March 2017

ZONE MEDICAL
STAFF ASSOCIATIONS
OF ALBERTA

VITAL SIGNS

COMMUNICATING WITH PHYSICIANS IN ALBERTA

Optimizing Physician Health
A Physician-Public Health Imperative
Physician Self-Care
Relationships What Works For Physicians?
Physician Mental Health
Opening Pandora's Box of Professional Courtesy
What the AMA Youth Run Club Means to Me
Confronting Sexual Violence In Alberta

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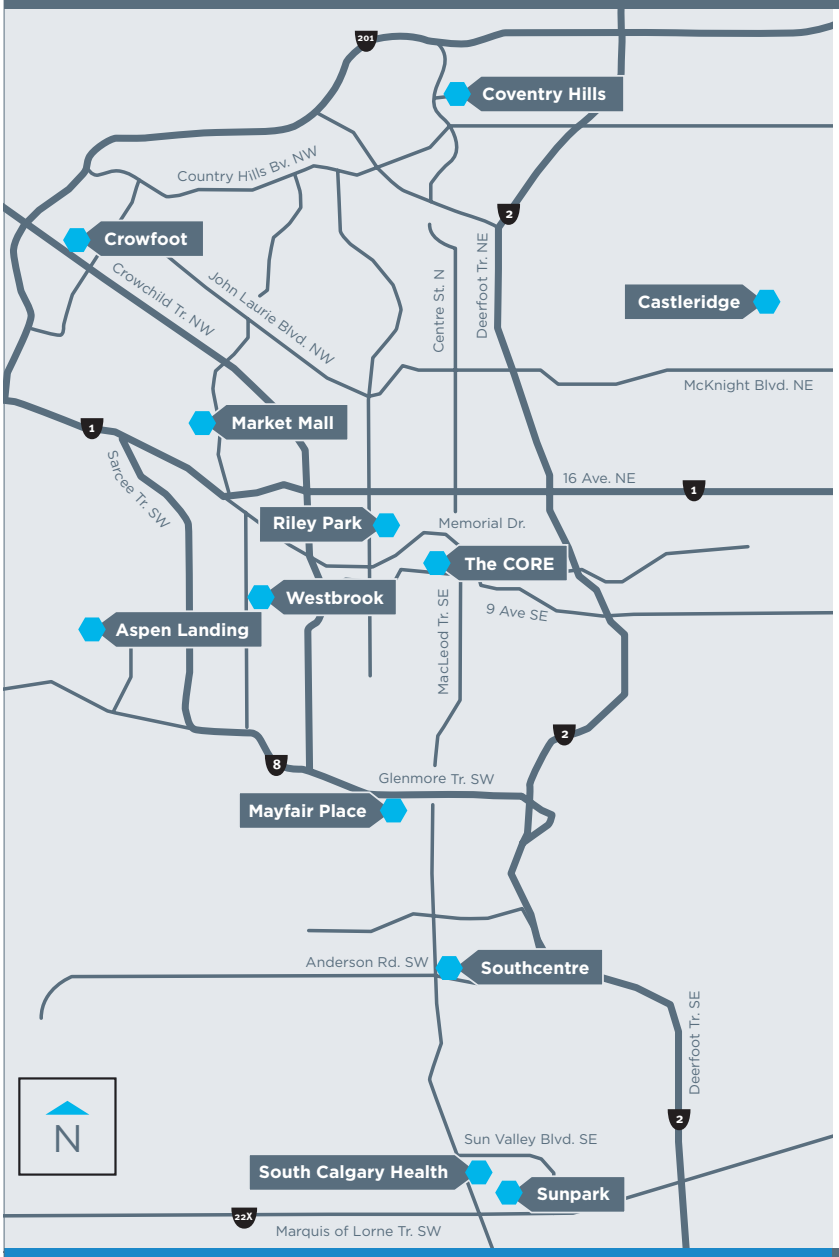

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Riley Park
110, 1402 - 8 Ave. NW

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VITAL SIGNS

A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

March 2017

CAMSS
CALGARY AND AREA MEDICAL STAFF SOCIETY

ADVOCATING
FOR PHYSICIANS,
CARING FOR PATIENTS

Calgary & Area Medical Staff Society (CAMSS)
350, 708-11 Avenue SW, Calgary, Alberta T2R 0E4

COORDINATOR: Adrienne Wanhill 403-205-2093

SUBMISSIONS:
Vital Signs welcomes submissions (articles, notices, letters to the editors, announcements, photos, etc.) from physicians in Alberta. Please limit articles to 1000 words or less.

Please send any contributions to: Spindrift Design Studio Inc. Hellmut Regehr, hregehr@studiospindrift.com

Vital Signs reserves the right to edit article submissions and letters to the editor.

The deadline for article submissions for the next issue of Vital Signs is March 17, 2017.

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Save the Dates!

CAMSS

Council Meeting
March 8, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

ZAF
April 12, 2017 | Southport Tower Rm 1003 – 5:30-8:30 pm

Council Meeting
May 10, 2017 | ACH Room 06 – 4th floor – 5:30-8:30 pm

CZMSA

Executive Meeting
March 9, 2017 | WebEx

Executive Meeting
April 13, 2017 | WebEx

ZAF
May 11, 2017 | Location TBD, 7:00-9:00 pm

EZMSA

General Meeting & Awards
March 16, 2017 | Ernest Restaurant, NAIT, 6:00-9:00 pm

ZAF
April 20, 2017 | Misericordia IN-106, 4:00-7:00 pm

Executive Meeting
May 18, 2017 | Misericordia, 5:00-5:30 pm

Council Meeting
May 18, 2017 | Misericordia IN-106, 5:30-7:00 pm

SZMSA

ZAF
May 1, 2017 | Location TBD, 6:30 pm

Vital Signs Subscriptions: Annual subscriptions to *Vital Signs* are available for $30.00; please contact info@albertazmsa.com for more information.

President's Message:

Optimizing Physician Health

Dr. Sharron L. Spicer, CAMSS President

Posted in our kitchen, like a signpost directing traffic, is the family calendar. On each day there is a row for every family member – even the dog has one – to list the day's occurrences: meetings, dentist appointments, sports events. One day, my daughter noticed a large heart sticker prominently pasted and proclaimed, "How sweet, you and Dad are planning a date!" "No," I replied, "that's the day Mittens is due for his next heartworm pill." That's how life is sometimes. We hyperschedule the minutia but sometimes fail to protect our most important investments – our loved ones.

For those of us in medicine, we are particularly susceptible to this fault. We're dutifully available to our patients and our colleagues, but what about our families? And do we allow ourselves to experience the full range of feelings — sadness, disappointment, dreams — that reflect who we are as human beings, not just as physicians?

