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CHALLENGES
Despite letting the Minister of Health know of the importance of stability to the health care system, we have seen major changes to the upper echelons of Alberta Health Services. We had an AHS Board and then we did not; we had an AHS Administrator and then we had a different one. We had an experienced Chief Medical Officer and an experienced Chief Operating Officer, and then we had none. And we had a most experienced and committed CEO of AHS, and once again we have not.

As I have written previously, changes such as these create a “decisional paralysis” as those left behind instinctively know that the best way to survive is to avoid making decisions. And those in the trenches of health care delivery have every reason to become cynical about AHS and disengaged about participating.

With those negative thoughts out, I still think we can all agree that when Docs are engaged the health care system works better and patients get better care. And when heads are rolling faster at AHS than in “Great Expectations”, we should all catch ourselves from pulling back and cocooning in our own practices.

We must stay engaged! It makes a difference for our patients.

Letter from the Editor

Beware these words!

Words are great! They are powerful tools. They give us the ability to communicate, describe, share, argue and such. They have power and presence. They can make you cry or become enraged. They can also have great camouflage.

Hmmm....Words as camouflage, kind of a strange concept. Let me explain. One of the current “organizational words” is “transparency”. Have you ever asked someone for a simple definition of “transparency”? I doubt if you could get a simple answer. I liken it to CCTV (closed circuit TV). My wife and I travel to London (UK) a fair bit (great music, theatre and now food!) There you are always on TV. You stop anywhere in central London, look around, and you are sure to see two or three of these cameras blending into the buildings. Where I see “transparency” being linked to “CCTV” is that transparency in an organization is what others see, not what the organizations states. The CCTV tells it all, your actions are truly transparent (your reasons, not so much)
Oh, be ever so careful when you hear the word “surely”. You will have someone say “Surely you believe in “X”! With the use of this word, a message or superiority (them) and inferiority (you) occurs. It is actually demeaning in many instances. There implied (camouflaged) content of “You are wrong if you think anything else but my belief” Not that people always intend to be demeaning when they use this word; it is just there are many better choices/tools to engage in conversation.

That brings to mind “engagement”! This is a very important measure of an organization’s overall health. Engaged employees feel valued, believe they are productive, and understand the purpose of the organization. They also contribute to the mission of the organization.

Organizations are healthier wealthier and more successful with engaged employees and partners. I continue to shake my head when the Government and AHS say “You need to be engaged”. They should be saying to themselves “How do we get them engaged?” Or more importantly “How can we turn around the Titanic?”

The words an organization uses and the methods it creates change, in addition to the belief of the front line about the organization’s structure, function and relationships are extremely important in creating an environment of stability and growth. I think the sad thing in health care is the “Introducing the next best idea from the next best person, so forget yesterday and tomorrow is another day!” Change fatigue is throughout, yet the Minister does not speak to this.....oh Emperor’s new clothes, yet again!

Not to just rag on the insanity of Health Care Administration and the Alberta Government. We are to celebrate a lot of the care that Albertans get and the quality of care. Yet, our role from the position of the physician is to care for the patient. Should the system not be able to provide care, it is our problem, yet the responsibility of the “system”. I would advocate for all physicians to remember their role in patient advocacy. If the Canada Health Act needs to be rewritten, let the legislators re-write same, and also be accountable for same. We, as docs need to continue to provide and advance care for those who seek our knowledge, ability and foremost compassion. For without compassion, our patient becomes a commodity. And this is a word of which we should be truly frightened should we confuse patients with commodities.

Clinical Teaching and Clinical Academic Colleagues in the Edmonton Zone
T K Lee MB,BS FRCPC.
(Dr. Lee is a general internist at the Grey Nuns hospital and in private office practice. He is also Associate Dean, Clinical Faculty at the University of Alberta.)

Again I begin this month’s column with a question: Does being a clinical teacher make you a better physician?
Some years ago, I approached the late Dr. Brian Ward of the College of Physicians and Surgeons of Alberta to see if special credits could be given to clinical teachers as part of their revalidation (relicensing) process. My proposal to him was that clinical teaching likely improved the way we practiced medicine, so would the number of hours which we recorded on the CPSA relicensing webpage every December count for something extra?

He asked me to show him the evidence. For now, CPD credits (from the CFP and RCP process, many of us remember the old acronym MOCOMP) would be all they would consider. But it seemed to make sense to me. The tennis player plays his forehand 1,000 times to get the muscle memory to perfect his stroke. Physicians can’t practice on their patients that way, but the research literature suggests a similar process. Clinicians learn and maintain their peak performance through so-called focused reflective practice (deliberate practice), using repeated communication and role modeling with comparisons to their own performance from their peers, and in some their residents and students. We all know that if we don’t know something that a resident asks us, we go back and read it up and come back to teach them. Teaching should help us be better at our craft.

So I duly did a literature search (with the aid of a real librarian from the John Scott library) to prove my point to Dr. Ward.

I came empty handed. There were no published studies looking at this. There were some studies correlating better outcomes for patients treated in academic settings, but these may have been confounded by better resources and equipment in these institutions. The problem appeared to be that there were no real tools out there to measure physician performance. I was surprised and a little dispirited.

Wait a minute. What about the PAR program that all of us in Alberta go through every 5 years? Couldn’t that multisource feedback data be cross-tabulated with amount of time spent teaching?

