December 2016

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STAFF ASSOCIATIONS
OF ALBERTA

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

The First Five Years of Practice

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DIAGNOSTICS
COVENTRY HILLS

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BACKGROUND

Mayfair recognized an opportunity to provide patients with a different kind of health care experience. An experience designed with empathy, and shaped after the kind of service today's most service-orientated companies deliver to their customers.

APPROACH

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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

December 2016

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CONTRIBUTING WRITERS
Dr. Sharron L. Spicer
Dr. Linda Mrkonjic
Dr. Kathryn Andrusky
Dr. Rabiya Jalil
Dr. Darren Hudson
Dr. Rafiaa Valji
Fahad Shaikh
Dr. Sara Taylor

MANAGING EDITOR: Hellmut Regehr, hregehr@studiospindrift.com

EDITORIAL ADVISORY COMMITTEE:
Dr. Sharron Spicer – sharron.spicer@albertahealthservices.ca
Adrienne Wanhill – adrienne.wanhill@albertadoctors.org
Hellmut Regehr – hregehr@studiospindrift.com
Dr. Tobias Gelber – tgelber@pinchermedical.ca
Dr. Steven J. Patterson – spatterson@plcgas.net
Dr. Alayne Margaret Farries – amfarries@me.com

Calgary & Area Medical Staff Society (CAMSS)
350, 708-11 Avenue SW, Calgary, Alberta T2R 0E4

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.
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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 December 15, 2016.

CONTRIBUTORS:
The opinions expressed in Vital Signs do not necessarily reflect the opinions or positions of CAMSS or CAMSS executive.

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Save the Dates!

CAMSS

Council Meeting
January 11, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

Council Meeting
February 8, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

CZMSA

Executive Meeting
January 19, 2017 | videoconference

Executive Meeting
February 1, 2017 | videoconference

Annual General Meeting
February 1, 2017 | Location TBD

EZMSA

Executive Meeting
January 19, 2017 | Misericordia – 5:00-5:30 pm

Council Meeting
January 19, 2017 | Misericordia 1N-106 – 5:30-7:30 pm

SZMSA

Council Meeting
January 9, 2017 | Location TBD & tele/videoconference – 5:30 pm

Editor's Note
We always welcome feedback from our readers. Several physicians correctly noted a potential conflict of interest in one of the articles in the November 2016 issue. Dr. Michael Giuffre is on the Board of Directors of Brightsquid, a company referenced in his article (*Secure Mail and e-Consulation*). This commercial interest should have been noted.

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

President's Message:

Advice to (or from) My Younger Self

Dr. Sharron L. Spicer, CAMSS President

"On the sheet of paper that is your life, keep a wide margin around the edges of your writing." This advice from a mentor more than 20 years ago has served me well. Life, as it turns out, happens in the margins. Far from being boring, the margins allow curiosity, joy, and spontaneity in our lives.

Do you, like me, sometimes feel so busy that you can't enjoy the moment because you're busy planning the next — like my colleague who finds yoga stressful because it gives her time to focus on all the things she needs to do?

We all need buffers in our lives, in big things and in small. The advice I would give my younger colleagues would be to create the conditions for resilience. Leave a bit of cash in your office drawer in case you forget your wallet. Keep your gas tank over ¼ full. Be judicious with finances. Nurture your relationships with your partner, family and friends. Find mentors. Storms will come, but it is in the "margins of your page" that you will find meaning and growth.

In reality, it is not our young colleagues who need this advice; Millennials are characterized by being connected, expressing their opinions, collaborating with others, multitasking, and maintaining work-life balance. It's what we in medicine have been encouraging for a long time, but now that Generation Y has emerged, some docs wish things were "like they used to be." I'm confident, though, that this new cadre of young doctors will have the strengths to carry on the profession of medicine in our changing social and economic milieu. Dr. Kathryn Andrusky notes in her article on opportunity cost *(page 4)* that medical treatments have vastly advanced in the past 50 years since the advent of our national health care system, creating new social and economic realities for our healthcare system. Innovation and collaboration need to be part of the skillset that physicians possess, and my recent experiences teaching in the medical school have shown me that current trainees are well-poised for the challenges.

In this issue of Vital Signs, we highlight challenges and accomplishments of physicians in their first five years of practice. Drs. Darren Hudson, Rabiya Jalil and Rafiaa Valji provide advice about the practical elements of starting in practice. Fahad Shaikh gives tips on office leasing. We share with you the young doctors recognized in Avenue Magazine's Top 40 Under 40 in Edmonton and Calgary. Dr. Sarah Taylor provides a sobering reminder that the stresses of physicians, at any career stage, can feel overwhelming and put us — and our colleagues — at risk of burn-out and even suicide. Let's take care of ourselves and one another. I hope that you find this issue practical and informative. As always, your feedback is welcome.

Who Will Be Our House-Staff?

Dr. Linda Mrkonjic

Twenty-six years ago, in 1990 I was an intern at the Royal Columbian Hospital in New Westminster, B.C. The internship year at that time served the purpose of allowing graduated MDs to learn how to be working doctors. The internships also served to provide a work force for the hospital.

It was an intern run hospital, meaning that the interns were the house-staff available to everyone within the hospital and community that needed assistance. Every night 5 out of the 20 interns were on Call and responded to all patient needs within the hospital. We were the hospital's workforce. Shortly after my internship year, the internship concept was eliminated, with the available postgraduate tracks becoming more streamlined towards specialty training. The focus became educational issues and somehow the workforce component fell by the roadside.

Historically, learners have had an apprentice type of role within the healthcare system. There has been an assumption that in order to learn, service must be a component of the learners' role. The assumption 25 years ago was that the historical apprentice role would always provide enough service to the system; service needs were never really discussion points. So, when internships were eliminated, the discussion of

Service needs and service delivery should be our responsibility. We, the medical staff and leaders should know what safe and consistent patient care is required, and we also need to know how to deliver this care.

replacement workforce house-staff never really took place, as it was assumed that learners would always be providing the service.

We have always assumed that service and education go hand in hand. Back then no one predicted that both our learners and educators would transition from a service focus to an education focus. The healthcare system has not proactively responded to the service gaps that are emerging as learner roles change. We now see expanding service gaps and we do not have a coordinated strategy to address these needs.

As an orthopedic surgeon working at a Level I trauma center I was surprised to discover this summer that there does not exist any guidelines anywhere that state I have to have someone on Call with me. The Canadian Orthopedic Association has no position statement on this. We have always just assumed there would be help, so there has not been a focus on developing standards/guidelines and we do not have a long-term house-staff strategy.

The looming transition to competency based residency programs is the next major change that will add another shake-up to the service issue. How much service does a learner need to provide/experience in order to meet their educational goals? I was again surprised to discover that no one can answer this question as this is the key question that needs to be addressed first. The answer will have a significant impact on service delivery and the service gaps I expect will exponentially increase.

Change is scary, but it is less scary, if you are an active participant in the change. With the new agreement between the Alberta Medical Association, the government and AHS, this may be the perfect time that we start thinking about how we will be delivering care going forward. I think that we need to come up with strategies that are not learner dependent.

