THE VOICE FOR PHYSICIANS IN ALBERTA
VITAL SIGNS
MARCH 2020

With 16 YRC fun runs hosted by schools across the province last spring, we wrapped up the school year in busy style!

Two adaptive fun runs – featuring the Paralympic Sports Association's Trail Rider – 36 Go! (Girls Only) Run Clubs and 32 Indigenous School Community clubs demonstrated the YRC's commitment to health equity and inclusion.

Goals for the 2019–20 season include adding to last year's 402 schools and 20,000 students; and continuing to develop club resources in support of inclusivity.

Moving kids of all abilities!

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VITAL SIGNS

MARCH 2020

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Vital Signs welcomes submissions from physicians in Alberta. Please limit articles to 1,500 words or less.

Please send contributions to: Shauna McGinn, Staff Editor/Writer, mcginnshauna@gmail.com and cc 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 20th.

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!

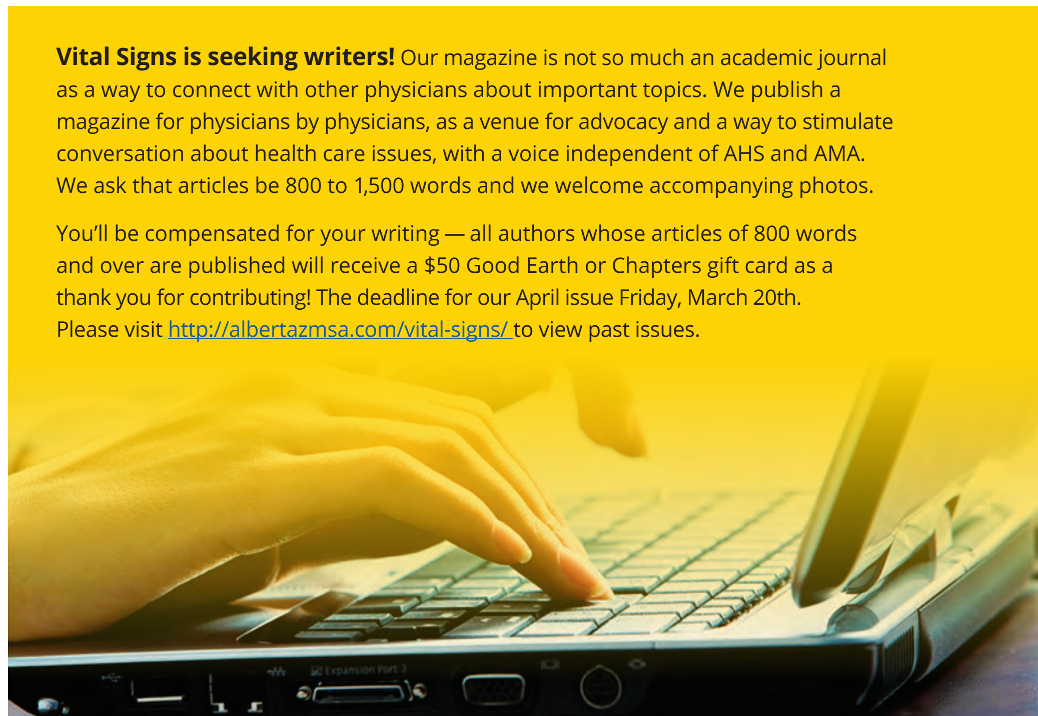
CAMSS
Council Meeting: March 11, 2020 | FMC Admin Boardroom 152, 5:30-7:30 pm
Council Meeting: April 8, 2020 | Location TBD, 5:30-7:30 pm
Council Meeting: May 13, 2020 | FMC Admin Boardroom 152, 5:30-7:30 pm

CZMSA
Executive Meeting: March 19, 2020 | WebEx, 7:00-8:30 pm
Executive Meeting: April 16, 2020 | WebEx, 7:00-8:30 pm
Executive Meeting: May 21, 2020 | WebEx, 7:00-8:30 pm

EZMSA
Awards: March 19, 2020 | NAIT Ernest Restaurant, 6:00-9:00 pm
Council Meeting: April 16, 2020 | Misericordia 1N-106, 5:30-7:30 pm
Executive Meeting: May 14, 2020 | Location TBD, 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 April issue Friday, March 20th. 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

The beginning of the end. The end of the beginning.

Dr. Scott F. Beach

These two thoughts have swirled in my head like two weasels in a bag since the surreal events that took place on February 20, 2020 (a date, shall we say, that will live in infamy). Indeed, I am no closer to resolving this debate as the magnitude of the impending universe tilt that will arrive on April 1st continues to settle in.

The beginning of the end.

The end of comprehensive longitudinal care in the medical home, as family docs and community-based specialists run twice as fast to stand in place as overhead supports are gutted and gone.

The end of the care web created by community and AHS that supports the Pantheon of Pronounced Pathologies:

- The frail elderly
- The complex patient with multiple comorbidities
- Mental health
- Addiction
- Chronic pain

All of these require a collaborative approach and investment of time, which the UCP apparently feels is of no value (and heck, according to health minister Shandro, there "aren't that many" complex patients in Alberta).

It may be the end of the care continuum. The end of established practices, both specialist and primary care, whose patients cannot be absorbed by those who remain. The end of those about to begin: residents who will decline an Alberta match and medical students who will flee from professional suicide. Who can blame them… who in their right mind will run in to a burning building (with all due respect and accolades to the firefighters out there).

The end of — or at least a serious hit to — rural medicine. The end of the heroic provision of emergency coverage, in-patient management, LTC support, and primary care delivery all rolled into one. The end (naturally) of rural hospitals, obstetrical care, and adequately prepared emergency rooms. The end of stalwart form, as a wave of burnout could inevitably begin. Ends of careers, and as a result, maybe of some families. And poignantly, tragically, *avoidably*, the end of lives.

The end of the beginning. The abrupt end of the master agreement and, symbolically, the end of democracy with the beginning of a new age of government in Alberta.

