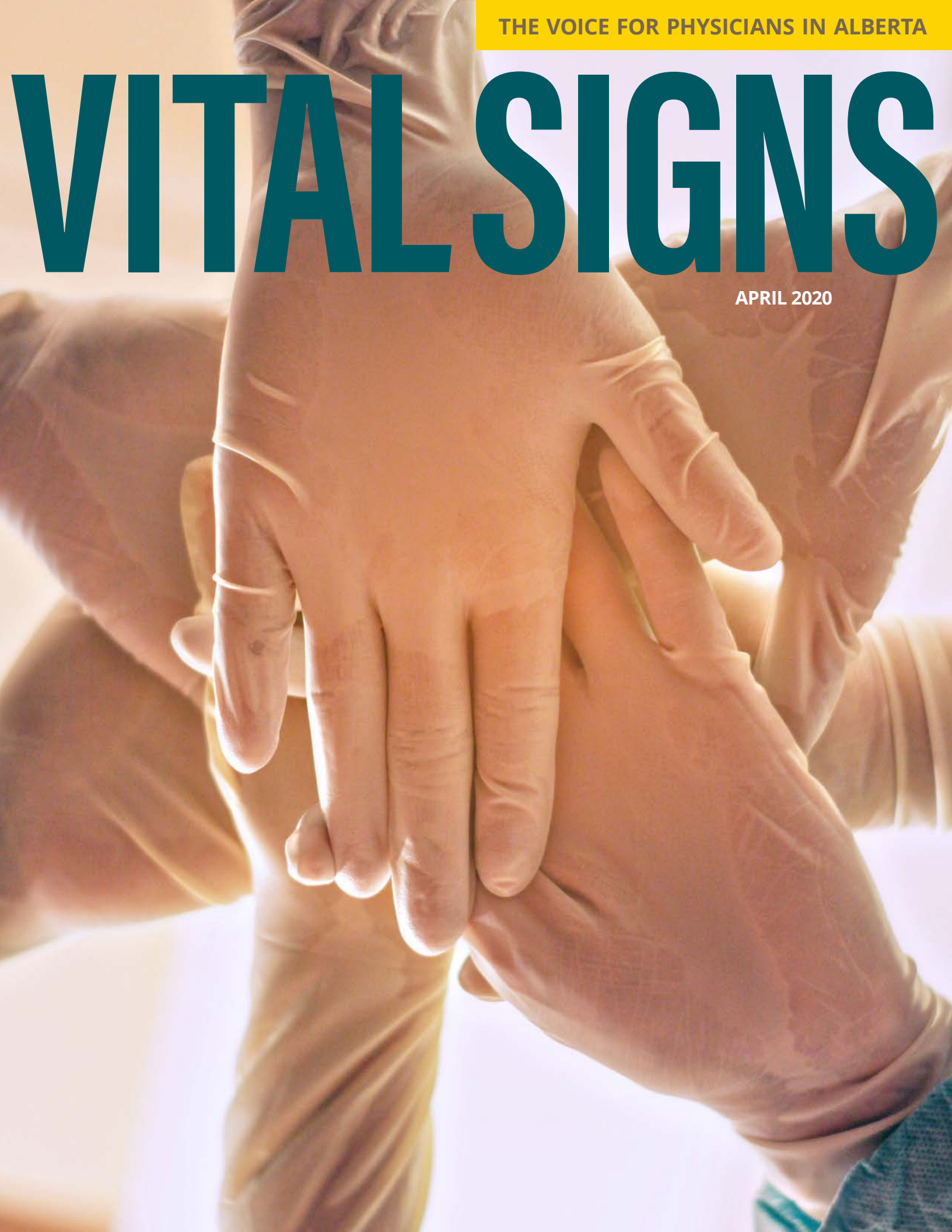
THE VOICE FOR PHYSICIANS IN ALBERTA

VITAL SIGNS

APRIL 2020



Kids on the *move*

Alberta Medical Association

YOUTH RUN CLUB

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!

amayouthrunclub.com

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VITAL SIGNS

APRIL 2020

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A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

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SUBMISSIONS:
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, April 17th.

CONTENTS:

SAVE THE DATES!

CAMSS
Council Meeting: April 8, 2020
Council Meeting: May 13, 2020
Zone Advisory Forum: June 10, 2020

CZMSA
Executive Meeting: April 16, 2020
Executive Meeting: May 21, 2020
Executive Meeting: June 18, 2020

EZMSA
CANCELLED – Council Meeting: April 16, 2020
Executive Meeting: May 14, 2020 | Teleconference, 5:30-7:30 pm
Zone Advisory Forum: May 21, 2020 | 4:00-7:00 pm

View from the Beach

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

Dr. Scott F. Beach

From here, it all looks pretty apocalyptic.

The financial crisis plaguing the province, the ongoing title match between Alberta Health and the AMA, and now the most recent of global pandemics to grip humanity in a generation.

Yes, it looks grim from here indeed.

However, under the harsh lens of history, quiet heroes have always emerged to stand as bright points of light beaming in this tapestry of darkness.

Our Chief Medical Officer of Health (CMOH) Dr. Deena Hinshaw: composed, compassionate, and eminently capable as she allays our fears and guides our journey. Her emissaries, the local MOH's, embody the very same as they work diligently, tired but tirelessly, on our behalf.

Our Executive Leadership Team composed of Drs. Francois Belanger, Laura McDougall, Ted Braun, and Mark Joffe, who, in synergy with the field marshals at the Emergency Command Centre in Edmonton, create nimble and granular processes to guide physicians during this dynamic crisis. *(Apologies to anyone I've forgotten to name here).*

Our Zone Emergency Operation Centres and local site commands are stationed by committed physician leaders who, with grim resolve and stoic form, have taken on yet another burden of leadership in exemplary form.

Our teams at the labs throughout the province, who, incredibly, have found the resources as well as a sixth gear to create a COVID-19 screening system that, per capita, is second to none in the world.

Finally, the physicians and allied health providers who are on the front lines, ready to stand with our fellow Albertans; many of whom, when encountering this virus, will face the fight of their lives.

To all of those above — and to many, many more I did not mention — I offer my deepest personal thanks.

However, as this pandemic goes on, my concern does not lie with attending to process, as our proficiency with the use of PPE will continue to evolve, and the sophistication of care delivery will naturally mature. My greatest concern lies in the need to address the grinding attrition on our person.

The mental, physical, and emotional fatigue that will inevitably arise within the pervasive opacity of uncertainty is a threat that we will all face. It is during such times that silver-gilded opportunities for solace and relief must be taken.

Be with our families, for in honouring these relationships, we can see the reflected value brought through the pursuit of our chosen callings. Reach out to friends — within the etiquette of proper social distancing, of course. Be in one's faith, as it can lead to peace. For me, a PRN bolus of emotional support ice-cream has also been a godsend.

In closing, I would like to remind everyone that we are in this together, and we are there for one another. I take comfort in this as I know in my heart we will get through the journey ahead, perhaps more united and stronger than ever before.

