March/April 2010

THE ALBERTA DOCTORS' DIGEST

AMA carries Olympic Torch: A once-in-a-lifetime experience

Patients First®

ALBERTA MEDICAL ASSOCIATION

Volume 35, Number 2

Thoughts on the curriculum

Dennis W. Jirsch, MD, PhD
EDITOR

Lately, whenever a medical student appears at my side on rounds or in the coffee room, I've been asking him or her to define what a portal system is. I'm hoping to get into some of the relationships that exist between vascular flow, pressure and resistance, which might change, say, with cirrhosis of the liver.

Few of the students know what a portal system is, in the first instance, but they scurry to the nearest computer and, minutes later, return somewhat better informed.

We've become incapable of deep thought, Carr argues, but have become adroit at skipping over metaphorical lily pads on the pond of knowledge while losing the ability to troll for real substance, the larger connections.

Now I like to think I'm as au courant as the next fellow, that I'm not at all put off by this. There's much less anatomy and other of the one-time core subjects in medical school nowadays. Perhaps this kind of thing is to be expected.

It's gotten me thinking, though, about teaching students in this new age. There would seem to be at least two aspects worth thinking about. What should we teach? And, secondly, how should we teach it?

The "what" needs considering. I've gone on before about the need to develop some degree of financial savvy in medical students, but there are other topics, too. The stresses of medical school loom greater than ever and I'd certainly favor instruction in stress management.

Come to think of it, life management skills, in general, need attention. Death, retirement and taxes are still inevitabilities and, alone or in combo with other semi-predictable crises, can make life seem like an exercise in free fall.

A stable clinical practice – if ever a reality! – is unlikely nowadays. And most medical careers typically involve some mix of parenthood, clinical activity, research, teaching and administrative responsibilities, and in a variety of locales. Add continual learning and personal reinvention to the mix and, I think, it's daunting.

These matters get short shrift in the curriculum and I don't know why. Is it that these "soft" subjects are considered a personal responsibility?

Collectively, do we refuse to recognize their pertinence and cogency, perhaps like the evidence for global warming or the link between poverty and disease? Do we think they can't be taught?

The "how" of teaching has undergone huge change, too, and much instruction is now computer-based.

At rounds, for example, there's the usual kerfuffle and wasted time when the laptop and its projector won't work or there's a tiresome monotony of PowerPoint slides crowded with minutia and distracting musical intros. But I'm thinking of more than this.

In a recent article in *The Atlantic,*[1] author Nicholas Carr asked, "Is Google making us stupid?" Carr, of course, was referring to the amazing ability we have to find anything online immediately.

It's become something we've become accustomed to – short bursts of factoids linked to one another in an electronic ether. We've become incapable of deep thought, Carr argues, but have become adroit at skipping over metaphorical lily pads on the pond of knowledge while losing the ability to troll for real substance, the larger connections.

This nostalgia and fear of novelty is old stuff.[2] Plato warned if we depended on writing, we would lose the ability to remember things. Thoreau objected to the telegraph. And Samuel Morse, inventor of the telegraph, objected to the telephone's inability to preserve conversation.

Indeed every new communication advance that's come along has met skepticism and a longing for the medium that's been displaced.

There are many, nevertheless, who maintain that in this new world they ▸

- are capable of things they were never capable of before – of richer, more abundant creative lives.

Perhaps, Neanderthal-like, I'm caught in the past. But Marshall McLuhan's "the medium is the message" seems increasingly relevant today.

I'll try to illustrate. Parse the following, by Martin Rees,[3] England's Astronomer Royal. Would you think this would resonate within you the same way if you happened upon it hop-skip-and-jump, Google-wise, or if you read it from the real thing – a piece of paper.

> "Most educated people are aware that we are the outcome of nearly 4 billion years of Darwinian selection, but many tend to think that humans are somehow the culmination. Our sun, however, is less than halfway through its lifespan. It will not be humans who watch the sun's demise, 6 billion years from now. Any creatures that then exist will be as different from us as we are from bacteria or amoebae."

On Google or Yahoo I'm sure I'd skip to the next link without reflection, and on to the one after, and so on. The same sentences read from a book or, sometimes better yet, heard aloud elicit something like awe in me, and a tumbling web of connections and reminiscences.

For me, at least, this new technology is no elixir and the jumble of binary codes inhibits my thoughts.

Zigzagging hither and yon in an egalitarian slurry of all knowledge, linked to itself and to everything else, is a problem. Where to stop, focus, and attend in this electronic soup is an ability I need for post-Google literacy.

It used to be said that there are two kinds of knowledge – that which you know and that which you know how to get.

"Getting stuff" has become painless in the age of Wikipedia and Yahoo. There is, it must be said, a third kind of knowledge – knowing what matters.

There's still no better way to find out what matters, for my dollar, than with lectures, seminars and discussions. Consider the help you'd get from even a short talk that introduced you to a strange city, telling you about major intersections, rivers, bridges, the town centre and so on.

At a meeting some time ago, a presenter couldn't get his projector to work. There was nothing colorful or distracting – there was nothing

Where are we and our students going? How best to get there?

at all. The presenter, unfazed by the muddle, calmly stood *sans* overheads and gave his news and its significance.

Guess what? I remember more of that talk than I did of the "multimediocrity" of the remainder of the morning.

Now I am not being critical of students here, in any way. Whenever I get the chance to look over their youthful résumés, I am awed at their burgeoning accomplishments, their industry and vigor.

Neither am I saying that computer technology, as has become so richly evident in teaching technical skills, hasn't revolutionized our reach and our possibilities.

I maintain, though, that we are not being as smart about things as we could be.

We should periodically ask questions. Where are we and our students going? How best to get there?

References available upon request ■

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Small photo: Igniting the torch. (📷 Carin McCowan, Smiling Dragonfly Photography.)

AMA MISSION STATEMENT

The AMA stands as an advocate for its physician members, providing leadership and support for their role in the provision of quality health care.

AMA carries Olympic Torch: A once-in-a-lifetime experience

The day couldn't have been more beautiful. In a blissfully mild zero degrees, the sun poured out from behind the snowy mountain peaks, piercing a sparkling blue sky on January 21. Banff became one of 1,000 communities across Canada to get very close to the Olympic spirit.

Anticipation and excitement hung thickly in the air as people gathered along Lynx Street. Many were brightly adorned in red, some in Olympic gear, waving banners and pendants, ready to cheer.

The 19-member Alberta Medical Association (AMA) Olympic Torch Relay team, full of nervous energy, waited in the middle of the street, eager to carry the torch on this leg of its 106-day journey to Vancouver – site of the 2010 Winter Olympics.

The team was decked out in a uniform of colors and images representing Canada's geographical diversity – mountains, forests, prairies, ocean, sky and snow. Their red woollen mittens were adorned with olympic rings and a white maple leaf.

AMA torchbearers made us proud

Suddenly, in a flash, another team handed the Olympic flame to AMA President Dr. Christopher J. (Chip) Doig. Cheers erupted from the crowd as he jogged between two lines of his mates to the front of the AMA team.

The enthusiasm was infectious. AMA team members cheered each other on, smiled and waved to delighted onlookers. Teammates passed the torch to each other while running one kilometre (km).

At the end of their route, the Olympic flame was placed in a cauldron and whisked away to Lake Louise, the next stage of its journey across Canada.

The AMA was invited by Coca-Cola Limited, one of the Olympic sponsors, to participate in the Olympic Torch Relay because of the association's history of advocating for healthy living and putting Patients First®.

Fifteen Representative Forum members and four AMA staff were selected, in a draw, to participate.

"When chosen to run as a torchbearer, I knew it was truly a privilege and honor," said Dr. R. Michael Giuffre, a Calgary-based pediatric cardiologist. "We were one of a hundred teams who had this opportunity, and we were able to represent physicians and the AMA so very well."

The AMA team was part of a pan-Canadian team of 12,000 carrying the flame in a record journey. When ▸

> "The actual carrying of the torch was somewhat surreal! I felt an incredible energy flow through me and the 18 others in our group 'carried' me quickly down the pavement. I almost broke out in a singing of our national anthem as pride enveloped me and our AMA super-group!"
>
> Dr. Noel W. Grisdale, AMA Immediate Past President

Team AMA celebrates their participation in the historical torch relay. (Carin McCowan, Smiling Dragonfly Photography.)

Dr. Dianne B. Maier leads with the flame. (Carin McCowan, Smiling Dragonfly Photography.)

◂ Dr. Wendy L. Tink caught up in the spirit. (Carin McCowan, Smiling Dragonfly Photography.)

Go Canada, Go! Suzanne Doig, Stephen, Dr. Christopher J. (Chip) Doig, Lauren, Stuart and Benjamin. (Carin McCowan, Smiling Dragonfly Photography.)

it reached its destination, February 12, the torch had been carried across Canada for more than 45,000 kms, via land, air and sea, farther than any other torch relay in a host Olympic country.

The 2010 Olympic Torch Relay was created to inspire and engage Canadians from coast-to-coast-to-coast, as it travelled along the path of northern lights, on its way to the Vancouver Olympic Winter Games.

"The team concept was great! Meeting everyone and having that common bond or goal will be there forever," said Dr. Verna W. Yiu, an Edmonton pediatric nephrologist. "I got lots of Facebook comments and emails from friends and family all over the world stating how cool it was that I got to carry the torch."

To help the torch along its way to the site of the Olympics was a unique event the AMA team shared not only with each other, family and friends, but also others who watched online via CTV's Olympic Torch Relay webcam.

"It was powerful and inspirational to experience the hugely unifying force of the Olympic flame bringing the world together!" said Dr. Wendy L. Tink, a Calgary family physician.

"I will be attending the opening ceremony in Vancouver and when the cauldron is lit, I will be in the crowd knowing that I was part of the thousands of Canadians who carried that flame with pride, coast-to-coast," said Dr. Phillip W. van der Merwe, a Calgary-based family physician.

The AMA Olympic Torch relay team will cherish forever their once-in-a-lifetime experience amid fellow Canadians and the snowy mountain peaks of Banff.

Team AMA. (Dave Lowery ©2010.)

"My wife ran alongside us all the way in a Calgary Winter Olympics' torchbearer suit that belonged to her late father, who was a torchbearer for the Calgary games in 1988. It was so distinctive she had a call on her cell phone, while running, from friends in Newfoundland. They were following the webcam and could pick her out, and asked if she could please wave at the camera."

Dr. Tzu-Kuang (T.K.) Lee, AMA Past President

The AMA Olympic Torch Relay Team

- Dr. Christopher J. (Chip) Doig, President, Calgary
- Dr. Patrick J. White, President-Elect, Edmonton
- Dr. Noel W. Grisdale, Immediate Past President, Black Diamond
- Dr. Tzu-Kuang (T.K.) Lee, Past President, Edmonton
- Alexis D. Beamer, Communications Consultant, Public Affairs
- Dr. T. Malcolm Campbell, Ponoka
- Dr. Robin G. Cox, Calgary
- Dr. Nathaniel J. Day, Ponoka
- Dr. Howard Evans, Edmonton
- Dr. R. Michael Giuffre, Calgary
- Ronald A. Kustra, Assistant Executive Director (Public Affairs)
- Dr. Carolyn A. Lane, Calgary
- Dr. Dianne B. Maier, Calgary
- Dr. Maeve O'Beirne, Calgary
- Sean T. Smith, Director, AMA Practice Management Program
- Dr. Wendy L. Tink, Calgary
- Dr. Phillip W. van der Merwe, Calgary
- Kevin S. Wasko, Calgary
- Dr. Verna W. Yiu, Edmonton

Unfortunately, Dr. Elijah Dixon, from Calgary, was unable to make the run. Susan M. Black, Consultant, AMA Practice Management Program, ran in a different leg of the relay the previous day. ■

Members' views critical to the AMA

Trends over seven years

One way Alberta Medical Association (AMA) members give the association valuable input on issues important to physicians is through regular surveys.

