COMMUNICATING WITH PHYSICIANS IN ALBERTA

VITAL SIGNS

MARCH 2019

5 tips for when the markets get rocky

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

WHEN STOCK MARKETS CHANGE SUDDENLY AND DRASTICALLY, SOME INVESTORS MAKE EMOTIONALLY-CHARGED FINANCIAL DECISIONS. IT'S A NATURAL REACTION TO UNCERTAINTY, BUT IT CAN DAMAGE YOUR POCKET IN THE LONG-RUN.

WHEN VOLATILITY STRIKES THE STOCK MARKET, FOCUS ON LONG-TERM SUCCESS WITH THESE FIVE STRATEGIES:

1. DON'T PANIC - MAINTAIN YOUR ORIGINAL INVESTMENT STRATEGY

Work with your financial advisor, trust in the plan you created together, and use investment statistics to keep your emotions in check. For instance, you can feel confident that long-term investments produce solid returns over 20–30 year periods, despite market volatility.

2. MANAGE RISK WITH OPEN COMMUNICATION

Every investor has unique risk tolerance based on age, personality, and short and long-term financial goals. If you become uncomfortable with your strategy, risk tolerance assessment, or investment portfolio, discuss it with your financial advisor before making any rash decisions.

3. HAVE AN INVESTMENT POLICY STATEMENT

An Investment Policy Statement (IPS) is drafted with your financial advisor to set guidelines for meeting your investment objectives. It includes criteria for monitoring performance, addressing risk, rebalancing your portfolio, and more. An IPS is a reference point for your financial decision-making – markets and emotions aside.

4. MAINTAIN A DIVERSIFIED PORTFOLIO

Work with your financial advisor to achieve a diversified portfolio. It's proven to cushion you when the market takes dramatic swings. Your portfolio should include a variety of domestic and foreign large, mid, and small cap investments, with a number of industries and investment styles.

5. DON'T RELY ON FINANCIAL HEADLINES

It can be difficult to ignore the doom-and-gloom of stock market news. Remember, no one has a crystal ball when it comes the markets, and even past events and trends cannot guarantee the future. Instead of poring over news articles, reach out to your financial advisor.

Concerned about how you'll fare in times of market volatility? We're here to support you.

With offices in Calgary and Vancouver, PlayCheques can review your current investment strategy, portfolio, risk tolerance and Investment Policy Statement to provide guidance. Connect with us today for a complimentary and no-obligation second opinion:
info@playcheques.com & (403) 837-9344.

VITAL SIGNS

MARCH 2019

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ADVOCATING FOR PHYSICIANS, CARING FOR PATIENTS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

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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, March 22th.

CONTENTS:

View from the Beach: Urgency and the Hot Hand 2

Would You Vote for a Doctor? 4

Why Advance Care Planning Matters 6

Facts, Opinion, Truth and Everything in Between 8

Coalition of Crusaders Works to Change the Narrative Around Lung Cancer..... 10

SAVE THE DATES!

CAMSS

Council Meeting: March 13, 2019 | FMC Boardroom 152 – 5:30-7:30 pm
ZAF: April 10, 2019 | Meredith Block – Boardroom 347 – 5:30-7:30 pm
Council Meeting: May 8, 2019 | FMC Boardroom 152 – 5:30-7:30 pm

CZMSA

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

EZMSA

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
ZAF: May 9, 2019 | Misericorida IN-106 – 4:00-7:00 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 April issue Friday, March 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

Urgency and the Hot Hand

Sounds like a fantastic name for an Arcade Fire tribute band. Unfortunately, this sentiment rings true for an ongoing challenge: continuity with patient flow between care in the Acute setting, to follow-up in the Community clinic.

A thousand years ago (timescale used to make a point that it was a while ago) I started my journey here in Alberta providing locum ER and inpatient coverage for small town hospitals throughout the province. During this time, I became exquisitely familiar with the CTAS triage system of urgency when addressing the wide variety of care concerns that would grace our ER from the rural setting. After my time in the field, I formulated a similar approach in my community clinic with the hope of addressing my patient's concerns in a timely fashion, based on their acuity needs. Nowhere near as fancy as CTAS, I, with my care team, derived a colorimetric scale vis-à-vis a traffic light to guide our appointment strategy and weekly scheduling.

Day to day, our Red-Orange-Green algorithm works fairly well, with fit-in spots available each day for red zone needs, and a grouping of slots for orange zone folks who I then address within the week. Although it runs pretty smoothly overall, I'm sure from the patient's perspective on urgency, it isn't perfect. Over the years, where I've found this to be most conflicted is when a patient completes his or her journey in acute, and I receive either an earnest call or a template-based discharge summary regaling me on their adventures. The scenario that unfolds in these cases has evolved as I've grown my practice over the years. It's looked something like this.