On one hand, physicians are not unlike others in the workforce: we may face challenges related to inter-personal conflicts, poorly defined leadership roles and expectations, generational differences, financial constraints, changing social expectations, and others. On the other hand, some factors are unique to our profession: the complex unknown risks inherent in the biology of the "human condition;" being witness (or even contributing) to pain, suffering and death; conveying genuine empathy without crossing professional boundaries. Add to those stresses the competitive, high-achieving personalities that allow most of us to succeed in our academic pursuits, and you have set the scene for potential tensions.

We have probably all had moments of sober reflection, personally or with a colleague. A conversation over a hastily eaten cafeteria sandwich or a replay of events after a difficult case reveals feelings of frustration, a loss of purpose, disconnection from work, irritability and fatigue. Is this "normal"? Is it healthy? Is stress a badge of honour for working in a noble profession day in and day out? If you want a quick checklist for yourself of whether you might be in the danger zone for burnout, have a look at the Oldenburg Burnout Inventory *(https://web2.bma.org.uk/drs4drsburn.nsf/quest?OpenForm)*.

Most times, a conversation with a friend or partner can help us get through a difficult day. A laugh or a good movie can reset our emotional barometers. For some, an adrenaline rush induced by scaling a mountain can reinvigorate. Creative outlets such as art, writing or photography can inspire. Self-care may include spending time alone or with loved ones. But sometimes the needs go beyond the simple things.

How do we seek help or support a peer who is expressing a degree of burnout, marital discord, or even outright suicidality? Despite being healers ourselves, there is no shame in seeking professional resources when we need them. It is essential that physicians have a family doctor themselves, preferably someone who is not a colleague in the same office. Consider how comfortable (or not!) you would feel openly discussing your bowel habits, sexual history and substance use with the same person you negotiate the terms of your lease. And just as we shouldn't treat our own family members because of the inherent lack of objectivity, your office partner is likely to over- or under-investigate when you report new symptoms.

The Physician and Family Support Program (PFSP) of the (AMA) is a good place to turn when you need professional support; it can be accessed by telephone 24 hours per day, 7 days a week, at 1.877.767.4637 *(https://www.albertadoctors.org/services/pfsp)*. PFSP offers confidential, professional support for physicians, residents and medical students, and their immediate family members. Benefits are extended as part of membership in the AMA. Services may include advice, counselling, and assistance with finding other resources.

I think we are fortunate that the culture of medicine is shifting. Physician health is gaining attention, both academically and in our workplaces. I am pleased that this issue of Vital Signs highlights mental health. I hope you find it practical and informative. As always, your comments are welcome.

CAMSS President's Update

Many of you have replied with letters and phone calls in agreement with recent articles in Vital Signs cautioning against a hasty imposition of restrictions in physician billing numbers as a response to escalating health care costs. One such letter is included in this issue. Based on recent conversations, I have renewed confidence that the Physician Resource Planning Group (PRPG), comprised of members from Alberta Health, Alberta Health Services, the AMA, and other groups representing medical students, residents and international medical graduates, is carefully considering various options for managing costs and maintaining quality care. The zone medical staff associations will continue to follow the progress of the PRPG and will continue to advocate for solutions that address the needs of our communities and province.

A Physician-Public Health Imperative
Respond to Physician Mental Illness and Suicide

Dr. Dianne B. Maier

Editor's Note: *This article about physician mental illness and suicide was first published in 2008. Not surprisingly, mental illness, addictions and substance abuse, and suicide are still prevalent within the medical profession. We include this excerpt (with permission) as a reminder of the importance of our response to mental illness in our colleagues and ourselves.*

It was the early 1980s. As a young family physician, I had been sitting on the medical staff executive for only a few months. With no information provided, I recall being summoned, along with the rest of the executive, to the hospital administrator's office one day.

There had been an allegation that a surgeon was seen taking cocaine from a cart in the emergency room; he was to appear before all of us at high noon for an inquiry and with regard to a possible suspension.

He did not show. We discovered none of his family or local colleagues and friends had been notified to support him through these potentially devastating developments. We were dismissed but I received a call in my office later that day. The surgeon had been found on his rural property — he died by suicide.

I agree with authors Dr. Michael F. Myers and Carla Fine: "Suicide touches you and you are never the same. We know from experience."[1]

The account from Dr. Helen Tolhurst, an Australian family physician, may sound familiar: "I felt ashamed of my inability to cope and being unable to talk with my colleagues about the desperation I was feeling. My practice partners were overloaded with work and I felt that to tell them how miserable I was would just sound like whining. So I struggled with my depression, trying to hide how I was really feeling from those around me. Looking back, I sometimes wonder how I survived."[2]

Physicians Suffer Mental Illness, Too

One in five Canadians of all ages, education, income levels and cultures will experience a mental illness.[3]

Like other Canadians, physicians not uncommonly suffer from the gamut of mood and anxiety disorders, post-traumatic stress disorder, eating disorders, obsessive compulsive disorder, adjustment disorders and personality disorders. Issues within our marriages and our families may also impact our mental health.[4]

We know physicians experience depression as commonly as the general population. In cross-section, residents and medical students experience a higher level of depression than the general population.[5]

Substance-use disorders (e.g., alcohol) are as common with physicians as anyone else. Many physicians with substance-use disorders have concurrent mental illness.[4]

Mental illnesses have associated mortality. Four thousand Canadians are lost every year to suicide.[2] These Canadians include our patients, neighbors, loved ones and colleagues.

The 2004 *Journal of the American Medical Association (JAMA)* consensus statement on physician depression and suicide reports physicians having higher suicide rates as compared to the general population. The relative risk for male physicians is 1.1:3.4 and for female physicians 2.5:5.7.5 *Current Canadian statistics are unavailable.*

Two Questions:

What priority does Canadian culture put on mental illness prevention, early intervention and treatment?

What priority does our culture of medicine put on mental illness prevention, early intervention and treatment?

The best principles of public health are important for our medical culture to endorse and practise.[6] This is particularly important as we know that taking better care of ourselves and our colleagues translates into better care of our patients.

We Need to Give Up Our Self-Treatments

Physicians respond to their own mental illnesses in many ways. Many deny their illnesses. Others have anxiety or feel shame with regard to having a serious illness. Many struggle as they attempt to control their symptoms, their treatment or the lack thereof.

Physicians may fear the impact of such illnesses on their financial situation. Moreover, they may fear the risk to their professional standing, whether in the local hierarchy of their department, their academic centre or with the regulatory body.

Do we suffer in a more pronounced way because of the stigma towards mental illness in our medical culture?

Have you used vernacular language in describing patients or colleagues with a putative mental illness? Do we consider the impact of our thoughtlessness and expression of stigma on our patients, our families or our colleagues?

A psychiatrist who regularly treats physicians suffering with depression commented, "The hard-ass attitudes of some specialties and departments certainly do not make it easy for people to seek help."[7]

Would you be able to consider a mental health issue in a colleague? You might be aware that your colleague has uncharacteristically displayed the following:

- Decreased job performance or impairment
- Increased absenteeism

– continued on page 4

– *continued from page 3*

As a medical community, we must encourage each other to overcome our "physician character" to seek help and treatment early. Treatment is as effective for us as the general population.