Quarterly trackers reflect the AMA's commitment to effective two-way, symmetrical communications; 2,000 members have the opportunity to participate in each survey.

Members' views help the Representative Forum, Board of Directors and senior staff identify priorities and develop the AMA's annual business plan, strategies and activities, plus evaluate how effectively the association meets members' expectations and needs.

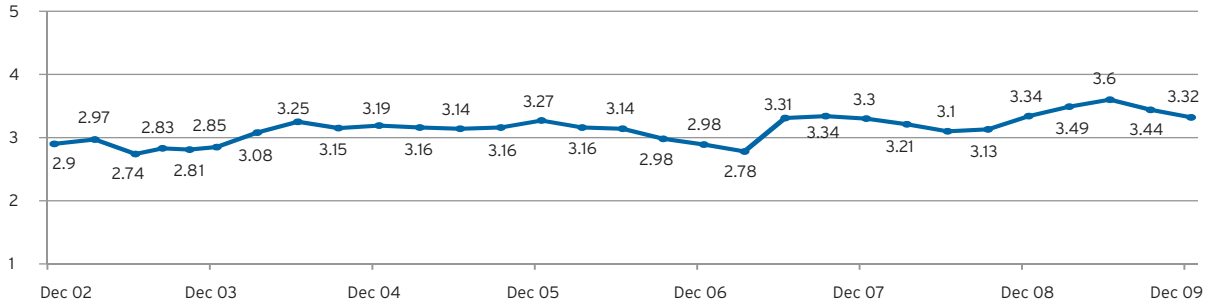
twi*surveys*, from Vancouver, assists in designing and administering the tracker surveys. Respondents' anonymity is assured.

One of the more valuable benefits of members' feedback is the trend data. Trends are analyzed against a five-point Likert scale. Scores of over 3.5 are very significant while scores of 3-3.5 are important.

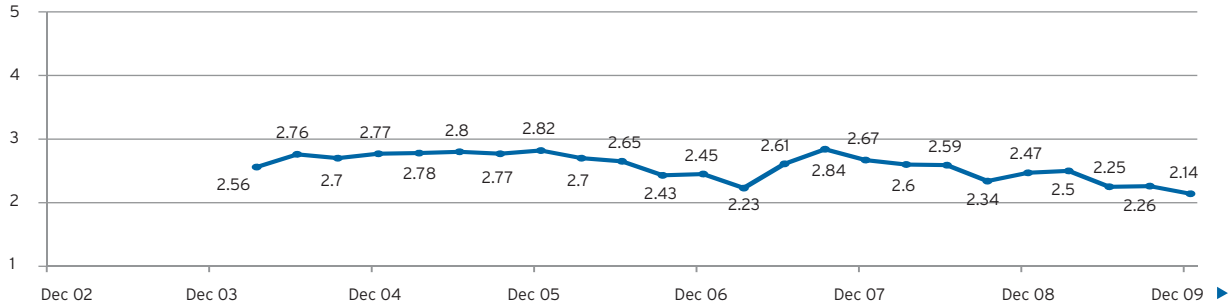
Trend data follows for surveys administered December 2002 through December 2009.

AMA member tracking data December 2002 through December 2009

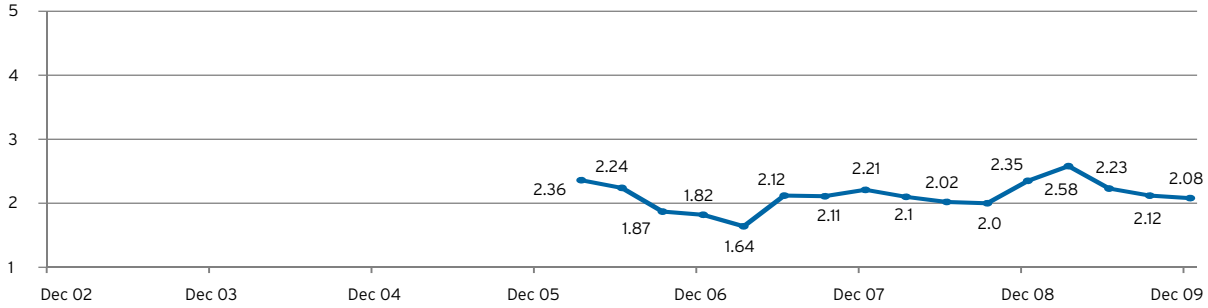
The AMA is making progress in achieving fee equity.



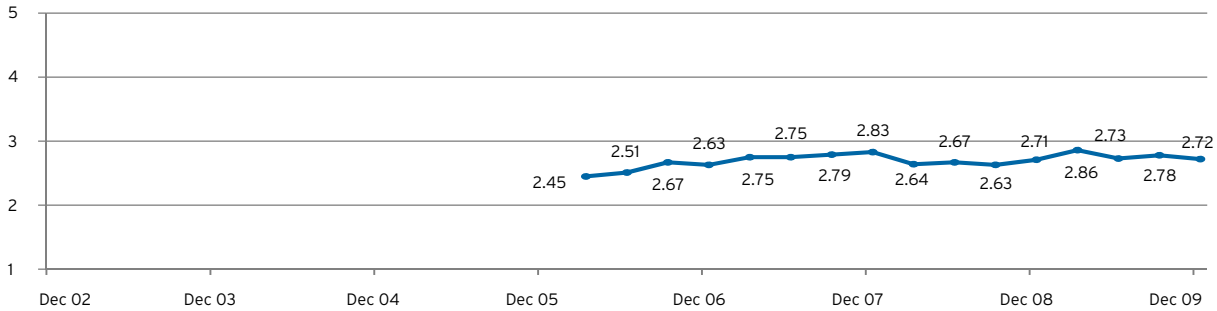
Changes in the health care system during the past 12 months have improved my ability to meet the needs of my patients.



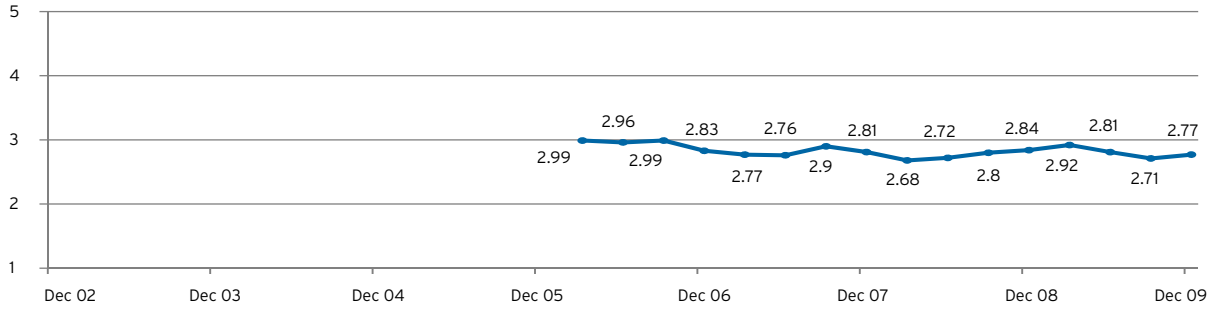
Funding of the Alberta health care system is keeping pace with the province's economic growth.



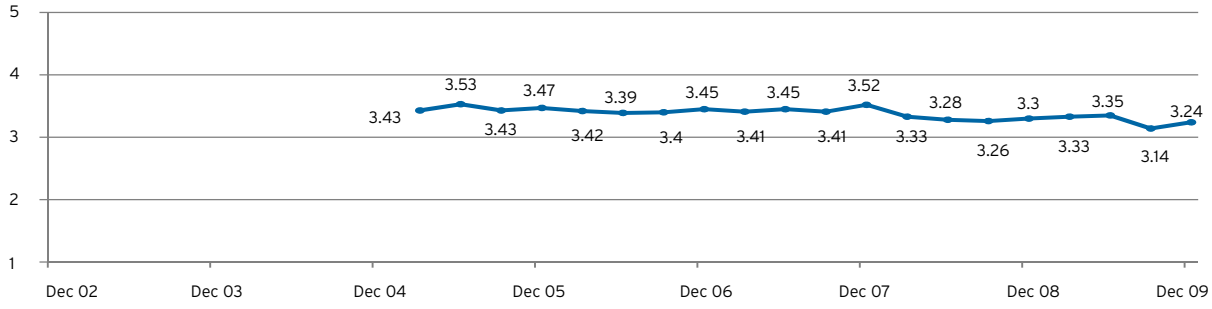
Allowing physicians to practise in both public and private health care enhances the availability of physicians in the public sector.



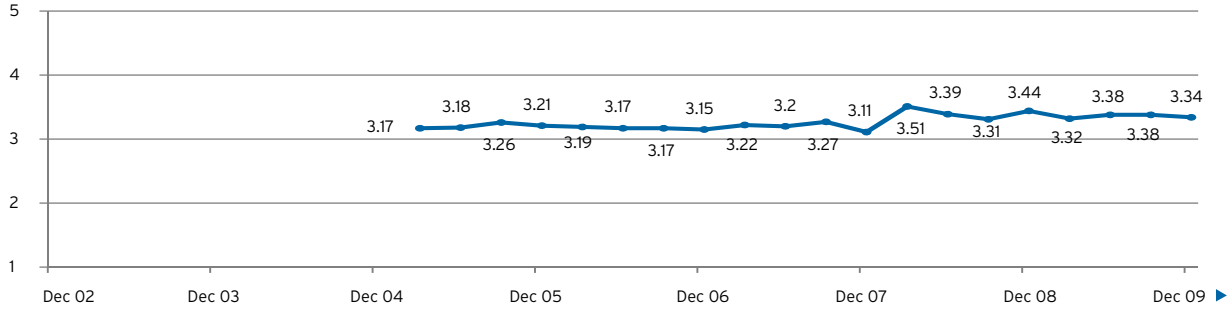
Health care guarantees will improve access to care.



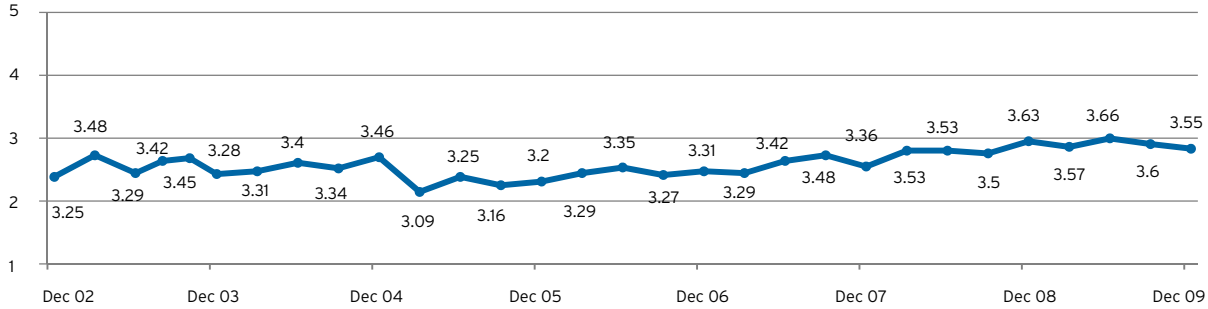
Whether or not I am compensated for it, I have a professional responsibility to provide on-call coverage for my patients.



