President’s Corner ............................................................... page 2
Letter from Editor ............................................................... page 3 & 4
T K Lee Clinical Teaching & Clinical Academic Colleagues ........ page 5
Physicians needed to interview medical school applicants ........ page 6
EMWC ................................................................. page 7

Please contact your representative with any concerns or issues.

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Editor, Dr. Richard Bergstrom
Attached update regarding the laboratory. Further feedback/questions can be sent to LabModel@albertahealthservices.ca.

Practitioner Advocacy Assistant Line (PAAL) Moved to AMA
The Practitioner Advocacy Assistance Line (PAAL) is a central point of contact for Practitioners to share concerns or advise of challenges in advocating for patients and reporting intimidation.

In August 2013, management and support of PAAL was transferred from Alberta Health Services (AHS) to the Alberta Medical Association (AMA) and a confidential third party intake operator. The resolution of calls was also transferred from the Office of the Chief Medical Officer (CMO) to the Zone Medical Staff Association (ZMSA) Presidents.

This transfer was completed as part of AHS’s commitment to supporting effective Practitioner advocacy for patients and the health system and to helping Practitioners feel more secure in their ability to report concerns regarding advocacy and intimidation.

Continued confidential reporting is assured. Anonymous calls will be accepted, documented and reported. However, the level of resolution of concerns and support provided may be reduced by remaining anonymous.

To contact PAAL, please continue to call the toll free number: 1-866-225-7112.

For more information, please visit www.albertadoctors.org/about/leaders/zmsas/paal or contact your ZMSA president. For a list of ZMSA presidents, please visit: www.albertadoctors.org/media/media-contacts#ZMSA%20pres.

Please attend this meeting: “time to be engaged”

EZMSA ANNUAL GENERAL MEETING

THURSDAY, October 10 2013
Reception: 5:30 p.m.
Dinner: 6:00 p.m. (Phone EZMSA for Reservation & Cost)
Meeting: 7:00 – 9:00 p.m. (free)
**AGENDA**

1.0 CALL TO ORDER

2.0 Mr. Kavis Reed, Coach EE  
   10 min

3.0 EZMSA President’s Report  
   30 min

4.0 Dr. David Mador, Zone Medical Director  
   45 min

5.0 Dr. Trevor Theman – Prohibiting Private MRIs…NOT!  
   30 min

Call EZMSA office to reserve a dinner spot! $85.00 each or $150.00 for two

EZMSA Office: Ph: 780-735-2924   Fx: 780-735-2517   laurie.wear@covenanthealth.ca

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**Letter from the Editor**

Trust, physicians and our work...

I know that we used to joke about this in medical school “Trust me, I’m a doctor!” As I have aged, experienced a lot in life (though being protected within the Western Hemisphere), now looking at the end of my career (not yet looking at the end of my life), I can reflect back on what I have learned. To that end, I truly believe that “trust” is a vital component of a physician/patient relationship. Not blind trust, rather earned and human trust.

I practice as an anesthesiologist and have the privilege and pleasure of providing care for those needing surgery or procedures that need sedation. For me, after almost thirty years of providing anesthetics, I have grown from someone who was so excited with the procedures and intensity to someone who has focused so very much more on the patient; their journey, what they feel and how I can serve their needs. Technology is so very sexy, cool and fun; the ability to measure intra-arterial pressure, pulmonary artery pressure, now to perform transesophageal echo, we see deeper and deeper into the physiology of the patient. With these tools we can take more and more challenging patients and provide needed care. At the beginning of my residency I was so focused on what I was learning I gave no heed to where I might be in thirty years. Wow, what a journey.

