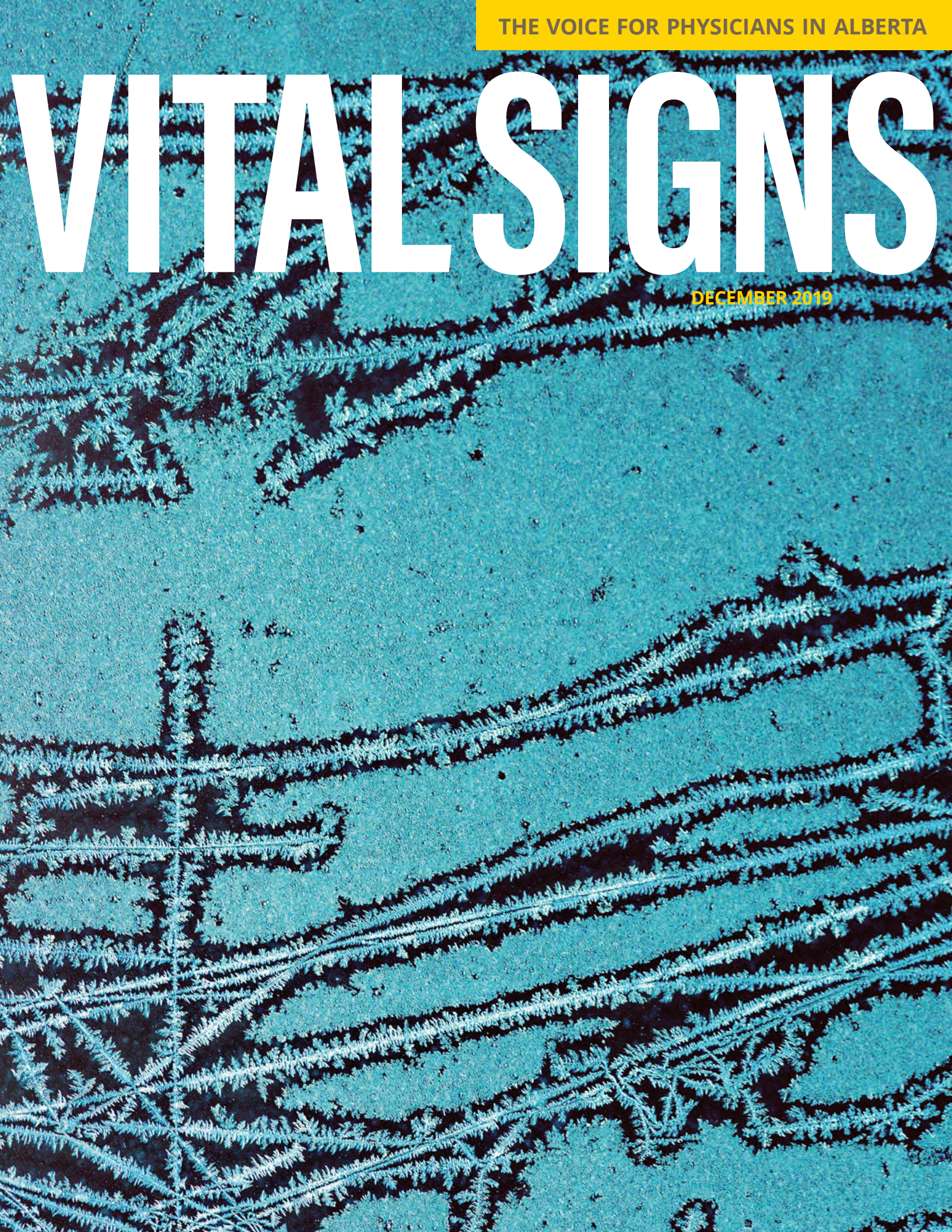
THE VOICE FOR PHYSICIANS IN ALBERTA

VITAL SIGNS

DECEMBER 2019



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A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

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

Please send contributions to: Shauna McGinn, Staff Editor/Writer, mcginnshauna@gmail.com and cc Dr. Scott Beach, Medical Editor, zmsaadmin@albertadoctors.org

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

The deadline for article submissions for the next issue of Vital Signs is Friday, January 24th.

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

ADVERTISING:
Please visit http://albertazmsa.com/vital-signs/ to view media kit or contact Hellmut Regehr at hregehr@studiospindrift.com.

Claims made in advertisements are not verified by CAMSS and CAMSS assumes no responsibility for advertising accuracy.

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SAVE THE DATES!

CAMSS

Council Meeting: January 8, 2020 | FMC Admin Boardroom 152, 5:30-7:30 pm

Council Meeting: February 12, 2020 | FMC Admin Boardroom 152, 5:30-7:30 pm

CZMSA

Executive Meeting: January 16, 2020 | WebEx, 7:00-8:30 pm

Executive Meeting: February 20, 2020 | WebEx, 7:00-8:30 pm

EZMSA

Executive Meeting: January 16, 2020 | Location TBD, 5:30-7:30 pm

Council Meeting/AMA Rep Forum: February 20, 2020 | Misericordia 1N-106, 5:30-7:30 pm

Vital Signs is seeking writers! Our magazine is not so much an academic journal as a way to connect with other physicians about important topics. We publish a magazine for physicians by physicians, as a venue for advocacy and a way to stimulate conversation about health care issues, with a voice independent of AHS and AMA. We ask that articles be 800 to 1,500 words and we welcome accompanying photos.

