COMMUNICATING WITH PHYSICIANS IN ALBERTA

VITAL SIGNS

FEBRUARY 2019

The "F" Words of Medicine

Notes from the Field

Data Privacy, Access and Utilization

Is debt elimination one of your 2019 resolutions?

Words by Adrian George CFP, CLU, TEP
Speaker, Certified Financial Planner, President PlayCheques Financial Solutions
www.playcheques.com

BECOMING DEBT-FREE IS A MAJOR ACCOMPLISHMENT, AND HAVING AN EFFECTIVE DEBT ELIMINATION PLAN IS THE BEST WAY TO ENSURE YOU GET THERE. DETERMINING THE APPROACH THAT'S BEST FOR YOU IS A 3-WAY TUG-OF-WAR.

LET'S ASSUME YOU'RE INCORPORATED AND HAVE A NO-INTEREST CAR LOAN AND A MORTGAGE AT 3.5%. WHICH ONE YOU PAY FIRST, AND HOW AGGRESSIVELY, HINGES ON A PLAN BASED ON WHAT MATTERS MOST TO YOU:

Cash-flow

A lower balance car loan can be paid off much faster, and without prepayment penalties, than your typical mortgage. This means one less monthly payment, which can be redirected to compound on your mortgage afterwards.

Saving interest

If paying interest concerns you most, look at your highest after-tax rate of interest, not just your highest rate. However, outstanding credit cards should always be at the top of your list.

Minimizing taxes

Paying down your debt faster than required means exposing more of your income to higher personal tax rates. You might prefer to save $.89 of each dollar earned by keeping your money in your company, rather than saving a lower mortgage interest with as little as $.52 of the same dollar.

Cash-flow, saving interest, or minimizing taxes: Which is most important to you for debt repayment, and how does it impact the rest of your savings, retirement and protection goals?

VITAL SIGNS

FEBRUARY 2019

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
FOR PHYSICIANS,
CARING FOR PATIENTS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

PRODUCED BY: Spindrift Design Studio Inc. studiospindrift.com
PRODUCTION COORDINATOR: Hellmut Regehr, hregehr@studiospindrift.com
GRAPHIC DESIGNER: Leona Regehr, lregehr@studiospindrift.com
STAFF EDITOR & WRITER: Shauna McGinn

Zone Medical Staff Associations
Mailing Address:
350-611 Meredith Road NE, Calgary, AB T2E 2W5
Reception:
Suite #310, 611 Meredith Road NE, Calgary, AB T2E 2W5

SUBMISSIONS:
Vital Signs welcomes submissionsfrom physicians in Alberta. Please limit articles to 1,500 words or less.

Please send any contributions to: Dr. Scott Beach, Medical Editor, zmsaadmin@albertadoctors.org

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 Friday, February 22th.

CONTENTS:

SAVE THE DATES!

CAMSS

Council Meeting: February 13, 2019 | FMC Boardroom 152 – 5:30-7:30 pm
Council Meeting: March 6, 2019 | FMC Boardroom 152 – 5:30-7:30 pm
ZAF: April 10, 2019 | Meredith Block – Boardroom 347 – 5:30-7:30 pm

CZMSA

Executive Meeting: February 21, 2019 | WebEx – 7:00-8:30 pm
Executive Meeting: March 21, 2019 | WebEx – 7:00-8:30 pm

EZMSA

Executive Meeting: February 14, 2019 | Misericorida IN-106 – 5:00-5:30 pm
Council Meeting: February 14, 2019 | Misericorida IN-106 – 5:30-7:30 pm
AGM and Awards: March 21, 2019 | NAIT Ernest Restaurant – 6:00-9:00 pm
Council Meeting: April 18, 2019 | Misericorida IN-106 – 5:30-7:30 pm

Vital Signs is seeking writers! Our magazine is not so much an academic journal as a way to connect with other physicians about important topics. We publish a magazine for physicians by physicians, as a venue for advocacy and a way to stimulate conversation about health care issues, with a voice independent of AHS and AMA. We ask that articles be 800 to 1,500 words and we welcome accompanying photos.

You'll be compensated for your writing — all authors whose articles of 800 words and over are published will receive a $50 Good Earth or Chapters gift card as a thank you for contributing! The deadline for our March issue Friday, February 22. Please visit http://albertazmsa.com/vital-signs/ to view past issues.

