Physicians as Stewards of Resources
Public Health Surveillance of Congenital Anomalies: How it Can Help Prevention
Catholic Health Legacy Strong and Vibrant in Alberta
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Save the Dates!

CAMSS
Council Meeting
March 9, 2016 | ACH 06 – 5:30-8:30 pm
ZAF
April 6, 2016 | Rm 1003, 10301 Southport Lane SW – 5:30-8:30 pm
Council Meeting
May 11, 2016 | ACH 06 – 5:30-8:30 pm

CZMSA
Executive Meeting
March 3, 2016 | Teleconference
Executive Meeting
April 7, 2016 | Teleconference
ZAF
May 11, 2016 | Location TBD

EZMSA
General Meeting and Awards
March 17, 2016 | NAIT Ernest Restaurant – 6:00-9:00 pm
ZAF
April 14, 2016 | Misericordia 1N-106 – 4:00-7:00 pm
Executive Meeting
May 19, 2016 | Misericordia – 5:00-5:30 pm
Council Meeting
May 19, 2016 | Misericordia 1N-106 – 5:30-7:00 pm
Golf Tournament
May 26, 2016 | The Links – Spruce Grove – 2:00 pm (shotgun start)

SZMSA
Council Meeting
April 4, 2016 | Teleconference – 5:30-6:30 pm
ZAF
April 4, 2016 | Teleconference – 6:30 pm
Physicians as Stewards of Resources

Dr. André van Zyl

For those who did not attend the Physicians as Stewards of Resources forum, I would like to share what I took away from it. This international panel was convened by AMA and the government to create a forum to discuss the physician’s role in the stewardship of resources. Presenters included Dr. Carl Nohr, Dr. David Naylor, and Mr. André Picard among others.

The profession is being challenged to ask not just about rights but also responsibility. Health care in many parts of the world is a privilege, in North America and in Canada it is considered a right. The patient responsibility is a variable factor, but physicians’ responsibility needs to direct our mission to sustain health care in Canada. This is a groundbreaking discussion among stakeholders to review medicare and to construct a vision for health care in Alberta/Canada. These discussions will have a significant impact on how we move forward to provide care and receive remuneration.

Ms. Hoffman noted that “Physicians play an important role in stewardship of this system and how we remunerate these services is crucial.” She believes doctors can play a major role through collaboration to address and curb the 6% annual growth in health care cost and the more than $4,000 annual per capita spending. She adds that rewards need to go towards those who are willing to take on the responsibility to bring about improved care, access and team-based health management. According to evidence, fee-for-service is just not robust enough to address the aforementioned issues. Quality of care is not at issue, but rather addressing health care efficiencies and fiscal effectiveness; that includes access, information technology (IT) support, resource usage (lab & DI) and culture.

**Access:**
Innovation is required for how we link remuneration to access. Access does not equate seeing your primary care provider in a timely fashion. According to the Veteran Affairs (Dr. Peter Kaboli) of the USA, access includes “the potential ease of having virtual or face-to-face interactions with a broad array of healthcare providers including clinicians, caregivers, peers and computer applications.”

The Hamilton, Ontario, model suggests population-based health care that is based on equitable care, not equality of care. Geographical rostering and patient care grouping with public health partnerships, having physicians in leadership positions, shifts the responsibility of access away from the individual physician towards the community team.

**EMR/IT Support:**
There needs to be a finite number of electronic medical records (EMRs) that are interchangeable and communicate with each other. IT capacity should ensure that all patients can have access to at least some data in their own electronic medical records. This will also create a pathway for the physician to digitally and directly respond to the patient.

**Lab Utilization:**
Despite the advent of Toward Optimizing Practice (TOP) and Choosing Wisely, there has been no noticeable or tangible impact on health expenditure. Per Dr. Mador, implementing a top down restriction (eg. restricting the ordering of vitamin D levels) was the only action that showed any actual impact on spending. If just publishing this valuable information does not change culture, practice guidelines (TOP, ASaP [Alberta Screening and Prevention Program], Choosing Wisely) need to be built into the system at all levels: EMR, Office, emergency departments, acute care admission, transfers, etc.