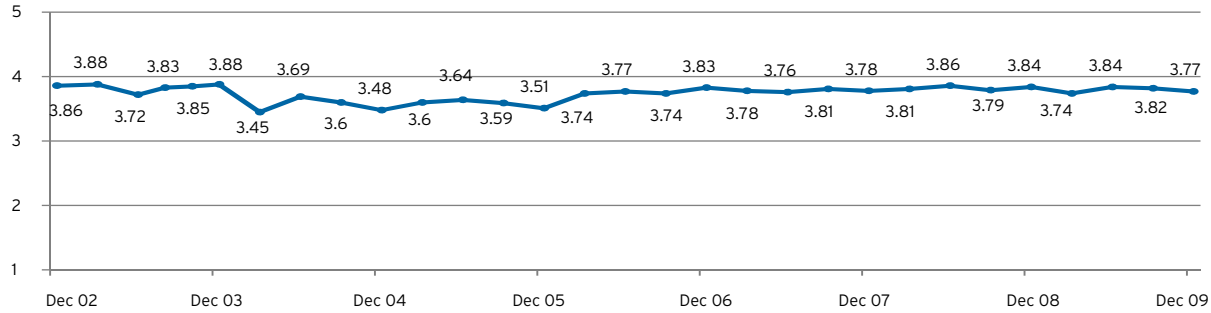
I feel informed about the primary care networks.



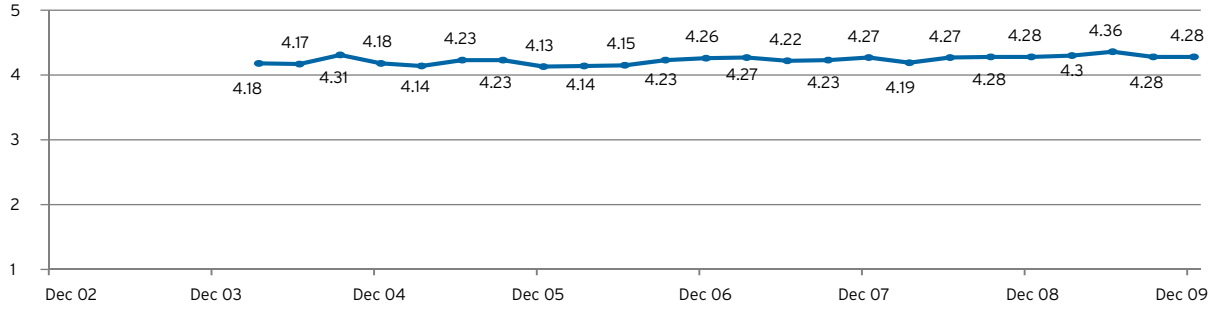
Primary care networks will help physicians to improve the delivery of care to our patients.



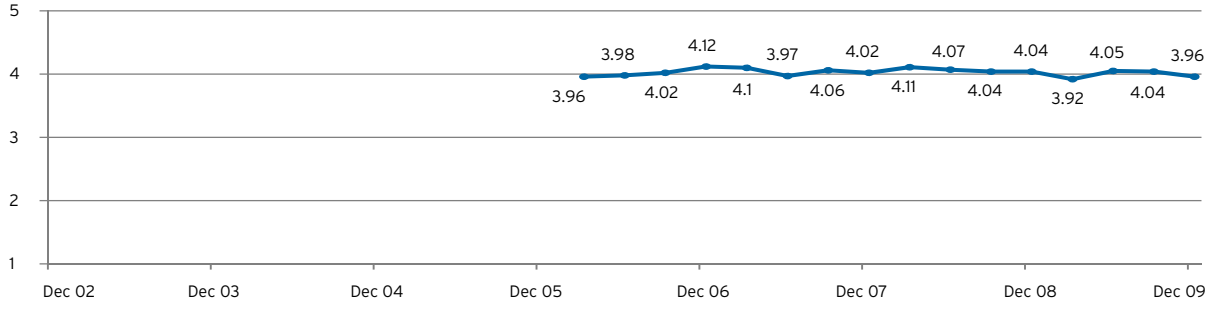
The development of computerized health networks is improving the delivery of health care to my patients.



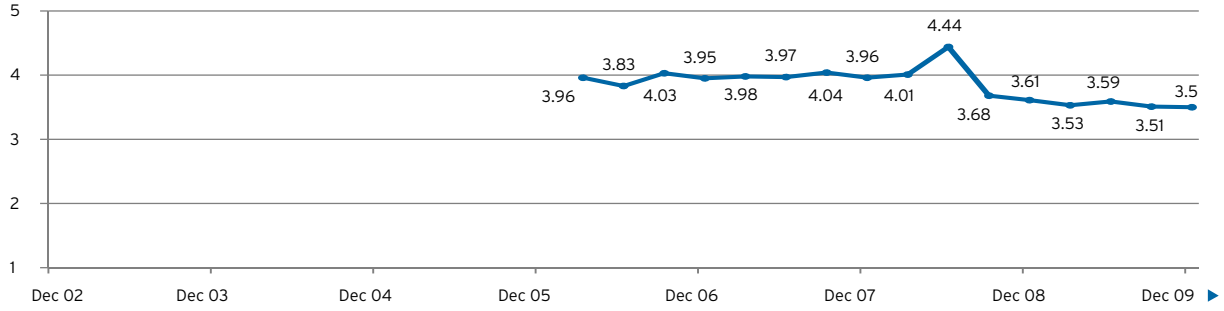
The physician's traditional role as manager and gatekeeper of the patient's record must be maintained in the design of electronic health and medical records.



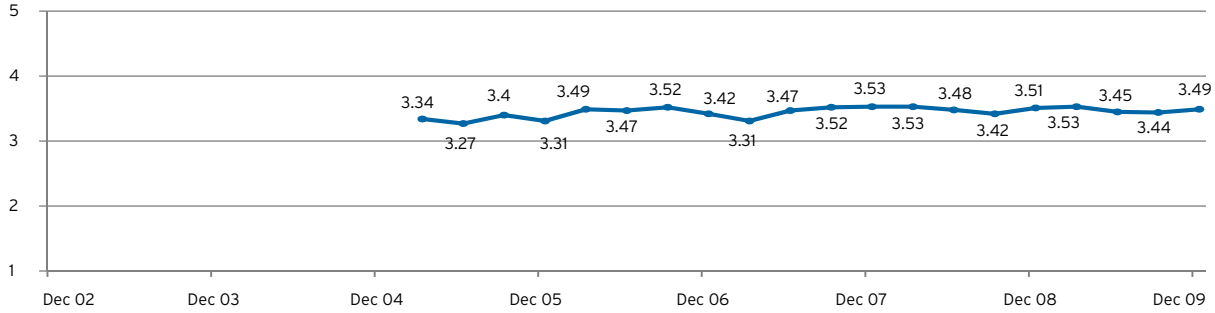
Having physicians' offices computerized will enhance the value of the provincial electronic health record.



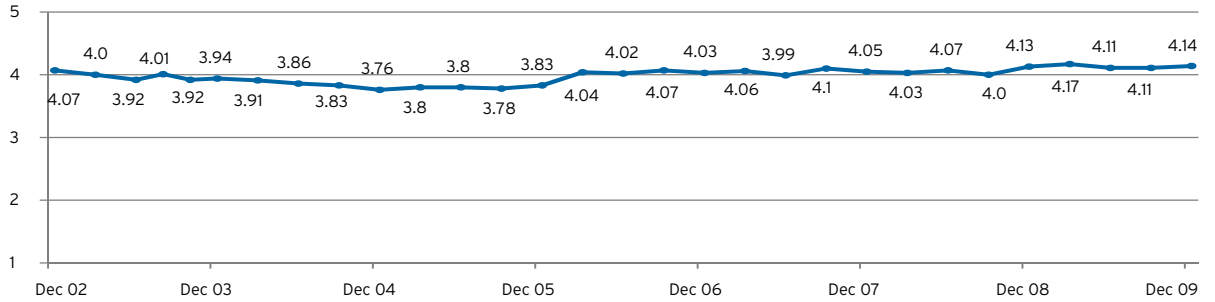
Funding for computerized office systems should be independent from Alberta Health Services.



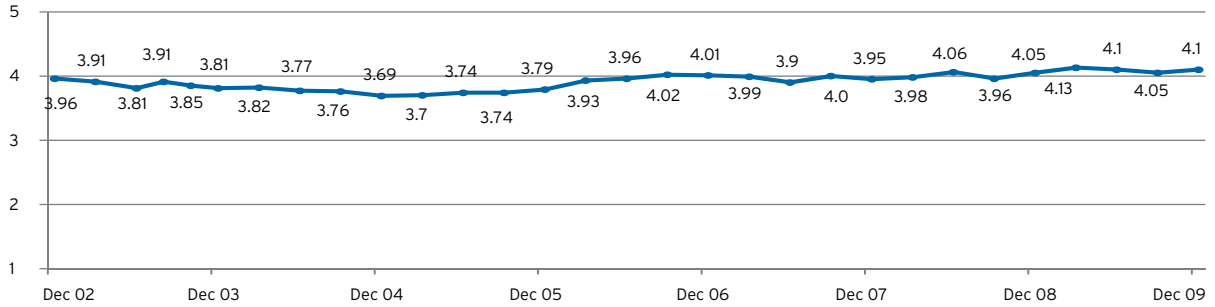
In the past 12 months, I have taken steps to improve the balance between my professional life and my personal life.



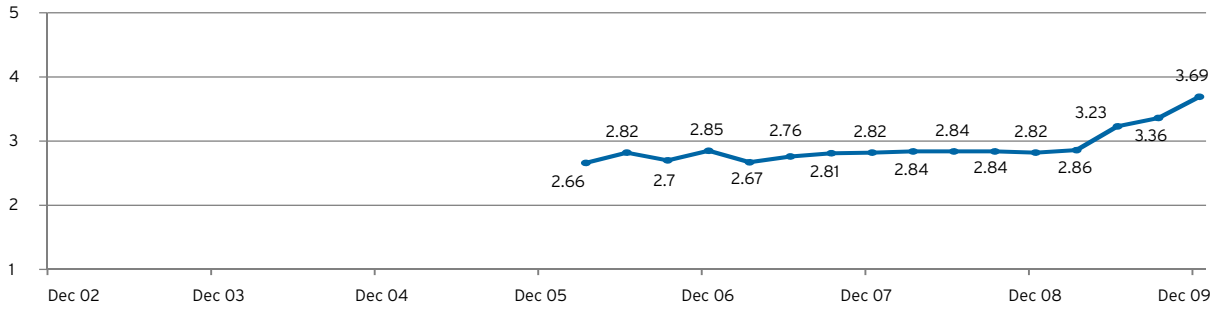
The AMA keeps me informed about association activities.



