May 2017

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VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

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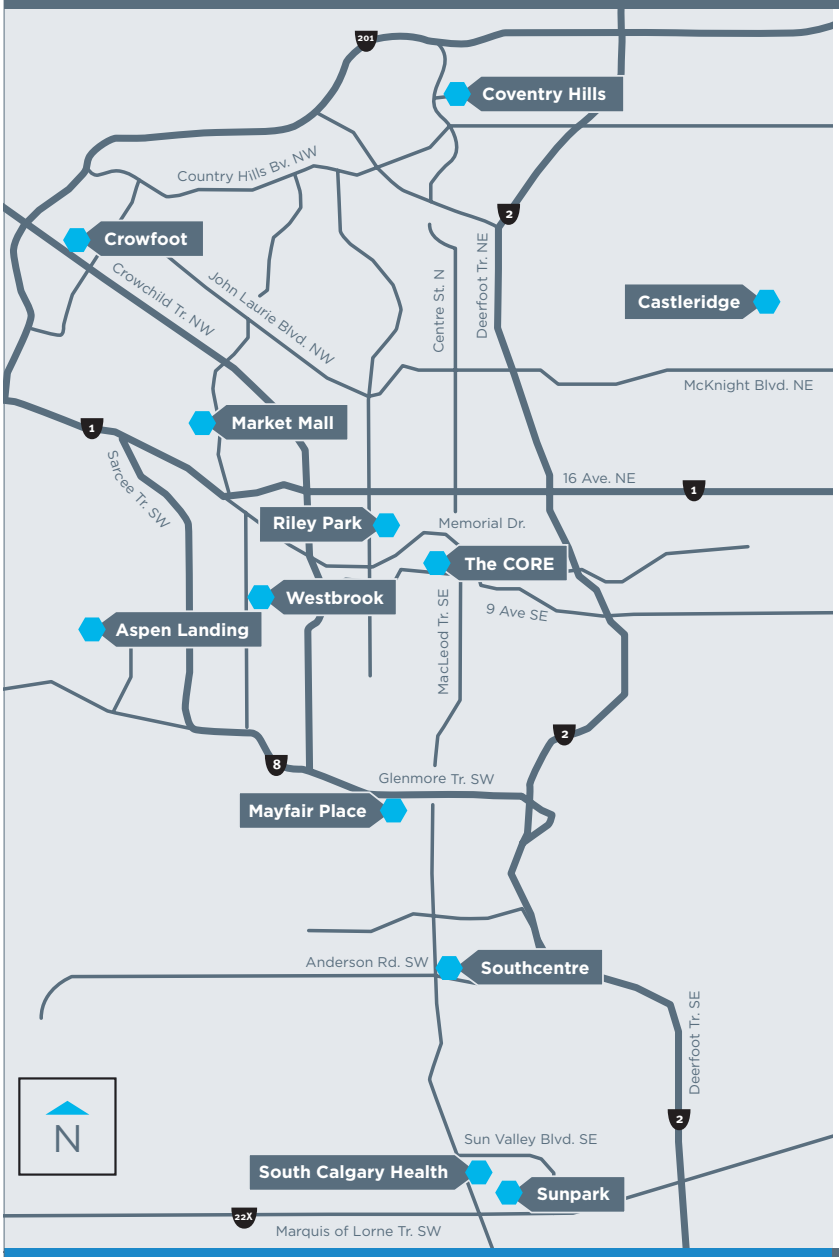

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401, 400 Crowfoot Cres. NW

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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

May 2017

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
FOR PHYSICIANS,
CARING FOR PATIENTS

Calgary & Area Medical Staff Society (CAMSS)
#350, 611 Meredith Road NE, Calgary, AB T2E 2W5

COORDINATOR: Adrienne Wanhill 403-205-2093

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Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in Alberta. Please limit articles to 1000 words or less.

Please send any contributions to: Spindrift Design Studio Inc. Hellmut Regehr, hregehr@studiospindrift.com

Vital Signs reserves the right to edit article submissions and letters to the editor.

The deadline for article submissions for the next issue of Vital Signs is May 17, 2017.

CONTRIBUTORS:
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Contents:

Save the Dates!

CAMSS

Council Meeting
May 10, 2017 | FMC Boardroom Rm 152 *(next to Physician's Lounge)* – 5:30-8:30 pm

Council Meeting
June 14, 2017 | FMC Boardroom 152 – 5:30-8:30 pm

CZMSA

ZAF
May 11, 2017 | Location TBD, 7:00-9:00 pm

Executive Meeting
June 8, 2017 | WebEx

EZMSA

Executive Meeting
May 18, 2017 | Misericordia, 5:00-5:30 pm

Council Meeting
May 18, 2017 | Misericordia IN-106, 5:30-7:00 pm

Executive Meeting
June 15, 2017 | Misericordia, 5:00-5:30 pm

Council Meeting
June 15, 2017 | Misericordia IN-106, 5:30-7:30 pm

SZMSA

ZAF
May 1, 2017 | Location TBD, 6:30 pm

Council Meeting
September 11, 2017 | Teleconference, 5:30 pm

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President's Message:

Whose Autonomy is it Anyway?

Dr. Sharron L. Spicer, CAMSS President

In my family, we love words – puns, plays on words, even borrowing expressions from other languages when they seem, um… apropos. So it was only natural that we all howled (pun intended) at the headline "Calgary man fights off coyote in living room with vacuum." *(http://www.cbc.ca/news/canada/calgary/calgary-man-fights-off-coyote-in-living-room-with-vacuum-1.2749744)* I mean, where would a coyote get a vacuum? Or was it the living room that had the vacuum? I'm not sure. (If you enjoy this sort of grammatical logic, pick up Eats, Shoots & Leaves by Lynne Truss (Gotham Books 2003) for an even more engaging praise of punctuation.) My point is that language matters.

I have had a recent curiosity about the meanings of the word "autonomy." Autonomy can convey a general connotation of political freedom, such as that enjoyed by citizens in a democracy. Sometimes we use "autonomy" to describe the rights of patients in making decisions for their own health care; that is referred to as "patient autonomy." Other times, the word is attached to the word "physician," as in "physician autonomy." The concept of physician autonomy is so implicitly embedded in our medical culture that we may not fully appreciate the limits of or threats to our autonomy. I would like to dig deeper into the meaning of physician autonomy, especially in context of this Vital Signs issue's theme of physician resource planning.

Let's first explore the political portrayal of autonomy, at least from my arm-chair observer perspective of politics and history. Democracy is currently widely held as the ideal structure for protecting and promoting individuals' rights and freedoms. The Warsaw Declaration of 2000 (*http://www.community-democracies.org/values/warsaw-declaration/*) describes the mechanisms by which human rights are protected internationally; principles of choice in selecting government, freedom from coercion, privacy of the individual, and accountability of government are all key factors. Clearly, the Declaration — and the principles of democracy more generally — describe the collective features of a democratic nation, within which the individuals can behave in limits tolerated by the society. In other words, democracy has accountabilities at the collective and individual levels. Autonomy, by extension, also has collective and individual components.

Similarly, with physician autonomy, there are components of collective and individual rights and responsibilities. A thoughtful 2016 policy statement on Professional Autonomy from Doctors of BC states that "[a]utonomy at the collective level speaks to a profession's ability to police its boundaries; regulate the initiation of new members; and advocate for populations and systems level improvement, while autonomy at the individual level involves individual discretion and control over the terms and content of the daily work." *(https://www.doctorsofbc.ca/sites/default/files/professional_autonomy_policy_statement_final.pdf).*

Doctors of BC further explains that professional autonomy allows for physicians to have self-regulating professional bodies, to advocate on behalf of patients and society, and to exercise professional judgment in the care of their patients. Each of these is explained in turn, with the recognition that limits exist in the exercising of autonomy. For example, they say, "physicians should have the ability to make decisions about the care of the patient that are in the best interest of the patient without unduly restrictive external or system constraints… however, physicians acknowledge their responsibility to their health care system by recognizing that the application of clinical autonomy is carried out in alignment with the principle of resource stewardship." Further, "another dimension of professional autonomy in medicine is the ability to make choices related to the conditions of one's work. Decisions related to remuneration models and practice environments should be made in collaboration with the medical profession."

Autonomy is not a trump card that supersedes other values in decision-making.

I see many parallels in the political and medical understandings of autonomy. For example, self-regulation relies on selection of and accountability of medical leaders, just as a nation does with its governments. Likewise, self-regulation protects the members of the profession (or the nation) from undue coercion from other parties. Accountability is also key, whether it be a government facing re-election after its term or a professional association reporting its fiscal or outcomes data.