Years 1-5 (Fresh and Eager): Call from patient

"I've just been discharged from hospital and doctor X here says I have to be seen in one week." Okay. Do you know why? "Nope. They just told me to tell you." Go to (if available) D/C summary. Follow-up: To be seen by FP in one week. Patient to arrange." No help there. Must be something urgent though. Move time, shuffle space. Await with bated breath. See patient. How are you? "Looking good and feeling fine. How's by you?" Hmmm. Where was the fire?

Years 5-15 (Busy and Harried): Call from patient

Same opening as above. Rant to staff that Acute has no clue about how Community runs. Stomp around office until calm. Move time, shuffle space. See patient. Diatribe to patient on how Acute doesn't get to tell me when I should see my patients and how sneaky it is to use the patient as the messenger (for I traditionally don't shoot same). Rant to spouse at end of day. Move on.

Years 16-onward (Even busier and more Harried): Call from patient

Same opening. Resigned sigh. Move time and shuffle space. Play out with my inside voice my poignant quid-pro-quo for my next referral:

> Dear Dr. X,
>
> Please see patient Y with problem Z. Must be seen in one week. Patient to arrange.

Give patient Dr. X's office number. Stand back and watch world go all Purple Minion. Now, this will always remain an internal dialogue as I was once read something by a colleague that said "You are the professional. Be the professional." From this, I know my compatriots in Acute are exemplary as embodiments of professionalism, but the scenarios above reflect the frustrations that have challenged the keystone to the collaboration required for continuation of care: communication.

As a resident, my attending believed that inter-collegial communication was an important element for the care of the patient. Thus, she expected that I and my fellows would call the patient's FP at the time of discharge to close the loop on

As a resident, my attending believed that inter-collegial communication was an important element for the care of the patient.

care in-house, and bring community up to speed on what the patient may need going forward. Each call was well received and put a positive tick mark on my clinic day. To this day (contrary to what has been written here might suggest) contact with one of my colleagues from acute is still a high point in my day.

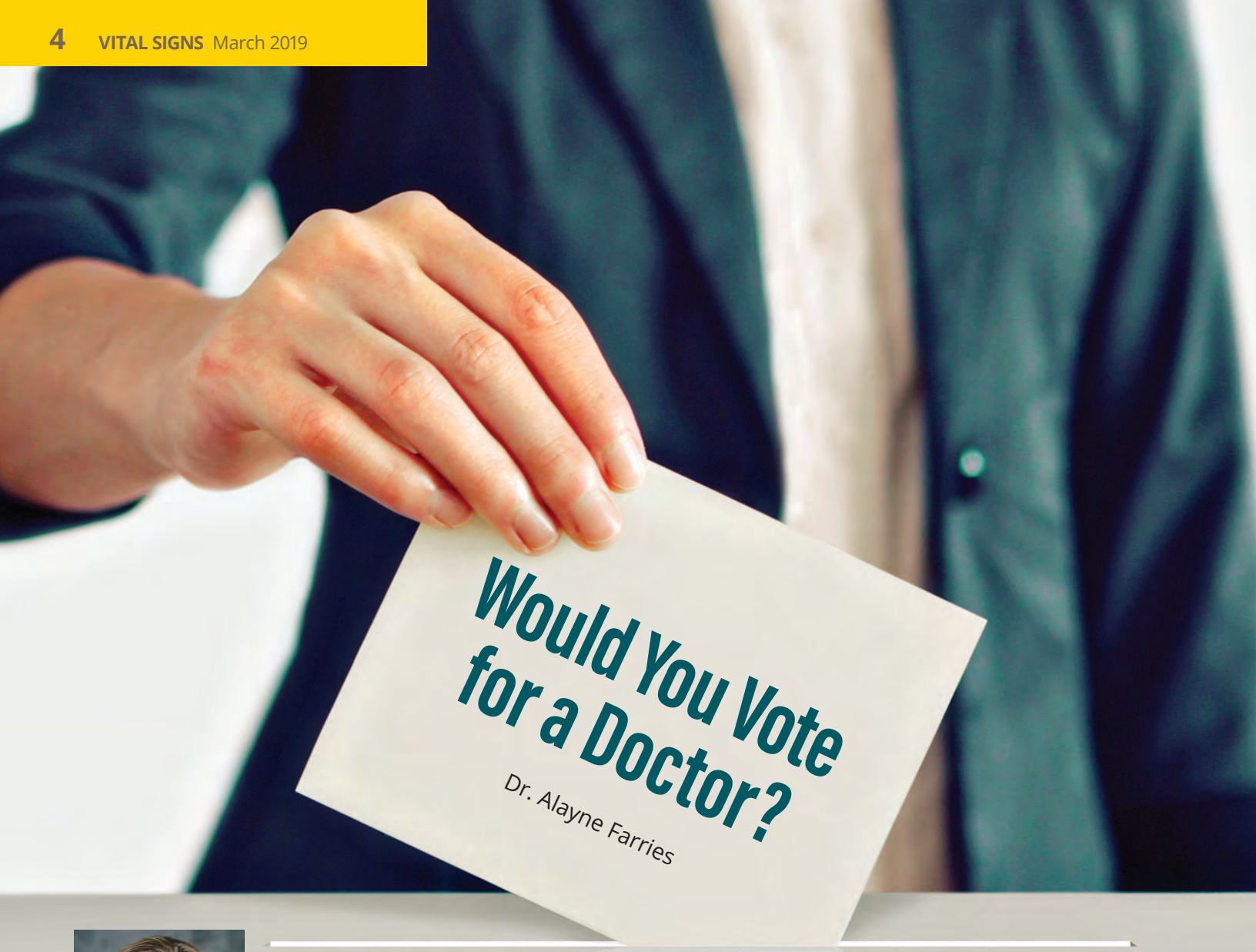
First, it allows me to put a voice to what would otherwise be just a name at the bottom of a sheet (and vice-versa). Second, it allows me to understand my patient's care needs going forward, and learn something that will enhance the care of others with similar concerns in the future. Finally, it closes the loop on continuity, ensuring an upward trajectory on the patient's recuperative curve.