- Withdrawn
- Irritable, argumentative
- Decreased care in appearance
- Increase/change in physical complaints

Remember, with mental illness, as with substance use disorders, work is often the last to go.

Physicians are at risk for suicide for a variety of factors that may include:

- Mood disorders
- Substance-use disorders
- Long hours and decreased social supports
- Excessive work/life harmony conflicts
- Losses personally, professionally or financially
- Career dissatisfaction, administrative problems, excessive professional demands
- Greater familiarity and access to drugs (a specific risk)[8]

Dr. Myers describes the deadly triad of physician suicide risk as:

- Unrecognized, untreated or under-treated psychiatric illness
- Suicidal diathesis
  - » Impulsivity
  - » Aggression
  - » Agitation
  - » High anxiety
- Stigma in the patient and internally in the treating physician[8]

It is important to be able to recognize the warning signs of a person considering suicide. These signs might include the following:

- Threatening/talking of wanting to hurt or kill himself
- Looking for ways to kill himself by seeking access to firearms or available medications or drugs
- Talking/writing about death, dying or suicide, when these actions are out of the ordinary for the person
- Exhibiting one or more of the following signs:
  - » Hopelessness
  - » Rage
  - » Acting recklessly or engaging in risky activities
  - » Feeling trapped, like there is no way out
  - » Increased alcohol or drug use
  - » Withdrawing from family, friends and society
  - » Anxiety, agitation, unable to sleep or sleeping all the time
  - » Dramatic mood changes
  - » No reason for living; no purpose in life[1]

Choosing to help your colleagues by recognizing these signs and assisting them in getting help is as essential as CPR.

However, we may experience losses by suicide that we could not have predicted or perhaps happen subsequent to the ravages of what can be severe, chronic illnesses.

"Suicide is a death like no other. It is deliberate and chosen. Is it rational? Rarely. Desperate? Always. Ignited by internal pain, suffering and absence of hope? Almost always. And it always leaves behind a legacy of mystery and devastation."[1]

As colleagues, we may experience the gamut of feelings, individually and as a community, when a physician dies by suicide. We need to support our colleague's family and each other. We will grieve.

Dr. Myers fondly quotes Elie Wiesel: *"Memories, even painful memories, are all we have. In fact, they are the only thing we are. So we must take very good care of them."*[8]

As a medical community, we must encourage each other to overcome our "physician character" to seek help and treatment early. Treatment is as effective for us as the general population. This is sometimes surprising to physicians.

A physician with post-partum depression, treated with psychotherapy and an antidepressant, once remarked to me, "That antidepressant really works. All those years I prescribed it and I thought it was probably just a placebo effect."[9]

We need to give up on our always inadequate self-treatment. We can learn to appreciate the gift of a physician-physician-patient relationship and of being cared for. It is time to address the poor practice of "curb-side" consultations and treatment. Do you really want to be complicit in your colleague receiving suboptimal care?

We must fight the stigma of mental illness for our patients, our families and our colleagues. It is imperative that we work to eliminate consequences for physicians seeking treatment.

Confidential access to assistance, support and referral is available to Alberta physicians, residents, medical students and their immediate families by calling the Physician and Family Support Program (PFSP) at 1.877.767.4637.

Dianne B. Maier, MD, FRCPC
Past Program/Clinical Director, PFSP

REFERENCES

[1] Myers, M. and Fine, C. *Touched by Suicide: Hope and Healing After Loss*. Gotham Books/Penguin, September 2006.

[2] Tolhurst, H. "The black hole of depression: a personal perspective." Medical Journal of Australia, October 2004; 181(7): 404-5.

[3] Quick Facts: *Mental Illness and Addiction in Canada* (Booklet). Mood Disorders Society of Canada, May 2006.

[4] Myers, M. "Treatment of the mentally ill physician." Canadian *Journal of Psychiatry*, 1997; 42(6): Insert.

[5] Center, J.D. Davis, M. et al. "Confronting depression and suicide in physicians: A consensus statement." Journal of the American M edical Association, June 18, 2004; 289(23): 3161-66.

[6] Hendin, H., Reynolds, C. "Licensing and physician mental health: Problems and possibilities." *Journal of Medical Licensure and Discipline*, 2007; 93(2).

[7] Alberta psychiatrist participating in Physician and Family Support Program clinical network.

[8] Myers, M. *Physician suicide: Towards prevention* (Paper). Vancouver: Alberta Medical Association/Canadian Medical Association International Conference on Physician Health, October 2002.

[9] Anonymous – Alberta physician of courage

Letter

Dear Editor,

Dr. Spicer's message "Not What I Signed Up For" brought back memories of how I ended up practicing medicine in Alberta thirty years ago. I graduated from UBC Medical School in 1987 during the time when the BC government was restricting billing numbers. I was engaged to a classmate and there was a real concern once we finished training there might not be two available billing numbers in the same area. Instead, we chose to move to Alberta and began our Family Medicine residency at the FHH. Eventually this billing restriction was removed but by then we were established in Calgary and moving forward professionally. Neither of us ever moved back to BC.

Restricting billing numbers is a poor solution for controlling costs or managing underserviced areas. It could instead have young physicians looking outside of Alberta for opportunities to practice their profession.

Dr. Vicki Kendrick
Pediatrician, Alberta Children's Hospital
Cleft Palate Clinic
Vascular Birthmark Clinic

Note from the Editorial Committee

Vital Signs is produced by the Zone Medical Staff Associations (ZMSAs) of Alberta. Over the past two years, we have grown from a Calgary Zone publication to a provincial one, reaching across all Zones of AHS. Although ZMSAs are independent of AHS, we seek to have collaborative relationships in our shared work.

Our Editorial Advisory Committee has reps from multiple zones. We aim to cover events and issues of importance to all medical staff members across Alberta.