The end of collaborative negotiations and the beginning of legal girding and online goading. The end of trust and good faith, and the beginning of cynicism and suspicion.

The end of patient-centered medicine, and the beginning of high volume survival.

The end of the stable medical home and the beginning of mass migration to urgent care. The end of fee for service, and the beginning of mandated ARP's (I would be cautious in taking the life ring from he who just torpedoed my boat). The end of portability and autonomy, and the beginning of physician control. The end of healthcare as we know it, and the beginning of a journey into the gaping maw of uncertainty.

Part of me wants to believe and hopes desperately that AH is ignorant to these inevitabilities, and with time and patience, eyes will open and ears will hear. Part of me also shudders that with premeditated intent, insectile awareness may lead to decisions with deliberate harm.

At this new beginning, we will pursue all just means to address this challenge to the health of our patients, and to our Alberta democracy. In the interim, I will continue to embrace my emotional support ice-cream and meet my patients needs as best I can. As a believer in collaborative team based care, I of course will bring enough for all to share.

Good luck to us all and godspeed on the journey ahead.

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

We all want the same thing:

A family physician perspective on the AHS review

Dr. Fozia Alvi

Dr. Fozia Alvi

An initial version of this article appeared as an op-ed in the Edmonton Journal.

On Friday, February 14th, our provincial Health Minister Tyler Shandro made the announcement that negotiations with AMA have been "unsuccessful."

The Minister said: "The government of Alberta is spending more than ever before on our public health care system… in order to ensure that our public health care system remains sustainable, we must act to maintain physician spending at current levels."

He then went on to associate the sustainability of our entire healthcare system with physician spending levels, noting that "cost overruns are forecast to amount to $2 billion over the next three years", and that this is "unacceptable."

I also find this unacceptable, but for different reasons.

Firstly, it's simply not possible that physicians' pay alone is responsible for $2 billion of forecast cost overruns. It is reckless for the government to imply that physician payments are related to this much cost increase in the overall system.

Second, physician payments are being dealt with separately from healthcare system costs. One was analyzed by Ernst & Young in a review of Alberta Health Services (AHS) costs and operations. Doctor's costs were dealt with through the provincial budget finance report, known as the MacKinnon report. How can Mr. Shandro reasonably relate these two?

The Minister says he wants to reduce payments to physicians in order to then "reinvest it into front-line services." But physicians, especially those in primary care, are the front-line services.

1) Family physicians are the backbone of Canadian health system and are getting burned out within the current

We believe that family physicians, as the most trusted group of medical professionals, should have been consulted about how best to optimize the "system" and bring even greater health benefits to Alberta. What has been entirely missed is that we know our patients and community best. We are the facilitators and the matchmakers for how people move in and around the "system."

healthcare system. Many of us are working 70-80 hours per week and are dealing with the complexities of the healthcare system, long wait times for the referrals and surgeries of our patients, as well as high overhead costs as inflation increases each year.

2) All of us want to see our patients healthy, and want to avoid emergency visits.

3) We're also dealing with the overall management of a clinic, including rent, which continues to become more expensive each year.

As physicians, we can proudly say that Alberta has one of the best healthcare systems in the world. It's there if and when we need it, for both us and the public at large. But this system can only be great because we spend the effort and resources to keep it this way. As health workers, whether we are physicians, nurses, administrators, or social workers, we know what these efforts entail, and what our patients need.

Family physicians are vital in many ways. We are the front-line and the de-facto integrators between individuals and the vast and complex healthcare system. From this view, primary care is the "barometer" of individual and community health. We are also the group that determines who proceeds from primary care into the broader, and ever more expensive acute care system. This synergy is needed to keep our system as efficient as possible, so that we can allocate our limited resources to those who need them most.

In the Ernst & Young AHS review, theme 4 states that: "Alberta has the right foundation in place to maximize the benefits of its position as a provincially integrated system." This is the system working as is, but unfortunately, there is a general lack of understanding and appreciation for the integrative role of family physicians and our value to this system.

We remain in a separate part of the system, despite the reality that we are often the group that determines which patients get escalated from the community into AHS services. This has a direct, measurable impact on increasing or decreasing system costs.

The MacKinnon report makes the recommendation to "limit the high cost of doctor services by having physicians move to alternative payment plans, renegotiate its agreement with the Alberta Medical Association and also consider legislation."

The current fee schedule for primary care practitioners is what guides what we pursue with respect to our patients' health, and what allows us to operate sustainable businesses in support of our patients and the community. However, it is also deficient in providing incentives to family physicians to provide preventative care, to spend time providing education, or linking patients to community services. At a time when our system is trying to move away from institutional care to a focus on self-care and improving social determinants of health, the separate review and consideration of primary care is counter-productive to those goals.

We believe that family physicians, as the most trusted group of medical professionals, should have been consulted about how best to optimize the "system" and bring even greater health benefits to Alberta. What has been entirely missed is that we know our patients and community best. We are the facilitators and the matchmakers for how people move in and around the "system."

We all want the same thing: better health care for all Albertans within a sustainable system. This sentiment is also found within the AHS review: "While AHS isn't seeing its funding reduced, it has unavoidable growth pressures that it will need to address — things like a growing and aging population, new hospitals opening, scheduled collective agreement rate step increases, and commitments to improve services in areas such as surgical wait times."

The review also states: "While the scope of this review focuses on AHS, the scale of the fiscal challenge facing Alberta will require a response across the system." The truth is, you can't have a response across the system while ignoring a profession that is one of its backbones.

Family physicians are not just another budgetary line item for the government "to manage uncontrolled growth in the physician services budget." We are the very people who can help make and keep Albertans healthy, and our healthcare system even more the envy of the world, in a sustainable way.

Unfortunately, we weren't asked how.

Fozia Alvi, MD
Airdrie, Alberta

What does it mean to be rural?