My thoughts are with you as we travel the road ahead. Be safe and be well.

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

Loss, grief, and hope in a pandemic

Dr. Gregory Sawisky

Dr. Gregory Sawisky

It was when we cancelled my sons' birthday party that the scope and weight of this pandemic set in.

He's almost four, old enough to know that birthdays mean friends, activities, cake and candy. And it was when I was tucking him into bed one night that my heart broke.

"My birthday is cancelled Daddy," he said. Not sad, not angry — just matter-of-fact in the way that children are.

His playschool is closed, his beloved day-home shuttered, and his gymnastics classes are no more for the time being.

But it was his quiet little voice of acceptance that pushed me over the edge.

Like many healthcare workers, I had been trying to compartmentalize this pandemic. I had pushed my fears and worries aside to focus on getting through each day, but it was being a parent that brought me back down to earth.

And it was grief that gripped me in the early days — grief for all that I perceived my son had lost: contact with friends, activities, his birthday party.

Now that we are into the thick of this pandemic, he has adjusted to a new normal at home. My wife has found new activities and opportunities to pursue and explore, and he is, dare I say, thriving?

Being this far in, I feel my grief begin to lift as I see his resilience outshine my own in a way. The questions about gymnastics grow farther apart, and new activities take over his attention.

Seeing him navigate this new reality has given me moments to pause and reflect on what my patients and their families are going through right now. I recognize my own fortune in that my wife was already working from home when schools were closed, meaning relatively little has changed in our day-to-day lifestyle.

But that is far from the case for so many of my patients, all of whom might be going through their own grief at the losses they have had to face down and will face in the weeks and months to come. Loss of income, loss of freedom, loss of a sense of security, loss of identity… the list seems heartbreakingly endless.

As physicians, we have had our own series of losses: the billing changes, the cuts, the loss of the master agreement, the breakdown of the relationship with the government. Although all of that seems to have been put on hold for now, the future remains uncertain. Any one of those issues would be enough to affect us deeply.

Then a pandemic is thrown into the mix, the likes of which no one alive today on this planet has ever seen before.

And, at the time of writing this, there is still so much we don't know. We don't know what billing changes are happening in hospitals at the beginning of April. We don't know how telephone and virtual appointments will play out or be paid in the end. We don't know how long this will last. It seems around every corner, at every hour, we are being met with another question that has no foreseeable answer.

We weren't ready for this pandemic. No one was. There wasn't enough of anything ready to go, and there won't be. Not enough PPE, swabs, information — every corner reveals another challenge we must meet without "enough."

That is why I chose to write about my son in the last days of Vital Signs. He gives me purpose, he fills me with love and he has helped me realize how fortunate I am to be able to continue to work and help people at this chapter in human history. He has helped me see that it is okay to mourn and grieve that which we have lost and all that we have yet to lose moving forward into this new reality. If this pandemic lasts for months then the losses will continue to build, each loss begetting more grief.

But perhaps, in all of that loss, pausing for a few moments to not only recognize what we still have, but what will remain, can keep us grounded enough to make it through this pandemic and out the other side.

We will have a birthday party for my son. It might just be the three of us at our kitchen table, but there will be cake and games and candy. And we are going to tell him that pretty soon he is going to be a big brother.

And that life carries on.

Gregory Sawisky, MD CCFP
Ponoka, Alberta

#COVID-19

In the midst of the COVID-19 pandemic, healthcare workers around the world are stepping up to the frontline every day to battle the virus and care for the rapidly growing number of patients in need. Here in Alberta, physicians have risen to the challenge within an already precarious time for healthcare in the province. These quotes provide a snapshot of how Alberta physicians are facing COVID-19.

These quotes were collected from Twitter. Some have been edited for length and/or clarity.

Gabriel Fabreau
@gabefabreau

Just spent 5 days under #quarantine b/c developed a fever after only working 1 day in #hospital last week. My #COVID19 test was negative, but I'm benched while #GIM colleagues picked up for me.

Feeling useless at home, but will def do same for next teammate who goes down.

Katie Wiltshire @MDforChange · 17h
Held clinic today entirely by phone. Saved one person a 4 hr drive. #neurology twitter might not agree, but there are definitely some (not all) patients that do not need to be seen in person by #neurologists - pandemic or not. #patientcenteredcare #learning #changecanbegood

5 7 88

Samina Ali
@drsaminaali

Pandemic Day 8: spent hours on the phone today surge planning for our ER. Who will be backup? Where will equipment come from? And then I sent my husband to his ER shift. And I prayed that he would be alright. I didn't perform CPR on him 2 years ago to lose him to COVID-19 now.

10:12 PM · Mar 18, 2020 · Twitter for iPhone

Dr Javeed Sukhera
@javeedsukhera

In the past 5 days I have had:

- anxiety
- insomnia
- panic
- grief

If you work in healthcare you are human too. Don't let this crisis hold you back from your humanity. Reach out. Stay connected. You are not alone.

5:09 PM · Mar 18, 2020 · Twitter for iPad

Shannon Ruzycki
@ShannonRuzycki

Thanks #yyc for staying home and staying away from your work, friends and family. Today is my last day social distancing because I'm heading to the hospital tomorrow to work.

12:08 PM · Mar 19, 2020 · Twitter for iPhone

1 Retweet 10 Likes

Shannon Ruzycki @ShannonRuzycki · 1h
Replying to @ShannonRuzycki
When you social distance, you could literally be saving my life.

1 2

Dr. Deena Hinshaw @CMOH_Alberta · 19h
The days and months ahead will be difficult for all of us.

We need to face this pandemic together and respond to this extraordinary crisis with extraordinary kindness.

I want to remind Albertans: it is together that we will overcome.
#COVID19AB

120 1.2K 4.8K

Jillian Ratti @JillianRatti · 15h
I have been in self-isolation for 48hrs and have had 3 care packages dropped off so far: donuts, flowers & kinder surprise & a bottle of booze. A stranger is picking up my groceries tomorrow night.

I'm in awe of the love and support.

Thank you, AB.