I also remember an acquaintance telling me a story regarding his daughter’s tonsillectomy. It was a powerful story. He looked at me with intensity and focus, then wonder. “I gave my daughter to them, I gave her to them, to someone I did not know”. Sure, it was “just” a tonsillectomy and let me tell you another story. I was asked to come in for a stat post tonsil bleed. I was not on call but came in grumpy and muttering. The patient comes through the doors. A pale, pale 17 year old athletic looking boy. His mother was as pale as he was. It was a quick whisk down to the room for a quick anesthetic and control of the bleeder. I told him he had to lie down and the response I got was “I cannot, I will drown in my own blood”. Unbelievable. He then trusted me to give him an anesthetic as he knew he was dying. Another story of an individual who had her husband rush her to hospital knowing something was wrong. (She had a bleeding ectopic pregnancy) She felt like she was going to die and she relates a
hand came out and held her hand. “We are going to take care of you” She related those words were so powerful and gave her hope as she felt the icy cold of death’s hand.

This is not about us being heroes, it is not about “us” rather, what “we” do. Patients trust us empirically. In survey’s taken, physicians routinely score very high when it comes to trust. But that is just empirical trust. The journey with patients can deepen that trust from an assumed trust to a deep, deep appreciation for the “care and caring” that you provide. Hope for health and “getting better” is also a given. Yet, we are all human and have limited lifespans. I think the ability to allow patients to trust us, to listen to them, provide advice for them (as opposed to from us) will simply strengthen an already strong bond.

Even though we have a regulatory body, relationships with Educational Institutions and Government Agencies, these like us, are not always infallible. We cannot trust them implicitly. They suffer the same aliment as all of us, imperfection. If you read Daniel Kahneman’s “Thinking, Fast and Slow” you will realize just how non-logical we are, even when we are completely sure that we are thinking in the most logical way possible.

Argument is vital to getting to “better”. I do not support “You idiot, you are not listening to me” argument. I do support “I hear what you are saying and find part of your argument flawed. My take on this is.....”. Argument is like negotiation. Each side has a view and a position. Should they always end up with a winner and a loser? Not always; I think that exchange of ideas and competition leads us to better. As I have said before, competition is not about beating someone, it is about developing a better product. Open argument can stimulate organizations to become stronger with a more focused workforce. As is said in Buddhism, it is not my way or your way, it is a better way.

Now, back to the beginning, what about trust and sorry. How does this mesh with argument? We are well trained as physicians. We are also human and can be wrong. I think we need to ask ourselves if we have listened well, advised well and if we are not sure, make it known. As I have said before “What I do makes my reputation but others decide what my reputation is”. Trust is imperative in medicine, saying sorry can mean so much and argument is only about finding out what is best.

Now, I just forgot one of the very important, if not the most important part of our work, decreasing suffering. This last aspect is separate and apart from delivering a healthy baby, removing an inflamed appendix, helping those with mental health problems see more clearly and manage better, setting broken bones, mending broken hearts and the such. We also advance care and that is both innovation and invention. We also need to look at those in their last stages of living. To bring dignity, care, compassion and comfort to those who are dying; I truly believe that is integral to what we do as physicians.

Peter Drucker (the management consultant guru from the last century) helped me understand the essence of business and therefore helped me see health care from a different perspective. We provide a service to someone, or should I say for someone (one of my frequent comments is that it is not important what we do “to” someone, it is much more important what we do “for” them) and that service is of “value” to the patient. We do not diagnose a “cold” more than we provide reassurance that this is not serious, it will be gone in five days and all you need is analgesic and to stay away from infecting people (a note that says you can stay away from work is not about “you and how you poorly you feel” it is about “you not infecting the office”...some social responsibility). When someone needs a knee replacement it is more about the improvement of mobility and activity than it is about the operation. The value of a new knee is twofold. You have decreased pain (a very good thing) and you also have the ability to maintain independence, activity and overall health. What we do is provide “value” for patients.
I am an old dog. I graduated in 1981 and have been in active full-time private practice for over 25 years (I do work in a University Department and the University Hospital but have no signed contract with the former and have “Privileges” to practice in the latter). This does not make me any smarter than the young docs coming off the assembly line (yes, it is an assembly line). It does make me wiser. By that I mean I have experienced the influence of health care administration and the University opinions over the last quarter century. Not all of these changes have been congruent with my focus on providing valuable care for patients. I have learned to listen to these agencies and then contrast and compare that with my own views and beliefs.

