July 2017

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OF ALBERTA

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

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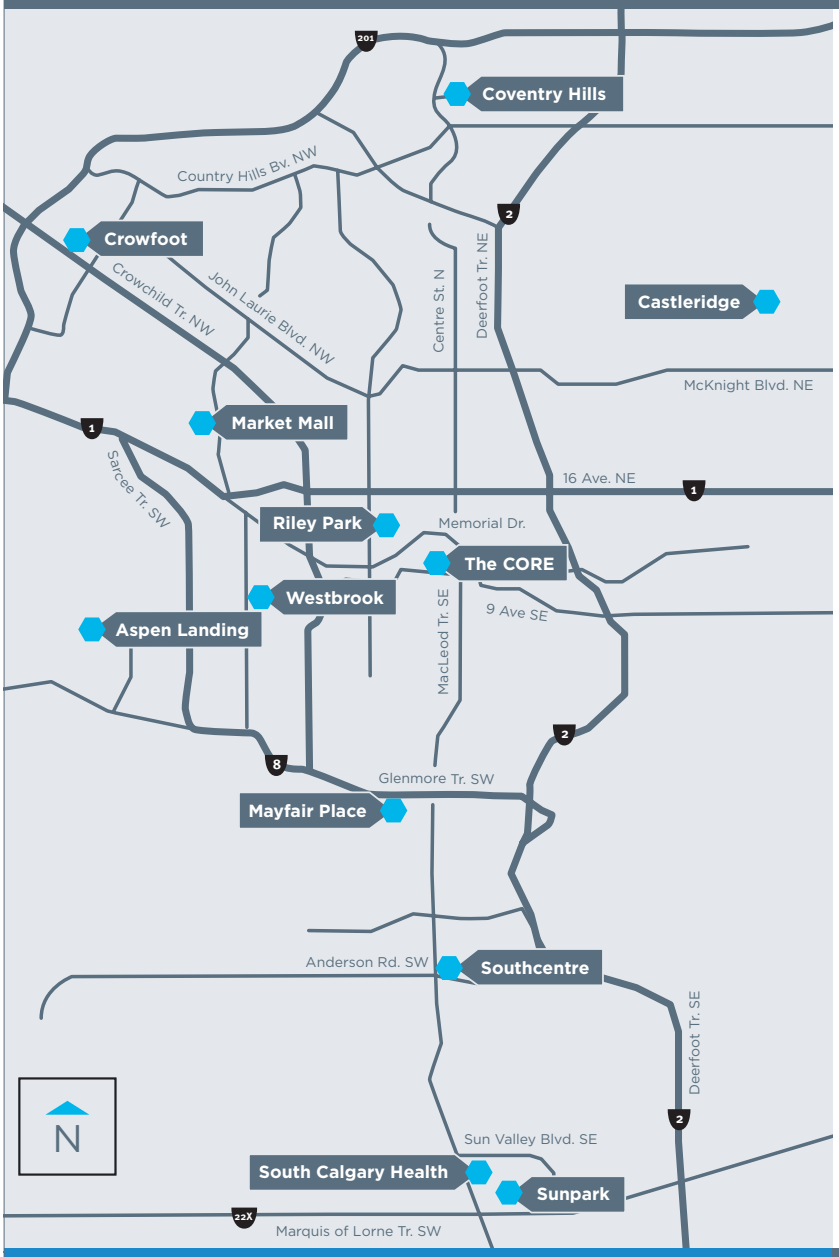

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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

July 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

SUBMISSIONS:
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 August 16, 2017.

Contents:

Save the Dates!

CAMSS

Council Meeting
September 13, 2017 | FMC Boardroom 152 – 5:30-8:30 pm

ZAF
October 11, 2017 | Southport Tower Room 1003 – 5:30-8:30 pm

CZMSA

Executive Meeting
August 10, 2017 | WebEx

EZMSA

Executive Meeting
September 14, 2017 | Misericordia, 5:00-5:30 pm

Council Meeting
September 14, 2017 | Misericordia IN-106, 5:30-7:30 pm

SZMSA

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

ZMSA Address Change

The ZMSA office has moved. This change also applies to CAMSS, CZMSA, ACH MSA and FMC MSA.

MAILING ADDRESS:
350-611 Meredith Road NE
Calgary, AB T2E 2W5

RECEPTION:
Suite #310, 611 Meredith Road NE
Calgary, AB T2E 2W5

Phone numbers remain the same.

Vital Signs Subscriptions: Annual subscriptions to *Vital Signs* are available for $30.00; please contact info@albertazmsa.com for more information.

President's Message:

Colouring Outside the Lines

Dr. Sharron L. Spicer, Calgary and Area Medical Staff Society President

Like most analytic types – many of whom are attracted to the medical sciences – I'm pretty comfortable with data and statistics. Artistic pursuits, though, are better left to those who have some natural talent that I seem to lack. Yet I find myself increasingly enjoying the creative aspect of the medical profession, perhaps for its intellectual challenge *(you see, my analytic side even needs to explain it!)*. Every time we seek to discover a new treatment, develop a new process or try things not done before, we are channeling creativity into innovation.

In *Creative Confidence*, the authors describe that General Electric high-tech designer "Doug [Dietz] wrapped up a project on an MRI machine that he had spent two and a half years working on. When he got the opportunity to see it installed in a hospital's scanning suite, he jumped at the chance. Standing next to his new machine, Doug talked with the technician who was operating it that day. [He] was prepared to come away patting himself on the back for a job well done. But then he saw a frail young girl walking toward him, tightly holding her parents' hands. As Doug watched, the little girl's tears rolled down her cheeks… and that was when Doug learned that hospitals routinely sedate pediatric patients for their scans because they are so scared that they can't lie still long enough. When Doug witnessed the anxiety and fear his machine caused among the most vulnerable patients, the experience triggered a personal crisis for him that forever changed his perspective. Rather than an elegant, sleek piece of technology, worthy of accolades and admiration, he now saw that — through the eyes of a young child — the MRI looked more like a big scary machine you have to go inside.[1]" With renewed fervor, Dietz reworked his MRI machine, adding the necessary decals and décor, to transform the experience into an adventure story, with the child having a starring role. Now, boarding a pirate ship or a spacecraft for a voyage, the patients participate in an imaginary trip. "Just before the whirring and banging of the machine gets louder, the operator encourages young patients to listen closely for the moment that the craft 'shifts into hyperdrive'. This reframing transforms a normally terrifying 'BOOM-BOOM-BOOM' sound into just another part of the adventure." The number of patients needing to be sedated was dramatically reduced, more patients could be scanned every day, and patient satisfaction scores went up 90 percent. That is creativity at work!

Creativity is fuelled by imagination. When my daughter was young, we played countless hours of pretend. Her imagination — or "magic nation" as she aptly called it — took us to all sorts of places. Somehow, I was always the antagonist in the story and she had the role of the hero who rescued the poor victim. There's probably some developmental psychology lesson demonstrated about a child's developing self-confidence in that role-playing.

Imagination is a precursor to empathy. We need to be able to take the perspective of "another" to be able to see the world as they do and respond accordingly. Sometimes this means doing things in different ways than we do them now.

The creative part of medicine for me is to imagine how to make the system better for patients and families — and then make it happen. As our care paradigm shifts from paternalism to patient-centred care, we need to use empathy to consider the system from a patient and family viewpoint.

Sometimes, the biggest threat to creativity is being overspent: physically depleted, sleep-deprived, mentally drained, "busy" or frustrated. Self-care promotes a healthy creativity so that we can be inspired; we can imagine something that could be better than what it is now. So walk, run, meditate, play, explore, colour outside the lines… let your creative side come out!