View from the Beach

Message from Vital Signs Medical Editor Dr. Scott F. Beach

Dr. Scott F. Beach

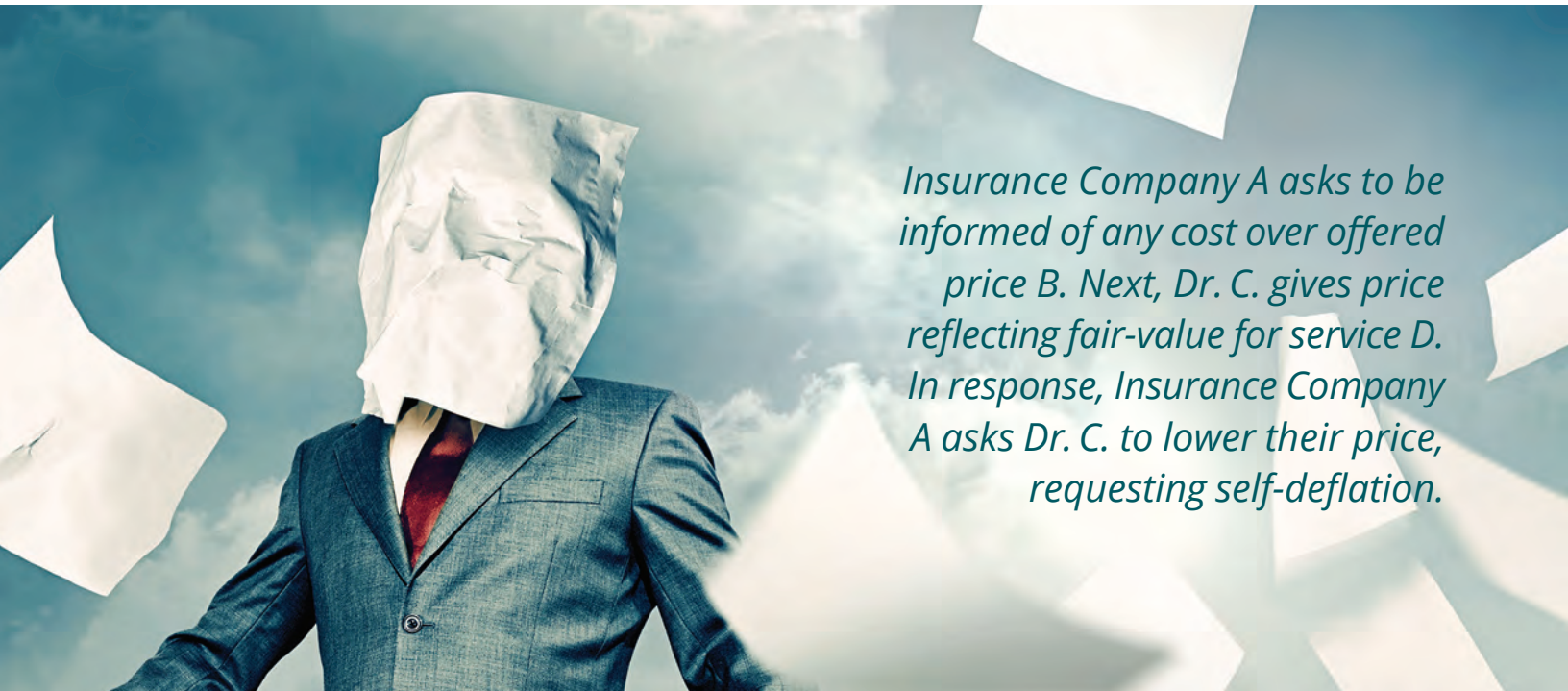
The "F" Words of Medicine

Open any medical dictionary and under the 'f', you will find a rich cadre of polysyllabic constructs one can use to connect with colleagues and wow your friends. Amidst all of them are two four-letter elements that, upon utterance, tend to bring on a hyperbolic adrenal response: FREE and FORM.

For my good friends recently arrived from Mars, a quick FYI: healthcare is not free. As I sat with a patient not so many days ago, she regaled me with the details of her recent journey through urgent care. At the conclusion of her narrative, she expressed her gratitude for the 'free' care she received. As the extolled emote of this folksy mythology grated across my dorsal root ganglia, I inhaled deeply, prepared to deliver my patented lecture on the true costs of healthcare. But at the apex of inspiration, I paused. The clinic that day was unfolding well, and I liked this nice lady, who has been a friend of the practice for a long time. I exhaled slowly and let the teachable moment pass.

In my heart, I know that she knows (like the majority of thoughtful Canadians) that healthcare is indeed not free. At the macro and meso levels, better humans than I with far greater minds wrestle constantly with the perpetual conundrum: getting high value care as a return for dollar investment. One of our former Premiers once stated that healthcare was a bottomless pit that can never be filled.

From my perspective, I feel that the Sea Captain's observance on Homer S. summed up our system best when he described our friend from Springfield as a "remorseless eating machine." Any way you slice it, as time goes on, the indolent grind of healthcare



Insurance Company A asks to be informed of any cost over offered price B. Next, Dr. C. gives price reflecting fair-value for service D. In response, Insurance Company A asks Dr. C. to lower their price, requesting self-deflation.

Vital Signs is now on Twitter

Follow us to see what's new and join the conversation.

https://twitter.com/vitalsigns_ab

continues to consume greater portions of provincial budgets, challenging system stability on the grand scale. Solutions to this challenge are diligently being sought, though they remain frustratingly elusive.

On the front lines of delivery, physicians are intimately aware of the cost of providing care to our patients. For me, the notion of 'free' immediately conjures a need to give the listener insight into monetary investments docs makes before the lights go on and patient one has been seen. At one point, I listed to a captured soul the tolls physicians pay to pursue our craft: CPSA, CMPA, CCFP/FRCP, AMA, and a myriad of insurances well before one code is submitted or recompense received.

In a place to call the medical home, it is nice to have a light on and chairs to welcome your guests (which IKEA was happy to provide at quite a reasonable price). Additionally, that pleasant and infinitely patient young person at the front desk's smile broadens ever so slightly every second Friday of the month. I will not go on, but suffice to say doctors have the double honor of both providing and paying for care. This does not jive with the dictionary definition of 'free'.