Dr. Matthew McIsaac

Dr. Matthew McIsaac

A long blue sky stretches out before me, dotted by a few small wisps of cloud, high and white. A familiar smell of grass, earth, and prairie tarmac comes with every deep breath. The road surface is surprisingly smooth. At times I hold the white line, at times it does not exist. Fence posts come and go at regular short intervals. Telephone poles are fewer, but just as regular. I pass a sign for the town of Fleet and snap a quick picture to send to my wife, who is in her first year of medical school. We will giggle about it later. As a Saskatchewan boy, I am used to silly town names.

With only 2 wheels on a 24 pound road bike and a layer of spandex, I am certainly lowest on the totem pole out here. I wonder: if I was ridden off the road, would the ambulance still come? Before I hopped on my bike, I called the ward where I was working to let them know. "Go ahead Dr McIsaac," they said, "If someone comes in sick, we'll just send the ambulance to get you!"

How long before they would come looking?

I ponder the town I am in, the similarities to the place I grew up, and the return to rural that I swore would never happen. This town is almost twice the size of my home town. It's easy to double such a small number. I first came here on a Rural Physician Action Program locum. I was dirt poor after four years of undergrad, four years of medical school, and two of a rural family medicine residency.

There was a signing bonus, and I could make my own schedule. Aside from the actual placements, I had no obligations. No overhead. It seemed like a no-brainer, and it was. I cut hard into my sizeable debt in my first 2 months of practice; turns out it is awfully hard to spend money in the middle of nowhere. It should have been a short path to financial freedom, then on to settling somewhere a bit more urban. But there I was, 2 years later, back again. Why did I keep coming back?

I was born and raised in rural Saskatchewan, in a town with a footprint of 1.24 square kilometres. As a child, it was not a great fit for me. The town passions were hockey and baseball. Education seemed unimportant. As a piano playing, bookworm, school loving non-athlete, I was not what one might call 'popular'. I picked up the saxophone and learned quickly, but there was nobody around with the skill to teach me. New books were hard to come by. There was no internet or Amazon then (the website, not the rainforest), and I felt stunted.

On the other hand, there were many great things about living rural. For the most part, the 'grown ups' in town were polite to me. Everyone knew my name. I could ditch my bike in a yard and find it 2 days later, completely unmoved. The town bordered a valley, and I would walk out the front door with an axe over my shoulder, and nobody took notice. If I walked out of the valley onto one of the grid roads, any truck driving by would inevitably wave, as it was likely driven by a client of my father's.

The hospital was also the de-facto walk in clinic, so the nurse would stack everything non urgent until an agreeable time. There were many characters and personalities who wandered through, checking out the new guy, keeping things fresh.

We lived across the street from the doctor; not because we were in an affluent neighbourhood (there were no affluent neighbourhoods), but because we just happened to be so juxtaposed. He was an immigrant from Mauritius, via med school in Galway, Ireland. He came to Canada with his Irish wife and started a family in this small town. He was truly the jack of all trades. He gained infamy when he finger clamped the slashed ends of a carotid artery and held them for 3 hours on the ride to the city for a fix with the vascular surgeon. The incident had happened at a hockey game. As the skate tore apart the artery, the doc was over the boards and had the bleeding stopped in seconds.

He was the true family doc. He knew me and all my siblings since birth, and knew all of our little health tics. Our wellbeing was best measured with a firm pinch on a cheek, which hurt. I guess it told him we still felt pain, and had enough vigour to pull away.

He knew everyone the same way. Now, knowing what I know, I can only imagine how hard this would have been: having a social existence in a place where you knew everyone's physical, mental and social health status. Being respectful of a despicably behaving patient. Having compassion for the frequent fliers. But he did this all, and despite being a relative 'outsider', the town respected him. Eventually, people told me I should be a doctor. Like him? I thought. It sounded reasonable.

As my efforts at social integration proceeded, I was offered the opportunity to go away to boarding school — a fresh start. I left the small town to explore the bright lights and big city of... Regina. Any Calgarian or Torontonian will probably laugh at that, but from a town of 600-700 people, this was a huge leap. The first time I went to walk across the Lewvan (6 lanes where I stood) I stared, stunned, for 2 light changes. I had never seen so much pavement, and I was scared witless. Eventually I crossed, and quickly, the city grew on me. I found a breadth of learning and opportunities that I had never imagined. Interests I didn't even know I had blossomed, and it wasn't long before I vowed never to go back to a small town.

So what the hell was I doing back in a small town... again? And thinking of moving there, no less?

My first placement in this town was my first work as a fully fledged physician. I was lodged in a room on the upper level of a house, with a shared bathroom. Meals were cooked for me, three per day. I was expected 'home' at lunch. There were 2 docs in the clinic. One lived two houses from the hospital to make life easy. Neither took many holidays. I worked one in two call, and all weekend.

As this was my first time on call, solely responsible for a whole town, I did not sleep so easily, which turned out to be a good thing. One of my first nights on, I was called about a patient's chest pain. It was just myself and one nurse, who was also taking care of the ward. Luckily, this was an NSTEMI. We treated and kept him at his home hospital. The next MI was a STEMI, and needed thrombolytics and a quick ride to the tertiary centre — ninety minutes away going red. That week, I also fixed a thumb that met a chainsaw. The patient refused to drive to the city. Using what remained, I put it back to what looked about right; 'right' being a bulbous bloody pulp. That was just one of a surprising number of big lacerations.

In a sense the days were rote, but always interesting and new. I would round early in the morning, and clinic would start not long after. The clinic was attached to the hospital, so I was readily available to head to the ward. A 90-minute lunch was given, usually requiring a stop in emerg for a few walk-ins who knew when to come. Afternoon clinic. Clean up labs and charts. Another emerg stop. Home for supper and a bike. Back to the hospital at 8 or 10, depending on the night and the nurse.

The hospital was also the de-facto walk in clinic, so the nurse would stack everything non urgent until an agreeable time. There were many characters and personalities who wandered through, checking out the new guy, keeping things fresh.

