die; we whispered the words we had heard our parents whisper… bleeding, blood transfusions, infections. My aunt had a still birth from Rh incompatibility. Funerals were common as families were big and disease was part of life. You went to the cemetery and were reminded of the cousins who died within the first year of life; it was not a surprise, just a fact. The world had "pink bits," the Commonwealth nations on a map. My grandmother had the trip of her lifetime, a trip back to her native country, Sweden. She dressed up (as you always would for any trip of any sort) and her propeller airplane had two stops before landing in Sweden.

Then was then, this is now and tomorrow will lead us not necessarily in another direction, rather it will move us forward with new opportunities and challenges to meet. I think we need to embrace reality and accept these. Should we not, the evolving world and the changes with which we will be encumbered will be forced upon us. It is much easier to work with something than fight with it.

I was at a meeting in London, regarding State of the Art (do you not love that euphemism?) of cardiac CT. Sounds like a boring meeting with which I could write off airfare to London. Wrongo!!! It was a great meeting. One day of cardiac CT. Sounds boring…. again WRONGO!!! Why wrong to think this way? We, as physicians and leaders (do you not love that euphemism….yet, it is my belief that as physicians we should all be leaders) need to be seen and heard (that is the hard part) about how health care should provide. We can be advisors with respect to how it should evolve but I do not think that is our domain since we are not funders of the system. This meeting spoke to me about two main issues. First, the science of true medical research, that is, seeking better care. CT can now look at coronary arteries almost as well as angiography. Secondly, the more important message, "How does Medicine evolve?". Let me explain. The executive of this group was not focused on Radiology, Cardiology, Ultrasound, CT, or any of the subgroups (silos) that we recognize. They were focused on "Imaging" and how "Imaging" advances patient care. They spoke to the need for advocacy for infrastructure, training and how to create the leverage to have funding agencies understand what is "best practice" as opposed to "fund my practice." They thought about "change management," something that physicians often forget.

What I would like to see in the next year is possible but highly unlikely. I am anything but a Pollyanna, yet, I would be most doubtful if healthcare would put the "patients and their care" front and centre when budgets and cost are first and loudest (just read the newspaper). I do understand that "patient" centric care occurs but what about the real challenge; "patients centric care." By that I mean all patients, not just a select group. What will this take? It is easy for me to advocate (which I should) for cardiac care, for that is the group I am most intimately involved with. Yet, as a part of the "physician brotherhood," should we not have a bigger voice for all patients, especially those who fall through the cracks? Oh, I am not involved in complex mental health, elder care, homelessness, aboriginal issues, drug addiction, abusive relationships. These are far from my world. Wait a minute, Bergstrom. They are a part of your world. Look at your patients. (Read Dickens and A Christmas Carol). Do you not see those who come from these areas in your hospital? Of course I do. I need to advocate for more.

The Provincial and Federal Government, I think, need to be seen to argue less, work more and enter that most difficult discussion "What can we do?" which involves the more difficult question "What can't we do?" This is not about abdicating a political role; the discussion of how to use tax dollars wisely. Rather, it is reflecting on "What is do-able?." A bunch of band-aids does not a strong cast make. And we do not need a cast, we need healthy bones in health care.

So, for the coming year, I will not continue to advocate for cardiac care alone. I will challenge myself first (for you need to be the change you want to see) and then others to not just start the talk but start the walk of care for those in need. Is that not our mission, our mantra, our ethos?

As I sit in this lounge, I see how things have changed. There are airplanes landing every minute here, every sixty seconds. There is unbelievable richness in the world. Yet, do we fight the good fight, that is, to not just bring ourselves up, rather to bring opportunity for everyone.

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

Vital Signs 2017

Hellmut Regehr

Resolutions

I have never been one to make New Year's resolutions. Announcing on January 1st, "I resolve to eat more broccoli" has never seemed to me to be a great motivator. What motivates me to make plans and follow through on them is family, friends and a sense that what I do matters, in other words commitment to someone or something. I try not to let pride, recognition or money be my motivation, although I admit that can be difficult at times.

So what does that mean for Vital Signs in 2017? Lets start by saying the Editorial Committee will be making no resolutions for 2017. What we will do is make a commitment. Our tag line is, *Communicating With Physicians In Alberta,* our commitment is to build on the success of 2016 with that tagline in mind. Not only to communicate but to engage with doctors and the political decision makers on health care issues.

