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Please contact your representative with any concerns or issues.

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Editor, Dr. Richard Bergstrom
The recent dismissal of the AHS board has created a great deal of controversy and an equal amount of anxiety for docs working in our Zone and through the rest of the province. What I’ve been hearing is that most of you don’t want needless change –change for the sake of change. Many of us who’ve been in practice for a while have experienced two major health care delivery revolutions: from hospital boards to regions and from regions to AHS. I grant that some of the changes were positive but there were major difficulties. With the re-organizations, a decision-making void appeared which only slowly dissipated over the following years, and patient care suffered. Nobody seemed to know who was responsible to make which decision and everything stalled. Good work in programme planning done for the “old administration” was set aside or lost forever.

My personal example was detailed planning between Neurosurgery, Orthopedics, Neurology, Rheumatology, Psychiatry, and Family Medicine was done to create a medical multi-discipline spine clinic for medical spine care. The work was done for Capital Health and when AHS was formed it was all discarded, leaving all the docs involved cynical and disengaged.

And consider the cost of re-organization, none of which benefitted patients. Couldn’t this money be better spent on improving outcome, quality care issues, etc.

Finally, I’m concerned about physician engagement with which we struggle daily. Disengagement started with the first revolution when many docs lost their medical homes, the hospital. The chance to know your colleagues was lessened; the chance for that Medical Staff Lounge “consult” was lost; the chance to button-hole a fellow doc to help out of this committee or that disappeared. We need stability to help grow physician engagement.

Docs don’t fear change, but the change we need is a constructive evolution of the health care delivery model based on consultation and focused on improving outcomes and being sensible with costs. Docs fear the other kind.

Dismissal of the board need not result in a major overhaul of the system and we hope the Minister carefully weighs are further changes and allows a dialogue.

RWB
Epiphany

I am 55 years old; when I was 20 that seemed ancient. So, I guess I am ancient too many. Yet, I can learn. When I learn some things I think to myself “Richard, that was so obvious, why didn’t you pick that up earlier?” One needs to be in the right frame of mind to hear, or listen, to the obvious. It is fun to learn things, really fun. The sad part about it is I so often wish I had learned them earlier. But, all things being equal, I learned something. So, onto the story....

I have been involved in medical politics for a long, long time. It was never my intent to go in this direction, but it has been a road that I have experienced both enjoyment and great frustration. The enjoyment has come with the ability to advocate for patient needs and see them come to fruition. The frustration comes when the most reasonable need is, it seems, put on the back burner.

So, I find myself in a new position at the EZMSA Council. I am not representing a hospital, being the vice president, president or past president. I am the “editor” and have a familiar constituency, that is, you, the physicians of the Zone. My role is to write these editorials (which seem to resonate with the front line) and review articles submitted for publication in our newsletter. So, I am to a certain degree, a fly on the wall.

I am listening to the Council Members speaking and also to the report from out new Medical Director of the Zone, Dr. David Mador. The discussion is most interesting (and not a new one). Dr. Mador reflects on having been an administrator in the days of Capital Health and the current state of affairs. He comments that there has been a lot of change and improvement in some areas. The “push back” from some of the EZMSA Council members is to the effect of there are still patients who are not getting the care they need. In fact, they are experiencing poor care, unacceptable care and the physicians are upset and disturbed that there seems to be no recognition of this problem.

Then, for me the penny drops. I have been at enough of these meetings to remember presentation after presentation of the success that either Capital Health or Alberta Health Services had achieved. New programs, new ideas, investment in new care, better care and better access. These were great to hear, engaging and they did make you feel like a difference was being made. And a difference was being made, just not to everyone.

That is the problem with physicians. We care about success but we care more about when success is not achieved. As I tried to explain my thoughts I referred to my background, that is, facilitating surgery (me being the anesthesiologist). When you have a list of 8 cases and get to do only 7, we grumble, moan and our brow furrows. The hospital looks at doing 7 out of 8 and that seems a pretty good score. We focus relentlessly on the one cancelled case. For to us, it is not a case, it is a patient and one of our patients. We have focused on the failure not on the success.

Therein lies my epiphany. It is your focus and your concern. The hospital, the organization looks at “What works”, “What we can celebrate” and “What we have done”

We, as physicians, often consider what we have been able to accomplish as “water under the bridge” and we then focus on “What has not been done”.