You'll be compensated for your writing — all authors whose articles of 800 words and over are published will receive a $50 Good Earth or Chapters gift card as a thank you for contributing! The deadline for our February issue Friday, January 24th. Please visit http://albertazmsa.com/vital-signs/ to view past issues.

View from the Beach

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

Equity.

Dr. Scott F. Beach

By definition, it's an aspirational state that allows for equal access to opportunity while taking into account understood differences between individuals or populations.

According to a recent AHS report investigating the role of women physicians in leadership positions within the organization, AHS is really bad at it.

And, as was found in a recent publication by Ruzycki, Bharwani et al., the Department of Medicine here in Calgary is really bad at it. (Dr. Ruzycki also wrote an excellent feature in the last issue of Vital Signs about the important difference between equity and equality).

Finally, sitting amongst my peers at the recent Women in Medical Leadership forum hosted by all seven of the Medical Staff Associations here in the Calgary Zone, I was shocked (though not really) at how bad our profession as a whole is at it. Not just really bad: we suck.

I was humbled to be part of three separate forums where those who have faced barriers and overt discrimination throughout their careers when pursuing opportunities to lead our profession brought this challenging reality to light. At the session following the release of the AHS report, Dr. Francois Belanger, our CMO, received poignant and painful stories from women physicians at all stages of their careers. At the Zone Medical Advisory Council held this past month, the authors of the aforementioned Department of Medicine report went through a litany of ugly, erosive, and downright criminal behaviors demonstrated by male physicians toward their female colleagues.

The themes of abuse and derision, with some more subtle, masquerading as well meaning (read: patronizing) suggestions,

From the summary report authored by Ruzycki and Bharwani, collaborative language infused practical and realistic suggestions for catalyzing changes in the approach to integrating women physicians into leadership roles within the Department of Medicine.

to some just as overt and cruelly blunt were shared in our small groups at the evening hosted by the MSAs. As a quiet listener, what struck me was the consistency of the theme that arose in each setting: the sexist idea that women and their biology are a liability, not strength.

As this settled in, I thought that if it were me in this position, I'd start kicking butt and taking names, no prisoners until the day was won. But as the redness faded from my vision, I saw on my colleagues' faces not berserker transformations, but unifying acknowledgement of their professional reality, evolving to a firm resolve that now was the time for change. Real change.

From the summary report authored by Ruzycki and Bharwani, collaborative language infused practical and realistic suggestions for catalyzing change in the approach to integrating women physicians into leadership roles within the Department of Medicine. Similarly, each of the small groups at the recent evening forum presented summaries of the existing barriers and behaviors that deter leadership aspirations, but these too were equalized by thoughtful and pragmatic ideas to affect real and positive change. These were all punctuated with a call for a continuum of momentum and a push for accountability at all levels of leadership in our profession. These were not just words — they were an earnest yet steeled call to arms; change not just for someday, but starting right now.

As the president of CAMSS, I am grateful to all of the MSAs and their executives for collaborating successfully to provide a platform that will motivate change in our Zone to break these barriers. I hope that with this action, more and more women physicians will stand in equitable form as advocates and innovators in leadership roles, be they within academic settings, departments within AHS facilities, or in the community as galvanizers within our Primary Care Networks.

I and the executive at CAMSS look forward to playing an active role in partnership with those who seek to shine a bright light on the challenges within our profession, and who hold it high to light our way forward to a betterment for all who lead us now, and into the future.

In closing, as this is our last issue of Vital Signs for 2019, I would like to take this opportunity to wish all my colleagues in all of the Zones, and their families and loved ones, a safe and joyful holiday season. All the best to you for the year ahead.

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

Ending the opioid crisis is a shared responsibility:

A call for physicians to support the Street CCRED COPE Initiative

Dr. Alana Luft

Dr. Alana Luft

This article is about the current fundraising campaign for the Street CCRED COPE Initiative in Calgary. If you can, before reading, please visit the fundraising website and review this page: https://www.gofundme.com/f/Street-CCRED-COPE-initiative

At a time when most people are bystanders, Dr. Bonnie Larson and Dr. Alan Chu are taking action. This summer, they started a fundraising campaign to get a mobile Overdose Prevention Site (OPS) project in Calgary off the ground, which had previously been shelved due to a funding freeze by the incoming provincial government.

By now, we may be numb to the term "opioid crisis," but there are still two deaths per day in Alberta as a result of it; and as physicians, we should all be aware of the evidence for supervised consumption sites. This fundraiser was fanned out to healthcare providers, and physicians in particular, as we are a relatively sympathetic audience with little convincing needed to support it.