Aspirationally, this idealized interaction unfortunately conjures the theme song from our favorite medical game show: "Who is the Biggest Martyr?" From Acute's side (which I still know pretty well as a locum hospitalist), time is precious, as making a call for rounds, clinic, teaching and administration responsibilities, admissions, and call consume the day almost entirely. From Community's side, there is no time to take a call, for the clinic is an hour behind, there are ten 3M's from the staff that need addressing, the carpet guy is here for a quote for the exam room flooring, and there is a PCN meeting that one is going to be late for.

Between the two settings, the common denominator that challenges connections is the rarest of non-renewable resources: time. In the wisdom of the system, to breed efficiency of communication and thus better manage time, template-based D/C summaries were created to streamline information dispersement and bridge continuity of care. My experience would argue that in some ways these documents have challenged this, where stock statements pertaining to follow-up need have been more enigmatic than clarifying. From this, time management has been effectively hamstrung.

So, where to go from here? I personally have no quick answer on how the system can forgive more time to allow colleagues to connect in person or by phone to hand-over care from acute to community. I hope that great minds from both the Primary Care and the Acute worlds will examine this issue going forward to identify ways for connections to be made, without creating greater burdens on already weary souls. At that point, the title of my column would be something akin to a group seen at Lilith Fair: Empathy and the Clasped Hands. Until then, as the alpha and omega in my own little microverse, I will continue to bend the time space continuum and provide the best care I can.

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



Dr. Alayne Farries

The famous writer Robert Louis Stevenson once said, "Politics is perhaps the only profession for which no preparation is thought necessary."

There is an upcoming election here in Alberta, and a number of doctors have added their names as candidates. There are a reported 234 physicians per 100,000 people in Canada (1), and when statistics show that only 6 per cent of Canadians would consider running for political office (2), it's no surprise that physician politician numbers in our country are so small.

Doctors are certainly not the most common profession elected to office. That position is taken by law, business and diplomacy. The so-called "professional politician" — someone with a career entirely in and around politics — has been on the rise in democracies like Britain and the U.S. (3).

Given the merits of experience in the medical field, should we begin to more seriously consider doctors for political office? When we vote, does the consideration rest on the politician as a person and a professional, or do we weigh more heavily on how well they will do the job of representation?

If we consider physicians as a group, we can look at how the profession might positively reflect suitability for public office. Integrity is a word often used to describe the ideal political candidate, and physicians rate high in trustworthiness — 92 per cent of people polled in one study trusted a physician to tell the truth (4). Working doctors have skills necessary to get

through the selection process to enter medical school, and have demonstrated rigorous academic, personal and professional skills to complete medical training.