In this issue of Vital Signs, physicians share what inspires them to do things outside the box — in other words, to "create". Dr. Richard Bergstrom writes about innovation in the high-tech world of Anesthesia, where technology has transformed what can be done for patients — yet at the core, health care is still about the patients, not the technology. Dr. Shelley Duggan, Past President of the Edmonton Zone Medical Staff Association (EZMSA), tells us about the EZMSA's Quality Improvement Grant to fund innovative projects that will enhance communication between medical groups (such as family physicians and specialists) and target vulnerable patient populations. Dr. Brian Cornelson outlines the work of Family Care Clinics in Alberta. Dr. Bonnie Larson describes her team's work with inner city populations, and recently-graduated medical student Jordan Iannuzzi writes about Inclusive Health addressing psychosocial and medical issues facing sexual and gender minorities. Further from home, where Western technology meets developing world, we hear from Dr. Robin Cox and Dr. Brian Knight about their experiences on surgical teams in Vietnam and Ecuador. Reminding us that enjoyment of life is important to keeping us well, Dr. Maire Duggan and Dr. Randy Naiker highlight the importance of supporting the arts and having fun with our colleagues. We are also proud to highlight Vital Signs' community support; we work closely with the clients at the Carnat Centre to send out our magazine. I hope these stories of physicians' work in varied settings sparks your creativity in medicine.

FOOTNOTE

[1] Kelley, T. and Kelley, D. (2013). Creative Confidence: Unleashing the Creative Potential within Us All. New York: Crown Business.

What to Wear Today?
A Day in the Life of an Inner-City Doc

Dr. Bonnie Larson

Dr. Bonnie Larson

I stand in my closet at 7:30a.m. on a Friday morning, trying to decide what to wear for my day of clinic, call, and meetings with funders and collaborators. A skirt and blazer would be appropriate for my afternoon meetings, and for many family docs that would be a great clinic "uniform" as well. I stand frozen. Recently, at a leadership workshop given by highly respected medical women, I was informed that if you want to make an impression, it is *crucial* to wear nice shoes, and to ensure they aren't *scuffed.*

Twenty minutes later, I'm out the door in jeans, a leather jacket, and boots *(quite scuffed).*

I follow my usual route into the downtown core, peering into back alleys and under bridges, annoying my fellow commuters by creeping slowly past the places where my patients dwell: warm air outflows, grates, bridges, group homes. I see a patient we have been looking for (joy!); he has pulmonary function tests booked for the next week. I pull over and hop out, sloshing over the snow-piled curb. I approach slowly so as not to startle him. We chat: he's feeling short of breath. He lives outside. We arrange a spot for the Community Paramedic City Centre Team[1] to pick him up on the day of his PFTs; they will take him to his appointment. I send a text to the team to update them on the arrangements.

I stop at Starbucks. I am running late as usual, but I know I shouldn't practice medicine caffeine-free. My colleagues know this too, and we have each other's coffee orders memorized.

Latte in hand, I head to Alpha House,[2] continuing to stalk the street-dwellers along 11th Avenue, 4th Street, and 17th Avenue. I make a quick stop at a "harm reduction building" *(staffed by heroes)* to coordinate care for one of the residents, an ornery schizophrenic gent who has had a razor blade up his nose for the past several weeks. He had missed an urgent ENT appointment due to competing priorities related to survival. While paused, I check my text messages. One patient has gone AWOL from hospice and another no-showed for surgery. We fan out.

From left: Bonnie Larson, Diana McGregor, RN, patient who wishes to remain anonymous, and Ty Eggenberger, EMT-P. We have permission from the patient to publish the photo.

Finally, 9 a.m. I park near Stampede Station and make my way to the client entrance at Alpha House. I verbally spar in good humour with those who ask for sips of my latte, or for a cigarette. I actually have started carrying cigarettes *(I've never smoked a day in my life!)* because, along with bus tickets, these can make or break deals to attend a specialist appointment, HPTP for IV antibiotics, or a meeting with one's parole officer. Imagine! A family doc — the supposed epitome of preventive health — bribing a patient with a cigarette!

Our team attends to a patient suffering a seizure on the floor of the shelter, and I haven't even taken off my jacket. The morning is just getting rolling. We pack the patient off in an ambulance only after Connect2Care[3] and DOAP[4] are aware to bring him safely back to our care upon discharge. Our nurse changes dressings on complicated non-healing wounds, while I confer with community paramedics about a patient they have brought in with frostbitten digits. We manage severe alcohol and opioid withdrawal. We assess lacerations, fractures, GI bleeds; share trauma, grief, loss, and hope. We hear stories, witness injustice quietly, pass the tissue box, and try to remember to breathe. We laugh at the drama, at the absurdity, and

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– *continued from page 3*

at some patients' excellent jokes. We roll our blood pressure machine out to our patients in the shelter, into the street if needed. We roll up our sleeves. My astoundingly brave and calm nurse *(I suspect she was a stellar Girl Guide)* wears knee-high snowboots all day in the winter. We go to where our patients are. To us, this is the meaning of patient-centred care.

I leave the fray and head away to my afternoon meetings, acutely aware of all that I have not done, of what I have left behind. I smell of the shelter *(people, stale tobacco, wet socks, sage smoke, and last evening's beer),* which is somehow comforting to me, but likely offensive in an ivory tower meeting room. I dab on some lavender oil and carry on, stench of homelessness thereby concealed by the scent of flowers and my advocacy hat set firmly in place.

My motivation to attend medical school came from working as an anthropologist in poverty-stricken communities in Central America and Africa. This work I do now — in my own community — is really no different day-to-day, except that I don't get on a plane and return "home" at the end of the mission. Here, with our people on the streets and most definitely not wearing a skirt, I am already home.

Dr. Bonnie Larson
Dr. Bonnie Larson is a family physician at CUPS and leads the Street CCRED Collaborative, working closely with community partners and the O'Brien Institute for Public Health and Community Engagement at the Cumming School of Medicine. She was the recipient of the CAMSS Advocacy Award in 2016.

To learn more about how Calgary physicians are improving women's health through ending homelessness go to: http://www.resolvecampaign.com/calgary-alpha-house-society/. Please join CUPS physicians who have already donated more than $5,000.

Dr. Larson working in the health room at Alpha House.

REFERENCES

1. The **AHS Community Paramedic City Centre Team** is a mobile medical resource providing on-site clinical treatment for vulnerable patients facing homelessness, mental health issues, and addiction. http://www.albertahealthservices.ca/info/Page12557.aspx
2. The **Calgary Alpha House Society** is a non-profit charitable agency that provides safe and caring environments for individuals whose lives are affected by alcohol and other drug dependencies. http://alphahousecalgary.com/
3. The **Connect 2 Care Team** connects with people who are experiencing homelessness in hospitals to help support them with social and health care needs during their stay and once they are discharged to the community. The goal of the program is to reduce inappropriate use of the health care system while assisting with better health outcomes for this population. http://alphahousecalgary.com/services/outreach/
4. The **Downtown Outreach Addictions Partnership (DOAP) Team** offers a collective response to substance abuse in Calgary communities. The DOAP Team is an alternative and more appropriate response to substance abuse issues and public intoxication, resulting in reduced pressure on Calgary Police Services (CPS), Emergency Medical Services (EMS), Transit, Bylaw and local city hospitals. The team seeks to remove the barriers for individuals with multiple risk factors by coordinating access to a range of medical, shelter, housing and addiction programs.

OPERATION ESPERANZA

Dr. Brian Knight

Dr. Brian Knight

In 1997, Dr. Tom Greidanus was visiting Ecuador when he was asked by Dr. Manuel Avila, a local doctor, to see an adult patient, crippled with severe hip dysplasia. After recognizing only a total hip replacement would help this patient, Dr. Greidanus phoned contacts in Canada to see if the equipment could be sent to Ecuador. After several days and many phone calls the equipment arrived and the surgery was successful.

After being asked by Dr. Avila if he would return to Ecuador the following year, Dr. Greidanus returned with a small team. This was the start of Operation Esperanza, which has visited Cuenca, Ecuador every year since. The team has since grown to include a pediatric orthopedic and a dental team in addition to the adult orthopedic team.

Hip dysplasia is sadly relatively common in Ecuador. There may be a genetic component but there are two other factors. While in the developed world, neonates are screened for hip dysplasia, this is largely not done in Ecuador. Another factor is the way that Ecuadorian women carry their children. In much of the world babies are carried either on their mother's front or back, straddling her with their legs. This has the effect of keeping the hip in the sockets. In Ecuador, babies are traditionally carried diagonally in a sling, which allows the hips to sublux leading to hip dysplasia in babies so pre-disposed.