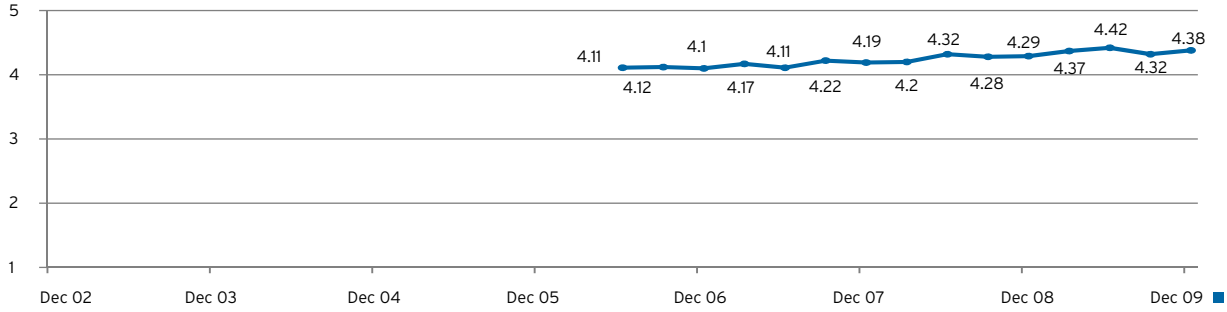
The AMA keeps me informed about the major issues in the health care system.



My medical office is prepared to respond to a pandemic.



The AMA should be involved when physicians negotiate with RHAs and others, e.g., Alberta Cancer Board, WCB.



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AMA seeks nominations to recognize outstanding achievements in health care

The Alberta Medical Association (AMA) is calling for **Achievement Awards** nominations for individuals who have contributed to the improvement of the quality of health care in Alberta.

The AMA must receive nomination submissions by April 30. Awards will be presented at the AMA's annual general meeting, September 24, in Edmonton.

The **Medal for Distinguished Service** is given to physicians who have made an outstanding personal contribution to medicine and to the people of Alberta, and in the process have contributed to the art and science of medicine while raising the standards of medical practice.

In 2009, three physicians were recognized with Medals for Distinguished Service – an Edmonton neurosurgeon and educator, Dr. Peter B. Allen; a Calgary rheumatologist and professor, Dr. Martin H. Atkinson; and a Spruce Grove family physician and primary care network leader, Dr. Allan L. Bailey.

The **Medal of Honor** is awarded to a non-physician who has raised the standards of health care and contributed to the advancement of medical research, medical education, health care organization, health education and/or health promotion to the public.

The 2009 Medal of Honor recipients were Walter Doll (awarded posthumously), of Fairview, who worked tirelessly to ensure the citizens of Fairview have access to quality health care; and respiratory therapist Rick Linton, of Lethbridge, who has spent his entire career caring for the people of the Chinook Health Region.

To request a nomination form, please contact Pat Shinkewski, Coordinator, Public Affairs, AMA: pat.shinkewski@albertadoctors.org, 780.482.0315, toll-free 1.800.272.9680, ext. 315 or visit the AMA website (www.albertadoctors.org/AwardsScholarships/AchievementAwards). ■

Obesity in Canada

What can physicians do differently to better help patients manage their weight?

Canadians are facing a crisis when it comes to excess body weight and its profoundly negative health and economic consequences.

An estimated 59% of Canadian adults and 26% of children and adolescents are overweight. The epidemic is expected to worsen as today's obese children face a lifetime of weight-related problems.

An estimated 59% of Canadian adults and 26% of children and adolescents are overweight.

Excess weight is strongly associated with dozens of diseases including diabetes, hypertension, cancer, mental illness, osteoarthritis, gastroesophageal reflux disease, obstructive sleep apnea and chronic pain, to name a few.

Yet few health professionals have more than cursory clinical training in obesity management, often finding it difficult to discern which overweight patients should be targeted for weight management intervention.

Physicians often ask: Why it is so difficult for patients to lose weight, and even harder to keep it off? Which weight reduction approach is best – low fat? low carb? low calorie? very low calorie?

How strongly associated are mental health issues (e.g., depression, addictions or attention deficit hyperactivity disorder) with weight problems? Is it possible for a 150 kilogram (kg) patient to lose 75 kg as a prerequisite to joint replacement surgery? Why does hedonic overeating require a different management approach than homeostatic overeating?

These are just a few of the challenges facing medicine today, and the *raison d'être* of the Canadian Obesity Network - Réseau canadien en obésité (CON-RCO).

www.obesitynetwork.ca

CON-RCO was founded in 2006 through the federal Networks of Centres of Excellence program. Its goal is to reduce the socioeconomic, mental and physical burden of obesity on Canadians.

Through its national office in Edmonton, CON-RCO has stretched its reach from coast-to-coast, cultivating a base of more than 4,000 members who reflect virtually every sector in the country, including academic institutions, research organizations, clinical experts, individual practitioners, industry and government.

Testament to the interest in obesity was the organization's first national summit in 2009, attracting more than 500 scientific leaders and practitioners from across Canada.

Recognizing the importance of a national obesity strategy, in 2008 the Canadian Medical Association's Annual Scientific Meeting passed a resolution to "Encourage provincial/territorial medical associations to work in conjunction with the Canadian Obesity Network to help develop chronic care models for obesity prevention and management."

In 2008 the Canadian Medical Association's Annual Scientific Meeting passed a resolution to "Encourage provincial/territorial medical associations to work in conjunction with the Canadian Obesity Network to help develop chronic care models for obesity prevention and management." ▸

▸ Discussions between the Alberta Medical Association (AMA) and CONRCO are just beginning as the two organizations consider collaborative opportunities in the fight against obesity.

Want to learn more about the network?

Physicians may join the Canadian Obesity Network to access practical clinical resources. Membership is free and restricted to health professionals, researchers and other professional stakeholders (organizations) with an interest in obesity research, prevention and management.

Membership benefits include unlimited access to:

- News and features about obesity research and policy developments in Canada
- Information about professional learning opportunities such as scientific conferences, workshops and preceptorships for family health teams
- Access to CONDUIT magazine, Canada's only professional magazine targeted exclusively to obesity management, research and best practice
- OBESITY+, a premium online service offering access to the best evidence for obesity practice in medicine, nursing, nutrition and rehabilitation from more than 130 clinical journals
- Networking opportunities with more than 4,000 health professionals and obesity stakeholders Canada-wide

If you have a commentary about obesity in your practice, email your views to the network (docspeak@obesitynetwork.ca).

Did you know . . . ?

Even the most aggressive treatments for obesity (lifestyle + pharmacotherapy + bariatric surgery) will produce a net long-term weight loss of only 30% or less?

The relapse rate following weight loss is 100% unless patients adhere to a *lifelong weight management program.*

Up to 80% of individuals with severe obesity have a co-morbid mental health condition such as addictions or mood, binge eating and attention deficit disorders.

For many patients, prevention of further weight gain is a realistic and appropriate clinical goal.

Weight reduction goals stated in terms of actionable benchmarks (being able to walk up 12 stairs without pain) are often more meaningful to patients than goals stated in kilograms. ■

Letters

Dr. Nancy S. Maguire wrote that she "read with great interest the courageous article by Dr. Jillian M. Schwartz, 'The part-time stigma,'" from the "Residents' Page" in the January/February Digest (pages 23-24). Dr. Maguire's letter follows to support the message – "don't denigrate part-time women physicians."

Having emigrated from the UK in the 1950s with very young children, my first part-time job was with the City of Calgary Health Department, as it was then called, during which time we adopted three more children.

Due to some much-needed whistleblowing in the then Public Health Service, which I could not have risked if I had been the sole breadwinner and for which I was both applauded and condemned, depending on one's point of view, I ended up a chairperson of the Calgary Board of Health in the 1970s.

During this time I was also occupational health physician at the Foothills Hospital, a part-time job, where I made excellent professional contacts that stood me in very good stead when I finally took on a solo full-time family practice in the 1980s, which I still enjoy.

I have had a very interesting and varied career while being wife, mother and part-time doctor, with a lot of community involvement, and contributed to society in a way which I could not still be doing at my age if I had been practising clinical medicine 70 hours a week for the past 55 or more years.

The "moral" of all this? Don't denigrate part-time women physicians. We are capable of a tremendous contribution to society over a lifetime of medicine.

Nancy S. Maguire, MBBS, FCFP
Calgary AB

Recipient of the Outstanding Family Physician Award (2009), nominated by her patients, via Department of Family Medicine, Faculty of Medicine, University of Calgary

Dr. R.D.M. Lewis followed up the January/February Digest medical history story, "Canadian freeze: Application of hypothermia and other advances in blood oxygenation in cardiac surgery during the 1950s," (pages 18-19), by University of Calgary MD candidate Kate E. Elzinga. Excerpts of his letter follow.

Dear Ms Elzinga,

I have recently read your article in the *Alberta Doctors' Digest* about the start of "open-heart" surgery. After my ▸

service in the military, compulsory at the time, I obtained a position at the General Infirmary at Leeds, UK. I was a senior house officer in the Department of Anaesthetics. This would be in 1954.

We were just at the beginning of the great steps to be taken in heart surgery. The senior surgeon was Philip Allison, who went on to be the Nuffield Professor of Surgery at Oxford. His main interest was in the surgery of congenital heart conditions such as tetralogy of Fallot, patent ductus arteriosus, lung surgery, mitral valve splits, hiatus hernias, etc.

One of the foremost other surgeons in Leeds at that time was Mr. Geoffrey Wooler, who recently passed away.

As the junior member of the anesthetic staff, it was often my job to look after the patients as they were being "cooled." They were given a "lytic cocktail" (a mixture of Demerol, Largactil and a paralyzing agent) and placed between two sheets of rubber that had multiple tubes through which the cooling fluid flowed until the desired temperature was achieved and the operation could be carried out.

Later, we developed a heart-lung machine. This needed many pints of blood to fill and was the despair of the blood bank. It was a monstrous machine and needed full-time technicians to run it and keep it working.

I remember the de-bubbling part of the machine that was essential to keep the bubbles in the blood, formed during the oxygenation process, from being delivered to the patient with the inevitable results.

At the time none of us thought we were making medical history. It just proves, if you live long enough, you will be surprised at what you thought nothing of but, all in a day's work, might have a great effect on the future of everyone.

Best wishes,
R.D.M. Lewis, MB ChB, LMCC, CCFP, FRCPC
Calgary AB

The Alberta Medical Association welcomes comments about Digest articles and suggestions for future topics. Please contact Editor-in-Chief Candy L. Holland at candy.holland@albertadoctors.org, visit www.albertadoctors.org and click on the Discussions link (at the top of the site, near the Site Map and Search links) or write her c/o Public Affairs, Alberta Medical Association, 12230 106 Ave NW, Edmonton AB T5N 3Z1. The association reserves the right to edit all letters. ■

OIPC criticizes missing EMR audit trail

Jonathan P. Rossall, QC, LLM
PARTNER, McLENNAN ROSS, LLP, BARRISTERS AND SOLICITORS

A recent investigation report issued by Alberta's Office of the Information and Privacy Commissioner (OIPC) has underlined the need to maintain an accurate audit trail in an electronic medical record (EMR).

At the same time, the report points to the need for accurate and complete data migration when moving from one EMR to another.

> "Audit logs are an essential safeguard in electronic health records systems, including EMRs."