I support learners having just an educational role, with service options being offered once we have clarity about how much service is needed to reach educational goals. The historic feeling that you can never have too much service exposure clearly is no longer appropriate. The transition to competency based learning is overwhelming on its own and I believe that the educators should solely focus on educational issues.

Service needs and service delivery should be our responsibility. We, the medical staff and leaders should know what safe and consistent patient care is required, and we also need to know how to deliver this care.

We are a business that delivers healthcare. It is illogical to design a health care delivery system that has the learners be the drivers. Safe patient care and services that are delivered 24/7 with the same standards across all facilities (urban/rural/inpatient/outpatient), must be the driving principle. It must always start and end with the patient.

Staff doctors can no longer (and never really have) delivered care alone. We have to acknowledge this. We need a team, we always have. The only real difference is the labels that may be applied to these team members. Years ago, the intern was the helper. In addition to residents we now have many alternative healthcare provider options — physician assistants, clinical assistants, clinical associates, nurse practitioners, and independent contractors. We just do not have a coordinated master plan that has maximally integrated all available resources.

We are at a cross roads. Twenty-six years ago my internship allowed me the opportunity to learn how to be a working doctor. Twenty-six years of working as a doctor has taught me that I cannot do this job alone, I need house-staff. I currently work regularly with both a clinical assistant and a physician assistant who I see as being possible representatives of the house-staff we are likely to have in the future.

We need to start the discussion now on how we are going to develop a comprehensive workforce/house-staff strategy. I encourage all of us to think about how we, in our own area of care, will be delivering the highest standard of patient care safely 24/7 going forward. Who will be there for you?

Linda Mrkonjic
Orthopedic Surgeon, Foothills Medical Centre, Calgary; Past President, Foothills Medical Centre Medical Staff Association and President-Elect, Calgary and Area Medical Staff Association

The Challenging — and yet Useful — Concept of Opportunity Cost

Dr. Kathryn Andrusky

Dr. Kathryn Andrusky

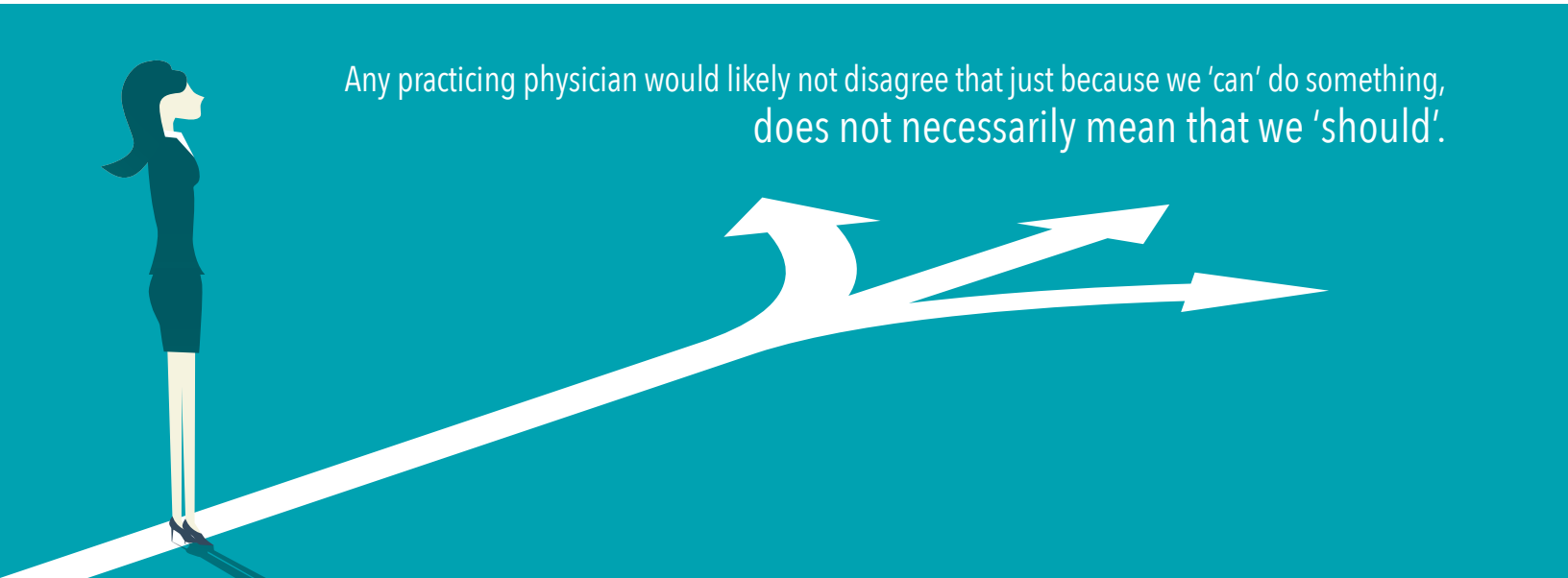
Economics and medicine seem at first glance to be mutually exclusive and at odds: economics is financially driven and medicine, clinically-driven. Yet, at its most basic definition, economics is the study of scarcity: be it time, money, personnel, etc. And what could be more applicable to the practice of medicine today than the realities and challenges of scarcity? Economics seeks to optimize benefits gained (individual or societal), by simultaneously minimizing 'costs' and/or by selecting which decision or action evokes the most benefit.

Fifty years have passed since Lester B. Pearson's government approved and enacted the fundamental Canadian health care system. However, when Tommy Douglas proposed a national health care system, it was primarily a safety net — basic health care for all Canadians — and not with the intention that all conceivable investigations, management and treatment options could (or, arguably, should) be covered by the government. Back in the 1960's when provincial and national health coverage plans were being adopted, Mr. Douglas and his cohorts could never have imagined medicine's subsequent evolutionary path: from organ transplantation to pharmaceutical achievements, from genetic laboratory investigations to radiological imaging capabilities; the advances have been astounding.

The caveat to these amazing and truly laudable advances though is it brings us back to the economic considerations: how do we achieve the biggest benefit through the decisions that we make? These are not questions we can defer to administrators and government bureaucrats, these are the real, and often uncomfortable, questions that clinicians need to face on a regular basis. Evidence-based medicine analysis techniques readily address the clinical side of that equation — what is the NNH or NNT (number needed to harm/treat) and weighing the risks or side effects or complications versus anticipated clinical benefit. But, there seems to be an inherent squeamishness in physicians to simultaneously consider the economic or financial side of those same decisions (cost-effectiveness analyses).

There is a large part of me that cannot disagree. I recently heard from a non-medical colleague that there is 'something' about physicians — about our training, about our value systems — that is unique. Since then, I have been mulling over his statement to try to place my finger on it and could not, other than there is a deeply rooted 'protectiveness' and an almost ingrained need to ensure the best possible care and outcome for "my patient." This is not meant to be paternalistic or 'physician-centred', but rather a rationalization to explain why the multitudes of population health studies and statistical analyses published are sometimes at odds with my decision making surrounding the individual patient currently sitting in my examination room.

