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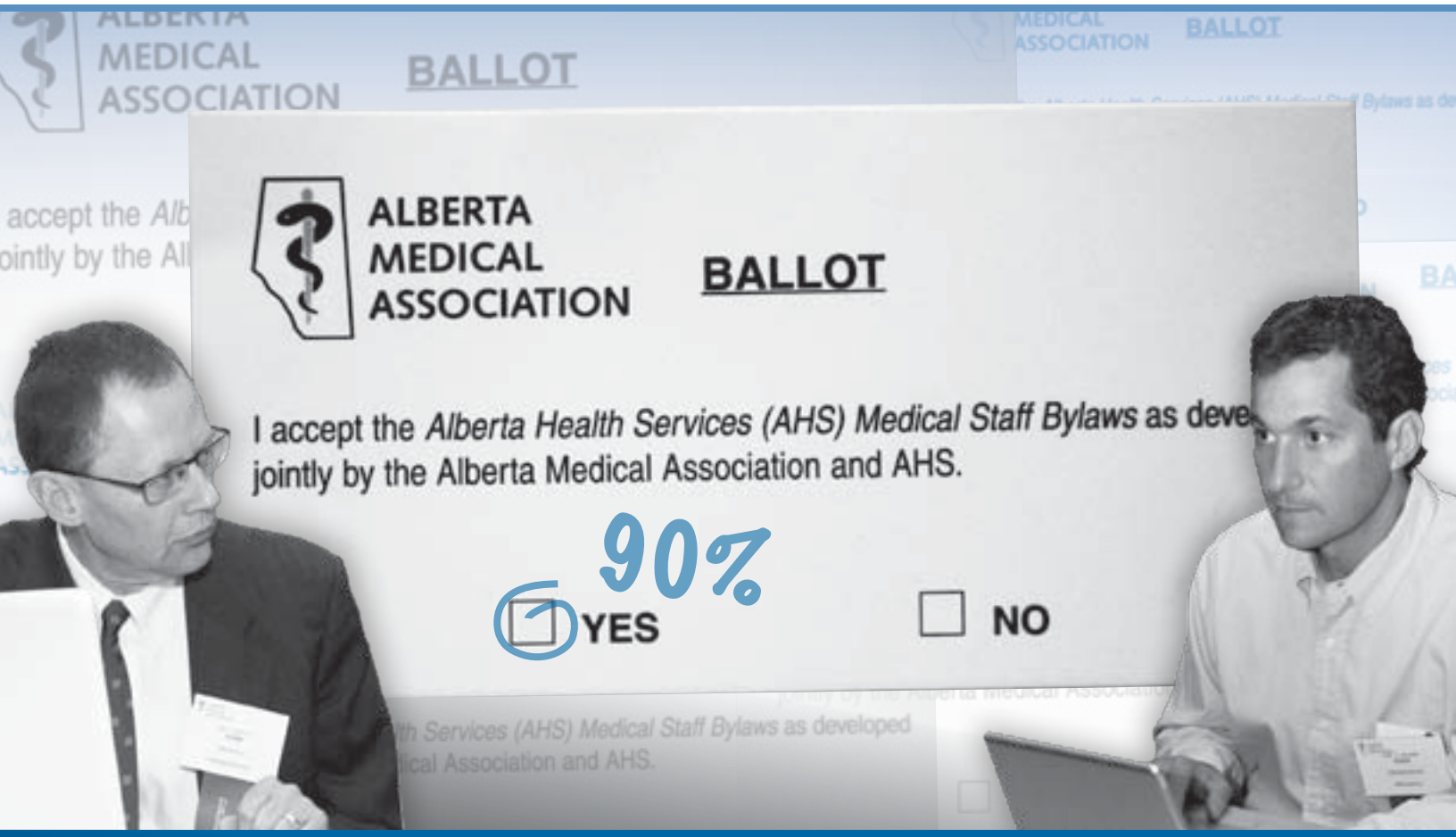
THE ALBERTA DOCTORS' DIGEST



Expect single set of medical staff bylaws soon

Patients First®

ALBERTA MEDICAL ASSOCIATION

Volume 36, Number 1

Managing as if people mattered

Dennis W. Jirsch, MD, PhD
EDITOR

Our health care world remains mercurial.

The hullabaloo over emergency room wait times and the precipitous departure of the inaugural CEO of Alberta Health Services (AHS) may have become old news – nearly forgotten, perhaps – as new plans to whisk patients hither and yon, and rosy performance goals for waiting lists distract our attention.

The modus operandi of the health department remains concerning. AHS was evidently borne of political resolve to bring the health care spending juggernaut to its knees. But there are, after all, only a couple of ways to save money quickly in health care: cut services and cut salaries.

Who believes that bed closures, service displacements and hiring freezes that raised such a ruckus a short while ago weren't vetted, and vetted repeatedly, before caucus and cabinet politicos before being advanced publicly?

One by one, I'm sure the worthies muttered, "Yup, we just gotta do this" as they heard the plans for cost-cutting mayhem. Their agreement with plans laid out for them by their hired gun went south, however, once it looked as if angry citizens might storm the ramparts.

There may even be agreement – now! – that we have inadequate capacity in acute and continuing care sectors, but it's hard to forget the restraint of mere months ago.

And who can forget the continuing flip-flop over whether we have too many or too few staff – nurses, in particular – and the trouble finding anyone in government or AHS who'd admit there was real trouble in Neverland.

There may even be agreement – now! – that we have inadequate capacity in acute and continuing care sectors, but it's hard to forget the restraint of mere months ago.

Things change, mirabile dictu, and AHS spokespersons have even started to mention "change fatigue."

I'm happy to hear that AHS plans an "organizational review" but don't quite know what they have in mind. Riffling through umpteen pages that describe its organizational pyramid, I'm inclined to think that, absent the common sense not to have invented this in the first place, an organizational review is long overdue.

The monolithic AHS is dated and unwieldy from any point of view and its command-and-control structure relies too heavily on standards, procedures and statistics to regulate the organization.

It stems from the thinking of Frederick Winslow Taylor, with notable application by Henry Ford and Alfred P. Sloan, Jr. from the motor car industry – there is a world of difference between the privilege and power that must be accorded executives on the one hand and workers on the other.

Command-and-control organizational structures have gone the way of the dodo bird, however, in businesses that regard the commitment and knowledge of workers as a valuable resource in complex working environments.

We seemed to be working in this direction once-upon-a-time. Remember where we've been. In 1995, 200 hospital boards, long-term boards and facilities were regionalized and joined together in 17 regional health authorities.

The regional health authorities were merged into nine in 2003, but the devolution of health care on a regional basis prompted admiration ▸

of the rest of the country as a new and more responsive way to manage.

This was all reversed in 2008 with the advent of the AHS superboard and centralization of authority in a manner analogous to that of, say, the North Korean army.

The new structure regards people and programs in mechanistic terms, ripe for re-engineering, and expecting performance to specifications with machine-like obedience.

Is it any wonder that problems – "issues" in corporate newspeak – float, nay, are pushed up the corporate ziggurat in this dated world?

We'd be well advised not to pursue this much longer. The stress and the fatigue in the system are palpable, offset with deep cynicism at endless programs and fads.

I watch my folk – the lumpen proletariat – listen patiently to yet another 5-year plan and know there are two solitudes: the governed and the governors.

For the rest of the world there's good news. We've known for half a century or more that self-managed teams are far more productive than any other organizational form, with a clear correlation between participation and productivity.

For years now, workers in all manner of sophisticated institutions have asked for – and received – more local autonomy, insisting they can do a better job of things than any huge and overarching organizational Big Brother. They're right.

Why isn't everyone working in a self-managed environment now? The answer has to be that leaders, however misguided, have consistently chosen "Control" as the cardinal corporate goal.

I watch my folk – the lumpen proletariat – listen patiently to yet another 5-year plan and know there are two solitudes: the governed and the governors.

Policies, procedures, protocols, laws, bylaws and regulations have accordingly become byzantine, visiting a sort of paresis on employees and managers alike.

It's crazy. Most of us know deep down that the residual good in the system has to do with the plucky resilience of workers at the coalface who truck on, despite inept political machinations, bureaucratic gridlock and mindless obstructions.

This isn't to say, however, that participatory management, or whatever we choose to call it, is simple. If we've learned anything from the past 20 years of turbulence, it is that there are no quick fixes.

It stands, though, that if we want organizations of greater and enduring capacity, we must turn to the people in our organizations themselves.

Loyalty and commitment are essential for our human relationships, so how can we pretend that these aren't necessary at work?

Performance indicators are the current "hot poop" just now, but the truly overarching organizational indicator must be: *Are more people in the organization committed to their work lives right now than they were before our latest effort at reinvention?*

I write this at my peril, perhaps, and expect many will say my view is simplistic, that the situation is far too complicated. I'd remind, though, that the AHS behemoth is a man-made creation, too, and so is its inordinate complexity.

To my way of thinking, developing a model for distributing power in the organization is the essential next step in any successful organizational review.

The political powers-that-be are clearly in placatory mode after repeated stumbling and falling badly. I hope they've learned something and are more open to changing structure and processes than has heretofore been the case.

Dr. Chris J. Eagle, acting AHS CEO, has said more in his short tenure about the importance of developing convivial relationships than I've heard in years.

The residual good in the system has to do with the plucky resilience of workers at the coalface who truck on.

Chris and I were near-contemporaries in MBA studies a decade ago, and I remember him as thoughtful and considerate.

I think he'd make a good CEO. Whether this might be his good luck or bad, he's now astride the health care bull-at-the-Alberta-rodeo and I wish him well on his ride.

Good luck, Chris Eagle. ■

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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.

Expect single set of medical staff bylaws for Alberta physicians soon

A new milestone will be reached in Alberta this year regarding medical staff bylaws.

It is expected, at the time this article was written, that Alberta Health Services (AHS) will implement, on March 1, one set of medical staff bylaws across the province for all physicians who have AHS appointments.

A new set of medical staff bylaws became necessary in the spring of 2008 when the Alberta Health and Wellness minister at the time, Ron Liepert, amalgamated the former regional health authorities (RHAs) into a new, single provincial entity.

Current legislation requires medical staff bylaws to define the framework for the relationship between medical staff and AHS. These bylaws apply only to sites/facilities operated by AHS (i.e., owned by AHS or its subsidiaries, Carewest and CapitalCare).

Over the past two years, the AHS/Alberta Medical Association (AMA) Provincial Medical Staff Bylaws Working Group representatives worked to develop new bylaws to replace the individual sets of bylaws from the former RHAs.

The working group finalized the draft proposed bylaws in September 2010.

Background

The AMA's president at the time, Dr. Christopher J. (Chip) Doig, via his June 5, 2010 *President's Letter*, invited association members to review a draft set of medical staff bylaws and medical staff rules that the working group had created.

Dr. Doig pointed out that these "bylaws have implications – direct or potential – for every physician in the province, and every physician should give them due attention."

Physicians were invited to provide their feedback and discuss any concerns in three ways: through email messages, at face-to-face meetings in seven Alberta cities and through arranged rural/urban videoconferences.

During the summer, the joint working group discussed feedback collected from physicians who emailed or attended meetings/videoconferences. Where consensus could be reached, the working group revised the bylaws to address concerns.

The working group reached a unique landmark in their agreement on a final version of a single set of provincial medical staff bylaws in August. At its August 25, 2010 meeting, the AMA Board of Directors voted unanimously to send the bylaws out to AMA members for a vote, with a recommendation to accept.

"Bylaws have implications – direct or potential – for every physician in the province, and every physician should give them due attention."

AMA members vote to accept the proposed bylaws

In early September 2010 the AMA sent ballots to almost 6,000 AMA members, who have AHS appointments, for their vote. AMA President Dr. Patrick J. (P.J.) White announced the results to members soon after, in his October 7 *President's Letter*.

Of the almost 6,000 physicians who received ballots, 1,091 voted. Of these, 985 voted to accept the bylaws, 95 voted to not accept (and 11 ballots were spoiled). ▸

▸ This strong support by voting physicians endorsed the working group's inclusion of strong physician engagement and protection of physician rights in the bylaws. (In addition, AHS ballots from non-AMA member physicians, as well as the ballots of dentists and podiatrists were counted: 61 voted, with 56 voting to accept, one voting to not accept and four ballots were spoiled.)