Patients with hip dysplasia in Ecuador like many countries in the developing world are left with pain and decreased function with little or no social safety net. In Ecuador's public medical system arthroplasty is not readily available and surgery in the private system is too costly for most of the poor patients. In hip dysplasia, the hip socket is often severely abnormal, so arthroplasty is more difficult than that done for degenerative osteoarthritis. We also see patients with advanced rheumatoid arthritis who may benefit from TJA.

Cuenca, a city of 580,000 inhabitants is located in the Eastern foothills of the Andes at an altitude of 2,500 m. Cuenca was settled by the local Quichua people and become an important colonial town after the conquest by the Spaniards. It has been designated a UNESCO world heritage site. It is a bustling town with narrow cobbled streets, overhung by wrought iron balconies. The large Catedral Neuva with its distinctive blue domes dominates the central town.

Planning

In Canada we are used to everything just falling into place. Equipment is ready, the patients arrive in the OR, surgery is done and somebody looks after them. Working in an overseas environment in a short mission, each individual item of patient care has to be thought out.

Planning for the next year's mission starts during the previous year's mission as we think about and discuss what worked well and what has not worked in the current mission.

Planning continues only a few weeks after our return to Canada. Team leads in surgery, anesthesia, OR and ward nursing, and physiotherapy meet at monthly intervals to plan for the next year. In the fall, the entire Edmonton based team meets at monthly intervals

It is necessary to anticipate every sponge, piece of equipment and the drugs we will use. We need to think of how many of each item we will need, how and where to obtain them, and how to get everything to Ecuador. We have to anticipate the surgeries and obtain sufficient prostheses to do the cases we need to do. Fortunately over the last three years Smith & Nephew has donated the prostheses. We have high rates of returning members, but it is usually necessary to recruit new staff in multiple areas each year, looking not only at their competencies but also in their ability to function as part of a team.

Fundraising is important and we have been fortunate to have the backing of the Rotary Club of Edmonton Riverview. In addition we often get some generous donations from individuals and also have a number of small fundraisers during the year.

The equipment and supplies are packed into hockey bags to be checked as luggage. Much of this packing is done by the OR and floor nurses who spend a great deal of time making sure we have everything we need. Personal items are usually brought down in carry-on luggage.

Most years we go back to the same hospital, but the situation on the ground can change so it is important to be flexible and have a Plans B and C. In 2017 for example, we learned on arrival that we had a patient with a peri-prosthetic fracture, which required us to adjust on the fly to be able to do her surgery. We have also had to deal with changes in OR availability.

Doing the Best You Can with What You Have

The mantra in the developing world is: "Doing the best you can with what you have." This does not mean delivering sub-standard care. This is important in a mission like ours where surgery is life-enhancing, not life-saving. We do not ever use expired drugs or disposables and we insist on sterility and infection control practices that are identical to Canadian standards.

This means you examine your practice and decide what you can eliminate without affecting safety or quality. In anesthesia rather than using spinal trays, we add syringes and needles to dressing trays or sometimes

The wrong way to carry a child.

The right way to carry a child.

use our glove wrappers as a sterile surface. Disposable supplies such as paper drapes or trays that would ordinarily be thrown away can be re-used as clean, non-sterile equipment and we think hard before we throw away anything. Before opening any disposable supplies or drawing up drugs, we have to think whether we really need them. We often hear our OR nurses talk of MacGyver-ing equipment which means modifying a piece of equipment to serve a different purpose.

This principle extends to patient assessment. Patients in Ecuador pay for their lab work. As we are only there for a week, if we delay surgery, it means the patient will have their surgery next year. There are no internal medicine or cardiology consults. As anesthesiologists we have to balance this against the risk of preventable medical complications of surgery. This means dusting off ones clinical examination skills and your clinical judgement. This means hard discussions, and hard decisions. All of this based on your examination skills and the patient's history you got through an interpreter.

Many of the patients have robust hemoglobins due to the altitude, but they will not tolerate lower hemoglobins at the 2,500 metre altitude at Cuenca and some live at higher altitudes. For a patient to have a blood transfusion in Ecuador, the family has to donate blood *(this is not a direct donation, it goes into the donor pool)* and pay $50.

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Pre-assessment clinic is an overwhelming experience. Every year we arrive to hundreds of patients or their extended families crowding the entrance and spilling out into the street.

We previously had a transfusion rate of about 25%; with the routine use of tranexamic acid, we now seldom transfuse primary TJA. This opens a quandary where family members may ask that blood be transfused anyway because they paid for it. We are considering whether we should not cross match primary joints; this would depend on how quickly we would be able to get blood in an emergency. Blood when used is often whole blood.

Our average length of stay is 1.1 days. Patients are mobilized early and aggressively. Good pain control is necessary. We have over the years devised a cocktail of NSAIDs, gabapentin, dexamethasone and tramadol which is effective without much nausea or sedation. We started using tramadol 3 years ago when CR Oxycodone became unavailable. To our surprise we found it more effective than the oxycodone. Injectable narcotics are rarely used.

The line up outside our clinic.

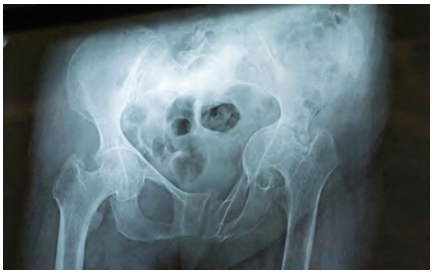
Saying No or Not Yet

Pre-assessment clinic is an overwhelming experience. Every year we arrive to hundreds of patients or their extended families crowding the entrance and spilling out into the street. These patients come from Cuenca, the mountains around Cuenca, the coast or the headwaters of the Amazon. We have had patients from Peru and Columbia.

Most years we are not able to do more than 40 cases. This means prioritizing patients who will benefit the most from surgery that year. Some people aren't bad enough yet or worse some patients' overall condition is too advanced to benefit from the surgery. While most of the patients are younger and in better physical condition than the TJA population in Canada, there are a small number of patients too sick for surgery in this environment.

It is sad to tell patients they must wait for another year or that they will not be getting their surgery at all.

While we bring down an excess of joint prostheses, at the end of the week, the decision as to who to operate on often depends on what equipment is left over.Having to prioritize patients according to finite resources is not something we have to knowingly do in Canada.



An X-ray of typical hip dysplasia.

Being Guests

We just drop in for 1-2 weeks. 50 weeks of the year we are not there.

The hospitals where we work are active hospitals that are trying to go about their own work, with 30 or so strangers now in their midst. For the most part our group is not fluent enough in Spanish to communicate in a medical context. While the locals' English is usually better than our Spanish, communication is mostly through interpreters. Communication is not just translating word for word. It is important to also understand cultural differences and to always be respectful of our hosts.

We also have to ensure that our patients get the necessary after-care from what is major surgery. We are fortunate to have Dr. Manuel Avila on the ground to look after our patients after we fly home.

Team Work

A medical mission is only as strong as its weakest member. We come down with various skills and experiences. We are accustomed to working in our own silos. You quickly learn that every role is equally important in its own way. Personally, I soon learned how important the work of the ward nurses and the physiotherapists are to the overall success of the mission. Things like transporting patients and cleaning the instruments are hugely important.

There is a shifting of roles during the mission. As an anesthesiologist I might assist on cases (while somebody else does the anesthetic), and sometimes help move patients. There are lots of examples during the mission of people working outside their formal role.

The importance of the team is reinforced in team meetings prior the mission. Most of the team stay in the same hotel and eat breakfast and supper together. I often wonder how much more efficiently things would work in Canada if our teams were that close.

Working in a developing country is both challenging and rewarding. Many of the skills acquired by necessity have applications in everyday "first world" practice

Dr. Brian Knight

Dr. Knight is an Edmonton based anaesthesiologist. He has travelled to Ecuador with Operation Esperanza for 11 consecutive years. He likes to ride his bicycle slowly and plays the saxophone badly. He lives with his wife Mary (who has come on 8 consecutive missions) and their dog Freyja.


Dr. Robin Cox and patient.

