Please contact your representative with any concerns or issues.

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Editor, Dr. Richard Bergstrom
PRESIDENT’S CORNER

Dr. Robert Broad

Improving Communications
Sean Cahill, a Family Doctor in Sherwood Park and member of the EZMSA Council phoned me a couple of weeks ago to share the difficulties a community doc has in communicating with a hospital-based Specialist about a patient they share in common. This isn’t about trying to refer a new patient - that’s a thorny issue on its own – but rather (for example) you trying to get a hold of Dr Broad, that Neurosurgeon at the “U” and talk to him about Mr. Smith, who’s got a cervical spondylotic myelopathy. You’ve just seen the patient again, something concerns you, and the battle of left messages and telephone tag begins. Or Mr. Smith turns up in your office, having had an operation about which he seems to understand little, there’s yet to be an OR report on Net Care, and feel the frustration building at having to get through to his office, get through his Secretary, and then play telephone tag before finally having that two minute conversation that sorts it all out.

We know we need to do something but what?

Ernie Schuster, Zone Lead of Primary Care, Sean and I are going to sit down in August to talk about the problem hopefully to begin to assess its scope and find some directions to head.

On that point, if you are aware of the problem in your practice, let us know and particularly how it interferes with good patient care. And if you think you have a solution, send that along.

The best way to get the problems to us is to email the Zone Medical Staff Association secretary, Laurie Wear, at Laurie.Wear@covenanthealth.ca

For many years, the Medical Staff Association has had a Waiting Times survey of Family Doctors – how long does it take to get an elective patient seen – and pondering here on paper, I wonder if a survey of where the communications are would help improve the problem?

Again, let Laurie know.
CONFIRMATIONS:
A) Locum’s require privileges. A locum is defined in the Medical Staff bylaws as; “A Practitioner temporarily placed into an existing practice and/or Facility in order to facilitate short term absence of another Practitioner, or to address a temporary shortfall in Practitioner workforce.” As such locums are considered resource/cost neutral.

B) 1. Although privileging can sometimes seem to be cumbersome, the current credentialing process is effective for all cases, including locums.

2. There exists a variety of processes that would allow for rapid response from medical affairs.
   - If physician already has privileges a “change application” can be done that decreases processing times
   - In extremely tight timelines an Emergent/Unusual Circumstance (EUC) can be done – this will be determined by Medical Affairs once all facts on the case have been reviewed.

3. There is still significant confusion regarding the privileging process and review of the process needs to be done with key stakeholders and physician groups. Provincial Medical Affairs has recently released a “Guide to Credentials that will help inform users of the process (see attached AHS Guide to Credentials)

RECOMMENDATIONS:
Committee had a variety of resolutions that could potentially streamline locum credentialing:

1. Locum privileging for a year and specific to zone such that a locum position could be ‘assigned’ to a specific locum position with zone without re-privileging.

2. Locum pools consistently prove to be effective - There is interest in forming locum pools in the Edmonton Zone but at this point there is no concentrated/centralized effort to do so.

3. Notification to Medical Affairs of need for locum would allow time to process the necessary documentation and/or make the determination that an EUC is required.

4. Ongoing education process for zones is necessary. Contact Bev Armstrong, Medical Affairs for further assistance in setting up sessions.

5. Changes to credential process may allow increased flexibility; however, such changes may require changes to Bylaws and would therefore be out of scope for this committee.

Committee Members: Dr. Tim Gillese, Dr. Doug Faulder, Mr. Barry Brayshaw, AMA, Dr. Bill Johnston, AHS, Dr. Christine Kyriakides, Ms. Bev Armstrong,

The Guide has just been posted to the internal and external websites! Here are the links:

- External (Medical Staff website): http://www.albertahealthservices.ca/7086.asp
- Internal (Insite): http://insite.albertahealthservices.ca/8273.asp.
Mark your Calendars – EZMSA Dinner at the Art Gallery & AGM Meeting: **THURSDAY October 10, 2013 6:00- 9:00 p.m. more details TBA.**

Have a wonderful summer and watch for the annual EZMSA Waitlist Access Survey – we need your input.

RWB

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**Letter from the Editor**

**What does M.D. stand for?**

In the business world there is a lot of talk about “branding”. By that term, they mean your company’s name has a specific connotation. We all know who “Sick Kids” is. “Mayo Clinic” and “The Cleveland Clinic” evoke certain thoughts about the quality of health care. We also know what a “Benz” is along with a “Porsche”. “Coke” means Coca Cola. “Nike” means Nike. “Madonna” is no longer a religious term for so many. “The Stones” is about a specific type of music and performance, not about renal colic or biliary colic. Now what about the brand “M.D.”?