#AbLeg #abpoli #COVID19AB

3 28 501

Dr. Amy Tan @AmyTanMD · 51s
This is a time for WE. Please STAY HOME. We're all in this together, we need to work together to help each other & the healthcare system get through this. #COVID19 #stayhomesavelives #physicaldistance #SocialDistancingworks

Dr. Fiona Mattatall @FionaMattatall · 21h
Life inside my hospital today:

Visiting limited to very few situations so very few people in the common areas

Staff saying hi, smiling, and thanking each other in the hallways (while keeping appropriate distance)

The usual important work being done by all workers

2 2 61

Dr. DaisyCFung
@can_doc_mom

Dear patient.
Don't lie to me about travel/symptoms.
You are endangering me, your family, my nurses, and all sick patients my nurses and I see after you. Don't be a murderer. Yes I'm upset. And maddeningly not alone in being lied to. #SelfIsolation #COVID19AB

10:38 PM · Mar 18, 2020 from Edmonton, Alberta · Twitter for iPhone

UAlberta Med & Dent @UAlberta_FoMD · 15m
#UAlberta medical students are volunteering to provide emergency child care for doctors and other health workers on the front lines of the #Covid_19 pandemic. Thank you for stepping up to support the medical community, you make us proud 👏👏

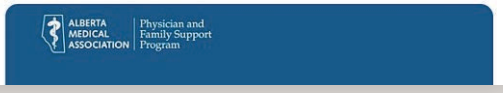
3

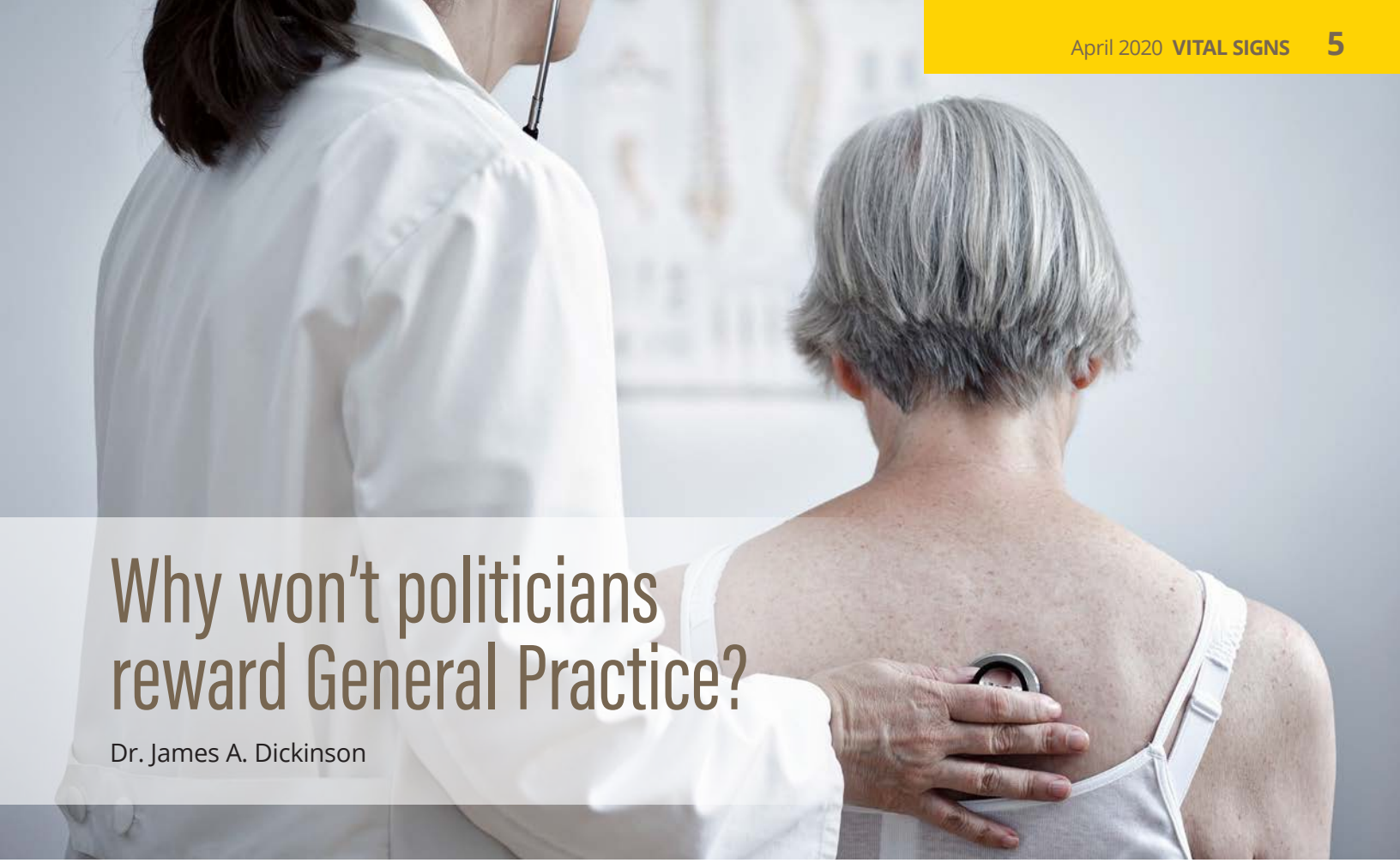
Jamil and 6 others liked

Kelsey Ragan @kelsey_ragan · 14h
I don't know who needs to hear this right now, but #yyc's emergency departments are staffed by some of the most dedicated, kind and competent health professionals I know This is what we do - we will be here if you need us! #albertacares #strongertogether @UCalgaryEM

2 20 164

Well Doc Alberta @WellDocAlberta · Mar 16
In these difficult times, remember you are not alone. Asking for support is a sign of strength.





Why won't politicians reward General Practice?

Dr. James A. Dickinson

Dr. James A. Dickinson

In light of current events, I'm sure we are all relieved that the provincial health minister has decided to back down on part of his ill-considered package of changes to Alberta Medicare. For now, it seems that he is firing in other directions.

Still, we have to ask why the government's first impulse was to cut fees to primary care, particularly rural practice. They could have spread the pain evenly, and yet the cuts were disproportionately targeted at family medicine, rural physicians, psychiatry, and primary care paediatrics. Unfortunately, these groups have been at the bottom of the physician income scale since the dawn of Canadian Medicare.

Despite the evidence that strong primary care produces the best health outcomes, statements of political support, even for rural practice, never quite lead to sufficient investment to enable solutions on the ground. Such information and arguments are reproduced in government documents, but seldom lead to commitments in the provincial budget. After all, health is a long-term outcome, and most governments are driven by the short-term election cycle.

I have observed the same patterns in Australia (where I worked for 3 years in the Department of Health), Hong Kong, the U.K. and Canada, though I have not been deeply involved in Alberta. But because it is all fairly consistent, we must ask: What are the systematic factors that lead to politicians and civil servants ignoring the needs of their populations, especially rural communities, in this way?

I believe many leaders are well-meaning, but misguided. I perceive that ministers, their staff, and many people in health departments do not fully see the value in primary care. After many years of involvement in health policy, I offer some hypotheses in the hopes of rethinking the discussion.

First, we must consider who really needs and makes good use of quality family medicine, a practice that provides primary, comprehensive and continuing care. I would argue that it is mainly mothers with children, the chronically ill (including, those with mental health and addiction issues), and the elderly.

Fit and healthy working adults, especially men, do not need family medicine as much, nor value it. Their most frequent health needs are for care of acute injuries

or illnesses, preferably with an immediate "fix," and often outside of usual working hours. These needs are provided largely by walk-in clinics and hospital emergency rooms. If they need further care, it will usually require a procedural specialist for an operation or intervention.

Who makes health care policy? At the top of the list are health ministers, who are generally men in the prime of life: in their forties or fifties (Sarah Hoffmann, the most recent Alberta NDP health minister, was an exception). The details of policy, however, are mostly developed by ministerial staff. They are usually young, in their twenties or thirties, and highly educated in political and economic topics, but have little knowledge about or personal experience of primary healthcare.