Our articles are submitted on a volunteer basis from medical staff like you. We value your contributions and can assist in the writing or editing process. Articles can be submitted through your ZMSA President or directly to **hregehr@studiospindrift.com**. *Vital Signs reserves the right to edit or decline articles.*

THE WELL-BEING OF THE RELATIONSHIP WITH YOURSELF

Physician Self-Care

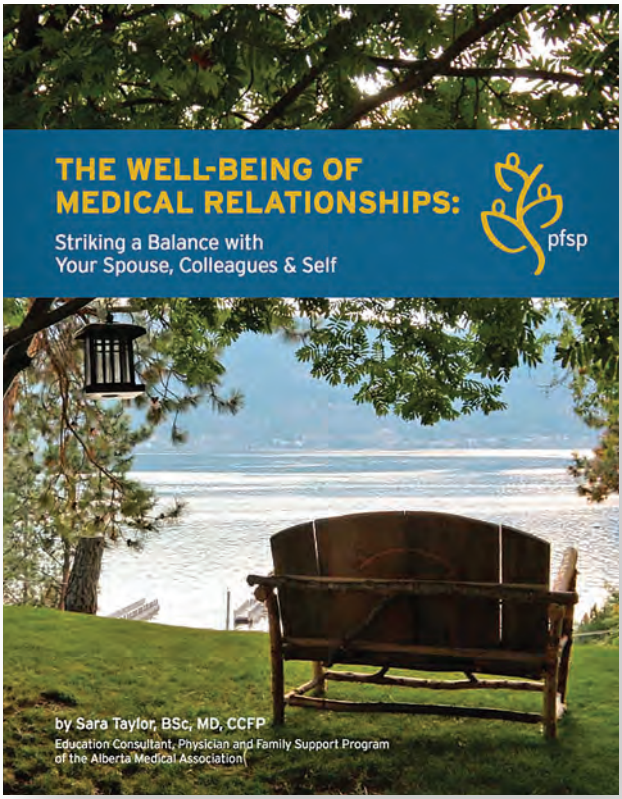
Dr. Sara Taylor

Editor's Note: *In the e-book "The Well-Being of Medical Relationships," Dr. Sara Taylor explores the nature of physicians' various relationships. In this first of a two-part series in Vital Signs, we have taken (with permission) excerpts from the chapter "The Well-Being of the Relationship with Yourself." Dr. Taylor discusses the concept of physician wellness, including the risks and protective factors for physician burn-out, the importance of self-care, and some cognitive and behavioural strategies to enhance well-being. We encourage you to read the entire e-book available at https://www.albertadoctors.org/services/pfsp/pfsp-ebook.*

What is Wellness?

The term "wellness" is used commonly, with a variety of meanings. In fact, it's difficult to find a universally accepted definition of wellness. From my perspective as a physician, wellness refers to your personal state of well-being, where all components of your wellness are optimized. Many schematics exist that demonstrate the dimensions of wellness; however, it is difficult to use distinct categories to define a concept that blends into one.

What makes wellness different from health is that we have more control over our wellness than we do over our health. For instance, despite an adverse health state such as cancer, we can still strive to enhance our well-being through strategies to improve our nutritional, physical, emotional and social wellness.



Physician Wellness

What makes physician wellness unique? For one, as caring, healing professionals, we often overlook our own wellness needs. In the article *Physician Well Being and Quality of Patient Care: An Exploratory Study of the Missing Link*, Wallace & Lemaire identify two broad themes that deter physicians from caring for themselves:

1. **The culture of medicine** – physicians view themselves as invincible caregivers who must look after others first; they cannot be vulnerable and take time for themselves.
2. **Overwhelming workload** – prevents physicians from thinking about their own wellness.

They cite a study that found that the majority of physicians worked when they were sick and the few who took time off felt guilty. Another study cited found that physicians feel compelled to appear well because they believe their health is viewed as a reflection of their medical competence. The study concluded that physicians, peers, patients, employers and the health care system need to support physicians to maintain their own well-being.

Physician Wellness: The Layers of Skin

Another way to view physician wellness is by using the three layers of the skin as an analogy:

1. Epidermis: What physicians allow us to see

The culture of medicine promotes the image of physicians as all-knowing healers who possess exemplary diagnostic skills and are incapable of making mistakes. These ideals lead to physicians striving to uphold this image in one of the oldest, most noble professions. Concern arises when this layer does not connect to the deeper layers of the physician, represented by the dermis and hypodermis.

2. Dermis: Factors contributing to a physician's well-being

We are all humans, born to humans, with our own unique needs and desires beyond those that serve as basic functions. This layer represents the factors that contribute to physician wellness: emotional (mood, anxiety), social (relationships), physical (health, activity), nutritional (diet) along with other factors such as sleep, self-esteem, spirituality, hobbies, creativity, finances and family of origin.

3. Hypodermis: What is vital to sustaining physician health
The top two layers cannot be sustained without the deepest layer, which is essential to a life of meaning and purpose. These vital aspects include attributes and practices such as resilience, self-awareness, gratitude, compassion, empathy and mindfulness. This layer can be continually developed in order to protect the other two layers, thereby buffering stressors and enhancing physician wellness.

Physician Burnout

"Burnout is a syndrome of emotional exhaustion, loss of meaning in work, feelings of ineffectiveness, and a tendency to view people as objects rather than human beings." ~ **Shanafelt et al. – Mayo Clinic Proc (2015)**

Continuing with the skin analogy, at times accumulating stressors make it difficult for the deeper layers of a physician's skin to uphold the superficial layer, leading to symptoms of burnout.

Unfortunately, burnout symptoms affect up to a staggering 75% of physicians. In a study by Shanafelt et al., they cite that burnout is more common among physicians than among other United States workers, with front line physicians (Family Medicine, Internal Medicine and Emergency Medicine) being at the highest risk.

In fact, job burnout/chronic work stress is a universal theme that does not limit itself to socioeconomic status, gender, age or place of work. Although its impact can vary from person-to-person, it tends to result in significant physical and emotional stress on both the individual suffering from job burnout and the people closest to them.

Other health concerns that arise with chronic work stress include headaches, mood disturbances, musculoskeletal disorders, gastro-intestinal symptoms, workplace injuries, etc.

Some of the reasons for increased symptoms of burnout in physicians include:

- The complexity of medicine
- Lack of control
- Doctors often use denial and avoidance as ineffective coping styles
- Physicians work in emotionally charged situations associated with suffering, fear and death
- Excessive cognitive demands

Do I Have Symptoms of Burnout?

You may be interested in assessing your level of work stress and potential warning signs of burnout. A Tel Aviv University study led by Anne Fisher posed these five questions (slightly modified for our purposes), asking participants to answer with never, sometimes, often, or always:

1. How often are you tired and lacking energy to go to work in the morning?
2. How often do you feel physically drained, as if your batteries were dead?
3. How often is your thinking process sluggish or your concentration impaired?
4. How often do you struggle to think over complex problems at work?
5. How often do you feel emotionally detached from colleagues or patients and unable to respond to their needs?

If you responded to two or more questions with "often" or "always," you may want to consider it a warning sign and take action to reduce the impact of stress and ultimately burnout related to your career as a physician.

Creating a Culture of Self-Care for Physicians

In an informative study by Wallace and Lemaire (2009), the authors explored physician's awareness of the relationship between their well-being and patient care. Interestingly, their review of the literature highlighted some points about physician's self-care:

- Physicians are less likely to seek medical care for themselves and have a higher than average suicide rate.
- Physicians often use denial as an ineffective coping strategy.
- Physicians often do not turn to their colleagues for support.
- Physicians may be reluctant to seek help for fear it may be an indication of their inability to do their job.