Helping Kids in Vietnam

Dr. Robin Cox

I have been privileged to provide anesthesia in developing countries since 2009. I thought that moving to Canada from the UK thirty years ago was a cultural change, having to learn about "double-doubles" and "toques", but working in amazing countries such as Vietnam and Peru has been a real eye-opener. I am primarily associated with ReSurge International (formerly called Interplast), who are based in Sunnyvale, California, in the bay area. Interplast was founded in 1969, and was the first such organization providing free reconstructive surgery around the world. To date, this group has provided more than 100,000 surgeries in countless countries. On a very positive note, some 80% of surgeries are now carried out by surgeons from the developing world with oversight from ReSurge. Teaching a man — or woman — to fish can work! Through the Visiting Educator Program, ReSurge sends expert volunteer medical professional teams all over the world to provide direct, hands-on training and support to local health care providers already doing this work.

There are still some locations, however, where it is necessary to send the whole surgical team to meet the needs of the local population, and it is on these surgical team trips, mainly to Vietnam, that I have been involved. Vietnam's population is very young, and they love children, so there are many babies being born, some with congenital defects such as cleft lip and palate, ptosis, syndactyly, microtia, and giant hairy nevi. As well, there are many unfortunate victims of burns of one sort or another, leading to significant functional disability. ReSurge cares for all such patients needing reconstructive surgery and do not focus on one diagnosis, such as cleft lip. Most of the patients are children, but we treat adults as well. Not very big adults typically in Vietnam! An average team trip treats about 60-70 patients over a two week period.

What is it like to be on one of these surgical team trips? Well, the preparation is very thorough. Nearly all the required equipment travels with the team out of San Francisco. The team consists of veteran members, together with some newer recruits in the mix. The typical team consists of two plastic surgeons, three anesthesiologists, a pediatrician, four nurses, and translators and logistics personnel as required. Without exception, I have found the individuals volunteering on these trips to be skilled, caring, and great team players; many have ended up being close friends. Local contacts in Vietnam are absolutely crucial to ensure the success of the mission, and to select appropriate patients to be treated. There are always local and national politics involved with all such missions, and tact and diplomacy are essential.

The typical trip consists of a clinic day on the first Monday when patients are screened, while we set up the operating room and recovery room. All potential patients are evaluated by a surgeon, pediatrician and anesthesiologist. Safety is crucial, so very high-risk patients are sadly not accommodated. Four days of surgery follows and four the next week. We generally have two tables running in one operating room. Days can be long, sometimes stretching into the evening, so the weekend break in the middle is a welcome change. Some memorable moments for me have included successfully treating a very large cleft lip on a six year old, who had been refused surgery on multiple occasions previously due to his mild cerebral palsy; a father of a child with a cleft lip not recognizing his baby postoperatively as she now appeared so beautiful to the grateful Dad; and, on a more unusual note, having to "deal with" a large poisonous pit viper who decided to join us in the operating room. FYI — reptiles can often be anesthetized through their skin using liquid isoflurane!

On reflection, there are multiple reasons why I value my work with ReSurge. The obvious one is the satisfaction of seeing reconstructive surgical results that the patient and family can also see immediately. As well, I have been able to become involved with the administration of ReSurge, and have had input into their processes, as a member of their anesthesia and quality improvement committees. Even on the academic side, my work with ReSurge has led me to write a paper, a book chapter, and a PowerPoint lecture for use in developing countries. The team members I travel with have taught me so much — where else would I get the opportunity to work side-by-side for two weeks with one of North America's giants in pediatric anesthesia? And finally, on my return, I get to appreciate our excellent public health care system in Canada, and the resources and facilities that we are lucky to have.

For these, and many other reasons, I plan on continuing my work with ReSurge or similar organizations for the foreseeable future. As a bonus I get to appreciate other cultures and escape the winter cold for a couple of weeks! For more information about their work, please refer to the website of ReSurge International: www.resurge.org

Dr. Robin Cox
Pediatric Anesthesiologist, Alberta Children's Hospital
Calgary, Alberta

Snapshots on the Wall

By Adrienne Wanhill

Adrienne Wanhill

When I step into the Carnat Centre, my first impression is of a typical clinical waiting room. There are two people sitting in chairs in a waiting area and a very busy woman at reception. I check in for my appointment with Jackie Rees, Case Manager/Intake Coordinator, much like I would if I were at my doctor's office. I'm early and take a moment to look at the photos lining the walls.

Here is where my initial impression starts to change. The photos look like family snap-shots. Mementos of places and people and times to be remembered. There are a lot of them. I notice the two people in the waiting room are chatting loudly and obviously know each other. A few more people trickle in and none of them are strangers to each other. The noise level is a little higher than I expected. Not the background elevator music of a clinic, but the hum of activity and familiarity. When Jackie steps into the room, she smiles at me, but first stops and chats with a few of the clients of the Carnat Centre. She admires a bracelet of a middle-aged women and remarks on the brilliance of a young man's yellow hoody. There are more smiles and talking and it is clear to me this is a place where people feel comfortable and safe.

The Carnat Centre provides truly multi-disciplinary health care to treatment-resistant patients with schizophrenia and schizoaffective disorder. There is a team of psychiatrists, a psychologist, and a family physician. The RNs, occupational and recreational therapists, and social workers all do double duty as case managers. There is also an independent living skills assistant, a psychometrist and a newly funded position of Peer Support Worker. What makes the Carnat Centre unique is the rehabilitation component of the care provided, which supports clients beyond just the medical aspects of living with a mental illness, and encourages individuals to reach their highest level of functioning.

The centre is open from 8:00am-4:00pm Monday to Friday and a variety of group programs are offered throughout each day. Activities include creative outlets such as arts and wood working, a focus on healthy living such as nutrition, wellness and stress management groups, and there are practical skills training and development opportunities such as cooking, computer use, and regular project groups such as preparing the nearly 2000 hardcopies of Vital Signs for mailing on a monthly basis to zone medical staff association members! Apparently this particular activity is a popular one. The clients sit at large tables covered with envelopes, labels and glossy magazines, and the music gets turned up. I brought with me today a small stack of $20 gift cards for Sunridge Mall to be distributed to the clients. We do this a few times a year — a small thank you — and the clients think getting 'paid' as part of a program is a pretty good deal. There are also therapeutic programs offered to help clients live with their illness — support groups for developing interpersonal skills, understanding medication, cognitive behaviour skills training, and addictions. One of the major side-effects of antipsychotics in weight gain, so many of the programs at Carnat are physical, such as playing sports, daily walking groups, swimming, and summer trips that include fishing, golf and hiking.

I'm given a tour of the centre and I get the feeling of being on a college campus with the combination of activity rooms and offices. The walls of the arts and crafts room are covered in brightly coloured pieces of artwork. Paints and supplies and books are organized neatly. The woodworking shop smells of wood-shavings and there are all sorts of projects on the go, such as bird-houses and decorative shelves. There is a computer room with a number of monitors all lit up, and many of the small meeting rooms come complete with the previous session's notes on the whiteboards. There is a large and bright community kitchen and someone is already prepping food for the day. In the lounge is a TV, some games tables and plenty of comfy seating. There are a number of people in the lounge as it's still early and the programs are just starting up for the day.

Patients come to the Carnat Centre voluntarily through physician referral. These clients range in age from 18-65 and the spectrum of their mental illness varies person-to-person. With schizophrenia and schizoaffective disorder, prognosis depends on the phase of the illness and is affected by the timing of intervention and supports *(early versus late diagnosis),* and if the illness is brought on by trauma, is drug-induced, influenced by genetic traits, or some combination. The goal is always early intervention. There is no single medication to treat schizophrenia and schizoaffective disorder. The treatment is as individual as the people affected by the illness, so it takes time to find the correct combination of psychotropics to stabilize a patient. Getting the right medical intervention and support at the right time, goes a long way to managing the impact the illness has on a

patient's health and quality of life. For most patient's schizophrenia and schizoaffective disorder is a chronic illness — much like diabetes or multiple sclerosis — management is maintained through medical compliance and ensuring the dose remains affective as the illness progresses throughout a person's life.

Early intervention requires someone to notice something is wrong. Behaviors change, routines shift, physical appearance is altered. In a place as unique as Carnat, where the skilled staff has daily interaction with the clients, and each client has a case manager who meets with them regularly, subtle changes of speech and perceptions, dress and behavior are all noticed. A relationship of trust exists between the staff and the clients, which means when a member of the team tell them there is something wrong, the client trusts that the recommended dose of medication is necessary, or a trip to the hospital is for their own health and well-being. This level of trust is imperative to managing their illness, a trust that for many of these clients is not easily earned outside the walls of Carnat.