As physician advocates, I think we need to maintain a voice for the patient. The Government wails about the ever increasing cost of health care; I suggest they speak up and tell the Albertans what you are not going to cover and meld that with the Canada Health Act. AHS speaks about costs, too; have them speak to the patients who could benefit from care and are sitting in the queue, suffering all the while. We have people sitting in hospital with broken bones because there are no funds for definitive care today. We have people who need primary care in the most basic sense; that is, changing the social determinants of health. We need to continue to provide a voice for each and every patient; not to squabble within our ranks and dismiss our colleagues ability to provide care (Why fund them and not me?). I believe we need to ask the question “Yes, Mr. Minister ‘Why them and not me?’” as to ask about disparity and appropriate support. It is the Government and AHS executives to speak with the people, the weary the worried and those who seek the care we can provide.

I would speak in favor of continuing a series of letters and conversations with our MLA’s, AHS executives, managers, and others. Both to make sure our patients know that we are advocating for them and secondarily to provide input for what is needed. Targets and goals have been a disaster in parts of the NHS; the tick box on the “out of ER within four hours” is more valuable than the care received.

Metrics are important but only if they deliver care to each and every patient that needs care. Metrics can show effective care, yet, for me they really identify areas where we are not serving enough, not creating the change that is needed, not being the true advocates we need to be.

I hope that we all continue to see our relationship with patients paramount to the value we bring to all who seek our service. Trust is so very important and it is not (as some in positions of leadership seem to think) an entitlement, it is an earned commodity. So, in ending, do enjoy the summer (no one moves to Edmonton for the weather) and have a rest then continue to provide care, value and the important part of advocacy for our patients. For they do matter, as much as what you do matters.

Clinical Teaching and Clinical Academic Colleagues in the Edmonton Zone
T K Lee MB,BS FRCPC.
Should clinical faculty be paid for teaching? The answer may seem an obvious yes – or is it?

Some months ago in one of my articles I’d mentioned the existence of a provincial committee called APESC (Alberta Physician Educator Steering Committee) comprising members from U of Calgary, U of Alberta FOMD and Alberta Health and Wellness, as well as Alberta Advanced Education and Technology (post-secondary programs). Initiated by AHW, its task is to develop a comprehensive provincial framework to meet Alberta’s need for physician preceptors, including consideration of remuneration for clinical teachers. We had our latest meeting a few weeks ago, and you may be one of those approached for interviews by Deloitte in the future as part of this committee’s work.

Clinical faculty (clinical academic colleagues or CACs) are integral to the running of undergraduate clinical rotations and to post-graduate residency programs. They provide exposure to a different type of practice in comparison to full-time academic physicians who tend to have more hospital-based disease and body system focused practices. CACs’ practices do involve the above as well but in addition often offer a community-based, patient-focused, generalist practice experience. This is beneficial in providing the broad based experience to the as yet undifferentiated medical learner.

CACs are a large and diverse group, and recognized for their teaching in different ways including being awarded university academic titles and the occasional stipend calculated and paid by different resources. Sometimes monetary support may be more forthcoming and robust, e.g. the Alberta Rural Physician Action Plan (RPAP) and the Alberta International Medical Graduate (AIMG) Program to name two examples. These programs provide defined monetary support to CACs who teach learners as part of these programs. However, the Times They Are A-Changing. The status quo is unsustainable. It is getting harder and harder to find volunteer faculty to teach for the university, without some form of greater incentivising, including a monetary one. This is creating a human resource problem of finding sufficient clinical teachers / preceptors in Alberta.

The UK has addressed this problem many years ago by compensating physicians as employees or through full-time service contracts that (among other things) specifies teaching deliverables of the attending physician. The General Medical Council (GMC would parallel our RCPSA and CFPC) works with UK medical schools to set the standards of knowledge, skills, attitudes and behaviours that medical students should acquire. GMC stipulates in their “Good Medical Practice” professional guidelines that if asked, a doctor in the UK is obliged to teach and in so doing, must develop the skills, attitudes and practices of a good teacher. This is reinforced through terms and conditions of employment and contracts for service.