By its very nature, the practice of medicine involves the physician being intimately involved in the lives of other people. Dr. Bob Turner, MLA for Edmonton Whitemud, listed the crossover skills from his career in medicine: "Social determinants of health, human rights, patient autonomy, listening skills, research skills, record keeping, staff management…" (5). Furthermore, the health care budget in Alberta makes up 40% of the overall provincial budget (6), and physicians (and other healthcare professionals) have nuanced insight into a system that consumes a large number of government dollars.

While the merits and transferable skills are clear, the question becomes: can a physician do the job of representation?

A physicians' intent in their career is to positively affect the lives of their patients, whereas a politicians' intent is to improve the lives of their constituents. Dr. David Swann, commenting on his turn in government, stated, "As a doctor, I would affect the lives of hundreds of people, but as a politician, you influence the lives of thousands, millions of people with policies that either improve their opportunities, or, in some cases, reduce their opportunities for healthy and successful lives." (7).

While each candidate should be judged by their individual merit, I believe doctors should be given the same measured consideration as those entering politics from other fields of expertise. This should be based on what the medical profession says not just about their personal character, but the skills they bring to the tough job of being in government.

Alayne Farries, MD FRCP(C)
Anesthesiologist, Red Deer Alberta

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EDMONTON ZONE MEDICAL STAFF ASSOCIATION | HELPING PHYSICIANS HELP PATIENTS

EZMSA 2019 Award & General Meeting

CONGRATULATIONS to the 2019 Award NOMINEES

The overall quality and varied talents demonstrated by physicians nominated for awards made the selection process very pleasant, but also very challenging. Thanks to those that took the time to nominate a physician you strengthen our organization and help us to serve our membership.

Dr. Denis Lefebvre
Dr. Benjamin Sugars
Dr. Gary Lobay
Dr. Gavin Oudit
Dr. Rachel Khadaroo
Dr. Keith Aronyk
Dr. Pierre Chue

PHYSICIAN OF THE YEAR:
Dr. Dilini Vethanayagam

RESEARCHER OF THE YEAR:
Dr. Sean Bagshaw

INNOVATORS OF THE YEAR:
Drs. Sheny Khera & Marjan Abbasi *(Joint Nomination)*

CHAMPION AWARD FOR YOUNG LEADERS:
Dr. Brian Buchanan

LIFE ACHIEVEMENTS–MEDAL OF SERVICE:
Dr. Lil Miedzinski
Dr. Richard Johnston

Thursday March 21, 2019

Ernest Restaurant, N.A.I.T. 11762-106 Street
Dinner 6:00 p.m. | General Meeting 7:00 p.m.
Awards Presentation 8:00 p.m.

Open to ALL Family, Friends, and Colleagues
Dinner Reservation Cost: $50.00 each
To Book a Reservation call EZMSA office 780-735-2924
Free Parking after 5:00 p.m. Lot C across Restaurant

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Visa, Mastercard, Cheques & Cash

This is an evening to celebrate outstanding physicians
Cocktail Attire – Academy Theme

Why Advance Care Planning Matters

Vital Signs Staff

Grave illness and death are difficult topics to discuss, let alone face the reality of. But lack of a plan in dealing with these inevitable parts of life can make a health crisis much more distressing for patients and their loved ones.

The act of advance care planning, where patients think about and share their wishes for future health and personal care, is a crucial part of the physician-patient relationship.

Dr. Ella Rokosh, Intensive Care Unit Physician at the Misericordia Community Hospital in Edmonton, says one of the main benefits of an advance care plan is that the patient's loved ones can help guide the primary care team in the right direction.

Advance Care Planning: What Physicians Can Do

What is an Advance Care Plan?

An advance care plan is a process where a patient considers their values when it comes to life and health, and then shares those thoughts with family, friends and healthcare providers.

If the need to plan is brought on by an illness, take time to explain the illness to the patient, so they have a full grasp on what they are dealing with.

An important part of the plan is that the patient will appoint a decision maker who will represent their wishes if they're not able to do so themselves. It is important to know who this person is, and to document the overall plan.

How the Plan Helps Patients and Their Loved Ones

The decisions associated with illness and end-of-life care can be a heavy burden if family members don't know or understand the patient's wishes.

Keep in mind that patients don't have to wait until they are seniors or facing grave illness to make a plan; it's important to reassure them that a plan can be easily adapted to reflect a change of heart.

"If the family has to make decisions and they have no idea what the wishes were, they don't really want to make decisions," Dr. Rokosh says. "They can be paralyzed by decision-making. Even if they do make decisions, they may feel guilty. That guilt can stay with them beyond the death of their loved one because they don't feel they accurately spoke for the person, and they'll never know."