**Culture:**
A team of health providers can provide more for patients than what an individual physician can.

As our profession takes responsibility for quality of health care, we need to also have a role in its sustainability. The forum gave a chance for dialogue.
“The field of public health has always been a poor relation of medicine” (i). To summarize Hemenway: a) The benefits of public health programs lie in the future, e.g. governments that enact them often only have short term goals in mind, i.e. the next election. b) The beneficiaries of public health measures are generally unknown. c) Public health has little news value and does not make for good human interest stories or photo ops. d) Some public health efforts encounter opposition, e.g. tobacco industry, seat belt legislation in Alberta.

Good data to monitor trends in congenital anomalies can identify clusters that may require investigation, and more important, can monitor the effectiveness of Public Health intervention measures. The Alberta Congenital Anomalies Surveillance System (ACASS) has been doing this since 1980 and is the only province with good long term data. Some Provinces and Territories are enhancing their perinatal health programs to include congenital anomaly data. Others such as British Columbia, which used to be a world leader, has declined to a point of irrelevance while Saskatchewan has recently discontinued an excellent pilot program in the Saskatoon Health Region.

Alberta has approximately 54,000 births/year of which 3-4% of newborns (1,500-2,000/year) will have one or more serious congenital anomalies. Children with congenital anomalies are a major contributor to pediatric hospital admissions, many with serious lifetime health issues. Leaving aside the sadness and emotional toll on parents and families, from a provincial government point of view, they are extremely costly to our health system.

Examples of where Alberta could do more to reduce costs by establishing or enhancing existing prevention programs:

**Spina Bifida and related neural tube defects.** Clearly folic acid fortification (FAF) has been a success in Canada with a 50% reduction in spina bifida (ii) (figure 1), but despite FAF some Canadian women have low levels of folate (e.g. women aged 15-24 with less than secondary education and women 25-49 with low income). Thus these women need folic acid supplements which should be taken pre-conceptionally. A simple matter would be to institute therapeutic monitoring of folate levels (iii) which would have to be pre-conceptional as testing in the usual prenatal care time would be too late to implement preventive measures. It is estimated extra folic acid will be required if the maternal red blood cell folate is less than 906 nmols/L. Alberta has about 40 cases/year with a neural tube disorder, half of whom are spina bifida.
Maternal overweight/obesity and Diabetes Mellitus. There is a definite correlation between these factors and an increased risk of a number of congenital anomalies including neural tube defects, cleft lip/palate (CL/P), cleft palate, some cardiovascular defects such as Tetralogy of Fallot and transposition of the great vessels (iv). A reduction in any of these congenital anomalies would result in considerable cost savings to the province. In addition, obesity or being overweight may lead to maternal diabetes which in itself is an increased risk factor if it is poorly controlled as it doubles the ordinary congenital anomalies risk.

Maternal Smoking. This is a major risk factor for CL/P particularly if smoking is heavy (more than 25 cigarettes a day). In Alberta we have about 70 new CL/P cases/year. These children require surgery, increased orthodontic care, speech therapy, and often treatment for hearing problems (v).

Gastroschisis. Rates of this disorder are rising throughout the Western world and essentially reaching epidemic proportions. Alberta has one of the highest rates in Canada (vi) and there is substantial evidence supporting the validity of a number of risk factors such as low maternal age (figure 2), cigarette smoking, genito-urinary infections in early pregnancy, alcohol, illicit drug use, and low socioeconomic status. Two recent Canadian studies linked diabetes as a contributing factor and substance abuse and smoking were associated with a greater severity of the defect. (vii, viii). Alberta has approximately 25 cases/year, the majority requiring prolonged care in a neonatal intensive care unit.

Summary

Good long term surveillance data is very useful in evaluating spurious newspaper or magazine claims about harmful environmental factors e.g. sea bathing causing limb defects in the United Kingdom (ix) and more locally, that chemicals in our water is increasing the rate of hypospadias in Alberta (x). ACASS data has shown no increase in the hypospadias rate for the 1980-2011 period (xi).

It should also be noted that many of the risk factors which contribute to congenital anomalies are also those for preterm births where Alberta has a very high rate, probably second only to Nunavut.

