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VITAL SIGNS

OCTOBER 2019

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A CALGARY & AREA MEDICAL STAFF SOCIETY PUBLICATION

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PRODUCTION COORDINATOR: Hellmut Regehr, hregehr@studiospindrift.com

GRAPHIC DESIGNER: Leona Regehr, lregehr@studiospindrift.com

STAFF EDITOR & WRITER: Shauna McGinn, mcginnshauna@gmail.com

Zone Medical Staff Associations
Mailing Address:
350-611 Meredith Road NE, Calgary, AB T2E 2W5
Reception:
Suite #310, 611 Meredith Road NE, Calgary, AB T2E 2W5

SUBMISSIONS:
Vital Signs welcomes submissionsfrom physicians in Alberta. Please limit articles to 1,500 words or less.

Please send any contributions to: Dr. Scott Beach, Medical Editor, zmsaadmin@albertadoctors.org

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 Friday, October 25th.

CONTRIBUTORS:
The opinions expressed in Vital Signs do not necessarily reflect the opinions or positions of CAMSS or CAMSS executive.

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CONTENTS:

SAVE THE DATES!

CAMSS

Council Meeting: October 9, 2019 | Meredith Block – Boardroom 347, 5:30-7:30 pm

AGM: November 13, 2019 | Fort Calgary, 5:30-7:30 pm

CZMSA

Executive Meeting: November 21, 2019 | WebEx, 7:00-8:30 pm

Executive Meeting: December 19, 2019 | WebEx, 7:00-8:30 pm

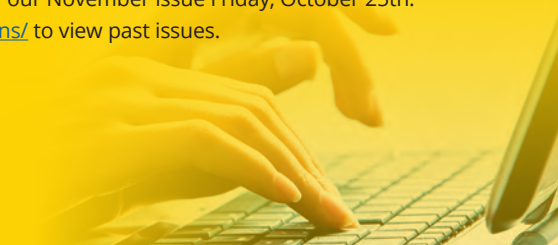
EZMSA

ZAF: October 17, 2019 | Misericorida IN-106, 4:00-7:00 pm

General Meeting: November 12, 2019 | TBD, 6:00-9:00 pm

Vital Signs is seeking writers! Our magazine is not so much an academic journal as a way to connect with other physicians about important topics. We publish a magazine for physicians by physicians, as a venue for advocacy and a way to stimulate conversation about health care issues, with a voice independent of AHS and AMA. We ask that articles be 800 to 1,500 words and we welcome accompanying photos.

You'll be compensated for your writing — all authors whose articles of 800 words and over are published will receive a $50 Good Earth or Chapters gift card as a thank you for contributing! The deadline for our November issue Friday, October 25th. Please visit http://albertazmsa.com/vital-signs/ to view past issues.



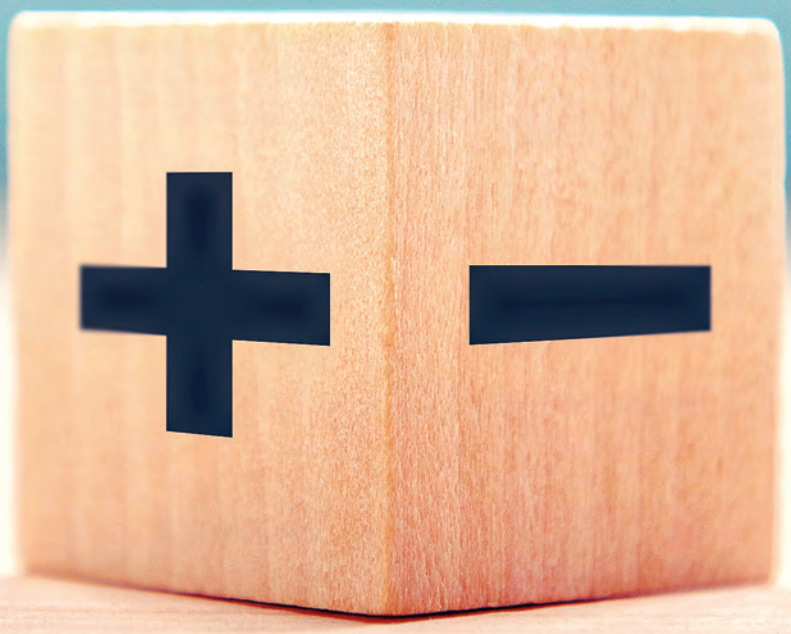
View from the Beach

Message from Vital Signs Medical Editor Dr. Scott F. Beach

Value.