The report arose as a result of a complaint filed with the OIPC by a patient of Dr. M. The complainant claimed that sensitive information about him was disclosed to his ex-wife by one of Dr. M's employees.

In the course of her investigation, a portfolio officer requested Dr. M obtain an audit log detailing accesses to the complainant's health records.

Shortly before the relevant time period, Dr. M's clinic had changed EMR vendors and the new EMR vendor was unable to generate an audit log for the two-year period prior to the changeover date.

The migration of data to the new EMR contained all key data elements but did not constitute the entire health record of the complainant.

While the new vendor claimed it had advised Dr. M's clinic to retain all health information that had not been specifically migrated, it could not provide documentation to that effect.

The problem was further exacerbated by the fact that, following the migration, the previous vendor was de-commissioned in its entirety, so the remaining health information was simply not available.

While Dr. M and his employee were ultimately exonerated on the issue of unauthorized disclosure (the employee had accessed the health records in the course of her duties, but there was no evidence of disclosure to any third party), the portfolio officer then focused on the absence of the audit trail arising from the migration of data.

The portfolio officer said, "Audit logs are an essential safeguard in electronic health records systems, including EMRs. These logs, when properly implemented, can allow a custodian to determine who has accessed and viewed health information within their EMR with a very high level of certainty.

"They also play a critical role in maintaining the reliability and integrity of data, as changes to information are also logged. Poorly implemented audit logging functionality renders the control ineffectual."

She also said that the risk of health information loss when migrating from one EMR to another is a threat that can be reasonably anticipated and must be mitigated against.

The custodians of the health information at the clinic were required to take reasonable steps to protect the health information in their custody and under their control from loss during the data migration process.

It should also be noted that section 41(1) and (2) of the *Health Information Act* (HIA) requires a custodian to retain audit logs for a period of 10 years following each disclosure.

In the result, the custodians at the clinic were found to be in contravention of the HIA, which resulted in a number of recommendations for improvement that were implemented.

This report is an eye-opener in the current EMR environment in Alberta.

It is not unusual for physicians and clinics to move from one vendor to ▸

- another for a variety of reasons, including service issues, availability of improved or updated software, economic issues or, more recently, the availability of new Qualified Service Providers with enhanced Vendor Conformance & Usability Requirements (VCUR) standards, as a result of the recent request for proposals issued by Alberta Health and Wellness.

In addition, the impending creation of a shared EMR in Alberta with the intent of linking to the Alberta Electronic Health Record (essentially Netcare) gives rise to an enhanced opportunity (some may say risk) of information movement, with the consequential increase in disclosures.

In addition, the impending creation of a shared EMR in Alberta with the intent of linking to the Alberta Electronic Health Record (essentially Netcare) gives rise to an enhanced opportunity (some may say risk) of information movement, with the consequential increase in disclosures.

This movement of information and the disclosures must be traced and logged, and the audit logs must be available for periodic or random review.

This is to ensure that disclosures are made in accordance with Information Sharing Agreements, and that unauthorized disclosures are identified and investigated with an eye toward avoiding repetition.

It is, therefore, critical that in the process of migrating data from one EMR to another, the integrity of the audit log is preserved.

This is not just for the well-being of custodians involved in the utilization of the EMR but, more importantly, for the patient whose information is being collected, used and disclosed.

It is also critical that the physicians retain a full, read-only copy of the former EMR as additional back-up. Physicians must work closely with their vendors in this regard.

As the portfolio officer concluded in her decision, "The obligation to address the risks associated with data migration rests on physicians, but they cannot effectively manage it without assistance from their EMR vendor."

"The obligation to address the risks associated with data migration rests on physicians, but they cannot effectively manage it without assistance from their EMR vendor." ■

Finding Balance – Prevent a fall before it happens

Confronts hurdles in second year

Falls hurt. We all fall at one time or another, but seniors are more prone to do so.

In Alberta, one in three seniors fall each year. The consequences range from minor injuries to fractured hips or head injuries. These injuries may mean loss of mobility and independence, which can result in separation from a spouse of many years.

Because of the frequency and impact of seniors' falls, the Alberta Medical Association (AMA) became a founding partner, in 2009, with the Alberta Centre for Injury Control and Research (ACICR) in an effort to raise awareness of the risks of seniors' falls and suggest ways to prevent them.

In its second year, the *Finding Balance – Prevent a fall before it happens* public awareness campaign was to roll out in November 2009 with a number of events and publicity. However, two major hurdles confronted the program.

"Watch your step! Wherever you are," is the message from Don Voaklander, PhD, ACICR, at the podium and, seated left to right, Dr. William S. Hnydyk, AMA; Pat Church, City of Edmonton; and Rosalie Freund-Heritage, Glenrose Hospital.

The major downturn in the economy seriously affected participation in, and funding for, the initiative by previous supporters. As a result, the campaign focused on securing in-kind donations (for printing and material distribution) plus more support from communities and media interested in getting the messages out. This proved successful.

With increased communication efforts directed toward community liaison, 156 communities around Alberta proclaimed November as Seniors' Falls Prevention Month. The resulting local publicity came at no financial cost to the *Finding Balance* initiative.

But the insidious ripple of H1N1 influenza cases in late October, turning into a tsunami for the health care system, proved a more difficult barrier for the *Finding Balance* campaign.

Media events scheduled in Calgary and Edmonton, in early November, were cancelled. "The optics of gathering a large number of seniors for these events, in the face of spreading disease, was seen by the steering committee to create risks that superseded the benefits at the time," said Dr. William S. Hnydyk, Assistant Executive Director (Professional Affairs), AMA.

Consequently, the *Finding Balance* campaign changed course. The November 3 news conference was relocated to AMA's Edmonton office, from a seniors' centre as originally planned. Campaign partners, represented by AMA President Dr. Christopher J. (Chip) Doig and ACICR Associate Director Kathy Belton, were joined by MLA George VanderBurg, Whitecourt-Ste. Anne.

In November, Dr. Doig and a number of other physicians provided 10 interviews.

New opportunity to promote *Finding Balance*

With Alberta fiercely encased in winter's grip, the AMA and ACICR decided to capitalize on the icy conditions by leveraging the ▸

Campaign resources for physicians

- Free posters and patient handouts with key messages
  - » Physicians may place orders by emailing Joanne J. Askewe, Administrative Assistant, Professional Affairs, AMA (joanne.askewe@albertadoctors.org).
- Algorithm for the prevention and management of seniors' falls
  - » Access by logging on the AMA website (www.albertadoctors.org/FindingBalance/Algorithm).

- "Watch your step! Wherever you are" campaign message at a news conference February 1.

Northgate Lions Seniors Recreation Centre hosted a morning event with a room full of active seniors. On behalf of the AMA, Dr. Hnydyk presented the key campaign messages emphasizing the need for seniors to stay active to maintain strength and balance, check medications with their physician or pharmacist, and to watch their step indoors and outside.

ACICR Director Don Voaklander, PhD, spoke about the high costs of falls to seniors and to the health care system, providing statistics on the incidence of falls.

Glenrose Hospital Falls Prevention Coordinator Rosalie Freund-Heritage demonstrated tools to assist seniors, including walking canes with built-in ice picks, grippers for shoes and boots, and impact-absorbing hip pads.

Pat Church, with the City of Edmonton Waste Management Department, let seniors know that if they are unable to take their waste to the curb for pick-up, Edmonton has an assisted waste management collection program.

The session ended with two seniors demonstrating Wii Sports games to keep seniors active and healthy while enjoying camaraderie and fun. ■

Finding Balance key messages

Check your medications!

- Have your doctor or pharmacist review all medications you are taking each year.
- As you age, the way some medications affect you can change and increase your risk of falling.
- Medications include prescriptions, over-the-counter pills, vitamins and herbal supplements.
- Medications that relax you, help you sleep or improve your mood can increase your risk of falling.
- Alcohol affects medications – be careful.

Keep active! Exercise for strength and balance.

- Regular physical activity and exercise can increase muscle strength, improve balance and help prevent falls.
- Ask your doctor or health care provider about the best type of exercise program for you.
- Do at least 30 minutes of activity every day.
- Walk, dance, swim or take an exercise class.

Watch your step! Wherever you are.

- Keep pathways, halls and stairways well-lit and free of clutter.
- Watch out for ice, cracks and uneven surfaces while walking.
- Have your eyes checked every year.
- Wear shoes that support your feet and help you keep your balance.
- Avoid rushing and doing too many things at once.

Demonstrating how to keep active and have fun together with a Wii Sports game.

Glenrose Hospital Falls Prevention Coordinator Rosalie Freund-Heritage (left) illustrates some tools to help keep seniors active throughout the year.

(Karin Locke, Play It By Ear Productions.)

Determine best overhead model for your circumstance

PMP Staff

A number of options are available to determine a model for sharing practice expenses.

Staff at the Alberta Medical Association's Practice Management Program (PMP) often get asked which is the best model, which one should our clinic use, etc.

Although there is no single best answer, the following three broad principles seem to correlate with physicians' satisfaction regarding their choice of overhead model:

1. Knowledge of available options/issues
2. Transparency of information
3. Participation at the desired level of each physician

There is no perfect model and each physician group needs to determine the best choice for their circumstances.

1. Knowledge

To make an informed decision, it's beneficial to know the various options available. Samples of different models follow. There is no perfect model and each physician group needs to determine the best choice for their circumstances.

Proportionate expense sharing

Physicians determine expenses every time period (usually every month) and charge each physician a fixed share. In its simplest form, if five full-time physicians practised in a clinic, with $50,000 of expenses for the month, each physician would be charged $10,000 for that month.

This is a simple, straightforward model. However, it does present some challenges, including:

- Equitable proportion. A challenge for many clinics is to effectively define an equitable proportion for each physician.
  - » Should all clinic expenses be shared equally between all of its practising physicians?
  - » What if some physicians work part time verses full time?
  - » What if some physicians work full time, but only part time in the clinic (e.g., spend a significant portion of time in the hospital or in long-term care facilities)?
  - » If a physician bills twice as much as his colleagues, should he or she pay more or less overhead?
  - » For staff costs, should each physician be responsible for his or her own assistant or is this a shared cost to the entire clinic? If a shared cost, how does the clinic allocate the costs of assistants when the physician is not in the clinic?
- Timeliness. If the revenue is paid directly to each physician, there is a risk that a physician disagreement could impact the timely collection of clinic expenses.
- Extraordinary expenses. Payment toward a type of reserve fund is usually not part of the expense calculation. This can make it difficult to agree on/pay for large expenditures (e.g., office renovations, burst water pipe, etc.) because it must come out of each physician's current pool of funds.
- Loans. Taken by participating physicians, loans can present challenges without forethought and written agreements. If loans (e.g., for an office renovation) have been taken out by the physician group, and one physician leaves the group, does the loan obligation stay with the departing physician, attach to a new physician (if one can be found) or get shared between the remaining physicians? If a loan is taken out and is to be part of the shared expenses, how does the group determine a fair amortization period for the loan?

Percentage of billings

Under this model, the physician is charged a fixed percentage (e.g., 40%) of his or her billings, usually on a monthly basis.