Having good data is not a luxury as you cannot deal with a problem unless you know its extent. Innovative preventive programs could reduce highly expensive healthcare. For more details of congenital anomalies prevalence in Alberta see the ACASS report which can be reviewed online: (http://www.health.alberta.ca/documents/Congenital-Anomalies-Report-10-2014.pdf) or a paper copy can be obtained from our office – Room C4-500 ACH.

R. B. Lowry, MD, DSc, FRCP\nProfessor Emeritus, Departments of Pediatrics and Medical Genetics\nMedical Consultant, Alberta Congenital Anomaly Surveillance System, Alberta Health

REFERENCES


(xi) Lowry RB. Gender Bending Water. Alberta Views 2014; December:11.
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Today, Covenant Health brings the strengths of this Catholic legacy as a key partner within the single, integrated health system that serves Alberta—a system that is enriched by partners who work together to sustain a comprehensive service delivery model, using the assets and skills of each organization.

Covenant Health was officially incorporated through legislation in 2009, merging Catholic health organizations across Alberta, including the former Caritas Health Group in Edmonton. As Canada’s largest Catholic health care organization, Covenant Health serves people of all faiths and traditions and provides large scale, high value and high volume core acute, continuing care and palliative services across the continuum, as well as specialty services in 12 communities.

The team of 15,000 includes 775 physicians who designate a Covenant Health facility as their primary practice site. Another 1,200 physicians have privileges to care for patients and residents in Covenant Health’s 17 sites, which includes the Grey Nuns and Misericordia Community Hospitals in Edmonton.

Covenant Care, a separate Catholic non-profit organization formed in 2013, is home to over 500 people with six continuing care centres and hospices in Calgary, Red Deer and the Edmonton area, and will be opening 310 more beds in 2017.

**Significant Contribution**

Catholic health care is a significant contributor in Alberta—accounting for 1 in 10 emergency visits, one in five births and 11% of acute care beds in the province, including 30% of hospital capacity in the city of Edmonton. Covenant Health and Covenant Care serve Albertans at their most vulnerable, with 118 palliative and hospice beds and 254 mental health beds.

Covenant Health makes a difference in Alberta through its reputation and performance as a top-accredited provider and good steward of resources. The organization has been recognized as one of Canada’s Top 10 Most Admired Corporate Cultures and as a top Alberta employer. Small enough to be nimble but large and broad enough to have real impact, Covenant Health brings innovation, choice and flexibility to help make the system stronger.

**Story of Compassion**

How did we get here? This story began with groups of courageous and resourceful religious women who served pioneer Alberta, called to serve and foster a just and caring society.

Before the nation of Canada or the province of Alberta were formed, the Sisters who established hospitals and responded to needs of early settlers laid down a foundation that would support the population explosion on the prairies and help Alberta through its darkest days. Their example of practical love and wise discernment based on enduring values had a profound impact on Alberta society and health care.

In the desire to cure and repair, the Sisters knew that we cannot forget the people, their stories, where they came from, where they are going, their hunger and their need for emotional, social and spiritual connection in times of challenge and crisis.

The name Covenant reflects this legacy and guides the organizations’ work today, building on the enduring promise at the core of healthy communities and the healing relationship—to serve the whole person with dignity, respect and compassion, recognizing the full dimension of what it means to be human.
Called to Serve

The Sisters opened Alberta’s first hospital at the Catholic mission founded by Father Lacombe in St. Albert in 1863 and, as the West opened up and prairie towns exploded along the railroads, and other orders followed. The first Catholic hospitals in Alberta — among them the Holy Cross (1891) in Calgary, Edmonton General (1895) and Misericordia (1900) in Edmonton — were entirely charitable institutions.

The Sisters were firmly focussed on a gospel call to seek out, care for and give voice to those most vulnerable. As a wave of immigration brought 1.5 million people to the Canadian prairies at the turn of the century, the Sisters served as hosts and helpers, caring for newcomers and poorer, disadvantaged individuals and families with no means or status to hire nurses or doctors to care for them at home. Following World War I, the Sisters played a leadership role in battling the Spanish influenza in makeshift hospitals and travelling house to house.