Dr. Scott F. Beach

This term has many definitions and is often fraught with emotional overtones. When it comes to healthcare and the recent forthcoming challenges in its delivery, this term is often used to defend stakeholder beliefs and demand further resources, or promote certain agendas. Interestingly, proximity to value-based discourses can be imbued with partisan rhetoric. From arms length or greater, the individual campaigns actually synergize around goals of greater system efficiencies, allowing for improved patient outcomes.



Value, as it is applied to patient care, is a convenient weapon that is readily wielded when hackles are raised on who provides more value to the patients and the system.

From the provider perspective, value is defined by the simple ratio of outcome/cost. Alberta Health and Alberta Health Services are keenly in tune with this, perhaps more so than ever given the fiscal realities facing our province. Bound by pre-election platforms and promises to the electorate, senior leadership will be diligently pursuing what they believe to be value-based outcomes to address system sustainability. What this means in both the near and distant futures remains to be seen, but in the end it will all come down to the beans… the more count, the better.

From the standpoint of care delivery, value is a hot-button element of mercurial form within our collegium. The measure of the worth of the care we provide to our patients is an endpoint belief made up of income stream, intra and inter-speciality beliefs, and pop-culture mythos of the population at large. Value, as it is applied to patient care, is a convenient weapon that is readily wielded when hackles are raised on who provides more value to the patients and the system. Clouded by personal and sectional anxieties, these discordant beliefs can hamstring the dialogues designed to strengthen the collegium, and at worst can threaten the stability of our profession as a whole.

In the eyes of patients and their families, value is much simpler, poignant, and, most importantly, should act as the cooling balm for conflict. Ideally, it should also act as a guidepost when it comes to goal setting in program development and deployment.

As no surprise to anyone, patients value a reliably funded, stable system that acts as a platform for timely access to trusted, well-trained physicians. Granted, this simple ask can be incredibly difficult to deliver within the realities of the current system. Still, it should be noted that despite these barriers and challenges, dedicated and compassionate providers are realizing these needs for patients each and every day. However, coalescing beliefs on value by the system and care providers, compared with those of the key stakeholders, would be catalytic in promoting improvements in care delivery.

As we head into this fall season, all stakeholders in the healthcare realm in Alberta are holding their collective breath as we await the provincial budget's inevitable release. In the context of the MacKinnon report, the upcoming federal election, and pending negotiations between the AMA and the UCP, the storm clouds of change are breeding uncertainty and even fear. What should get us through is the belief in shared values, which inform our ongoing conversations on system stability and collaborative programming. Hopefully, this will provide a unifying clarity to chart our course ahead. Critical to this is stakeholder willingness to set aside personal anxieties and reactive rhetoric with an investment in value-based decisions. It sounds optimistic on my part that this will occur — but for all of our sakes, it must.

Scott F. Beach, MD, CCFP
Medical Editor, Vital Signs

What providing medical care in a refugee camp is like — and why it should matter to physicians here at home

Dr. Fozia Alvi

A young Rohingya girl in one of the medical clinics Dr. Alvi worked in.

Dr. Fozia Alvi

It's the girl in the red dress that haunts me.

I first saw her when I sat in a refugee tent, listening to a woman tell me about the horrors she'd lived through: her baby snatched from her arms and tossed into a burning homestead; her husband's throat slit in front of her; how she endured rape over a two-week period. It was all too much to bear, but then I saw the woman's daughter, sobbing silently in the back of the room. The girl was about 12 — the same age as my daughter — barefoot and wearing a filthy red dress.