FORM is the second four-letter F-word that derives a response akin to an unwelcome IBS flare. Oft clutched in our patient's hands, these 81/2" x 11" bundles of advocacy are at best an occupational irritant. At worst, they are one more opportunity to erode our professional value. Now, to be clear the patients are merely the messengers, and I don't make a habit of shooting same. My frustrations arise from the smug assurance of governments and insurers that do-gooder docs will happily waive the fee when small print "patient responsible for any fees associated" catches the eye. This is done knowing that many, if not all patients could not embrace the cost as charged by comparable professions — our 'street value' if you will.

One of my all-time favourites is what I call self-deflation. It goes a little something like this: Insurance Company A asks to be informed of any cost over offered price B. Next, Dr. C. gives price reflecting fair-value for service D. In response, Insurance Company A asks Dr. C. to lower their price, requesting self-deflation. My desired (and to date inside voice) response has been, "Okay my friend, I will devalue my service if you work today for free." Quid pro quo Clarice. Quid pro quo.

In the construct of our system, we as doctors are asked to be both physician-healers and physician-advocates. Completion of what seems to be a never-ending stream of forms can instead create a harried state of physician-secretary. When governments, insurers, and at times our leadership bodies encourage devaluation of our professional services under the guise of what may be deemed an 'occupational hazard', the 'death by a thousand invalidations' ensues, creating physician-irritated. If Lotto Max were to ever deem me worthy, I may be tempted to go and explore the occupational hazards of physician-bartender in the Bahamas.

Before that windfall arrives, I, like all my colleagues, will soldier on until a solution that results in just reward for just work is found. Until then, feel 'free' to carry on!

Scott F. Beach, MD, CCFP
Medical Editor, Vital Signs

Notes from the Field

Dr. Alison Clarke

As a family doctor in Strathmore, the title of this inaugural column, "Notes from the Field" seems particularly apt — I'm surrounded by fields on all sides, with a hint of the mountains to the West!

I have been so fortunate to have my working life in Strathmore, a town with more than 13,000 residents just 50 kilometers East of Calgary. The rural experience was the last rotation of my family medicine residency, and it was so gratifying to be able to use all aspects of my training here. Each day saw me spending time in Emergency, Acute Care, doing procedures, and dealing with a wide range of issues from a diverse patient population. I was hooked. The support I received from the other physicians in town made it possible to make the transition from trainee to doctor.

As I started to practice, I saw how system frustrations were affecting patient care and impacting how we doctors were able to do our jobs. My personal feeling is that rural docs have a unique perspective that allows us to see how all the system issues affect care delivery. We see our patients in every venue: our offices, the Emergency room, in hospital, and in long term care facilities. We interact regularly with specialists, facilities, and of course, our team of colleagues. Often, we take on a role of advocacy as part of the work.

Initially, my leadership life began as a kind of "tag – you're it!" experience. Right away, the importance of having physicians give input on care delivery and system needs became very clear. We have an understanding of the patient's journey through all levels of care and we also look out for barriers, because it is our job to build a better road for them. I began seeking opportunities for leadership, and realized that the Alberta Medical Association was the venue that would allow me to bring together everything I felt was important: putting Patients First®, and supporting physicians in improving the health care system as well as our work environment.

My personal feeling is that rural docs have a unique perspective that allows us to see how all the system issues affect care delivery. We see our patients in every venue: our offices, the Emergency room, in hospital, and in long term care facilities.

While the spotlight is on me this year as President of the AMA, the quiet leadership that happens every day in physicians' practices is essential to a high performing health care system. The physicians that commit to their patients by ensuring their health journey is as smooth and connected as possible is the foundation of our work, and the source of our greatest satisfaction.

It is time that we recognize this contribution. Very soon, the AMA will launch a new physician recognition program called Shine a Light. It will be an opportunity to celebrate those making a difference every day in both little and large ways. Watch for more information coming soon about how to nominate a colleague (or even yourself!). Hopefully, through Shine a Light as well as this new column, we can continue to see and honor the vital work of physicians throughout Alberta.

Alison Clarke, MD
Strathmore, Alberta

ONE YEAR IN
Building a Community MSA

Dr. Elisabeth Woolner and
Dr. Margot McLean (co-author)

Dr. Margot McLean (left) and Dr. Elisabeth Woolner have been GPs in Calgary for over 20 years.

Greetings to Vital Signs readers, and all members of the Community Medical Staff Association (CMSA). We've been in existence for just over a year, so I felt it was time on behalf of our executive to let everyone know what we've been up to in our inaugural year.

I'm pleased to inform you that our membership has greatly increased over the past year. We welcomed 60 new members as of January 1, 2019, bringing us to nearly 220 members in the entire CMSA. Nearly 40 of our members are from outside of Calgary, and 32 members are specialists rather than family physicians. We are of course a small MSA compared to some of the hospital-based MSAs. However, I like to think of us as small but mighty!

A highlight of our first year was our participation in the MacKid Symposium in June, where we hosted a wine and cheese and had a booth at the Family Medicine Showcase. These events, combined for the first time as the Department of Family Medicine Main Event, gave us a welcome opportunity to meet with many of our colleagues in family medicine. At the Main Event we had a chance to have personal conversations with numerous members. We heard about their concerns and struggles, as well as their successes and accomplishments. We definitely plan to be back at this year's symposium, so watch for that announcement later in the year.