Physicians without AHS appointments were offered the opportunity to comment on the medical staff bylaws through an online survey. While the response rate was quite low, 76% of respondents said they would vote to accept the bylaws if they could vote, 82% said the bylaws were fair to physicians and 90% agreed the bylaws allow physicians to advocate for their patients.

Once approved by the AHS Board of Directors in mid-October, the bylaws were sent to Minister of Health and Wellness Gene Zwozdesky for his final approval. It is expected that the bylaws will take effect March 1.

Medical staff rules to accompany the bylaws were almost finalized in December 2010. Once the working group reaches consensus, the Council of Presidents (former presidents of the regional medical organizations or RMOs) will be asked to review and approve them.

Next steps

Transitioning to the new bylaws

AHS will transfer physicians' current appointments and privileges to an equivalent appointment category and grant equivalent privileges and sites for privileges. Before the new bylaws are enacted, physicians will receive written notice from the AHS Medical Affairs Office about how the bylaws will be transitioned.

New Zone Medical Staff Associations (ZMSAs)

A ZMSA will be established in each of the five zones to act as a collective voice for zone physicians who join the ZMSAs. The ZMSA is independent from, but has a relationship with, AHS and the AMA:

- A mandate from AHS for medical staff bylaws functions
- A mandate from the AMA for advocacy and other AMA functions at the zone level

Highlights of the bylaws

The bylaws:

- Define: AHS medical organizational structure; bylaws-related processes, e.g., amending bylaws, periodic reviews, etc.; and notification provisions for the College of Physicians & Surgeons of Alberta (CPSA)
- Allow physicians to work with province-wide medical staff appointments
- Confirm that physicians who practise only in community-based practice, without appointments, will have access to basic lab, diagnostic imaging, home care, community rehabilitation and Netcare
- Clearly outline what medical staff and AHS administrators are responsible for – and the rules of respectful working relationships between them
- Make the *Canadian Medical Association Code of Ethics* and self-regulation (*CPSA Code of Conduct*) the basis of physician conduct
- Streamline and significantly improve peer review, credentialing and other processes – based explicitly on fairness

Before the new bylaws are enacted, physicians will receive written notice from the AHS Medical Affairs Office.

The players

The Council of Presidents were important advisors to the AMA as the bylaws were developed. This group appointed Dr. A. Mark Joffe, from Edmonton, and Dr. Carl W. Nohr, from Medicine Hat, to act as their representatives on the AHS/AMA Provincial Medical Staff Bylaws Working Group.

Dr. A. Mark Joffe.

Dr. Carl W. Nohr.

Drs. Joffe and Nohr expended countless hours and indefatigable efforts to ensure fairness, autonomy and an advocacy voice for physicians, along with openness and transparency in the bylaws.

Their efforts and those of AMA staff – Assistant Executive Director (Professional Affairs) Dr. William S. Hnydyk, supported by Professional Affairs staff Dr. Lyle B. Mittelsteadt and Janet E. Boyer – and AMA legal counsel, Jon Rossall, were also critical to the process.

AHS representatives included Executive Vice-President and Chief Medical Officer Dr. David W. Megran, Associate Chief Medical Officer ▸

(Fred Katz Fine Art Photography.)

▸ Dr. Rowland T. Nichol, Associate Chief Medical Officer Dr. Tyrone M. Josdal and AHS legal counsel.

Both sides worked toward a mutually satisfactory outcome in each situation to create an open and transparent set of bylaws that recognize:

- Due process and procedural fairness
- Balance between AHS policy adherence on the one hand, and professional ethics and physician freedom to advocate for patients on the other
- AHS recognition of physician autonomy and fiduciary responsibility to patients
- The ability of physicians to speak out on behalf of their patients, as long as they clearly identify that they are not speaking on behalf of AHS

For more information about all things bylaws-related, visit the AMA website (www.albertadoctors.org; from the Advocacy drop-down menu, click on Provincial Medical Staff Bylaws). ■

The *Alberta Health Act*: Debate in the Legislature

The Alberta Health Act (Bill 17) was passed into law on November 30, 2010 by the Legislative Assembly.

The act will come into force upon proclamation.

Read more about Bill 17 in Alberta Hansard online (www.assembly.ab.ca/net/index.aspx?p=bills_status&selectbill=017).

Alberta Hansard excerpts follow, which highlight the debate from the November 30 afternoon and evening sessions.

Leader of the Official Opposition, Liberal Leader Dr. David Swann (MLA for Calgary-Mountain View): In the middle of the health care crisis, you've chosen not to listen to a respected emergency room physician, instead booting him out of caucus for standing up for Albertans. You've chosen not to listen to my own emergency plan for the emergency room, instead releasing yet another toothless plan to develop a plan that will be forgotten along with the other plans collecting dust over many years.

Considering the information released to the public yesterday, don't expect Albertans to believe your fairy-tale nonsense. You're so frightened of the public that you're champing at the bit to get out of the Legislature and retreat to home.

But all that can happen here is denial, dissembling, and ducking for cover. Alberta Liberals and, I dare say, the members of other opposition parties and our independent members believe in democracy with room for dissent. Progressive Conservatives believe in covering their butts when the going gets tough. You have the power to shut down this debate in the Legislature, it's true, but that's where your power stops.

Outside of the dome, back out in the real world, the debate continues around every kitchen table in this province. You can do your best to punish and threaten and suppress debate inside; you can't stop the rising tide of Albertans who have lost confidence in this government's ability to manage public health care among many other services. You've lost the moral authority to govern.

Minister of Health and Wellness Gene Zwozdesky (MLA for Edmonton-Mill Creek): It shouldn't be lost on people that more than 3,000 people were consulted and had input into this *Putting People First* report, including the people that live in about 23 communities plus numerous other communities.

More than 1,500 completed online surveys were recorded, and more than 80 organizations provided written submissions, and many of them touched on the issue of emergency rooms, such as this amendment refers to.

Mr. Chairman, just to emphasize to you that Bill 17 really is the voice of thousands of Albertans being reported through this legislation. It's important work that has given us greater understanding of what Albertans expect from their publicly funded health care system and what we as a government are doing to make it even stronger.

That's why we're proposing in there establishing a health charter that will set out even more clarity on principles and responsibilities with regard to the health system. It talks about establishing a health advocate to resolve citizens' concerns with the health system as they relate to the health charter that is forthcoming. Within that context they will have yet more opportunity to talk about lengths of stay in emergency rooms or access to a specialist or access to cancer treatment start-up after the point of referral.

What we're getting here is a bigger picture of a large number of issues, not just the ER issues. The ER issues are critical – of course they're important – and nobody from this side of the House has said anything different. We understand that, and we're actively pursuing what we can to help strengthen the emergency room scenarios.

This is not just about emergency rooms. This is about a Rubik's cube of health care delivery that impacts ▸

emergency rooms. Beds in acute-care settings impact that. Transition beds impact that. Community care beds impact that. How much service people are getting from home care impacts that. The number of doctors in the system impacts that. So there's a wide range of latitude here.

You can't have this kind of an amendment going into law for fear of some of our doctors or nurses being put under pressure that they shouldn't break the law and perhaps rushing a treatment for a patient that's come in with a legitimate concern.

The doctor or the nurse doesn't need to have this kind of legal issue hanging over their heads in addition to the legal obligations and the moral obligations and the Hippocratic Oath obligations that they already have.

If you take a look at the risks and dangers of putting something like this into law, that would be one significant factor.

Another important factor . . . Mr. Chairman, is that you would have so many issues going forward to the courts that you would have the health system, potentially, in the court system more than it is out there serving the public. We wouldn't want that to happen.

Progressive Conservative MLA Fred Horne (Edmonton-Rutherford): In fact, the solution, Mr. Chair, in my view, would not be the enshrining of those maximum wait times, as important a symbolic gesture as that may be.

The real solution, I think, is a determined effort to look at the areas that I mentioned, the areas that drive ER wait times – principally primary care, continuing care services, making some improvements in those areas . . . that have already been announced and, in fact, not proceeding with what I would call a right-space solution, which would be the approval of an amendment as proposed, as this one is, as part of the bill, but a practice-based solution that is supported by adequate resources, of course, that is supported by the recognition and the adoption of appropriate evidence-based clinical protocols that are recommended not by government but by health professionals, by practitioners who have reviewed evidence, who have refined procedures, and who are in a position to speak with authority on such matters.

The other concern I would have is whether we could make a commitment that the achievement of these guidelines could be equally delivered in all parts of our health care system. I did visit a number of rural communities where the emergency department, unfortunately,

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News release

Alberta ■

December 1, 2010

Alberta passes new health legislation

Alberta Health Act focuses on putting people first

Edmonton – Principles to guide the health system, as well as a commitment to a public input process, and requirements to establish a health charter and a health advocate, are important features of Bill 17 – the Alberta Health Act 2010 which was passed by the Legislative Assembly on November 30.

"This is an important day for Alberta's health system and the people it serves," said Health and Wellness Minister Gene Zwozdesky. "Following consultation with Albertans and a rigorous debate in the Legislature, the passing of the Alberta Health Act is an important next step in our plan to build the best-performing publicly funded health system in Canada. The Act recognizes in law our commitment to the principles of the Canada Health Act while establishing a set of principles that describe the health system Albertans want now and in the future."

The Alberta Health Act will require the Minister of Health and Wellness to establish:

- a health charter that sets out expectations and responsibilities within the health system
- a health advocate to address citizen concerns with the health system as they relate to the health charter
- a process to provide for public input in the development of health regulations made under the Act.

Work will now begin on establishing a health advocate and validating a health charter which will include public input.

The Legislative Assembly's passing of the Alberta Health Act follows on the heels of the release of the government's *Becoming The Best: Alberta's 5-Year Health Action Plan*. Both are important pieces in the government's overall plan to create the best-performing publicly funded health system in Canada. Other pieces of the overall plan include having one, single health delivery area for Alberta (Alberta Health Services), and introducing the first of its kind 5-year funding model for the province.

The Alberta Health Act has the support of the *Putting People First* report released September 10. The report made 15 recommendations and summarized the views of Albertans during extensive public consultations over the past year.

The Alberta Health Act will come into force upon proclamation. To read or obtain a copy of the Alberta Health Act, visit the Legislative Assembly of Alberta website at www.assembly.ab.ca.

The Alberta government has a clear plan for a strong economic recovery. An important part of The Way Forward is maintaining support for programs and services Albertans need most, such as health care, education and safe and vibrant communities. For more information on the plan visit Alberta.ca.

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- is functioning in large part as the family practice clinic for that community because of things like lack of physicians and lack of facilities for physicians to practise in.

"Albertans should have access to a primary care team, including a family physician."

The third is that we really need to get our heads around what we can do in primary care. The *Putting People First* report proposed that the proposed health charter include a commitment that all Albertans would have access to a primary care team. By virtue of being residents of Alberta, Albertans should have access to a primary care team, including a family physician. That needs to be part of the discussion before considering an amendment such as this, I would suggest.

Independent MLA Dr. Raj Sherman (Edmonton-Meadowlark): Mr. Chairperson, the reason we're talking about this very important bill is because I was in Dr. Paul Parks's position, and I had brought this matter up to the hon. Member for Sherwood Park when she was the Minister of Health and Wellness. My colleagues before me had brought this matter up in 2002, 2003, 2004, 2005.

In 2007 we worked with the hon. Member for Edmonton-Whitemud. We achieved some short-term gains, but the hon. member was busy passing Bill 41, beating up the doctors and the College of Physicians & Surgeons, and dropped the ball. All of these 322 cases and these deaths have been under the hon. Member for Edmonton-Whitemud when the hon. Member for Edmonton-Rutherford was his executive assistant.

Then, come 2008 and the election in 2009, we had a decent health care system, that was jackhammered by the hon. Member for Calgary-West. The health care system became worse.

That sequence of events led to Dr. Paul Parks writing a letter on October 8 to the Premier saying that the emergency medical services are on the verge of a catastrophic collapse. This is after letters were written to all these ministers and reassurances were given. Announcements were made in my home of God knows how many long-term care beds to address this issue. Mr. Chairperson, God knows what's going to happen after 2011.