As I looked at her, my heart sank; her mother's account was horrifying, and it was devastating to know this girl was a part of it all. My daughter is worried about volleyball try-outs; she bristles over the injustice of the lack of a girl's rugby team at school. That girl in the red dress will forever be haunted by her father's murder, and will have to live with her PTSD-ridden mother in a makeshift refugee camp alongside thousands of other traumatized survivors. I never got the girl's name, but her eyes are seared into my memory. I met this girl on my first trip to a Rohingya camp, and her tears are part of what drives me to continue to work and advocate for these refugees.

I have made several trips since then, and having returned recently from one, I thought it was important to share some reflections with my fellow physicians — both those who have done this kind of work, and those who may have never heard much about these issues.

The medical clinics I worked in were packed full of patients. Skin diseases were common, as people were living in hot, humid and cramped spaces, usually with up to eight people sharing one tent. I saw lots of children with recurrent diarrhea and upper respiratory tract infections, and many of these children came alone to the clinic with their toddler and infant siblings. I didn't know how to take the full medical history of an infant from an eight-year-old.

These conditions also make the situation dire for those with chronic health conditions. A surgeon from the Turkish field hospital told me how devastated he was to see the complications diabetic patients were experiencing. He showed me one young patient who had his leg amputated due to infection, as his diabetes was not treated. Since there's no electricity, people are unable to keep insulin, and are thus getting very sick due to inadequate treatment. This is the same for kidney

Dr. Alvi speaks with one of her patients, Rohingya refugee Gulbahar

failure patients; I was told that although there's a lab available at the field hospital, they are unable to do any further treatment. I was also told by other doctors that the Rohingya people cannot leave the camps under any conditions, not even if they are about to die.

On this trip I also reconnected with Gulbahar, a woman I met in 2018 when she brought her two young grandchildren to the medical clinic. She told me how she escaped from Myanmar and brought her grandchildren to Bangladesh with the help of neighbours, after her son and daughter-in-law were murdered by the Myanmar army. She herself was very sick at that time; her body was skin and bones. I suspected she had some underlying cancer and took her to a Malaysian field hospital, but she couldn't get treatment there as no one was able to take care of her grandchildren.

Last month when I returned, I asked my colleague, Bangladeshi physician Dr. Mosleh Uddin, if Gulbahar was still alive. I was glad to learn that she was, so I asked Dr. Uddin to call her back to the clinic, and she recognized me and was glad to see me. I asked her how she was doing, and if she needed anything; she told me that she needs everything, as she has nothing. I gave her some money to buy food, and she was crying towards the end in appreciation. I asked her if she needed anything else, and she said something so profound that I recorded it on my phone. She thought of me as one of the policy makers, deciding what to do with the Rohingya refugees, and she told me not to send her back to Burma — that she would rather die underneath some truck in Bangladesh than go back there.

Among these stories of extreme brutality, there are many stories of great humanity. I am humbled by this contrast, and the Rohingya people have inspired me with their resilience. I also draw inspiration from colleagues like Dr. Uddin; he's been working in the camps since the Rohingya refugee influx began more than two years ago. I met him in 2017, and continue to work with him every time when I go back. I have heard from a few patients in his medical clinic about his life-saving efforts that go beyond basic medical care: how he has helped them buy formula for their babies, how he's transported sick people to a local hospital and lived with those patients there for days. These are just a few examples of the noble acts he performs every day.

I met local Bangladeshi people who were busy day and night helping build shelters, arranging for children's education, maintaining toilets and distributing food, all mostly for free. Spending just a week in those camps is extremely difficult, and these Bangladeshi volunteers are doing it for months on end. I was impressed by their attitudes, and how they still managed to smile politely every time I talked to them.