So, what to do? This gut-level, individual-patient-focused value system of physicians must inherently and persistently be at odds with the financial and statistical decisions of economists, mustn't it? These are not — and likely never should be — easy decisions. Any practicing physician would likely not disagree that just because we 'can' do something, does not necessarily mean that we 'should'. It is a similar concept here. And this is where an extremely useful economics concept of opportunity cost enters in. Opportunity cost is essentially the cost of giving up one thing, to do something else. In its truest economics definition, it would be the cost of whatever course of action is chosen, in addition to the cost of the alternative action that would have been chosen otherwise (i.e. the second-best or most likely alternate choice). A useful concept in that it immediately forces one to recognize that, for every decision, there is a course of action that can now not be taken due to that same decision (due to inherent scarcity as mentioned at the beginning of this article).



The difficulties with economic theory though is that it assumes a closed system, and it is my hypothesis that physicians don't inherently think that way. We are focusing on our patient, our clinic, our staff; not generally on the system as a whole and the part that each of us as individuals play within that system. Which is fine if resources are infinite, but the reality is they are not. Whether those resources be time, money or people; for every decision that is made, there is an opportunity cost in terms of those particular resources now not being available for other things.

This is not easy, I readily admit. Since I have become more cognizant of 'appropriateness' and 'stewardship' concepts, there are days when I feel the majority of my time is now spent explaining why I will not be ordering "x" test or "y" intervention. No one wants to be the 'mean parent' all the time, but this is the role that physicians are being asked to play when we are expected increasingly to be the gatekeepers of the health care system. Sometimes this is even at odds with fellow physicians, when generalized lists of pre-consultation investigations are required as prerequisites for specialist referrals; or with other health providers as per the patient who announces that "[insert alternate health provider here] told me my physician should order this test." And then I need to explain why I will not be doing so.

It is not an easy position to be in, as it defies professionalism concepts to critique another health provider, yielding an extremely challenging fine line to walk when one disagrees with whether that investigation is indicated. This is where stewardship decisions cannot be made in isolation — we need to work together as groups of physicians to determine not only appropriate clinical indications/drivers, but also examine the opportunity costs of the decisions we are making, as stewards of the health system. It will not be an easy or a comfortable process as the anecdotal counter-arguments (the "n of 1" patient experience) are powerful, emotional triggers. But economics and opportunity cost remind us that the reality is a system of scarcity — and I suspect each of us would agree with the economists that we want the best possible benefit for all.

Kathryn Andrusky, BSc, MD, CCFP
Family Physician, Links Clinic, Edmonton

FMC Parking

In late September 2016, demolition began at Foothills Medical Centre (FMC) to help make way for a new four-story 2,000-stall parking structure to replace the main parking area (Lot 1) at the hospital's main entrance. When complete, the new parkade will not only significantly improve patient and visitor experience when it comes to parking on site, but will also allow construction to begin on the new Calgary Cancer Centre which is proceeding at the FMC site, on the current location of Lot 7.

Building the new parking structure is only part of the picture. Giving patients, families and visitors priority parking on site has required extensive planning and logistics. It's also required the cooperation of 1,200 or so staff and physicians who have agreed to park in a temporary off-site lot adjacent to Alberta Children's Hospital during the three-year construction period. Regular shuttle services to and from the FMC site are also being provided.

Staff and physicians with regular evening, night or weekend shifts or on-call, those with mobility limitations, multi-site responsibilities, and those with reciprocal permits used more than three times a week are exempt from having to use this temporary off-site lot.

The process hasn't been without its challenges and frustrations for physicians who are now required to park off-site, or who have been moved to Lot 6, 7, or 8. The balance of the number of parkers in each lot has been gradually improving as parkers have been re-assigned between lots. We're continuing to work on this, to improve the ability of everyone to find a parking spot in their assigned lot.

We are continuing to work with parking services to ensure urgent-access spots are available when needed to respond to clinical emergencies. Our commitment to this has included more than doubling the supply of urgent access stalls and providing them in an additional new location, as near as physically possible to the Emergency Department. There has also been a dedicated and streamlined approach to hourly physician parking.

Public parking has been another major area of focus. Getting patients to appointments on-time, and within reasonable walking distances, is a priority. The total number of public stalls on site has actually increased slightly, and public parking is now at four locations: North Parking beside 16th Ave. N.W., South Parking under the South Tower, adjacent to Tom Baker Cancer Centre, East Parking beside the Women's Health Centre and West Parking in the heated parkade under McCaig Tower and the TRW Building.

In many cases, these parking locations have actually made it easier for patients to park closer to their appointment. But helping people find the right lot is an ongoing area of work! One strategy has been to add designated drop-off areas to allow drivers to drop passengers as close as possible to their building, before finding parking. These areas are clearly marked and we are working with media to help get the word out that visitors should plan their trip by visiting www.ahs.ca/fmcparking for maps and other information.

Finally, construction necessitates some road closures on site, and a change to historical traffic patterns. Most vehicles coming on-site are encouraged to enter and exit the site via 16th Ave., Hospital Drive Way or West Campus Blvd. rather than routinely using the 29th Street entrance. Emergency Department traffic will continue to be encouraged to access the direct route from 29th Street NW.

For a number of years, patients and family members and staff and physicians on site have expressed the need to improve parking at FMC. Consulting broadly, and listening and responding to concerns, continues to be a vital part of planning and the decision-making process around parking. Future parking changes will include commissioning the new Lot 1, and decanting Lot 7 to support the construction of the new Cancer Centre. This project continues to evolve and we will need the continued support and input of physicians to help make it a success

Thank you for your patience and understanding as we work through this complex and important project. Your feedback is welcome. Please email us at **peter.jamieson@ahs.ca** or **linda.mrkonjic@ahs.ca**.

Dr. Peter Jamieson, *Facility Medical Director, Foothills Medical Centre*

Dr. Linda Mrkonjic, *Past-President, Foothills Medical Staff Association*

Letters

Dear Editor,

On October 14, Dr. Padraic Carr, AMA President, advised the membership that the proposed amendments to the 2011-18 Agreement were ratified.

Dr. Carr put a favourable spin on the result noting it passed with 74% of the votes in favour, while innocuously mentioning the 'bit lower than average' voter turnout of 29%!

This is a delightful presentation of statistics: one can calculate that only 1 in 5 members voted in favour of amending (breaking?) the existing contract. A rank minority carried the day — YOWZER!

It is hard to believe that anything should pass — ever — if 2 out of every 3 do not even vote and 4 out of every 5 are either voted against or abstained. Low voter turnout is multifactorial and does not bode well.

Hard times are upon us.
Kevin Hay

Patients First?

In October, the doctors of Alberta voted to amend the "Master Agreement" that they had reached with the government a couple of years earlier, which was to run from 2011 until 2018. Of the 29% of doctors who voted, 74% voted to accept this amendment. In last month's issue, Dr. Van Zyl commented that he was disappointed that more had not participated, as this amendment radically transforms our relationship with government. I agree that this represents a radical transformation. It is not for the better. This complex agreement is flawed in many ways. However, underlying its flaws is a core failure of principle. With this amendment, the AMA has undermined the notion of professionalism, and the result will put patients at risk.

As a physician and professional, my sole duty is to my patient. I am at all times to act in his or her best interest. This duty underpins the physician-patient relationship. Without the trust of the patient that we are there to care for them, the relationship falters, and we fail in our duty. This is not to say that we should do everything and anything for our patients. Unnecessary tests or procedures are, by definition, not in the best interests of our patients. Insofar as we should be optimizing care, with the right test for the right patient at the right time, there is no argument: that is merely good medicine and should be our hallmark.