Courage in Adversity

In the early years, Alberta’s growing population faced diphtheria, typhoid and influenza epidemics, which ravaged settlements and required isolation capacity and additional clinical skills and training. By 1920, the Sisters had built 15 hospitals, many in small communities, which formed a collective response to the health crises and acted as a key driver for medical standards and progress. Three of the first schools of nursing were established by Catholic hospitals.

The Sisters were resourceful and astute leaders. They were problem-solvers and not afraid to risk, whether courageously speaking up or quietly and purposefully gathering the resources and support they needed. Guided by their values, they expertly navigated public policy, powerful forces, and ethical conundrums.

The Stock Market Crash, Depression and Great Drought (1929-1939) forged our core values as a province. During this period — when unemployment hit 30%, thousands of farms were abandoned and towns disappeared — the Sisters built a social safety net of 25 hospitals across the province. Collaborating with others, they pioneered a pre-paid hospital insurance plan, responded to tuberculosis, trained medics and cared for returning injured and shell-shocked soldiers.

Watershed Moment

As Alberta prospered, medical care advanced and a publicly-funded health system was established, the orders of Sisters were growing smaller. From 1969 to 1975, twenty Catholic hospitals, including Calgary’s Holy Cross, made the difficult decision to either close or transfer to municipal or provincial government systems. It was a crucial point for Catholic health care.

In 1976, a Catholic sponsoring body was formed to take on the Sisters work as a voluntary organization to operate hospitals under agreement with Government. With skill and wisdom, the Sisters shepherded a successful transition from charitable entity to non-profit partner with Government and lay people. This resourceful response to changing times laid the foundation for the robust integrated system that serves Alberta today.

Catholic Health Care Today

Much has happened in Alberta health care in the past 25 years — including a great deal of structural change with the formation of health regions and, most recently, Alberta Health Services (AHS). Throughout it all, Catholic health providers have navigated the modern world of health care with one thing in mind — continuing their mission of compassionate quality care both as a provider of health services and as a good partner.

A Master Agreement between faith-based providers and Government underpins this, paving the way for Catholic hospitals to operate in the system while safeguarding their ethical and faith principles. Covenant Health is accountable for providing services as defined in the Co-operation and Services Agreement with AHS, which outlines the delivery of services by Covenant Health, the delivery of shared services, and establishes principles and expectations to be followed by both. Covenant Health has its own medical bylaws, similar to AHS bylaws, and medical organizational structure with separate staff associations. There is a collaborative approach with AHS to credentialing, appointments and delineation of clinical privileges.

The two Covenant Organizations are governed by a Board of Directors, appointed by the Catholic sponsor. The Boards hold dual accountability to AHS and the sponsor for quality and performance and are also accountable to the sponsor to keep the Sisters’ legacy alive, safeguarding a vibrant mission and core values.

This year, Covenant Health asked staff and partners to define the potential of Catholic health care into the future. The resulting vision statement is a testimony to Sisters’ ongoing impact and a bold future: “Inspired by our mission of service, we will be leaders and partners in transforming health care and creating vibrant communities of health and healing.”

Dr. Owen Heisler, MD, MBA, FRCS
Vice-President and Chief Medical Officer, Covenant Health

— continued on page 8
Covenant Health Resources:
Covenant Health: covenanthealth.ca
Medical Staff Portal: https://medicalstaff.covenanthealth.ca/
Ethics Centre: covenanthealth.ca/ethics-centre/
Research: covenanthealth.ca/research-centre/
Covenant Care: covenantcare.ca

Covenant Health
SERVICE ACTIVITY (2014-15)
- Acute patient days: 329,387
- Resident days: 523,492
- Emergency visits: 196,910
- Outpatient visits: 421,346
- Surgery Cases: 42,962
- Deliveries: 9,825
- Diagnostic imaging exams: 259,614
- Laboratory tests: 3,189,907

Covenant Health Facilities
- Banff Mineral Springs Hospital
- Bonnyville Health Centre
- Edmonton General Continuing Care Centre
- Grey Nuns Community Hospital, Edmonton
- Killam Health Centre
- Mary Immaculate Hospital, Mundare
- Misericordia Community Hospital, Edmonton
- Our Lady of the Rosary Hospital, Castor
- St. Joseph’s Auxiliary Hospital, Edmonton
- St. Joseph’s General Hospital, Vegreville
- St. Joseph’s Home, Medicine Hat
- St. Mary’s Health Care Centre, Trochu
- St. Mary’s Hospital, Camrose
- St. Michael’s Health Centre, Lethbridge
- St. Therese Villa, Lethbridge
- Villa Caritas, Edmonton
- Youville Home, St. Albert