A Look Back at 2016

We produced 11 issues in 2016, which were distributed to MSA members through a number of means. Each member received a hard copy as well as a PDF copy emailed to them along with a link to an online version. Vital Signs can also be accessed through the albertazmsa.com website.

- 64 contributors wrote articles for Vital Signs, a 48% increase from 2015. That is an amazing number considering all writers are volunteers with extremely busy schedules;
- 84 articles were published, a 20% increase from 2015 on topics ranging from financial stewardship, doctor assisted death, medical marijuana, rural and indigenous issues, to name just a few;
- Our Editorial Committee increased from four to six members with broader zone representation.

There was also a noticeable increases from the previous year in comments to the Editorial Committee from readers. It is always a good sign when we can increase engagement with our readers.

Forward to 2017

As I look ahead to this new year I am committed to find ways to increase the number of physician writers for Vital Signs with the purpose of communicating health care issues, ideas and solutions to our readers and, secondly, to increase communication and engagement in a positive and productive way.

Physician Writers

Thank you physician writers! I appreciate all those who have submitted articles in the past, your articles have enriched, enlighten, entertained, educated and sparked conversation. I would encourage all who have written for Vital Signs in the past to please consider doing so again. For those who have never participated in Vital Signs, I encourage you to give it a try. I realize the amazingly busy lives doctors lead, I also realize that we all somehow seem to find the time for things that are important to us. I would humbly suggest that your thoughts, ideas and opinions are important to your fellow doctors and those involved in health care in this province. Themes for this year are listed on our website, please visit albertazmsa.com/vital-signs/. Issues are themed, however, please do not hesitate to submit articles on timely issues or topics that you are passionate about. The themes are there to get your creative juices flowing and allow you time to better schedule your writing. If and when someone from the Editorial Committee, or your local MSA approaches you to write for Vital Signs consider it as an adventure not an inconvenience.

"An inconvenience is only an adventure wrongly considered; an adventure is an inconvenience rightly considered."
– G.K. Chesterton

Communication and Engagement

Heath care in Alberta, or any other province for that matter, is a very complicated set of issues. Trying to find solutions aka: better ways of delivering health care is a very sensitive balance between real emotional situations and pragmatic choices. With that in mind the way we communicate our ideas with each other and our readers can either lead us down the road to further discussion and solutions or stop us dead in our tracks. My hope for Vital Signs 2017 is to engage as many doctors as possible and where we are able to discuss health care issues with respect, integrity and honesty.

Hellmut Regehr
Managing Editor, Vital Signs Magazine

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Adrienne Wanhill, Coordinator

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"How much weight should I gain in pregnancy?," "I can't get my baby to sleep," and "What do I do about temper tantrums?." These are some of the common questions that many of you hear in your practice from expectant parents and parents of young children.

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Intended for expectant parents, parents of children less than six years of age (as well as health care providers), there are a variety of resources under the HPHC umbrella, available in print and online.

These resources are provided at no cost, to help support the families in your practice:

HealthyParentsHealthyChildren.ca – Our online resource provides information including videos, interactive tools and search features to provide further support to parents and other caregivers.

HPHC: Pregnancy and Birth and The Early Years – Our print resources include a 2-book set that can be ordered and distributed to expectant parents and available in a minimum order of 2 cases (20 book sets).

Redemption cards – If storage space is a challenge, you can order and distribute redemption cards to expectant parents during prenatal visits. Expectant parents then redeem the card for a print copy of *Pregnancy and Birth* and *The Early Years* at their local Community/Public Health Centre.

Promotional cards, Bookmarks and Posters – You can also order posters to display in the office or promotional cards and bookmarks to distribute to expectant parents or parents of children under six years of age. These items all provide information on accessing the online resource.

Again, all health care professionals can order these HPHC resources (as well as other Alberta Health Services' preconception, pregnancy and parenting resources) at no cost.