Mr. Zwozdesky: Bill 17 responds to the principles that Albertans told us that they want to see enshrined in legislation that would guide actions and decisions in our health system. The principles, acknowledged in word, in deed, and in law, reflect and acknowledge our commitment to the principles of the *Canada Health Act* and also to a set of made-in-Alberta principles, principles that are progressive and that reflect Albertans' values.

We have spent a lot of time listening to what Albertans said they want in their health system and how they want to be involved in decisions about their publicly funded health system. This bill as proposed, otherwise known as the Alberta Health Act, will allow us to deliver and to address those expectations. Bill 17 is an integral part of our ongoing work to build the best performing publicly funded health system in Canada.

Liberal MLA Harry Chase (Calgary-Varsity): Bill 17, the Alberta Health Act, has been touted, trumpeted by this government as the cure to what ails the system. However, it offers nothing in terms of timelines or targets, nothing in terms of financial commitments. The escape clause is: over the course of the plan. The escape clause is "that the Minister considers appropriate."

Nothing is being promised. Targets can be changed. Timelines can be changed. Any of the requirements can be left to ministerial discretion. How is this going to move us from where the destruction of the system began back in 1993-94? I don't see it.

Simply coming up with numbers – for example, the *Sesame Street* number of the day brought to you by the minister of health is five, so we keep hearing about five this, five that, five the other. This is a wish rather than a plan.

Wildrose Alliance MLA Heather Forsyth (Calgary-Fish Creek): Mr. Speaker, where I'm struggling and, more importantly, what Albertans are saying is that if the government is serious about fixing the system, they first have to acknowledge that it is in crisis. We have heard from the health minister, and not only does he disagree that we are in a crisis, but he also doesn't believe that the health care system is broken.

Albertans want answers, and they want to know numbers, like how many net new acute-care beds there are in the health care system and how many beds have been closed. They want to know how many family doctors there are in the province and why it is so difficult to find one.

They want increased home care and want to know how many nursing beds are available. They want to know how many long-term care beds are available, and they want our beloved seniors to quit being nickelled and dimed to death.

The government pretends everything is all right. While they can live in their la-la-land, Albertans know differently. Albertans are tired of the government not listening. Albertans are tired of the government's gobbledygook. Albertans are proud people. ▸

They want their MLAs to do the job that they were sent to do. They want their MLAs to listen and to represent their views. They want their MLA to stand up on their behalf, for them and their loved ones. What is truly sad, Mr. Speaker, is that the government has let the people of Alberta down. That is not acceptable.

New Democrat MLA Rachel Notley (Edmonton-Strathcona): Now, many people have said already that what Albertans actually want is a functional health care system. It's truly unfortunate that we're not able to say that that's what they have right now, but we're not able to say that.

> "What Albertans actually want is a functional health care system."

I believe that the reason we have so many challenges within our health care system is because this government is actually quite interested in creating an appetite for more private delivery and more private funding within the health care system.

What's important about this act? Why do we care if it's so meaningless? This act according to this document is, in fact, phase 1. When you get through phase 1, then you have to be worried about what's going to happen when you get to phase 2.

Phase 2 is where this government plans to put one over on Albertans. Phase 2 is something that this Government will not have the courage to bring forward or admit to Albertans until after the next election.

Phase 2 includes opt-in, opt-out privileges for physicians. Having a privately funded parallel system does not magically create more doctors. It does not magically create more nurses. It does not magically create any of that. What it does is that it allows doctors to practise in both.

So for those doctors who decide to put a few more hours of the day in the private system and for whomever can afford to walk into that private system, they get their services first.

The public system is starved. The public system gets less. The services that we've talked about being so inadequate, the pain and the suffering that we have heard about in excruciating detail over the course of the last few weeks: it gets worse, Mr. Speaker, if possible. That's what happens when you allow physicians to opt in and opt out of the public system, to do both.

Mr. Horne: I think, you know, as a society we have been perhaps preoccupied with the question of funding for health care. I say "preoccupied" in a sense not because financial resources are not important but because Albertans recognize two things.

One is numerous attempts over the years to find a magic bullet, to find one approach, one fix to the issues in health care. What they told us quite convincingly and quite strongly right at the beginning of the consultation was: "We're not interested in a search for a magic bullet.

"Neither are we interested in a debate about the right amount of money the government should be spending on health care." People would frequently say to me: "Well, whether you ask me if $10 billion is enough or $15 billion or $20 billion, I'm not going to know that answer. I'm not interested in cost. What I'm interested in is value."

Mr. Speaker, you know, it was very clear – and it should be a surprise to no members in this House – that the majority of people that we spoke to are not in favour of additional privatization of the health care system.

There are no avenues that open that in this bill. In fact, there are some very stringent restrictions in this bill that would not allow the consolidation of some of our existing legislation or future legislative changes without consultation.

There's nothing in this bill that allows a Minister of Health and Wellness to unilaterally by ministerial order or by order in council amend any existing legislation and move what's in statute today into regulations tomorrow. That is not enabled by this bill in any way, shape, or form.

Dr. Sherman: The stars are aligned for this thing to happen. I've got nothing to do with this, guys. I had nothing to do with this as a parliamentary assistant. I heard about it. I advised the minister: bad thing for the election, that privatization stuff.

I wish that somebody would actually be honest. If you want to privatize, just say, "We want to do it," and do it. Have the courage to actually bring it up and have a real debate on it.

Now, if you actually, really want to fix the public health system, all of those folks over there – there are two past ministers of health, a current minister of health, an ex associate minister of health, and a major adviser to this government for a decade – have not brought in accountability measures.

Now we're bringing them in, and they're probably the most mediocre measures I've ever seen on the planet. You know how I know that? I've been to the top hospitals in Canada, the top hospitals in the US. I've been to the top hospitals in India. I just went to

- the top hospitals in the UK, that have the top performance measures on the planet. I know this because I actually toured the planet, and I sort of know what I'm talking about.

These are the guys who buggered up health care when I was working on the front lines. I'll take the words "buggered up" back. I apologize. Maybe "wrecked" is better. And the minister that smashed it: he ain't here.

Mr. Speaker, you can censure me all you want. I can't take that back because that's what the front-line staff are saying. They say you guys all deserve to be locked up in a mental health institution.

But guess what? There are no beds. They were going to blow it up. They'd have to wait for God knows how many hours in the Royal Alex emergency department. My friend's brother hung himself, unfortunately, God bless his soul, and God bless his family. That's what front-line staff see, patients suffering metres from care, and they feel helpless.

I don't know how I can communicate in any other way. I've appealed to the humanitarian side of my colleagues. I've appealed to the evidence-based side of my colleagues. I've appealed to the common-sense side of my colleagues.

I am not going to give you any inspirational speech here. I'm going to cut through the malarkey and just be brutally honest. I think this government needs to go.

When I was section president, I was advocating during the election campaign. I met Mr. Jim Dau, who was the communications person for Premier Ralph Klein when the cutbacks happened. He sat me down at Century Grill and said: Raj, I've got to tell you that you don't want to criticize the Conservatives because they'll get you after the election; it's best to work with them. He advised me that he was working with the hon. Premier. He said: it's better to work behind the scenes.

Medicare in Canada began in Alberta

Approval of the *Alberta Health Act* comes 75 years after Alberta passed *An Act Respecting Health Insurance*, thus becoming the first province in Canada to pass such legislation with royal assent April 23, 1935.

As noted medical historian Dr. J. Robert Lampard recounts in *Alberta's Medical History: "Young and Lusty, and Full of Life,"* the act contained Plan A (based on a municipal hospital region or a district) and Plan B (covered employers/employees in a larger urban community).

In each plan the government agreed to pay two-ninths of the cost, to cover the premiums for those who could not afford them. The election of the Social Credit government several months later, however, ended this initiative of the previous United Farmers of Alberta administration.

Also in 1935, the Canadian Medical Association (CMA), with its Alberta president, Dr. J.S. McEachern, endorsed a plan for health insurance that featured 17 principles.

"They would serve for a decade as the foundation for the CMA's position. The CMA would nominally revise them in 1937, 1941/42 and 1943, before unanimously agreeing to support a Health Insurance Plan for Canada on January 19, 1943, in a 78-0 vote," writes Dr. Lampard.

The CMA's plan was based on a 35-page report a year earlier from its Committee on Economics.

According to Dr. Lampard, the important points were "the maintenance of the fee-for-service system, the protection of the doctor-patient relationship without state intrusion, free choice of doctors, the CMA's need to federate so it could present a unified position on health insurance in discussions with governments . . . the need for the 'state' to subsidize the premiums of those who could not afford them, and the desire that guardianship of health care be a national responsibility."

In his CMA presidential retirement speech June 10, 1935, Dr. McEachern said, "The CMA needed to prepare itself to face the growing interest of provincial governments in the access to medical care and the need to have a set of principles to guide it." ■

Calling for TD Insurance Meloche Monnex/AMA Scholarship applicants

Family medicine resident Dr. Michael W. Aucoin was the 2010 recipient of the scholarship, which also marked the 20th year it was awarded. He received the award from AMA Past President Dr. Noel W. Grisdale. (Dawn C. Wyver, AMA.)

Just picture it – $5,000 of assistance for additional training in a clinical area of recognized need in Alberta. If that fits your situation, apply for the TD Insurance Meloche Monnex/ Alberta Medical Association (AMA) Scholarship by March 31.

Scholarship applicants must be seeking additional training in a clinical area of recognized need in Alberta, be an AMA member, plus be enrolled and accepted in a clinical program, at least three months in length, in a recognized educational facility.

The proposed program must be supplementary to completion of a Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada certification program, or the physician may be in an established practice and wishing supplemental training.

To request a scholarship application form, please contact Ava L. Butterworth, Administrative Assistant, Public Affairs, AMA: ava.butterworth@albertadoctors.org, 780.482.0312, 1.800.272.9680, ext. 312 or visit the AMA website (www. albertadoctors.org/AwardsScholarships/MonnexAMA).

The scholarship recipients of the last three years were:

- 2010 Dr. Michael W. Aucoin, Calgary (Working with the underserved)
- 2009 Dr. Janette A. Hurley, Calgary (Addressing the health needs of the underserved)
- 2008 Dr. Julie M. Jarand, Calgary (Tuberculosis fellowship)

Visit online to see the names of other recipients who have been recognized since 1991, when the first scholarship was awarded. ■

The *Alberta Health Act:* A principled approach to legislative change

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

There's a saying in sport, that tying a game is a bit like kissing your sister. The new *Alberta Health Act* (Bill 17) is a bit like that – bland, friendly and non-threatening.

The legislation had been touted as the flagship of Alberta Health and Wellness' long-awaited overhaul of health-related legislation; a collection that includes archaic laws like the *Hospitals Act* and the *Nursing Homes Act*.

Introduced at the outset of the fall sitting of the Alberta Legislature, Bill 17 breezed through first and second readings, Committee of the Whole and, ultimately, received third reading on November 30.

The act received royal assent on December 2 and will come into force on proclamation, which essentially means when the minister of Health and Wellness issues an Order proclaiming the legislation in force.

As opposed to establishing rules or prescribing penalties, the act is rather a statement of beliefs and principles and broad-based, sweeping oversight.

As opposed to establishing rules or prescribing penalties, the act is rather a statement of beliefs and principles and broad-based, sweeping oversight.

For example, in the Preamble:

> "WHEREAS Albertans acknowledge that individuals, families, communities, health professionals and the Government of Alberta all share in supporting and enhancing the health and wellness organizations that deliver health services to Albertans;"
>
> and
>
> "that the health, wellness and quality of life of Albertans are influenced by their economic, social, cultural, physical and spiritual context;"

Nicely written, but hardly the stuff of which supposed sweeping reform of legislative bedrock is made. The opposition even found it hard to criticize, referring to it as "nice."

The act establishes a health charter (to guide the actions of regional health authorities, provincial health boards, operators, health providers, professional colleges, Albertans and any other person specified in regulations).

Failure to comply with the principles of the health charter (which, as an aside, have not yet been created) will result in the person being "dealt with by the Health Advocate . . . or by the Minister." Dealt with?

The health advocate (also not yet established) is an appointee of the minister (actually the lieutenant governor in Council) whose functions will include the review of complaints, or "any other duties that are set out in the regulations."

The regulations have also not yet been created. The complaints, of course, are that a person has failed to act in a manner consistent with the health charter.