Due to the treatment-resistant nature of their illness, many of the clients at Carnat are treated with Clozapine, which requires administration by a physician or specially-licensed pharmacist. The severity of the side-effects also requires stringent, on-going monitoring. Carnat provides a regular drop-in clinic for clients, to receive the necessary blood tests and health check. The flexibility of a drop-in clinic helps ease the burden of illness to the patient, while providing consistency, structure and opportunity to engage with the health care team.

When I'm introduced to Halina Bower, who manages Carnat among other services at this AHS facility, I'm also introduced to many benefits of Carnat's model of care. Everyone who works at Carnat recognizes each client as an individual. There is no one solution that fits all. Care at Carnat is about meeting the client just where there are, and appropriate care is interpreted by a health care team. The strong therapeutic relationship between staff and client is hugely beneficial for a vulnerable population whose backgrounds are often fraught with trauma, addiction, and a lack of social and family supports. The rehabilitation programs at Carnat give structure to the clients who need it, a sense of community and belonging to many who haven't experienced this before. Everyone gets the opportunity to be the best version of themselves through learning new skills, exploring activities, taking an exercise class or playing sports, enjoying a board game and creating meaningful connections.

Recently Carnat added a Peer Support Worker to their staff. This new, non-clinical role is grant-funded and there are only a few such positions in Calgary. The Peer Support Workers bring with them a lived-experience of dealing with mental illness. The inclusion of this position at Carnat has been welcomed by the clients. Here is someone who speaks their language and knows from first-hand experience what it's like to live with mental illness. The Peer works beside the clients, in group settings and one-on-one, to provide courage and company if a client is afraid to attend a group for the first time, offer positive relatable experiences when clients are in need of encouragement, and provide a sense of hope. The good news is the funding for this position has been extended to March 2018.

The Carnat Centre is truly patient-centred and provides a community to a population of patients who face a life-long battle with their illness. The goal of each day is to support the clients where they are at in any given moment. Both the multi-disciplinary team and the rehabilitation programs encourage autonomy and independence for the clients, while continuing to support them as they manage their illness throughout their life. People are seen for who they are and care is provided accordingly. Change occurs, challenges faced, but everyone adapts. Together.

Adrienne Wanhill
Coordinator, Zone Medical Staff Associations (ZMSA) and Vital Signs magazine.

The author would like to thank the Carnat Centre team and Dr. Arlie Fawcett for their time and contribution to this article.

INCLUSIVE HEALTH:
An Intervention To Address LGBTQ Health And Medical Education Deficits

Dr. Jordan Iannuzzi


Dr. Jordan Iannuzzi

Physicians are responsible for the health of all patients, but medical students unfortunately receive inadequate formal training on the healthcare needs of LGBTQ (Lesbian, Gay, Bisexual, Transgender and Queer) patients (Obedin-Maliver, 2011). Education about cultural issues and terminology are known to be critical, and are consistently under-addressed. Healthcare practices that fail to demonstrate inclusivity, risk alienating sexual and gender minority patients and perpetuating existing barriers to care for this underserved population.

In response to the lack of LGBTQ-specific curriculum at our own institution, a small group of medical students at the University of Alberta developed a platform to share best practices in LGBTQ health. The Sexuality and Gender Advocacy group (SGA) is a student created and student lead initiative designed to create a safe inclusive space to support medical students and residents who identify as LGBTQ or as allies. We have been able to work with faculty to address deficits in the U of A medical school curriculum, raise funds for charitable causes, and organize events to raise awareness of pertinent social issues. This organization is comprised of medical students from all levels of training, but we are actively recruiting students from allied

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Our goal is to have an annual conference that educates attendees on the psychosocial and medical issues facing sexual and gender minorities.

health disciplines to create a more inter-disciplinary group. We plan to work and continue to grow our initiative in the hopes of potentiating real change in the healthcare field, translating to better patient care.

In 2014 SGA organized the Inclusive Health Conference. This began as a grassroots, medical student organized primer targeted towards the deficits in our curriculum. Over the last four years our scope has expanded to include an audience of residents, physicians, allied health professionals, and interested community members.

Our goal is to have an annual conference that educates attendees on the psychosocial and medical issues facing sexual and gender minorities. As part of this program we invited multi-disciplinary experts to speak on topics including clinical / social terminology, disorders of sexual development, HIV pre-exposure prophylaxis, care of trans patients, and how to develop an inclusive medical practice. Self-identified sexual minority patients, and healthcare professionals, also contribute to panel discussions on their experiences in the healthcare system and across generations.

Our most recent keynote speaker was Dr. Marci Bowers, an exceptional surgeon from San Francisco who is currently at the forefront of Sex Reassignment Surgery (SRS). She not only shared her experience moving from a practicing Obstetrician-Gynecologist to full-time SRS surgeon, but her own experience as a trans woman in the medical system.

Healthcare professionals and students were asked to complete a post-conference survey on their knowledge and comfort with LGBTQ care. A vast majority of respondents stated that they "better understand LGBTQ health issues", "better understand social issues related to LGBTQ healthcare" and "feel more comfortable exploring and discussing these issues with LGBTQ people".

The qualitative data from each year of the conference was collected and presented at the Canadian Conference of Medical Education (CCME) and the Canadian Professional Association of Transgender Health (CPATH).

The SGA have received significant Faculty and University attention and support. It has earned long-term financial sponsorship from the University of Alberta's Faculty of Medicine and Dentistry and initiated formal curriculum changes. Our organizing committee also received the Community Connection Award from the University of Alberta for translating evidence into meaningful change for the community.

This initiative has led to similar conferences at other medical schools and is attracting extensive media attention in the local community. This success speaks to the power of a student led initiative that re-dressed an essential omission in their medical curriculum, found a way to engage the LGBTQ and healthcare community, and closed critical gaps in knowledge to optimize care for the underserved LGBTQ community.

We are currently working on Inclusive Health 2018, our 5th year of the conference. As we are currently securing a date and keynote speaker in the next couple of months, feel free to contact or follow us via sga@ualberta.ca and https://inclusivehealthconference.com/ for more updates. We hope that this initiative will continue to grow and reach a greater number of health professionals in the future so as to better serve all Albertan's.

The Inclusive Health planning committee members are all members of the SGA, made up of medical students in all levels of training. We also have the good fortune of having Ms. Stephanie Booth on our team (mid-person, third row down). With a Masters of Public Health she is involved in every facet of the conference organization and we couldn't run without her. The woman in the first row is Dr. Marci Bowers, our most recent Keynote speaker.

These are the members of the 2016-2017 Inclusive Health Conference planning committee while receiving a Community Connections award from the University of Alberta. Dr. David Turpin, president of the University of Alberta (left), and Mr. Don Iveson, Mayor of Edmonton (right).

Dr. Jordan Iannuzzi
Jordan Iannuzzi is a graduate from the University of Calgary where he received his Bachelor of Science degree with honors, majoring in Zoology. He has recently completed medical school at the University of Alberta, and will be returning to Calgary to start his residency in Internal Medicine for the 2017-2018 year. He was an executive member of the SGA initiative for four years, and has been a co-author on research which has been presented at both the Canadian Conference of Medical Education (CCME) and the Canadian Professional Association of Transgender Health (CPATH).

REFERENCE:

Obedin-Maliver, J. (2011). Lesbian, Gay, Bisexual and Transgender-Related Content in Undergraduate Medical Education. *Journal of the American Medical Association*, 306(9), 971-977.

Awash in the Tsunami of Chronic Disease

Dr. Brian M. Cornelson


Dr. Brian M. Cornelson

Five years ago, Alberta Health Services (AHS) established three pilot comprehensive Family Care Clinics (FCC), one each in East Calgary and East Edmonton in response to a perceived lack of family physician availability, and one in Slave Lake in response to devastation of existing facilities by fire. AHS envisioned a network of over 100 similar clinics throughout the province that would provide convenient and efficient primary care services under one roof. The plan was controversial, and ultimately abandoned after a change in provincial leadership along with an increase in the availability of family physicians in Calgary and Edmonton. Nonetheless, the three original clinics continue to operate. Slave Lake and East Edmonton FCCs also incorporate urgent care services, and East Calgary focuses on complex patients who have multiple medical, mental and psychosocial issues.