When I learned of this fundraiser, my first instinct was to support it for the following reasons:

1. The opioid crisis is a humanitarian issue, and in a system where the goal is to treat all manner of addictions, the fact that this issue is often left off the table as "controversial" is an ethical oversight.
2. It's cost saving. Having a resource with limited requirements for staffing for a straightforward life-saving intervention saves ambulance rides, ER visits and costs related to death. To me, these facts are easy to see and get on board with.
3. Personally, I think this fundraiser is an opportunity to feel useful in a situation where most feel powerless, and help the dedicated professionals who want to do this kind of sorely needed work, where I do not. It is a way to get life-saving treatment to where it is needed, and quickly, despite the political, ideological, and bureaucratic quagmire that has been holding it up.

The reason I'm writing this is to help the fundraising effort reach a wider audience. Despite the efforts of Drs Larson, Chu and a few sympathetic helpers, the response from the hundred or so recipients of the ask has been surprisingly limited. I say surprising because I know first-hand how dedicated, compassionate and justice-minded physicians are.

I know that it is not the intended role of physicians to personally fund the healthcare system, and we are already at or beyond our personal capacities due to the demands of our jobs. However, when the chips are down and people in our local community in Calgary are dying preventable deaths, are these excuses not to act?

Some may be concerned about the mode of fundraising being a non-registered GoFundMe, and this is valid. But I can say that the fundraiser is headed by well-respected, known, and dedicated colleagues who deserve the benefit of the doubt and some trust.

It is also true that there are terrible things happening in the world every day, and it is not possible to prevent or be responsible for all of it. To this, I would counter that in Canada, the goal is to assess and treat all comers (See Canada Health Act). The people who attend safe consumption sites and OPSs are seeking help. They do not want to die, or they would not be there.

Please consider a small donation to support this project, and/or please write to your provincial representative - there is a template letter on the website linked at the beginning of this article.

Again, this is Canada, where healthcare is not supposed to be based on double standards, especially in life-or-death situations. If these are not our values, then I suggest that we be honest about this. But if these are our values, and until the government gets on board, it is up to us as physicians, as leaders in the community, to uphold them.

Please note this submission was composed and submitted prior to the provincial government's proposed physician funding cuts that were announced in late November.

Alana Luft, MD., MSc., CCFP
Calgary Foothills PCN

Disclosure: *Neither I nor any family member have any affiliation with Street CCRED.*

Physicians in Calgary and Edmonton make Top 40 Under 40 Lists

Every year, the magazines Avenue Calgary and Avenue Edmonton publish a Top 40 Under 40 List, celebrating the achievements of young professionals in each city. This year, five physicians in Calgary and three in Edmonton made the list — below is a sample from their profiles. To read the full article on each physician, visit the link embedded in their name.

**Original selection, reporting and writing from Avenue Calgary magazine and Avenue Edmonton magazine.*

CALGARY

Dr. Oluwatomilayo (Tito) Daodu

"Dr. Tito Daodu is an award-winning researcher, volunteer and pediatric surgery fellow who works to break down barriers to patients in need of surgical care.

'When we help the worst off or those with the least access, we do a service to the entire system,' she says."

Dr. Shafeena Premji

"Dr. Shafeena Premji is improving women's access to health care with two family clinics focused on women's health and by advocating for quality care with the South Calgary Primary Care Network.

'They need to feel trust in their care provider to be able to completely open up and be honest about what their health needs are,' she says. 'They're not just another patient [coming through] our door, they're coming to a place where they are the priority.'"

Dr. Marshall Ross

"Dr. Marshall Ross created a new protocol for addressing opioid addiction in Calgary emergency rooms that has formed the basis for ER treatment of overdoses throughout the province."

Dr. Ryan Todd

"A practicing psychiatrist on a mission to improve the mental health of Canadians, Dr. Ryan Todd founded headversity, a start-up that measures, tracks and trains mental health resilience in the workplace."

Dr. Fareen Zaver

"Zaver is an emergency physician at the Peter Lougheed Centre and the South Health Campus and her medical curriculum is used around the world. She could have returned to Canada earlier if she had been willing to train in a different specialty, but that wasn't an option she would consider.

'Emergency medicine is the place where you get to hold someone's hand, look them in the eyes and tell them that you're going to try to provide safety for them on what might be their worst day,' she says."

EDMONTON

Dr. Neeja Bakshi

"Bakshi, who continues working at the Royal Alex, is hopeful that through education and awareness more people, the medical establishment included, will come around to a more holistic way of thinking.

'Health care is not just physical health. It's emotional health, it's physical health, it's mental health and how all those factors actually contribute to the physical health of the patient.'"

Dr. Rehana Chatur

"For 10 years, Dr. Rehana Chatur has treated children who have complex medical needs, including terminal or chronic illnesses. But she and her medical partner, Dr. Lyle McGonigle, offer more than that through their practice at Garneau Pediatric Associates.

They are also the only two pediatricians in Edmonton who still actively choose to admit their patients to the Stollery Children's Hospital. This means that they provide care both in hospital and through their clinic, and are on call at all times in the event that one of their hospitalized patients needs care."

Dr. Debraj Das

"To date, Das has more than 40 awards, 26 research presentations — to local, national and international audiences — and has 10 published academic papers to his credit. No matter how demanding his career in medicine has been, — including time as chief resident of adult cardiology at the Mazankowski Alberta Heart Institute, — Das has always remained actively involved in clinical research.

'I've always been passionate about the research I'm doing... You're always trying to push the boundaries and improve care, and never really settling for current standards.'"