I mention this after a couple of experiences that opened my eyes... they frequently need opening. In the first one, I watched a fascinating show on counterfeiting. The second was an article I read in the APSF (Anesthesia Patient Safety Foundation) Newsletter. Within the newsletter there was an article on a large fungal outbreak in the U.S. secondary to medication contamination. As I watched and read, I thought about what M.D. stands for. I was not thinking about it standing for Medical Doctor. Rather, I was thinking that it stood for a “standard of care” and ability to trust.

So, let me digress a bit and tell you about the show and the article. This show was about counterfeiting. It was led by a lawyer in Toronto who is an expert regarding same. He went with a hidden camera to a large conglomerate of stores and found “bargains” throughout. He asked the shop keepers if this was really “Apple” or “Ray Ban” or “Burberry” or “Gucci”. Post purchase, in the mall parking lot, he examined these “great buys”. The “Apple” product had “Appol” on its side. Now, he showed that this device, which on the exterior looked like an Apple charger but when plugged had a much greater chance of overheating and bursting into flames. The sunglasses were tested for ability to exclude UV rays, you can imagine what they noted. As people say now “Not so much”. Then this lawyer spent some time with the CEO of “Canada Goose”, the east coast winter jacket company. They examined a “knock off” and the differences, which were subtle on the outside. The most impressive
difference was in what you could not see. The CEO sliced open the lining of coat and pulled out what should be down. It was feathers, twigs, dirt and some fluffy down like substance. Now, the CEO asked if this material had been sterilized. Yeah, like I would like to put on that jacket and be exposed to the microbes, fungi and spores contained within. It was not what it looked like, it is what is contained within that told you the real story.

For the newsletter article, it spoke to a terrible story from the U.S.A. It involved fungal contamination of preservative free methylprednisolone acetate which eventually led to 730 cases of fungal meningitis and 51 deaths, as reported by the Center of Disease Control. The drug had been provided to health care facilities after being prepared by a “Compounding Center”. I had no idea what a Compounding Center is and was fascinated to learn just what this beast is. These Compounding Centers will “make a product for you”. That is, they will make your vials of methylprednisolone acetate, having purchased the drug from a manufacturer. Hospitals can “outsource” their having to make different solutions, including chemotherapy and TPN, as to decrease costs. (It is easier and cheaper to make something in bulk as opposed to making it in small quantities). This Compounding Center did just that. They would make drugs in bulk and sell them to Health Care Organizations. Post identification of the contamination, regulators had found deficits in testing procedures, leading to the problem. The article then went on to describe a large series of deaths from other drug contamination errors.

Now, back to “Branding”. This, for me, relates to “What do I do” and “What patients can expect from me”. In addition it relates to “What can I expect of others”. In June I had the great opportunity to travel to Barcelona and take in two meetings (and some damn good tapas). The European community has the same problem that we have, that is, escalating costs for health care. One of the best points I took from the meeting was “Are you decreasing costs or decreasing costs and margin of safety”.

I am totally convinced (until proved otherwise) that we should focus rigorously on error not on success. In addition we should spend more time measuring outcome not income (fair and reasonable compensation should occur; it should reflect time, intensity and complexity, not just the ability of the Government to want to pay). We, as physicians, are routinely quite successful. Yet, error and harm happens. Error does not always result in harm. If you look at the expectation of patients, they appreciate that risk is present, that is why they are coming to you, as a physician. We discuss risk and obtain informed consent then proceed with treatment.

Now, how would you feel if you were the doc who injected your patient with the steroid and then find out they had fungal meningitis and perchance would die because of what you did? You would feel sick, perchance not wanting to do that procedure any more. You would be the second victim. Our trust would have been compromised.

Patients trust us and they trust us implicitly. As the cost of care does go up we should be at the table discussing unnecessary tests, treatments and futile care. Yet, we should remind ourselves and remind the organizations that decreasing costs should not decrease safety, nor care. Australia has no multidose vials after a series of patients contracted HIV, presumably, from a contaminated multidose vial.

Counterfeiting is different from innovation. The later is making something better, faster, cheaper. We do that in medicine. We also provide invention. That is, making something new. Both of these “I” words are important in the evolution of care. We do need to make things better, faster, and cheaper and we also strive to care for others who need care. That is the invention part.

Overall, let us continue to work such at the letters “M.D.” stand for something real, true and trustworthy. We have a long tradition of providing trustworthy care. Let our brand continue to signal care,
compassion and improvement. For it is not what M.D. stands for, it is what we show patients, regulators and health care organizations what it stands for.

SUBMISSIONS: EZMSA monthly newsletter welcomes submissions (articles, notices, letters to the editors), announcements, photos, ec.) from practitioners and healthcare providers in Alberta. Please limite articles to 600 words or less.

**Deadline:**
The deadline for article submission to EZMSA is the 20th day of the month for distribution.

**Laurie Wear**, Phone 780-735-2924 Fax 780-735-2517, Email laurie.wear@covenanthealth.ca
**Dr. Richard Bergstrom, Editor**