This model is also relatively simple and straightforward, however, it ▸

can have several variations. Thus, a number of questions need to be answered including:

- Full or partial billings. Does the percentage payment (e.g., 40%) apply to all or only some of the physician's billings (e.g., fee-for-service, WCB, third-party medicals, hospital work, other non-office work including long-term care facilities, committee work, etc.)?
- Level of billings. Does the percentage payment vary based upon physician billings? (E.g., same rate charged for part-time versus full-time physicians, physicians with lower- versus higher-average billings, etc.?)
- Location of practice. Two common contrary questions include: Why should a physician pay for overhead on revenue generated outside of the clinic? Given overhead costs must be covered regardless of how much or where each physician chooses to work, why should these costs be borne by someone else?

Mixed model

This is a bit of a catch-all category and often includes elements of the above two models, with some variants in the calculation of overhead including:

- Ceiling – providing a fixed-dollar amount for overhead. Participating physicians are charged a fixed amount or percentage, usually on a monthly basis, up to a maximum dollar threshold, e.g., $150,000. Thereafter, they retain 100% of their billings.
- Multiple rates – differing overhead rates based upon location. If a clinic operates out of more than one location, these locations may have differing overhead rates.
- Fixed verses variable – involves detailed separation between fixed and variable costs of the clinic. An attempt is made to determine the true fixed-cost elements that should be shared equally versus the variable costs that fluctuate depending on physician activity and, thus, can be assigned directly to an individual physician.

  This can get quite complicated and can invite intense discussion as staff time and other variable costs cannot always be so clearly allocated to a particular physician.

2. Transparency

When implementing an overhead formula for participating physicians, it is important to recognize, in the absence of information, there is a risk some people will fill in the blanks with false assumptions. It is ideal if both parties feel they are in a win-win situation.

So how do we get there? A key principle to help guide such a solution is transparency of information. It is critical both sides feel they are able to make an informed decision by being provided the relevant information in a timely fashion, including:

- Detailed costs. Share all the costs associated with running the clinic, from salary costs and rental rates to minor incidentals, as it helps both sides make informed decisions about where they should focus their spending.
- Risk premium. Understand the risk premium being charged by the owner(s) of the clinic. When participating physicians are not signatories to the lease/mortgage and/or are not responsible for other general office liability issues, there is often an additional cost within the overhead calculation to account for this added risk.
- Rationale. Understand the rationale/motivation behind each party's position. A physician may simply want to be free of all of the administrative and management duties associated with running a clinic and may be prepared to pay higher overhead costs to be alleviated of such stresses. Or the physician may be looking to share ownership, and may wish to be included in many of the clinic's decisions, etc.

3. Participation

It is important all parties understand and feel they have a choice in their level of participation in clinic operations and practice management.

Good communication, upfront and ongoing, helps to ensure a sense of fairness on both sides.

Some key elements for each party to consider include:

- Leasehold improvements. How are leasehold-improvement decisions and other relevant site-location decisions made? (E.g., who determines the quality and associated costs of waiting-room furnishings?)
- Assignment of costs. With a major leasehold renovation, are those costs payable by the participating physicians through personal loans or a clinic loan, an immediate cash call? If it is through a clinic loan, what is the amortization term of that loan and who carries the risk if a physician departs before that cost is fully recovered by the clinic?
- Rental rates. If the real estate is owned by some of the practising physicians, how are rental rates determined? What elements are included in the rental costs, etc.?
- Review period. Once an agreement is reached, how often is it reviewed?
- Legal review. Is a legal review of the overhead agreement required or are physicians comfortable and accept the risk of a less formal approach?

▸ In general, overhead models need to address two key objectives – provide sufficient monies for the clinic to cover its expenses and provide sufficient incentive for physicians to participate.

In general, overhead models need to address two key objectives – provide sufficient monies for the clinic to cover its expenses and provide sufficient incentive for physicians to participate.

The ideal overhead formula is rarely about the numbers or securing the best financial deal. Rather it is more often a function of many elements including:

- providing a satisfactory work-life balance
- allowing a desired level of participation in clinic and practice management
- having an understanding and perception of financial fairness by each party
- working in an environment that meets one's professional and personal goals
- working with colleagues one can trust and respect

In the end, there is no single best overhead model. However, physicians who are collectively knowledgeable of the different overhead formulas, who seek transparency of information and are able to participate in their practices to a desired degree, will be positioned for win-win relationships and overhead models that works for them.

The Alberta Medical Association Practice Management Program (PMP) provides high-quality business consulting services to Alberta physicians as they develop and implement primary care networks. With offices in Calgary and Edmonton, the program serves physicians throughout the province. For more information about PMP services, please contact program staff at pmp@albertadoctors.org, 403.205.2089 or toll-free 1.866.830.1274. ■

History of medicine contributions

The article below, written by MD candidate Erin M. Kwolek, has grown out of course work and the student's research project in the History of Medicine & Health Care Program at the University of Calgary.

Similar to the history of medicine contribution in the January/February *Alberta Doctors' Digest*, this paper was also presented at the Dr. Margaret Hutton Lectures at the Alberta Medical Association's 2009 annual general meeting.

In contrast to today's perception – largely driven by the influence of the media – that plastic surgery is only a tool for enhancing patients' bodies, Ms Kwolek's article takes us back to the field's origins in trauma and military surgery, where the aspect of plastic procedures lies at the basis of the medical core. (*Dr. Frank W. Stahnisch, Alberta Medical Foundation/Hannah Professorship in the History of Medicine & Health Care, University of Calgary.*)

Plastics and politics:

How Canadian soldiers and surgeons influenced the field of cosmetic surgery

Erin M. Kwolek
MD CANDIDATE, UNIVERSITY OF CALGARY

"Sometimes the only useful salvage of war is the medical knowledge gained."[1]

Modern perceptions of cosmetic surgery are generally negative. The field of plastics is thought to be elective by many, particularly in the lay community.

We watch as the faces of Hollywood starlets seem to look younger and younger with time, as many manipulate their faces and bodies to live up to a perceived ideal.

The origins of plastic surgery, however, may change an individual's perception of the field, especially because modern techniques were first developed in response to the horrific facial injuries and burns suffered by soldiers during the First World War. Many of these techniques have been refined but are still in use today.

Founder of the modern field

Sir Harold Gillies (1882-1960), a New Zealand-born otolaryngologist, would become one of the most prominent surgeons doing facial reconstructions on soldiers during the First World War.[2]

Dr. Archibald McIndoe with Guinea Pig Club members, ca. 1941. (📷 courtesy Royal College of Surgeons of England).

He oversaw the establishment of a facial injury ward at the Cambridge Military Hospital in Aldershot, England. He later performed more surgeries at Queen Mary's Hospital in Sidcup, where many techniques in facial reconstruction were developed.

Trench warfare led to an increased prevalence of severe facial injuries, and surgical teams (comprised of medical and dental surgeons, anesthetists and medical artists) developed techniques that could preserve and, in some cases, restore facial esthetics.[3] ▸

Sir Gillies would ultimately perform the first surgeries involving tubed pedicle flaps and found great professional satisfaction in restoring appearances of soldiers who sustained significant facial injuries.

Just as techniques in facial reconstruction were developed, advancements in other areas of medicine took place as a result of the injuries sustained by soldiers and subsequent innovations by military physicians.[4]

Plastic surgery during the Second World War

Sir Archibald McIndoe (1900-60) was another New Zealand surgeon who had a significant role furthering the field of plastic surgery.

During the Second World War he helped develop surgical suites at the Queen Victoria Hospital at East Grinstead, England.[5]

He was also responsible for establishing the Guinea Pig Club for men who had sustained horrific facial injuries in battle and were in the process of major surgical reconstructions.

The reconstructive surgeries helped horribly disfigured men reintegrate into society following the war.

Many patients found great comfort in communicating with other soldiers who had experienced similar injuries and surgeries.

Sir McIndoe would come to be known worldwide for the significant contributions he made to the field of hand surgery.[6]

Many Canadian soldiers received reconstructive surgeries at Sidcup and the Queen Victoria Hospital.

In addition, surgeons from Canada – most notably Dr. A. Ross Tilley (1904-88) – were actively involved in performing reconstructive surgeries on wounded soldiers.

In 1939 Dr. Tilley was one of four Canadian plastic surgeons working in England, where he became specifically concerned with the surgical aftercare for burn patients and the reintegration of wounded soldiers into society.[7]

Dr. Tilley reached out to the community of Grinstead and activated locals to socialize with wounded soldiers, convinced of the important social component to the healing process.

Discussion

The reconstructive surgeries helped horribly disfigured men reintegrate into society following the war.

While preservation of physical appearance had hardly been a priority of military medicine before, several individual physicians made this a priority of their practices and, ultimately, improved quality of life for injured soldiers.

As warfare weaponry grows ever more sophisticated, injuries become significantly more disfiguring and military physicians continue to be on the front lines of new developments in the field of plastic surgery.

The public, however, too often overlooks this important interdisciplinary working field of plastic surgery.

References available upon request. ■

A penny raised . . .

Valerie A. Brulé, BSc
MEDICAL STUDENT, CLASS OF 2011, VP, STUDENT AFFAIRS, MEDICAL STUDENTS' ASSOCIATION, UNIVERSITY OF CALGARY

The CanMEDS 2005 framework roles* include health advocacy and collaboration as being important for medical experts.

The University of Calgary (U of C) medical students really take these two roles to heart, making fundraising for important causes a medical student pastime.

Since July 2008, classes have raised more than $130,000 for many different causes. From smaller endeavors to larger undertakings, med students are able to turn their passions into cash. At the U of C, a single bake sale can bring in more than $600.

U of C medical students come from diverse backgrounds and this is exemplified in the wide variety of health-related causes that have been supported through students' efforts. Money has been raised for causes such as AIDS awareness, bed nets in Tanzania, and the Canadian Cancer Society.

Some students saw a need for a student-run clinic at the Calgary Drop-in & Rehab Centre that serves the lower-income population of Calgary and is one of the largest homeless shelters in Canada.

A desire to raise funds resulted in the Rich Man Poor Man Dinner, which was held in November 2009. Hosting a dinner where participants had a meal that reflected being either "rich" or "poor" raised awareness of the reality of poverty and also accrued more than $12,000 for the centre.

The medical students also responded quickly to the January 12 earthquake in Haiti. In just two weeks, more than $16,000 was raised to support Haitian relief.

As a member of the medical class of 2011, I feel very privileged to work with such generous colleagues. The initiative shown by medical students and the efforts that go into each fundraising event is quite remarkable.

U of C medical students come from diverse backgrounds and this is exemplified in the wide variety of health-related causes that have been supported through students' efforts.

This crowd, at the U of C med students' fundraiser Rich Man Poor Man Dinner, raised $12,000 for a local homeless shelter. (Natarie D. Liu, MD candidate, Class of 2011 president, U of C.)

Financial strain is often a burden associated with students. While this burden is very real, I am happy to say that I belong to a group of people who are willing to give what they have.

I look forward to being inspired by the continued and future efforts of my colleagues at the U of C medical school.

**The Royal College of Physicians and Surgeons of Canada's Canadian Medical Education Directives for Specialists (CanMEDS) framework is incorporated into specialty education worldwide. Core competencies include the roles of Medical Expert, Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional that physicians fulfill in their daily practices.* ■

Aggression and violence in our backyard:

Cultivating an improved landscape

ALBERTA MEDICAL ASSOCIATION Physician and Family Support Program

Dianne B. Maier, MD, FRCPC

PROGRAM/CLINICAL DIRECTOR, PFSP

Civility and respect are important contributing factors to healthy medical workplaces and to healthy lives. And we all play a part in a healthy workplace.