Shauna McGinn
Vital Signs Staff Editor/Writer

Where's the evidence?

Dr. Gregory Sawisky

Dr. Gregory Sawisky

"There's no evidence for it." That's a sentence we may hear often at conferences, read in journals, or from colleagues when discussing approaches to patient care. Evidence is continually evolving, as it forms the backbone to the practice of medicine as new treatments are discovered and older treatments discovered to be ineffective.

But what happens when the evidence contradicts a patient's experience?

The foundation for the altar of evidence begins in medical school, with an academic focus on research and outcomes. There is probably no medical student who has not been quizzed by a preceptor asking, "What does the evidence say?" and, "What do the guidelines say?"

Evidence is, perhaps, the most important tool for us in continuing to refine and improve the practice of medicine. It is, one could argue, the very thing that sets medicine apart from the world of homeopathy and naturopathy. As the comedian Dara Ó Briain observed, "Herbal medicine has been around for thousands of years, then we tested it and it became real medicine."

But what happens if the evidence is wrong? Take this case study for example:

A 60-year-old male limps into my practice. He injured his knee skiing in the Alps when he was in his 20s. Forty years ago he did physio, rehabilitation and recovered quite well; not perfectly, but quite well.

Recently, he fell again on a ski hill and re-injured the same knee — lots of pain,

locking, and he needed to walk with a crutch to simply feel stable. He had done lots of physio and despite his best efforts, his knee was causing him significant disability. An X-ray was unremarkable, and a physical exam suggested some meniscal damage.

With his symptoms suggestive of a meniscal injury, I was on the fence. Do I continue with physio knowing that knee injuries can take a significant amount of time to heal, or do I refer for an opinion on whether an arthroscopy would be helpful?

That was when a kernel of evidence in the back of my mind came forward: There is no evidence that arthroscopic knee surgery is effective, which was what I had heard or been told some years prior (orthopedic surgeons, hear me out until the end).

I did some digging and discovered that that bit of "evidence" may have stemmed from a Rapid Recommendation in the British Medical Journal titled: "Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline," published in 2017.[1]

The recommendation was created after the publication of a randomized control trial published in the BMJ in 2016, which found that, "Among patients with a degenerative medial meniscus tear, knee arthroscopy was no better than exercise therapy."

A systematic review was conducted ("Knee arthroscopy versus conservative management in patients with degenerative knee disease: a systematic review ")[2] and concluded that, "Over the long term, patients who undergo knee arthroscopy versus those who receive conservative management strategies do not have important benefits in pain or function."

Now, the important point here is that they differentiate that this rapid recommendation applies, "To patients with or without imaging evidence of osteoarthritis, mechanical symptoms, or sudden symptom onset."

So, what's a simple GP to do with this confusing evidence?

Well, the orthopedic surgeon thinks an arthroscope will help, and several weeks later the patient practically leaps into my office: no cane, no crutch, and with a huge smile on his face.

"It's amazing doctor," he said, "The pain is gone, my knee feels wonderful and I am going skiing again."

I didn't have the heart to tell him that, despite what appears to be a highly successful arthroscopy, the evidence tells us that what he is experiencing is not an "important benefit in pain or function," (as the rapid recommendation writes).

Is the evidence wrong? Did the knee become better simply over time, and the arthroscopy was generating some placebo effect? Is that randomized control study wrong? Or is it the logical fallacy of *post hoc ergo propter hoc* ('after this, therefore because of this') at play here?

The patient's knee was painful, he had an arthroscopy and now his knee feels better… therefore it must have been the procedure that fixed it, right?

I do not wish to debate the utility of arthroscopes here, but instead use this one case and intervention as an example, knowing that my own anecdotal study with a sample size of one is fraught with issues.

How do we navigate the world of evidence when so much new evidence is constantly being generated, and those conclusions have very real impacts on medical decision making?

Perhaps it is simply to interpret everything — evidence, expert opinion, studies, and patient experiences — with a bit of skepticism, trusting our instincts and treating the patient, and not simply blindly following studies, but using our minds to critically evaluate both a patients' condition, and the options available.

Maybe not all evidence is equal — perhaps some evidence is less correct than other evidence.

Or is that already evident?

Gregory Sawisky, MD CCFP
Ponoka, Alberta

FOOTNOTES

[1] https://www.bmj.com/content/357/bmj.j1982

[2] https://bmjopen.bmj.com/content/7/5/e016114

A REMINDER TO READERS:

Due to the holidays, Vital Signs will not be publishing a January issue. However, we are still accepting submissions and pursuing story ideas for the next issue (February 2020) and all 2020 issues.