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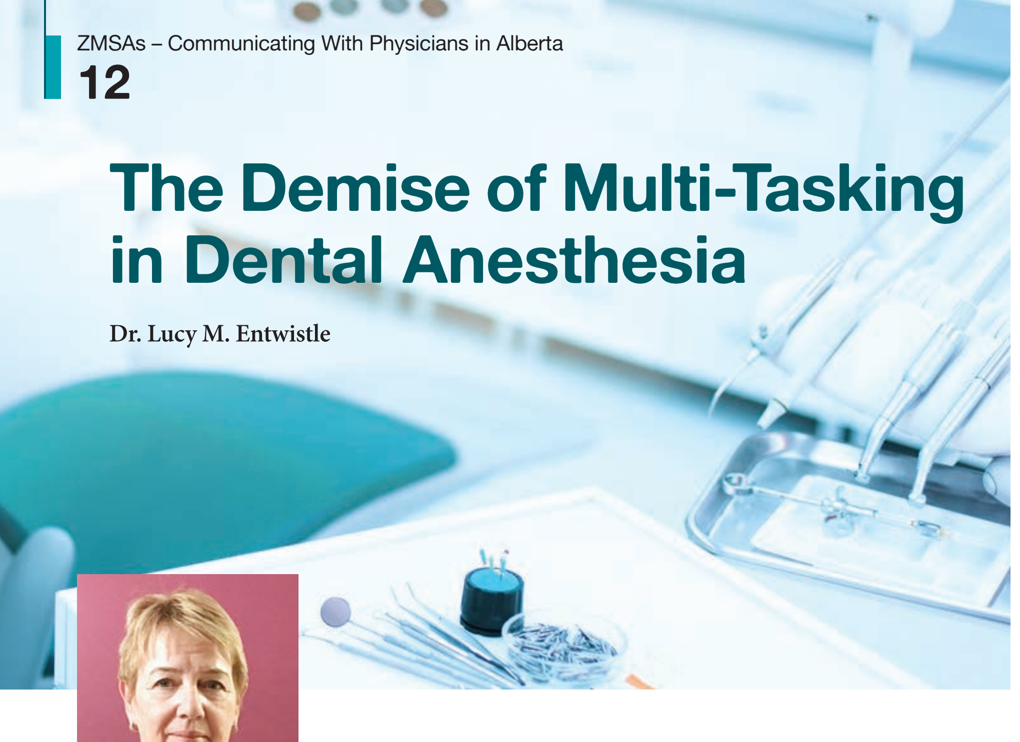


The Demise of Multi-Tasking in Dental Anesthesia

Dr. Lucy M. Entwistle

Dr. Lucy M. Entwistle

Parents in Alberta expect that when their child is administered an anaesthetic for dental work the standard of practice for that anaesthetic should be the same whether the child is treated in hospital or in a non-hospital setting. In September 2016, a 4 year old healthy girl suffered a hypoxic brain injury during a dental anaesthetic administered by a dentist who was performing her dental work simultaneously. The Alberta Dental Association and College [ADA and C], the organisation responsible for both ethical standards in the dental profession and the interests of its members, allowed dentists to administer general anesthesia in their office, and the same dentist could then perform the dental procedure. This practice of being Operator and Anesthetist can only be done in one other province, Ontario.

As a pediatric anesthesiologist it is difficult to understand how one practitioner can do two highly skilled jobs at the same time. On October 28th, 2016, ADA and C disallowed this operator/anesthetist practice.

General anesthesia administration by a physician or dentist in dental offices has been prohibited in the U.K. and Australia since the mid 1990s. Why would this obviously dangerous situation have persisted in North America?

Maybe the answer lies in the statement of the American Dental Association Policy Statement on the use of sedation and general anesthesia by dentists which reminisces about the supposed first administration of anesthesia in the U.S. when the dentist Horace Wells had a tooth removed by his assistant using nitrous oxide in 1844 in Hartford Connecticut. (Supposed, because in fact the first administration of anesthesia is now accepted to have been by the family doctor Crawford Long in1842 in Jefferson Georgia using ether to remove a neck tumour). Perhaps dentists believe that history gives them the privilege to provide anesthesia and perform procedures at the same time, which for good reason is denied to all other surgical specialities.

If a child presents for a dental procedure under general anesthesia in the hospital or in dental facilities where anesthesia is provided by a physician, the protocol is the same as would be followed if the child were having an anesthetic for any surgical procedure.

The person conducting the anesthesia is a physician either a specialist anesthesiologist with at least five years post medical school training or a family doctor with at least three years post medical school training one of which is a full year of anesthesia and who also provides anesthesia on a regular basis in a hospital.

All anesthetic drugs (except ketamine) in addition to depressing brain function, depress the heart and lungs leading to changes in respiratory rate and depth which may lead to hypoxia and changes in cardiac function and vasodilation which will cause decreases in heart rate and blood pressure. These are anticipated effects of anesthesia which an anesthesiologist monitors with blood pressure measurements, EKG, oxygen saturation and respiratory gas monitoring and adjusts the level of the anesthetic drugs accordingly.