At times our workplace can become challenging and, indeed, hostile with harassment, aggression or violence, no matter who the perpetrator.

These occupational risks affect the safety and health of physicians and staff. This should not be minimized by anyone or regarded as "just part of the work" in health care.

Literature reviews reveal that aggression and violence are more common in the health care workplace than in any other work site.[1] Patients carry out the majority of these acts.

Literature reviews reveal that aggression and violence are more common in the health care workplace than in any other work site.

While nursing staff experience the majority of incidents, physicians at all career stages, in hospitals and in the community, encounter the complete range of aggression and violence more often than we think.

Perhaps this occurs more often than is discussed within our culture of medicine and/or is reported in the health care system. And this is not limited to patient-initiated aggression (PIA).

A 2002 New Zealand survey revealed verbal threats and intimidation were the most frequently reported types of PIA in general practitioner experience. Complaints and sexual harassment were more common than assault or injury.[2]

The literature involving physicians is limited.[2-8] However, reviewed studies of residents and practising physicians indicate the following:

- **More than half to two-thirds of physicians have experienced verbal aggression.**
- **Five-40% of physicians have experienced physical violence.**
- Female physicians would seem to be at greater risk.
- Residents and early career physicians are at a higher risk.
- Practitioners at high risk include psychiatrists, emergency physicians, family practitioners and anesthesiologists.
- All physicians in all spheres bear potential risk.

A proposed schema, adapted from Magin,[6] for perception of risk includes:

- Patient factors:
  - » substance-use disorders
  - » psychiatric issues
  - » sexual motivation
  - » physical illness, including chronic pain patients[9]
  - » personality
- Societal factors:
  - » poverty
  - » population density
  - » respect for authority
  - » culture of fear
- Proximate factors:
  - » frustration accessing care – wait lists and waiting times
  - » failure to discourage or circumvent violence – includes unsafe environments and lack of training regarding practical skills for recognizing risk and response
- Physician vulnerability:
  - » naïve practice culture – "illusion of safety," e.g., a lack of awareness when to call police (threats of harm, stalking or assault)
  - » deficient personal skills
  - » provision of information to third parties
  - » duty to serve all patients ▸

▸ Physicians likely underestimate and underreport stalking. Patients who stalk their physicians are commonly motivated by hopes of having an unobtainable intimate relationship and less commonly motivated by thoughts of revenge for a perceived wrong.[10]

Stalking should be taken seriously. It's a criminal offence. It is important physicians set clear boundaries and protect their personal information.

Physicians should document every incident in a file separate from the patient file. Do not hesitate to call the Canadian Medical Protective Association. Terminate the physician-patient relationship. Notify the College of Physicians & Surgeons of Alberta. Call the police. Get support from peers.[10]

PIA is an important issue for physicians as employers regarding occupational health and safety. One British study reported family physician receptionists experienced verbal and physical violence.

It reported 68% of receptionists experience verbal abuse (60% telephone, 55% face-to-face). A "zero-tolerance" policy did not positively impact the occurrence or experience of staff.[11]

Australian surveys of general practice staff in Australia revealed reception staff being subjected to considerable verbal abuse.[12] This may motivate us to discuss and reflect upon the issues with these important partners in our practices.

The medical business is a service business. Will you work with your staff to provide effective and responsive services to patients and a safer working environment?

Staff may have information to help identify hazards and suggest steps to minimize risks for everyone in the practice.[13]

While we are not responsible for the range of violence we experience, it is important to reflect and learn from our possible contributions to incidents.

Perhaps this will lead to improvements in practice processes and policies. Perhaps creation of a calm, relaxing waiting-room environment will follow. Spa music, anyone? The importance of staff education and support cannot be underestimated.

The schema described above confirms complexities that may lead to PIA. While we are not responsible for the range of violence we experience, it is important to reflect and learn from our possible contributions to incidents.

Have we been disrespectful toward the patient? Have we been less than professional when speaking about the patient to others? Did we miss the behavioral cues indicating a need for distance or, perhaps, for care? Did we pay attention to our environment?

How do you respond to colleagues and trainees when they have experienced aggression and violence? Are you supportive? Do you listen? Debrief?

Do you suggest colleagues call the Physician and Family Support Program (PFSP) for support? Are you aware of your local workplace resources, including to whom physicians can and should report?[14]

Remember, physicians also perpetrate aggression and violence in the workplace toward staff, colleagues, residents and medical students.

The 2004 Canadian Association of Internes and Residents' *Happy Docs Study*[15] revealed 39% of residents perceived intimidation and harassment from staff physicians and 29% experienced intimidation and harassment from fellow residents.

Sexual harassment has historically been a problem for trainees,[16] is rarely reported or addressed appropriately and, sadly, continues. Thus, staff, colleagues and trainees can have their work lives, career paths and health adversely affected by fellow health care professionals.

All of these issues impact physician health and well-being. Physicians who experience aggression and violence may experience a range of mental health issues.[17]

Experiencing violence may impact work performance, treatment decisions for patients and negatively impact a physician's family and quality of life.[3] Potentially, physician resources will also be affected because it may lead to subsequent restriction of practice[5, 7] and perception of risk in the future.

This is a systemic issue. The health care system has a responsibility to provide a safe work place for all health care personnel, including physicians.

Physicians cannot be left out of prevention and intervention programs. While "zero-tolerance" policies have been adopted by multiple organizations, use caution if advised as the only approach.[18] This implies an attitude of punishment toward any aggressive behavior, thereby negatively impacting aggression management.[18]

Prevention, education and early intervention are important for physicians at all career stages and in each workplace. Anticipating and defusing violence is an important clinical skill to acquire.[1]

As yet, there would seem to be limited policies nationally that deal ▸

Definitions:

- **Harassment:** Behavior that threatens or torments someone, especially persistently.
- **Sexual harassment:** Unwanted sexual advances or sex-related behavior toward someone.
- **Stalking:** Act of steady harassment with persistent, inappropriate and unwanted attention. Some authors define clinically significant stalking as harassing behavior that extends beyond a two-week period.
- **Aggression:** Threatening behavior or actions directed toward another person.
- **Violence:** Use of physical force to injure, damage or destroy.
- **Patient-initiated aggression:** Threatening behavior or actions of a patient directed toward a health care worker.

with this range of adverse experiences. However, the Canadian Centre for Occupational Health and Safety has prepared a useful resource, *Violence in the Workplace Prevention Guide*, adaptable to individual workplaces.[19]

It is time to wake up and think about our civility and respect toward each other. Kowalczuk invites us to recall "good manners"[20] in our work with one another.

Manca et al recently discussed the challenge of respect for family physicians in relation to specialist physicians.[21]

Respect depends upon civility, appreciation of the work and responsibilities of the other in this era of "post-modern medicine," and renewed efforts among colleagues for improved communication, collegiality and conflict resolution. Our health and resilience as a profession depends upon it.

Physician health is important to Alberta Medical Association members. Healthy physicians and healthy medical workplaces are the concern of PFSP.

Do not hesitate to call PFSP for support and assistance – toll-free 1.877.SOS.4MDS (1.877.767.4637), 24-hours-a-day, 365-days-a-year.

References available upon request. ■

FEATURE

Alberta Medical Association Board of Directors 2009-10

Back row (*left to right*): Dr. Carolyn A. Lane; Dr. Pauline Alakija; Kevin S. Wasko, Medical Students' Association observer; Dr. Jillian M. Schwartz, Professional Association of Residents of Alberta observer; Michael A. Gormley, Executive Director; Dr. Michael J. Caffaro; Dr. Daniel J. Barer; Dr. Padraic E. Carr; Dr. Linda M. Slocombe. **Front row (*left to right*):** Dr. Fredrykka D. Rinaldi; Dr. Noel W. Grisdale, Immediate Past President; Dr. Christopher J. (Chip) Doig, President; Dr. Patrick J. White, President-Elect; Dr. R. Michael Giuffre; Christine A. Fleck, Executive Assistant. (📷 Fred Katz Fine Art Photography.) ■

Who's who at the AMA?

Visit www.albertadoctors.org/WhosWho/Index for a quick online reference to the:

- President, president-elect, past president
- Members of the Board of Directors and Representative Forum
- Presidents of sections and regional medical organizations
- Committees ■

Water damage:
An ounce of prevention is worth a pound of cure

Phil Cunningham, BA (Hons), CIP
VICE-PRESIDENT, MARDON GROUP INSURANCE

Water damage is no laughing matter. Increasing in frequency and severity over the past 10 years, it now accounts for approximately 40% of all property insurance claims.

Suffering water damage at your medical office can be an enormous inconvenience, especially if forced to move out for a number of weeks during repairs.

Prevention, with regular maintenance and inspection, is the best weapon against water damage.

Whether you own the building or rent your office space . . .

- Follow maintenance recommendations listed on your hot water tank. Hot water tanks have a life expectancy of approximately 10 years but this depends on water quality, use and maintenance.
- Inspect, on a regular basis, all sinks, tubs, showers, toilets, dishwashers, washing machines, water filters and fridges for signs of water damage and wear and tear, perhaps every three months. Contact a professional immediately if any repairs are needed.
- Check appliance hoses every six months for soft, weak spots and kinks. Replace hoses with better quality steel-braided ones if they show wear and tear or replace them every five years, whichever occurs first.
- Turn off the water supply to the fridge, dishwasher, water filtration system and any other water appliances when you leave the office for more than a couple of days.
- Water sensors can be used to prevent damage. They either sound an alarm or shut the water off to the dwelling. Some new models do not require hard wiring or plumbing. They simply attach to the faucet. Ask your local plumbing supply centre (e.g., Rona or Home Depot) for assistance.
- Keep drains clean. Dirty drains are more likely to back up or break. Older buildings are more likely to have damaged drainage systems from silting, shifting, and other ground and vegetation issues. TV/video pipe inspections, which take about two hours, are the first step to resolving and preventing drainage problems and they are inexpensive.
- Consult a roofing professional if there are signs of ice damming on your roof. Ice damming is caused by improper ventilation or insulation of the attic and can cause considerable damage to your building and, perhaps, lead to injuries.
- If you are going to be away for any length of time during the winter season, have someone check your office daily to ensure it is heated and that the pipes are not freezing.
- Maintenance of your building is critical. Update the pipes, if they are old, before they rust and leak. Insurance policies will pay for any resulting water damage but not to fix and update old piping. Gutters need to be checked for rust, and leaves should be removed to prevent water backing up under the roof.
- Always consult a professional before doing any repairs.

Helpful websites to visit for more information regarding water damage and how to prevent it follow:

- Canada Mortgage and Housing Corporation www.cmhc-schl.gc.ca/en/co/maho/gemare/index.cfm
- Insurance Bureau of Canada www.ibc.ca/en/BeSmartBeSafe/Loss_Prevention_Tips/Keep_Dry.asp ■

Get the right touch

J. Barrie McCombs, MD, FCFP
MEDICAL INFORMATION SERVICE COORDINATOR, THE ALBERTA RURAL PHYSICIAN ACTION PLAN

A recent article in the *Canadian Family Physician** about electronic medical records (EMRs) mentions the speed and accuracy of handwriting, dictation and typing as problem issues when using an EMR.