And if the health advocate makes such a finding, his remedy is to "make recommendations to any person as the health advocate considers appropriate." If a person fails to comply with a recommendation, then the health advocate may report that person to the minister.

It is not at all clear what the minister is supposed to do with the report, although in a separate section, the minister is empowered to "direct a regional health authority, health ▸

provider, professional college or operator or any other person involved in the provision of a health service to comply with the health charter."

There's no indication of what happens if the minister's order is ignored.

That's it. In a nutshell, the *Alberta Health Act* empowers the minister to (a) prepare a health charter, (b) appoint a health advocate to (c) investigate complaints of non-compliance, which (d) may result in a recommendation to a person by the health advocate, and (e) a report to the minister who (f) may direct the person failing to comply to (g) comply.

One wonders what the point of this is? This legislation was intended to set the backdrop for the eventual upgrading of outdated legislation, but instead appears to create a set of motherhood principles with a meek and toothless request for compliance.

In fairness, the health charter has not been drafted and may well (in fact, likely will) incorporate meaningful principles that will guide the application and interpretation of existing or new health legislation.

But it seems the energy of the drafters might have been better served in actually addressing the shortcomings of the existing legislation and fixing them, so that, for example, Alberta Health Services is not trying to implement medical staff bylaws in the context of legislation that still requires hospitals to maintain independent boards of management and still speaks of the establishment and composition of hospital foundations.

Or perhaps one of the principles in the health charter will be that health legislation should be relevant. ■

Hidden costs of employee turnover

ALBERTA MEDICAL ASSOCIATION Practice Management Program

PMP Staff

Very few people have a good grasp on how much it costs to replace an employee.

One could reasonably assume advertising and interviewing are the main costs. Actually, these are just the tip of the iceberg. The true cost is much more significant.

> A common mistake is to overlook the opportunity cost, the cost of staff time redirected to the new employee and lost productivity.

Human resources studies consistently find the cost of employee turnover is at least 25-50% of the annual wage of the departing employee. As a general rule, this increases the higher up the position, i.e., invested training and experience in a long-time employee in a management position results in greater disruption and cost.

Some studies have shown it can cost up to 18 months of salary to replace a manager. Numbers sound high? A common mistake is to overlook the opportunity cost, the cost of staff time redirected to the new employee and lost productivity. Let's consider some of the real costs involved:

- Administrative expenses related to an employee leaving and a new employee starting
- Advertising the position
- Management time involved in the recruitment effort
- Potential overtime for other staff while the position is vacant
- Orientation and training the new employee (time and resources)
- Loss of productivity while a new employee is learning

Scenario

Let's calculate the cost using some very conservative assumptions and the following simple scenario.

Your medical office assistant resigns. She is not necessarily unhappy and is leaving of her own accord. There are no costs related to disputes, disciplinary action leading up to the resignation, any severance pay or legal costs.

The position is 37.5 hours per week with no employee benefits. You are successful in attracting qualified applicants with minimal advertising. Five applicants are interviewed and one accepts the offer. Fortunately, the position has been vacant for only two weeks.

How much did this cost you? Keep in mind this scenario was very cordial. If the separation involves conflict, the cost increases.

This calculation also does not consider the "soft" impacts of discontent or instability created among remaining staff, loss of accumulated knowledge of physician practises, lost productivity due to early "check-out" by the departing employee or the inconvenience of disturbed routines for you, the physician.

The key in avoiding a similar scenario is in getting and keeping the right people. Research shows that while pay is important, other key reasons why people leave include:

- Job or workplace is not as expected
- Mismatch between person and job
- Little or no recognition for good work
- Loss of confidence in leaders
- Few opportunities for growth and development

Here are a few suggestions to reduce the likelihood of good employees leaving.

- **Hire the right people for the right job** – Interview and evaluate on objective criteria; hire for capability, personality and potential, as well as qualifications.
- **Provide a good start** – Formalize the employee contract, provide ▸

	VACATED POSITION	CLINIC MANAGER
Assumed wage cost		
Base annual wage	$30,000	$50,000
+ Employer EI, CPP expenses	7%	7%
Actual cost/hour	$17.64	$29.40

	COST
Costs related to departure	
Pre-departure counselling/discussion – vacating employee[1]	$94.07
Administrative work – vacating employee[2]	$58.79
Costs related to recruitment	
Job posting	$500.00
Handling and reviewing résumés or applications[3]	$176.37
Interviewing time[4]	$146.98
Reference checks[5]	$58.79
Administrative work – setting up new employee[6]	$235.16
Costs related to position vacancy	
Coverage of position during vacancy[7]	$2,204.67
Costs of orientation/training	
Initial orientation/training time (new hire)	$141.10
Initial orientation/training time (supervisor/co-workers)	$235.16
Costs of diminished productivity or "learning curve"	
Supervisor time assigning/explaining/reviewing tasks[8]	$1,763.74
New employee productivity:[9]	
Weeks 2-4 lost productivity (75%)	$1,488.15
Weeks 5-12 lost productivity (50%)	$2,645.60
Weeks 13-20 lost productivity (25%)	$1,322.80
Existing clinic staff productivity:[10]	
Co-worker support weeks 2-4	$264.56
Co-worker support weeks 5-12	$282.20
Co-worker support weeks 13-20	$70.55
Total cost of replacing employee	**$11,688.69**

ASSUMPTIONS

1. Two hours of cumulative discussion or meetings for clinic manager and vacating employee.
2. Two hours to calculate final pay, issue record of employment, remove user accounts, etc.
3. Six hours handling and reviewing résumés by clinic staff.
4. Five interviews conducted consisting of one hour each (15-minute prep/30-minute interview/15-minute debrief).
5. Two hours to perform reference checks and select final candidate, make offer, etc.
6. Eight hours to set up TD1 forms, payroll, email, user passwords, phone hook-ups, access cards, etc.
7. Temporary staff coverage or existing staff covering the position vacant for two weeks (no overtime).
8. Additional time (seven hours/week) spent by supervisor over the first eight weeks of employment.
9. Generally accepted ratios in human resources studies on productivity cost or learning curve of the new employee during the 20 weeks following initial orientation/training.
10. Assumed additional combined support from co-workers during the new employee's learning curve period:
    - Weeks 2-4, total of 5 hours/week
    - Weeks 5-12, total of 2 hours/week
    - Weeks 13-20, total of 0.5 hours/week

formal orientation to clinic operations; establish Human Resources guidelines and policies.

- **Put it in writing** – Clearly define roles and responsibilities; clearly define and communicate behavioral expectations.
- **Pay fair wages** – Base wages and raises on objective data including market data, skills, role and performance; be consistent among staff.
- **Promote a positive and collegial clinic culture** – Address poor behavior, negativity and performance of staff; encourage a culture of improvement.
- **Tell them how they're doing** – Provide regular formal performance reviews; give both positive and improvement feedback verbally.
- **Look for job enhancement opportunities** – Consider additional training or courses; consider enhancing variety, challenge or level of responsibility to keep competent employees.

This involves time and effort. Is it worth it? You do the math. How many employees have left your office in the past year?

Stay tuned for the next article by the Practice Management Program. It will look, in more detail, at the real reasons employees leave.

Alberta Medical Association Practice Management Program (PMP) staff Susan M. Black, Stephanie A. Crichton, Cindy C. Michetti and Sean T. Smith in Calgary, as well as Robert L. Brick, Lucy L. Grenke, Glenda M. Nash and C. Grant Sorochan in Edmonton, contribute articles to the Digest. PMP provides high-quality business consulting services to Alberta physicians as they develop and implement primary care networks. Contact PMP at pmp@albertadoctors.org, 780.733.3632 or toll-free 1.800.272.9680. ■

FEATURE

AMA helps seniors in *Finding Balance*

Falls are life-changing and costly

Dr. William S. Hnydyk, Assistant Executive Director (Professional Affairs), represented the AMA during the campaign launch at the Seniors Association of Greater Edmonton (SAGE). (Yuri Wuensch, contractor with Play It By Ear Productions.)

With one in three seniors experiencing falls each year in Alberta, the Alberta Medical Association (AMA) has partnered for the third year running with the Alberta Centre for Injury Control and Research (ACICR) to help seniors "prevent a fall before it happens."

The *Finding Balance – Prevent a fall before it happens* public awareness campaign aims to raise awareness and educate seniors about the risks of falls and how to prevent them. Each year, the campaign runs in November.

Two launch events were held on November 2. Dr. Peter C. Jamieson, Representative Forum delegate and former member of AMA's Health Issues Council, represented the AMA at the launch in Calgary. Dr. William S. Hnydyk, Assistant Executive Director (Professional Affairs), represented the AMA at the Edmonton event.

Drs. Hnydyk and Jamieson and a number of other physicians around Alberta reinforced the campaign's key messages in local media interviews:

- Keep active – Exercise for strength and balance.
- Check your medications – Tell your doctor about all the medications you are taking.
- Watch your step – Wherever you are.

In addition to media stories that raise awareness about seniors' falls, *Finding Balance* posters, flyers and collateral materials help spread the messages to seniors and caregivers.

This year the uptake of campaign resources has been the best yet, with materials going to Alberta Health Services' falls prevention programs, pharmacies, libraries, seniors' residences, municipalities, seniors' organizations and, upon request, to physicians' offices. So far, 639,500 pieces have been disseminated, with two-thirds going to pharmacies.

And this year, for the first time, some of the materials present messages in various languages to support those who don't speak English.

While the costs to the health care system are significant, the personal consequences of falls can be life-changing ▸

From the *Calgary Herald*

Dr. Peter Jamieson, a family physician, said many seniors don't report their falls. "I think they're (seniors) afraid of the implications of the fall and the fear is loss of independence," Jamieson said.

"Forty per cent of all nursing home admissions are a result of a fall."

Jamieson added there are a few important steps to take when preventing plunges: Exercise at least 30 minutes a day, review medications with a doctor or pharmacist, remove clutter from homes and wear supportive shoes.

Storry, Lea. "Campaign aims to reduce risk of seniors falling." Calgary Herald, November 3, 2010.

Senior belly dancers and a Westlock seniors' drama group, with humor and grace, highlighted key messages of the third annual *Finding Balance: Prevent a fall before it happens* public awareness campaign during its launch, November 2, in Edmonton. (📷 Yuri Wuensch, contractor with Play It By Ear Productions.)

for seniors. Minor-to-severe injuries can lead to reduced mobility, and loss of independence and existing lifestyle.

The AMA is a founding partner and major sponsor of the *Finding Balance* program. The AMA's Health Issues Council oversees the association's involvement in the campaign and reports to the Board of Directors on campaign progress.

In addition to the AMA and ACICR, other sponsors include Physiotherapy Alberta, Alberta Blue Cross, Alberta Therapeutic Recreation Society, College and Association of Registered Nurses of Alberta, Professional Association of Residents of Alberta, Global TV and McCallum Printing Group Inc.

It's a fact:

- In Alberta, approximately 62,500 seniors fall each year.
- 90% of hip fractures are attributed to falls.
- In 2003, fall-related injuries among seniors resulted in approximately:
  - 50 deaths
  - more than 6,200 hospital admissions
  - more than 17,350 emergency department visits

Resources for physician offices and primary care networks, at no cost

- Flyers, posters (8.5 x 11 inches) and bookmarks
  - Contact Joanne J. Askewe, Administrative Assistant, Professional Affairs, AMA: 780.482.2626, ext. 224, 1.800.272.9680, ext. 224 or joanne.askewe@albertadoctors.org
- Falls assessment algorithm for primary care physicians
  - Visit the *Finding Balance* website (www.findingbalancealberta.ca/practitioner/885BUØ/index.html) ■

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.

Nominations must be submitted by Friday, April 29. The awards will be presented at the AMA's fall 2011 annual general meeting in Calgary.

The **Medal for Distinguished Service** is given to physicians who have made outstanding personal contributions 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 2010, three physicians were recognized with Medals for Distinguished Service.

- **Dr. Tajdin P. Jadavji** has devoted his medical career to caring for Alberta's children. He established the Division of Pediatric Infectious Diseases, within the Department of Pediatrics at Alberta Children's Hospital, and the Prediatric Infectious Disease Royal College Fellowship Program at the University of Calgary. In addition, Dr. Jadavji helped educate and inspire young physicians, while building links with other countries, as an associate dean of International Health at the University of Calgary from 2001 to 2009.