Autonomy is a cornerstone principle in our professionalism but it is not, in itself, a "right." Just as democracy is a complex social construct that values collective and individual rights and freedoms, professional autonomy comprises a complex interlay of collective and individual accountabilities. Autonomy is not a trump card that supersedes other values in decision-making. Rather, it is a summation of our professional responsibilities through which we manage the dynamic tensions between our profession and our society, and within our profession itself.

Back to my grammar lesson, we may sometimes need to distinguish between "physicians' autonomy" and "physician's autonomy." Nowhere is the tension between collective and individual autonomy currently more apparent than in discussions of physician resource planning in the

province. On one hand, Alberta physicians acknowledge and embrace the need to be involved in the planning and distribution of physician resources. Our AMA Amending Agreement was a commitment to this principle. Yet, we acknowledge that individual practitioners may suffer individually from plans that are made for the collective good (of society mainly, though perhaps of our profession to some lesser degree). Case in point is the reaction elicited when there is consideration of restriction of entry to new graduates or physicians entering the province. The dilemma is that we as a profession need to contribute to this planning, yet we also are protective of the individuals in our midst who are most vulnerable, especially trainees and emerging residents and fellows. For them, facing un- or under-employment, or disrupting the lives of them and their families through relocation, seems a heavy burden for the collective good.

I don't have the answers, but I am paying more attention these days to physician autonomy. Does physician autonomy refer to the collective or the individual? In our current fiscal and social context, I am moving more to the idea of our shared responsibility, but let us not forget those in our midst who still need us to watch out for them. Oh, and watch out for the coyote in the living room with a vacuum.

Letter

The cost of poor communications

As physicians we know the results of inadequate communication first hand. The results can be disastrous or, more commonly, it can lead to wasted time, damaged trust in the relationship, and the loss of opportunity to make a positive difference in our patient's life. It is probably the loss of opportunity to make a difference that is most unfortunate. In the business environment, the cost of poor communication has been linked to significant financial losses. It is thus surprising that the AMA communication strategy does not always seem to be as effective as one would expect of a large medical organization.

The environment of rapid change (PCC, SOMB, potential billing numbers restrictions, approaches to income equity, etc.) where AMA is taking on increasing role in managing the health care system, has already created a charged environment. Robust communication is crucial to navigate this uncharted territory.

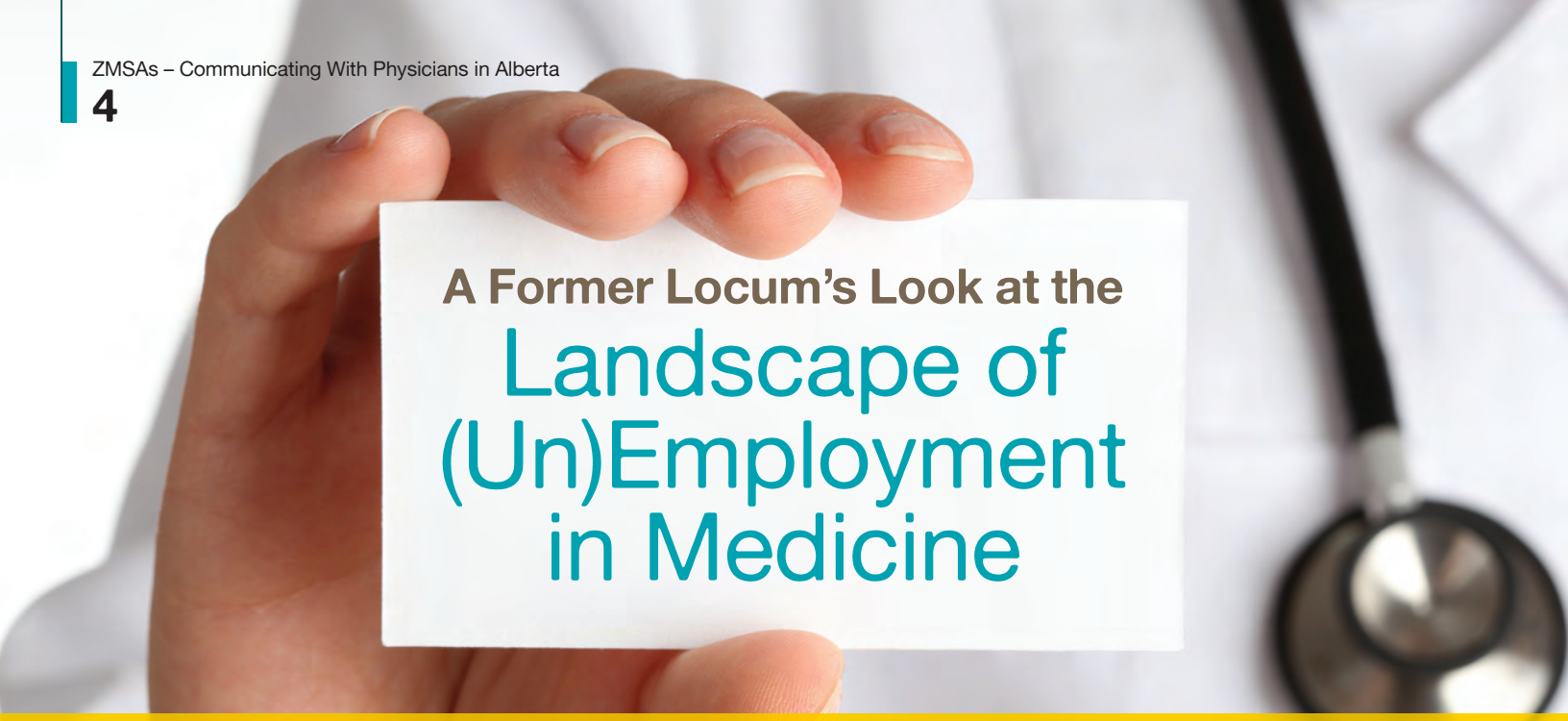
Delayed release of information (that can be sometimes perceived as forced) has already happened over the past year, leading to calls for greater transparency. Yet again, before the last Representative Forum meeting, the communication fell short of ideal. Only ten days before the "pivotal" RF meeting, the president's letter stated that "given the importance of these policy questions, the Board of Directors agreed that members should also have a chance to review this material before the RF." Such approach suggests that members are really an after-thought for the organization, and only adds fuel to the fire. The immediate result was hundreds of e-mails sent to the myRFdelegate@albertadoctors.org address over a span of a few days, and I presume many more were sent to president@albertadoctors.org. In fact, an e-mail may be the best way to communicate one's views to the organization, as I have not heard of any recent surveys or calls for general input on AMA's direction since the vote on the Amending Agreement that garnered 29% voter turnout.

Despite extending the Spring RF, where some of the most difficult discussions were left to the end, there was not sufficient time to address all the concerns. This eventually lead to announcing the "Special RF," which will cost time and money: the direct cost of involving the over 130 delegates and staff is likely at least $250K, and the collective indirect cost of spending time away from our patients and our families is probably even higher. This energy could be better conserved for more important battles ahead that will inevitably come when we fully engage in upcoming negotiations — after all, our contract expires in 2018.

At the level of an individual member, clear communication would help to plan for the future — potential restrictions in billing numbers may affect career plans of the trainees and the uncertainty is likely already affecting their career choices right now. For those physicians running their own practices, the lack of certainty is likely to stall commitment, development and innovation. In turn, those decisions will affect the delivery of patient care. Although many members see a bright future, for others it may be hard to see through the opacity of the messages that get to us.

What is really worrisome, though, is poor communication causing a potential division within the membership on the eve of negotiations — something that may cost us and our patients much more than the special RF meeting. Hopefully we can pull together soon. Hopefully the majority of the membership can realize the importance of unity at this critical time for our profession. We need not look too far in other provinces to see that the alternatives are not favourable

Mike Kalisiak, MD, FRCPC
Calgary Zone RF Delegate



A Former Locum's Look at the

Landscape of (Un)Employment in Medicine

I was accepted into an increased medical school class-size "anticipating the retirement of a generation of physicians" by the time we were ready to enter practice. We were told "You can hang your shingle anywhere when you graduate." Fast forward eight years to my final year of residency. Ready to enter practice, a job posting came up in my hometown (the only posting in my hometown this particular year), and with a spouse wanting to return home, who had willingly moved to support my training, I applied.