With this limited background, they are susceptible to lobbying from groups who peddle simple solutions to the intractable problems of health care. They live in urban centres, and if they came from rural areas, they left those roots behind. They work long hours, often nights and weekends, and as a result they are generally single, or partnered but without children. Once they start a family, they usually move on from this role, since it is unsustainable for a parent. If they develop chronic illness or mental health issues, they leave their posts.

Some policy advice also comes from the public service, but the policy branches of health departments are often staffed by similar people to the minister's office. They may be more likely to have healthcare service experience, but generally in hospital or public health settings, not primary care. Few are there long enough to work through a policy cycle, gain a deep understanding of the effects of policy change, or understand the history that led to past decisions.

Thus, there is a systematic bias: many of those who make healthcare policy have little comprehension of the value of general practice, geriatrics, mental health care, or something as vital as the role of paediatricians in reassuring anxious parents. They are schooled in simplistic transactional economics, believing that everyone responds primarily to financial incentives, with little concept of medical ethics and ideals.

They are awed by technology and mechanistic medicine, but do not understand the importance of communication and relationships (i.e. "slow medicine"). Once they have regular needs for quality primary care, and learn the value of continuity at an emotional level through personal experience, they tend to leave those policy roles.

In the modern post-truth world with strongly partisan approaches, some politicians and their advisors select ideas that will resonate with their supporters, regardless of any factual basis. Each communication piece is a carefully curated selective distortion. By repeating them regularly, they and their supporters come to believe them. As playwright George Bernard Shaw said: "The liar's punishment is not in the least that he is not believed, but that he cannot believe anyone else."

In this political world-view, they believe that everyone else also communicates in partisan sound-bites, so they have difficulty believing and accepting factual corrections from the profession.

On the ground, the situation is worse than that. Members of the Legislative Assembly get a steady stream of complaints from their constituents about healthcare issues, and those are passed on to the minister's office for response. Due to the way that healthcare is organised, complaints about access to or quality of hospital or specialty care are mostly directed to hospital administrators.

Family medicine has no such filter, so a high proportion of the complaints that reach the provincial minister's office are about family medicine. Some complaints are justified, some not, but the minister's staff tend to hear only one side of the story. This steady diet of stories about poor quality care in general practice dampens any enthusiasm to support it. They also hear many complaints about mental health services. That reinforces skepticism about the value of psychiatric treatment — still common in this society — and thereby continues the inadequate funding that is a large part of the cause of those complaints.

Ministers and their staff try to visit healthcare services to understand what they are governing. But they tend to visit major hospitals with expensive new technology: what Monty Python categorised as "machines that go bleep." They are usually escorted through in an entourage after plenty of pre-warning, giving time for the administration to prepare, so political staff see a (literally) sanitized version of how things work.

It would be better for them to see the usual grotty chaos that really exists in health services. They also need to learn about the real world of community general practice and Indigenous health services, more like the descriptions by Jonathan Tomlinson on his blog.

As an academic in family medicine, when advocating for the value of family medicine to ministers and their staff, I have found they often challenge the quality of care in practice. Questions about poor quality place advocates on the defensive, and undercut arguments about the high quality provided by most. In addition, few of those who most appreciate the value of family medicine are politically active or influential. No wonder there is no enthusiasm to "waste" money on improving primary care, paediatrics, geriatrics and mental health.

Around the world, family medicine is largely funded for short consultations: 8 to 15 minutes. It is intense work that gives minimal time for comprehensive care, nor communication. It is inherently difficult: often disease is early and ill-defined, without the obvious features that occur later in the disease state. Much illness resolves without intervention, so predicting who will benefit from investigation and treatment is an

Despite their simplistic economic view of the world, politicians and their advisors seem unwilling to observe the economic realities of supply and demand.

uncertain probability game. Problems are frequently "messy" mixing biological, psychological and social issues. The amazing thing is that so much is done well, so much of the time, but it is not surprising that sometimes we do not get the diagnosis right, fail to understand the patient's concerns, under or over-investigate, or over-prescribe.

The extended visit fees with complex modifiers developed in 2008 provided a way to promote longer, higher quality consultations, and thereby improve what we do. Since then a new generation of family physicians have adapted to provide this new pattern of care. They routinely take more time with patients, and see fewer in a day, while making use of the extra support staff and resources provided through Primary Care Networks (PCNs). When these fees were threatened, they had to contemplate learning a whole new pattern of practice: like we had to do in the "bad old days."

While the vast majority of family practitioners earnestly do the job well, are well-trained, conscientious and careful, sadly some are not. Some chose it because the short training program is the fastest way to open the cheque-writing machine for doctors that Medicare provides. Some choose a style of practice to maximise income, rather than doing good work and taking the payment that it generates. These few make advocacy about the quality of family medicine more difficult.

In rural areas, family physicians are the vast majority of physicians. In these settings, they are compelled to cover a wide range of work with minimal support. They are often pushed to the limits of their expertise and endurance. Not surprisingly things go wrong at times, and while the majority of rural people are forgiving of doctors who did their best, some complain to their political representatives.

Rural doctors and the primary care system receive much verbal support from political leaders but little action, despite a strong case for extra support for initial training and continuing education. Inadequate support occurs even when governments depend on rural ridings and members to maintain power. Once the election alarm is past, it is easier to make a few cosmetic changes or shuffle the organisational and educational deck-chairs than to address the deep-seated problems, and the high cost of doing so.

Since most rural doctors also work in hospitals, buck-passing between hospital and health services on who pays for which components of training or care masks evasion of investment. Healthcare services are repeatedly told how they can be more "efficient" by closing rural hospitals, neglecting that such closures load costs onto members of those communities who must thereafter travel for care.

They also change the economics of rural physicians, who often leave once the hospital is gone, since caring for sick and injured patients in rural towns without hospital services becomes extraordinarily difficult, and being on call without a hospital stipend is a major economic loss.

The political efforts of some of the professions within the medical field are effective. Various specialist groups have enough spare income to afford lobbying that aims to extract more "rent" from government, whereas few general practitioners working on the financial margin are willing to provide such extra funds to their organisations. The medical associations represent all parts of the profession, and are thus conflicted about making transparent the wide disparities between procedural specialists, those with hospital-based incomes, and GPs and cognitive specialists, who usually fall at the bottom end of the income spectrum.

We must recognise the financial impact of changing visit fees. Because of the large numbers of visits, a dollar taken from the basic visit fee produces more quick savings than $5 taken from each of many procedure fees. In the past family physicians have not been overly outspoken about this, so the government thought we would be compliant this time too. But the converse also applies. Adding to basic consultation fees, to even partially fill the income gap between primary care and specialists, would cost more than any minister feels able to spend. Since a partial increase would be criticised for inadequacy, politicians see no political gain from increasing these fees — only budgetary pain.