Another opportunity we were given was partnering with our colleagues in Airdrie to be of assistance as they navigated some choppy waters having to do with proposed changes in their medical community. We've been pleased to offer them financial, administrative and moral support during these challenges. We expect that this group of physicians may well end up starting their own medical staff association in the coming year or two, which is an exciting development.

Most recently, we hosted an information session for all of our members, at which Dr. Rollie Nichol graciously gave his time to discuss the changes to the medical staff bylaws on which we will vote in the spring. It was a small but highly engaged group, and again, it gave the CMSA executive a chance to connect personally with some of the membership.

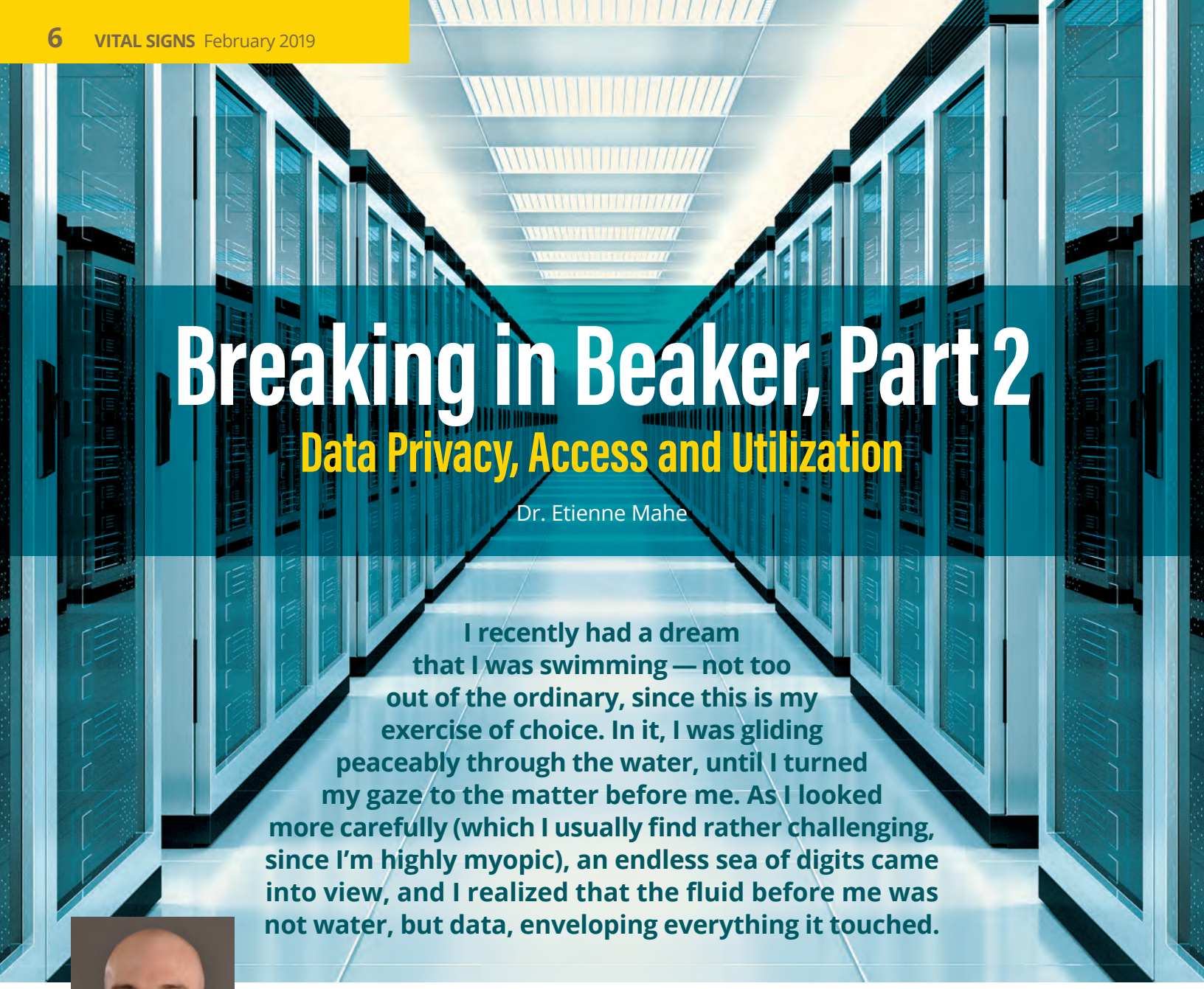
As we turn toward our goals for this year, we need your help. Right now, we are small but mighty; the executive of the community MSA consists of just the two of us — the president, Dr. McLean, and me, Dr. Woolner. If you are interested in helping guide this young MSA, please come on board!

We would also like to understand how we can best connect with, and represent the needs of, our specialist members. So, to this group: please get in touch and let us know how we can meet you, and how we can be of service to you. Dr. McLean and I are eager to hear from you, as we are sure that you have issues and concerns in your practice lives that we as family physicians may not share. We plan to hold a casual social event soon, so keep an eye on your e-mail for that announcement, and do come by to introduce yourselves.

In a similar vein, we'd like to get to know our colleagues from outside of Calgary. If we come to your communities, would you come out to meet us? Again, look out for an announcement in your Inbox, and let us know what you think.

In the meantime, please reach out with your suggestions, concerns and ideas. I'm at ewoolner@shaw.ca and Dr. McLean is at margot@shawcable.com.