The AMA notion of stewardship, advocated as part of the amendment process, undermines this relationship. By definition, it implies that the interests of society must be considered alongside those of our immediate patient. This results in competing, and in certain circumstances, opposing interests. Our obligation is to our patient; we are our patients' advocate. Once patients no longer feel that their doctor is treating their interests as paramount in providing care, the relationship fails. Moreover, so does health care. It is only if we optimize the care we give each and every patient that we will optimize population health.

As a profession, we are wrong to embrace joint stewardship of resources. Through this agreement, the AMA has publicly taken the side of the provincial insurer, and is now coordinating efforts with the insurer to revise the Statement of Medical Benefits to deny patient access to certain procedures, exams and care. It must be remembered that Alberta Health is only a public insurer for health services in Alberta. If Alberta Health were instead a private insurer, would it seem proper for the body representing all physicians to be aiding that company in restricting available health care options for patients for insurance purposes? I understand that an insurance company may need to contain and restrict benefits, and Alberta Health is no different. Also, some changes may be based on best practice guidelines. Medicine, however, is performed on individuals, and for every guideline there will be a valid exception. The participation of Alberta doctors in this process means that there is no one advocating for those who are hurt or left behind by such changes.

The potential for our actions now to undermine confidence in health care by siding with "the system" over our patients is real, and must be resisted. We must recommit to do our best for each patient every day, and the AMA would be wise to put "patients first." Systems come and go; our professional commitment to our patients must remain.

Graham Campbell, MD, FRCPC

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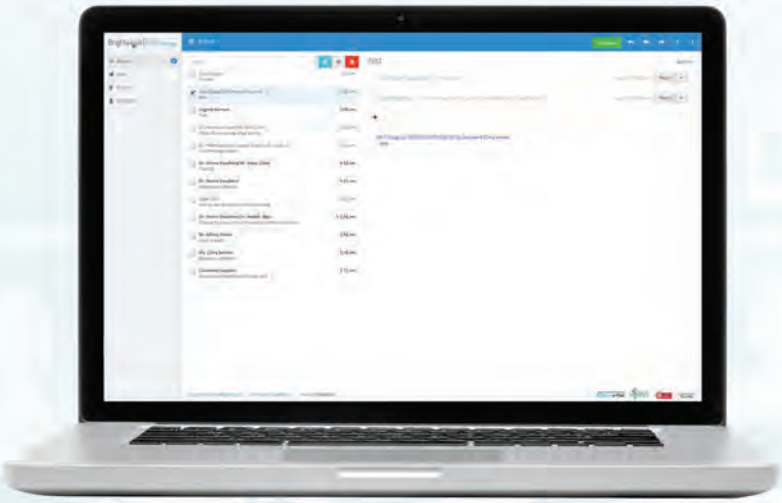

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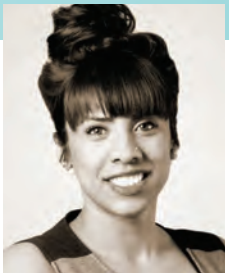
The First 5 Years

Dr. Rabiya Jalil



Dr. Rabiya Jalil

Medicine is many things. It is constantly challenging, humbling when you least expect it, stressful within an instant and rewarding in circumstances you would never anticipate. The ways in which medicine can surprise, and even fool you, is particularly evident in a physician's first five years of practice.

The early stages of medical practice are met with beaming optimism as a long educational journey finally comes to a close. Despite this enthusiasm forging a new path can be outright terrifying at times (okay maybe even all the time). One often longs for the patiently observing staff to come forth from the shadows and peer over their shoulder once more.

One of the best ways to get ready for this exciting new frontier in one's career is to quite simply — prepare. It may sound obvious but preparation can truly make a difference when starting practice and this most important step should start well before you even enter practice. While physicians are well educated for clinical roles and responsibilities, it's all the other stuff that many of us tend to ignore which requires attention as we commence practice.

So Where To Begin…

Getting one's privileges and licenses in order is one of the most time consuming and paper-work heavy aspects of the process. Considering that this has fun written all over it…many seem to stall on this opportunity at form completion nirvana. Yes, it will take forever to complete all the forms, and having them reviewed and signed off will take even longer than eternity, so it's best to start as soon as you can!

The Alberta College of Family Physicians First Five Years Committee has a link to all the general privileges and licensing steps required for Alberta (applicable to FRCPC colleagues as well.) This may be a good place to start to get one's bearings on the process. Try to cover off all the forms and registrations at once as most require similar documentation and you won't have to worry about it later should the need suddenly arise. (Link: https://www.acfp.ca/membership/first-five-years/transition-to-practice/)

Other important aspects to set in place include establishing your professional team. It is imperative to find a lawyer for your practice basics (for example document notarization, establishing your professional corporation etc.). In addition, finding a good accountant will be essential as you move through your early years of practice when there are a lot of financial changes occurring. A financial planner will also be crucial in this regard.

When searching for such professionals its best to ask around, as your colleagues will know competent professionals with experience in medical practice. Since physicians have unique accounting and legal needs, look for someone who has worked with several physicians, and has an interest in this area. Having trusted professionals in place from the start will help you ease into early practice.

Another essential element of early practice is having mentors. There are assigned mentors throughout training, often a primary preceptor or a program director; but what happens when you finish? Who will that be now? Unless you're proactive, you might find yourself without a mentor. Having a more experienced mentor to talk to and advise you through the more complicated parts of medicine is of immense value. Inevitably challenges will arise, often not directly clinical, and having access to a trusted mentor you can call or text to ask questions can really make all the difference. Soak in the knowledge and experience of others.

Furthermore, whether with a mentor or a peer, when you confront a difficult or stressful situation try to debrief. It's important to have a group of trusted peers or practice colleagues you can talk to when you've simply had a bad day. Knowing that others have gone through similar challenges or hearing their words of comfort can make a stressful situation manageable, or help to process a difficult experience.

Another important principle in early practice is "err on the side of asking." If you're not sure about how to manage a dilemma or scenario just ask. I often find that physicians are reluctant to call expert colleagues, designated lines or even CMPA. These services are there to help you, and even if you think your question is inconsequential or small, do not hesitate to call them. At minimum it's a learning opportunity and at best, its rescuing clinical or legal advice on how to manage a challenging situation.

When establishing your practice, try to weave variety into your day to day work. Doing five days of clinic a week can be very draining and may burn you out. Having even a half day for an area of interest, procedures, or an administrative role can help keep your work schedule varied and fresh. Those with more diversity in their practice, and utilizing their full set of skills, are often more satisfied professionally. Furthermore,

once you commence practice you can lose your skills very quickly if you don't use them, so capitalize on opportunities to participate in many areas of interest early on.

It is essential for early career physicians to be engaged and involved. There is already so much on the go during this phase, and just keeping afloat with clinical medicine can be exhausting but in today's environment new doctors also need to have a strong voice and participate in whatever ways interest them. If you're interested in education, take on teaching roles, or if you have an interest in policy or advocacy look for leadership and administrative opportunities. Expand your scope beyond just routine clinical duties from the start, and it will enrich your career.