Every primary care provider is awash in the tsunami of increasing incidence of chronic disease. The leading edge of the baby boomer generation is now in its 60s, and its numbers are growing. Many of the diseases that used to kill patients have now become chronic, with greater need for monitoring and adjustment of treatment. Furthermore, as patients age they become more likely to develop other chronic conditions that only complicate their care.

East Calgary FCC includes family physicians, primary care nurse practitioners, chronic disease management nurses, psychologists, social workers, physiotherapists, dietitians and a pharmacist. General internists provide onsite clinics two or three times a month. Patients who have had six or more emergency visits or two or more hospitalizations in the past year are assigned a case manager who ensures that internal and external contacts and referrals are coordinated. Staff participate in biweekly complex care rounds to share challenges and solutions in addressing the many unique problems with which patients present. Staff have developed pathways for conditions like diabetes and chronic pain to ensure optimal and efficient care.

Most primary care providers find it extremely challenging to provide the sort of wrap-around health care service that their complex patients require. What provider has the time and resources to access and coordinate the myriad services these patients offer require? Patients find it difficult or overwhelming to travel to the different sites of their referrals and treatments, sometimes giving up in frustration or exhaustion. Would not most providers and most patients prefer their care to be consolidated?

Providing comprehensive coordinated care is more expensive than standard care, but is it really, in the long run? Patients with case managers at East Calgary FCC have markedly reduced rates of utilization of emergency services.

Providing care in a clinic focused on complex patients is good for providers. Many family physicians in usual settings experience a feeling of dread when the name of a complex patient shows up on the appointment list. At East Calgary, complex is the norm, appointments are longer, time for patient administrative tasks is built into the schedule, and most other health care providers are on site for informal consultation or complex case rounds. Just as some family physicians focus on mental health, care for the elderly, sports medicine, low-risk obstetrics or other areas of expertise, physicians in complex care settings develop knowledge and expertise that makes their work less challenging and more rewarding, efficient and effective.

Comprehensive coordinated care is not needed by most patients, who can be managed quite well in traditional offices and clinics. However, when we consider that 5% of the population consumes 66% of Alberta's health care budget, doesn't it make sense to provide comprehensive care in the community rather than have patients ending up in emergency departments, often resulting in hospital admission, for unmet needs? Emergency departments and hospitals are the most expensive and inappropriate places to be addressing the chronic complex needs of patients, and the lack of a coordinated system to meet their needs often results in a revolving door approach to health care, with provider frustration and poor outcomes for patients.

Should a comprehensive primary care service be provided by AHS, or should it be provided by PCNs? That's primarily a political decision, to be made by people a few pay grades above mine. It would seem to make sense to have comprehensive care provided within a network of other primary care services that would make it easier or even seamless (buzzword du jour) for patients to transition to or from comprehensive care clinics as their needs evolve, all the while keeping them out of emergency departments or hospital beds.

As a provider and medical director of East Calgary FCC, I think the concept of a comprehensive coordinated approach to people with complex health conditions is easier, more efficient and more effective for both patients and providers, resulting in improved care at lower cost. These services should become an integral part of primary care throughout the province.

Brian M. Cornelson, MD, CCFP
Medical Director, East Calgary Family Care Clinic, Clinical Professor, Department of Family Medicine, University of Calgary

Outside the Box


Dr. Richard Bergstrom

I am a physician, an anesthesiologist; I work in complex cardiac care at a quaternary health care institution, thus I am constantly surrounded by the assistance of equipment to provide care for the complex patient. I work "inside this box". There are expectations with respect to drugs, equipment, supplies and assistance in my provision of care. It is pretty staggering for the medical student to come in and be surrounded by screens of information, transesophaageal images *(especially 3D images)*, the cardiopulmonary bypass pump, all the vasoactive drugs and the fact that the heart stops with no blood pressure as we know it. It is both surreal and impressive. This is what I do and that is where I am comfortable.

The former paragraph sets the scene for me trashing all of what I just said. Just a minute, Bergstrom. Why trash it? Well, to challenge our own viewpoint of where "care" can occur. Health care needs to evolve. The evolution will not just be about improving our own environment of care *(that should happen)*, but to realize that care can happen in other environments. It might not have all the bells and whistles, yet care still happens.

Now, I challenge myself and others to define the word "care". I ask if "care" is what we do "to" people or what we do "for and with" them. I ask you to read Michael Porter from Harvard Business Review. He is a health care economist with a fair bit of credibility. He speaks to the focus of "what is the value for patients"? We are moving from a world where the physician arbitrarily decides. We have moved from prescribed care to advised care.

So, will I be providing cardiac anesthesia on a kitchen table… with the first anesthetics? No. This is both ludicrous and wrong. Wrong because of the increased risk for the patient. Well, actually the fact that the patient would die, period.

Yet, the medicine does evolve and so it should. It also moves into uncharted territories; both within our concept of western medicine and areas where twenty years ago you would never have thought that a certain level of care could or would occur.

Let me give some examples. The easiest one is where first world physicians and their teams provide care for people in worse than third world conditions. These individuals volunteer their time and efforts *(often during their "holiday" time)* to provide true, undeniable care to the fringes of our world. Surgical operations where the lame, crippled, destitute obtain interventions that allow them to walk, work and eat. Some patients get the first opportunity to live what is as close to normal a life as they could imagine.

An acquaintance of mine went to Uganda for a month as he wanted to have a greater experience in anesthesia delivery. He came back a changed individual. In Uganda, he knew every day he would run out of oxygen and electricity. He had almost no monitors, just a handful *(and a small one at that)* of drugs which came from any source possible. He was humbled by the ability the physicians who work there to do so much with so little. Mostly, he was humbled by the humanity and humility and pragmatism of the patients he served. He had to stretch himself and journey into arenas where he had never placed even a toe, but it was needed else someone was going to die. It was life and death, simple as that.

Now, I also think that we have these changes within western medicine. Complacency is easy; it is so easy to just "do things like they have been done before". Yet, does this provide value to patients? Some value but not "value added".

I have been at this business a long time, in fact, over thirty years. It is long for me, but it is a blink in the true journey of time. I believe you need to know history, as it tells you from whence you came. It gives a sense of trajectory. What we do now, and how we do it, would be thought not only ludicrous but probably dangerous from the aspect of care fifty years ago. Even thirty. Laparoscopic surgery, day surgery, outpatient hip arthroplasties, remote monitoring of devices, patients reviewing their own results. Crazy talk twenty years ago, frankly dangerous!

These care paradigms are new, uncharted territory. They do make you uncomfortable as they take you out of your current arena. In Europe, people have been asked to drink fluids liberally pre-surgery. Surely crazy talk! In some hospitals intravenous fluids are almost unseen in many post-surgical patients. You are out of your bed most of the day. You are eating in recovery room! This must be insanity I behold. Well, not quite. It is better for patients, the measures of recovery show this is better care. We need to embrace this as challenging as it might be for us. The difficulty, in my mind, is summed up in the words "challenge" and "change".

Health care is not about "us" as physicians. Nor it is about "health care organizations". It is about "care" and "compassion". It is about patients.

Should we remain comfortable in our own first world environments and not see the bigger picture, we diminish our role as physicians. For we have been asked by patients to be the ones who lead care. We can always sit back and enjoy the ride but then we do not serve the greater good that is health care of tomorrow. We can learn from austere environments. We can learn from hardship. Some good, some bad.

As a physician, I have had the privilege of providing care. It can seem commonplace to do this as it is a day-to-day event for me. Yet, it is not a day-to-day event for so many patients. Care needs to be our mantra; care needs to grow into uncharted territories. Both outside our first world nations and also within. Care matters.

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


LARGER
70 CM WIDE-BORE
FASTER
UP TO 50% SCAN TIME REDUCTION
STRONGER
3 TESLA MAGNET
QUIETER
UP TO 99% SOUND REDUCTION
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The QI Grants

EDMONTON ZONE'S NOVEL INVESTMENT

Dr. Shelley Duggan

Dr. Shelley Duggan

The Edmonton Zone Medical Staff association (EZMSA) launched a QI Grant competition in the fall of 2016.