The USA addresses their needs by delivering the majority of their teaching through hospital and hospital-based clinics owned by the medical school, with community based teaching delivered through practice networks affiliated with the medical school. This affiliation has substantial market value to the physician in a private-for-profit health care delivery system and provides the incentive to volunteer as a clinical teacher / preceptor.

In Canada i.e. Alberta the regulatory bodies (CPSA) and RPCSA and CFPC do not obligate doctors to teach. Very few of us are on service contracts (AARPs) that specify teaching, and in fact clinical ARPs only require that we deliver a clinical service. We do not have the same University affiliation market force as in the USA given our socialized system of health care delivery. Except for full-time academic clinical teachers, the medical education system relies on our sense of obligation to our profession and to society, a form of “social contract with the public to ensure continued competence, integrity, and altruism of doctors, as well as promotion of the public good”.

Of course, there are other reasons that many colleagues have told me over the years as to why they continue to teach: it is fun, it is mentally rewarding, it enriches our professional (and personal) lives, and it keeps us current. So now, APESC will attempt to add one more regular dimension – it may actually include recognition by remuneration.
But are we in danger of viewing teaching as a commodity? Are we now possibly going to have it spelled out for us that, in return for committing to teach for remuneration, we will agree to provide to the learner what is expected of given curriculum deliverables in our contract, maintain our skills at teaching and undergo periodic assessments of our teaching performance? What will happen to our sense of volunteerism, altruism, social contract, Hippocratic view of see-one-do-one-teach-one? We know that monetary remuneration has been traditionally low on the list of priorities of CACs in past surveys. Is it time for that paradigm to change?

Should clinical faculty be paid for teaching? Let me know your thoughts.

TK  
(Email: tzulee@shaw.ca)

References:
2. Quoting: Bob Dylan

Physicians needed to interview medical school applicants.
"Who are the best people to decide who will become the physician workforce of tomorrow?" Some of the best people would be those who understand the job; that would be "You", the workforce of today. We need your assistance to help us decide who will be the next generation of physicians. Should you be able to volunteer, we would love to have you help us in the interview process.

Saturday, March 15 or Sunday March 16, 2014, 7:00 a.m. – 5:00 p.m. Interviewers are required to commit a FULL day.

Being an interviewer is a volunteer position. MAINPORT credits for family physicians can be obtained.

It is always more complex than it seems. We want you to have the ability to make the decisions for the interview process to the same degree you have in your clinical decision making. Therefore there is a session where new interviewers will have the training and support to confidently enter into the interview process.

For all new interviewers, 90 minutes for you to be acquainted with the process, sessions are available:

Thursday, March 6, 2014 from 1700-1830hrs or Saturday, March 8, 2014 from 0930-1100hrs

Please contact Gisele Lepage-Wilcox for more information: glepage-wilcox@ualberta.ca

AHS Worker Safety Moment, Bullying in the Workplace.
Bullying is increasingly being recognized as a serious problem in the workplace. AHS is developing and implementing policies, procedures and supports to address violence in the workplace accordance with an Accreditation Canada Required Organizational Practice.

Follow this link for more information.

C:\Documents and Settings\lauriewear\Desktop\AHS Worker Safety Moment.pdf
We hope you are all enjoying a lovely summer. The Edmonton Medical Women’s Club’s regular interest groups will reconvene starting in September and October. We also have the following upcoming event.

**Save the Date:** Fall Dinner and Biannual Meeting Wednesday October 9th, 6 p.m. at the Edmonton Country Club. Entertainment will be provided by musician Keri Zwicker, a popular harpist and singer who specializes in Celtic and Latin music with a modern slant that has broad appeal. For more information please contact Deann at [edmonton.medwomen@gmail.com](mailto:edmonton.medwomen@gmail.com).

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**SUBMISSIONS:** EZMSA monthly newsletter welcomes submissions (articles, notices, letters to the editors), announcements, photos, etc.) 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](mailto:laurie.wear@covenanthealth.ca)

*Dr. Richard Bergstrom, Editor*