Around 2008 in Alberta, there was a shortage of family physicians, and people were vocal about not being able to find one. This persisted long enough that the provincial government developed new policies, and changed others. The federal government contributed funds to develop the PCNs. The extended visit time modifiers and the business cost program for doctors working in high cost areas were instituted. The Rural Remote and Northern program was developed. Current politicians and their teams likely have little to no corporate memory of that time. No wonder they were surprised at the outrage that greeted their "dialling back."

Despite their simplistic economic view of the world, politicians and their advisors seem unwilling to observe the economic realities of supply and demand. There are multiple applicants for most specialist positions in the city, so that graduating residents take extra fellowships in their attempt to "get the job, not do the job."

The competition is even greater for resident positions in those specialties. Posts for general specialists in regional centres

are much harder to fill. Family medicine positions in urban and suburban hospitals, working as hospitalists, low-risk obstetrics, or emergency medicine have plenty of applicants. Meanwhile, rural practices often have difficulty attracting any qualified applicants, and family medicine residency programs do not fill. As a result, the public gets what the government has chosen to pay for.

"Effective income" comprises not just direct payments, but the conditions of work and daily living. Usually in city specialist practice, clinic space, staff and management is provided. There are supporting residents and other team members, along with facilities and equipment provided not only by the government but also generous donors: pharmaceutical companies and private benefactors. True, they must take their turn being on call, and deserve appropriate payment for that. There is also the factor of "social income" that comes with living in a city and all of its cultural and sporting facilities. While city housing is expensive, it generally inflates in value, providing capital gains over time.

In community practice, physicians must establish, equip, staff, manage and operate their clinic entirely from their fee income. They work in relative isolation. While the PCN movement has provided a degree of ancillary staff support, and other developments provide support for clinic operation, it falls far short of the levels provided in city hospitals. Even specialists in regional centres have much less support than in the teaching hospitals.

In rural practice, the range of skills demanded is wide. Learning and keeping them up to date is difficult, time-consuming and expensive. Some rural towns have good collegial practice teams, but they require substantial (usually unpaid) effort to maintain them. Other rural towns have difficulty maintaining good teams, and one reason is the minimal resources available to develop and maintain them.

The income for rural doctors appears high, but since the earning rate is only a little higher than in the city, high incomes actually come from working long hours. While housing costs are low, choices are few, and when it comes time to leave, there is seldom much capital gain, and often a loss instead. There is some advantage in the rural lifestyle, but social, religious and cultural facilities, and even food options are limited. So the "social income" of living in a rural town or even a regional centre is less than in the metropolis. Thus, the effective income of rural doctors is lower than first appears, compared to the city. No wonder it is difficult to attract applicants.

The Alberta Medical Association fees committee is focused on the value of individual items, and stalled over whether practice cost data is accurate. They are focusing on the leaves, and are deliberately not looking at the trees, let alone the forest — so they fail to see that the peripheries are wilting, while the city thickets are filled with unhealthily crowded trees.

The test of the right "total income" is basic "Goldilocks economics." When there are no applicants for a position, clearly income is too low. When there are three or more applicants for a position, it is probably too high. When there is a choice of two well qualified applicants, that means it's about right. If we apply that test to incomes across the range of city specialists, regional specialists, family physicians and rural doctors, it is clear that substantial adjustments are needed.

Good healthcare policy entails not just adjusting fees, but considering how to provide appropriate incentives for the right kind of care and improve the total working environment for family physicians in the city and country. This requires better training, with more investment in the patient medical home, technology, support for quality care through community care teams, and for rural hospitals at a level closer to that for city dwellers. Doing so could enable more immediate care on the spot, reduce need for referrals, and thereby reduce the queues that produce so much angst for patients and politicians.

In summary, policy is made by people who simply do not perceive the relevance of family medicine, pediatric, geriatric and mental health care, sometimes have unfavourable personal experience, and regularly hear negative reports about it. Given the funding deficit for so long, the cost of really fixing problems in family medicine, psychiatry, or even just the rural components of practice, is so great that politicians will not do so in the current crisis. Given the constraints on funding now, we cannot expect increases, but the pain of reductions needs to be shared across the whole profession, especially by specialists who routinely earn three to four times as much.

So the question of the day is: how do we change perceptions, and reallocate funds to channel resources toward primary care? This includes building on successes in PCNs, supporting better electronic connectivity, better education and feedback systems, and support for associated healthcare staff.

To achieve this, policy-makers need to be better informed and emotionally aware about what we do in the front lines, and how to improve. We must develop robust measures of quality family medicine care, building on current measures within PCNs, to ensure cost is not the single metric used to inform policy. Family medicine needs a greater input to remuneration negotiations and there must be greater transparency about the numerical impact on incomes of changes in payments, whether by fees, Alternate Relationship Plans, or other means.

It is time for family medicine to not only be valued, but rewarded for that value.

James A. Dickinson, MD, CCFP, FRACGP
Professor of Family Medicine & Community Health Sciences, University of Calgary
Calgary, Alberta

Career interrupted

Dr. Sharron Spicer

It was a day that started out the same as any other for our family, but by bedtime, our world had changed. Cancer had entered our home as an unwelcome house guest.

Dr. Sharron Spicer

In early September — the first week back to school — our morning routine was not yet smoothly choreographed. As we were all heading out the door with lunches and backpacks in hand, my husband gave himself a self-congratulatory pat on the belly. "Can you feel this?" he asked me. Anticipating a hernia or some other minor malady of middle age, I had him stretch out on the couch. His flanks spilled over their previous margins. *Why hadn't I noticed this girth before?* I ran my hand over his abdomen. In the right upper quadrant, just below his ribcage, a grapefruit-sized mass rose up to meet my fingers.

This was no hernia. We both instinctively knew that this was bad. It was a quiet drive to the family doctor's office that morning. By afternoon, we were sitting with a radiologist in a small room, listening to his opinion. Everything on the differential diagnosis was a malignancy.

It would be another four weeks before we had a definitive diagnosis. Bloodwork, multiple scans, and a biopsy confirmed an aggressive lymphoma. The recommended treatment was chemotherapy with a stem cell transplant in first remission. With this approach, his prognosis for recovery is good. As I write this, he is nearing the end of his chemo and preparing for his "Day 0" of transplant. He will be, as the doctor puts it, part of the new cohort for "rewriting the textbooks" on this cancer.

Having myself worked in pediatric palliative care for over a decade, the world of oncology is not totally foreign to me. I have been witness to the suffering caused by cancer as well as other life-limiting conditions in childhood. Like the families of my patients, we had not signed up for this journey, yet here we were on an unexpected detour — an unmarked exit ramp from the highway, not shown on the map.

How has the experience of cancer affected me as a physician? It has been a deeply profound and personal journey. I humbly share with you some of my experience, hoping that it might encourage you in some way.

I made the decision early in the course to take a leave of absence from my work as a physician. My husband had been the *de facto* at-home parent for the past few years, and I knew I was needed by my family. Granted, this transition was made easier because my clinical load was small with some recent changes to my practice. I am grateful to my department head and colleagues who graciously pulled together to cover for me during my absence.