Betsy Woolner, MD
Secretary-Treasurer, Community MSA
Calgary, Alberta

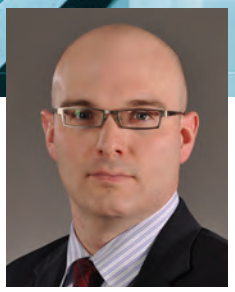


Breaking in Beaker, Part 2

Data Privacy, Access and Utilization

Dr. Etienne Mahe

I recently had a dream that I was swimming — not too out of the ordinary, since this is my exercise of choice. In it, I was gliding peaceably through the water, until I turned my gaze to the matter before me. As I looked more carefully (which I usually find rather challenging, since I'm highly myopic), an endless sea of digits came into view, and I realized that the fluid before me was not water, but data, enveloping everything it touched.



Dr. Etienne Mahe

In reality, this dream isn't so far-fetched: no matter where we are or what we do, we are surrounded by data. With the expansiveness of wireless networks, we are, quite literally, awash in a sea of it. Good data management involves navigating this vast sea, charting courses through streams, and working to control and regulate never-ending flows of information.

The waters in healthcare can be a bit troublesome. There are many ships trying to navigate through the sea of healthcare data, but as they do, they risk sending waves of it crashing outside of safe confines. If these waves break beyond the banks of control, it can be disastrous for patients, their families, and the broader healthcare community. As we embark on a major change here in Alberta by adopting the new Connect Care Clinical Information System, we must be certain that data will be both secure and appropriately managed.

The AHS describes Connect Care as a "common provincial clinical information system" meant to make healthcare data more secure and accessible between physicians and their patients, as well as among healthcare providers in general. The AHS has partnered with the company Epic Systems Corporation (referred to here at EPIC) to help run this new program.

At a recent Connect Care information session, I approached Sansira Seminowich, who is a Connect Care Beaker application specialist, to ask her some questions about data management, security and privacy. I wanted to be sure that Albertans' medical data were being stored in Alberta — not in the U.S., or in a cloud-based platform. This stemmed from my concern that EPIC data could be subject to the U.S. Patriot Act, which might theoretically violate Alberta's information privacy laws (1). I was assured that none of Connect Care's data would be stored within the U.S., and that EPIC would not have direct access to any of the Alberta content within the system.

Notwithstanding the serious need for state-of-the art security, data integrity, and ethics oversight, I am hopeful that Connect Care will make cutting-edge medical research in Alberta all the more fruitful.

But the aegis of the Patriot Act — which, put simply, makes it easier for the government or law enforcement to access sensitive data if they believe there is a threat at hand — might extend to the EPIC Care Everywhere function. This tool allows EPIC users to share data between different information centers. An example might be sending patient data for a "second opinion" to another EPIC-enabled center. In the lab where I work, we occasionally send materials for review to leading U.S. medical centers, and it would be very convenient to do this through the EPIC Care Everywhere function. Data sent to a U.S.-based EPIC center from Alberta might therefore be subject to the broad powers of the Patriot Act, which includes healthcare data (2). If and when Care Everywhere is used to pipe Alberta information to outside systems, I was reassured that such data exchanges would be subject to an AHS/Alberta Privacy Commissioner Privacy Impact Assessment.

We should also be aware of Connect Care's mandate for clinical data dissemination to patients. The system will allow patients the opportunity to access much, if not all of, their own clinical charts, made possible through the EPIC MyChart functionality. While noble in intention, this might raise the ire of concern for both clinicians and laboratorians. For those physicians in the former category, the literature notes that "open access" medical records might impact a physician's ability to relate medical information in a fully honest manner (3). In certain specialties such as psychiatry, in which highly sensitive information might be perceived negatively by patients accessing their charts, the concern is that clinicians may err toward less candid assessments.

In contrast, for those of us in lab medicine, patient access to their charts might embolden us and our specialty. Indeed, a well-informed patient with access to the completeness of their medical record would see their laboratory diagnoses rendered by laboratorians, rather than interpreted through their primary care-giver. Thus, we laboratorians will need to take greater care still to ensure the perpetual accuracy, contemporariness and timeliness of the reports we produce.

Turning back to an area of medicine that I find very stimulating — research — there is optimism to be found. The Connect Care initiative promises to include a breadth of research and research-related components. The EPIC system offers levels of data analysis and integration, ranging from routine quality assurance to population-based data analyses. Once implemented, the Connect Care system promises to be one the vastest seas of clinical data in North America. Notwithstanding the serious need for state-of-the art security, data integrity, and ethics oversight, I am hopeful that Connect Care will make cutting-edge medical research in Alberta all the more fruitful. But for now, the goal should be to have all the right hands on deck when it comes time to steer through the changes ahead in this sea of important data.

Etienne Mahe, MD, MSc, FRCPC, FCAP
Consultant Pathologist with the Division of Hematology of Calgary Lab Services. Clinical Assistant Professor in the Department of Pathology & Laboratory Medicine at the University of Calgary. President of the Calgary Lab Services Medical Staff Association.

REFERENCES

1. Province of Alberta. Freedom of Information and Protection of Privacy Act. Sect. RSA 2000, c. F-25, s. 92(3).
2. Lenzer J. Doctors outraged at Patriot Act's potential to seize medical records. BMJ. 2006 Jan 14;332(7533):69.1.
3. American College of Physicians Ethics, Professionalism and Human Rights Committee, Sulmasy LS, López AM, Horwitch CA. Ethical Implications of the Electronic Health Record: In the Service of the Patient. J Gen Intern Med. 2017 Aug;32(8):935–9.