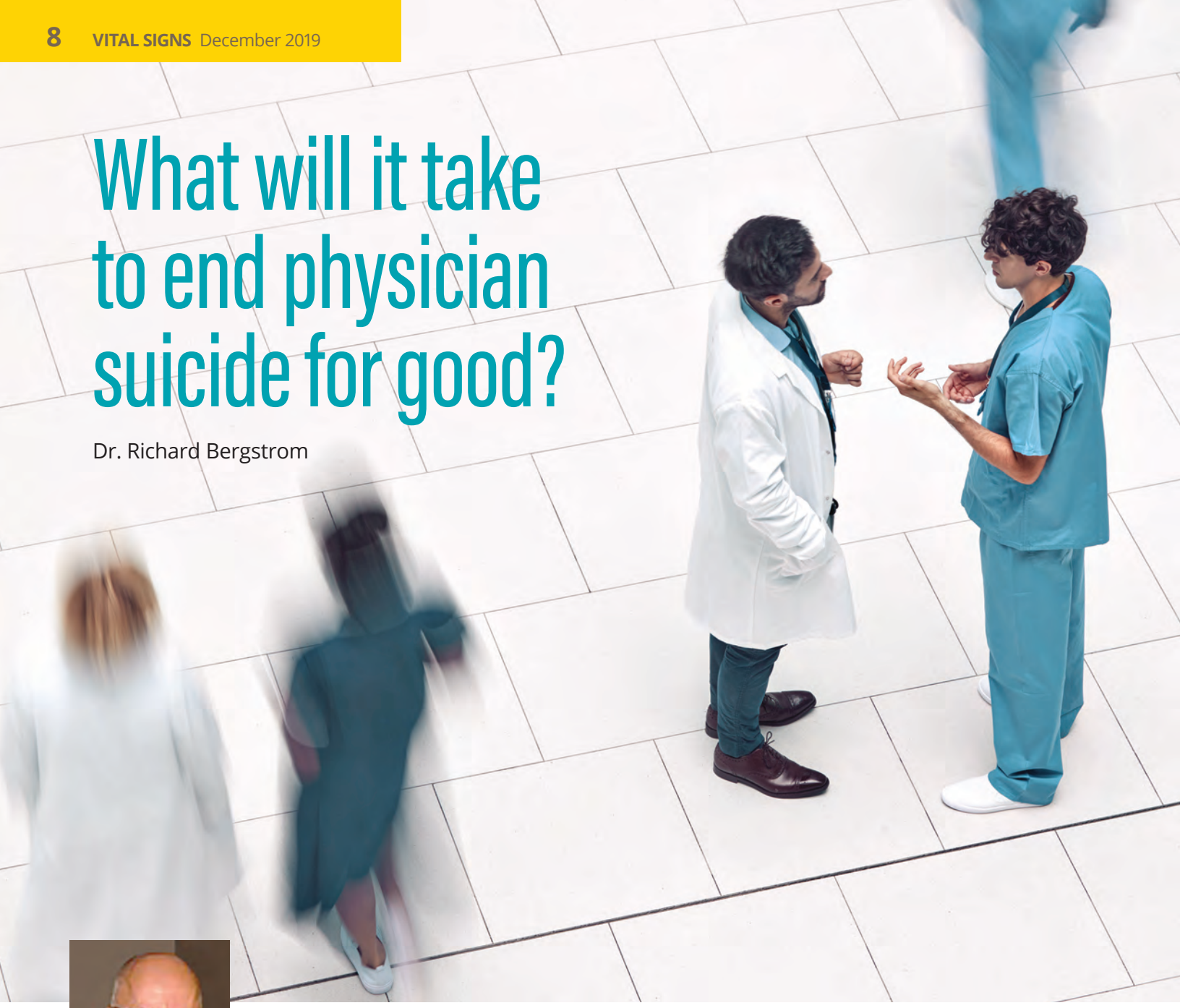
Staff Editor/Writer Shauna McGinn is available for the months of December and January to work with contributors via editorial support, reporting, research, writing, and so on. As usual, if you would like to contribute to the magazine in any way, please contact her at mcginnshauna@gmail.com.

Thank you for your readership and contributions to Vital Signs. We wish you a wonderful holiday season and a happy new year.

Sincerely,
The Vital Signs Editorial Team

What will it take to end physician suicide for good?

Dr. Richard Bergstrom



Dr. Richard Bergstrom

There's a popular adage that age comes quickly, but wisdom, not so fast.

I'm slated to be on a panel dealing with physician suicide, so I thought I should be diligent and research the subject, rather than just relate what I have seen over the years. This has been an interesting task. There is a lot of information out there about physician suicide, mental health, and the culture in medicine of ignoring these things. There are some very moving stories, talks, and comments.

Yet, physicians continue to have the highest suicide rate of any profession, more than doubling that of the general population.

Knowing this, and after doing research, I think it's important to discuss suicide in terms of how our understanding of it has grown and changed within medicine.

Our country's laws have evolved so much so that we now have MAID (Medical Assistance in Dying) which many physicians agree with, yet some do not. It serves as a reminder that legislation and medicine do not always walk hand in hand, and neither does each and every physician.

The law is comprised of what legislators determine as either right or wrong, but this doesn't always stand the test of time. Knowledge changes understanding; cultures vary, and society advances. Suicide used to be a crime. Just think about it — a crime; something looked upon as wrong, and something that we denigrate.

Medicine has had both good and bad influences on the general understanding of suicide. The good part is that we know and can help others see that it is not evil, or an act of weakness. We try to save the lives of those who have attempted suicide;

Can we create a culture where we care deeply enough about our colleagues to ask these difficult questions? To listen with understanding to people who are hurting? To put our own agendas aside and show compassion?

we value life, and see these people as valuable to their loved ones. We think of attempted suicide as something we're desperate to reverse, and I think it has to do with our sense of the sanctity of life, and the fact that we cannot always see a person's inward trauma and feelings of hopelessness.