- **Dr. M. Elizabeth (Betty) MacRae** is a neurosurgical pioneer and mentor whose refusal to be restricted by gender roles paved the path for future female physicians. After receiving her medical degree from the University of Toronto, she became the first female resident in Toronto's neurosurgery residency program. Dr. MacRae spent her entire career in the Division of Neurosurgery at the Foothills Medical Centre in Calgary, and was renowned for both her surgical skill and her commitment to providing outstanding ongoing care to patients. Recently retired, she is credited with inspiring the careers of many neurosurgeons across Canada and around the world.

- **Dr. Eric A. Wasylenko** is a palliative care specialist and clinical ethics expert who, together with a team of dedicated community volunteers, co-founded the Foothills Country Hospice Society. In 2008, after raising $5 million, the society opened one of Canada's first rural, private, free-standing adult hospice homes. He is executive director of Clinical Ethics with Alberta Health Services and serves with the Ethics Advisory Committee of the Chief Public Health Officer of Canada.

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 2010 Medal of Honor recipient was **Austin A. Mardon**, who has spent the past two decades working tirelessly to educate Canadians about the challenges that face people living with mental illness.

To request a nomination form for these awards, please contact Ava L. Butterworth, Administrative Assistant, Public Affairs, AMA: ava.butterworth@albertadoctors.org, 780.482.0312, toll-free 1.800.272.9680, ext. 312 or visit the AMA website (www.albertadoctors.org/Awards Scholarships/AchievementAwards). ■

Letters

Calgary family physician Carolyn A. Lane explores ideas and encourages discussion about solving Alberta's challenges in health care.

"Those who cannot remember the past are condemned to repeat it."(*George Santayana, Reason in Common Sense, The Life of Reason, Volume 1, page 284.*)

Remembering past events in the evolution of our health care system and the repercussions of our failed solutions would be helpful in evaluating our current situation and designing solutions that have the potential to resolve issues effectively.

So how did we get to the current situation of crowded emergency departments (ERs), long surgical wait times and limited access to primary care providers?

I believe we got there by high-level decision-making, often at the acute-care level. After all, we believe acute-care sites are where we consume more health care resources. So controlling acute-care activities made sense.

When initially in practice, if my patients required admission to hospitals, I would call the admitting department, arrange a bed and send a patient to the hospital with a written history and physical set of medical orders.

As the province's population began to swell, it was felt that community physicians were not aware enough of the pressure on in-patient beds to independently assess the need for admission of patients. So we were required to clear all admissions with ER physicians.

As in-patient beds continued to be in high demand, we were required to send patients through the ER for assessment prior to admission. Soon I was left with no connection or control to admit my own patients.

At the same time, my ability to meet my patients in ER, evenings and weekends, similarly disappeared. I used to arrange to meet someone in need, deal with his or her issue and discharge him or her from ER without needing to involve the ER physician.

I would also be able to call up a specialist colleague and have that specialist meet a patient in ER for care.

The changes implemented in good faith had the adverse effects of discouraging family physicians from maintaining hospital privileges, dismantling primary and specialist care relationships and changing the system from a multiple-point access system to a single bottleneck system.

In other words, we have contributed to our ER crisis by disempowering primary care and specialist physicians who know the patients and imposing decisions on ER physicians working in a pressure cooker.

As I read about new surge-capacity protocols being tested in ERs at major city hospitals, I fear we are continuing to come up with solutions to an evolving crisis without fully recognizing the fallout because we continue to implement from the top.

We all know the admonition of learning from past mistakes, but do we really apply our learning from past successes? We have the answers and the success stories within our grasp.

Primary care networks are a validated success associated with empowering local providers to strategize and implement solutions for their communities. Why are we continuing to impose central solutions?

If we want to know how to improve efficiency of surgical care at a site, let's ask the physicians, nurses and other staff involved in the care of a surgical patient – what inefficiencies are there at their sites and how can we eliminate them?

Let's ask patients if they have suggestions for how they could receive high quality of care in a more efficient manner within our system. We can still learn from one another's initiatives, but we need to empower local people to implement local solutions.

Joni Mitchell wrote, "We're captive on the carousel of time. We can't return, we can only look behind from where we came."

I don't know about you, but I have had enough of this pony ride. I want off the carousel and I want to look forward to a future where we value and trust our health care providers to find the solutions for an efficient, caring health care environment to flourish.

Carolyn A. Lane, MD
Calgary AB
Member of the AMA Board of Directors
Delegate to the AMA Representative Forum

The Alberta Medical Association (AMA) 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. ■

FEATURE

Patients First®: AMA Vision for Primary and Chronic Care

The Alberta Medical Association (AMA) has released a discussion paper on a vision for primary and chronic care.

The Section of General Practice, Section of Rural Medicine and the Primary Care Network Physician Leads Executive Committee, with participation from the Alberta College of Family Physicians, are leading the discussion as well as development of future plans and activities.

Physicians and stakeholders are invited and encouraged to provide feedback and commentary.

An excerpt of the discussion paper follows below. To read the complete document, visit the AMA online (https://www.albertadoctors.org/PresLet/PrimaryCareDiscussionPaper2010).

Vision: Patients First®

Alberta's physicians are committed to a future where:

- Alberta's health care system is defined by quality: patient-centric; safe; timely; effective
- Albertans are supported in attaining optimal health with access to:
  - Healthy lifestyle choices
  - Healthy environments
  - Healthy communities
  - Health care services, with access based primarily on need, not ability to pay
- The patient-physician relationship, founded on compassion, trust and respect, remains a cornerstone of the health system:
  - Patient choice of a physician
  - Physicians as the agents of patients, acting always in the patient's best interests
  - Clinical and professional autonomy is honored
- Resources:
  - For the health care system are allocated on the best evidence as to the overall contribution of these investments to a healthy economy and to the health objectives of patients and populations
  - Within the health care system are allocated on the best evidence as to what is most effective and efficient in meeting health care needs
- Patients and providers are partners with funders and managers in the management of the health care system, with roles and responsibilities that are clearly specified with appropriate accountabilities.

MISSION: LEADERSHIP AND SUPPORT

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

INTRODUCTION

This document:

- Creates a vision and strategy to shape and guide AMA decisions and directions with regard to primary and chronic care delivery
- Presents our position to be shared with our partners in the process of developing a provincial strategy for primary and chronic care
- Is consistent with the AMA's mission and priorities (key result areas) as most recently expressed in its overall Strategic Plan and 2008 and 2009 Business Plan
- Considers:
  - The AMA's vision of Patients First®
  - Alberta Health Services' (AHS') *A Discussion Paper on Primary Care Models*
  - College of Family Physicians of Canada's (CFPC's) discussion paper ▸

▸ *Patient-Centred Primary Care in Canada: Bring It On Home*

Patients First® and primary and chronic care

In order to realize our vision of Patients First®, we first require a sound, comprehensive, well-planned and adequately resourced primary and chronic care system. Only then can primary care be organized and structured to optimize its delivery to best advantage for all Albertans.

With this document, the AMA proposes an initial approach to defining such a system. Within a workable model we provide goals, strategies and indicators of success to lay out, monitor and measure our progress to the system we hope to build, together.

SEEKING A NEW APPROACH

Many organizations and individuals are working to improve and reform primary care in Alberta. The aforementioned AHS discussion paper on primary care models, for example, seeks to build upon the success of primary care networks (PCNs), essentially proposing an "enhanced PCN" as the hub for Alberta's primary and chronic care system.

The concept of Patients First® seeks to provide improved patient wellness and optimal Value for Patients™ by establishing the family physician as the leader of a team of health care professionals. In the AMA's view, PCNs are essential on a go-forward basis, but represent only one strategy to move us toward the system we seek in which the patient is at the hub.

This document, while aligning with many of the components of the proposed AHS model, goes beyond it by suggesting many other strategies to achieve our vision of Patients First®. The AMA believes that all parties involved need to broaden our thinking to achieve a vision in which:

- Every Albertan has a responsible primary care physician supported by an inter-professional team
- The system looks after the health needs of populations as well as the health of individuals
- The scope of primary care services increases to better accommodate a focus on prevention and health promotion as well as a more organized and systematic approach to chronic disease management
- Care is truly coordinated between the primary care team and the larger health care system
- There are stronger connections, enhanced support and improved access to specialist care for primary care physicians

Achieving such a vision will require thoughtful consideration and discussion. The AMA recommends that the concept of the **patient-centred medical care** home is a strong starting point.

The CFPC presented such a model in their 2009 paper *Patient-Centred Primary Care in Canada: Bring It On Home (www.cfpc.ca/PublishedReports)*.

THE PATIENT-CENTRED MEDICAL CARE HOME

A medical home is a patient's personal source for multifaceted primary health care. It is based on a relationship between the patient and physician, formed to improve the patient's health across a continuum of referrals and services.

The CFPC defines a medical home as a medical office or clinic with the following "pillars" where each patient would have:

- Her or his own family doctor
- Access to other health professionals in a team led by the patient's own family doctor
- Timely appointments for all visits with the family doctor and with other primary care team members
- Arrangement and coordination of all other medical services, including referrals to consulting specialists
- An electronic medical record (EMR)

The above model, sourced from the CFPC paper, provides a pan-Canadian perspective. In Alberta, the AMA suggests the medical home would also include:

- Appropriate funding and resources
- Necessary system supports for ongoing evaluation and quality management
- A comprehensive information and knowledge management strategy
- Practice management support for increased scope, complexity, etc., of primary and chronic care systems
- Relationship management/governance support for and among physicians, clinics and the broader health care system, e.g., AHS ▸

In addition to the CFPC medical home model, the AMA's strategy for primary and chronic care should also consider the principles suggested and adopted by the American Academy of Family Physicians (AAFP), the American College of Pediatricians, the American College of Physicians and the American Osteopathic Association. While the principles are similar to the CFPC's model, those relating to care coordination and integration are highlighted more strongly.

AAFP'S PRINCIPLES OF THE PATIENT-CENTRED HOME

Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation: The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life (acute care, chronic care, preventative services and end-of-life care).

Care is coordinated and/or integrated across the complex health care system and the patient's community: Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care, when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centred outcomes that are defined by a care-planning process. Evidence-based medicine and clinical decision making support tools guide decision making. Physicians accept accountability for continuous quality improvement through voluntary engagement of performance measurement and improvement. Patients actively participate in decision making and feedback is sought. Information technology is used appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.

Systems enhance access to care: Systems such as open scheduling, expanded hours and new options for communication between physicians, patients and practice staff improve access.

Payment appropriately recognizes the added value provided to patients: Payment is based upon a structure that reflects value provided, supports adoption and use of health information, supports enhanced communication, recognizes case-mix differences and allows physicians to share any savings.

The AMA discussion paper explores the five pillars of the Medical Home Model:

- A personal family doctor for every patient
- Access to a patient-centred team
- Timely access to patient-centred care
- Coordination of care including access to consulting specialists
- Electronic information and communication

Other fundamentals are:

- Appropriate funding and resources
- Quality improvement and evaluation

For more information on the proposals for goals, strategies and indicators of success under each of these pillars, view the full-length discussion paper at https://www.albertadoctors.org/PresLet/PrimaryCareDiscussionPaper2010.

To comment, email AMA President Dr. Patrick J. (P.J.) White (president@albertadoctors.org). ■

Selecting residency daunting, finding employment tough

Centralized physician resource planning needed

Brock J. Debenham, MD

FOURTH-YEAR RESIDENT, RADIATION ONCOLOGY, CROSS CANCER INSTITUTE, EDMONTON; VICE PRESIDENT OF OPERATIONS AND FINANCE, PROFESSIONAL ASSOCIATION OF RESIDENT PHYSICIANS OF ALBERTA

One of the most stressful, intimidating and life-altering decisions a medical student must face is choosing and applying for a residency.

This choice will forever influence our lives: what we do; how we practise; where we live; and, sometimes, even if we will have a position after our training.

Although alternate career paths may be selected during or after residency, these opportunities can be few and far between, never mind difficult to access.

One of the most stressful, intimidating and life-altering decisions a medical student must face is choosing and applying for a residency.