Throughout my experiences in rural practice, I have been endlessly entertained. Instead of society's vices, I am availed of its hilarities. One person told me how they had cured a wart: they had burnt the skin to bone with hydrochloric acid, and regrown the flesh with a layer of polysporin. Another brought in a sure broken arm — but not to worry, he had casted it to last the day at work... in duct tape.

I have also been amazed by the deep level of community and caring. I saw this firsthand on many occasions, like when a fellow with a bad headache walked into the hospital. The nurse took one look at him and stated that something was wrong; she knew him well, and had never seen him look that way, in so much pain. Indeed he was having a subarachnoid hemorrhage. In this same place, I then went to listen to a dying man play me the fiddle music of his Métis heritage. Nobody questioned that the man should be allowed to play his fiddle.

— continued on page 8

— continued from page 7

I went back to that first town many times. My first return was at Thanksgiving. I worked the full 2 weeks on call, no breaks. There were enough sleepy nights. The staff remembered me, and one of the nurses gave me a big old chicken to cook. A turkey would have been more modest; but my wife and I cooked that old beast, and while it was as tough as burnt leather, I was quite touched.

When I returned once again, this time about a year after my first visit, I ran into the fellow with the chainsaw wound. He happily wagged a damn near perfect thumb in front of my face — fully functional, pain free, and with minimal scarring. I did not believe it was him at first, or that he was showing me the correct thumb. Shortly after that, I received a thank you from the STEMI guy, and his extensive family. It was obvious how much the care meant to the people of this town, and they were forthcoming with gratitude. In fact, they found out when I was coming back, and made sure to stop by. During all my years training, I had only ever felt like a burden. To feel the opposite was almost too much to take.

In the grand scheme of the world, what does this town matter? What does any town matter? The rural landscape as it sits now was forged by generations of intrepid explorers and people looking for a new start. As the people came west, so too came dreams. A better life. Money, not destitution. A sense of great adventure. What the settlers found instead was often a dying ground. The breadbasket of Canada is a fragile place, totally at the behest of commonly unfavourable weather. Our western fore-bearers faced starvation, privation and separation. Remarkably, they persevered.

While urbanization has been a fact from the first day of settlement, there have remained a surprising number of rural towns. Urbanization makes sense. Economies of scale rapidly grow, and expertise can accumulate and create new jobs, new trade. The truth is, density of population wards against many natural hardships. Much more can be had for less, or no, travel.

With such a sensible allure of an urban setting and the crushing difficulties or rural life, it is a wonder that rural settings still exist. However, places like Krydor in Saskatchewan (population 17) and Bottrel in Alberta (population 5) still hold on. These people have a tenacity and will; a hardness. In a world of centralization and specialization, it is a rare thing to have people dedicated to going it alone. From keeping the septic system clear to repairing a roof; milking a cow or birthing a calf; mowing two acres or shovelling a landing strip, these people persist. And for it, they have soul and grit. These experiences enrich the individual, which subsequently enriches the society they live in.

I am a product of that settlement, and I have a unique upbringing because of it. As a child, I helped skin and tan animals. I got lost in the rugged wilderness. I cleaned cow manure off the floors and walls of a large animal veterinary clinic. I knew where my food came from, and could churn butter if needed. When I moved to the city, I met people who had never seen a farm animal, and did not know that wheat meant bread. The breadbasket was the local baker. Their parents sometimes called down farmers as freeloaders, taking another government handout when the weather went bad. They literally bit the hand that fed. And in the face of culture, information, and so many people, I was pulled along. For a while.

While the city had culture, to me, rural is culture.

The big city would put a prairie small town into a museum alongside Babylon, or the Abyssinians. A culture worth studying, a relic.

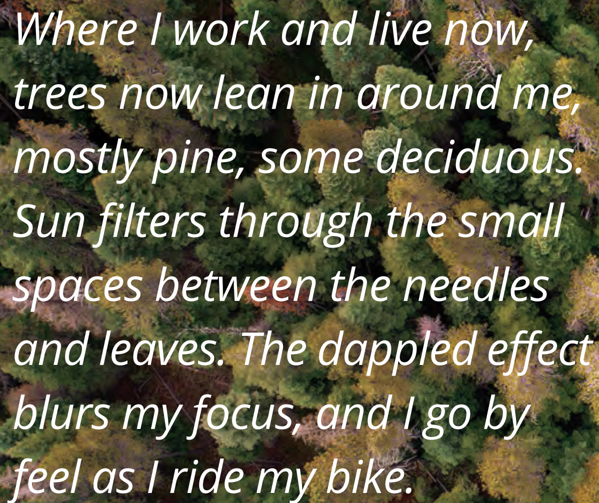
This is the culture that was, and is, part of Canada. The fishing village in Cape Breton, a farming hamlet in Eastern Alberta, and a logging town in a BC valley. These places are Canada. Back-breaking labour. Harsh climates. Loneliness. Strife. Daily burdens borne with a smile and a nod. These places are what formed the Canadians who stormed Vimy Ridge and Juno. The Canadians who skate circles around the NHL. Canadians like Frederick Banting. These places need doctors.

Where I work and live now, trees now lean in around me, mostly pine, some deciduous. Sun filters through the small spaces between the needles and leaves. The dappled effect blurs my focus, and I go by feel as I ride my bike. I see a movement ahead and to the right. I pull tight both brake levers and slide to a loud, gravelly stop. A large black bear rears her head. The sight of a man astride some two-wheeled machine sends her scrambling up a slope. I lose sight of her instantly, and somehow she makes no sound. No barbed wire fence to save me here. Perhaps those 2 cubs a ways back were hers. I quickly move on, a canister of bear spray now dangling from my finger.

I now find myself in a different rural setting. I am in the mountains. Here, too, lives the heart of Canada. Intrepid explorers continue to put in new lines on mountain climbs. Some skiers drop bigger cliffs, while others pack for a 320km ski traverse across our desolate ice fields, possibly a harder task now than 50 years ago. The rest of the world comes to experience even a sliver of our rugged and true wilderness. Most make a luxurious and easy stop, taking a bus to a look out. Others go big and tempt fate. Some lose.