Having an advance care plan in place takes the burden off of loved ones and helps them navigate the difficult time together.

Keep in mind that patients don't have to wait until they are seniors or facing grave illness to make a plan; it's important to reassure them that a plan can be easily adapted to reflect a change of heart. "Advance care planning is a conversation, not a one-time discussion," Dr. Rokosh says.

Let the Patient Lead

In most cases, it's easier if the person in need of the advance care plan starts the conversation. As their care provider, be open to the conversation and allow loved ones to be part of it as well.

Dr. Rokosh says it's important to guide the patient through questions like, "What would you be happy with? For example, if you cannot return home or live independently, would that be OK? It's more than, 'I don't want machines to keep me alive.'"

Advance Care Planning – Video

Link:
https://www.youtube.com/watch?v=j6uky-ZsrCE

This video was prompted in large part by Dr. Ella Rokosh, and sponsored by the Legacy grant through Covenant Health.

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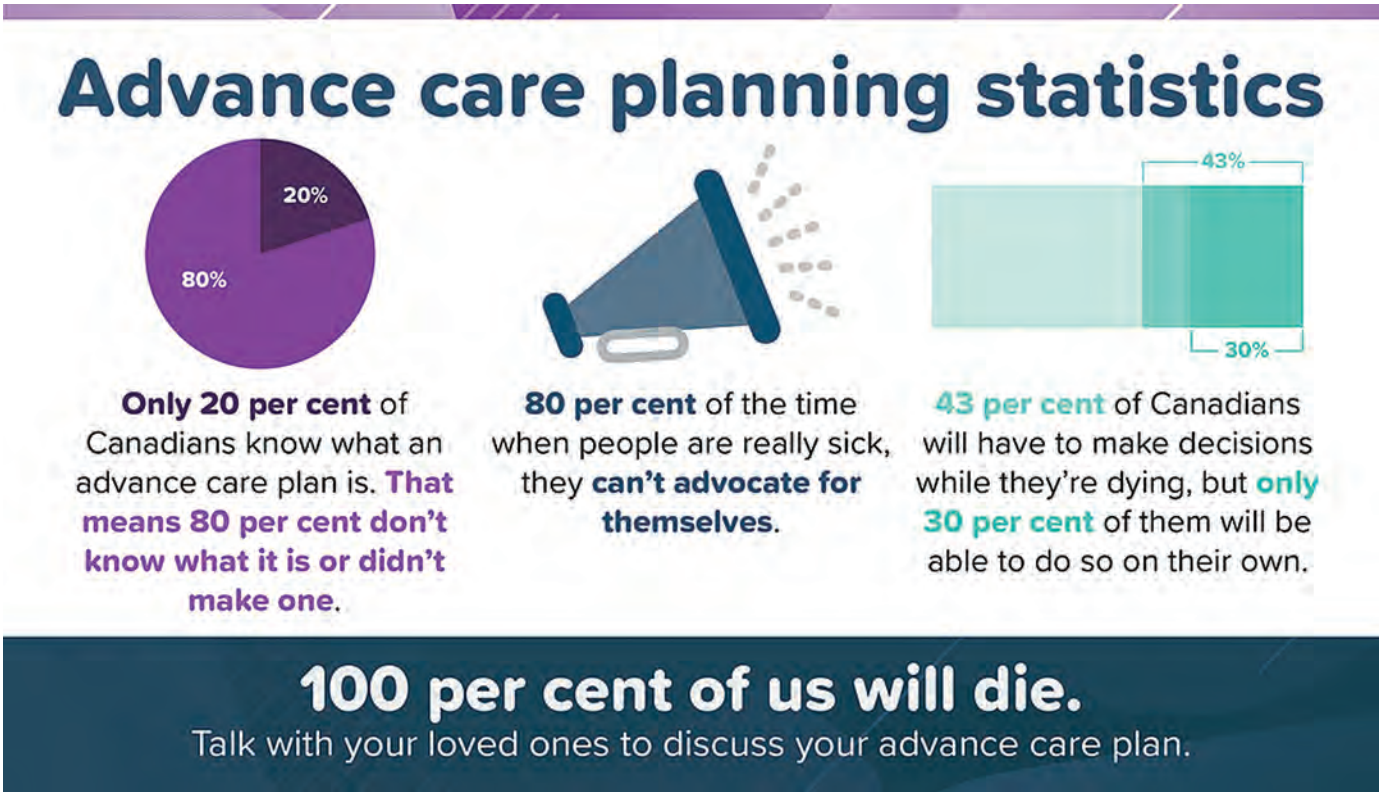
Alicia Johnson, *Videographer at Covenant Health*
Jessica Hopley, *Creative Services Specialist at Covenant Health*



Facts, Opinion, Truth

and Everything in Between

Dr. Richard Bergstrom

Dr. Richard Bergstrom

I often like to repeat a phrase coined by the late American politician Daniel Patrick Moynihan: "You are entitled to your own opinions, but not your own facts."