Making Changes

How Everyday Interactions Can Help Reduce the Stigma Around Suicide

Dr. Richard Bergstrom

Dr. Richard Bergstrom

Suicide. It's a difficult subject, but it's real, it's happening, and it's something we need to talk about and take action on. We can make a change if we want to — and the question is how.

We live in Canada, a so-called "first world" country, meaning many of us have first world problems. Though they are problems to us, those in other countries might think us fortunate to have them; things like choosing "organic," "gluten free" or "carbon neutral" products. I am not saying that these everyday worries are inappropriate or wrong. Yet, for those with true gluten intolerance it is a serious health issue. "Organic" does often result in good food, but in our currently reality, there would be more starving people if only organic food were available.

But one of our problems is no different from the other "worlds," and that is suicide.

Suicide is not a good, popular or easy topic to discuss. My grandfather killed himself when my dad was sixteen years old. That scarred my father for life, and I only saw that fear in his later years.

I recently watched an episode of CBC's *The Passionate Eye*, which focused on suicide. A comment that stood out to me was when the presenter noted that as a middle-aged man, the category with the highest risk of suicide, the most probable cause of his death would be himself. The show went on to address suicide and its impact on others, and then how to prevent it.

One of the individuals interviewed was a man in San Francisco who, in the midst of his mental health crisis, had heard voices telling him to jump off the infamous bridge there. He walked out onto the bridge and seconds after he jumped, he realized he had made the worst mistake of his life. He lived, though he fractured a thoracic vertebra. He found himself alone, and, in his view, without support.

Recently, the Medical Staff Association in Edmonton had a viewing of *Do No Harm*,

a documentary by American filmmaker Robyn Symon, on suicide in the medical profession. I was worried it might be somewhat saccharine, but I ended up impressed and moved. It was an excellent documentary in a style similar to *The Passionate Eye, Frontline*, and other in-depth journalistic works.

Symon's film included interviews with medical trainees and their families, and something that came up was the inability to speak about mental health issues. I will bang my drum on this one. When we see a fracture of a broken leg, we react with the internal focus of physicians to fix it, and quickly. If the fracture is horrendous, we then think about the difficulty of returning this individual to a normal state. If the fracture is intra-articular, we then think about the future and possibility of arthritis. Yet, when we see someone with delirium, we sometimes have a tendency to look sideways and think, "Boy, that is awful — hopefully it will get better." I know that, because that is how I thought.

I had no idea what delirium was, is, or how to treat it. I recall something that happened while I was a medical student at the Misericordia Hospital on a medical rotation. It was late at night, and the nurses called me to see a little old lady who was delirious. She was very upset and clawed, scratched and spit at all of us. So, what did we do? We pulled her bed into an ante room and tied her down. Looking back now, I feel awful about this. We had neither the understanding of nor treatment for this episode of delirium. Since then, I think we have made some improvement, but not enough; delirium and other related mental health issues kill.

I do not know why our society has a different face and reaction to different situations. I am not a sociologist nor a psychologist, and have been so far removed from psychiatry that what I know is perhaps ancient knowledge. But I do know that when we were in elementary school, we all thought it was "cool" when a friend came to school with a cast on their arm. They were not disfigured; they stayed in a social group and they had something that made people take interest — but when someone had some sort of "disfigurement", we reacted differently.

As children, we looked at someone different and stared. I was like this, and so were my children. But I think things are improving on the mental health front. Namely, we are starting to treat mental health as a health care problem, not as, "They have a problem and are a problem." We are hearing from sports stars, actors, and other celebrities who have struggled with mental health issues. Many of these people sought help, and it was help they received.

Our inward and outward response to humankind should be that of compassion, whether it is a leg or a mind that is injured. To shun someone because of their injury is not what docs do. I need to continually remind myself that the drug addict is still a human being. I need to remind myself that those with dementia still have feelings, maybe not cognition and understanding, but real and important feelings. I also need to be brave, for myself and for others, and stand up for the need to be human and treat people as human.

Reflecting on these kinds of necessary changes makes me think of a trainee I knew a number of years ago who was constantly being talked about behind their back. This individual knew what was going on, and spent a lot of time at my house working through oral exam prep. I could see that deep down, this individual did not feel they had self-worth. After a lot of oral exam prep, which was pretty frank and in-your-face, this individual passed and sent me a card expressing appreciation for the help and support. I was not their doctor (they had one); I was someone who said: "You have value." They had the impression they had none. We need to say this more often. It is vital to make people feel that they have a sense of worth.

This is one of the most crucial things we can do when addressing the topic of suicide. *The Passionate Eye* noted that the most important thing to say to someone who might be at risk is: "Are you thinking of killing yourself?" That is a hard question to muster, and it is going to take some practice for me. But if it prevents one person from committing suicide, however difficult it would be to say those words, the result is worth it for the individual, myself and our world. Physicians are important, patients are important, people are important. Showing compassion, courage and care is how we can begin to affect change.