The bad part is that when suicide happens within our own profession, we can have the tendency to grieve quickly and move on. How often have we learned from it? Given the consistently high rate of physician suicide, not very often; or at least not often enough to have a paradigm shift where this becomes a "never event" in terms of quality of care.

In my own experience, there is one story that has stayed with me, as it demonstrates the important role physicians have in reducing the stigma associated with suicide in the care environment.

One Saturday afternoon, I was on call for the general OR. We had a patient who was a gentleman about my age, and was coming in to have bilateral tendon repairs where he had cut his wrists. We wheeled him into the room, asked him to move to the OR table, and started to do the usual thing. In the midst of this, the patient said, "I am so sorry to make you all spend your Saturday afternoon looking after me with what I did."

I looked at him and said, "We are here to provide care for you, not to judge you." Then I said something that was important to him: "Because you thought it was the right thing to do." We often forget this when discussing suicide: that a person can be suffering so much mental and emotional pain, that they believe taking their own life is the right thing.

He told me I was right, and it was as though a light bulb had gone off in his head; he looked at me with deep emotion and thankfulness in his eyes. He explained that the triggering event was his wife leaving him, and that ten minutes after it happened, he felt he knew exactly what he had to do. His young son was home and was luckily able to rescue him in time.

It was a powerful moment for me. This man "knew" it was the right thing to do, but after surviving, he would not have done it again. He was grateful for his children and the medical system, and I truly felt that I helped him more by listening and caring than by providing the anesthetic. In the end, I don't think he felt the same shame that he had when he first came into the room. As care providers that day, we listened and showed empathy and compassion.

I think the words 'I care' are important, but they are not the most important words when talking to someone who believes they have no value and may be contemplating suicide. In my experience, people who are in this state will not always say, "I am suicidal". Yet, when asked in a non-confrontational way by a trusted person, they might well say something that reveals their inner turmoil.

I have spoken with physicians who have contemplated suicide, and those who have been treated poorly by the system or their colleagues. You've probably seen it happen: someone gets a reputation, and then many jump on the bandwagon and contribute to the negative impact on this individual. I am not speaking to poor performance, lack of care, or ignoring the rights of patients, but rather, the attitude of, 'I just don't like them', and soon the mob (yes, we can be a mob in medicine) decides that they need to shun this person.

In speaking with these individuals, I've learned that they need more than 'I care', because when I say 'I care', that makes it about me. But when I emphasize that someone has value and is valuable, I find a spark from which I can encourage someone to realize their worth. Helping someone gain self worth by allowing them to see that they are both a valuable person and have the potential to provide great care, has been an important experience for me.

It's clear that part of our medical culture is broken. Can we create a culture where we care deeply enough about our colleagues to ask these difficult questions? To listen with understanding to people who are hurting? To put our own agendas aside and show compassion? Alongside this, we need to learn to properly mourn and grieve for those we've lost, or who are lost.

We need to be brave enough to say, 'I've noticed you haven't been yourself lately, can we talk?' We listen to our patients, but we don't always listen to our colleagues and ourselves — and we can and should do better.

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

If you or one of your colleagues is struggling with mental health issues or thoughts of suicide, please reach out to the confidential support line at the AMA's Physician and Family Support Program: 1-877-767-4637. It is open 24/7, 365 days a year, and immediate assistance is available.

Being "out" in medicine

And why we need more active allyship in the care environment

Dr. Caley Shukalek

Dr. Caley Shukalek

As a gay man and an openly gay physician, I've faced many challenges — but I've also been afforded a perspective that has allowed me to be a better care provider, and a more compassionate human being.

While I grew up in a loving family, I also attended a catholic school and was raised by a father who was on the church council. My parents did not have out gay friends, and despite having a large extended family — 13 aunt-uncle pairings and more than 40 first cousins — I did not have a single LGBTQ+ family member (that I was aware of). Amazingly, it would seem I still don't.

This environment led to some internalized homophobia, as I did not see LGBTQ+ people or issues represented in my daily life, making it seem like something that wasn't "normal" or accepted.

Despite this, I had a relatively easy time coming out to friends and family from the age of 17 onwards. My brother was the first to know, or at least the first person who asked that I didn't deny it to. Friends and other family came later, but I was not completely out of the closet (i.e. completely myself) until my early 20's.

Entering medical school at the age of 23, I promised myself I would move forward as someone who was open and honest about who I was. I didn't want to waste any more effort hiding. I never shied away from telling someone I liked hiking, soccer, or baking, so why wouldn't I tell them I was in a long-term relationship with a man? After all, people around me talked about their opposite-sex partners with ease.

Being new to Calgary, I was also mistaken about the open nature of this metropolitan city. When walking down the street with your boyfriend results in homophobic slurs like "fag" being shouted at you, you can't help but take a step or two back into the closet. Or at the very least, be afraid for your safety.

I'd be lying if I said I kept that promise I made to myself at the age of 23.