Covenant Care Facilities
- Villa Marie, Red Deer
- St. Marguerite Manor and Dulcina Hospice, Calgary
- Holy Cross Manor, Calgary
- Chateau Vitaline, Beaumont
- St. Thomas Health Centre, Edmonton
- Foyer Lacombe, St. Albert

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**FoMD Strategic Plan**

Dr. Neil E. Gibson

I have reproduced a section from the Dean’s January newsletter to update the Strategic Planning process as follows:

“The development of the FoMD Strategic Plan is now completed with a five (5) year vision, and one (1) year and ninety (90) day milestones in each of the seven (7) focus areas of education, research, partnership, people, innovation, funding and governance. The strategic plan and the milestones are structured to lead the faculty to excellence and provide “do-able” objectives. I am writing to ask you to be part of the teams leading each of the milestones and thus will play a significant part in the future. Please learn more about the strategic plan milestones at www.med.ualberta.ca/strategic-plan or email fomdplan@ualberta.ca to learn how to become a part of the team.”

I would encourage you all to review this document, as it is moving quickly; and the Dean fully intends to make this work. This will be of benefit to Clinical Faculty in many respects.

With this in mind, I would like to solicit your opinion as to what needs to be in a Clinical Faculty Annual Report. In past communications I have described that this process leads to strengthening the relationships within your Departments, and ultimately will be used for promotion consideration, as well as the determination of a teaching stipend. The ARO will be one of the 90 day projects in the Strategic Plan; and I need your feedback. What do you see as important components of this report, and what format (online, app, paper) makes sense to you?

Please let me know your thoughts at neil.gibson@ualberta.ca or feel free to call me directly at 780-918-9253. All opinions and ideas welcome. Together we can make this our document rather than having it made for us.

As always, I can be reached at neil.gibson@ualberta.ca

Neil E. Gibson, OMM, CD, BSc, MSc, DOHS, DTMH, MD, FACP, FRCPC
Associate Dean, Clinical Faculty
Director of Simulation
Clinical Professor
Department of Medicine
Division of Critical Care Medicine
Alberta’s Resident Physicians: Future Leaders In Health Care

Submitted by the Professional Association of Resident Physicians of Alberta

What does it mean to be a leader in health care? By including “leader” as one of the CanMEDS roles what is being implied? How do resident physicians become leaders?

These questions form part of the framework that the Professional Association of Resident Physicians of Alberta (PARA) uses to assist in the development of future leaders in health care. While some might believe that leaders are born, PARA believes that leadership is developed and strengthened through experience. PARA strives to provide opportunities for leadership development.

Through their involvement with PARA, resident physicians gain valuable leadership experience and training. Volunteering with PARA affords opportunities to network with colleagues and other health professionals, connect with the community they serve, advocate on behalf of all Albertans, and advocate on behalf of themselves and their colleagues.

Networking
By volunteering to be PARA ambassadors, resident physicians are provided with chances to meet and develop relationships with other physicians and other health professionals. They are exposed to the trends and best practices in the profession and they are encouraged to provide input into the future of health care. Being a PARA ambassador allows resident physicians to experience the issues facing the broader health care system moving them beyond the world of residency training.

Involved in their Communities
The PARAdime Campaign is PARA’s flagship annual community wellness initiative that provides support to some of Alberta’s most vulnerable. Collection bins are set up in several hospitals across Alberta where resident physicians and other allied health care workers are encouraged to drop off donations of new and gently used clothing and other items most needed by partner agencies. During Resident Awareness Week, donations collected are delivered by resident physicians to local shelters and agencies.

PARAdime is an opportunity to increase resident physician awareness of the challenges faced by some of their neighbours. It is also an opportunity to engage other allied health-care workers, those who along with resident physicians are part of the interdisciplinary teams providing patient care, in providing basic necessities that will improve the health of some of those at risk.