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

PLC MSA Members

This is a reminder to submit your nominations for the following awards for 2018: ***Physician of Merit, Clinical Teaching Award, and the Resident of the Year Award.*** A brief description outlining the criteria for the awards is attached along with a listing of the Physician of Merit Awards presented over the past years.

Please submit your nominations along with a brief letter documenting the nominees contributions and the rationale for the nomination via email to zmsaadmin@albertadoctors.org by February 22, 2019.

The nomination criteria can also be found on our website: http://albertazmsa.com/plc-msa

Save the Date!

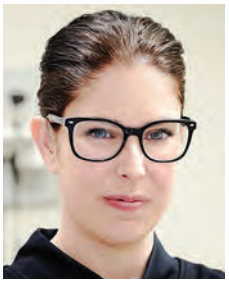
These awards will be presented at an award event being held on May 23, 2019.

Suffering in Silence

Intimate Partner Violence Amongst Physicians

Dr. Katie Wiltshire and Dr. Andrea Sereda

Dr. Katie Wiltshire



Dr. Andrea Sereda

Here is a story not commonly told, but too commonly experienced: A physician who has the world at her fingertips — someone who knew she wanted to be a doctor from a young age, and worked hard to excel every step of the way. She meets a man who supports her. Others would characterize him as charming, caring, and generous, and she falls in love.

To the outside world, her life seems perfect. As she succeeds professionally, her 'perfect' partner begins to change; showering her with affection one day then berating her the next, and always putting on a show for onlookers. He starts to make her feel guilty for her accomplishments. The threats begin one day, and then they never stop. This successful physician begins to leave work, unsure of what to expect when she returns home. Will she be endlessly admired, or will she have to lock herself in the bedroom in fear? She struggles to understand how she, a physician with intellect and support systems, could be caught up in this whirlwind of intimate partner violence (IPV). This isn't the narrative she worked so hard to achieve. Who would believe her if she told her story? Can she break free without risking her career? Her physical safety?

The expanding literature on physician wellness instills hope that a shift is happening in our dialogue around medical culture, but are we doing enough to underscore the reality that we are humans first, and physicians second? What we must be asking is how, as a physician community, we can support colleagues when their lives take an unexpected turn.

We lost our colleague Dr. Elana Fric just over 2 years ago. Her neurosurgeon husband is awaiting trial for her murder. For many of us, her death overwhelmed our emotions and invoked guilt over not doing more to help her and others facing IPV. Many wondered if this was a one-off situation, while also pondering how many other female physicians have suffered from IPV at some point in their careers.

The World Health Organization defines IPV as "behavior by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors" (1). The prevalence of IPV in North America is about 1 in 3 (2). No socioeconomic status is immune. With less than 3,000 female physicians practicing in Alberta Health Services (3), could it be that roughly 1,000 experience IPV in their lifetime, often during their medical careers?

An Australian study from 2018 confirms that these estimates are likely correct. In it, 1 in 10 female healthcare workers (including physicians) experienced IPV in the 12 months leading up to the study, with 45% of female physicians experiencing IPV or other familial abuse during their lifetime (4).

More compassion, research, and education are needed to change physician culture, which often expects its members to have immunity to issues like domestic violence, as well as super-human abilities to overcome.

The silence around the issue can be baffling, until you speak with a physician IPV survivor. They will often use words like 'shame', 'guilt', or 'embarrassment' to describe their experience, even after escaping the abuse, and it's been acknowledged that physicians may be less likely to report IPV than others (5). During times of need, doctors are often faced with inconsistent levels of support within their workplace, ranging from supportive to punitive, which can result in altering career paths just to survive the challenges associated with being in and leaving IPV.

It takes time to acknowledge being a victim, particularly if the abuse begins as indolent psychological and emotional abuse, which is often the case. Following that, it can take months or years to escape the situation, especially when it comes to co-parenting, legal proceedings, or abusers who work in the same healthcare system. There are unique — and not so unique — considerations for affluent IPV victims and their abusers, including legal abuse, a "culture of silence", and the fear of not being believed (6).

IPV is one example of the vast landscape of unforeseeable challenges that a physician can face during their career, including grief, addictions, mental health issues, and divorce. The literature around burnout and wellness recognizes the impact of personal factors, and often provides some framework for maintaining mental wellness, such as resilience training or mindfulness. It also recognizes the need for system improvements. Where the literature is sparse is the recognition that sometimes, when life takes unexpected turns, even a culture based on well deserved pride around accomplishments, leadership, and patient advocacy is still unlikely to allow all physicians to reach their potential.

Peer groups and institutions can affect how a person moves through serious personal events, and can limit someone's recovery and ability to regain their full potential. More compassion, research, and education are needed to change physician culture, which often expects its members to have immunity to issues like domestic violence, as well as super-human abilities to overcome. Ignoring this reality means losing countless contributions to the field from physicians who are not properly supported, or don't feel justified in taking action to protect their mental health.

The simple acknowledgement that all physicians are human would start to help physicians navigate the unexpected forks in the road that are often a part of life. It is crucial to let physicians know that no matter how successful, smart, careful, or hard working they are, they may wind up in an unimaginable situation, and they are not alone. We need to build space within our work places for any physician needing time and support to make it through unforeseeable challenges, so that in the end they can not only survive, but also thrive. It may not be possible to predict the difficult personal situations a physician could face. But it is possible to improve how we support them through those times, while allowing them to maintain their dignity, privacy, and ability to reach their professional goals.