This idea captures, in my opinion (it might be a fact!), the quintessential problem with social media: "If I feel it's true, then true it must be!" We've all met people with this attitude, people with whom it's difficult to have a real debate. They take your comments and reinterpret them in their own fashion. If you attempt to argue, there is no listening whatsoever on their end.

In medicine especially, "evidence based" is a strong touchstone. These words can have an impact that declare you as right. Quote the latest lead article from the New England Journal of Medicine (NEJM) and you need not say more. But perhaps we should think again. The lead article in the NEJM does not always have lasting truth. Studies in the Journal itself are not infrequently proven wrong. Consider the last line in so many scholarly articles: "More research is needed…"

I am not saying that as physicians, we shouldn't read or believe an article (unless you wish to keep practicing backwards medicine). I am saying that what we speak of as truth today, might well be bettered tomorrow. We need good researchers, truth seekers and people who can give us clinicians more knowledge to better treat those who ask for our help. And we need to be more up front with people and say, for example, "That treatment has been proven to not work, or not work as well as this one."

Of course, this can be a delicate balance. Take people who are adamant about avoiding vaccines as an example. I like vaccines. I and many others are alive because of vaccines. I get the flu vaccine every year. It does not always work, but it has allowed me to have winters without influenza. My son now gets a flu vaccine after experiencing a bout of, I am sure, H1N1. I told him that we put people like that on ECMO, and he paled a bit when he realized that his was a narrow escape. The anti-vaxxers are a loud voice and they have their own belief, or, perhaps we can say, opinion. They are adamant that vaccinations are harmful. I agree — they are harmful to the virus, bacterium that is the cause of disease.

Vaccination has been made mandatory in some school districts and workplaces. We can be vectors of disease; look at the use of hand washing in the Netherlands,

We need good researchers, truth seekers and people who can give us clinicians more knowledge to better treat those who ask for our help.

and how it has led to better experiences for patients. I did a course at Gordon Ramsay's signature restaurant, and we washed our hands like there was no tomorrow — it felt like every time we turned around, we washed our hands. It was part of the culture, and it was easy, convenient, and it worked. Vaccines are not without any downside — just talk to someone who has suffered Guillain-Barré syndrome. Still, the incidence of GBS is lower than ECMO for H1N1. I choose the chalice from which to sip.

I often tell the residents I supervise: "I tell you not the truth, rather, my current set of lies." This is said in a sort of jest, but it reminds the residents and myself that knowledge evolves, so all of us, too, must evolve in our thinking and doing.

I suppose I cannot say exactly what "truth" is in medicine. I know that 2 plus 2 equals 4, but it is not that easy in some areas of medicine. Opinion is just that: opinion. It might have great strength, but that strength should come from knowledge, not just belief and emotion. Evidence evolves over time, and I laud good researchers who give me more knowledge and tools to provide care. I need to get rid of some ideas and practices as we build a more robust system to provide care. It is a challenge to change, yet, change is what we need, for our sake and the sake of our patients.

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FMC Medical Staff Association

The FMC Medical Staff Association is seeking nominations for its 2018 Physician of the Year Award!

This award is presented annually by the FMC MSA to recognize a physician for their outstanding commitment to the patients, staff and students of Foothills Hospital and to the community they serve.

You can find more details, previous winners, and the nomination form on our website: **www.albertazmsa.com/fmc-msa**