Dr. Meriah Fahey

Dr. Meriah Fahey

I was unsuccessful with that position and went about looking for locum work. Fortunately, connections through my mentors in residency helped me find a placement and I was able to return to my hometown after graduation. For the next five years there was no shortage of locum work. I was able to work and worked hard; in fact, at one point, I was advised by administration to work less for fear of needing to find locum coverage for the locum. There were two more job postings over those five years, with me and a crackerjack cohort of local graduates vying for the positions.

Always with the nagging concern that locum work was not a guarantee of work, I continued to hunt for a permanent position locally and was finally successful thanks to the opening of a new hospital and an abundance of positions to fill. This position was a 1.0 FTE, which was defined as the amount of call that needed to be covered divided by the number of people hired (provincial funding and OR time were factors when determining the number of people hired). With the exception of a new hospital facilitating my current employment, I'd venture to say my story is not unique.

Exploring the Canadian Physician Employment situation further, I have come across some interesting reports, each of them worth a read *(see references)*. The first is a 2013 Royal College physician employment report from a respectable cross-section of our profession *(Table 1)*.

With the unemployment rate of Canadians close to 7% in 2012,[2] it is notable that 16% of new specialists and subspecialists reported 'no job placement' *(Figure 1)* the year of their graduation. This doesn't account for locum positions; these are folks entering practice without work or the prospect of work.

	Province of Post Grad Training	AB	BC	MB	NL	NS	ON	QC	SK
Specialists 2011/2012 Cohort	Responses	140	129	53	25	47	393	260	20
	Population	392	286	145	63	132	1196	851	56
	Response Rate	35.7%	45.1%	36.6%	39.7%	35.6%	32.9%	30.6%	35.7%
Subspecialists 2011/2012 Cohort	Responses	38	32	11	3	11	94	55	1
	Population	120	90	27	**	29	365	192	5
	Response Rate	31.7%	35.6%	40.7%	–	37.9%	25.8%	28.6%	20%
ALL 2011/2012 Cohort	Responses	178	161	64	28	58	487	315	21
	Population	512	376	172	**	161	1561	1043	61
	Response Rate	34.7%	42.8%	37.2%	–	36.0%	31.2%	30.2%	34.4%

* Province of educational institution that certificants reported where their residency training was completed
** Population data missing for subspecialties

Table 1 – Royal College Employment Survey, 2011 and 2012; Response rates by province of postgraduate training* [1]

Not surprisingly, there is heterogeneity among those with employment from full-time, to part-time, to locum work *(Figure 2)*.

Over a span of five years, the Royal College was able to report plans for employment, training, and unemployment for graduates *(Figure 3)*. It is interesting to see the rates of employment and the apparent interaction in employment/unemployment over the years of the survey. It strikes me that there seems to be an increase in unemployment that would parallel the egress of graduates from increased class-sizes that began a decade before. Is this a blip or a trend? I'm keeping my eye out for the next iteration of the Royal College Survey to see what became of the rates of graduates with 'no job placement — not pursuing further training'.

We can also see that every year an important proportion of graduates choose to go on to further training, whether it be for professional aspirations or to make themselves more employable; does further training make a difference to job placement? From the results of this survey *(Figure 4)*, I don't see much of a difference in the appearance of the pie with further training.

All of this is interesting to me and I have theories as to factors that would lead to these results. These results themselves cannot address all of the factors contributing the lack of employment, but there are likely common threads. Maybe those who aren't working full-time are doing so by choice? I would venture to say there may be some, but certainly not all. Is the picture of employment today a symptom of systemic disease? Or should there always be a surplus of employable physicians? The answer probably depends on who's answering the question. Becoming a physician is a heck of a long way to go to be unemployed, and alternate job prospects are not obvious if you find yourself in that position.

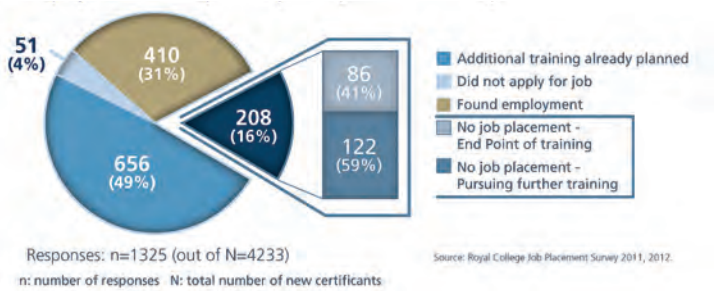


Figure 1 – Royal College Employment Survey, 2011 and 2012; Employment status reported by new specialists and subspecialists, Canada [1]

Figure 2 – Royal College Employment Survey, 2011 and 2012; new specialists with a job, by type of placement, by province of residency training (1)

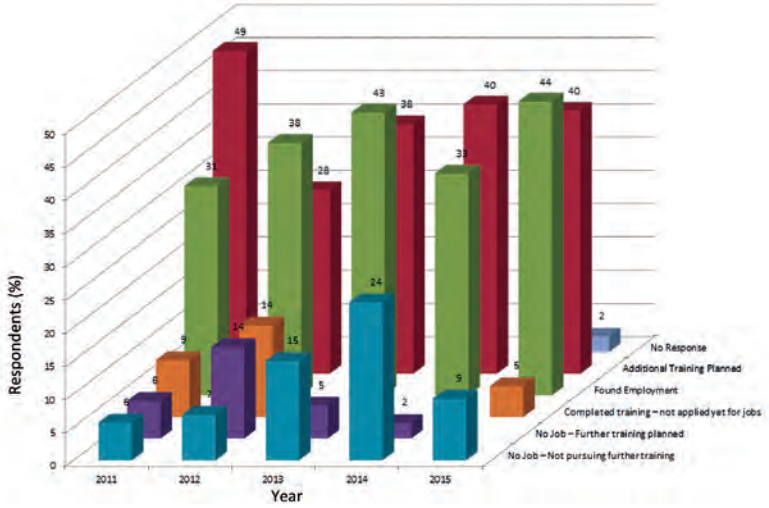


Figure 3 – Royal College Employment Survey, 2011-2015; [3]

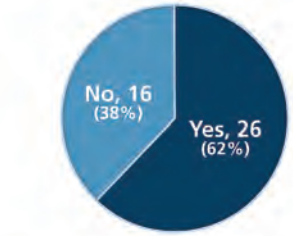


Figure 5 – Royal College Employment Survey, 2011 and 2012; "Is your locum placement satisfactory to you at this time?", percent response of specialists and subspecialists, Canada [1]

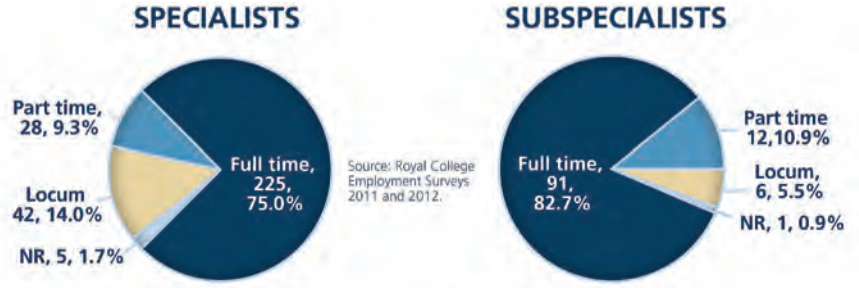


Figure 4 – Royal College Employment Survey, 2011 and 2012; new specialists/subspecialists with a job, by type of placement, Canada [1]

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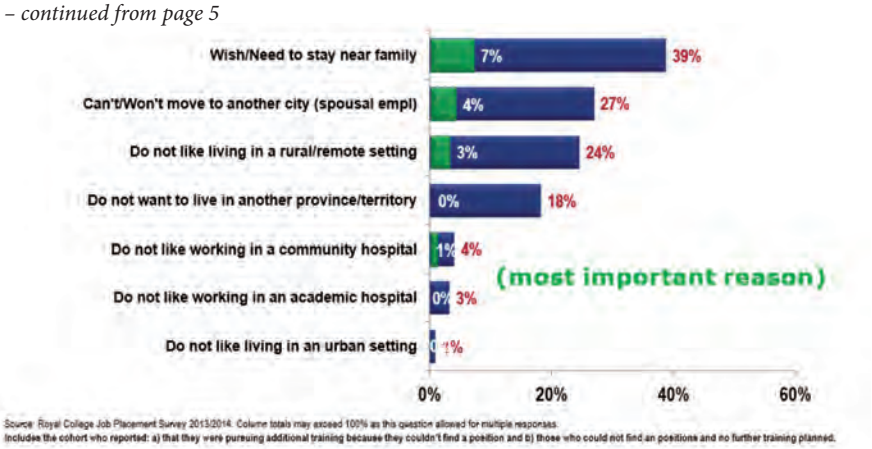