Wallace and Lemaire concluded that within the culture of medicine, physicians are regarded as "super humans" and they must look after others before themselves. In addition, the excessive workload contributes to their perception that they do not have time for self-care.

What Can Be Done to Enhance Physicians' Perception of Self-Care?

Some effective strategies to improve well-being include:

- Introduce the importance of physician wellness in medical school and residency as part of the curriculum.
- Organize retreats for students and residents where they can connect with one another in a relaxing environment, introducing stress management and personal development topics.
- Introduce non-medically focused opportunities for physicians to connect during their career, such as conferences, retreats and "lunch and learn" sessions on mindfulness, meditation and gratitude.
- Provide online tools, workbooks and resources for physicians that offer realistic ways to modify their work-life balance.
- Include physician's families in activities and events involving self-care and well-being.
- Provide an area within a group practice, hospital or community health centre where yoga/fitness/ meditation classes can be held.

REFERENCES

Fisher, Anne. "Your Job Might Be Killing You". Fortune, 2 April 2013. Online. (http://fortune.com/2013/04/02/your-job-might-be-killing-you/

Shanafelt, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Archives of Internal Medicine. (2012) 172(18):1377-85. http://archinte.jamanetwork.com/article.aspx?articleid=1351351

Wallace, J.E. & Lemaire, J. (October 2009). Physician well being and quality of patient care: An exploratory study of the missing link. Psychology, Health & Medicine, 14(5), 545-552. http://www.saratmd.com/wp-content/uploads/2015/06/Wallace-Article-2.pdf

Wallace, J.E., Lemaire, J.B. and Ghali, W.A. Physician wellness: A missing quality indicator. Lancet. (2009) 374:1714-21. https://soci.ucalgary.ca/sites/soci.ucalgary.ca/files/Wallace_in_Lancet.pdf

(A full list of references and resources can be found in the e-book.)

In our next issue of Vital Signs, we will highlight four pillars of physician wellness, including practical tips for enhancing resilience, mindfulness, gratitude and creativity.

Relationships

What Works For Physicians?

Dr. Monica Hill

What Do We Know About What Works Well in Personal Relationships?

- What challenges does our marriage face if one of us is a physician or both are?
- What can I do to increase the chance my partner will care and listen to what I'm saying?
- Is it important to be influenced by his or her opinion? What about when we disagree?
- What can we do to feel more of the fondness that brought us together in the first place?

There is a lot known now about relationships that are working well, thanks largely to the research of Dr. John M. Gottman and his many colleagues.

For more than 30 years they have examined couples and learned much about constructive conflict, what nurtures a couple's connection, and how they find a shared purpose through the years.

A grand overview of these areas follows and I invite you to explore them through the resources provided.[1-6]

Drs. Wayne and Mary Sotile are psychologists who have spent their careers working with physicians and increasing an understanding of what is challenging in physicians' personal relationships. Their book, *The Medical Marriage*, is practical and valuable.[7]

Conflict

"Can't live with you, can't live without you." Not "you," your partner, but, "you," conflict. According to Dr. Gottman's findings, the following would be a more accurate summary regarding conflict: "We've gotta live with you so let's make it the best possible."[1]

Every relationship over time will have conflict. Research tells us only 31% of our conflicts are solvable. This leaves 69% as ongoing areas of disagreement.

It seems with whomever we make a match, we will need to live with our differences, which are at the heart of these chronic conflicts. The first step to living with them is recognizing our differences in personality, some values and needs. We can expect these differences to endure.

Having a constructive way to talk about them, when they cause conflict, is how thriving couples cope. If we can "be on the same team" when we approach these issues and "yield to win," our relationship can be victorious in defeating the differences that could pull us apart.[1]

As for the solvable problems, there are specific skills that work to get past them.

- Being able to deliver a message in a way that increases the chance your partner can hear it and care about it. Sticking to speaking up for yourself using "I" statements is one of the best ways to avoid blaming, which will turn off your partner.

"When I see/hear this, I feel this and I need this." A gentle delivery is one of the most important communication skills practised by couples who are doing well.[1-4, 5]

Research backs this up in an astonishing finding. The tone of the first three minutes of the conversation predicts accurately the outcome of the conversation, as well as the likelihood of the couple remaining together happily.[1]

- The next skill starts with an attitude — the belief that my partner has a right to be influential in our relationship. This means his or her opinions, feelings and needs are important and deserve attention and consideration.

This is really an attitude of respect. This is not a requirement to agree with, or even experience the same feelings or needs, but to hear him or her out and accept him or her, even while we disagree (gently!).

Dr. Gottmann's resources provide important information about these and other ways to make conflict constructive.[1-6]

Friendship

Remember when you met your loved one? Typically, when we meet, we cannot get enough of each other. We invest energy to spend time together, we are curious about each other, we look for ways to have fun together.

As the years pass and the responsibilities and to-do list lengthens, we do not invest in our relationship in the same way. We can become strangers if we do not keep updated on who our partner is.

The key to knowing your partner is asking open-ended questions. Who and what's important to you at this point in life? What are you excited about? What are your worries?[5]

For most couples, especially if they have children and both work outside the home, much of their opportunity to connect will be in day-to-day life.

Finding ways to spend time together that fits with the weekly routine is key. Many couples find time to talk by sharing the homework, dishes, home and yard maintenance, and child-care responsibilities.

Going out as a couple can seem intimidating if out-of-touch. But finding ways to get out and relax or have fun together, as a twosome, is one of the best opportunities to nurture the friendship.

Creating Shared Meaning

What dreams do you share? What do you or your partner want to accomplish before you die? What is most important to you, as a couple, to teach your children? What would you like to be known for as a couple?

These are the kinds of issues thriving couples know about each other and work towards. So how does this apply to a relationship when one or both people are physicians?

As a married physician myself, and as a couples therapist, I find this material applicable to physicians in the same way as non-physicians.

We can best apply this to our own lives by asking ourselves questions like:

- Can we disagree agreeably?
- Do I speak to my partner or spouse with the same kindness and respect I offer colleagues?
- Do I speak up clearly but gently from my perspective or am I quick to point the finger at my spouse?
- Am I willing to share power in this relationship or do I prefer to "give orders" as I do at work?
- Am I truly open to my partner's point of view and preferences?
- Are we both aware of our differences and willing to accept them, figuring out a way to live alongside them in a win-win way?
- What do I know about what is going on in my partner's life and how he or she feels about it?
- When did we last go out as a couple and spend time relaxing or doing something we found fun?
- Do my partner and I share hopes and dreams for the future and what are they?
- How do I make sure I have time and energy for our relationship?

Calls regarding intimate relationships are among the most common reasons people contact the Alberta Medical Association's Physician and Family Support Program (PFSP).