A bunch of us (including Drs. Bruce Fisher & Carol Hodgson from U of A) in collaboration with Drs. Jocelyn Lockyer & Claudio Violato from the University of Calgary (the originators of PAR concepts and tools some 20 years ago) studied anonymized PAR data derived between 2007 to 2011 from colleagues, patients and co-workers in 1,831 Alberta family physicians, 1,510 medical specialists (mainly internists) and 542 surgeons. We correlated time spent teaching (data available from the CPSA relicensing database) with PAR scores. We weren’t expecting too much. Maybe the PAR tools would be too insensitive anyway to pick up differences, being designed more for feedback purposes for our own quality improvement than for picking up clinical performance.

The results were astounding. We found very significant correlation (p values of < 0.01 to 0.001) between higher PAR scores to more time spent in clinical bedside (as well as classroom) teaching. We saw what looked like a dose-response curve. The effect size was also very high. Was this simply self-selection i.e. those who were good at their work also loved to teach? I believe it reflects causality. For example, most of the study sample comprise clinical academic colleagues, those of us who did not choose to teach, but were “conscripted” into teaching roles when we began practicing in teaching hospitals. And the results were similar whether we were a full-time academic or a “volunteer” teacher.

This study has been presented in abstract at the recent International Association for Medical Education conference in Prague in August* (Dr. Lockyer) and the International Conference on Resident Education in Calgary in September (Dr. Fisher). It has also been submitted for publication, and we are busily rewriting following the first round with the reviewers. If successful, we hope it will be the first of many studies that objectively link clinical teaching to being a good doctor.
In the meantime, we can continue to teach secure in the knowledge that teaching most likely makes us better physicians. We always felt that it did, so here’s perhaps some objective evidence that it does.

TK  
(Email: tzulee@shaw.ca)


Link to abstract:  

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Dr. Scott McLeod  
Pediatric Resident Physician, University of Alberta

Attracting Residents to Rural Medicine  
Clinical rotations in rural areas are commonplace amongst resident physicians from all disciplines. From Family Medicine to General Surgery, there is likely a resident physician in a small community near you. Rural rotations pose both welcome challenges and a significant opportunity. Interacting with a new community offers new perspectives. One needs to learn about the varied supports and resources available for care. Most importantly it is about being more involved in caring for patients. On the other hand, the uncertainty and the lack of familiarity with the community can be overwhelming: where do I find the charts?, where do I buy food?, and where can I exercise or play sports? Ensuring that resident physicians are aware of the abundant advantages that can be found in a rural setting is important for both recruitment and care for rural citizens. By addressing the uncertainties and highlighting the opportunities around rural rotations, there is an enhancement of the experience of resident physicians, rural staff physicians, and community members who are affected by rural rotations.

My own experience as a paediatric resident in High Level, Alberta was extremely positive. After spending the better part of a year in a big hospital, the thought of practicing at a rural clinic was quite appealing to me. I felt excited about gaining exposure to the potential of an inside perspective on living in a rural community. The clinic that I worked at was very busy, with many patients needing care and assessment. In one day, I saw patients seeking assessment and care for: a heart murmur, short stature, low body tone, and rectal bleeding This diversity is something that I would be unlikely to see all in the same day in the city. The clinic had even booked consultation appointments especially for me, which allowed me to be more involved in creating work-up and treatment plans. Certainly, I am grateful to the staff and the family physicians at the clinic and my preceptor, who significantly influenced my educational experience.

Along with the many rewards rural practice has to offer, there are also challenges that resident physicians must overcome in a new community. Not knowing where to get food or exercise, being unfamiliar with the community, and not knowing anyone can create challenges. In a rural community
where everyone knows each other it is easy to feel like an outsider. In our work lives, learning who is available to provide medical support and knowing how to access the resources available to patients can take some time and cause worry. When we are unfamiliar with the system and resources available, it can be difficult to provide the highest quality of care. Yet, these challenges also present a great opportunity for self-growth. I encourage resident physicians to learn a new system; explore their new surroundings. To discover farmers’ markets, local events, curling rinks and the hidden abundance a rural community has to offer is enriching. Engage with local community members and allow them to share their hometown.

When resident physicians can enjoy utilizing the skills that they have attained through their training and have the opportunity to broaden their experience and skills in the smaller centres of Alberta, it is inspirational. I hope that resident physicians continue to acquire wisdom from both the rural patients and the physicians in our great province. It is only by continuing to experience medicine and the lifestyle provided in these communities that rural practice will be seen as the opportunity it truly is.

Consultation 0005 – The College is seeing your comments and suggestion on the following:
Charging for Uninsured Services (revision)
Obligations to Patients and Colleagues When Closing, Leaving or Relocating a Practice
Relocating a Medical Practice (NEW)
Terminating the Physician Patient Relationship in Office Settings (revision)
Closing or Leaving a Medical practice (revision)
Physician Health
Duty to Report or Treating Physicians and Physician Health Programs (NEW)
Methadone Maintenance Treatment
Methadone Maintenance Treatment Standards & Guidelines (revision)

Here is the link to the CPSA consultation page:
http://www.cpsa.ab.ca/Consultation/Consultation/CurrentConsultation.aspx

The link to EZMSA news is on the AMA website, go to:
https://www.albertadoctors.org/about/zmsas/news

SUBMISSIONS: EZMSA monthly newsletter welcomes submissions (articles, notices, letters to the editors), announcements, photos, etc.) from practitioners and healthcare providers in Alberta. Please limited articles to 600 words or less.
Deadline:
The deadline for article submission to EZMSA is the 20\textsuperscript{th} day of the month for distribution.

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