Thus it is concerning that dentists are permitted to do all this and at the same time perform dental extractions and restorations.

In the non-hospital setting the ADA and C standards for the administration of sedation and anesthesia require the same pre-procedure preparation as in hospitals. The major difference in the administration of the sedation/anesthesia lies in the training of the person responsible for the care of the patient while their level of consciousness is altered.

The ADA and C divides the level of sedation into 4 categories:

- **Modality 1.** Light sedation meaning the inhalation of nitrous oxide;
- **Modality 2.** Light sedation using an oral sedative medication, e.g. lorazepam;
- **Modality 3.** Moderate sedation using nitrous oxide plus an oral sedative;
- **Modality 4.** Deep sedation and general anesthesia.

It is required that the provider of the sedation be certified in the modality to be used.

Undergraduate dental programs in Canada provide training that enable credentialing for general dentists to administer nitrous oxide. Nitrous oxide is used for reducing the anxiety during injection of local anesthesia in the mouth and for allowing the extraction of first dentition in small children who have early childhood caries.

The administration of nitrous oxide does not require pre-procedure fasting nor is pulse oximetry required during the treatment.

During nitrous oxide administration the dentist uses oral communication with the patient to ensure safe conditions.

The guidelines for Modalities 2 and 3 sedation from the ADA and C state that any dentists who wish to provide oral sedation or combined oral/nitrous sedation must take a 3 day course which involves didactic lectures, practice in the use of nitrous sedation where the course participants serve as each other's patients, assessment of clinical competencies and a multiple choice written exam.

Should a dentist wish to provide parenteral moderate sedation, they must take a course that includes the above, and airway management (a total of 12 days classroom/laboratory instruction), then complete a minimum of 20 cases under supervision. Both courses are available through the University of Alberta Dental Continuing Education Department. These courses DO NOT teach moderate parenteral sedation for children, this may be a component of some pediatric dentistry specialty programs.

The Deep Sedation/General Anesthesia guidelines apply to Dental Anesthesiologists. These dentists have completed a three year post graduate training in dental anesthesia at an accredited university. There is a program in Toronto and several in the U.S. but only three dentists in Alberta have this certification. Dental Anesthesiology is not recognized as a dental specialty nationally.

The other groups that are permitted to provide deep sedation and general anesthesia are dentists who have taken an Oral/Maxillofacial Surgeon post-graduate program. These programs are up to five years in length and include 3-6 months training in anesthesia.

All dentists and their clinical assistants providing light sedation have to have current (i.e. within 2 years) CPR certification. Those providing moderate sedation must have current ACLS certification. Dentists who provide deep sedation to children must have current Pediatric Advanced Life Support certification and their clinics must do mock medical emergency drills every six months.

Canadian Anesthesiologists have as their motto, '*Science, Vigilance, Compassion*'. As medical practitioners it is our duty to advocate strongly that Vigilance is the number one priority whenever anaesthesia is administered, no multitasking.

Lucy M. Entwistle, FRCPC
Pediatric Anesthesiologist (retired)

Are We Keeping Up With The Changing World?