For the initial weeks after finding the tumor, my husband and I were both deeply introspective. Having cleared our work schedules, we lingered over morning coffee with conversations about life's meaning, suffering, regrets and hopes. As the fall mornings grew crisp, our dog happily accompanied me on many long walks. My emotions were labile, as was my outlook about the future.

Reflection is so important, time alone, reckoning. You can't be your best self when you're submerged in useless busy-ness.

I kept oscillating between the positive and negative; for every good bit of perspective, there was a balancing negative and vice versa — "It's cancer… but he's otherwise healthy," "It's already spread… but he's young." I was overwhelmed at the thought of losing my spouse. I felt like I was in a Credit Karma commercial, waiting for the dial to land on a number that would somehow define our cancer score. I still don't have that Credit Karma score, but with time and reflection, I have become more comfortable with uncertainty, not needing to grasp at the outcome, but allowing it to unfold as I sit with palms open to what comes.

The singer, songwriter and author Jann Arden wrote these words following the death of her father and while caring for her mother with advancing Alzheimer's:

> Losing people is what happens to humans. Like the constant drip of an old tap. To try to avoid that loss only leads you to avoid true happiness. When you don't argue with grief like a drunk husband, much good can come from its stillness. Reflection is so important, time alone, reckoning. You can't be your best self when you're submerged in useless busy-ness. Most people choose not to stop long enough to think about how they feel… Change is taking hold of me and morphing me into a much better version of myself, and that morphing comes with some discomfort. And yes, sometimes it feels like I'm being crushed by that boulder.[1]

As time went by, we became more pragmatic. There were appointments to keep and medications to organize. We moved from the questions of "why" to "how." Our philosophic questions were replaced by a more simple understanding: Shit happens, let's deal with it. We resolved to keep cancer as our "day job," trying not to have its influence spill over into family time. We kept up with friends and hobbies. When he was feeling well, my husband hiked and played badminton. To his credit, even when he was breathless with a flight of stairs, he continued to do the family's laundry. And I took seriously the instructions to thoroughly clean the house before his transplant. It is amazing how cathartic cleaning can be!

At times, I have wondered how I might manage if I lose my partner — not just emotionally, but with practical household things. My husband, sensing this, became a patient teacher as he narrated for me the subtleties of changing car tires and fixing furnace fans. Friends and family have walked alongside. We have had our freezer filled with food, words of encouragement sent in cards and e-mails, and offers fulfilled of dog-walking and errands to be done. We have appreciated all the thoughts and prayers made on our behalf, and I know that somehow, everything will be okay.

At the centre of our thoughts, always, is our teenage daughter. More than anything, our goal is to have her continue to be a teenager without shouldering adult burdens. No doubt cancer will cast its shadow upon her, but we do everything we can to create memories of happy times.

Adolescence is a developmental stage that is profoundly egocentric — necessarily so to enable the launch toward independence — and her initial questions reflected her worries of how her world might change. Frightfully honest, she would ask lots of things that began with 'If Dad dies… Will we move? Will we be poor? Can we get a puppy? Will you remarry?' (No, no, yes, let's just stick with a puppy.) Over time, she has become more indifferent as she integrates this new reality into her life.

I have learned much about supporting myself and my family from Facebook COO and author Sheryl Sandberg. Known by many for her 2013 bestseller *Lean In: Women Work and the Will to Lead*, she went on to write *Option B: Facing Adversity, Building Resilience, and Finding Joy* following her husband's sudden death in 2015. Along with some funny words of advice for responding to another person's bad news ("When life gives you lemons, I won't tell you a story about my cousin's friend who died of lemons"), she describes how she fostered resilience for herself and her young children. As she says: "Option A is not available. So let's just kick the shit out of Option B. Life is never perfect. We all live some form of Option B."[2]

Whether you are living a Plan B, C or D, or walking alongside someone who is, I hope that you, too, find support along the way. Taking time away from work has been a part of my coping and resilience. It has allowed me to be fully present for my family and for my own reflection and growth. I do not know what my future holds but I know I will be a healthy, stronger and more compassionate medical doctor when I return to work.

Dr. Sharron Spicer is a former President of the Calgary and Area Medical Staff Association. Previously the Medical Editor of Vital Signs, she remains on its editorial board. Her husband and daughter give their permission to be referenced in this article, although Sharron did receive a scolding from her daughter for her use of profanity. She is currently on a personal leave of absence.

Sharron Spicer, MD
Department of Pediatrics, Calgary, Alberta

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Adverse Childhood Experiences

What physicians need to know

Shauna McGinn

Advancements in modern medicine might evoke thoughts of cutting edge technology, or fancy machinery aimed at treating the most complex conditions. That's not the case for lapsed pediatrician and practicing psychiatrist Dr. Chris Wilkes — for him, the first major study linking Adverse Childhood Experiences and health outcomes signalled what he calls his profession's "Renaissance period."