Access to health care is a focus and timely access is an issue dear to the hearts of doctors. I have been fortunate to have, for many years, reviewed the Access Survey produced by the docs of this area. Access and the barriers to access is a common theme for so many. We often focus on the
challenges to care, and rightly so. When someone comes to you with a concern, it is a concern, a worry and a problem. Our role is to provide care, comfort, concern and compassion. We cannot do that when there is no access, therefore the focus on what does not work as opposed to what is working.

So, I would encourage all of you to continue to be the “voice of your patient”. When things work, celebrate. When things do not work, let it be heard. Yet, I would advise tempering your voice to speak for and of your patient. We, as physicians, need to recognize both the success of programs and also their failures. Failure is not failure of the program, yet, failure to deliver care to an individual; our patient. As physicians, when our patient does not get the care they need, it is a failure. That is, a failure to deliver care, not a failure of the whole system. I would encourage all docs to recognize both the success and the failures of AHS; not to demonize nor discredit AHS, rather to point out areas where their program failed.

We as physicians will, as I said above, treat success as “water under the bridge” and also will speak loudly and strongly when the patient (whom we serve) fails to get the care, the timely care and the support they need. We all work for them.

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Dr. Ganesh

Aligning Medical Education and Health-care Delivery in Canada

It is no secret that graduates from several residency programs in Canada can expect to have a challenging time finding meaningful employment in their specialty for at least a few years after training. In September of 2012, Dr. Brain Goldman spoke to new cardiac and orthopedic surgeons about their tribulations in finding postings in Canada, as part of CBC’s “White Coat Black Art,” in a segment entitled, “Will Operate for Food? The Unemployed Doc Paradox.”¹ The hyperbole of the title aside, the fact remains that this issue is becoming increasingly prominent in the Canadian media, as reflected in a recent article by the National Post’s Tom Blackwell.² Mr. Blackwell’s article focuses on pediatricians in training and notes the concerning mismatch between the types of physicians being trained and the ones the system actually requires. For instance, Blackwell notes that the number of pediatric neurologists being trained is twice what is needed to meet Canadian health-care demands, while, at the same time, we are training only half of the number of neonatologists required. Specialities reporting unemployment or underemployment of new graduates include cardiac surgery, neurosurgery, plastic surgery, orthopedic surgery, otolaryngology, nephrology, and radiation oncology (this is not a comprehensive list).³ Yet, we all know of rural and smaller urban areas that continue to struggle with a shortage of various medical and surgical specialists.⁴ Moreover, roughly two million Canadians

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³ In addition to Tom Blackwell’s article, see: Vogel L. Specialty training out-of-sync with job market. CMAJ 2011;183(13):E1016.
continue to have difficulties finding family physicians.\(^5\) These challenges reflect not only a discrepancy between the training and hiring of specialist-physicians, but also a misalignment between the allocation of physician resources and the actual health-care needs of our citizens.

This misalignment is a serious cause for concern in a public health-care system. Unlike our American counterparts whose training positions rely more on private funding, sometimes precariously,\(^6\) our residency programs are funded by Canadian taxpayers, and our medical education is heavily subsidized by them. In fact, based on recent Ontario estimates, it costs the public approximately $285,000 to train a family physician and about $760,000 to train a specialist in Canada, excluding the costs of medical school and further subspecialty training.\(^7\) Therefore, it is important for our medical education system to be fiscally and socially accountable to Canadians by working to ensure that their health-care needs drive the physicians we train and how we train them.

Fortunately, the misalignment in health human resources has been recognized and the wheels of our health-care machinery appear to be responding. At the Canadian Conference on Medical Education (CCME) in Quebec City this April, the Association of Faculties of Medicine of Canada (AFMC) presented its “Collective Vision” for the future of Post-Graduate Medical Education.\(^8\) First on their list of recommendations is “Ensure the Right Mix, Distribution, and Number of Physicians to Meet Social Needs.” Dr. Nick Busing, President and CEO of the AFMC, in his address to the CCME, highlighted the need to create a national data-founded approach to determine, on an ongoing basis, the number and type of specialty positions needed in Canadian residency programs to meet our society’s needs. Meanwhile, the Royal College of Physicians and Surgeons of Canada is currently compiling a report from the first phase of its mixed-method research study to examine national factors underlying specialty physician unemployment/underemployment, including geographical variations in health-care needs\(^9\) – information that could be invaluable in helping determine our allocation of training spots in various specialties. This work is definitely a step in the right direction.