For me, the choice of residency felt very much like I was cementing in a rigid future. This reality of our career choice is daunting, considering that a quick online search reveals that an average person switches careers six to 10 times during his or her life.

Sometimes it seems like we, as physicians, have one chance to get it right and, further, this one chance is made manifest by matching to what we may naively perceive as the ideal fit for us.

I did, and still do, feel as if I was woefully unprepared to make that choice.

When I was 21, single and living at home, I started medical school in Edmonton. In retrospect, I had no idea at the time how the medical system functioned or even what medicine was all about.

I don't think I'll ever fully understand how it works. I remember telling interviewers, in my medical school interviews, that I thought it would be exciting to work as many overnight shifts as possible as a surgeon or an internist.

And why not? Most of my exposure to medicine at that point had been through the media – TV medical dramas. Shows like *ER* made medicine look continually fast-paced, exhilarating and dynamic.

As I made my way through medical school I quickly realized that the reality of medicine did not match my media-constructed expectations. Medical student experiences made me realize that the fast-paced, stress-intensive life was not for me.

I still loved medicine. Taking care of people was, and is, a priority. But I also realized that my family is very important to me; I had just gotten engaged and we wanted to stay close to our families.

After four years of medical school, the decision on which residencies to pick loomed. My medical interests and my determination to live a balanced life helped me narrow my future medical field to radiation oncology. Yet, I had worries associated with this decision.

During medical school, senior resident physicians warned me that the job situation in radiation oncology was poor. They suggested I consider radiology or internal medicine.

I didn't listen. I figured the situation would be temporary. There was more than half a decade before I would be looking for a position – lots of time for the job situation to improve. ▸

My colleagues in other specialties reflect on similar fears of finding employment.

I rationalized that an aging population would have a higher incidence of cancer and, therefore, the demand for radiation oncologists could only increase.

It turns out that, despite increased demand, I was wrong. Throughout my residency the primary concern for most of the senior resident physicians has always been about finding a position.

Senior physicians have told me that this worry always exists, regardless of specialty or whether the economy is in a boom or bust cycle. Even in the best of times, one never knows where one will end up, and few like uncertainty.

Today, it seems as though I may even have difficulty finding a fellowship position in Canada. Canada's lack of radiation oncology career opportunities is frequently masked by workforce migration, often south of the border.

A survey of Canadian radiation oncology graduates from the last five years, currently submitted for publication, shows that about 50% of radiation oncology resident physicians have left Alberta since 2005.

This is not a surprise considering that, on average, most American resident physicians reported having five to six job interviews in their final years of training.

My colleagues in other specialties reflect on similar fears of finding employment. These fears were given a national sounding board in the August 10 *Maclean's* magazine article "The first signs of a coming health care crisis."

The article details challenges for cardiac surgery resident physicians seeking employment in Canada. Similar challenges were also noted for other medical fields.

I believe physician job scarcity can sometimes be difficult to conceptualize, considering the high demand for my colleagues in generalist specialties like family medicine and internal medicine.

For me, these reflections highlighted the importance of linking medical education with future health care needs.

I recognize that a training system aligned with resource needs may limit a physician's autonomy of choice but, ultimately, a public medical education system should be cognizant and responsive to the health system's needs.

To meet these needs, responsible human resource planning is essential.

The work of Alberta's Physician Resource Planning Committee demonstrates this importance. The latest report, released in 2006, offered a prediction for the number of required physicians from 2005 to 2010.

This type of planning is to be applauded. Moreover, Alberta will need to renew its commitment to responsible human resource planning. In turn, consideration of these recommendations by our medical education stakeholders must follow suit.

I would love to practise in Alberta. It would allow my wife, committed to her employer, to continue to pursue her career with an Edmonton-based company. It would allow my daughter, challenged with health issues, to continue to receive excellent care from physicians we know and trust. Furthermore, it would allow my family to continue to be close to our extended families and friends.

Most other Alberta-trained resident physicians feel the same way. They would also choose to remain in Alberta if opportunities were available.

There can be no doubt that centralized physician resource planning is needed to ensure we have the medical students and resident physicians today to meet the system's needs in future years.

Alberta will need to renew its commitment to responsible human resource planning. In turn, consideration of these recommendations by our medical education stakeholders must follow suit.

Achieving this equilibrium is neither easy nor straightforward. The process involved in training a physician is intensive, lengthy and expensive.

Luckily, I believe resident physicians and the public at large appreciate and understand that such planning is essential but will never be perfect.

Certainly, medical education is a challenging investment, one from which our province deserves to benefit. ■

Cultivate gratitude
and thankfulness for daily living

Vincent M. Hanlon, MD
PFSP ASSESSMENT PHYSICIAN

The brevity of our short wintry days is a reminder of how quickly not just a day but a whole year can go by.

If you didn't have time on New Year's Eve to count your blessings from 2010, let's do it now.

Pick up a pen, cast your thoughts over the last 12 months and write down three things for which you are grateful.

The benefits of being thankful is a recurring topic in the press and online, along with "strategies" to help us cultivate gratitude regularly.

Witness books like *A Grateful Heart*, a collection of 365 blessings for the evening meal, culled from a variety of sources "from Buddha to the Beatles." Editor M.J. Ryan explains, "[W]hen we give thanks, we take our place in the great wheel of life, recognizing our connection to one another and to all of creation."

Other recent books on the gratitude theme include Louise L. Hay's *Gratitude: A Way of Life* and Dale Turner's *Grateful Living*.

Popular interest in gratitude is not so surprising. It has been a topic of enquiry for moral philosophers. The encouragement of thankfulness is also part of many religious traditions and aboriginal spirituality.

David Steindl-Rast is a member of a Christian monastic community. In his book *Gratefulness, The Heart of Prayer* he sees gratefulness arising out of a perception and philosophical orientation that life is a gift.

What each of us eventually does with this gift, individually and collectively, does not alter the initial giftedness of our life in this universe. Sufi poet Rumi encourages us to express our appreciation for the goodness in our lives in our daily activities: "Let the beauty we love be what we do. There are a hundred ways to kneel and kiss the ground." (*A Grateful Heart*, page 142.)

> "When we give thanks, we take our place in the great wheel of life, recognizing our connection to one another and to all of creation."

Given the place of gratitude in contemporary culture and its significance to a variety of spiritual traditions, it then becomes a task for social scientists to investigate such a popular but unproven assumption that gratitude constitutes a valuable personal resource for daily living.

As one part of that empirical enquiry, psychologists Robert A. Emmons and Michael E. McCullough have conducted research about the effect of gratitude on our actions and perceptions, and edited the book *The Psychology of Gratitude*.

Their study (2003), entitled *Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life*, examines "the effect of a grateful outlook on psychological and physical well-being." Study populations included university students and a group with chronic neuromuscular diseases.

The study method involved a brief intervention to induce gratitude by asking one subset of participants to recall and record, on a daily or weekly basis, "five things in your life that you are grateful or thankful for."

Another subset was "hassle-focused." This group was charged with recording annoyances or hassles in their lives. In addition, the participants were asked to complete, daily or weekly, a series of questions about their moods, physical symptoms, reactions to social supports and global life appraisals.

The authors concluded that "[S]elf-guided daily gratitude exercises were associated with higher levels of positive affect. People led to focus on their blessings were also more likely to report having helped someone with a personal problem or offered emotional support to another."

In the study involving persons with neuromuscular disease, two additional observations were noteworthy. "[T]he gratitude intervention led to ▸

(Vincent M. Hanlon, MD.)

reductions in negative affect" and the participants' spouses or significant others noticed the salutary effects on their partners' well-being.

The bottom-line, according to Emmons and McCullough, is that an attitude of gratitude may have positive effects on well-being, although "this relationship is neither inevitable or unequivocal."

Such studies stimulate further thinking about the topic. This study took place over a relatively short period (two-to-10 weeks). Would the deliberate practice of gratitude over a longer term strengthen or weaken the apparent positive effect on well-being?

Their study was not designed to look at the effect of expressing one's gratitude, especially towards individuals to whom one feels grateful. Gratitude might provide us with an opportunity to be generous. Recognizing our thankfulness for the action of a colleague, and taking a moment to tell him or her, is one modest way of making our interdisciplinary workplaces a little healthier.

"Ordinary people doing extraordinary things."

At the same time, being grateful is not incompatible with an awareness of the ongoing difficulties in our personal and professional lives. The positive effect that being grateful appears to have on our well-being may provide us with additional clarity and energy to address problematic areas.

How did you manage with your gratitude list for 2010? In my case, I'm grateful for the opportunity of having worked with the Alberta Medical Association (AMA) Physician Locum Services® (PLS). I spent Labor Day weekend 2010 in Oyen, doing my final PLS assignment.

Labor Day was an apt endpoint for my work with the Rural Locum Program that I began in January 2002, with a weekend in Rimbey (see the May/June 2002 *Alberta Doctors' Digest*).

During that span of eight years or so, I usually worked one weekend per month in a small town in southern Alberta. As I'm a fan of both numbers and classical music, I've discovered some musical equivalents of those hundred-plus weekends to the Haydn symphonies, including #92, the *Oxford Symphony*, and #104, the London.

I want to express my gratitude to my fellow "orchestra" players on those locum weekend "performances" of the Milk River symphony and the Oyen symphony at the Big Country Hospital there.

To extend the musical metaphor, occasionally we failed to play in tune and, I admit, sometimes I dropped the conductor's baton. Still, I remember with fondness many stellar performances of the Bow Island Health Centre orchestra.

It's not possible for me to thank everyone for their good work, but it is important to name a few whom I consider skilled and compassionate representatives of the many who provide care in these rural communities.

Alicia is an admitting clerk in Bow Island. Charlotte, Janice and Paulette are nurses in Milk River. Laurie is a lab and X-ray tech in Oyen. Suzanne is a paramedic in Fort Macleod.

I am also thankful for the welcome and wisdom of my many physician colleagues, especially Pieter and Elizma in Oyen. On that particular Labor Day weekend I appreciated the cheerful telephone assistance of Dr. Gripp, the radiologist on call in Medicine Hat.

It's easy to overlook the team at STARS. I was doubly grateful that they provide assistance when needed and that I didn't need them that weekend.

And, finally, thanks to Barry and Teresa and the rest of the staff at AMA Physician Locum Services®.

I am reminded of the statement on my T-shirt marking the 50th anniversary, in 2009, of the Bow Island Health Centre: "Ordinary people doing extraordinary things." This is something to be grateful for.

References

1. Emmons R.A. and McCullough M.E. "Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life." *Journal of Personality and Social Psychology*, February 2003; 84(2): 377-89.
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3. Steindl-Rast, Brother David. *Gratefulness, The Heart of Prayer: An Approach to Life in Fullness*. New Jersey: Paulist Press, 1984. ■

Manage lists in Excel

J. Barrie McCombs, MD, FCFP

MEDICAL INFORMATION SERVICE COORDINATOR, THE ALBERTA RURAL PHYSICIAN ACTION PLAN

The Excel spreadsheet program is a handy tool for managing lists of names and addresses and other contact information. I've just finished updating my Christmas card list and thought some readers might be interested in learning how to create a similar list.

Getting started

To create a new blank spreadsheet:

- Open the Excel program.
- Click on File in the main menu.
- Select the New option.

Excel gives the new file a default name such as Book1.xls. It's a good idea to rename the file and save it in a file directory that can be easily found again.

For instance, within the main My Documents folder, create a new folder called Contacts. The new file could be renamed Contacts 2011.xls.

Terminology

Excel refers to the entire new file as a workbook. When a new workbook is created, it contains three worksheets labeled Sheet1, Sheet2 and Sheet3.

Move between these worksheets by clicking on the tabs at the bottom of the screen. If desired, a sheet may be renamed by right-clicking on the tab.

For example, think of Sheet1. Within a worksheet, each small box is called a cell. Columns of cells are labeled with letters and the rows with numbers, giving each cell a unique address (see example below).

Data organization

In the example, information about one person will be stored in a row and different types of information, such as Last Name, First Name, Address, City, Province and Postal Code, are stored in columns.

To facilitate later sorting, it is a good idea to store last names and first names in separate fields.

Header row

The first task is to create a header row that contains the name of each column.