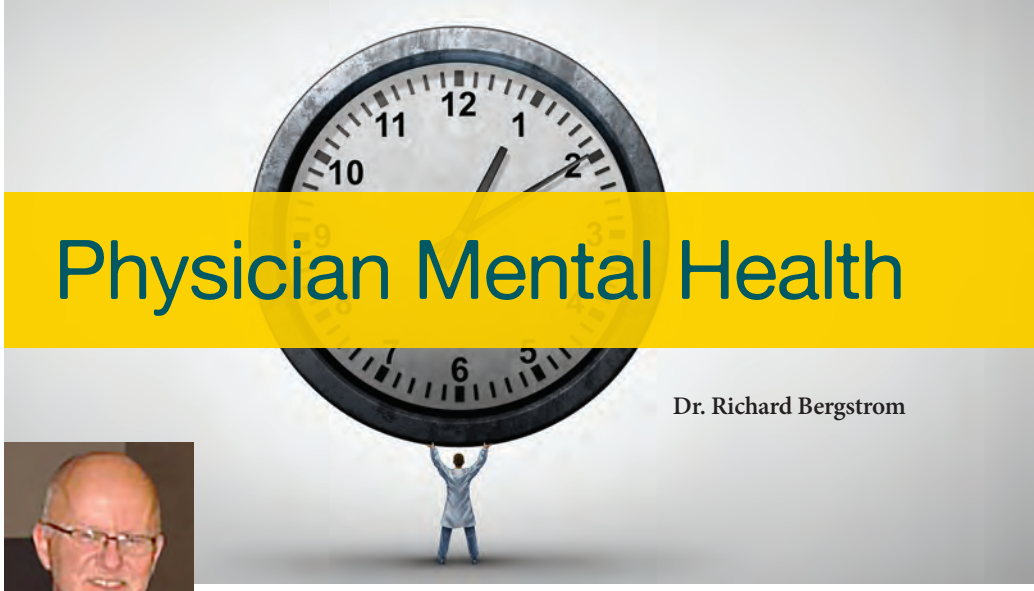
Although there are no perfect people or relationships, we are here for you, to help you have comfortable and satisfying relationships with whom you choose to spend your life.

Monica Hill, MD
PFSP Assessment Physician

Excerpted from March/April 2011 Alberta Doctors' Digest, updated for Vital Signs magazine.

FOOTNOTES

[1] Gottman, J. The Marriage Clinic, 1999. W.W. Norton & Company, New York.
[2] Gottman, J. Silver, N. The Seven Principles for Making Marriage Work, 1999. Three Rivers Press, New York.
[3] Gottman, J. Schwartz Gottman, J. De Claire, J. 10 Lessons to Transform Your Marriage, 2006. Three Rivers Press, New York.
[4] Gottman, J. De Claire, J. The Relationship Cure: A 5 Step Guide to Strengthening Your Marriage, Family and Friendships, 2001. Three Rivers Press, New York.
[5] Level II Training Manual (Gottman Method). Assessment, Intervention & Co-Morbidities.
[6] www.gottman.com
[7] Sotile, W. Sotile, M.A. The Medical Marriage: Sustaining Healthy Relationships for Physicians and Their Families, 2000. American Medical Association.



Physician Mental Health

Dr. Richard Bergstrom

Dr. Richard Bergstrom

I do believe in the "basic truths" which have been spoken by true "world change agents." People such as Mohandas Gandhi, Nelson Mandela, Martin Luther King Jr., The Dali Lama have all spoken truths that have echoed individuals from the past, both religious and secular. They coalesce, to me at least, in variations of the Golden Rule; do unto others as you would have done unto yourself. You can morph that into "Be the change you want to see" and other's comments that speak to how we can work to be better individuals who make our world a better place to live.

As physicians, we are held in high regard. Either that or vilified. If we look at the "held in high regard" part, what we say, what we do, how we act and, even more important, how we react is observed by others and often mimicked or mimed. I think back to the days when I was in Medical School. The personal abuse thrown out to students was just awful. It was not all abuse and derision, yet, there was enough that you were reminded that you were on the bottom of the Totem Pole. That meant that you did not challenge authority, or any one above you in the food change. I was witness to public embarrassment/shaming having not known some obscure fact, watching my colleague's work picked at for the sake of finding wrong. I enjoyed my medical school, I really did. Yet, when I look back I had some terrible role models. For the bullies could bully all they wanted and no one ever did anything about it. You suffered in silence.

To be honest, I had a great number of excellent role models in my early years. I would be completely remiss if I only spoke of the unpleasant and unnecessary derision. I am constantly reminded of Dr. Lorne Tyrrell, one of the most inspiring physicians and leaders I have had the great opportunity to meet. Our current Dean, Dr. Fedoruk, inspires me as he has married his work as a clinician and a researcher so well.

So, Bergstrom, how does this relate to physician mental health? Look at the current President of the United States, Donald Trump. For me, he is not inspiring. More importantly, look at what he does and what he says. What I see in his actions are those of a bully and someone who does not inspire us to take the high road…unless you can make a lot of money there! His characterization of a disabled reporter (Serge Kovaleski), from my viewing and that of many others, was demeaning and disrespectful. I know that many laughed at his characterization of someone who is disabled; how non-inspirational is that.

Now to tie this together. When we come upon someone bleeding we have a reflex to help. Certainly there is a great swell of interest and activity in the OR when someone comes in hemorrhaging. Yet, as I have often said, do we have this reaction when we see someone with delirium? I have not seen that visceral reaction to the same degree. Yet, both can lead to significant morbidity and, yes, death. When we hear of a colleague with cancer, we are moved and there is an outpouring of sympathy and empathy. When a medical colleague has surgery, I have seen two sides to this. One is the tabloid side….What do they have?….Is it serious?….How did they get this?….It is the seeking of the sensational.

I think that mental health is an area where we have yet to make great strides as a community of physicians in recognizing that it is an "illness" not a "weakness."

A common, human reaction. The second, learned reaction, for me, is to say "This is confidential," "I am not here to pry," "How can I help?," "What do you need me to do?," and the most important, "I can keep this confidential." Then the hard part is when someone asks you about it you simply say that I cannot speak about it as it is confidential.

Mental health has stigmata. You can get cancer…many of us will. You can be in an accident, you can need care that you would not want to share with anyone on the street. For some, privacy and confidentiality is so very important. For others, they have few qualms speaking of their cancer and treatments. It is all so very personal. Mental health has acquired an aura that is not seen with many other diseases.

I think that mental health is an area where we have yet to make great strides as a community of physicians in recognizing that it is an "illness" not a "weakness." You are still a human being, as those with diabetes, cystic fibrosis, rheumatoid arthritis, ankylosing spondylitis and many others chronic diseases. As an anesthesiologist, I cannot speak with authority to the etiology and acute/chronicity of mental health issues. I can say that being involved with ECT, I have come to see many patients many times and some of the patients having maintenance ECT say they are alive and well because of this. It is so rewarding to see them progress and maintain health.