Canada was born as a new frontier. It remains one. These people are still exploring.

There is a whole new host of problems. Musculoskeletal injuries abound. Avalanches eat our young and old without care. Economies shift, and towns die. Other towns are reborn in a



swell of tourism. Then locals and the low paid move into vans, or to the next town. They are priced out. Many are not able to pay for medications. They cannot take time off for surgery.

While I have technically stayed rural, I find myself in a whole new culture. In the big city one can blend in, shift, find a new group. There are many cultures, but they mingle. It is not a melting pot, but more of a coalescing. Like an impressionist painting, things flow out of one another, but the composite parts are identifiable. One could find oneself in any of many cities, and believe it was the same place. Not here.

Living rural, one has to adopt the culture. There is no hiding; people are here for a reason. The culture both stems from and shapes this. Each place is its own unique snapshot, as any citizen will tell you. Many might look the same. Having had the luck to be in many, I know each one is unique. Despite my naive teenage oath, I cannot seem to escape being rural, nor do I want to. These places are important. And the people matter.

There is a health economic concept called the 'health burden' of rural life. It is a subject of much consideration and study as to why many chronic diseases are more prevalent in rural life. Mortality at a young age is higher. Many ambulatory chronic diseases are more highly prevalent. To get definitive care requires a greater hurdle simply in distance from tertiary centres. To even get local care might require hours of driving. That is, if your car works. If you have a heart attack, but the STARS chopper cannot fly or reach you, will you survive? Can you even get off the combine during the very brief window of dry, sunny days to have that chest pain checked? A patient might want to lose weight and become healthy, but there is no gym, no walking track, and 8 months of cold snowy winter. Rent and Ramipril fight for the same dollars.

These places are our living history. These places, and these people, matter. These rural places will not simply cease to exist, or stop needing health care if the hospitals are closed. But they might die a very long and painful death.

And if that happens, we will lose a part of ourselves as Canadians. Rural healthcare is not easy. There is not a single, simple solution, or we would have it. But we cannot simply give up. The rural people of Canada need nurses, hospitals, and doctors.

They need care.

Matthew McIsaac, MD
Canmore, Alberta

Overcoming the 17-year rule

Dr. Alika Lafontaine

Dr. Alika Lafontaine

In 2001, the National Academy of Medicine published research that identified a lag of 17 years between the discovery of impactful changes in care, and changes in health practitioner behavior.

This may seem extreme, but consider the Canada Health Infoway. It's an arm's length, federally funded, not-for-profit organization tasked with accelerating the adoption of electronic health records and other digital technologies at a cost of $2.45 Billion so far, and has been advocating for provincial and national EMRs since 2001. And in 2019, Albertans have adopted Canada's first pan-provincial, inclusive, one-stop electronic health records system: Connect Care. Although not true in all clinical situations, the 17-year rule often does apply.

I kept this rule in mind in 2013, when I joined a research team tasked with responding to a health crisis declared by three Saskatchewan First Nations. Early team discussions were focused on finding novel insights to the health crisis, but we later realized that basic transformational frameworks weren't being consistently applied. These included quality improvement, safety/accreditation, and patient-centered care.

Over four years, we built an Indigenous health transformation movement that included more than 150 First Nations across three provinces, and continues to inform Indigenous communities implementing health transformation in their own respective territories.

Shifting mindsets within this complex, multi-stakeholder environment did not take the Indigenous Health Alliance 17 years. Having had time to reflect on the experience, I offer some general advice to physician colleagues on how to avoid being trapped by the 17-year rule.

The first piece is to recognize that system change has many different approaches to resolving challenges. We used three change management philosophies to unpacking our challenge over four-years: systems thinking, design thinking and alignment methodology. Each has its own pros and cons. *See Table 1.*

Systems thinking should be familiar to many physicians, and was popularized by LEAN, a change management philosophy championed by health systems across Canada over the past two decades. LEAN encourages actions that lead to greater consumer value, operationalized as a "speeding up" of production through focused, highly consistent outputs. LEAN eliminates context switching, scope creep, and other wastes associated with a lack of focus. If you have a highly effective output, systems thinking works well at making that output more efficient and consistent.

Design thinking is slowly being popularized in health, with Alberta Health Services having its own in-house design lab, Design4AHS. Design thinking uses a prescribed set of steps to unleash human innovation towards rethinking the output of health systems and how we get there. Through Empathizing, Defining, Ideation, Prototyping and Testing, participants can find new ways to creatively problem solve. If you know you have an ineffective output and it is broadly accepted that a change is needed, design thinking is a great way of unleashing multi-stakeholder creativity and collaboration. *See Figure 2.*

Alignment methodology has yet to be broadly utilized in health, but its core concepts will be familiar. Alignment methodology uses different methods to articulate the degree that multi-stakeholder environments move towards their disparate priorities in the context of a shared outcome.

For example, in broad terms, providers and administrators can have disparate priorities in hospitals; providers prioritize patient demand for services, while administrators prioritize controlling costs. Sustainability of the health system is one of many places these priorities intersect. If you have an effective idea focused on a human-centred outcome, alignment methodology is an effective way to navigate social behavior and power dynamics within complex, multi-stakeholder environments.

After choosing the approach that has the most utility, differentiating between moments and momentum will help you strategize your next steps. Moments are opportunities for stakeholders to self-reflect on actions, and the utility of those actions in achieving an outcome, and momentum is the process of scaling up and out with specific actions. In health, we commonly conflate these two concepts, falsely reasoning that both can be done together.

The more intractable your challenge, the more you'll need to create moments within your multi-stakeholder environment. System thinking, design thinking and alignment methodology approach and address self-reflection in different ways. System thinking articulates efficiency and workflow, design thinking articulates creative approaches and product usability, and alignment methodology articulates power dynamics and system behavior.