Two of the key roles of physicians as per the CanMEDS framework at the heart of each Canadian residency training program, are those of the “Communicator” and the “Manager”.\(^10\) It is time for us, as physicians, to better fulfill these roles not only in the delivery of care to our patients at the individual level, but also at the population level in how we approach medical education in the first place. It may be challenging to identify societal patient care needs in the future in order to train physicians to meet those needs, but through close communication among physician trainers, hirers, and health-care researchers, we can begin to facilitate the more responsible and sustainable delivery of medical education and physician services in Canada in the 21\(^{st}\) century.

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**Provincial CIS Update – June 2013**

On June 12, 2013, the AHS Health Plan and Business Plan 2013 – 2016 was published and presents the overall direction of the organization and highlights significant actions that reflect AHS’ Triple Aim Approach – **Better Quality, Better Outcomes, Better Value**. The Plans specifically focus on investing in priority areas, aligning resources with priorities and realizing benefits.

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\(^5\) [http://www.statcan.gc.ca/daily-quotidien/110621/dq110621b-eng.htm](http://www.statcan.gc.ca/daily-quotidien/110621/dq110621b-eng.htm) - 4.4 million Canadians reporting no regular medical doctor, of whom 53% reported trying unsuccessfully to find one.


\(^7\) [http://www.afmc.ca/pdf/fmec/03_Abrahams_Inputs%20Outputs%20Outcomes.pdf](http://www.afmc.ca/pdf/fmec/03_Abrahams_Inputs%20Outputs%20Outcomes.pdf)


\(^9\) Dr. Danielle Hollenberg of Human Resources of Health at the Royal College of Physicians and Surgeons of Canada, Jan 2013, personal communication.

\(^10\) [http://www.royalcollege.ca/portal/page/portal/rc/resources/aboutcanmeds](http://www.royalcollege.ca/portal/page/portal/rc/resources/aboutcanmeds)
The Provincial Clinical Information System (CIS) is highlighted on page 15 (The Path Forward – Our Plan for Action for the Next Three Years) and reprises information presented to the Edmonton Zone Medical Staff Association over time by Dr. Tim Graham, one of the CIS’s provincial sponsors.

In alignment with AHS strategy, CIS will focus on:

- Value for patients and their families
- Safety and quality overall
- Clinically driven data analysis
- Continuity of care and service delivery
- Cross continuum communication
- Articulated measurable benefits
- Sustainability and scalability

The benefits of this investment can be more fully realized with a broader footprint – across the province and across the continuum of care. In the coming six months of intensive planning, the program will engage with stakeholders from within the Edmonton Zone specifically, but also from across all zones and service areas to assist in the development of a comprehensive CIS Strategy and roadmap.

There will be opportunities for engagement in many ways, from the planning and design / build phases through implementation and longer term optimization and benefits realization. This is a journey, one that will take years to complete, so we need to focus our valuable resources on not only delivering the CIS solution but achieving the transformation in healthcare it is intended to enable.

Work Underway

Establish provincial CIS governance structure encompassing AHS, AH, the AMA and other key stakeholders and entrenching clinician leadership.

Establish and support a contract negotiation team to complete the procurement phase with the recommended vendor.

Develop and validate a comprehensive provincial CIS implementation plan. This plan will include the vision for the program and the 5 year roadmap by which the vision is achieved.

Establish the provincial working committees, driven by clinicians, to design the solution and to identify and validate the clinical content (e.g. clinical best practices, order sets, clinical documentation templates).

Clinical leadership and clinical engagement are key success factors for the initiative. Clinicians from around the province will have numerous and ongoing opportunities to participate in the program in many different capacities.

Thank you again for this opportunity to share CIS information with you. We invite your review of the Plans and feedback of how a province-wide CIS can support your patients and your practice.