Advocating for Albertans
Each year, resident physicians participate in Resident Physicians in the Legislature Day (RIL). During face-to-face meetings with elected representatives and senior government officials, resident physicians share their perspective on issues relevant to health care delivery in Alberta. This continuing advocacy event provides resident physicians with an opportunity to engage with policymakers and positively impact health care policy in Alberta and gain experience in CanMEDS roles of health advocate and communicator.

On November 16, 2015, a group of resident physicians met with 15 MLAs including a meeting with the Minister of Health. This year’s theme was seniors’ health care and our specific ask was that Alberta’s resident physicians be included in policy decisions related to developing a sustainable seniors’ care strategy in Alberta. As frontline health care workers, we experience first-hand the impact of the current seniors’ care strategy on acute care delivery for all Albertans.

Our message and ask was well received by all MLAs, and we look forward to carrying this advocacy effort forward.

Supporting Resident Physician Wellness
Society — notably patients — is placing increasing emphasis on the importance of physician wellness being essential to effective health care. Resident physicians are no exception, but they are also in the challenging position of being both learners and front-line care providers. Initiatives such as Resident Physician Wellness Week, held the third week in May, encourages resident physician wellness and recognizes resident physicians for the work they do.

The third week of February marked Resident Physician Awareness Week. It celebrated the critical role resident physicians play as front-line health care providers. They are passionate about patient care, healthy working and learning conditions, and assisting in shaping the future of health care delivery in Alberta.

Resident physicians will indeed be some of the future leaders of health care. Part of PARA’s mission is to empower resident physicians to be passionately engaged in being part of the solution — a continuously improving health care system. The health of all Albertans is at stake.

The Professional Association of Resident Physicians of Alberta (PARA) is the voice of the more than 1,600 resident physicians providing round-the-clock medical care to Albertans in acute care hospitals and outpatient facilities. PARA advocates excellence in education and patient care while striving to achieve optimal working conditions and personal well-being for all its members. www.para-ab.ca
Many physicians maintain personal social media profiles to connect with friends and family members, share ideas and jokes, and provide a sense of community. Although most sites offer “privacy settings,” many physicians are unaware of how public the information on their social media profile actually may be — taking a screen shot immediately makes even read-only private information easily shared regardless of privacy settings. Although the internet can provide increased access to information, it also permits increased scrutiny of behaviour both at and out of work.

Most use of social media, whether professionally or personally, is well done. The limits are understood and most physicians maintain professional boundaries. However, some physicians get into trouble through inappropriate use. For example:

- A physician posted a photograph showing herself delivering a baby. The physician and associated hospital were identified easily. While this case is being investigated and her future career determined, the internet vilified her. Sadly, she is not alone — there was recently a trend on Instagram of “delivery selfies.”

- A physician posted enough information on social media regarding a patient she had managed to make this patient identifiable to others in her community. This resulted in a loss of job and privileges, and a reprimand from the state medical board.

- Most recently, a young resident appeared intoxicated while apparently berating the driver of a car service. This video was circulated widely, as were her personal social media photos. She is currently suspended pending the investigation by the healthcare authority she was associated with.

These examples appear evident and shocking and many people can easily identify them as inappropriate use. But some examples of misuse may be more subtle, or the ramifications of the action poorly understood.

- Does listing a health-care organization, for example, Alberta Health Services (AHS), as your place of employment impact your profile? Some patients may assume that statements or comments on your profile might be endorsed or supported by that organization. This is why AHS asks that employees be clear with their posts, indicating “when the comments are their own personal views, on behalf of an organization or profession, or if they are being made in an official capacity on behalf of AHS.”
How does “liking” something implicate you? You may not have posted an inappropriate statement about a patient but by agreeing to publically support it you too might be found at fault for betraying patient privacy. How might posting pictures of your evening out, including pictures of alcohol, impact your future job prospects? Many employers scour the internet for evidence that candidates might not represent the brand they are building, and to ensure the prospective employee represents the company’s ethics and values. In today’s connected work, a job application may extend well beyond the traditional boundaries of the resume and interview. Up to 10 per cent of young job seekers lose out on opportunities based on something they have posted online.9,10