In my own experience, decision-makers tend to have an affinity to one of the three philosophies, and articulating one philosophy can act as an entry point to understanding the others. Balanced together, our experience with the Indigenous Health Alliance is that each philosophy remediates the inherent deficiencies of the others.

Momentum is much more straightforward. Once you've created moments to prepare stakeholders to be emotionally and mentally ready to move forward, you can follow with massive action and iterate along the way.

The greatest challenge to overcoming the 17-year rule is likely not the intervention, output or system change itself, but the development of trust through applying these philosophies, moments and momentum. Trust is the currency for taking risk; the more trust you have, the more likely others will follow you into places unknown and unfamiliar. Remember: individuals and systems get stuck in the status quo, because it's usually the lowest level of risk.

Table 1: A Summary of the Different Approaches

Approach	Primary Question
Systems Thinking	Thinking How can we eliminate redundancy, mistakes and inefficiency?
Design Thinking	Are we focused on a human-centered outcome and does our service focus on the persons using it?
Alignment Methodology	What are the stratified priorities of multiple, disparate stakeholders and do our actions take us to the same shared outcome?

Figure 2: Design Thinking 101 (source Nielsen Norman Group "What is Design Thinking, Really?")

The proudest achievements we had with the Indigenous Health Alliance involved creating trust between individuals and organizations. Trust enables multiple stakeholders to choose novel directions and implement changes they had never considered.

To create the next iteration of Canadian healthcare, we're going to have to take on risk together. The status quo is no longer an option — and we don't have another 17 years to apply the best of what we already know.

Alika Lafontaine, MD, FRCPC
Region 8 Representative Forum Delegate
Past-president, Indigenous Physicians Association of Canada
Grand Prairie, Alberta

TRUST the unappreciated commodity in medicine

Dr. Richard Bergstrom

Dr. Richard Bergstrom

A few months ago, I spent the better part of an afternoon watching Walking the Nile, a TV series following a real-life adventure undertaken by the English explorer Levison Wood. I had read his book on the journey, and the show was a visual reflection of a very good adventure.

Levison Woods comes from a long line of English adventurers like Robert Falcon Scott, Wilfred Thesiger, and Richard Francis Burton to name a few. He is young and a good story teller. For this adventure, he started in Rwanda and did his best to follow the Nile from its source to the point at which the river enters the Mediterranean Sea, the town of Rosetta.

He walked through jungle, desert, met crocodiles and hippos, and faced gruelling environmental challenges. He encountered the social unrest in South Sudan, and had to flee from the civil war there with gunfire and rocket fire surrounding him.

Perhaps even more compelling is the story of the people he met, the tribesmen whom he befriended as he gained insight into their world. More than anything, I felt that the documentary was about human relationships. Wood did walk the Nile, but he did not do it alone; he almost always had a guide and translator with him. The number of language barriers he ran into, the cultural traditions he did not understand, and the ability of his guides to explain who this apparent lunatic was helped him achieve his goal. In the end, he reflected on all the people who helped him achieve this amazing goal, and knew he could not have done it himself.

Now, you might wonder, why am I writing a television review for a physician's magazine? Though it may not seem like it, I feel this story ties in exactly with health care.

What if we considered a patient's life as their own version of "walking the Nile", from the moment they enter this world, to the moment they cease to be? They too need guides, translators and interpreters, and these people are known as healthcare workers. We are the guides who know the route and can help with the journey. We are the translators who can help the patient understand the diagnostics. We are the interpreters who make words like "pseudocholinesterase deficiency" understandable.

We all have a role in helping our patients, and they trust us to be their guide. I was speaking about trust with colleagues recently, and we were all saying that the patient-physician relationship is vital, and it of course involves trust. I would ask: "As a patient, who do you trust with your healthcare? Would it be your doctor, or your government?" I think we all know that the answer is the former, not the latter.

I know that in the healthcare setting, I often take trust for granted. I am the doctor, the anesthesiologist. People do not come for anesthesia; they come for surgery, and I facilitate the latter. I have been doing this for over 30 years — it's just my job, what I do. But sometimes, I need to step back and see this event through the eyes of the patient. I am involved with cardiac anesthesia, which for me is immensely rewarding, but it's not the right job for everyone (the same way I would make a terrible family physician... just ask my wife).

I tell myself, as well as the residents and fellows around me, that for most of our patients, this is the biggest operation in their life. When you are over 65, you see things differently than when you were 25. I had a lady in her mid thirties come in recently for a sinus venosus ASD repair. She was absolutely relaxed in the holding bay, and then completely lost it in the OR; she had a young family and a devoted husband, and cried out that she did not want to die.

So, what did I do? With a degree of dexterity whilst the nurse and anesthetic technician were talking to her and putting on monitors, I quickly popped in an intravenous and then popped in the propofol. When she was awake in ICU, she thanked me and apologized for "losing it." I told her that there was no need to apologize, and reassured her that all had gone swimmingly well. With her tears drying up, her voice cracking a bit less and after a sniffle and a swallow, she looked at me and said, "Thank you." What a reward: trust and a thank you.

We help patients on their journey. Sometimes we need to find someone who can navigate the rapids, and find the direction when we are not sure of the way. To translate the medical avalanche which can hit an individual with the diagnosis of cancer, or any kind of grave or difficult illness. We can and do help them "walk the Nile," which is their life and their adventure. Each of us is a concierge, and we must never forget that, nor take it for granted.

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

RGH MSA Wine Tasting

Featuring wines from the Rhône Valley, France

Wednesday, March 25
6:30 pm Metrovino

Space is limited!

RSVP to:
zmsaadmin@albertadoctors.org
by March 16th

PLC Medical Staff Association

PLC Physicians are invited to attend the

PLC Medical Staff Celebration of Excellence!

Thursday, May 21, 2020
The Big Rock Grill

6:00 pm Cocktails & Appetizers
Buffet Dinner, Presentation of Awards & Door Prizes

The Physician of Merit Awards, Clinical Teaching Award and Resident of Merit Awards will be presented.