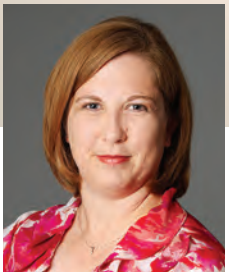
Mental health needs the same respect as does coronary artery disease in my world. Do we blame people for having coronary artery disease? We will speak to factors affecting it and strongly advise and advocate for changes that are needed. Ok, we do vilify some patients who seem to have not grasped the seriousness of their condition. Yet, does that help them and does that help us as doctors? We can and should speak clearly and strongly for care and change for better care.

Can you imagine how utterly awful it would be to think that you needed to kill yourself as the only release for your suffering? People do it and think it is their only way out. I have had the experience of a number of colleagues kill themselves over the years. Did I see this coming? Absolutely not. Could I have seen this coming? I am not sure. Yet, did I create an atmosphere where someone could come up to me and tell me they had a problem? I am not sure I did, at least not enough. I would speak to us as a profession acknowledging the fact that we all can and do get sick. We are great as physicians but usual wrecks as patients. We need to treat diseases as diseases, not as societal stratification. And we need to know we are all human, with all the great potential we have and the fragility that exists in the human frame.

Richard Bergstrom, MD
Department of Anesthesiology, University of Alberta.

Opening Pandora's Box of Professional Courtesy

Dr. Sharron Spicer



Dr. Sharron Spicer

It started innocently enough — the question was asked by one of our zone medical staff association (ZMSA) Presidents how to support a colleague when we become aware of a physician in distress, particularly if the physician is facing a disciplinary matter. You see, it is not unusual for the ZMSA to be called upon to give support when a practitioner is facing an investigation. In fact, through the Practitioner Advocacy Assistance Line (PAAL), physicians can access their ZMSA President in confidence to discuss concerns. Sometimes we become concerned by the physician's level of distress and want to link them with professional counselling or medical resources to help. The Physician and Family Support Program (PFSP) is well-known to physicians across the province for their support to physicians and families through linkages to short-term counselling or other services. The short answer was that anyone with concerns can phone the PFSP line, but the person in distress needs to make the call to PFSP in order to access the services. As you might suspect, the conversation drifted to other elements of accessing medical services for distressed or ill physicians, specifically whether requesting a consultation from a specialist apart from the regular queue would contravene the policies of Alberta Health Services (AHS) or the College of Physicians and Surgeons of Alberta (CPSA) specifically developed after the Health Services Preferential Access Inquiry *(https://www.assembly.ab.ca/pub/PDF/HealthServicesPreferentialAccess_Inquiry_Volume1.pdf).*

I'm sure there are people much better-informed than I who could navigate the terrain of professional courtesy guidelines. But from my vantage point, it is hard to know what to do. Put colloquially by Dr. Michael Giuffre, Past President of the AMA, "Getting to the heart of preferential access is somewhat like nailing Jell-O to the wall" *(https://www.albertadoctors.org/services/media-publications/presidents-letter/pl-archive/august-28-2013-pl).*

Take, if you will, a physician-patient in your practice who has mental health issues severe enough to limit their ability to continue their work. You deem them ill enough to warrant psychiatric evaluation. You understand the barriers that exist for the physician to access mental health care in the usual ways: long delays, issues of privacy where one is "known" to other patients and to the providers, and potential implications on their medical practice may deter some doctors from seeking care appropriately. You want to ease their way into the mental health system by facilitating an urgent referral. Do you request preferential access? Or, if you are a psychiatrist receiving a referral from a family doctor for an urgent consultation for a physician, do you offer an early appointment time on the basis of professional courtesy?

The question of preferential access is not limited to mental health, but to all specialties. Is there an advantage to society to maintain the health of physicians through expedited consultations, as long as other patients are not displaced?

There are certainly arguments on both sides, some of which are summarized in the Inquiry report. Perhaps if we facilitate expedited access for services to our physician colleagues, we can maintain or increase their ability, and in turn the system's capacity, to provide care to other patients. On the other hand, it would be inappropriate to offer preferred services based on occupation (and attached social positioning).

It turns out the answers are not readily apparent even from our professional bodies. In its "Advice to the Profession" documents *(http://www.cpsa.ca/wp-content/uploads/2017/01/AP_Professional-Courtesy.pdf?x91570)* published earlier this year, the CPSA defines professional courtesy as "when a regulated member gives priority to requests for care or treatment by other healthcare professionals, or the families, friend or contacts of those professionals. It becomes *improper* preferential access when the regulated member cannot medically or ethically justify prioritizing these types of requests ahead of other patients similarly situated" (emphasis mine). The guideline does not specifically prohibit preferential access on the basis of professional courtesy, as long as it does not displace other patients, but further advises that these professional courtesies occur only outside of normal working hours. AHS is more directive: "AHS personnel are not authorized to request or to accept a request for preferential access to publicly-funded health services within facilities and programs managed by AHS" *(https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-apa-policy-1167.pdf).* As yet, I am not certain I understand the final interpretation of the issue for AHS- or non-AHS-affiliated programs, but I will let you know as I hear. Let's hear from you as well. Send your opinions to Vital Signs at hregehr@studiospindrift.com.

Sharron Spicer, MD, FRCPC
President, Calgary and Area Medical Staff Society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What the AMA Youth Run Club Means to Me

Dr. Kim Kelly

Dr. Kim Kelly running with her son Alex

Climbing up the stairs today at my work, the Opioid Dependency Clinic, I noticed a "Ways to Wellness" poster. It shows cute graphics enlightening the reader that the ways to wellness are to be kind, be yourself, practice gratitude, get active, eat healthy foods, get your groove on, and laugh. I immediately made the connection that my involvement with an AMA Youth Run Club supports all of these suggestions.

By being involved as an assistant coach with our elementary school's run club, I was able to encourage kids to get active while also getting active myself. Positive role modeling is powerful. As a mom, I have had much better results when I enthusiastically say to my sons, "Get ready! We're going for a walk." versus "Boys — go for a walk. You are driving me crazy!"

I quickly learned in my assistant coach job that there were no special requirements. I simply needed to be myself. The kids expected very little and appreciated another adult's involvement. Relationships naturally grew over time and laughs became a frequent occurrence. It was heartening when a 9 year old boy remarked, "This is my first time running since I got my puffers. I was afraid of having an asthma attack but I knew I'd be okay because you're here. You know how to work these puffers, right?"

A personal highlight was spontaneously dancing with a few students in the gym before our runs when music wafted in from other events occurring simultaneously in the school. We definitely got our groove on and I thoroughly appreciated my elevated dopamine levels.

I always left the school with a huge smile and a sense of gratitude. Gratitude for being able to support a school through my actions and knowledge, gratitude for our hard working educators who have been promoting health for decades, and gratitude for sharing the kids' energy and curiosity. They thought it was "cool" to have a doctor around and I enjoyed answering their questions like how many bones are in our bodies, how to get into medical school, and what do I like about being a doctor. I found that spending time with students and staff was a refreshing and invigorating experience. It also made it easier to cope with the ongoing health system challenges and occasional frustrations that we all face.