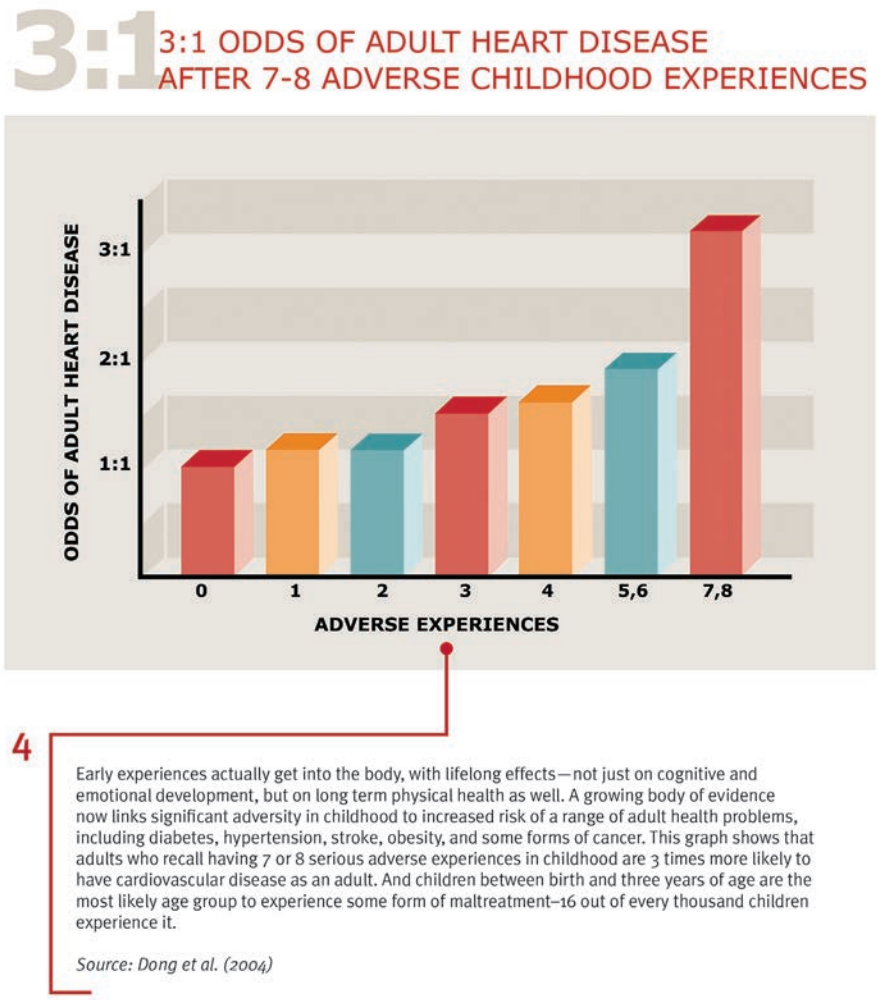
Proving the link

The landmark 2002 study was conducted by researchers in San Diego, who examined the health and social condition of adults with Adverse Childhood Experiences, or ACEs. These experiences encompass traumatic or stressful situations, such as growing up in poverty, in a household with physical abuse, or living with family members struggling with addiction or mental illness. The study found that the link between ACEs and an individual's overall health as an adult was powerful — and that the higher the ACEs "score," the greater the chance for multiple negative health outcomes.

One of the main causes of this link has to do with the coping mechanisms (and resulting health issues) related to these stressful childhood events, such as smoking, substance use issues, or unsafe sexual encounters. The other is what researchers refer to as "toxic stress": a state that weakens the body's immune system and is thought to alter gene expression towards things like cancer or heart disease.

Dr. Wilkes says that difficult subjects like family trauma and addiction are often overlooked in medicine, or are not considered seriously enough when treating a patient. "We tend to decontextualize the patient and look at where we are in the present and the signs and symptoms," he says, "But this (ACEs) is paying attention to the history, and often it has to do with parts of life that we don't like to acknowledge."

With the awareness that now exists about the correlation between physical and mental health, it seems obvious: poor childhood experiences lead to a higher chance of poor health as an adult.



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Early experiences actually get into the body, with lifelong effects—not just on cognitive and emotional development, but on long term physical health as well. A growing body of evidence now links significant adversity in childhood to increased risk of a range of adult health problems, including diabetes, hypertension, stroke, obesity, and some forms of cancer. This graph shows that adults who recall having 7 or 8 serious adverse experiences in childhood are 3 times more likely to have cardiovascular disease as an adult. And children between birth and three years of age are the most likely age group to experience some form of maltreatment–16 out of every thousand children experience it.

Source: Dong et al. (2004)

The case for early intervention & support

With the awareness that now exists about the correlation between physical and mental health, it seems obvious: poor childhood experiences lead to a higher chance of poor health as an adult. However, Dr. Wilkes says that it took this link being proven for there to be a major push towards early intervention for children and families at risk.

That's been a positive development, because the evidence for early intervention is strong. The Harvard Center on the Developing Child estimates that every dollar invested in early childhood programs leads to $4-9 in returns to the public, due to savings in the criminal justice system, social assistance, or reduced need for special education. The Center also points to the statistic that the odds of developing heart disease after having 7-8 ACEs are 3:1 — which means major savings to the healthcare system if there is an effort to reduce ACEs. (*See Figures 1 & 2)*

"The epidemiology of trauma corresponds with outcomes," Dr. Wilkes says, "So it really highlights that we need to provide support early on for families."

Early intervention ranges from social work support at home or at school, to helping children develop what Dr. Wilkes calls "mental health literacy" and positive coping strategies. "The most common ones now are the use of exercise and meditation," he says, "And looking at things like social-emotional learning particularly with teens, like safe dating or building a good network of friends, and providing appropriate counselling in regards to substances."

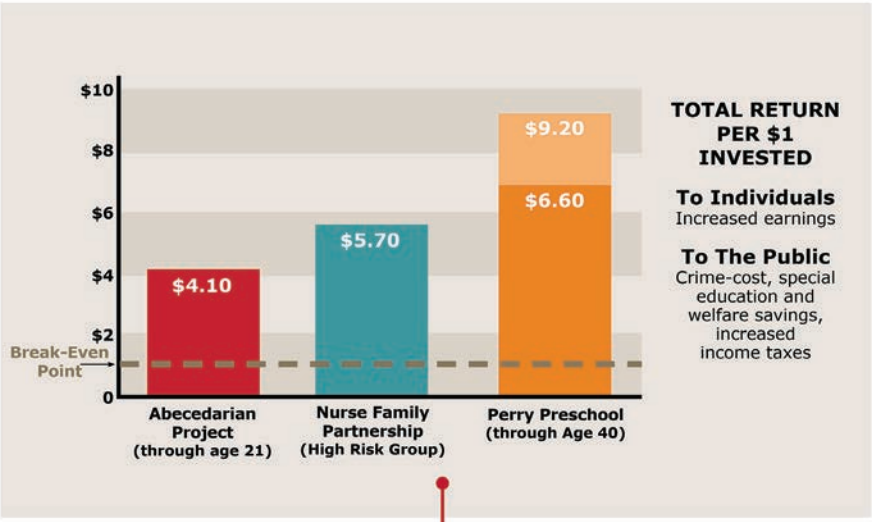
What can physicians do?

Preventing and addressing ACEs requires comprehensive care from an array of different health professionals. So what can the average physician do, and why is it important to understand the impact of ACEs?

"In the educational system I've been a part of, we've been teaching residents that you shouldn't think, 'What's wrong with them (the patient)?' but rather, 'What's happened to them that's brought them to this place?'" Dr. Wilkes says.

That approach could help a treating physician understand why a patient might be struggling to adhere to a care plan, or the factors that could make it difficult to build and maintain a healthy relationship. Overall, it's about acknowledging the patient from a holistic perspective, and building a trusting rapport that way.

4-9 $4 - $9 IN RETURNS FOR EVERY DOLLAR INVESTED IN EARLY CHILDHOOD PROGRAMS



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Providing young children with a healthy environment in which to learn and grow is not only good for their development—economists have also shown that high-quality early childhood programs bring impressive returns on investment to the public. Three of the most rigorous long-term studies found a range of returns between $4 and $9 for every dollar invested in early learning programs for low-income children. Program participants followed into adulthood benefited from increased earnings while the public saw returns in the form of reduced special education, welfare, and crime costs, and increased tax revenues from program participants later in life.

Sources: Masse, L. and Barnett, W.S., A Benefit Cost Analysis of the Abecedarian Early Childhood Intervention (2002); Karoly et al., Early Childhood Interventions: Proven Results, Future Promise (2005); Heckman et al., The Effect of the Perry Preschool Program on the Cognitive and Non-Cognitive Skills of its Participants (2009)

Beyond this, the goal is to create a "circle of care", where physicians can help connect the patient to the larger community and the resources they might need. To get there, the most important thing is to take on a non-judgmental attitude and create space for a supportive conversation.