I've always been thankful that I learned how to type in high school, but many physicians didn't have that opportunity.

This article discusses the principles of touch typing and lists some resources to help use your computer more efficiently by improving keyboard skills.

Touch typing

The two basic principles in touch typing follow. The first is to use all 10 fingers. The second is to type without looking at your fingers.

Start by placing your fingers in the "home position," to which your fingers always return after typing any key.

The fingers of the left hand rest on the ASD and F keys and those of the right hand rest on the JKL and semicolon keys. The thumbs operate the space bar.

Keyboard layout

The standard "QWERTY" keyboard layout was originally designed to keep the keys from jamming on manual typewriters.

By assigning the most commonly used letters of the alphabet to different fingers, the chance of jamming was reduced.

Other more efficient keyboard layouts have been designed but have never become popular.

On many keyboards, the F and J keys have a raised bump to let you know that your index fingers are on the right keys.

Typing drill

Open your word-processing program (e.g., Microsoft Word) and type the sentence "The quick brown fox jumps over the lazy dog." It contains every letter in the alphabet and is one way to become familiar with the keyboard layout.

Once you can type it comfortably, try these additional exercises:

1. Type the sentence without looking at your hands.
2. Type it with a capital letter at the start of each word.
3. Type it in all capital letters but without using the "caps lock" key.

Mavis Beacon Teaches Typing
http://www.broderbund.com

This program is one of the most commonly available typing tutorial programs in stores. It is designed to help beginners and advanced typists who wish to improve their skills.

Several games are included to keep you interested while learning new skills.

All The Right Type
http://www.ingenuityworks.com

An acquaintance who teaches keyboard skills prefers this Canadian program because it is more to the point and less intrusive than the Mavis Beacon program.

The vendor's website describes the program's features and provides copies of the user manual in PDF format.

TypingMaster Pro
http://www.typingmaster.com

This typing tutorial program offers a free trial version. Its list price is higher than the previous two.

Typing Software Reviews
http://www.typing-software-review.toptenreviews.com

Visit this site to read reviews of several commercial typing tutor programs, including the Mavis Beacon program.

Typing Pal
http://www.typingpal.com ▸

▸ The online version of this program is available as a 30-day free trial. The program slowly walks you through the basics by teaching the keys two at a time, with a lot of opportunity for practice.

A downloadable version is also available.

Mr. Kent
http://www.mrkent.com/kb/keyboard.htm

This online typing practice site gives typists of all skill levels an opportunity to practise their keyboard skills. No software download is required.

PowerTyping
http://www.powertyping.com

This online typing practice site also includes a few games.

Free downloads

If you do a Google search for "typing tutorial," you will find a number of websites that offer free typing software.

The risk of downloading a computer virus is too high to recommend any of these.

Reference

* Dawes M, Chan D. "Knowing we practise good medicine: Implementing the electronic medical record in family practice." *Canadian Family Physician*, January 2010; 56(1): 15-16.

Your comments and suggestions are welcome.
Please contact me:
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Cameron's *Avatar* Ativan

Alexander H.G. Paterson, MB ChB, MD, FRCP, FACP
CO-EDITOR

My briefcase felt heavy as I crunched through the snow to the office.

It contained a Sony VAIO X Series laptop with its 12-hour battery, a Palm Pilot, BlackBerry, cell phone, iPod, USB sticks and an Air Canada business-class toiletry bag holding cables, plug-ins, spare batteries and two universal plug adapters.

Perhaps it was the creaking of my shoes in the snow that brought to my mind's eye my first doctor's bag and memories of Saskatchewan.

It was a Webley bag – black, with spring-locks. When the lid opened, a miniature storage cabinet appeared.

That evening I dug it out and looked fondly at it. It had drawers of different sizes.

- The long, flat drawer for syringes and needles.
- A square box drawer for specimen swabs, a bottle of Clinistix and little EDTA-filled pink plastic tubes for blood counts.
- My stock of out-of-date emergency intravenous medicines in the middle drawers: a box of aminophyline, 250 mgm vials; smaller boxes of Demerol vials; 10 unused vials of ergometrine, 0.5 mgms in 1 ml ampoules; sachets of Penidural; Amoxyl syrup; a tube of deliciously named "Urolucasil" for urinary tract infections and a number of dark bottles, one of which was for Mr. Lewis – full of Largactil 50 mgm capsules, one to be taken twice a day and two at night. (Hmm, poor Mr. Lewis never got his pills.)
- Below the drawers a space for a stethoscope, blood pressure cuff and ophthalmoscope/auroscope.

Now that was a useful bag.

What have I become? Briefly I yearned for the days of carrying around something useful for others, rather than stuff for connecting to a crazy, tweeting, yammering world.

That bag had accompanied me in London, England as I picked up a guinea per visit, cruising around for the Pollock General Practice Locum Agency.

It had accompanied me to Saskatchewan when I rashly agreed, one February, to do a locum for Dr. Smith, who practised solo in the town of Balcarres.

Dr. Smith had had a stroke. It was a wonder he had lasted that long. The practice, I discovered, was brutal – continuous on-call.

Briefly I yearned for the days of carrying around something useful for others, rather than stuff for connecting to a crazy, tweeting, yammering world.

The Greyhound bus from Regina had deposited me at the surgery on the main street. Dressed for a hypothermic suicide in Saskatchewan, I wore a light gabardine raincoat and dress shoes.

Cars with engines idling were parked in the main street. It was the time of OPEC's first oil embargo in Britain but there was no fuel problem in Balcarres.

The doctor's office, next to the hardware store, had a façade of urine-colored stucco.

I stamped the snow from my thin black shoes on the hollow floorboards, saw a row of strange rubber overshoes and introduced myself to the receptionist, a blue-rinsed lady wearing Star Trek spectacles, the kind of lady who used to be the brittle backbone of medical practices in this country.

Over a mug of tea, Mrs. Bewley introduced me to the practice, with one of the essential pieces of information being problem patients.

"Well, there's a durned family from outa town that's a lot of trouble to us, and you'll get to know them for sure," she said. "They come into town weekends and get to drinking and all that 'n' the other and one'll end up at the Union Hospital with a cut or a bullet."

"And who are they, Mrs. Bewley?" I asked.

"The McClellands. And Joe and Al are the worst. You'll see, uh-huh." And she nodded her head in memories of her own.

But I had handled the McClellands in the emergency rooms of Scotland. I could handle them here. ▸

I plonked my bag of electronics on the floor of my office. It was Friday and the Hollywood publicity machine had penetrated my brain. I'd heard James Cameron's *Avatar* was a must-see movie, grossing $2 billion dollars and rising.

The secretaries' heads were fixed on computer screens.

"Has anybody seen *Avatar*?" I asked.

Agnes had. Twice. The IMAX 3D-Experience and regular 3D. "You'll have to book. There's no way to get in without a reservation," she replied.

For the first time ever, I reserved, on the Internet, two electronic tickets for a movie.

We were scanned in and handed a plastic bag containing RealD 3D glasses with a warning on the package: "Not safe for use as sunglasses."

Twenty minutes before the movie started, the place was packed.

We found two seats beside three youths, with their feet up on the seats, in front. The girls sitting in front didn't seem to mind.

Two overweight women stood on the stairs, cuddling their buckets of popcorn and looking for seats.

"Put on your special 3D eyeglasses" flashed on the screen. We obeyed.

Then it started. I looked around. A full theatre of spectacled refugees from a wintry, drab life seeking . . . what? Adventure? A reincarnation of the Hindu deity, Vishnu?

I took off my specs. The screen was blurry. I put them back on and was enclosed in the virtual world of Pandora for the next two hours and 40 minutes.

We arrived at the main camp of the Sky People on Pandora, an American world of electronics, display screens and busy, bossy people.

Serious scientists clamped people into coffins, then ran them through machines like CT scanners, thus transmogrifying them into fake Na'vi people – the local Pandorans.

Images of brains were examined by the serious, bossy scientists.

The US military deployed into the Pandoran atmosphere wearing thin, plastic face masks, like the one used to fit me for my personal anti-H1N1 mask.

These were not the space helmets that comic book spacemen wear, which are like diving suits. No, Pandora was a moon-world akin to Earth.

We then met the Na'vi people – large people with faces resembling the hare lip/cleft palate phenotype with prominent nasal-orbital ridges.

These Na'vi coves were supposedly dangerous. But it became obvious to the earthlings, who had been cunningly transformed into fake Na'vi, that the real Na'vi were OK.

It was the greedy earthlings who were the problem because they were after a precious metal "unobtainium."

The real Na'vi were in tune with their luscious environment and, though a bit primitive and a dab hand with a bow and arrow (echoes of American Indians), they were spiritual, athletic and aware of the killer instincts in the beasts around them. Yet they understood and tamed them.

Our Yankee-fake Na'vi gained our sympathy by his cack-handed, open-hearted approach along the lines of, "Hi, there. I'm Joe from Cincinnati and how are you today?"

The derision of the real Na'vi to this phony approach illustrates the problems the troops have in Afghanistan winning hearts and minds.

We were then transported to the beautiful, natural lives of the Na'vi in Pandora – spiritual, connected to each other and pure souls of their ancestors and to the birds, beasts, vegetables and insects.

I might start using my old Webley bag again. (Dr. Alexander H.G. Paterson.)

They possessed natural healing skills. Warriors they were but warriors who never invaded anyone else's property.

It then became a *Lord of the Rings* set-up between evil – the war-mongering Sky People (Bush/Rumsfeld-era Americans) – and the spiritual, primitive Na'vi.

And if you still didn't get it, the brutish general in charge of the Sky People's Army said, "We'll give 'em something to remember. Shock and awe."

OK. So here was a must-see grand spectacle, an experience with no emotional highs, no willing suspension of disbelief. It was more like wow, how did they craft that clever scene?

But Agnes has seen it twice. And others in drab jobs on a factory line or boring jobs staring at a computer screen all day, or out of work, love it for the escape into Pandora, a moon-world that is fading fast.

They don't want to return to our grey, drab world with a life regulated by screen displays, gadgetry, big-box shopping and big government.

I sensed a yearning in the young audience for much that has been lost to the autistic, robotic world of emailing, texting, tweeting, blogging and arm's-length social networking.

This yearning for a natural life has been elicited by the most technologically advanced movie ever made.

Spend more time chatting idly to your patients. Exercise more. Let your emails go to hell for a few days. If people want you, they'll find you.

In December I saw six Germans sitting together, in the lobby of a hotel in San Antonio, on their BlackBerries. We now have an elementary school in Calgary, the Samuel W. Shaw School, which has banished books, abolished the library and is totally "computer literate." God help the poor kids.

In the west, there has been a loss of personal contact, contact with nature and a simple spiritual life.

And here's a grand irony. This yearning for a natural life has been elicited by the most technologically advanced movie ever made. There's some kind of movement here and there's something important in it.

We're on a path I don't like, despite all its MBA-driven efficiencies: The isolation of chat-line communication and exchange of images, the superficiality of Internet information – a substitute for education.

What to do? Spend more time chatting idly to your patients. Exercise more. Let your emails go to hell for a few days. If people want you, they'll find you.

Instead of emailing, get off your bum and go visit a person, perhaps a radiologist. These souls have completely disappeared from sight.

And my black Webley bag? I might start using it again. I'd rather carry that around. But there's no place to put my super-light laptop. . . . ■

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