Do stuff that is not medicine. I don't think I could close this article without also mentioning that you should have a life outside of medicine. The first five years are often clinically heavy, but be cautious not to burn yourself out as soon as you start. There is no need to pick up every last locum or every open call shift. Learn to say "no." Spend time with your family and friends, travel, stay active, participate in activities you enjoy, or even take on new hobbies — because before you know it you'll be the one looking back on your first five.

Dr. Jalil grew up on the Saskatchewan Prairies. She obtained her undergraduate and medical degree in Saskatchewan before moving to Calgary for residency. After completing her residency in Family Medicine, Dr. Jalil did an R3 year in Women's Health.

Dr. Rabiya Jalil, BSc, MD, CCFP
Primary care for complex and vulnerable populations, surgical assisting, and women's/sexual health. Dr. Jalil serves on a number of committees and also takes an active role in medical education, teaching at the University of Calgary and as the Medical Director of the Alberta International Medical Graduate Program.

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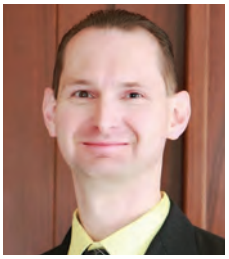
Dr. Darren Hudson

So there I was, freshly minted critical care physician with a brand-new job in a new city and a girl who, in a moment of youthful indiscretion, had agreed to marry me. On the edge of a new start, in many ways I had still to learn how to be an adult. That was 15 years ago. Fortunately, a guru taught me that there are five key people you need to start independent practice.

Family Physician: Like all young healthy people, I avoided doctors like the plague. Even though you now join a community of physicians and there is a temptation to draw on their knowledge and experience as necessary, only a fool follows this course. It is hard but do not forget that even doctors are human beings and subject to all of the frailties and denials that everyone suffers from. A family physician with whom you visit regularly will provide the necessary surveillance to ensure a long and healthy life. It is important to select a family physician who is not a friend, resident, or faculty. This person needs to be objective. Free advice from physician friends and colleague is worth what you pay. It also puts them in a bad position. No-one wants to tell their friend that they think the weakness is ALS. And it is hard to have Friday night drinks with the defendant in your malpractice case.

Financial Planner: You are as good of a business manager as an MBA is as a doctor. Your financial position is more complicated by your debt burden, earning potential and years of delayed gratification. You need someone to help you establish a plan through the woods. Financial planners are specifically trained for this. They will help you understand your current financial situation and chart a course forward. The vast majority will be able to produce returns similar to the market index with simple financial instruments. Your focus should be on finding a planner who will find investment opportunities that match your risk tolerance and are not trying to sell specific products. Investment planner who is trying to sell you specialized products or exclusive packages only available to select customers should be avoided like the plague. This is the siren song of the Ponzi scheme. Many smart people are made to feel stupid because they fall for these schemes. Early in your career, boring investments are good. They are safe and your most important goal should be getting control of your spending and managing your debt.

Accountant: An accountant is necessary to help you manage your taxes which will now change. For many years you are used to filing your taxes as an individual or couple but you are now effectively a business. The tax rules are different including payment schedule and deductions. An accountant will help you understand the nuances of the Canadian Revenue Agency. They will help you decide to form a professional corporation or sole proprietorship. Accountants have areas of specialization so in this case I would strongly recommend finding an accountant who does work with other physicians in your area and that they trust. The accountant will also prepare your tax returns and financial statements every year and can provide some general advice about your financial situation and strategies. It is usually helpful to have your financial planner and accountant speak to each other in order to optimize your finances and RRSP contributions.

Lawyer: It is an inevitability that you will be sued. CMPA lawyers are great but way too expensive to help you with your practice questions. You need to find a lawyer with a general practice who can help you with issues such as incorporation and any legal questions that may come up in your practice. If you establish a professional corporation, your lawyer will complete the necessary paperwork for the incorporation and yearly shareholder meetings required by government. Finally, now is a good time to update your will.

Banker: A bank is will be necessary to finance aspects of your private practice and personal life. You have probably been with a bank for years and you can now expand this relationship. All you need to do is set up an appointment with the branch manager to have a quick chat and get to know them. They will be able to help you with credit applications and ensure that your bank accounts are organized for your personal and business finances. Eventually, you will need to approach them about a mortgage and having a pre-existing relationship will facilitate the approval process. Note that branch managers change and once you have an established relationship with one you do not generally need to meet with the new guy as your file will be available for them to review if they want. They may occasionally reach out to you and it is in your best interest to take a half hour to meet with them.

Congratulations on finishing your training. Welcome to the adult world. You do not need to know everything anymore. There are people who you can develop a relationship with to help you succeed and thrive. Having good help is the secret to all successful people.

Dr. Darren Hudson, MSc MD FRCP(C)
Associate Medical Director, STARS, Associate Medical Director, eCritical Alberta, Adjunct Assistant Professor, School of Health Information Science, University of Victoria, Assistant Clinical Professor, Division of Critical Care Medicine, University of Alberta

5 MONTHS into Practice

Dr. Rafiaa Valji

Dr. Rafiaa Valji

After a grueling year of studying for the exam of all exams (aka Royal College), I have had the pleasure of making the leap into independent practice. As a pediatrician, I spend a lot of time counseling my patients about the transitions of life and now I have the opportunity to reflect on mine: from our white coat ceremony in medical school to going through the CaRMS year to starting residency.

I have been locuming in various clinics and hospital sites in Calgary and Red Deer and have developed a stronger understanding of the diversity in practice models, clinical care pathways, patient populations and clinic efficiencies. Interacting with so many different pediatricians and allied healthcare staff has helped me develop an appreciation for how important it is to take into account local resources and culture when designing clinical guidelines and coming up with innovative solutions.

Now five months into practice, I feel an emerging sense confidence in my clinical abilities and independent decision making skills, but this transition has certainly been challenging in terms of learning all of the important practical details of patient care that we do not learn in residency. In pediatrics, this entails: knowing local resources for developmental and mental health supports, identifying which medications can be crushed and swallowed without affecting pharmacokinetics and knowing which books on tantrums, ADHD and sleep training are the most helpful to parents.

The transition from residency to general pediatric practice has also opened my eyes to the high prevalence of mental health challenges within the pediatric population. In many of the clinics in which I locum, about half of the consultation list is comprised of concerns regarding behavioral challenges such as aggression, emotional dysregulation, anxiety, learning difficulties and ADHD. As well, a sizeable number of the medical consultations I see are for concerns such as headaches, abdominal pain and poor sleep also have a basis in similar mental health challenges. Ironically, much of my residency training was completed at a tertiary care site where I honed my acute care skills, but didn't develop as strong of a comfort level with the multitude of mental health challenges that present daily. As such, one the biggest challenges I have faced with this transition has been enhancing my skill set so I have participated in CME courses such as the Canreach course, a highly recommended six month mini fellowship which takes an interactive approach to building pediatric mental health competency. As well, my fellow pediatricians and colleagues in nursing and social work have been a tremendous source of wisdom in learning how to navigate the "system."

The transition to practice has been particularly gratifying in terms of the deep sense of responsibility I feel over the well being of my patients now that I am fully medically responsible for their care. As well, I have felt very humbled by the increased sense of trust they have placed upon me.