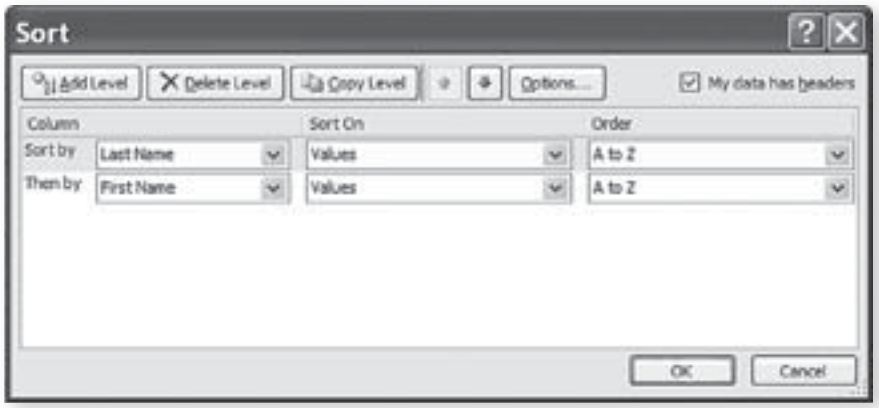
- Click in cell A1 and enter Last Name.
- Then click in cell B1 and enter First Name.
- Continue across the page until columns have been labeled for Address, City, Province and Postal Code.

If desired, other columns could be added, such as Country, Telephone and Email. Notice that information in one cell overlaps with information in other cells.

To format a column to a desired width:

- Right-click on the letter at the top of the column and then on Column Width.
- Enter a number for how many characters-wide the column will be.

	A	B	C	D	E	F
1	Last Name	First Name	Address	City	Province	Postal Code
2	Aardvark	Anthony	123 Memory Lane NW	Calgary	AB	T1A 3A3
3	Beagle	Bruce	456 Elm St SW	Calgary	AB	T2A 4B7
4	Jones	Anthony	10800 97 Ave NW	Edmonton	AB	T5H 1A3
5	Jones	Zelda	2700-10020 100 St NW	Edmonton	AB	T5J 0N3
6	Smith	John	350-708 11 Ave SW	Calgary	AB	T2R 0E4
7	Smith	William	12230 106 Ave NW	Edmonton	AB	T5N 3Z1



- Alternatively, hover the mouse over the line at the right side of a column until a double-sided arrow appears. Then click and drag the line to the desired width. Click on the number 1 at the left of the header row to highlight the entire row. Click on B in the text formatting menu to make the entire row appear as bold text. To remove highlighting, click anywhere else in the worksheet.

Enter data

Now enter a few names and addresses into the list. As information is added, the column widths may need to be reformatted.

Save the file and make a back-up copy by clicking File in the main menu and selecting the Save As option.

Sorting

To sort the list by Last Name and First Name and in ascending order A, B, C, etc., (see sample above):

- Click on the Data tab in the main menu. Click on Sort.
- Select Last Name from the pull-down list of column names under Sort by and select the ascending option.
- Then select First Name in the first Then by section and, again, select ascending.
- My data has headers should be selected. Then click OK.
- Experiment with this feature by sorting the list by City.

Getting help

As well as the built-in Help functions, Excel provides Internet-based help through the Office on the Web link in the Help menu.

Your comments and suggestions are welcome.

Please contact me:

barrie.mccombs@rpap.ab.ca

T 403.289.4227 ■

Robert Burns brightly in Alberta

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

People, of course, have short memories. During the last week in January each year, Scots and Scotophiles drink whisky, pretend to eat haggis and toast the Bard.

They drink to his Immortal Memory; they drink to the honour of the Ladies and they toast the Twa' Lands (Scotland and Canada or wherever). And, most of all, they drink to the Brotherhood of Man.

The next day they forget about a' that and it's back to international strife, road rage, complaints about wives or girlfriends and the winter in Canada. But for a few liquid hours they do try.

The Edmonton Burns Club has been around since 1920. Walter Mackenzie was its president in 1950. The annual dinner now hosts around a thousand inebriates and has the same format each year as if to support the philosophy of the 80-year-old who was asked: "Jimmy, you must have seen a lot of changes in your time?" "I have," he replied. "And I've been against them all."

The Edmonton Burns Supper is a wonder of timing. Every minute is coveted and caressed. If speakers go over the allotted time, they are publicly scolded.

Edmonton Burnsians and canines share this in common – there is comfort and security in known routine; the supper does not vary. It ends at 11:37 p.m. every year with the singing of *Auld Lang Syne*.

In stark contrast, the Calgary Burns Club is adolescent. Its first formal supper was held in 1976, with Grant MacEwan as patron. And, as with many upstarts, the program is volatile – sometimes the Calgary Fiddlers, sometimes the Dancers, but always a full military pipe band.

The rhetoric at both dinners is top class – or so it seems after a few drinks – and budding public speakers would do well to take note of the skills and techniques used by the leading Diogenes and Ciceros.

I left the Edmonton Club in 1990 under a cloud, escaping under night cover, having delivered a couple of ill-considered jokes that flopped badly. I assumed a joke I found amusing would amuse all. These stupid jokes can now be heard in perpetuity, like posting nude photos on the web, since all annual proceedings are recorded.

My delivery offered an embarrassing lesson in how not to tell a joke. The tapes may even be used in public speaking courses. I joined the Calgary Burns Club before word of the disastrous speech travelled down Highway 2 and I was kindly admitted under refugee status.

But poetry is in a sad state these days, isn't it? Even the "Arts" pages of the *Globe and Mail* give credence to the lightweight works of pop artists and rappers. Lyrics of songs have become trivial.

Serious poets write for a tiny group of the self-absorbed, their poetry incomprehensible even to most educated readers. It requires knowledge of the lives and loves of uninteresting people.

Great poets of the past wrote for huge audiences. Some have said that were Burns alive today, he would have been a rapper. At first I scorned this notion but then began to reconsider it.

He certainly matched today's pop poets and, in most cases, would have left them in the dirt. And the evidence? It's in *The Secret Cabinet of Robert Burns*.[1]

A top rapper of today is Cee Lo Green who has made a sensational hit, raking it in with his brilliant, plaintive new cut, *F * * K You!*, viewed on YouTube by more than 30 million.

His effort brings tears to sensitive eyes. I struggled with a globus hystericus. But a dip into Burns' *Secret Cabinet* shows he would make Mr. Cee Lo Green gulp:

"Now entered, and concentred,
The beauteous maid lay in a trance,
His bollocks went like elbows,
Of fiddlers in a country dance."

And this is the politest excerpt I can find in *The Secret Cabinet*. But enough! Robert Burns wrote poetry all could understand. A poetic genius he was, and his master quality was humour and satire: *Holy Willie's Prayer, Death and Doctor Hornbrook* and the world's greatest humorous epic poem, *Tam o'Shanter*.

None have better described that fleeting alcoholic euphoria felt by Tam o'Shanter, that befuddled sensation that the world is not such a bad place after all:

"As bees flee hame wi' lades o' treasure, (home)
The minutes winged their way wi' pleasure.
Kings may be blest but Tam was glorious,
O'er all the ills of life, victorious."

In 1786 there appeared a poem that was to shake the world and give to the poor and dispossessed a new ▸

- way of looking at their lives:

"The rank is but the guinea stamp,
The man's the gowd for a' that."
(*Gold*)

Abraham Lincoln could recite *A Man's a Man for a' That*. He loved Burns' poetry and often quoted it in his letters. Writers borrowed his lines for the titles of great books (e.g., *Of Mice and Men*, by Steinbeck).

For Burns, the honest, decent man or woman who speaks his or her mind was the pinnacle of civilisation – a rare characteristic in today's Alberta.

Burns was a fierce proponent of freedom of speech: "There's nane ever feared that the truth should be heard, but they whom the truth would indite." (*Here's a Health to Them That's Awa'*)

Burns would have honoured Dr. Raj Sherman. In fact, Raj, Robert Burns might have been thinking about you and a certain previous health minister when he wrote:

"Ye see yon birkie, ca'd a lord,
Wha struts, an' stares, an' a' that;
Tho' hundreds worship at his word,
He's but a coof for a' that:
For a' that, an' a' that,
His ribband, star, an' a' that:
The man o' independent mind
He looks an' laughs at a' that."

Robert Burns received no Canada Council grants and continued in an exhausting day job throughout his life.

Imagine yourself after a 12-hour shift in the emergency room, sitting down in the chill of a smoke-filled cottage with quill and parchment to compose a letter or a poem. Burns did back-breaking farming and writing in the evenings almost every day of his short adult life.

He hated hypocrisy and advocated tolerance for the weaknesses of man and woman:

"Then gently scan your brother man,
Still gentler sister woman;
Tho' they may gang a kennin
wrang (a little wrong)
To step aside is human."
(*Address to the Unco Guid*)

Certainly he stepped aside often enough, fathering 12 children, three out of wedlock.

There are so many aspects of his muse – his love of companionship and memories of childhood sung from Two Hills to Toowoomba each new year in *Auld Lang Syne*:

"We twa hae paidled in the burn
Frae mornin' sun till dine,
(have paddled in the stream)
But seas between us braid hae roar'd
Sin' auld Lang Syne." (broad
have roared since)

He had warnings for lawyers, bankers and preachers.

"A fig for those by law protected!
Liberty's a glorious feast!
Courts for cowards were erected,
Churches built to please the priest."

And for Alberta Health Services and the Tories, "The best-laid plans of mice and men Gang aft agley."

Some professors of English literature say Burns was not in the same league of poesy compared to the complexity of John Donne, the flights of Shelley, the language of Keats or the imagery of Wordsworth.

They may be right but that is not quite the point. If poetry is about conveying fine thoughts and feelings to the population (or low thoughts from his Secret Cabinet), then Burns outstrips them all.

I recently heard a rock/punk band singing "A Man's a Man for a' That." I've yet to hear a rapper recite *Ode to Autumn* (by John Keats).

Burns poked fun, satire and made uncompromising demands for freedom at a time that was a dangerous activity, with the American War of Independence lost only four years before and the French Revolution about to erupt.

"By oppressions woes and pains!
By our sons in servile chains!
We shall drain our dearest veins,
Yet they shall be free!"
(*Scots Wha Hae*)

Ralph Waldo Emerson wrote: "*The Confession of Augsburg, the Declaration of Independence*, the *French Rights of Man*, and the *Marseillaise* are not more weighty documents in the history of freedom than the songs of Burns. His satire has lost none of its edge."[2]

Burns died in 1796, poverty-stricken, yet loved and revered. His epitaph says it all:

"Is there a man whose judgment clear,
Can others teach the course to steer,
Yet runs himself life's mad career
Wild as the wave?"

The genius of Burns was a genius that immortalizes itself. He saw life accurately; other persons rarely deceived him.

"Oh wad some power the Giftie gi'e
us, to see ourselves as other see us."
(Stephen Cookie Duckett take note. . . .)

Burns had that power. He rarely deceived himself. He dug beneath the superficialities of the life he observed, driving his shaft so deep he touched the very core of universal human experience: the beauty of Nature, the sympathy between Man and beast, the dreams and aspirations of humble people, the joy and tragedy of human love, the miracle and mystery of birth and death.

These themes are not Scottish – they are the property of men and women the world over. And that is why the world celebrates the memory of this great poet and citizen of the world.

Byron said it best: "What an antithetical mind! – tenderness, roughness – delicacy, coarseness – sentiment, sensuality – soaring and groveling – dirt and deity – all mixed up in that one compound of inspired clay![3]

References available upon request. ■

Classified Advertisements

Locum wanted

RED DEER AB

Maternity leave locum needed to start March 1. 80/20 split. Very busy walk-in clinic with four full-time and three part-time physicians. On-call schedule is one weekend per month. Hospital work and obstetrics optional. Red Deer is a vibrant, growing community, ideally located between Calgary and Edmonton. Excellent specialist services available locally.

Contact: Dr. Lize Jones
C 403.505.5287

SLAVE LAKE AB

Congenial, extremely busy practice urgently requires a family physician locum for three-to-six month periods throughout the year. Good on-call schedule.

Contact: Merylin Hodge
T 780.805.0746 or
Dr. John Keaveny
T 780.849.4155
F 780.849.4574
assocmed@telus.net

Physician wanted

CALGARY AB

Busy, recently expanded, fast-paced, paper-based medical clinic in northeast Calgary, close to downtown, is looking for two part- or full-time general practitioners. Excellent split.