The Zone invited physicians and residents to apply with projects addressing enhanced communication between general practitioners and specialists or ones that addressed the needs of vulnerable populations in the Edmonton Zone. This project was the first time the Edmonton Zone Medical Staff Association pledged resources for a large scale endeavour that could enhance patient care.

The EZMSA is the formal voice of advocacy for practitioners in the Edmonton Zone. The members include medical staff of hospitals, continuing care facilities, PCN and Non-PCN based community physicians, community-based specialists, dentists and oral surgeons, clinical scientists and podiatrists. The organization offers an opportunity for meaningful engagement and a strong unified voice. With the significant surplus of funds, without hesitancy, the EZMSA chose to sponsor a QI grant competition in the Zone. It was a way to improve patient care and enhance practice environments. It was a way for our members to give back and demonstrate the importance of our involvement in achieving sustainable health care.

"Comprehending the very idea that the EZMSA had an opportunity to support physicians in improving the quality of care of patients was very appealing from the get go. It is highly desirable that an association of physicians be able to support fellow practitioners in their primary duty of patient care." – Dr. Jasneet Parmar

Conventional research projects are often long-term undertakings and typically require much time, funding and training. QI projects are different, in that a small change is applied and then studied to see if improvement has occurred. These projects can be done by "front line" care givers and often improve patient care and/or access. They also help energize teams and foster engagement. The steering committee determined 2 areas of focus — helping vulnerable populations (mental illness, addictions, homebound seniors, etc) and enhancing communication between medical groups (hospitalists, specialists, family physicians).

"We have a social responsibility to advocate for vulnerable populations and the focus could not have been more appropriate and timely. I am thrilled the Zone could effectively accomplish this and excited to see some wonderful outcomes." – Dr. Shelley Duggan

Under the leadership of co-chairs Dr. Shelley Duggan and Dr. Jasneet Parmar *(past EZMSA Presidents),* the process for advertising to the medical community as well as developing an application package was completed.

The inaugural launch in October (2016) drew response from approximately 100 attendees, some with no previous experience in research or QI projects. The forum allowed for communication with peers and experts in the area of quality improvement and hopefully inspired many to consider applying for a grant.

We received many applications from diverse practice settings including hospitals, PCNs, specialty clinics, dental offices and University based projects. A grants review committee composed of specialists, family physicians and healthcare quality experts was appointed to assist with the selection process. Successful projects were selected based on quality indicators in healthcare including acceptability, accessibility, appropriateness, effectiveness, efficiency, safety, and stewardship in healthcare. These indicators in addition to focus alignment, viable execution plan and potential for a greater impact on medical practice and patient wellbeing were central to the selection process.

Dr. Dawn Hartfield – Medical Director Quality, Integrated Quality Management Edmonton Zone

Dr. Verna Yiu – President and CEO of AHS at the launch event

After adjudication, 11 projects were identified to receive a combined funding total of just over $300,000. These projects are now underway and we anticipate results towards the end of 2017.

With technological advancements in medicine, policy choices and changing demographics, patient care dynamics will continue to evolve calling for practitioners to adapt and improvise care delivery processes. We hope funding opportunities like this continue to motivate our physicians in affecting significant changes in best practices. The EZMSA is committed to the success of the projects it sponsors and will continue to support its medical community in the future.

"Amidst recent concerns from the Auditor General's office of the healthcare system not emphasizing enough on quality, the QI grants undertaking by the EZMSA and its physicians have shown their commitment to providing quality care to our patients and fostering good healthcare stewardship.

I thank all grant applicants for their interest, congratulate the EZMSA working group and extend gratitude to The Network of Excellence – Covenant Health for their patronage." – Dr. Randy Naiker (President)

Dr. Shelley Duggan
Past President Edmonton Zone Medical Staff Association, Clinical Professor, Division of Nephrology and Transplant Immunology, Department of Medicine, University of Alberta

Support Groups

1. EZ Integrated Quality Management (IQM)
2. AHS Knowledge Resource Service
3. AHA Accreditation Quality & Healthcare Improvement
4. AHS Patient Safety Learning & Improvement
5. Process Improvement
6. Quality & Patient Safety Education & Provincial Simulation
7. Clinical Quality Metrics

Summary

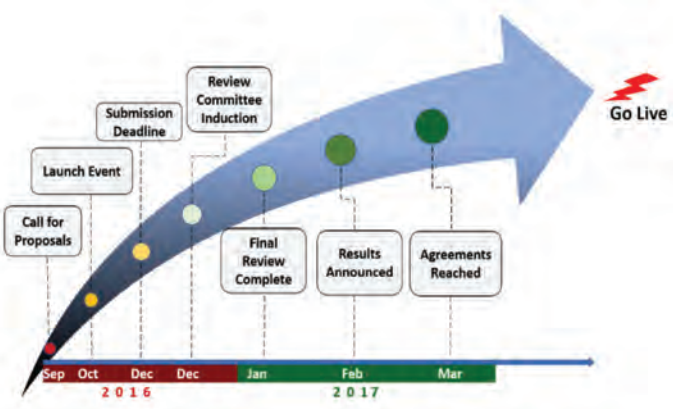
- Applications received – 27
- Grants Funded – 11

* Total Grants Commitment (2017) – $306,000

Project Tracking

- Agreement bound
- Funds dispensed out in 3 phases
- Subect to display of satisfactory progess
- A mid project report and final report is required

TIMELINES



List of Successful Applicants

PROJECT TITLE	LEAD APPLICANT
1. Interdisciplinary care of shoulder injuries: Improving access, quality of care for patients with prolonged shoulder pain	Dr. Terry DeFreitas
2. Reconnecting rural palliative patients	Dr. Dinesh Witharana
3. Optimization of hospital- primary care continuity for an inner-city patient population	Dr. Ginetta Salvalaggio
4. University of Alberta hospital general internal medicine-5D2. Inappropriate laboratory ordering	Dr. Narmin Kassam
5. Improving medication management for seniors living with frailty in the community – quality improvement project in collaboration with the Edmonton Oliver primary care network	Dr. Sheny Khera
6. Addiction and substance abuse program for students at the University of Alberta	Dr. Jennifer Walker
7. Closing the loop – enhancing communication between intensive care physicians and general practitioners for improved patient care following critical illness	Dr. Oleksa Rewa
8. Access partnership project	Dr. Narmin Kassam
9. The use of team engagement and the development of clinical algorithms to improve nutritional outcomes for paediatric patients with cystic fibrosis at the Stollery children's hospital	Dr. Tamizan Kherani
10. Improving quality of oral and dental health for head and neck cancer patients	Dr. Suresh Nayar
11. Changing profile and reasons for early drop out of patients attending the opioid dependency program (ODP) in Edmonton	Dr. Roshan Hegde

The Performing Arts in Calgary Are in Jeopardy:

Why I Care

Dr. Máire A. Duggan

Dr. Máire A. Duggan

The performing arts consist of drama, music, or dance performed for an audience. Calgary has a rich and diverse performing arts scene. Some performing arts groups are part of the cities "Cornerstone Companies" housed in the "Arts Commons" and other buildings close to city hall in the downtown core. They include *Alberta Theatre Projects, Theatre Calgary, Theatre Junction, One Yellow Rabbit, Calgary Philharmonic Orchestra, Alberta Ballet, Calgary Opera, National Music Centre, Calgary Folk Festival* and *Glenbow Museum*. The scene includes other professional companies such as *Vertigo Theatre*, smaller professional companies like *Downstage Theatre*, and many community groups which perform in a variety of venues. The professional organizations are funded by grants, donations, and tickets sales with grants contributing about 20% of the annual budget and the other 2 sources about 40% each.