Rafiaa Valji, MD, FRCPC
General pediatrician who locums at various clinics and hospitals in Calgary and Red Deer.

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Before You Sign Your Lease

By Fahad Shaikh, CA, CPA

The first five years of any profession are filled with new opportunities, challenges and sometimes mistakes. As a commercial real estate broker specializing in healthcare, I have had the opportunity to work with many new professionals starting their first practice.

Mistakes are a part of the learning process, if you can avoid them when it comes to negotiating your first lease agreement or renewal, your business will be better positioned to succeed.

The following are common mistakes healthcare professionals make that you can avoid:

Not Factoring Real Estate into Your Business Decisions

The healthcare field has become highly competitive, it is important that healthcare professionals differentiate themselves by shifting their strategy to be more patient centric. Factoring free parking availability, ease of access, quality of building, visibility, and proximity to patient base are all important considerations to make that will have an effect on whether a patient chooses your clinic or another.

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Not Having Renewal Options

Healthcare groups do not relocate as often as office tenants, it is important to negotiate several options to renew beyond your initial lease term to ensure you have long term control over your location. I recently advised a healthcare professional who had built a beautiful clinic 5 years ago, only to find themselves forced out after their initial lease term as they did not have any renewals options and a neighbouring tenant needed to expand.

Entering Into a Percentage Lease

A retail commercial property is ideal for many healthcare groups, look out for clauses in retail leases that should not apply to healthcare. The main one is a percentage clause where the Landlord has a right to a percentage of the Tenant's gross income. This should always be removed.

Personally Guaranteeing the Entire Lease

If you are a new to the industry you will be asked to personally guarantee your lease agreement, meaning you will be personally liable for payment and obligations under the lease if your corporation does not succeed. This could result in significant personal liability as the average lease term for healthcare groups is 10 years. I always recommend that you limit the term of the personal guarantee or the amount of the personal guarantee.

Not Having Flexible Assignment Provisions

Chances are you will probably stay in your location for a long time, for some all the way till retirement. You may eventually choose to sell your practice and if your lease does not allow you to assign to the purchaser, this may cause unnecessary roadblocks to your exit strategy. It is important to have a flexible assignment and sublease clause in your lease to avoid this issue.

Not Having a Long Enough Fixturing Period

A fixturing period is the time you have to construct your space before your lease term commences and start paying rent. Time and time again, I have seen physicians make the mistake of agreeing to a Landlord's standard 60 day period, when in fact you should always ask for 120 days. Clinic construction has different requirements compared to typical offices.

Not Reviewing the Landlord Relocation Rights in a Lease

Many leases allow the landlord to relocate a tenant if required, It is always best to have this clause removed. If your landlord does not agree, it is important to revise this clause and add provisions to protect your business. Some provisions include; the landlord covering the entire cost of the relocation including the complete build out at the new location, moving costs, ensuring the new premises is the exact same size and finding similar market exposure as your existing premises.

Not Getting the Help You Need

You can't be an expert in everything! It is important to not try to do everything yourself. I have met healthcare professionals that have tried negotiating a lease on their own only to find themselves reaching out when it's too late. Surround yourself with a capable real estate advisor, lawyer, contractor, and designer before starting your search. It will save you time, money and maintain the focus of your business on growth and exceptional patient care.

Fahad Shaikh, CA, CPA
Associate Vice President, Office, Colliers International. Fahad Shaikh is an office leasing and sales expert in the Edmonton market.

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Celebrating Young Alberta Doctors

We are pleased to profile six young physicians selected in Avenue Magazine's 2016 Top 40 Under 40 in Edmonton and Calgary. Congratulations to these doctors on their impressive contributions.

Dr. Justin Balko

Primary Care Networks Edmonton Area Lead; Family Physician; Emergency Room Physician; President at Leduc Beaumont Devon Primary Care Network (PCN), Medical Director – Cardiovascular Rehabilitation Program at Leduc Beaumont Devon Primary Care Network

Getting a prescription from physician Justin Balko doesn't just mean getting a note for medications. It can mean getting a suggestion for exercise along with access to a facility. Balko is the spokesperson behind Prescription to Get Active, a program that illustrates the work being done by Primary Care Networks (PCNs) in Alberta.

The Edmonton region has 11 PCNs, which are non-profit groups formed by physicians within an area who put together proactive health networks. Exercise specialists, dieticians, and mental-health experts are all part of the teams. Balko's the Edmonton Zone Lead for PCNs, meaning he studies the challenges of patients and meets monthly with Alberta Health senior administrators — including the Minister of Health — to suggest ways to move forward.

Prescription to Get Active was born of the Leduc, Beaumont, Devon Primary Care Network, where Balko is the president. It now operates on a national scale with local chapters in other provinces. Along with his family practice, Balko works as an emergency room doctor, an admitting physician at two nursing homes, as a medical director of cardiovascular rehabilitation and as an associate clinical professor at the University of Alberta's Department of Family Medicine.

"I'm passionate about my blood pressure rising in the emergency department. I love getting little pictures from my six-year-old patients. I love it all," says Balko.

Balko's seen specialist wait times reduced, and patients become more proactive about their health thanks to the work of local PCNs. "We know the biggest drive for improved health isn't in the hospitals; it's in the community," he says. – *Caroline Barlott*

Dr. Cameron Elliott

MD, PhD and Neurosurgery Resident, Li Ka Shing Centre for Health Research and Innovation, Faculty of Medicine & Dentistry, University of Alberta

Cameron Elliott points to an MRI picture on his laptop, an image of a child's brain with a tumour near the area responsible for speech. But thanks to his research, removal of the growth without negative impacts will be much easier.

Elliott is a neurosurgery resident who is pursuing research for a PhD in Experimental Surgery program. He has a few projects on the go, including the Preoperative Advanced Brain Tumour Imaging Program, which has allowed for 40 brain tumours — like that of the image on his computer screen — to be safely removed from difficult locations. During surgery, the brain moves, so this imaging helps to determine where important parts are in relation to tumours, allowing for less chance of damage.

Elliott originally wanted to be a general practitioner, but after his first elective focusing on neurosurgery, he was enthralled with the specialty. "I rescheduled everything and spent all my elective time in neurosurgery," he says.

Some of that time was spent in Zambia, during a two-month elective at a hospital where Elliott was one of two surgeons serving a population of about 15 million people. Supplies that are disposable in Canada were extremely rare and sometimes barely functioning in Zambia. After his return, Elliott, along with his mentor, sent a package of surgical equipment back to the facility where he served.

Elliott's passion for medicine is obvious, but he recognizes the need for balance, which is why he organizes a yearly neurosurgery resident retreat with a focus on wellness. "It's incredibly important for people in the medical field to recognize stress and fatigue," says Elliott. – *C.B.*

This article originally appeared in the November 2016 issue of Avenue Edmonton. Reprinted with permission.

Dr. Jaime Blackwood

Pediatric Critical Care Physician, Alberta Children's Hospital

Even as a young child, Dr. Jaime Blackwood knew she wanted to help people as a doctor. Today, she does just that as a Pediatric Critical Care Physician at the Alberta Children's Hospital, where she spends her days working with children in a unit she says can be "one of the happiest places [and] one of the saddest places, too.