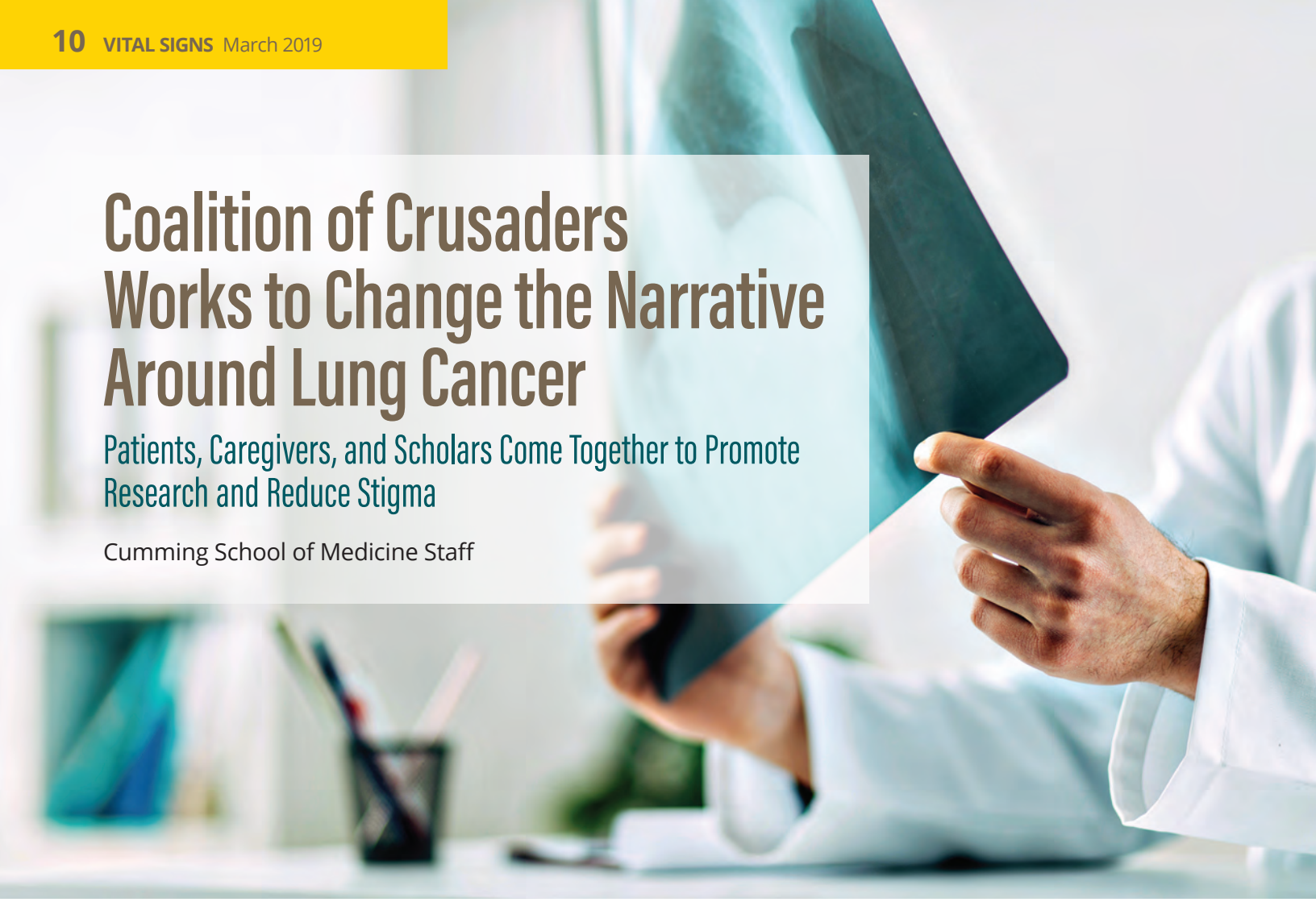
ACH Medical Staff Association

The ACH Medical Staff Association is seeking nominations for its 2018 Physician of the Year Award!

Do you know a physician who you feel should be recognized for their exceptional accomplishments, extraordinary clinical teaching or exemplary service? Nominate them!

You can find the nomination form on our website: **www.albertazmsa.com/ach-msa**

Save the Date!
The award will be presented at the Department of Pediatrics 4th Annual Spring Celebration will be held on April 27, 2019.



Coalition of Crusaders Works to Change the Narrative Around Lung Cancer

Patients, Caregivers, and Scholars Come Together to Promote Research and Reduce Stigma

Cumming School of Medicine Staff

Lung cancer is the leading cause of cancer-related deaths in Canada but one of the most poorly funded. Often seen as a smoker's disease, it carries a stigma that other cancers do not, despite the fact it is increasingly being diagnosed in non-smokers.

Enter Mavis Clark and Bev Longstaff, two women committed to changing the narrative on lung cancer. Both have a personal connection to the disease: Clark's father and her husband, Paul, a non-smoker, both died of lung cancer in 2010; Bev lost a brother. They came together after a mutual friend was diagnosed with the disease shortly after Paul's death. "We had to do something," says Longstaff, Hon. LLD'08.