One important lesson I've learned by being part of my school community is that activity is not controversial. What I mean by this is that stakeholders do not argue against initiatives that increase activity for kids. Increased exercise is a "no-brainer," but disappointingly many stakeholders are prepared to passionately argue against healthy nutrition. This includes parents, students, school councils, teachers, principals, community members and school boards. I was shocked with this discovery, but have realized that really our society does not support healthy nutrition. If we look at our current environment, we have a donut kiosk within 10 metres of the front entrance of our hospital, we have convenience stores within 500 metres of 80% of our schools in Calgary and Edmonton, and we sell fast food at the majority of our recreation centres only steps away from where we swim, run and work out. This in part explains why 60% of Canadian adults and 26% of Canadian children and youth are considered overweight.

The good news is that the AMA Youth Run Club is an initiative that gets physicians and medical students "in the door" to start conversations. It allows us to be health advocates and influence the development of healthy behaviours in children and youth that could last a lifetime. Physicians have an important role to play in the Comprehensive School Health movement which is leading the way in creating healthy school communities.

As physicians, we are keen to diagnose and solve problems. In 2012, I was eager to "solve" the problem of childhood obesity. I quickly learned from evidence and from wise partners that childhood obesity is a complex societal problem and can not be solved by a silver bullet. Food and home insecurity, addiction, trauma, decreased physical activity, increased screen time, lack of city infrastructure supporting active transport, and decreased financial resources to the education sector are a few factors that directly and indirectly influence the development of childhood obesity. The AMA Youth Run Club is an initiative that helps address a complex societal problem.

The AMA Youth Run Club is a successful collaborative initiative between the health and education sectors that has improved Alberta students' physical and mental health. Student participation in the AMA YRC has steadily increased from 6,000 to 22,000 in just three years. From the onset, sustainability was a priority and a recent partnership with Blue Cross supports this goal. The AMA YRC is a fun, inclusive, low cost, wellness initiative targeting improved long term health outcomes for children. It also helps kids build relationships, and increases their sense of belonging and connectedness, which are all very important outcomes when measuring kids' success.

We know that healthy students are better learners. If we connect health and educational outcomes both sectors benefit, and so does society. With your involvement, you stand (or run) to benefit too!

Dr. Kim Kelly
Edmonton Family Physician, Special Interests in Comprehensive School Health and Addiction Medicine

Makes me feel

(Comments from YRC members, Mee-Yah-Noh School, Edmonton)

… "healthier and happier." (grade 4)

… "more less stressed." (grade 6)

… "welcome and needed." (grade 6)

Favorite thing

(Comments from YRC members, Mee-Yah-Noh School, Edmonton)

"I feel that running club is my family." (grade 6)

My favorite part of run club is "running with my friends." (grade 6)

My least favorite part is "that it's only once a week." (grade 6)

YOUTH RUN CLUB

Survey says … healthy students are better learners

AMA Youth Run Club supports physician health advocacy in schools

Evidence shows that active children are physically, mentally and socially healthier and happier, and they're also better learners.

The AMA is proud to partner with Ever Active Schools on the AMA Youth Run Club, a school-based program that through organized activities (running, walking, hiking, snowshoeing and more) and *School Health Advocacy Talks* helps children and youth develop lifelong, healthy habits.

How can you get involved with the AMA Youth Run Club?

Be an AMA YRC CHAMPion! Run with or help coach a club, help school staff set up and manage a YRC, or give a *School Health Advocacy Talk* (talking points for seven suggested topics are available on *albertadoctors.org/YRC*).

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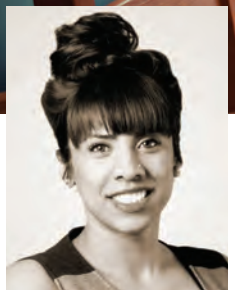
Confronting Sexual Violence In Alberta

Dr. Rabiya Jalil



Dr. Rabiya Jalil

As medicine evolves, treatments advance, disease awareness improves and education disseminates, many medical statistics are shifting at a staggering rate. The rates of sexual assault in Canada have, however, unfortunately been increasing since 2009, with actual disclosure and reporting only representing a fraction of that number. (It is estimated that up to 97% of sexual assaults are not reported to police.)

Despite a decrease among reported violent crimes, sexual assault is one of the few offenses that has shown an increase of 5%. According to extrapolated data from the recent Canadian General Social Survey, approximately 7,000 sexual assaults occur per month in Alberta (to persons over age 15.) The Calgary Sexual Assault Response Team saw a 25% increase in sexual assault cases in 2016 as compared to the previous year.

Studies indicate that victims of assault are more likely to be from marginalized communities that often have less access to health care. Racism, poverty and inequality are all factors which increase vulnerability to assault.

Sexual violence has often not received the same attention in the medical community as other causes with more extensive awareness and education campaigns. Sexual assault is a social issue, a community issue, a legal issue, and a medical issue. Considering that nearly 40% of Canadian women and 10-20% of Canadian men have experienced sexual assault, and considering the estimated annual cost of nearly 2 billion dollars nationally, this matter requires dedicated attention from the medical community.

A victim's first point of contact is often with health care, either in an emergency room setting or with their primary care provider. Many treating physicians find themselves ill equipped for the assessment and management of initial sexual assault presentations. Patients are especially vulnerable when they present, and the risk of re-traumatization is significant. It is essential that physicians are well-educated so they may better assess, treat, educate, and advocate for victims of assault.

On February 11th, 2017 the Cumming School of Medicine hosted the inaugural Alberta Sexual Assault Course and Conference (ASACC.) It was the first education program of its kind in Alberta. It covered a range of topics from sexual assault examination, to gaps in consent education. Presenters included Sheldon Kennedy, founder of the Sheldon Kennedy Child Advocacy Center and former NHL player, as well as Karen B.K. Chan, a sex and emotional literacy educator and "Service Provider of the Year" for Toronto's Planned Parenthood. Physicians and health care providers attended from communities across the province and out of the province.

It is our hope that ASACC will improve sexual assault care across the province. It will be a valuable resource to assist physicians and health care providers in their approach to disclosure, assessment, management and advocacy of sexual assault patients.

For anyone needing help, Connect Family and Sexual Abuse Network provides 24-hour support. For sexual abuse concerns and questions call 1-877-237-5888 and for domestic abuse concerns and questions call 1-866-606-7233. The Alberta Association of Sexual Assault Services can also provide information on local resources available to patients and practitioners. This information can be found on their website at *https://aasas.ca/get-help/*

#I Believe You

Dr. Rabiya Jalil, BSc, MD, CCFP
ASACC Founder & Course Chair

Susana Escobedo, Rabiya Jalil, Sheldon Kennedy, Linda Shorting

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