Figure 6 – Royal College Employment Survey, 2013/2014; "Why do you feel you do not have a job placement?"[3]

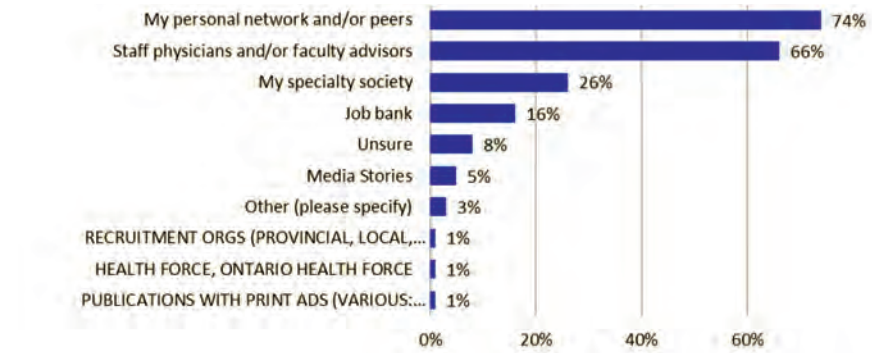

Figure 7 – 2015 National Resident Survey, Resident Doctors of Canada; "From what sources do you receive job prospects information?"[4]

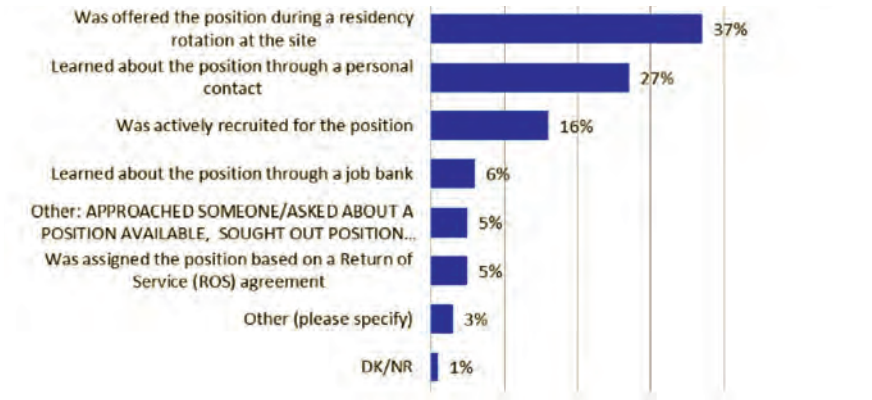

Figure 8 – 2015 National Resident Survey, Resident Doctors of Canada; "Which one of the following best describes how you secured that employment" [4]

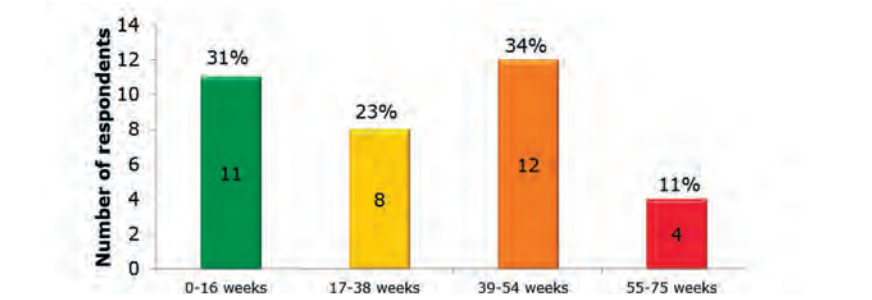

Figure 9 – Royal College Employment Study, 2013 Cohort Study [1]

For those who are locuming, maybe they are doing so because of the flexibility and by choice? Again, I would venture to say there are likely some, but certainly not all. The Royal College Employment Survey suggests this is the case by asking about satisfaction with respondents' placement satisfaction *(Figure 5)*. Almost 22% of new graduates reported they are staying employed by combining multiple locum positions. Despite the apparent flexibility as a locum, forty percent stated they were not satisfied with their locum placement.

For those who are not satisfied, what's preventing these individuals from seeking employment elsewhere? Certainly, it would appear from the other statistics, that finding employment may not be all too easy. We may gain some insight from those who do not have full-time employment; they report family factors or a lack of mobility, while others simply do not want to seek work elsewhere *(Figure 6)*.

What I learned from those who've found employment is that those personal connections are key. Most site personal contacts from peers and staff, as their access point. Specialty societies, job banks, recruitment organizations and advertising play a lesser role, while 8% reported they didn't know where to look for a job![4] *(Figure 7)* So for those without local employment, there may be justification for seeking employment in other unknown locations. Those personal contacts with peers and staff also played a key role in securing employment. *(Figure 8)* It was also made clear that finding a job is not done overnight. *(Figure 9)*

It seems that there are certainly many factors that contribute to employment as a physician in Canada, from funding for medical school class size, to specialty distribution and residency position funding, to location of training, to personal contacts, family factors, desires for location of work, infrastructure to support practices (OR space/time, hospital facilities), and egress of retiring physicians. All of these are in turn influenced by economic dynamics. How in the world is it possible to plan for this? It's not.

I think we can do better with the areas over which we have control. A national employment database to post and find positions, not just for full-time positions or locums, but for all the nuances to one's practice; the limit

No amount of actuarial analysis will be reliable enough to calculate how many individuals to train (with training that lasts from 5-12 years) to become physicians, factoring in the variables of those trainees' lives; there are just too many moving parts.

is our imagination. For those physicians in practice, there are many who would benefit from a blended model in their practice (to explore other professional endeavours, allow time for family, further personal or professional improvement, or simply to smell the roses), where full-time practice is a quilt rather than cookie-cutter with the extra bits added on; remuneration is likely a strong current maintaining the status quo which should likely be addressed to facilitate change.

And then there are those who plan to retire. I've often wondered if we could partner physicians who would prefer to transition into retirement with those who are entering (or already in) practice. Why should practice be all or none, as I have often seen? The pairing would be welcome, at least from my perspective. We can do better for both our graduates, those with young families, those with personal/professional needs and our colleagues winding down their practices. In many settings, mine included, we graduate from a supported community into a nomadic practice. Some departments have likely navigated these (dis)connections better than others, but the positive principles of support, mentorship, and connection remains and should be encouraged.

No amount of actuarial analysis will be reliable enough to calculate how many individuals to train (with training that lasts from 5-12 years) to become physicians, factoring in the variables of those trainees' lives; there are just too many moving parts. While we need to allocate funding to continue to train future generations, I would like discussion around workforce planning to be a call to all physicians to collaborate with current and future colleagues, and a call to our associations to help members find a comfortable practice-quilt.

Meriah Fahey, MD, FRCPC
Obstetrician/Gynecologist
South Health Campus in Calgary.

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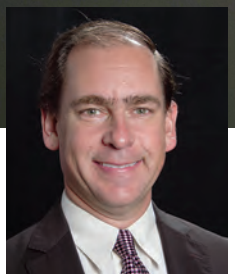
[2] Government of Canada – Annual Average Unemployment Rate, Canada and Provinces, 1976-2016; http://www.stats.gov.nl.ca/statistics/labour/pdf/unemprate.pdf. Accessed April 10, 2017.

[3] Royal College Employment Survey, emailed statistics 2011-2015; Communication February 26, 2016.

[4] 2015 National Resident Survey, Resident Doctors of Canada; http://residentdoctors.ca/publications/national-resident-survey/nrs-2013/. Accessed April 10, 2017.

A Canary in the Coalmine's View on Healthcare in Alberta

Dr. Eddy Lang



Dr. Eddy Lang

Healthcare policy is a contentious matter in Alberta. Not surprising if one considers that $59M is spent on health every day in this province. This represents approximately 40% of the provincial budget, and this spending continues to outstrip inflation and population growth. Areas of tension include balancing resources between acute care, and community and home care, as well as on various aspects of physician compensation and the promise of up to $400M in savings to be achieved through the AMA amending agreement.

As an Emergency Physician with 20 years of experience working in Quebec, and the current Clinical Department Head for the Calgary Zone, I have a perspective that is both out-of-province, and Albertan. While emergency medicine is only one of dozens of medical specialties, our vantage point is arguably unique. As the juncture between acute care and community care, we are something of a canary in the coal mine — that is, when the healthcare system faces challenges or experiences uneven distribution of risk, it is often magnified in the emergency department (ED) setting. A worrisome trend is that inpatient capacity is increasingly strained with growing proportions of Alternate Level of Care (ALC) patients. The fallout of this is felt in Alberta EDs that grind to a halt and lead to adverse patient outcomes when not infrequently, an excess of 100% of ED capacity is consumed by admitted patients. EDs are the safety net for all Albertans; they should not also be the safety valve for closed doors on admitting units and nursing homes.