"One of the things that the seminal study showed was that just by asking about those ACE scores — whether a patient was ever abused, or whether they went through a lot of childhood stress — they found that over that next year, there was a 30% decrease in doctor's office visits, and a 10% decrease of emergency room visits," Dr. Wilkes says. "So having someone who can see you as a whole person has an impact on your coping strategies, and also your ability to regulate and make better decisions."

For many overworked physicians, this may seem like a lot to take on — but just as the evidence for early intervention is strong, so is the case for holistic care.

"With adult internal medicine, for example, there's a lot of pressure to see a lot of patients, and it tends to be more of an algorithm of: you have a symptom and a sign, that's what you get treated for, and then you're out of the door," Dr. Wilkes says. "And that's not quite as effective as what we see from the data of having a holistic approach."

Beyond this, the goal is to create a "circle of care", where physicians can help connect the patient to the larger community and the resources they might need. To get there, the most important thing is to take on a non-judgmental attitude and create space for a supportive conversation. "The first step is to try and provide a safe space for them to share their story, and get some simple interventions and advice," Dr. Wilkes says.

Adverse Childhood Experiences are serious, traumatic events that affect not only a patient's health, but their quality of life and participation in their community. By having awareness, as well as the courage to ask and provide a supportive environment, physicians can make a major impact on helping the patient develop positive coping strategies.

Overall, Dr. Wilkes says the two most important takeaways are: "Try not to judge, and develop the relationship."

Dr. Chris Wilkes (MD, FRCP) is a Professor and Division Head of Child and Adolescent Psychiatry at the University of Calgary. He also serves as: Outpatient Section Chief, (Child and Adolescent Mental Health & Addictions), Consulting Psychiatrist (Young Adult Outpatient Services) with both Alberta Health Services & the University of Calgary.

Shauna McGinn
Staff Editor & Writer, Vital Signs

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Life of a Resident Mom

Dr. Sidra Javed

Dr. Sidra Javed

With the end of my fellowship on the horizon, I've finally found myself at the point where I'm able to reflect on what it took to get here — and looking back is not *always* horrifying!

I started my internal medicine residency with three young kids ages 5, 2.5, and 1.5 years old, and I consider that an additional accomplishment to claim. Recognizing that I was a mom, especially of not one, not two, but three kids, several of my senior colleagues tried to convince me not to pursue internal medicine. I dismissed all pieces of advice, deciding to pursue my own path and live life my way. Here is a glimpse of that life.

When I leave the hospital on a typical work day, my co-residents are planning on reading around the cases that night, while I'm thinking about what to pack for my kids' lunch for tomorrow. When my colleagues intend to watch a movie to relax, I am contemplating whether I should watch a few YouTube videos before doing math with my son.

The moment I enter my home, one of my sons announces my schedule for the next 4 hours (this many hours with your family is a dream as a PGY-1).

That schedule starts with a short reflection of my kids' day, followed by a list of homework assignments, and often a school project. This routine is then interrupted by supper time, and then getting them back on track takes another hour.

Eventually, it comes time to put them to sleep with a bedtime story — luckily, the kids don't like a robot mom here; dad works better. After getting their uniforms and lunch ready for the next day, yes, technically it's my time to "read around the cases." A mere plan like that, within seconds, rocks me off to sleepy town.

Spending a weekend at home is like squeezing your weekdays into 48 hours. Sometimes, I do get the "luxury" of spending the weekend at work. The next day, my colleagues often take no time to recognize how sensible I look compared to what I would be after a "free weekend." (One of my preceptors on a weekend call one said, "Oh, you have three kids! Well, enjoy your weekend, then!")

Studying at home does happen, and when it happens, I do not consider it less than a miracle. One day, I was reading my pocket medicine book and disciplining my kids at the same time (believe me, not a good idea). My youngest one pointed towards my book and said angrily, "Stop annoying me, mom! You better read your storybook!"

I remember making a dinosaur out of empty cans and cardboard a day before my Royal College examination, which I still passed.

My kids grew up alongside my training, and here I am now. Fortunately, I had the support of my lovely husband and my family. Still, there have been painful moments and sacrifices.

I feel terrible when I have to leave my kids early in the morning to get ready for school on their own, even when they have help from dad and grandma.

I feel heartbroken when once in a blue moon, I go to their school to pick them up, and their friends glare at me as though I am a new discovery. That always reminds me of my first-year of residency, when my husband went to every single parent-teacher meeting alone, and one of the teachers asked him if he was a single parent.

Parenthood combined with residency has been an encumbered trail. But believe me: If I can do it, anyone can. I often refer to this T.S Eliot quote: "If you aren't in over your head, how do you know how tall you are?"

It gives me pain when my kids ask me, "Why don't you volunteer in our school like other parents?"

In short, there have been several occasions (and there will probably be more) when I feel down and worthless. But of course, there is always a flip side.

I feel loved when my kids see me exhausted after a heavy clinical block, and they come and give me a warm hug.

I feel proud when after spending time helping them with their homework they say, "Mom, you are the best!"

I feel accomplished when their teachers say on parent-teacher meeting day, "Don't feel bad, they admire you when your hard work reflects in their grades."

I feel skillful when I take my patients' socks off and put them back on in no time (thanks to my kids for this training!)

Parenthood combined with residency has been an encumbered trail. But believe me: If I can do it, anyone can. I often refer to this T.S Eliot quote: "If you aren't in over your head, how do you know how tall you are?"

It might not turn out the way you planned, but that's life. We as healthcare providers work in a fast-paced, stressful environment. This can often be emotionally draining and taxing. Burnout is real. A Canadian Medical Association study reports that almost 30% of working physicians experience one or more symptoms of burnout.[1] There are unlimited factors contributing to burnout, including long years of training, stressful clinical situations, excessive workloads, and an inability to attain any sort of work life balance.

As many physician parents know, you will feel overwhelmed at times, so it's important to work on building resilience to endure difficulties. There are a lot of tips out there as to how to juggle family and parenthood,[2] but one size doesn't fit all. The experience will be different if one gets pregnant during residency, than if one is at the stage of chasing toddlers around.

A few of you may be dealing with some other stressful situations in their life. Remember, physical exhaustion and mental fatigue are detrimental not only to us, but also to the healthcare quality and safety that we are responsible for. I do not have any particular tips, but I would encourage you to seek an outlet to address these situations. Whether that is meditation, mindfulness, exercise, or sharing your thoughts with your partner or friends, which is my tool — whatever works for you, go for it!

Dr. Javed and her family.

I wrestled with trying to be the perfect mom, wife, resident, clinician, and more, but I soon realized that it's okay not to be an all-round perfect *everything*. I am grateful to my husband, my family and my friends who kept me composed, determined and confident on this journey.

I am proud to be a parent and a trainee at the same time, and I have no regrets.

Sidra Javed, MD, FRCPC
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Calgary, Alberta

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2. Parks T. Family matters: How to juggle residency training, parenthood. Resident and Student Health. 2016, American Medical Association. https//-ama-assn.org

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

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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.