Many health care providers participate in overseas medical experiences. And, many post pictures of these experiences without considering the privacy of the patients. Although some of the patients may not have access to social media or the internet, their patient rights are the same as those at home. Some sponsoring agencies have strict policies about taking and using photographs for either educational purposes or publicity.11

Physicians have to take responsibility for their actions and also how their actions are perceived. You may have to discuss with your friends and family how things they post on your profile can negatively affect you, your career and your patients. Learn how to maximize privacy settings and be accountable for your profile. The American Medical Association is quite explicit in its recommendations, stating: “physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers... and can undermine public trust in the medical profession.”12

Many governing bodies, such as the Canadian Medical Protective Association, the Canadian Medical Association, or provincial colleges have recommendations for the use of social media.1,13,14 In general, most organizations emphasize maintaining the same levels of professionalism, patient confidentiality, appropriate boundaries and respect as we do both at home and in the workplace. Additionally, the College of Physicians and Surgeons of Alberta provides excellent examples of both good and poor use of social media.1

The world is increasingly connected and being part of that larger community can increase your impact in providing excellent, evidence-based care to your patient population. With many resources available on the use of social media in health care, understanding when and how to use social media appropriately can make you a more connected and personable health care provider.

Anna Shawyer, MSc, MD, FRCS
Dr. Anna Shawyer is a pediatric surgeon at Alberta Children’s Hospital.

REFERENCES:
11 www.mercyships.ca; personal communication January 2016.
Central Zone Medical Staff Association:

WHAT'S UP DOC?

Dr. André van Zyl

PPEC – Resurrection of the AHS Board

From recent discussions at PPEC it is clear that the board does not intend to interfere with operations. Linda Hughes, chair of the board, emphasized “stability” and shifting management towards the CEO and appropriate leadership avoiding micromanagement.

NEW (interim) CEO Verna Yiu

Dr. Verna Yiu is well known among physician and non-clinical leadership, she is “home grown” and a graduate of the University of Alberta and of Harvard University. She is currently a Professor of Pediatrics at the University of Alberta. Prior to joining AHS in August 2012 as Vice President, Quality and Chief Medical Officer, Dr. Yiu served as Interim Dean of the Faculty of Medicine & Dentistry at the University of Alberta. She has a clear understanding of the service gap, escalating health care costs, concerns regarding health efficiencies or rather the lack thereof and familiarity with political interference with health care operations. Her aim is to have a “VISION” for Alberta’s health care in place regardless of the CEO of the day. Realization of the quest for “stability” might keep Dr. Verna Yiu longer than a day in office.

Make the Rural OR Part of the Solution

Regardless of the fiscal concerns of health care, Alberta still delivers high quality care, compared to the rest of the world. Specialization and centralization of care took steps towards higher quality of care: unfortunately that has left about 1 million rural Albertans with scattered health care. The generalist made way for the specialist. Unchecked, resource and access disparity widened — specialists without work and rural communities without services. A cultural change towards reciprocal supportive collaborative care might reverse the service gap.

Summit on Rural Surgery and Operative Delivery, Banff, January 23, 2016

Various colleges, SOGC, CARS, health administrators, education institutions and other stakeholders attended this one day summit. The importance of rural operative delivery and concepts of community, corridors of care and collaboration of services were explored as principles for resolution.

In summary five pillars were identified:

1. Recognition of physicians with added skill (CCFP);
2. a curriculum for physicians to achieve added skills;
3. a joint position paper among various organizations in support;
4. quality assessment and appropriate and standardized credentialing and privileging;
5. and above all a Community of Practice.

Rural Maternal Care

The SCN for Mother, Newborn, Child and Youth with collaboration of the provincial Maternity care steering group are in the process of developing an innovative network of care to address rural maternal care for all Albertans — “Sustainable and safer maternal health care closer to home.”

CZ Medical Staff Association Annual General Meeting February 10, 2016 was held in Red Deer in conjunction with accredited Continuing Medical Education. More on this in the next issue.