When one takes a step back however and asks how Alberta's healthcare system is doing in comparison to other jurisdictions, I would argue that the news is really quite good. The "explore your health system" resource on the Canadian Institute for Health Information (CIHI) *https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/* website suggests that among 36 metrics of0 health status and healthcare delivery in Calgary, 19 compare favorably to the rest of Canada and are trending in the right direction, 16 are average, and the Calgary Zone only falls short in the development of sepsis after admission. Edmonton is somewhat comparable, but shows worse performance in 9 of the 36 measures. The Health Quality Council of Alberta (HQCA)'s FOCUS *http://focus.hqca.ca/* website tells a similar story with regards to key hospital and emergency department metrics. The Calgary Zone hospitals are thus performing generally better than comparable sites across the province and the country and this may be the result of differences in hospital organization and leadership structure. As an example, the Alberta Overcapacity Protocols which was effective from 2010-2013 in ensuring an effective surge response and the safe distribution of patient risk across emergency and inpatient units was more rapidly picked up in Calgary than Edmonton.

The recent provincial health budget sees an emphasis on community and home care which arguably, comes at the expense of investment in acute care. Despite working in acute care, I am conditionally supportive of this direction for the following reasons. Firstly, the imperative of off-loading hospitals of their ALC patients has never been more important. Secondly, provincial data on practice variation and the literature on functional decline and patient safety in hospital settings make it clear that we are not doing any favors to our elderly patients by bringing them into hospital when avoidance is possible. Innovation and investment will be required to leverage the robust evidence on "hospital at home" and encourage interventions that see frail elderly treated for medical conditions without the risks associated with the hospital environment.

Currently in Calgary, over 6000 paramedic hours are wasted every month as a result of ED and hospital access block, a situation where a lack of available space leads to these providers idling for hours in corridors overseeing patients they've transported to hospital. This places the population at risk through fewer rigs on the road and is a serious blow to EMS morale. Moreover, these medics could be freed up to engage in community paramedicine, equipped with diagnostic modalities, established protocols and online medical control to provide care at supportive living facilities and the homes of frail elderly with mild to moderate exacerbations of chronic diseases.

I am also of the view that a number of encouraging developments will emerge out of the AMA amending agreement and related initiatives. Viewed from the lens of the physician's social contract with Albertans and the CanMEDS framework we may see important progress towards improved physician resourcing of the North Zone as well as implementation of recommendations contained within the Choosing Wisely program. Here again, progress will hinge on innovation and bold steps. For example, a provincial computerized information system (CIS) that measures and provides transparent and peer-accessible feedback on best and outlier practice patterns will be a powerful driver of change.

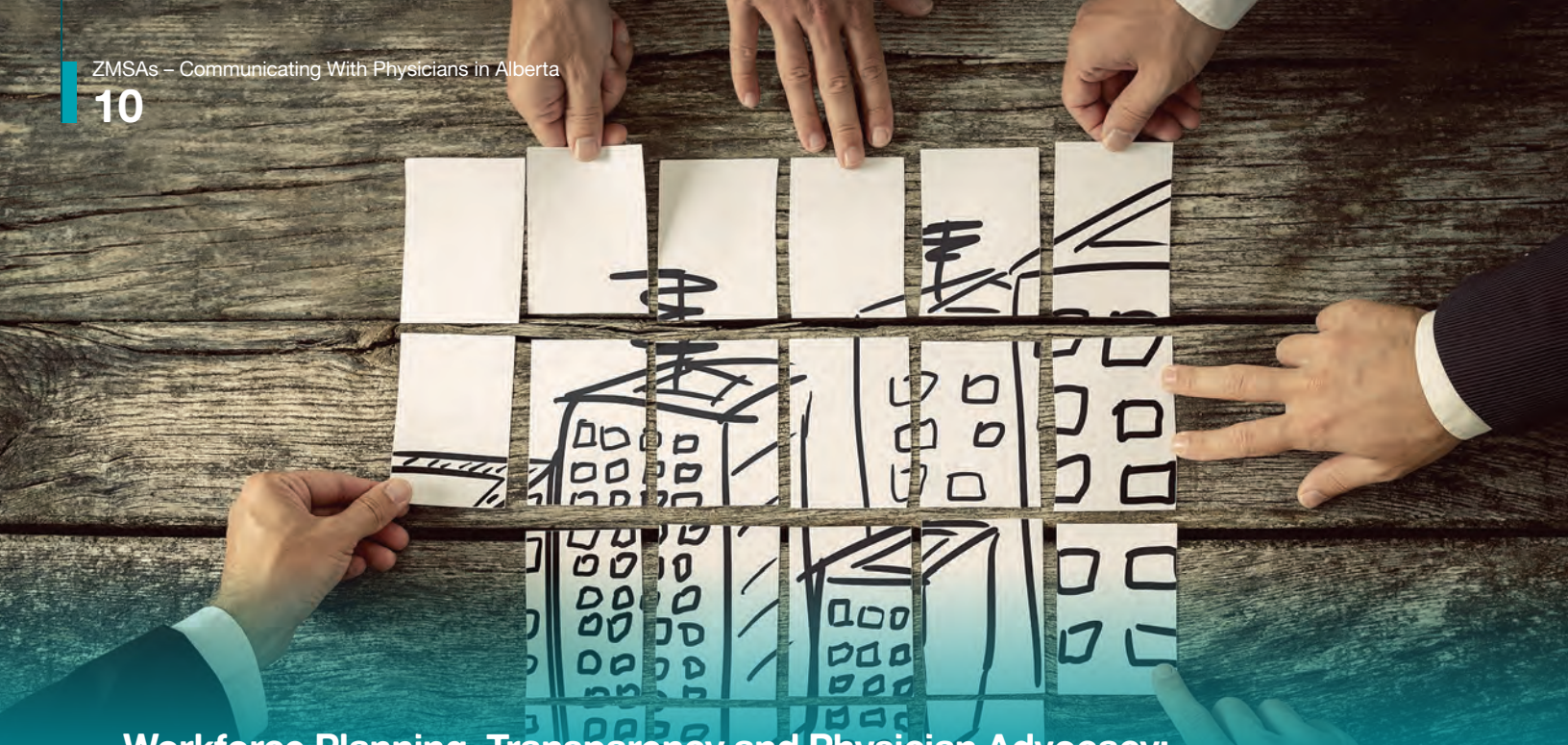
Modifying physician compensation to incentivize the conversations that enable Choosing Wisely will also be needed to bring this campaign further than websites and social media. Removing funding for procedures and interventions that are in contravention of evidence-based guidelines will further rationalize care and reduce wait lists and improve access to services for those in genuine need. Fee-for-service remuneration, and the perverse incentives it sometimes engenders, seems to be in the government's cross-hairs with a trend towards ARPs fostering innovation in care delivery and the fulfillments of professional responsibilities that relate to extra-clinical and academic expertise.

By comparison to other provinces, delivering healthcare in Alberta is a more expensive proposition. One example is that the cost of a standard hospital stay is 36% higher in this province than it is in the rest of Canada ($7851 vs $5789 in 2014-15). Based on 2015 CIHI data, physician supply in Alberta is only 4% higher than the Canadian average and compensation is also 10% higher but rivals Saskatchewan, Ontario and PEI. Are these costs worth it? From my vantage point I would offer an unequivocal yes. I remain impressed at how Calgarians enjoy a robust and well-organized healthcare system. For example, 32% of Quebecers do not have a family physician while less than 10% in Calgary are in the same boat with well over 200 physicians in this city accepting new patients. The hospital environment here is much more effective and cordial than my Quebec experience, something I attribute to investments in staffing and organization of care. If one considers how much lower we Albertans are taxed in comparison to other provinces, my take is that we are getting solid value for our healthcare dollar.

In both Quebec and Ontario we are seeing growing state of acrimony and bullying between physicians and government as physicians are often vilified for robbing the public purse and negating their responsibilities. The sense I have is that while there are clear tensions in Alberta related to health financing, much more progress is being made through an engaged collaboration between the current Health Ministry and both the AMA and AHS.