While my medical student peers seemed unphased at first mention of my boyfriend, I did catch pauses in conversations with preceptors and attendings if it came up. Perhaps I'm being overly sensitive, but these are pauses I didn't notice when my male peers mentioned their girlfriends or wives. I also like to think I kept this information conversationally appropriate, as I certainly didn't mention it to everyone I encountered, and to me, casual mention of a partner when discussing your weekend plans seems fair.

In case you were wondering, I'm not alone in these feelings.[1] LGBTQ+ medical students observe these behaviours all around the country, and it is not limited to gender and sexual minorities.

Certain experiences in my clerkship year in Calgary and in rural Alberta saw me halfway back into the closet, as I avoided mention of being in a relationship with a man. Come to think of it, going along with heterosexist questions about me and "my girlfriend's" plans for the weekend was putting me all the way back into the closet.

Residency gave me new courage — or at least I thought it did. When I returned to rural Alberta (different site) I was actually encouraged by a preceptor to keep "my partner" to myself, in order to make my experience in that rotation smoother. Was it because of other doctors, nurses, or patients? Does it matter? Who was I to disagree? Sadly, I can also say that a couple of years made no difference in the occurrence of homophobic slurs on the streets of Calgary.

Unfortunately, my residency experience was not limited to obvious workplace macro-aggressions such as this. As the (known) out gay male resident, I've been asked before if a new medical student or resident is gay or not. Questions like that have always made me wonder, would they ask the same thing of a heterosexual peer if they thought they were straight?

As a new attending, I think I've finally found the courage that was buried under the medical hierarchy to be myself in all situations. In a short period of time, I've found myself quietly and patiently correcting healthcare colleagues and patients that my "wife" is actually my husband, regardless of the occasional pauses and looks it has received. Sporting my rainbow paraphernalia, I have a new sense

of confidence to be my whole self, both in and out of the workplace. By doing this, I have the ability to focus completely on my job as a physician and care provider.

A recent perspective article in the NEJM outlines the trials and tribulations of a gay male American physician through his time in medical school and selection of a medical speciality.[2] Unfortunately, this persists from medical opinion articles about the LGTBQ+ friendliness of the medical profession from 20 years ago.[3] Some might argue Canada is different than the USA. However, as someone with lived experience, I can tell you it is not.

In a province (and world) where conscious rights objection is being proposed, I know more than ever that I need to be unapologetically myself in all situations. It's also especially important as healthcare workers that identify as women, persons of colour, Indigenous, gender non-binary and/or trans also continue to experience harassment and discrimination. Normalization of diversity is necessary, and requires participation from all of us.

I'm encouraged by the overwhelming number of requests I have had for rainbow stickers to adorn stethoscopes and rainbow pins for lanyards and lapels. The recent Rocky Mountain Internal Medicine conference went one step further with the inclusion of gender-pronoun specific name tags to go along with the rainbow pins I've been providing to whomever chooses to identify as an ally. I see this as an overdue start to more active allyship in the health system and society in general.

Resistance to social progress is not only hurting ourselves and our colleagues, but creating potential harms for our patients.[4,5] The interrelatedness of all aspects of life with health creates the need for physicians and other healthcare providers to openly identify and defend LGBTQ+ ally-ship for all persons.

As an industry devoted to service, we owe it to ourselves and to our patients.

Caley Shukalek, MD, MSc, FRCPC
General Internist & Clinical Assistant Professor, Cumming School of Medicine
Calgary, Alberta

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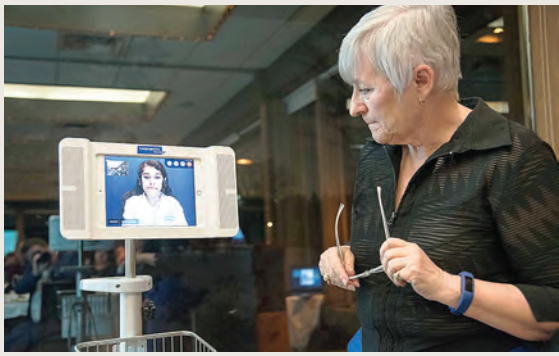
EZMSA Executive – Left to right: Dr. Paul Greenwood Member at Large, Dr. Ericka MacIntyre, Vice President, Dr. Marjan Abbasi, Member at Large , Laurie Wear, Admin Assistant, Heidi Andre, Admin Assistant, Dr. Ernie Schuster, President

Dr. Ernie Schuster & Dr. Keith Aronyk, "The Gamma Knife" Guest Speaker



Louise Behie, "Professional Medical Interpretation at AHS," Guest Speaker

An update from the Edmonton Zone Medical Staff Association

On November 14th, the Edmonton Zone Medical Staff hosted their Annual General Meeting, Dinner & Special Lecturers event.

One of the highlights was a very dynamic presentation by Louise Behiel, Manager, Interpretation & Translation Services, AHS East Calgary Health Centre. She discussed advanced technology available for video remote interpretation, and professional medical interpretation over encrypted livestream video. The service she presented on is available in 36 languages, including American Sign Language, with a one minute average connecting time.

This technology is particularly suitable for emergency departments, pediatrics, care for the deaf and hard of hearing, and in circumstances where a visual connection with the interpreter enhances communication and patient safety. This product is being rolled out provincially in a staged implementation (To find out more, contact: translation.services@ahs.ca).