Resources

If you are experiencing IPV, you are not alone.

The Physician and Family Support Program (PFSP) is a voluntary program that provides confidential support and help to physicians, residents and medical students with personal health issues in Alberta. The PFSP phone line is available 24 hours and managed by colleagues who understand the issues and working situations that impact physician health. The assessment physician will discuss your concerns and together you will determine the best resources to meet your needs. The phone number is 877-767-4637 and is available 24 hours.

There are a number of other external agencies that can help with safe exit planning including the YWCA Outreach Program accessed through the Sheriff King crisis line (403)-266-0707, the Distress Center (403)-266-HELP, and the Calgary Women's Emergency Shelter (403) 234-7233. Alberta Family Violence supports: https://www.alberta.ca/family-violence-find-supports.aspx

Katie Wiltshire, MD, MHA, FRCPC
Andrea Sereda, MD, CCFP (EM)

REFERENCES

1. Violence Against Women. World Health Organization https://www.who.int/news-room/fact-sheets/detail/violence-against-women
2. The National Intimate Partner and Sexual Violence Survey. 2010-2012 State Report. National Center for Injury Prevention and Control. Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf
3. Female Physician Leaders in Alberta Health Services. Alberta Health Services. Publication date December 20, 2018.
4. McLindon E, Humphreys C, and Hegarty K. "It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals. BMC Women's Health (2018) 18:113.
5. Carolyn Brown. Physicians not immune to intimate partner violence. CMAJ News November 1, 2018.
6. Shapiro, E. Domestic violence among the wealthy hides behind "Veil of Silence". 2013. https://www.thedailybeast.com/domestic-violence-among-the-wealthy-hides-behind-veil-of-silence

The 2nd edition of **Alberta Health Services' Healthy Parents, Healthy Children** is now available

The revised and redesigned HealthyParentsHealthyChildren.ca website and the Healthy Parents, Healthy Children: Pregnancy & Birth and The Early Years books are now available. The resources were updated to reflect the latest evidence and best-practices, and were reviewed by over 200 content experts. As always, these resources are available free of charge to help you support the families in your practice who have questions about pregnancy or parenting, such as:

- How much weight gain is healthy during pregnancy?
- What are my labour and delivery options?
- How can I keep my baby safe while they sleep?
- When should I start feeding my baby solids, and what foods are best to start with?
- How do I handle temper tantrums?

Key changes in the 2nd Edition resources include:

- The addition of a chapter specific to newborns with information on feeding, safe sleep, soothing a crying baby, and more
- Updated parenting information and tips reflecting the latest evidence
- Improvements to the organization of content as well as indexing and search, making it easier for parents to find the information they need
- The addition of more quotes from parents to better reflect Alberta's 'parent voice'
- A commitment to plain language and more pictures and illustrations to better serve all Albertan parents and families
- Use of quick response (QR) codes to easily connect readers to carefully selected links and value-added online tools
- A mobile-friendly HealthyParentsHealthyChildren.ca website that includes new interactive tools, printable resources, and improved search to help you and your patients find the information you need when you need you it

Visit HealthyParentsHealthyChildren.ca to see the changes! Additional pregnancy and parenting resources are also available free of charge to help you support the families in your practice. These include posters, promotional cards, clinical tools, and more. To view our catalogue or order the books or other resources online visit:

https://dol.datacm.com
Username: healthypublic
Password: healthy2013

You and your patients can also like us on Facebook at **/HealthyParentsHealthyChildren** or follow us on Twitter **@AHS_HPHC.**

For more information, please contact HPHC@ahs.ca

Alberta Health Services

Healthy Parents Healthy Children
HealthyParentsHealthyChildren.ca

Your Voice Needs to be Heard

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.

WHY WRITE?

Whether you have contributed countless articles or you merely enjoy reading Vital Signs, thank you for your time and attention.

With that said, we've got big plans for Vital Signs and we hope you'll join us on our journey. Certainly continue to keep reading Vital Signs but we encourage you to do more. Tweet about the things you read and interest you, share links to our online version with friends and colleagues and write for Vital Signs. The doctors who have contributed always find it a rewarding experience.

HERE'S WHY:

You'll be compensated for your writing
All authors whose articles of 800 words and over are published will receive a $50 Good Earth or Chapters gift card as a thank you for contributing!

Writing Makes You a Better Thinker
In an effort to create content that is succinct, reveals new ways to look at common things, or apply simple solutions to seemingly complex problems, you might think about health-care differently (1).

Writing Makes You a Better Listener
As you write more you begin to listen in different way. Considering new ideas and they can be developed into a story or article.[1]

Writing Makes You a Better Speaker
Your written work will produce some of your best presentation material (1).

Writing Keeps You Learning
The discipline required to create even somewhat interesting content forces you to study and contemplate your subject matter (1).

Writing Allows You to Create Bigger Ideas
Producing content over time affords you the opportunity to create larger editorial ideas that can be reshaped and repurposed for other settings (1).

REFERENCE

1. https://www.ducttapemarketing.com/benefits-of-writing/

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 approximately 800-1000 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 your article to zmsaadmin@albertadoctors.org and visit http://albertazmsa.com/vital-signs/ to view past issues.

Invite Two Patients

Help us make albertapatients.ca the most recognized online patient community in Canada.

albertapatients.ca

ALBERTA MEDICAL ASSOCIATION