Moving from Quebec in 2009, I quickly became aware of a fundamental difference in the healthcare culture between the two provinces. In Quebec, decades of fiscally driven and short-sighted policy decisions have led to a stressful and pervasively negative attitude that I would characterize by the phrase "Why are you bothering me?" at many of the points of interaction in healthcare delivery, be it between nurses and patients, or physicians and consultants as examples. In Alberta, from my perspective in the ED, this is more often the much more facilitative, "How can I help you look after this patient?" This state of affairs is the result of decades of smart investment in Alberta. Let's not risk those achievements by embarking on drastic or contentious changes driven by the view that Alberta's healthcare is broken; consolidating and strengthening the status quo has merit too.

Dr. Eddy Lang
Professor and Department Head for Emergency Medicine Cumming School of Medicine, University of Calgary Alberta Health Services, Calgary Zone



Workforce Planning, Transparency and Physician Advocacy:

Where will Alberta be in 15 years?

Dr. Paul E. Hardy

Dr. Paul E. Hardy

From the outset, let me be clear that I am happy for all Albertans who receive top-level health infrastructure and programs. While no one could decry the lofty goal to develop a first rate health care system, transparency and process should also be important to all.

On February 28, 2017, Central Alberta physicians held a "State of the Hospital Address," to inform the public of longstanding concerns about stalled development at the Red Deer Regional Hospital (RDRH) Centre.

The only hospital in Alberta that serves as the main referral site for an entire zone, RDRH has repeatedly fallen off provincial plans for expansion. Upon creation of AHS, newly minted CEO Stephen Duckett had no idea of the planning that physicians and others had undertaken for years prior to his arrival. Back to the drawing board; more plans for the much-needed expansion culminated in an AHS needs assessment study and Capital Master Plan, putting RDRH high on provincial priority list for two years running, only to be erased off the list in late 2016 for reasons that are still not entirely clear.

Dropping RDRH off the provincial priority list sufficiently galvanized physicians to go public with their concerns. The meeting on February 28th attracted approximately 800 central Albertans, such that two sessions had to be held and many were turned away from the meeting. Hundreds were able to watch it live online while thousands have seen the various online versions after the fact (Facebook: Diagnosis Critical — Your Central Alberta Regional Hospital).

In preparing for this meeting with my colleagues, I was astounded by money spent on infrastructure development throughout the province over the past two decades. When times were good, governments were building wherever they could imagine, whether needed or not. Sadly, as residents in ridings with safe conservative seats for decades, we believe Central Alberta has been overlooked. The causes are multifactorial and likely are related to geography, perception and politics. Unfortunately, only the latter two factors can be changed, and this is what we seek to do.

Now that economic boom times are no longer in the foreseeable future, change becomes even more challenging.

With Red Deer being an hour and a half from Edmonton and Calgary, we see an increasing trend where Central Albertans are required to travel for basic medical services. Just last week an octogenarian family member of mine was referred to a specialist in Red Deer. When the appointment for five months hence was given, the referring physician announced they could arrange a consultation much sooner in Calgary. Little discussion. Done. This is but one example of an insidious trend that seems challenging to address. From the AMA to AHS to governments, sometimes the path of least resistance is the simplest. Entrenchment of many interested parties is a barrier to change. Now that economic boom times are no longer in the foreseeable future, change becomes even more challenging. Short of a full-blown crisis, it is easier to tweak the system we have than to make wholesale transformations.

Red Deer Regional Hospital Centre is perceived by many to be a rural community hospital. When a senior executive physician from one of our two major cities questioned why RDRH needs an Intensive Care Unit, one has to wonder what Joe Public thinks. No matter that we measure similarly to Edmonton and Calgary hospitals with respect to Acute Physiology and Chronic Health Evaluation (APACHE) scores and ICU occupancy rates. We are actually a tertiary hospital serving a significant rural population over a wide geographical area. Our efforts to educate the public and others about the level of care we provide has met with incremental success. Through this process, we look forward to working with AHS and government to give Central Albertans the care they deserve close to home, where reasonable to do so.

Politics can be a less predictable factor to influence. In a perfect world, politics would not play a role in medical planning, but being pragmatists, physicians should spend time informing the public of issues important to them as tax-payers. It is regrettable that over the past two decades we have been too busy caring for our patients to pay heed to this very important issue.

I worry about the situation fifteen years from now. Expansion of the RDRH will not occur in my working lifetime, so it is not for personal and professional gain that motivates my efforts. But I do see a bunch of talented hard-working younger colleagues who may leave or decide not to recruit if resources do not support the health care system that Central Albertans deserve.

The principles of transparency and fairness should be high priority for all Alberta doctors, whether you live and work in a remote area or an urban centre.

Dr. Paul E. Hardy
General Surgeon
Red Deer, Alberta

Childhood Asthma in Alberta
Not Child's Play

Dr. David Johnson, *Senior Medical Director, Maternal, Neonatal, Child and Youth Strategic Clinical Network™*

Although asthma attacks are amongst the most common reasons for children to seek emergency care, historically the care they were provided was not always optimal and varied considerably across the province. To overcome this problem, a multi-discipline provincial team of clinical experts, supported by the Respiratory Health Strategic Clinical Network™ (RHSCN), developed and implemented the Alberta Childhood Asthma Pathway (ACAP) across Alberta's hospitals between 2013 and 2015. This Pathway guides front-line clinicians in how to treat children with acute asthma exacerbations in inpatient, urgent care and emergency settings. ACAP uses the validated Pediatric Respiratory Assessment Measurement (PRAM) scoring tool, which helps clinicians categorize presentations into mild, moderate, severe and impending respiratory failure, and tailors treatment for maximum results.

Implementation of ACAP across the province has resulted in substantial improvements in the consistent use of optimal therapies. Post-implementation evaluation reveals that both clinicians and families find value in ACAP interventions, while clinicians experience no net difference in the amount of time required for patient care.

Although now widely used, there is an on-going need to educate health care trainees and new staff about ACAP. On-line training modules (http://pert.ucalgary.ca/pathways/) have been widely and successfully used by over 2,000 nurses, physicians and respiratory therapists. In addition, the Pathway support team has developed the following to supplement the training modules:

- A new online ACAP Toolkit (http://www.albertahealthservices.ca/scns/Page13147.aspx): Visitors to the Toolkit can view samples of all reference documents and clinical forms, as well as short-snapper videos. Each segment shares the evidence and practical considerations for ACAP interventions.
- Quarterly Q&A Webinars: Site leaders and clinicians join Dr. Johnson and Kathy Courtney RRT, CRE for an open dialogue about their experiences and queries. If you would like to receive notice of these events, please email your interest to respiratoryhealth.scn@ahs.ca.

Thank you to all for embracing these practices in support of Alberta's children with asthma. Please join us in spreading word about the available ACAP modules, toolkit, and Q&A sessions. To contact Dr. Johnson or the ACAP support team, please email **respiratoryhealth.scn@ahs.ca**.

Navigating through Physician Resource Planning

Dr. Catherine Cheng

Dr. Catherine Cheng

Change is a journey to which people react very differently. With the many potential changes facing physician resource planning in Alberta and their implications on physician autonomy and health care delivery, there remains much uncertainty amongst the 1,700 resident physicians practicing in Alberta.

In my role as PARA President, I have heard the numerous concerns, suggestions and opinions of resident physicians across the province and continue to welcome this communication.

The Kubler-Ross change curve is frequently used in change management to capture individual reactions to change. I think it is a fitting way to capture the feelings of learners and physicians. The stages of the curve include shock, denial, frustration, depression, experiment, decision and integration. Understanding and transparent communication are crucial during the initial stages, as statements such as, "I can't believe this," "It's not fair," and "You can't do this" are common. Progressing to the latter stage of the curve allows for the focus to move to exploring options and finding solutions. Resident physicians and all physicians at various points in their career may be at different stages along the change curve. Many hope for answers and certainty in a time where neither can be provided in the current planning phase.

The impact of the AMA Amending Agreement on resident physicians has been multifaceted. On an optimistic and exciting note, the Agreement and the formulation of the Physician Resource Planning Committee (PRPC) has given PARA and resident physicians a voice and a seat at a table where we have and can continue to contribute actively to the discussion. A needs-based physician resource plan (PRP) also holds promise that one day in the near future both medical students and resident physicians will begin the journey knowing their careers will better align with the job market — helping ease fears of completing residency training with no job in sight — while ensuring the needs of Albertans are met. If done correctly, a PRP will lead to better health outcomes and access for all Albertans — something that every Albertan physician values and strives for in their practice.