Come and support your colleagues.
Tickets are $20 each – friends and partners are welcome. Please consider sponsoring a resident.

Please RSVP to
zmsaadmin@albertadoctors.org
to RSVP and secure your spot.

A time-out on Warfarin:
Is it really the cheaper option?

Dr. Gregory Sawisky

Dr. Gregory Sawisky

"You'll have to take this medication for the rest of your life and you will need to go for a blood test every one to two weeks."

Those might be the familiar words if you've had the dreaded warfarin conversation with a patient. It's a variation of one many of us have had: trying to impress upon people the severity of atrial fibrillation and the need for medication, including painful blood tests for the rest of their lives. Few diagnoses require as much time management as being on Warfarin.

"But surely there is another option," they might ask, "Isn't there something else I can take?"

Your internal monologue might go like this: Well, yes, but the government doesn't want to pay for it.

But is Warfarin truly the cheaper option? Or it is a classic case of being penny-wise and pound-foolish (a phrase from long ago, when a penny actually meant something).

So, here is a thought experiment:

The Alberta College of Family Physicians's annual "Price Comparison of Commonly Prescribed Pharmaceuticals in Alberta 2019" lists warfarin at $20 for a 5 mg, 90-day prescription. This means that a 1-year prescription costs a patient $80. This doesn't include dispensing fees.

Rivaroxaban is listed as $295 for the same 90-day prescription, totaling $1,180 for the same year's coverage (and obligatory disclaimer here, I have no vested interest in Rivaroxaban, it was simply the first DOAC I picked for this). So, it makes sense at first why Warfarin is covered and DOAC's are only covered under special authorization, right?

But what about the cost of those weekly INRs to monitor whether one is therapeutic or not? In December 2016, the provincial government released a laboratory bulletin titled "Laboratory tests and associated costs" listing an INR at $8, and INR and partial thrombin cost at $15. If this test is done bi-weekly for an entire year, the cost to the system is $390. If blood draws are done, as is more commonly the case, the cost rises to $780 per year.

Then there is the physician billing to factor in as well. Currently, the fee for a telephone call providing advice for INR management is coded as an 03.01N and costs the system $17.43. It can be done maximally every two weeks, or 26 per year, which brings the cost to $453.18. Accounting for the 3% business cost program brings that further to $466.78 to Alberta Health.

Now, before we do some simple math here, let us remember that there is a cost in terms of resource utilization that is not

captured by these numbers, including wait times, machine maintenance, supplies, and so on.

Then there is the time cost to both the physician and the patient, the dosage adjustments that physicians make, or calling their patients with advice: skip a dose then resume the same, double two doses then check in a week, ad nauseum.

So, what does a year of Warfarin, weekly INR draws and bi-weekly telephone advice cost? That total is $1,326.78, or $146.78 more than a year of Rivaroxaban that requires none of the monitoring, none of the lab tests and far less of the headaches. That total cost is adding together the cost to the patient (the Warfarin itself) plus the cost to the system (INRs, phone calls), whereas a year of a DOAC cost is entirely on the patient.

Now, some may argue that this situation sets out to find the maximal cost to the system, with weekly blood draws but only bi-weekly billable telephone consults and that the annual cost for Warfarin is not nearly that much. However, how many times does a patient have to visit their GP in person ($38.03 + 3%) to discuss their INR to raise that cost even higher?

Imagine if the provincial government negotiated a bulk purchase of one of the DOAC's, bringing that $1,180 cost down, even marginally. What could that do for resource utilization and cost to the system? Is warfarin truly the cheaper option? Is it truly the better option?

And what of the catastrophic GI bleeds that can occur with supratherapeutic INRs? What of the GI bleeds that require hospitalization, transfusion and stabilization? How do those costs factor into the decision to make Warfarin covered, and DOAC's only by special authorization?

The genesis for this observation began long before the current climate between the AMA, AH and the UCP took hold, so certainly we know that now is not the time to be trying to convince the government to spend a little more money upfront to save money long-term. But hopefully one day when there is more time to entertain such ideas, this could be considered.

If the government is keen on reducing healthcare costs, they might be wise to look at whether Warfarin truly is the cheaper and better option. In doing so they might avoid being penny-wise and pound foolish.

Gregory Sawisky, MD CCFP
Ponoka, Alberta

SAVE THE DATE: Monday, May 4th, 2020

In recognition of National Hospice and Palliative Care week, SASHA is offering two of Mr. David Maginley most requested presentations. Mr. Maginley is a counsellor focusing his work with oncology patients, a cancer-survivor, and a nationally recognized author and public speaker. When cure is no longer an option, he will take us through the journey of caring for our patients AND ourselves.

The St. Albert Sturgeon Hospice Association, SASHA, is a not-for-profit association established in 2013 with the goal of bringing a hospice in St. Albert. That goal was realized in 2016 and, since that time, SASHA's mission has been to "support, educate and empower those, living with or caring for, a person with life limiting illness".

May 4th 1200-1300Hrs: SASHA and Mr. Maginley have generously agreed to share his time and expertise while in Alberta by supporting a Grand Rounds presentation on Monday, May 4th from 12:00 to 13:00 at the Glenrose Hospital auditorium in Edmonton; in addition, AHS has granted Zone/Provincial webcast capability by registration.

Mr. Maginley will speak on **"Compassion Fatigue: The Cholesterol of Care,"** a timely topic given current rates of physicians, other health care professionals burn-out and suicide. More information about the topics and Mr. Maginley: **www.davidmaginley.com**

To receive weekly updates on Grand Rounds please make sure you subscribed to Geriatrics-News:
http://bit.ly/_geriatricgrandrounds

MAY 4th 7pm Arden Theater, St Albert:
Death is the most undesired event in life, yet one required for our transformation. Explore how practical and spiritual preparation helps one face mortality. End-of-life planning is reviewed along with steps that heal the heart. The final moments of life can be profoundly rich, this requires the deconstruction of ego identity — a process that erodes meaning, purpose, and the role we play in this world. Who and what we think we are is about to be radically altered. This, requires grief, lament, resistance and struggle. Yet, in the suffering and the silence, we can discover that hope incubates in the soul, and is born in the belonging we experience through love, rather than in the reaching for an imagined tomorrow that cannot be.