You can reach us anytime at: CISProgram@albertahealthservices.ca
Clinical Teaching and Clinical Academic Colleagues in the Edmonton Zone

In the last newsletter, I asked how important it was for you to be recognized as a teacher of medicine. From communications I’ve received, I guess it is important. So I’m going to write a second part to the last article. This is on how to go about achieving this in an effective and efficient way. It’s about the one thing we all hate to have to do – keeping records or logs.

First of all, having to keep logs is a fact of professional life. Like it or not (like death and taxes) it is unavoidable so I guess we might as well all get used to it. We have to keep logs in order to fill in details for our annual College of Physicians and Surgeons of Alberta (CPSA) professional license renewal. We have to keep logs to fill in our continuing professional development submission for credits from the College of Family Physicians or the Royal College of Physicians & Surgeons of Canada. And so on.

Wait a minute. So many of us already have some kind of system to keep a record of what we do during the year. Why not tweak it so it also fulfills the additional function of filling in your Annual Report form for the U of A, which supports your recognition for promotion? You may already have a system – laptop, computer, or (gasp) even a file folder or shoebox for your CME Attended certificates.

Whether it’s an electronic or paper log, how about starting off with the year on the top of the page, then make your columns. Draw a line down the middle, mark one side “Date / Activity” and the other “Details / Time Spent”. Then remember the KISS* principle in designing the rest – i.e. record only that which you will need to use. And it does require discipline to enter the information as soon as possible after you have completed the activity, so you don’t forget.

For Clinical Academic Colleagues (CACs), you only need to keep records each year of 4 things for your Annual Report.

(1) Your teaching activities - e.g. discovery learning, bedside / operating room teaching, office elective etc – and the estimated number of hours spent on each. Note if you were an organizer or presenter (more points) and if you were nominated or received any teaching awards for this activity (even more points). Also include any participation in faculty development that year – again either as attendee or presenter.

(2) All the Committees you were involved in. Similarly record type of involvement in the other column – member, or chair. Remember all committees count – your practice or PCN, hospital’s, any university, any AMA, CMA or CPSA committee.

(3) All your Continuous Professional Development activities. You probably already have a system for this, in which case use what you have, just hyper-link it to your above e-document if you are like me and can’t remember where I filed what. Again note whether you were attending or giving the lecture / workshop.
(4) Any research or publications for the year.

Remember, these are the only 4 areas where information is needed for a CAC Annual Report. It happens that one already needs to keep a record of many of these areas for other professional purposes. Why not amalgamate them?

I have kept a log similar to the above arrangement, with varying levels of detail – at first on paper, then in the last decade or more as a Word file (I know others who find Exel easier). I have found this helps me to complete my annual CPSA, RCP, U of A Annual Report etc. each year. It even comes in handy if you occasionally have to submit a CV for whatever reason.

Death and taxes and keeping logs. All unavoidable facets of professional life.

TK
*KISS = Keep It Simple Stupid

Please help with identifying patients in your practice with chronic illness who could be potentially recruited to be patient mentors in a new Patient Immersion learning experience for Year 1 medical students starting in September 2013.

General criteria for appropriate patients include:

1) Live within approximately 40 km radius of the university campus.

2) Have a diagnosis of a chronic illness that impacts their life in a significant or daily manner.

3) Are good storytellers who would be engaged and positive participants in the students' learning.

4) Have had or currently has regular contact with the healthcare system and are willing to share their experiences with navigating the system.

5) Willing to have a pair of students a) come to their homes approximately once every 2 months, and b) attend at least one medical appointment with them during the academic year.

6) Have family and/or others who support them, who would be willing to participate in these home visits and also share their experiences with the students.

7) Ideally willing to embark on a journey with the students over the first 2 years of their medical school training.

We have the contact cards (sample below) to distribute to patients. Please let Melissa Coumont at (780) 248-1311 or melissa.coumont@ualberta.ca know and we will send some to your office right away. Alternatively, if you have a patient who is interested, they can contact Melissa Coumont to provide their name and contact information so that an application form can be sent to the patient.
SUBMISSIONS: EZMSA monthly newsletter welcomes submissions (articles, notices, letters to the editors), announcements, photos, etc.) from practitioners and healthcare providers in Alberta. Please limit articles to 600 words or less.

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

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