In the short term, the Amending Agreement and the subsequent PRP process has also brought on very acute and uncertain times for resident physicians who are on a fixed trajectory determined by the Canadian Resident Matching Service (CaRMS) process that occurred years prior to the conceptualization of a needs-based plan and the PRPC. Having to face the potential and real consequences and outcomes of a PRP still in development creates anxiety. As resident physicians, we are grateful for the strong support from Alberta's physician leaders at various forums, including the Spring AMA RF with the passing of a motion to ensure physicians in training and early career are appropriately supported.

Over the past few months, ongoing discussions suggest Alberta Health is actively listening and consulting with various stakeholders critical to the creation of a PRP that reflects the complexity of our health care system. From the resident physician front, PARA and other PRPC members have been in discussions regarding the timing of the development and implementation of any physician resource plan. As a result of the advocacy efforts of PARA and other PRPC members, there have been changes in the timing of the implementation of any PRP, which will result in a better implementation strategy moving forward, while ensuring fairness to those expected to complete residency training in June 2017. This means that for those resident physicians completing residency in June, any potential new conditions on practicing in Alberta will not be in place before June 1. We have been informed that all commitments made by resident physicians completing training in June will be honoured. I believe that though these discussions are difficult, consideration of the impact any PRP might have on the new-in-practice physicians is a good step forward.

PARA and resident physicians remain actively involved and committed to working with all stakeholders and members of the PRPC to ensure any PRP provides for the fair and equitable treatment of all physicians regardless of the phase of their careers. I want to take this time to thank all the physicians who have and continue to advocate for learners and are determined that future generations of physicians continue to have the opportunity to flourish and serve Albertans.

A common goal brings people together. I believe our shared goal of improving patient care for Albertans through a needs-based approach in which physicians at all phases of their careers are supported can be achieved if we remember what our values are as a profession and continue to work together.

Catherine Cheng, MD, BSc
President, Professional Association of Resident Physicians of Alberta (PARA)
PGY 3, Psychiatry, University of Alberta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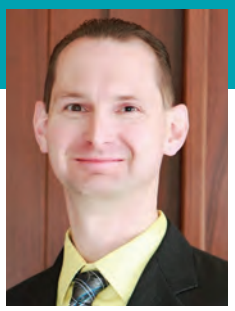
Until Apple Designs an Electronic Medical Record:

TESTING USABILITY WHEN SELECTING AN ELECTRONIC MEDICAL RECORD



Dr. Darren Hudson

Dr. Darren Hudson

An increasing number of physicians are choosing to install an electronic medical record (EMR) in their office. Most physicians appreciate the convenience of Netcare to access patient information and Alberta Health Services is in the process of selecting a province wide EMR. This article is for those who have decided to use an EMR or are choosing a new vendor.

EMRs are plagued by poor usability. Usability is a concept in human factors that relates to how well the user can use an object's functionality. Compare the excellent usability of the iPad to the clock on your VCR. EMR usability in the United States is so bad that physicians are spending hours completing their charts after clinic hours. There does not appear to be any relief in sight as the combination of governmental regulations and an evolving monopoly is preventing radical changes to the design of EMRs.

When selecting an EMR, there are many ways to evaluate usability. The best is to set up the EMR in a simulated environment and have users test it in a variety of scenarios. Obviously, this is not practical in your practice. One of the worst ways is the "show and tell." The vendor shows you what the system can do but you do not get to try it yourself. A reasonable middle ground is to get hands-on with the system using a vendor's pre-established test environment. During this time, you have the chance to test the usability of the system.

Here are 10 well established criteria that you can use to get a sense of the EMR's usability and grade the different systems you are evaluating.[1]

1. **Simple Layout:** the system should have a layout that is as simple as possible. The belief that adding more and more to a layout only increases your cognitive load. Simple layout is like obscenity; you will know it when you see it.

2. **Straightforward Language:** EMRs are designed by non-clinicians who are trying to guess what you will understand. The language being used to make sense to you, not the developer, and does not require explanation.

3. **Minimal Memorization:** it is easier to recognize than recalling. This means that a system should provide clues in the layout that allow you to recognize what to do. The system should not force you to memorize steps and formatting rules.

4. **Consistency:** the same actions should create the same results. "Control-V" should always be "Paste" and not something else other times. There should also be consistency in the layout, including the use of colour and fonts to facilitate recognition.

5. **Feedback:** the system should give you constant feedback on what it is doing. If the computer needs time to process a request, then there should be some indication like the cursor or an alert to tell you that the system is still working and not crashing.

6. Clearly Marked Escape Route: there should always be a way to get out of any process you are doing using a close or cancel button. You should have the feeling that you can always get out of the situation, especially if the system seems to be crashing.

7. Shortcuts: shortcuts are used by expert users to speed up their work. This is usually a keystroke like "Control-V" instead of selecting "Edit" then "Paste". You may not need it now while you are learning the system but will appreciate it later.

8. Useful Error Messages: all systems do have problems eventually so the error message should be clear. The worst type of error you can encounter is the one that does not provide any information as to the cause or solution. For example, "Fatal Error 2445" sounds bad but gives you no information. Alternatively, "File not found: check disk in drive" tells you exactly what the problem is and what to do next.

9. Prevent Errors: it is inevitable that you will commit errors while you are interacting with the system. This can be as simple as mistyping a patient name. A well-designed system will attempt to limit your chances for errors by preventing you from getting into the situations. For example, a well-designed system will provide a drop-down menu of medications instead of forcing you to type them out and make a spelling error.

10. Help And Documentation: finally, you should evaluate the quality of the help available online, including the ease of understanding and presence of any online support. Most software companies these days do not provide extensive volumes of printed user manuals and it is important that you know where you can get help both within the system and online when necessary. As well, you need to completely understand the amount of support the vendor is willing to provide. A frequent source of dissatisfaction after the sale is from poor customer support.

Embarking on an EMR purchase can seem like a daunting task. There are definite risks in a poor purchase decision and usability is frequently at the core. There are a variety of methods for evaluating EMRs for usability but realistically your best option is to get your hands on the system and test drive it using these usability criteria to help give you a better sense of which EMR is going to meet your needs.

Darren Hudson, MSc MD FRCP(C)
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FOOTNOTES

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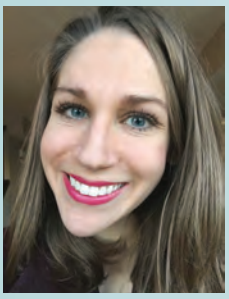
Burnout...
is it happening to you?



Dr. Shannon Ruzycki

Dr. Shannon Ruzycki

Dear colleague:

I hope you're doing well. No, really. I am worried about you. Evidence consistently demonstrates that about half of resident physicians will suffer from some form of burnout during training.[1,2] The main symptoms of burnout are emotional exhaustion, depersonalization and a reduced sense of accomplishment.[2]

Though not unique to medicine, physicians are much more likely to suffer from burnout than professionals in other high-stress careers, such as law or business.[2] In fact, higher education is generally protective against the development of mental illness — in every field except medicine.[2] Physicians are more likely to suffer from depression and other types of mental illness than the general public. Though first year medical students have similar depression and burnout scores to students entering other professional programs, by the beginning of residency training these rates are much higher than those other students in advanced degree programs.[2] Burnout and depression peak during residency with rates nearing 60 per cent and reach a nadir of just less than 50 per cent of all practicing physicians.[2] This worries me.

– continued on page 16

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We need to support ourselves and one another. If you recognize you are exhibiting signs of burnout, please invest in yourself. Purchase some free time by hiring a cleaning person, having your groceries or meals delivered, or hiring someone to do any task that is not making your life better.

Medical students and resident physicians are amazing individuals who are ambitious, goal-directed, intelligent and altruistic. We start medical school like most other students, but something happens the longer we are immersed in the culture of medicine — many of us develop emotional exhaustion and self-doubt that ends up dramatically reducing our satisfaction from our work.

What can we do about burnout?

Evidence suggests that the most effective interventions to reduce burnout are systems-level.[3] Examples include scheduling changes, increased physician autonomy and 'no-page' time periods at night for residents.[3] We need to work with our colleagues and our training programs to make changes that enhance wellness. Fortunately the University of Alberta and University of Calgary, along with the Professional Association of Resident Physicians of Alberta (PARA), recognize the stress of residency training and are actively working to help resident physicians recognize burnout and prioritize well-being.

But there is still much we can do as individuals. We need to support ourselves and one another. If you recognize you are exhibiting signs of burnout, please invest in yourself. Purchase some free time by hiring a cleaning person, having your groceries or meals delivered, or hiring someone to do any task that is not making your life better. Use this newfound free time to exercise. Find an activity you enjoy. Encourage your partner or best friend to participate with you. Avoid the reduced sense of accomplishment by celebrating your successes, no matter how insignificant they feel. Consider taking a flex day and seeing a movie or going for a hike. Consider keeping a journal.