Contact: Dr. Alizadeh-Khiavi
T 403.921.1249
andreakamel@shaw.ca

CALGARY AB

Westside Medical Surgical Clinic is looking for a part-time physician for late afternoon/evening and weekend walk-in shifts. This new, modern and fully electronic clinic is conveniently located near 17 Ave SW and Sarcee Tr.

You will enjoy helpful and pleasant staff, great working environment, low overhead and quality practice support.

Contact: Rob Filyk
T 403.815.8488
robfilyk@shaw.ca

CALGARY AB

Richmond Square Medical Centre, a modern electronic medical record clinic with qualified support staff, requires physicians to provide the following services: walk-in, general practice, internal medicine, and obstetrics and gynecology.

We have part- and full-time opportunities available with preferential rates for evenings, weekends and holidays. Pharmacy on site. Laboratory and X-ray facilities nearby.

Contact: Gary Mummery
T 403.585.2157
g.mummery@rsmed.ca or
Bernice Paul, Clinic Manager
T 403.542.5284
b.paul@rsmed.ca
www.rsmed.ca

CALGARY AB

Lynnwood Medical Clinic in southeast Calgary is looking for a part- or full-time family physician to start on or after June 1. Great colleagues, staff and location. Newly renovated clinic with electronic medical records. Part of the Mosaic Primary Care Network with a chronic disease nurse, behavior health consultant and shared mental health program.

Contact: Dr. Joan Meldrum or
Dr. Mark Sosnowski
T 403.279.3311
tnt.lynnwood@shaw.ca

CALGARY AB

Celebrating more than 30 years of excellence in serving physicians, MCI The Doctor's Office™ has openings available to fit your lifestyle in both family practice and walk-in shifts. Flexible hours and schedules, no investment, no financial risk, no leases to sign, and no administrative or human resource burdens. MCI Medical Clinics (Alberta) Inc. provides quality practice support in nine locations throughout the city.

Contact: Margaret Gillies
TF 1.866.624.8222, ext. 433
practice@mcimed.com
www.mcithedoctorsoffice.com

CALGARY AB

Med+Stop Medical Clinics Ltd. has immediate openings for part-time physicians in our four Calgary locations. Our family practice medical centres offer pleasant working conditions in well-equipped modern facilities, high income, low overhead, no investment, no administrative burdens and a quality of lifestyle not available in most medical practices.

Contact: Marion Barrett
Med+Stop Medical Clinics Ltd.
290-5255 Richmond Rd SW
Calgary AB T3E 7C4
T 403.240.1752
F 403.249.3120
msmc@telusplanet.net

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Contact:
C 403.880.2040
sdada@wellpointhealth.ca or
C 403.680.8885
jlewis@wellpointhealth.ca
www.wellpointhealth.ca

CANMORE AB

Partnership opportunity available. Silent business partner/developer seeking doctor(s) for a new medical walk-in clinic. We will provide all leasehold improvements and there are no lease payments. Turn-key operation in exchange for negotiated percentage of revenue. Easy access to new building in prime location. Surface and underground parking. We have new condos in the same complex – accommodations can be negotiated in the package.

Contact: Gurmeet Sidhu
C 780.264.1200
mtnviewinn@gmail.com

EDMONTON AB

Part- or full-time family physicians required to join a well-established, busy family practice in west Edmonton. X-ray, laboratory, ultrasound, mammogram, MRI/CT, stress test, MIBI, holter recording and pharmacy on site. Excellent environment, state-of-the-art clinic with professional staff. Reasonable overhead.

Contact:
T 780.483.1777
780.907.4234

EDMONTON AB

Newly built four-office clinic in the westend, expected to be busy, is looking for part- and full-time physicians. Fee-for-service, 70/30 split and have electronic medical records. February start date.

Contact: Lessard Medical Clinic
lessardclinic@gmail.com

EDMONTON AB

The Glenrose Rehabilitation Hospital is seeking interested candidates for position(s) of attending physician(s) for the Inpatient Geriatric Assessment and Rehabilitation Program.

The Glenrose has developed an international reputation for excellence in rehabilitation and specialized geriatrics. The Glenrose participates in academic training programs for physicians and allied health professionals and offers continuing education courses.

The successful candidate will be the most responsible physician for patients admitted to the inpatient geriatric assessment and rehabilitation program. The physician working within an interdisciplinary team will provide ongoing medical care for an assigned number of inpatient beds. Hours are flexible. Remuneration is competitive and on a per-hourly basis through a clinical ARP. After-hours in-hospital coverage is provided.

The ideal candidate is a member of the Canadian College of Family Physicians. Certificate in care of the elderly and/or five years' clinical experience working with older adults would be an asset.

If you are interested in pursuing geriatrics in a friendly, supportive interdisciplinary environment or have any questions, please contact us.

Contact: Dr. Hubert Kammerer
T 780.920.4773
hkamm@yahoo.com or
Dr. Elisa Mori-Torres
elisa.mori-torres@
albertahealthservices.ca
T 780.910.2509

LETHBRIDGE AB

Campbell Clinic, established in 1906, is seeking part- and full-time physicians; new graduates welcome. Currently, we have 17 family physicians, one pediatrician and one internist. Multidisciplinary primary care teams include a pharmacist, clinical educator, behaviorist and mental health/social worker. Fully integrated electronic medical records, on-site X-ray, laboratory service and pharmacy. Friendly support staff and professional management. Excellent start-up conditions and above-average income with a very competitive overhead. We welcome your enquiries.

Contact: Tim Neufeld, Clinic Manager
T 403.381.2263
tneufeld@campbellclinic.ca

RED DEER AB

Five-doctor clinic in Red Deer, population of 90,000, requires a family practitioner to replace departing physician. Established busy clinic, we offer electronic medical records and low overhead expenses. Hospital privileges available with excellent specialty coverage. Obstetrics are optional. Congenial call group is one-in-10. Fee-for-service remuneration and retention benefit.

Contact: Bruce
T 403.346.9945
(Monday-Friday, 8:30 a.m.-5 p.m.)
blben@shaw.ca

ST. ALBERT AB

Family physician is planning to expand office space and is looking for an associate to share office space and expenses.

Contact:
T 780.458.3318 (office)
C 780.983.0884

ST. ALBERT AB

Physician opportunities available. Incentives for full-time physicians available.

Contact: Sheila Cousineau
Business Manager
St. Albert and Sturgeon PCN
T 780.418.6721
sheila@saspcn.com
www.saspcn.com

KELOWNA BC

Medi-Kel Clinics Ltd. seeks physicians from across Canada for well-established family practice. International medical graduates also welcome. Kelowna is in the heart of the Okanagan in south-central BC and has excellent schools, recreational facilities, restaurants and wineries. Truly a great place to live and work.

Contact: Belinda Harris
officemanager@medi-kel.net

Physician and/or locum wanted

CALGARY AND EDMONTON AB

Is your practice flexible enough to fit your lifestyle? Medicentres is a no-appointment family practice with clinics throughout Calgary and Edmonton. We are searching for superior physicians with whom to partner on a part-time, full-time and locum basis. No investment and no administrative responsibilities. Pursue the lifestyle you deserve.

Contact: Lorna Duke
Manager, Physician Services
Medicentres Canada
T 780.483.7115
edmphys@medicentres.com
Shannon Klassen
Coordinator, Physician Services
T 403.291.5599
calphys@medicentres.com

EDMONTON AB

The Links Clinic, a 19-physician group with family practice, obstetrics/gynecology and pediatrics, has been in business for 56 years. We are currently seeking two part-time or one full-time and/or locum physicians who wish to work in an appointment-based practice. The Vein Clinic, which has been an integral part of the clinic for years, has relocated to its own larger location. The Links Clinic offers excellent patient volume, work hours and has been on electronic medical records for 19 years.

The Links Clinic is part of the Edmonton Oliver Primary Care Network. The doctors and clinic patients have access to a referral coordinator, INR nurse, dietitian, kinesiologist, two chronic disease management nurses, pharmacist, two mental health personnel, psychologist and screening staff. We have specialist linkages with an ENT, orthopedic surgeon, cardiologist and two psychiatrists. All services are offered at the Mira Health Centre, 11910 111 Ave, where the Links Clinic is located.

DynaLIFE Dx Diagnostic Laboratory Services and CML HealthCare Imaging Inc. are also on site, along with other health-related services. There are no clinic management responsibilities or capital investment required. You can devote your time to medicine. Many doctors have participated in the AIM and TOP programs and will be moving forward with the PDI program.

Please give us a call if you may be interested and we would be happy to answer any questions. Contact us if you would like a tour.

Contact: Dianne Walker, CA
Clinic Business Manager
T 780.453.9467
dwalker@thelinksclinic.com or
Dr. Lisa Burchett
T 780.453.9462
lburchett@thelinksclinic.com

RED DEER AB

Red Deer's Associate Medical Group, established in 1946, is central Alberta's largest family medicine clinic. We are currently seeking part- and full-time physicians, as well as locums, who are interested in seeing patients in booked appointments as well as in a busy walk-in environment. The medical practices are professionally managed with an excellent, knowledgeable support team, very experienced colleague base, competitive overhead rates and fully integrated electronic medical records.

Clinic is connected to Red Deer Primary Care Network and has a number of health care professionals collaboratively working with family physicians. We have a manageable obstetrics on-call schedule with a low-risk maternity group handling the majority of new obstetric patients. Last May the Associate Medical Group also opened a new state-of-the-art walk-in clinic in Red Deer's highest-traffic retail location, which is expected to generate large-income potential with generous financial splits. Laboratory and hospital nearby. Downtown location, pharmacy on site (downtown clinic) and close to walk-in location.

Contact: Dr. Maureen McCall,
Medical Director
Associate Medical Group
4705 48 Ave
Red Deer AB T4N 3T1
T 403.346.2057
maureenmccall@
associatemedicalgroup.com
www.associatemedicalgroup.com

Space available

CALGARY AB

The new 45,000 sq. ft. Southern Alberta Eye Center has leasing opportunities for related medical practitioners. There is space available for an individual practice or larger premises available for a two-to-three doctor clinic. This state-of-the-art facility includes four surgical suites along with a retail pharmacy.

Contact: Bob Parsons
Courtenay Real Estate Services Inc.
T 403.270.7886
403.369.8626
bob@courtenaygroup.ca

Courses

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Ship: Brilliance of the Seas

BERMUDA CME CRUISE

May 1-8
Focus: Orthopedics and sports medicine
Ship: Veendam

ALASKA GLACIERS CME CRUISE

July 10-17
Focus: Clinical medicine update
Ship: Celebrity Century

August 19-26
Focus: Crossroads in clinical medicine
Ship: Celebrity Infinity

BALTIC AND RUSSIA CME CRUISE

July 21-31
Focus: Endocrinology
Ship: Eurodam

MEDITERRANEAN CME CRUISE

September 5-17
Focus: Medicine in 2011
Ship: Celebrity Solstice

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Contact: Sea Courses Cruises
TF 1.888.647.7327
cruises@seacourses.com
www.seacourses.com

For sale

CANMORE AB

Canmore vacation Shangri-la. Brand spanking new. Three units for sale with choice of main deck views: Sunrise Crest (east), Chili Pepper (south) and Sunset Purple (west). Each boasts a master bedroom, second private deck on top floor. These condos, in the newly constructed Alpine Village Centre, are a short 10-minute jaunt from downtown Canmore. Our special Tourist Home zone allows use as permanent residence or vacation property (or both, your choice). Enjoy revenue stream if you wish. Two levels with good bedroom separation. These townhouse-style condos feature hardwood flooring on the main level. Nicely decorated kitchen has solid maple cabinets, granite countertops, stainless built-in dishwasher, fridge and stove. Bedrooms are carpeted and have vaulted ceilings. Bathroom has ceramic tile that surrounds a soaker tub. Each condo has a private storage unit right outside your door, plus titled parking stall in the heated parkade. Elevator access is available.

Contact: Jim Ridley, realtor
Royal LePage Rocky Mountain Realty, Canmore
T 403.493.4663 (direct)
TF 1.888.363.4551
F 403.592.6703 (confidential)
jimridley@shaw.ca
Skype: canmorerealestatepro
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