Dr. Mike Kalisiak

Dr. Mike Kalisiak

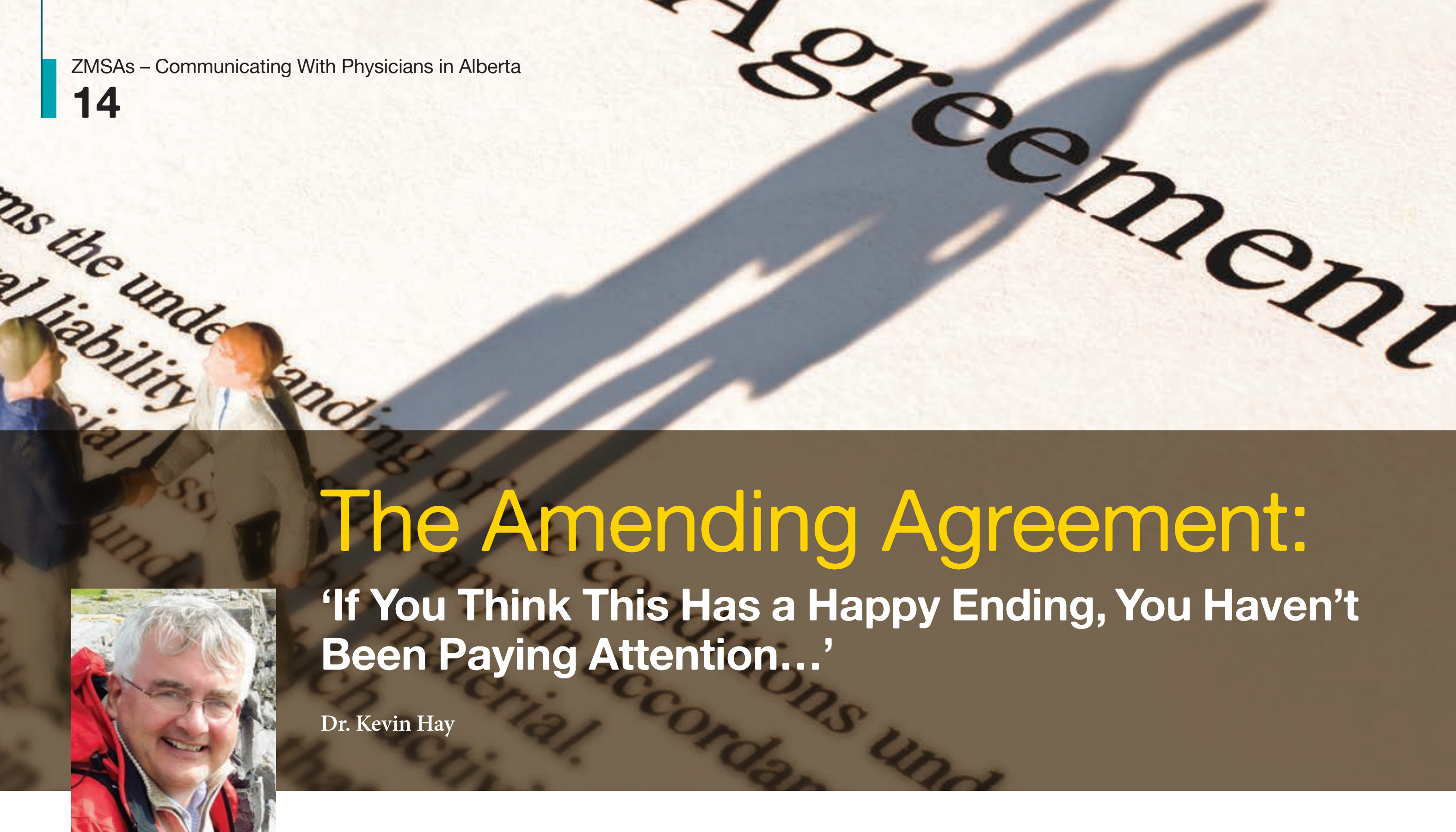
The New Year is always time for reflection and I often ponder on how rapidly the world around us changes, especially in terms of technological advances. I still remember (although vaguely) computers that were using perforated cards and paper tapes for data input. My first Atari computer had a casette tape to which, within a mere 20 minutes, I could save a day of programming work. Then there were floppies, zip drives, and so on. During my residency I used a 128 MB USB stick, now I use 128 GB one. Over the past couple years anyone can purchase a drone or a 3D printer, which belonged in the realm of science-fiction not so long ago. My new tablet recognizes my face and I see no reason why the next generation could not recognize a skin cancer on my face, should I develop one. Also, nobody is surprised any more with an idea of an autonomous car. In fact, my next car may indeed be a self-driving vehicle, as I still probably have a few years left on my 2009 dinosaur.

There are, however, many things that have not changed, especially within regular medical practice. The fax machine would be one such relic that has been proudly displayed in most offices throughout all these years. Even though other technologies are clearly superior, the fax is still omnipresent. Even during the recent dr2dr.ca roll-out, the greater powers of our system decided to warn some of us that this new communication platform may not be appropriate, presumably because a sheet of paper printing out on a fax machine is such a private and easily verified event. Fortunately, it seems, they did eventually come to realization that dr2dr.ca is an improvement on the tried and true fax technology. In my practice, secure messaging has allowed me to plan for procedures, start testing or treatments while patients still await their in-person consultation, and in many cases provide advice to the primary care physician without the need of ever scheduling an in-office consultation.