Look out for your colleagues and role model a culture where we prioritize our own wellness. Do not complain if a colleague takes vacation or a flex day during your rotation. Send a congratulations card to a colleague to celebrate their accomplishments. Be kind. Do not berate. If you think a colleague is struggling, reach out to them.

PARA is actively working with our partners on resiliency training and wellness initiatives. We also provide presentations on fatigue management during academic half-days. PARA's Community and Wellness Committee is a group of resident physicians from across the province that, as part of their mandate, organizes activities to promote resident physician well-being. From runs and bowling, to hockey games and dinner theatre, PARA sponsors social and recreational events throughout the year, supporting resident physicians in spending time outside of work with friends and family. In addition, one week each year — this year May 14-20, 2017 — is designated Resident Physician Wellness Week (RWW).

RWW provides opportunities for resident physicians to partake in well-being activities and also serves as a reminder to staff and resident physicians alike of the importance of finding the right balance between our personal and professional lives. Less explicitly, it broaches the often swept-under-the-rug issues faced by resident physicians — stress, burnout, relationship strain, depression and anxiety, amongst others — helping resident physicians to recognize that they are not alone in these experiences and that there is support available in addressing them.

You deserve to enjoy your life. If you are so far into burnout that you cannot imagine mustering the energy to re-invest in your own wellbeing, please tell someone. You can contact the AMA Physician Family Support Program (1-877-767-4637 or *https://www.albertadoctors.org/services/pfsp/pfsp-services*).

I am thinking about you. I hope you are doing well

Sincerely,
A colleague

Dr. Shannon Ruzycki
PGY 4, General Internal Medicine
University of Calgary

For more information on Resident Physician Wellness Week and scheduled activities, visit https://para-ab.ca/news-events/resident-physician-wellness-week/

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The Stewardship 'Chair'

Dr. Lloyd Maybaum

Public procurement is one of the government activities most vulnerable to corruption. In addition to the volume of transactions and the financial interests at stake, corruption risks are exacerbated by the complexity of the process, the close interaction between public officials and businesses and the multitude of stakeholders.

Preventing Corruption in Public Procurement – OECD – 2016

Lets delve right into scenario #1. We need new conference room chairs on my unit but my manager tells me that we can't purchase any because we don't have the budget. The chairs are simply too costly. My colleagues and I offered to purchase the chairs but we were informed that we are not allowed to buy just any chair. We must go through the preferred vendor. Subsequently, I was informed that the vendor chairs are $800 each. I was floored.

How could a simple conference room chair cost $800? The manager explained that they are 'special chairs', designed for hospital use. Looking around the conference room and our hodge-podge, mismatched collection of Korean War surplus chairs, one struggles to comprehend why we need 'special chairs' when clearly any old, rickety chair is currently good enough and have not seemingly caused injury to anyone. The manager explained that we have to go through the preferred vendor and $800 is the cost from this vendor. I lost it. In my flabbergasted state I went to Costco, since I needed a new chair for my office at home. I purchased a deluxe leather, executive, high backed swivel recliner on a set of castor wheels for a cool $139 with the Costco guarantee. *"We guarantee your satisfaction with every product we sell and will refund your purchase price."* This is an awesome chair and one could get almost six of them for the cost of a single chair from the AHS preferred vendor. To me, this underscores that there is something wrong with our procurement process in AHS and, I imagine, other publicly funded agencies in Alberta.

Scenario #2 was provided by a colleague of mine who did not want their name mentioned out of fear of retribution. A few years back this colleague needed to purchase a new office set for an AHS office at one of our local hospitals. Unaware of the purchasing process, this person headed straight to the local Office Depot to browse office furniture and prices. They settled on a set that was reasonably priced at $1500. This was reported to the manager who was asked how to go about purchasing it and having it delivered.

My colleague was quickly informed that we cannot simply go to any store and buy office furniture. We must use the approved AHS vendor — RGO Office Products. RGO was contacted and informed what was required. My colleague discovered that for a set similar to that found at Office Depot, it would cost $12,000. They balked — there was no way that this could cost $12,000. My colleague went to the manager and explained that they were not going to spend $12,000 on office furniture when a similar set was available for just $1500. They were told that this was the way it works in AHS and that the only other option was to look at the other preferred vendor, Grand and Toy. Even then, special permission had to be obtained since AHS was apparently no longer using Grand & Toy — they only worked with RGO. In the end, a comparable set was purchased for $7000.

All of this leaves me wondering, why are we forced to pay seemingly massively inflated prices with tax-payer dollars? If the taxpayer

knew what was going on, wouldn't they be outraged? Why can't we have a budget and choose the chairs/furniture that we would like and from the vendor that makes the most economic sense (amongst other considerations)? Moreover, do we have the kind of accountability that is needed to ensure a fair and fiscally sensible procurement process in this province?

In 2010, the Ontario government introduced a Public Accountability Act (Bill 122) to ensure fair, open and transparent procurement procedures in broader public sector organizations. The best I can make of our Alberta situation is that we have window dressing with respect to accountability measures. Naturally, such processes would seem to be the vestigial remnants of our 43-year PC dynasty here in Alberta. I refer the reader to an interesting Calgary Sun article from May 2, 2014 entitled, "Redford spent $28K on furniture as finance minister Horner warned of spending cuts." Matt Dykstra notes, "The documents obtained through freedom of information also reveal that Redford's office was warned the sole-source furniture order could violate the Alberta Purchasing Connection and the New West Partnership Agreement (NWPA)… "According to e-mail exchanges between government officials dated Dec. 19, 2012, Redford's special assistant John Hampson — requested the government "immediately proceed" with purchasing new furniture from RGO Office Products for staff at the legislature in Edmonton."

According to the author and former Liberal MLA, Kevin Taft we should "Follow the Money," so let me ask, who benefits from $800 chairs? The staff and patients don't. The tax-payer certainly does not benefit. The AHS and Health Minister's budgets certainly do not benefit — so who benefits? Who has a stake in what appears to be a $600 to $700 profit from each one of these vendor supplied chairs? Perhaps a better question is who is condoning and agreeing to the apparent procurement processes that we have in place and who condones such seemingly outlandish costs?

Our current NDP government and the health ministry want us to become stewards of the health care system. Whistle-blowing infrastructure and procurement costs should be seen as a part of that stewardship role. Although my colleague did not want their name mentioned, it is truly only physicians that can hold the system accountable. Thus, we designated stewards of the system must find our voices and truly speak out. We must work with managers who cannot speak out in the way physicians can. Managers, however, can leak their concerns through us and we, in turn, can strive to hold the system accountable. If infrastructure construction costs seem outrageous find your voice, speak up and challenge those costs. If procurement costs seem ludicrous, speak up and protest.

Searching for a solution to these issues, perhaps AHS needs to create an independent ombudsman role that concerns can be reported to. This ombudsman, in turn, could perhaps report to the auditor general or other independent agency in government. In addition, I encourage every physician to write your concerns either to your medical staff association or perhaps to the Alberta Medical Association. Conversely, pen a letter to Vital Signs (they love controversial articles ;-) or call your MLA and express your concerns. As a last resort, drop me a note with your concerns on it and we will see what we can do about it.

I remain faithfully yours, entrusted in our mutual stewardship of the health care system.

Dr. Lloyd Maybaum
Past President CAMSS
Calgary, Alberta

Rockyview General Hospital Medical Staff Association Annual General Meeting

The Rockyview General Hospital Medical Staff Association is pleased to announce that its Annual General Meeting is going to take place on

Tuesday, June 6, 2017 from 6:00 to 9:00 p.m.

Railway Orientation Centre at Heritage Park's Town Square
1900 Heritage Drive Southwest, Calgary

Entertainment: **The May Trio Led by Jonathan S. May**

Rockyview General Hospital Physician Recognition Awards
"Very Important Presenters to our Very Impressive Physicians"

Dr. Borys Hoshowsky,
President, RGH MSA

Rockyview General Hospital Medical Staff Association Members 2 tickets to the AGM are included in your membership & you are invited to attend with a partner

Seating is limited, your RSVP would be appreciated by May 9, 2017 stella.gelfand@ahs.ca Tel: 403-943-3428

The RGH MSA is hosting your parking at Heritage Park Please use parking code: 30208

Non RGH MSA Members $100 per ticket paid in advance
Buffet Dinner/Cash Bar

Dr. Borys Hoshowsky, President, Rockyview General Hospital Medical Staff Association

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