Since then, Clark and Longstaff have worked tirelessly to raise awareness, reduce stigmatization, fund research and save lives. "We can't change the past or our losses, but we can make a difference in other people's lives going forward," says Clark, MEd'82, a member of UCalgary's Senate.

Walking The Talk

"Advancements in the treatment of cancer are only made through systemic and ongoing investments in research," says Longstaff.

Fundraising for lung cancer research is a priority for both women, who serve as ambassadors and backers of the cause. Arising from their work is the Lung Cancer Translational Research Initiative, a provincial program dedicated to advancing lung cancer research, and translating it as efficiently as possible to the public sphere. The same passion led to the establishment of the Paul Clark Lung Cancer Fellowship, which supports postdoctoral students and funds lung cancer research projects.

Dr. Don Morris, MD'92, PhD, is head of the Lung Cancer Translational Research Initiative, an associate professor in the departments of Oncology and Medicine and member of the Cumming School of Medicine's Arnie Charbonneau Cancer Institute. He first met Clark when he was treating her husband at the Tom Baker Cancer Centre.

Morris says he has seen increasing momentum around lung cancer research and treatment since he began his research in the late 1990s. Advancements in treatment have seen people

Morris says he has seen increasing momentum around lung cancer research and treatment since he began his research in the late 1990s. Advancements in treatment have seen people living longer and his own work is bringing hope to reality for early detection and precision medicine and immunotherapies.

living longer and his own work is bringing hope to reality for early detection and precision medicine and immunotherapies. Early results are encouraging with significant improvements in overall survivals and quality of life for those lung cancer patients with molecularly targeted treatment options; however, with an overall survivorship rate of just 17 per cent, there's still much work to be done.

Advances Through Partnership

Clark and Longstaff's advocacy caught the attention of the Canadian Cancer Society, which will host the first Alberta Lung Cancer Consensus Forum this February.

Participating UCalgary researchers will include Drs. Alain Tremblay, MDCM; Dr. Andre Buret, MSc'88, PhD'91; Dr. Aaron Goodarzi, BSc'99, PhD'05; Dr. Barry Bultz, PhD; Dr. Darren Brenner, PhD; Dr. Douglas Stewart, MD; Dr. Doha Itani, MD; Dr. Gwyn Bebb, MD, PhD, and Dr. Don Morris, MD'92, PhD. They will join forces with experts from the University of Alberta, Alberta Health Services, the provincial government, non-governmental organizations, patients, caregivers and community members to explore and find consensus for action across the continuum of lung cancer.

From left: Mavis Clark, Don Morris, and Bev Longstaff. *Photo by Adrian Shellard, for the Cumming School of Medicine*

The event is a platform to produce action in primary prevention, screening and diagnostics, treatment and research, and supportive care. It is also a chance to educate and engage the province in conversation around the public health and economic burden of lung cancer.

"This conference is a significant step forward to have agencies like the Lung Association, Lung Cancer Canada and the Canadian Cancer Society working as one with clinicians/researchers and members of the community to develop a strategic plan of action," says Clark who, along with Longstaff and Morris, is on the forum's organizing committee.

Morris says the forum's goal is to pick a defined number of initiatives to move forward and keep timelines crisp to keep advancing. "Small steps now will lead to big steps soon," he says.

The forum is open to all, but is not the only way to join the fight. Giving to lung cancer research at UCalgary is one way to effect change. Others, Morris says, include getting the word out and making lung cancer research a priority when it comes time to vote.

Clark and Longstaff's advocacy has turned their Calgary-based grassroots initiative into one that is now being noticed provincially and nationally. Morris says it's essential that both the public and researchers alike keep advocating and advancing the Lung Cancer cause on the national and global stages.

"Lung cancer doesn't respect boundaries," he says.

The Lung Cancer Consensus Forum will take place Tuesday, February 20 at the Hilton DoubleTree Hotel and Conference Centre in Edmonton. Learn more by contacting angeline.webb@cancer.ab.ca.

About Energize: The Campaign for *Eyes High*

The Energize campaign for the University of Calgary is a transformative fundraising initiative that fuels excellence in student experiences, research outcomes and community connections. Thanks to the generosity of UCalgary's friends and supporters, we are igniting discovery, creativity and innovation to make lasting positive change at the University of Calgary, in our city and beyond. Learn more about the work being done and hear from those who have been impacted. Donate directly to the Lung Cancer Translational Research Initiative.

The Energize campaign is more than three-quarters to its overall goal of $1.3 billion.

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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://.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.

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