In March 2014, Calgary Arts Development (CADA) launched "Living a Creative Life: an arts development strategy for Calgary". This project provided a fuller understanding of how citizens experienced creativity and arts in their lives. Approximately 1,000 Calgarians were surveyed to determine their participation in **1.) Media consumption** *(watching TV, downloading music, reading magazines, etc.),* **2.) Attendance** *(visiting galleries, attending performances, etc.),* and **3.) Creation** *(photography, sketching, playing music, etc.).* The survey concluded in September 2015 and the analysis showed an 87% participation rate. Up to 48% of respondents reported at least one type of media-based arts engagement, 70% reported attending some type of arts activity or event, and 59% engaged by creating art. They attended a broad range of arts activities throughout the year and notably 47% attended live theatre performances. These CADA findings runs contrary to the common but out-dated stereotypes associated with Calgary and highlights a community that interacts with the arts to a much greater degree than previously thought.

The CADA research occurred at the beginning of the economic downturn in Calgary and may be more reflective of Calgarians with disposable income and which they chose to allocate to the arts. With the continuation of the downturn into 2017, additional surveying in all probability would show that Calgarians' appetite for the arts remains but is satisfied by lower cost engagement. This probability has now been realized however, and has translated into a harsh reality for the performing arts. Lower ticket sales, lower individual donations, and significantly reduced corporate donations threaten the survival of the performing arts in our city. The ability of many arts groups to continue is jeopardized and some such as Alberta Theatre Projects, a company which has weathered the turbulent economy of Calgary for 45 years have been forced to launch a special fundraising program to ensure their viability beyond the 2017-18 season.

The CADA research tells us Calgarians value the performing arts. They are also of immeasurable value to the status of Calgary as a city. They attract tourists and other businesses to the city, as well as individuals who may wish to relocate and settle here. The performing arts are important to the Cumming School of Medicine since many of Calgary's actors play simulated patients for the students' examinations. The performing arts contribute to a community of feelings, fellowship, trust, and understanding. The Calgary Folk Festival is an example of this experience where music enthusiasts gather in the outdoor venue of Princes Island Park over 3 days and share their enjoyment of live and varied musical performance; regardless of the weather. The performing arts also enhance perception and promote expression, deepen awareness, and nurture fulfillment. The anti-war message of the magnificent "Mother Courage and her Children" is as relevant today as it was in 1939 when written by Bertolt Brecht. The play draws attention to the inanity of sacrificing lives to a war which no side wins while at the same time highlighting the business and profiteering aspects of war. While the process of engaging in the arts varies from person, the tangible benefit is unquestionably positive. They entertain us and provide an opportunity to engage vicariously with the experiences of others, express empathy, experience a range of emotions, and reflect on issues that are timeless. Socialization and mood benefits occur when those who may be isolated e.g., seniors living alone and those who feel unsupported attend live performances. When groups of women with breast cancer stood up and removed their wigs at the end of the play "Wit" by Margaret Edson it was a powerful symbol of their determination to collectively defy the odds of their disease. It would not have been as powerful if it had just been a single woman. The new play "1979" by Michael Healey used the failed 1979 federal budget of Prime Minister Joe Clark to chronicle the comedy of Canadian federal politics and its personalities from that date to the current. Audiences laughed out loud and their discussions as to whether Mr. Clark was a principled fool or a foolish principal continued all the way to the parking lots.

For all of these reasons and many others I believe the performing arts in Calgary must continue and they must also thrive. The performing arts open my mind and touch my emotions. I feel strongly that it is both my duty and responsibility to engage with and to support them since without them, this city would be a dull place to live. My own engagement with the performing arts began at age 4 as a member of the McTaggart School of Irish Dancing in Cork, Ireland where I grew up. The troupe performed at all types of events including the pantomime which was my favorite event. I was enthralled by the spectacle created by the costumes, lights, and sets, and later by the humor and irony of the satirical dialogue and gender role reversals when I was finely old enough to understand that aspect of the pantomime. As time passed, I became more of an attender than a performer and my appetite for different forms of performing arts expanded. I have had the privilege of experiencing a large number of very varied performing arts events enabled by my living in a number of countries and travelling to many others. In Calgary, I attend as many live performing arts events as I can. In addition I have subscribed to and donated to Alberta Theatre Projects since 1985 and am currently a member of their board of directors. It is hard work but I believe in the mission and vision of the company. In the past I was a member of the board of directors of Theatre Junction and was a donor and subscriber to several other arts companies in the city. I look forward to many more years of excellent live performances on the Calgary stages, but unless we collectively care about the performing arts and show that we care, I fear the scene will deteriorate both in quantity and quality.

Máire A. Duggan, MD, FRCPC
Department of Pathology and Laboratory Medicine, Cumming School of Medicine, University of Calgary

The Legacy of the EZMSA Golf Tournament


Dr. Randy Naiker

"It's good sportsmanship not to pick up lost golf balls while they are still rolling" – Mark Twain

What started out as a golf tournament, has created a legacy of Super Senior Physicians,who golf annually in the tournament.

1932 was a busy year, its activities perhaps best exemplified in the Edmonton Academy members' enthusiastic interest in golf. The Academy golf tournament, organized by Drs. Jim Young and Doug Leitch, took place at the Highlands Golf Course. That year the "Brown Cup," to be awarded to the tournament's best golfer, was instituted. It was named after Harold Brown, and eye, ear, nose and throat specialist who had been an active golfer with the Academy for some years.

The Edmonton Academy's golfers played in regular matches with members of Calgary Medical Society as well. The following year would find that these two groups in pursuit of the McEachern Cup, which was named in honour of Dr. I.W.T. McEachern, an Edmonton physician since 1904, and J.S. McEachern, a Calgary physician since 1907 and founder of the Canadian Cancer Society.

Even though the Government is managing to make physicians change their governance and geography, Edmonton Zone Medical Staff Association stands tall in history as a social, governance and educational association for Edmonton and surrounding physicians… brings a tear to one's eye just thinking about it. – current Super Senior Physician

Dr. David Vickar, Radiologist, has been the MC for what is now called the Edmonton Zone Medical Staff Association (EZMSA) Golf Tournament for the past 20 years. The history of the tournament is long and, in the past, many golfers looked forward to the opportunity to "compete", but it may be that golfer's attitudes are evolving, and the tournament now sponsors Residents, Students and Fellows to attend — this gives many the opportunity to mingle with EZMSA, AMA, College, Faculty and other major stakeholders. The golf tournament has been very successful over the past years.

This year participants in the 2017 tournament were: 24 Residents & Fellows, 4 Women Physicians, 6 Seniors, 11 Guests and 35 Physicians.

Dr. Randy Naiker
President EZMSA

GOLF RESULTS

Thursday June 1, 2017

Men Low Gross	**Dr. Dwaine Larose**
Men Low Net	**Dr. Gordon Johnston**
Women Low Gross	**Dr. Nargis Rayani**
Women Low Net	**Dr. Charlene Barnes**
Senior Low Gross	**Dr. David Bond**
Senior Low Net	**Dr. Jim Metcalf**
Labour in Vein	**Dr. Daniel Wong**
Longest Drive Men	**Mitch Wilson**
Longest Drive Women	**Carol Connick**
Closest to the Pin Men	**Brian Ritchie**
Closest to the Pin Women	**Gail Albrecht**
Longest Putt Women	**Allison Jerome**
Longest Putt Men	**Florin Manolea**
Resident Low Gross	**Chris Chapman**
Resident Low Net	**Gil Eamer**
Visitor Callaway Low Net	**Tarek Brahim**

SAVE the DATE: Thursday May 31, 2018


Dr. Randy Naiker & Dr. Dwaine Larose


Dr. Randy Naiker, Laurie Wear and Dr. Nargis Rayani

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ALBERTA MEDICAL ASSOCIATION

SAVE THE DATE

The Rockyview General Hospital Medical Staff Association Meeting

Tuesday, September 12, 2017 from 6:00 – 8:00 p.m.
Members' Dinner at 5:30 p.m.

We are delighted to announce our Guest Speaker: Dr. Jeff Way
Topic: War Surgery in Iraq

Dr. Borys Hoshowsky, President, RGH MSA

Dr. Charlene Lyndon

We hope to see you at the Rockyview General Hospital Medical Staff Association Meeting in Fisher Hall, on Tuesday, September 12, 2017 for this presentation and a terrific dinner. Please RSVP to stella.gelfand@ahs.ca by August 28, 2017.

Dr. Borys Hoshowsky, President, Rockyview General Hospital Medical Staff Association
Dr. Charlene Lyndon, President RGH MSA commencing October 2017

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