We also heard from Dr. Keith Aronyk, Neurosurgery Co-director of the Gamma Knife Unit at the University of Alberta Hospital. The Gamma Knife is a remarkable versatile treatment modality mainly used for brain tumors, and heralded as the, "long awaited alternative to open brain surgery."

Unlike open surgery, Gamma Knife neurosurgery is non-invasive. It replaces a scalpel with beams of gamma rays that are guided with surgical precision, minimizing the impact on nearby healthy brain tissue.

Patients with lesions or malformations in the brain may have previously required open brain surgery and in-hospital stays, but now many patients, "Are able to walk in for Gamma Knife treatment and be home the same day in time for dinner with their families," says Dr. Aronyk.

Roughly half of the referrals in the Gamma Knife's first year of operation have been for cancer patients in treatment at the Cross Cancer Institute for brain metastases, a cancer that's travelled to the brain from elsewhere in the body. Gamma Knife treatment is a more precise alternative to whole brain radiation therapy for cancer that has travelled to the brain from elsewhere in the body. Access to Gamma Knife treatment has been a game changer and has dramatically improved the care that teams provide, as well as the experience for many patients.

These are a few examples of the exciting information and ideas shared at our AGM. For other updates and announcements, visit our website: **http://albertazmsa.com/ezmsa**

EZMSA Staff

Edmonton Zone Medical Staff Association

EDMONTON ZONE MEDICAL STAFF ASSOCIATION

HELPING PHYSICIANS HELP PATIENTS

2019 CAMSS Advocacy Award Winner

At the CAMSS Annual General Meeting on November 13, 2019 Dr. Fozia Alvi was the recipient of the 2019 CAMSS Advocacy Award.

History of the Award:

In early 2010, then CAPA president Linda Slocombe suggested CAPA establish an award to present to a CAPA member who best exemplifies the spirit behind our mission statement: *Advocating for physicians, caring for patients*. She envisioned a plaque with the names of the award recipients presented to each doctors lounge in Calgary and to all six of our rural hospital sites.

A list of previous winners can be found on our website:
http://albertazmsa.com/advocacy-award-history

Nominations for Dr. Alvi:

Dr. Alvi has been a Family Physician in the Calgary/ Airdrie are for the past 12 years. She started doing advocacy for victims of the Rohingya genocide after doing a medical mission in 2017. She has spoken at various national and international platforms and started her own foundation- Humanity Auxilium. She has been nominated for the 2019 Nobel Peace Prize.

Dr. Alvi teaches Family Medicine residents at the University of Calgary and is Chair of the Airdrie Community Physician Association, Vice Chair of the Highland PCN and Chair of the Uninsured Services Committee of the AMA.

As well as her humanitarian work, Dr. Alvi is a strong advocate for her patients at home. Four years ago she stepped in to help the patients of Bieseker after their local physician died. She went to Beiseker twice a week until six months ago when replacement physicians were found.

Dr. Margot McLean

Dr. Fozia Alvi is a family physician who has worked in the Airdrie area for the past 12 years. She started doing humanitarian work in 2017 with the Rohingya refugee population after a medical mission. She spoke at various national and international platforms (including the UN). and started her own foundation (Humanity Auxilium). For her advocacy work she has been nominated for a Nobel Peace Prize.

Dr. Mindy Gautama, Dr. Fozia Alvi and Dr. Margot McLean

Locally Fozia has been hard at work at her family practice, teaching University of Calgary residents, and acting as the chair of the Airdrie community physicians association and as vice chair of the Highland PCN. She is a strong advocate for her patients and their medical needs. She was contacted by the community of Beiseker 4 years ago when one for their long term physicians died. The community was unable to find a doctor to come to the community (a particular concern was their elderly patients who were unable to drive). Fozia provided services, driving to Beiseker twice per week for over 3 years, until she was able to recruit a physician to take over this care.

Dr. Mindy Gautama

Your Voice Needs to be Heard

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

Whether you have contributed countless articles or you merely enjoy reading Vital Signs, thank you for your time and attention.

With that said, we've got big plans for Vital Signs and we hope you'll join us on our journey. Certainly continue to keep reading Vital Signs but we encourage you to do more. Tweet about the things you read and interest you, share links to our online version with friends and colleagues and write for Vital Signs. The doctors who have contributed always find it a rewarding experience.

HERE'S WHY:

Writing makes you a better thinker
In an effort to create content that is succinct, reveals new ways to look at common things, or apply simple solutions to seemingly complex problems, you might think about healthcare differently.

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

Writing allows you to create bigger ideas
Producing content over time affords you the opportunity to create larger editorial ideas that can be reshaped and repurposed for other settings.

EDITORIAL GUIDELINES

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

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

Content submitted should be original and is published at the discretion of the Editorial Committee. Content should reflect the goals of the ZMSAs and be respectful and constructive. It's also important to remember that this is not an academic paper: this is a chance to use a more casual tone — Vital Signs is an ongoing conversation, physician to physician.

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

Please observe writing conventions:

- Be brief, but engaging. Limit unnecessary words and adopt plain language where possible.
- Use action words and make it clear how this information will directly benefit the reader.

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

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