Tickets $30.oo at the Arden Theater (in person purchase) or Ticketmaster

SASHA Contact Board Member:
Lindsay.torok-both@sasha-cares.com | elisa.mori-torres@sasha-cares.com

Alberta Health Services (AHS) will be implementing the next wave of Connect Care in May 2020.

Community practitioners are a huge part of the healthcare team, and we want to make sure we have the right information on file about your clinic.

If your clinic is in an area impacted by this implementation, AHS will contact your clinic staff to collect this information. This process will help ensure diagnostic imaging and laboratory test results are routed correctly to your clinic once Connect Care is in place. *For more information, please review* **https://bit.ly/2Pw7cEQ**

Connect Care

Connect Care implementation – what does this mean for your clinic?

Alberta Health Services (AHS) will be implementing Connect Care in May 2020. Community practitioners are a huge part of the healthcare team, and we want to make sure we have the right information on file about your clinic.

In the coming weeks, AHS will contact your clinic staff to collect this information in order to ensure diagnostic imaging and laboratory test results are routed correctly to your clinic once Connect Care is in place in your area.

Connect Care is a province-wide initiative which will transform how patient information flows between patients and their healthcare providers. See links to learn more about Connect Care.

Your clinic will be impacted

The first Wave of Connect Care was launched at some sites in Edmonton Zone in November, 2019. Your clinic will be impacted in the next Wave, launching in May 2020 and will include:

- Calgary Zone rural and urgent care sites; and
- Edmonton Zone suburban sites.

We need your help. What can you do to prepare?

When AHS contacts your clinic, we would appreciate if your clinic staff could have the following list of information ready:

- Current providers working at your clinic, new providers that will join your clinic before June 30, 2020, and providers who have recently left your clinic to work elsewhere.
- CPSA registration numbers for each provider.
- Facility/clinic name used on requisitions, facility/clinic address (including suite number and postal code), and main and alternate fax and phone numbers.
- Electronic Medical Record (EMR) Vendor(s)' name.
- Other clinic locations your providers work at in addition to your clinic.
- Known Provider, Submitter, and Department IDs we previously mailed to your clinic.
- Method of current results delivery providers at your clinic use, i.e., electronically, or paper (fax/mail) or both?

Connect Care links, resources and support

- Connect Care implementation timeline: www.ahs-cis.ca/waves
- To learn more about Connect Care: https://www.albertahealthservices.ca/info/cis.aspx
- Connect Care impact in community practices https://www.ahs.ca/ccproviderbridge
- To ask questions, contact ccproviderbridge@ahs.ca
- To learn more about Connect Care IDs, including contact information and a FAQ: https://www.albertahealthservices.ca/assets/info/cis/if-cis-cc-connect-care-identifiers-faq.pdf

CONGRATULATIONS to the 2020 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. Elizabeth Rokosh
Dr. Joshua Wong
Dr. Kim Kelly
Dr. Gavin Oudit
Dr. Barry Finegan
Dr. Georg Schmolzer
Dr. Meena Kalluri
Dr. Bob Hudson
Dr. Brice Fisher

EZMSA Awards and General Meeting

Physicians of the Year
Drs. Susan Nahirniak & Curt Johnston

Researcher of the Year **Dr. Richard Camicioli**

Innovator of the Year **Dr. Richard Lewanczuk**

Champion Award for Young Leaders
Dr. Christopher Fung

Life Achievements-Meadl of Service
Dr. Bob Hudson

Thursday March 19, 2020

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 Co-workers
Dinner Reservation Cost: $50.00 each

To book a reservation call EZMSA office
780-735-2924 or laurie.wear@covenanthealth.ca
Visa, Mastercard, Cheques & Cash

Cocktail Attire – Academy Theme

Free Parking after 5:00 p.m. Lot C across Restaurant

This is an evening to celebrate outstanding physicians

Vital Signs on Twitter

Join the conversation.

https://twitter.com/vitalsigns_ab

Your Voice Needs to be Heard

Please take the opportunity to share your voice with us. Vital Signs exists to inform, inspire, and advocate for physicians in Alberta by sharing issues and ideas pertinent to the profession. We do this by publishing articles written by physicians that have something to say, and are looking for a place to translate and discuss their ideas. The Vital Signs team can help see your ideas to fruition, so that your story is told in the strongest way possible.

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:

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 healthcare differently.

Writing keeps you learning
The discipline required to create interesting content forces you to study and contemplate your subject matter.

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.

EDITORIAL GUIDELINES

CONTENT:
Content submitted to Vital Signs should be of interest to and advocate on matters pertinent physicians in Alberta, such as:

- Patient care: quality, safety, and interdisciplinary aspects
- Service planning and delivery
- Medical and workplace culture, and wellness — Specific issues within your field that other physicians should be aware of
- Medical Staff bylaws and rules

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. It's also important to remember that this is not an academic paper: this is a chance to use a more casual tone — Vital Signs is an ongoing conversation, physician to physician.

FORMATTING:
Articles submitted should be approximately 800-1,000 words in length (sometimes longer depending on the subject matter) and in MS Word format with sources cited and trademarks and copyrights honoured.

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.

*__Note:__ *With the addition of a Staff Editor/Writer to the Vital Signs team, there is now the option to have an article produced via interview or a writing framework, should you prefer that. Please get in touch with the Staff Editor/Writer (e-mail given below) for more details.*

Please send your article to Staff Editor/Writer Shauna McGinn, at mcginnshauna@gmail.com, and visit http://albertazmsa.com/vital-signs/ to view past issues.