André van Zyl
President, CZMSA

Letter To The Editor

Vital Signs Magazine,

I feel strongly that Vital Signs needs to become a truly provincial publication for physicians. Vital Signs origin is in Calgary under the direction of CAMSS. Presently CAMSS is funding the magazine in total at $32,000 per annum. The Editorial Board is mostly Calgary based with Dr. Tobias Gelber from Pincher Creek. Over a year ago at a meeting of the Council of Zonal Leaders CAMSS agreed to take the first step which was to distribute the magazine to all members of Zone Medical Staff Associations.

It is time for the other zones to take ownership and share costs, submit articles and contribute to the editorial structure. Further, I suggest that Vital Signs might need to leapfrog past the constraints of a provincial magazine on glossy paper to an Alberta physician supported social media platform, accessible from any device.

Sincerely,
Stephanus Andreas van Zyl, MD
Everyone Wants to be a Writer

Deep down, we know everyone wants to be a writer; now is your chance. You have passion, knowledge and a perspective that is all your own. We want you to share that passion with Vital Signs readers. If you have an interest that fits into the Vital Signs mandate, we are asking you to consider submitting an article. Some topics include, but are not limited to: medical marijuana, physician-assisted death, communicating with patients and their families, working smarter, funding, workplace issues, work-life balance, new technology and of course, the many aspects of patient care.

The Benefits of Being Involved

Your participation in Vital Signs educates, enlightens and encourages colleagues. It also benefits you in many ways: satisfaction for a job well done, connection with new people and the excitement of a new experience. Make a difference, be part of a group of doers and grow in ways you never expected.

Upcoming issue themes you might want consider participating in.

2016 April issue – Spaces (where we work)
2016 May issue – Rural Issues
2016 June issue – Alternative Medicine
2016 July issue – First Nations Issues

Editorial Guidelines

CONTENT:
1. Content submitted to Vital Signs should represent and advocate on matters pertinent to medical staff and patient care at the zone and provincial levels, such as:
   • Quality and safe patient care
   • Service planning and delivery
   • Practitioner workforce planning
   • Inter-disciplinary patient care
   • Workplace and wellness
   • Medical Staff bylaws and rules
2. Content submitted should be original and is published at the discretion of the Editorial Committee. Content should reflect the goals of the ZMSAs and be respectful and constructive.
3. Content with commercial interests will only be accepted as paid advertisements. The following may be submitted for possible inclusion as paid advertising in Vital Signs:
   • Third-party sales/product and promotional offers
   • Private/for-profit conferences or seminars
   • Job ads
   • Want ads

FORMATTING:
1. Articles submitted should be no more than 1000 words in length and in MS Word format with sources cited and trademarks and copyrights honoured.
2. Please observe writing conventions:
   • Be brief, but engaging. Limit unnecessary words and adopt plain language where possible.
   • Use action words and make it clear how this information will directly benefit the reader.
3. Graphics are welcome. Please provide logos in .eps format if available; jpegs should be at least 300 x 300 to allow for cropping. Images should be supplied at 300dpi at original size. Stock photos may be provided at the discretion of the managing editor.
4. Articles are approved and may be edited by the Editorial Committee prior to being published.

Please send submissions and inquiries to: Hellmut Regehr, Vital Signs Managing Editor at hregehr@studiospindrift.com
SAVE THE DATE

The Rockyview General Hospital Medical Staff Association
Annual General Meeting

Tuesday, June 14, 2016 from 6:00 to 9:00 p.m.
Railway Orientation Centre at Heritage Park’s Town Square
1900 Heritage Drive Southwest, Calgary
You are invited to attend with a partner
Featuring entertainment by the May Trio
Lead by Jonathan S. May
Buffet Dinner/Cash Bar
Rockyview General Hospital Physician Recognition Awards
"Very Important Presenters to our Very Impressive Physicians"

Rockyview General Hospital Medical Staff Association Members 2 tickets to the AGM are included in your membership and you are invited to bring a partner
Non RGH MSA Members most welcome, cost $100.00 per ticket
Seating is limited, your RSVP would be appreciated by May 17, 2016
stella.gelfand@ahs.ca Tel: 403-943-3428, Fax: 403-476-8797

Dr. Borys Hoshowsky, President, Rockyview General Hospital Medical Staff Association

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THE CALGARY MEDICAL SOCIETY MINI DIRECTORY
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