Another thing that has not changed is an in person visit to a doctor, even when not entirely necessary. While many of those visits cannot be replaced even with the best technologies, in the era of Skype and Facetime, a significant number could be averted, such as when a low-risk follow up needs to be provided. Some of these approaches are already used for remote locations or within specific practices. Perhaps even within regular practices there is sometimes no need to make our patients leave work early and sit in the waiting rooms full of aerosolised viruses. With proper attention to the issues of safety, privacy, and remuneration, we could perhaps deliver care much more efficiently, not only from doctor's but also from the patient's point of view, utilizing telehealth.

There are many more examples, and indeed, even more that are not yet obvious but will surface over the next few years. While some aspects of our practice will remain the same, some have to change drastically to keep up with the changing world. If our practices don't adapt, we may actually lose the opportunity to positively influence the lives of our patients.

Mike Kalisiak, MD, FRCPC
Assistant Clinical Professor of Dermatology, University of Calgary



The Amending Agreement:

'If You Think This Has a Happy Ending, You Haven't Been Paying Attention…'

Dr. Kevin Hay

Dr. Kevin Hay

Albertan physicians believed the Master Agreement with Alberta Health was set to run from April 2011 through March 2018, ("*…guaranteed to exist until at least March 31, 2018*"). That 2011-18 Agreement was negotiated under the former PC government. The dire financial circumstances in the province caused the NDP government to approach the AMA 'about working together to seek savings' in the current agreement. The Amending Agreement was ratified by the AMA membership in October.

Some of us might be bitter that this financial sink-hole is not being filled by the Heritage Savings Trust Fund. Thanks to previous management, the AHSTF was only worth $17.5 billion in 2014.[1] For comparison the Norwegian Government Pension Fund Global / the 'Oil Fund' stands at a paltry $873 billion — almost a trillion dollars![2]

There are aspects to the Amending Agreement which are long overdue. The focus is to develop the Medical Home and multi-disciplinary care. The Agreement also introduces a dynamic review of the Schedule of Medical Benefits [SOMB]. (The AMA plans the SOMB changes will be guided by solid principle such as using recommendations from 'Choosing Wisely'; using national guidelines/peer-reviewed literature; adding incentives to encourage high-quality patient care; spreading the impact over a broad range of specialties and family medicine etc.).

That said there are three major drawbacks and the potential for a grievous public misperception about the Agreement. Politicians already know that when '*you play the Game of Thrones you win…or you die!*'

1. An Amending Agreement Without Legislative Recognition for The AMA?

Though the "AMA is recognized as the sole and exclusive representative of all physicians who are authorized to practice medicine in the Province of Alberta for the scope purposes **and term of this AMA agreement…**" [The original 2011-18 agreement / my emphasis] there is no recognition entrenched "within an appropriate legislative framework."

If physicians are prepared to break guarantees provided by government, it is reasonable to expect legislative recognition for our representative body, the Albert Medical Association, in return. Without this recognition perhaps we should just say 'NO', with the comment: "I wish you good fortune, in the wars to come…"

2. Flaws with Capitation:

In a publically funded health-care system there are four basic methods for remunerating physicians: each has advantages and limitations.[3]

- Fee for Service;
- Capitation (population based);
- Case Payment (paid on a specific case or episode of care for a specific patient);
- Salary (time based).

A properly-funded capitation system might improve multi-disciplinary care. Unfortunately our dire financial straits mean this government is probably unable to fund a capitation system adequately — blended or otherwise.

For example the capitated NHS (in the UK) is in crisis because there is no limit to a FP's daily workload. 'Urgent' is defined by the patient ('until they are assessed') and the populist government guarantees that EVERY patient who comes through the door perceiving they have an urgent problem is seen that day (*Hodor! Hodor! Hodor!*). The docs are dealing with increased patient complexity, downloading from secondary level care and decreased funding. "The BMA pointed out…the proportion of NHS funding spent on general practice has fallen from 10.4% in 2005/6 to 7.4% in 2014/15, leaving practices receiving an average of only £141 per patient per year — equivalent to an effective funding deficit for general practice of at least £2.5bn."[4] As a consequence the BMA is calling for a national standard for the maximum number of patients which can reasonably dealt with in a day.[5] '*Here we Stand*.'