"I like when people don't know exactly what my job is, because it means that they've never had a child so ill that they've needed to come to me," Blackwood says. "I don't ever want someone to need me, but, if they do, we're there and we're all focused, dedicated and doing our best."

At the Pediatric Intensive Care Unit (PICU), Blackwood provides hands-on, life-saving care to critically ill children suffering from conditions such as cancer, infections and organ failure — all while managing the unit's multidisciplinary team of doctors, nurses and respiratory therapists.

Blackwood is also the director of the hospital's Extracorporeal Life Support (ECLS) program, which she spearheaded in 2009. Calgary is now home to the country's largest and most-established ECLS program in a pediatric hospital without an accompanying pediatric cardiac surgery program. ECLS is used as a last resort for children suffering from heart or lung failure, and is similar to putting a person on bypass so they can try to recover. Since 2011, the program has saved the lives of 28 children at ACH who would have died without it.

"We had children who came in really sick because their heart was failing or their lungs were failing, and [we knew] that if they had ECLS, it might give them a better option," Blackwood says. "We knew that we wanted to be able to offer the best of the best to the kids of Calgary, and we needed ECLS to be able to do that."

Blackwood and the ECLS team have already expanded the program beyond the PICU so it can benefit children in the hospital's operating rooms, the emergency department and the neonatal intensive care unit, as well. They're aiming to have it available to the entire hospital by the end of 2016.

"I truly think my job is a privilege," Blackwood says. "It's tough, it asks a lot of me and of my family, but it is absolutely a privilege to do what I do." – *Alana Willerton*

Dr. Gabriel Fabreau

Clinical Assistant Professor, General Internal Medicine, Departments of Medicine and Community Health Sciences, Cumming School of Medicine, University of Calgary

Dr. Fabreau works with Calgary's most vulnerable populations to provide efficient and effective health care.

As the son of political refugees from Uruguay, Dr. Gabriel Fabreau knows first-hand how valuable immigrants are to the fabric of Canadian society.

"Refugees matter," Fabreau says. "They add to the texture and the colour and the diversity of our country and can contribute in a million ways."

Fabreau is focused on helping these people. He currently splits his time between researching, teaching and "doctoring," working as a clinical assistant professor at the University of Calgary's Cumming School of Medicine and a specialist in internal medicine with shifts at the Peter Lougheed and Foothills Medical Centre. He also works three to four days a month at two clinics for immigrant Calgarians, the Mosaic Refugee Health Clinic and the East Calgary Health Centre, the latter which he co-founded a shared-care general internal medicine-primary care clinic.

The shared-care model means the patient stays in one place and health care practitioners work collaboratively on each file. It's a model that is effective for newly arrived refugee patients who might find it daunting to navigate the health care system on their own. "Instead, we embed ourselves where they are," Fabreau says.

Fabreau, who graduated with a Masters of Public Health from Harvard University in 2014, is also working on a major research project called the CUPS Coordinated Care Team (CUPS CCT) that addresses another vulnerable population: Calgary's homeless. The CUPS CCT is a partnership between CUPS (Calgary Urban Project Society) and Alpha House, and Alpha's Downtown Outreach Addictions Partnership (DOAP) team, to coordinate and evaluate health care for homeless Calgarians in hopes of reducing the need for hospitalizations and emergency room visits. Like refugees, homeless Calgarians often struggle with access to health care. The project recently won a $1.8-million grant from Alberta Innovates Health Solutions.

"We train people from the community as lay health workers and provide patients all the help that they need, including mental health, addiction, medical care, housing and food," Fabreau says. – *Meredith Bailey*

Dr. Derek Roberts

General Surgery Resident, University of Calgary; Knowledge Translation Researcher

While completing his own surgical residency, Dr. Roberts has earned worldwide recognition for his research in a new form of clinical science known as knowledge translation to ensure surgeons are using the most effective practices.

Surgery has long subscribed to the master-apprentice model, and, as a general surgery resident at the University of Calgary, Dr. Derek Roberts is continuing this tradition. But he's also expanding the scope of surgical training worldwide through his research in a new field of clinical science known as knowledge translation, or KT — research that looks to bridge the gap between what surgeons know and how they actually practice.

As a resident, Roberts noticed surgeons using damage-control surgery — a series of procedures that aim to prevent the deadly triad of hypothermia, coagulopathy and low pH that could develop during a one-time definitive surgery — but, to Dr. Roberts, the reasons why they were taking the damage-control approach were not always clear. Roberts' Ph.D. work set out to use a form of KT known as integrated knowledge translation to develop a list of indicators to help a surgeon determine whether it is appropriate to perform damage-control or definitive surgery. He enlisted the involvement of nine experts on the subject from around the world in his research and, even though his findings were only published within the last year, there are already surgeons worldwide using and promoting Roberts' indicators.

On a local level, Roberts has applied KT at Foothills Medical Centre, where he's involved in planning electronic medical record intervention systems to keep physicians alert to patients' needs and vitals. He has also consulted on the development of WikiTrauma, a Canadian wiki (an online hub curated by experts), where physicians and surgeons will be able to create and edit pages on various injuries and best surgery practices.

Roberts is due to complete his residency in July 2018 and plans to pursue additional sub-specialty training in vascular surgery while continuing to use his unique skill set in KT to keep himself and his peers at the top of their game.

"The key in surgery is effective collaboration, that you involve all sorts of master surgeons — the people who are teaching people — so that everyone's on board," he says. – *Fraser Tripp*

Dr. Tony Truong

Pediatric Oncologist, Division of Pediatric Oncology and Blood and Marrow Transplantation, Alberta Children's Hospital; Assistant Professor, Departments of Oncology and Pediatrics, University of Calgary

Dr. Truong's innovative research in the field of stem cell transplantation offers hope to children and their families suffering from painful and life-threatening blood conditions. For children and teenagers facing cancer and serious blood conditions, the work done by Dr. Tony Truong in stem cell transplantation (SCT) could be a potential life-saver.

"When people hear 'stem cells,' they think embryonic cells," says Truong, but he stresses that his research does not use stem cells derived from human embryos. Rather, family members with matching blood types donate peripheral blood, which is blood containing immature stem cells that are stimulated with medications. Working from the Division of Pediatric Oncology and Blood and Marrow Transplantation at Alberta Children's Hospital in Calgary, Truong is one of only three physicians in the province specializing in pediatric SCT. "SCT is a way to use blood stem cells to treat and cure the most life-threatening cancers and chronic blood conditions such as thalassemia and sickle cell disease," says Truong.

Truong designed a clinical trial to expand the availability of SCT for children with sickle cell disease who were previously ineligible due to a mismatch in their blood type with that of their donor. This will be the first study seeking a level of tolerable risk using mismatched blood or bone marrow in a reduced-intensity transplantation.

Truong's proposal earned him a Department of Pediatrics Innovation Award in March 2016 and grant funding for an additional two or three patients each year. He hopes to attract sickle cell patients from across the country for SCT treatment in years to come.

Truong is also recognized for a recent study examining how children tolerate SCT infusions, that was published in the prestigious journal, Bone Marrow Transplantation. As well, Truong is the principal investigator in Canada for a multinational, multi-institution clinical trial examining SCT in patients with high-risk acute lymphoblastic leukemia, with the intent to develop a chemotherapy-based treatment that would avoid the high risks and painful side effects of total body irradiation.