– *continued on page 16*

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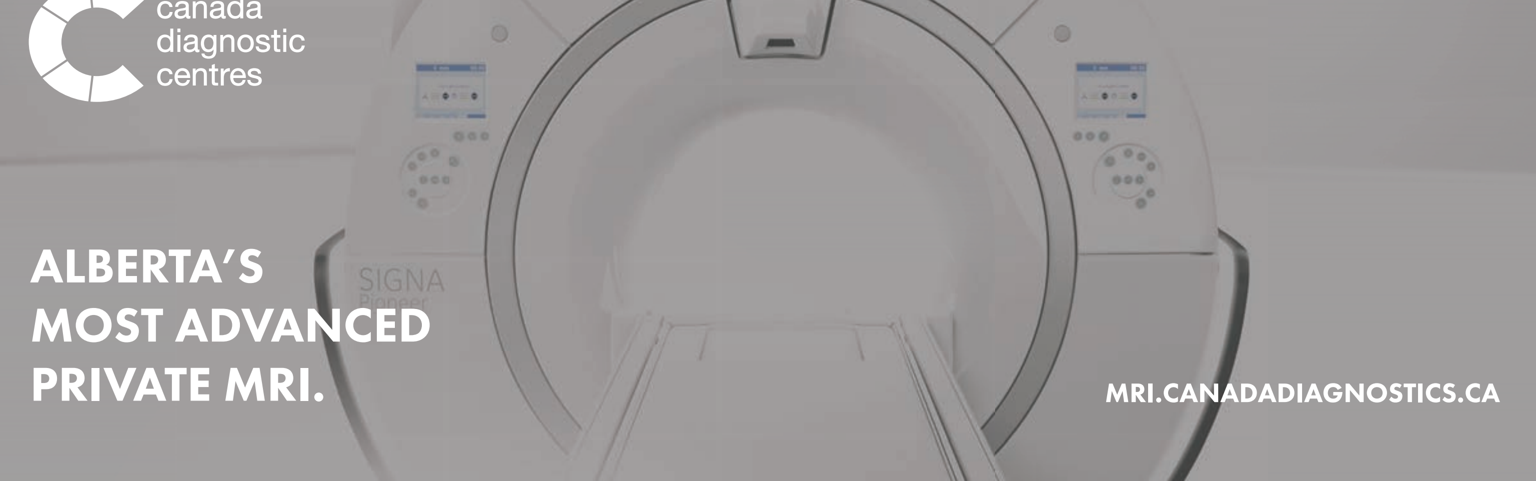

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– *continued from page 15*

3. High-Speed Changes to the SOMB.

The Ratification Vote was completed by October 14. The First Stage of about 60 codes and rule changes were approved mid-November to be implemented January 1, 2017. The second stage of about 120 fee codes and rules will be finalized February 3, 2017 for implementation April 2017!

Errors with these changes will only be apparent after implementation when some doctor's pet code is modified or removed. Remember that four out of five AMA members were silent or opposed to the Ratification. If the cutbacks hurt too much then possibly the silent majority's motto becomes *"Ours is the Fury..."* If someone's life is badly affected by a major SOMB change the AMA could face the equivalent of the Red Wedding and the medical version of *"The Lannisters send their regards…"*

Bureaucrats and politicians will not be upset if this process ends with internal AMA strife: "*A lion doesn't concern itself with the opinion of sheep…*"

THE FATAL PUBLIC MISPERCEPTION:

It is my (limited) understanding of the very complex Amending Agreement that the Retention Benefit & COLA have been put up as a type of 'collateral' in case the AMA is not able to find the required reductions of $85 million (2016-17) and $100 million (2017-18). If we achieve those reductions the RB and COLA will be returned. If not, then pro-rated or retained.

A lesson from Social Media: Perception is Everything!

When a doctor tells a patient that (for example) they do not need an MRI it must be absolutely clear that we will not profit one penny from that advice. If the RB & COLA are returned it could look like — *or be construed* — that we are profiting from making cutbacks. It would be so easy for the public to believe this idea and then we would experience their castigation like never before: *'Shame! Shame! Shame!'*

The Braavosi phrase, *'Valar Dohaeris'* is an appropriate motto for our profession: *'everyone must serve...'*

Kevin Hay, MRCPI, CCFP, FCFP
Family Physician, Wainwright

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[6] Quotes from the Game of Thrones!

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Dr. Pierre Crouse
3223 17th Ave. SW Calgary, AB T3E 7R8
403-255-6196 403-255-1166
www.intramed.ca