"In bone marrow transplant, we deal with the sickest kids — so that's the inspiration," says Truong. – *Jay Winans*

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PFSP Perspectives

Out of the Shadows: Shining Light On Physician Suicide

Dr. Sara Taylor

"The life so short, the craft so long to learn." – *Hippocrates*

Sara Taylor

Canadian Indigenous communities are in the midst of a public health crisis related to suicides. Some of the newspaper headlines include: "First Nations' suicide crisis focus of talks with Trudeau; PM to meet with chief in bid to solve mental-health woes at embattled Ontario reserve" (*Toronto Star*); "The Canadian First Nation suicide epidemic has been generations in the making" (*The Guardian*); "Five more suicide attempts made in Attawapiskat" (*The Globe and Mail*).

Widespread attention has grown around the number of suicides involving Indigenous Peoples, with focus on certain reserves and, alarmingly, on the pediatric population. This awareness has prompted a call to action.

Parallel to this awareness is a more hidden epidemic within the medical community that has also seen newspaper headlines, including André Picard's November 2015 article in *The Globe and Mail*, "Suicide should not be an occupational hazard for doctors".[1] Although conversations around physician suicide are happening, the true gravity of the situation is difficult to appreciate with the secrecy and shame that often goes along with suicide.[2]

Why is Suicide More Common Among Physicians than the General Population?

The statistics around physician suicide are undeniable. Each year in the United States, 300-400 physicians commit suicide. The rate in male and female physicians is 40% and 130% higher than in men and women in general, respectively.[2] In an interview with CTV's *Canada AM*, Dr. Derek Puddester, Associate Medical Director of the Ontario Medical Association's Physician Health Program, said: "The concerns here mirror those in the United States. We've known for a number of decades that physicians have a higher risk of attempted and completed suicide."

One would wonder if it is the proverbial chicken or the egg. According to Picard: "The very qualities that make someone a good doctor — empathy, caring, perfectionism — make them vulnerable to burnout, depression and suicide."[1] In fact, a study found that when students started medical school, they actually had lower rates of burnout and depression and a higher perceived quality of life compared to their counterparts.[3] Higher levels of burnout are independently associated with suicidal ideation which is concerning given that more than half of physicians are experiencing professional burnout.[5]

Some of the other reasons cited[4] for an increased rate of suicide in physicians include:

- Not recognizing mental illness in themselves, self-treating a mental illness, or not seeking help because of the stigma surrounding mental illness;
- Fear that disclosing suicidal ideation (and the underlying cause) or a mental illness may result in professional consequences such as losing their medical license;
- Increased professional expectations from student to resident to practicing physician;
- Higher rate of completed suicide versus attempted suicide due to knowing lethal methods (not due to an increased rate of depression);
- Untreated comorbidity factors such as depression and substance misuse;[6]
- Impaired judgment from an underlying medical disorder such as substance misuse or depression;[7]
- Physicians often use denial as an ineffective coping means and are not good at tending to their own wellness needs.[8]

What Are Some of the Warnings Signs of Possible Suicide of a Trainee or Physician?

Many of these signs are applicable to the general population. However, certain personality traits such as perfectionism and workaholism are more common among physicians, which makes physicians at a higher risk when things go wrong. Intervention and support become crucial when any of the following signs appear:

- Escalating substance misuse;
- College complaint, medical license suspension;
- Separation/divorce or dissolution of an important relationship;
- Death of a loved one;
- Serious financial troubles;
- Recent relatable suicide;
- Withdrawing socially/obvious change in behavior (could present as contentment/euphoria);
- Apparent despair and hopelessness.

What Can be Done to Help Physicians Who Might Consider Suicide?

As with most things in both medicine and in life, awareness is the key in order to identify ways to help our colleagues before suicide happens.

At the physician trainee level:

- Ongoing discussions related to self-care and personal wellness through courses, academic half days, retreats and conferences;[7]
- Access to supportive resources through medical schools and provincial health programs.

At the practicing physician level:

- Ongoing dialogue in the form of presentations to and publications for physicians to decrease the stigma of mental illness and stress-related conditions;
- Formal physician groups such as Balint groups which consist of between six and 10 physician members with one or two trained leaders. These groups focus on doctor-patient relationships with peers, improve empathy and improve resilience (both personal and professional). In a commentary by Dr. Michael Roberts that appeared in the Canadian Family Physician, he states, "The goal is to improve physicians' abilities to actively process and deliver relationship-centered care through a deeper understanding of how they are touched by the emotional content of caring for certain patients;"
- Informal physician groups such as book clubs or journal clubs, which provide a supportive environment to promote expression of emotions;
- Reflection exercises such as narrative/creative writing and journal writing;
- Build physician resilience through various elements such as balancing work and family life, prioritization, organization, maintaining perspective and setting boundaries.

To Anyone Who Has Been Personally Touched by Physician Suicide

Unfortunately, I am sure most of us know of a colleague, either directly or indirectly, who has ended his or her own life. During my 16 years as a practicing physician, I know of a handful of physicians who have committed suicide, but I am guessing there are more that I am unaware of.

If you have been more personally impacted by suicide, you may experience feelings such as blame, shame and anger. Reaching out to health care professionals, your physician health program, colleagues, family and friends can make all the difference to your own emotional health. Shining light on physician suicide and having an open conversation about it can save the life of someone you know or even yourself.

We are physicians, but first and foremost we are imperfect humans. As Brené Brown says, "Imperfections are not inadequacies; they are reminders that we're all in this together."

Sara Taylor, MD, CCFP
Family Physician in Red Deer. Education Consultant and Assessment Physician with the Physician & Family Support Program of the Alberta Medical Association.

RESOURCES

Physician and Family Support Program of the Alberta Medical Association – confidential support line 1.877.767.4637

American Foundation for Suicide Prevention – Physician and Medical Student Depression and Suicide Prevention DVDs

The American Balint Society

The Canadian Association for Suicide Prevention

Centre for Addiction and Mental Health

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2016 CAMSS Physician Advocacy Award

At the CAMSS Annual General Meeting on Nov 9, CAMSS Secretary-Treasurer Dr. Davinder Sidhu presented the annual CAMSS Advocacy Award to Dr. Bonnie Larson.

In the words of Dr. Alan Chu, Dr. Larson is an inner-city physician and a key player in Calgary's ability to address poverty and health. She founded the Street CCRED (Community-driven, Clinical care, Capacity-building, Research, Education, and Development) Collaborative which partners key organizations in health and housing to provide medical support for highly vulnerable and medically complex patient populations. She is a key contributor to the upcoming Calgary Recovery Services Task Force which drives our city's approach to homelessness. She has helped materialise a palliative care outreach program and an inpatient safe needle program. She works with a community paramedic program to appropriately manage complex patients on the street and in shelters.

Her advocacy spans students and residents as Program Director for the Family Medicine Global Health program, a leader in the "global is local" movement. Most importantly, her advocacy reaches every patient she encounters; as an anthropologist, she truly understands her patients and can see ways forward!

Dr. Bonnie Larson (L) and Dr. Davinder Sidhu

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