Connecting this to our lives here in Alberta, I think it is very important for us as medical doctors to get involved with some sort of humanitarian work. Physician voices are very important, and when we speak against human right issues and genocide, people listen. In this corner of the world we don't often see these kinds of things, but our small efforts can make a huge impact, and I encourage all of you to get involved with this kind of work in some way.

I have met Turkish Red Crescent people — one of Turkey's largest humanitarian groups — in Bangladesh, and was impressed by their tireless work on the ground. Their on site manager showed me the Red Crescent hospital, where the operation theatre was fully functional, but was closed due to the lack of surgeons available. This is just one example of how my Alberta colleagues can donate their time, by going there to work for even just a few days. If you're interested in humanitarian work, this is a great opportunity to step up: we need surgeons, pediatricians, OB/GYNs, infectious disease specialists, family doctors and anesthesiologists.

I never realized that the hardest part of seeing crimes like this in real time is gathering the strength to keep going: fundraising, increasing awareness, and spending days working in humid 40-degree weather in a cramped field clinic. Sometimes my efforts end up feeling meaningless; the Rohingya are still there, Myanmar still feels no need to stop wiping them out, and at times it feels like I'm ultimately just helping delay their demise. I have received lots of support from my fellow Canadian doctors for my causes, and they are a big part of what encourages me in these times of hopelessness. If nothing else, your involvement in this cause will let the victims know someone that cares, and they are not forgotten. Please donate, write to an elected official, or even simply tell a friend or family member about this issue. In the best case scenario, you'll have played a small role in mitigating a genocide, and in the worst case, you'll have fulfilled a commitment to your fellow human beings. After all, as physicians we are guided by the principle that each human life is precious, and equal — even the ones far away from home.

If you are interested in working overseas like Dr. Alvi, or would like to get involved with this cause somehow, please visit humanityauxilium.com.

Fozia Alvi, MD
Airdrie, Alberta

Dr. Kim Kelly

WHY OUR 'EQUITY IN MEDICINE' COMMUNITY OF INTEREST MATTERS

Dr. Kim Kelly

"But we want the most qualified person in the role."

"She's just not ready."

"She is too emotional."

"We've already had a female Chair."

"She's too busy to take on that role."

"Zero women applied? They had the same opportunity to apply as everyone else."

As members of search and selection and nominating committees, these are common responses that I and other physicians have heard, and perhaps have even said ourselves, when considering women candidates for leadership positions. The Female Physician Leaders in AHS report states, "The gender distribution of medical leaders lags behind the gender distribution of AHS medical staff,".[1] I have previously written in Vital Signs [2] about the underrepresentation of women physicians who have served as AMA President: our outgoing President, Dr. Alison Clarke, is only the fifth female President since AMA's inception in 1889. Women are making gains, and in solidarity we celebrate trailblazers like Dr. Christine Molnar, the sixth woman AMA President, Dr. Verna Yiu, the President and CEO of AHS, and Dr. Brenda Hemmelgarn, the newly announced Dean of the Faculty of Medicine and Dentistry at the University of Alberta, who is the seventh female Dean of Medicine in Canadian History!

In addition to gender bias and prejudice, there are multiple reasons for underrepresentation of women in healthcare leadership, such as: lack of family-friendly policies, decreased mentorship and networking opportunities for women, an absence of transparent evaluation processes, and a lack of resources and commitment from top leadership to address equity, diversity and inclusion (EDI). Improving EDI is a shared responsibility, and we can advocate to improve processes in our organizations that manage the biases we all have. Addressing EDI is not only economically sound, it is simply the right thing to do.

My experience of gender discrimination over my career, plus the desire to improve medical culture for the younger generation, was a huge motivating factor when I applied to the Canadian Medical Association for a Community of Interest (COI) one-year grant. We learned that our application was successful in the summer of 2018 and quickly went to work to help build our online engagement platform and to host live discussions with COI members and other participants. Our leadership team consists of seven physician leaders across Canada, and includes: Dr. Finola Hackett (AB), Dr. Alika Lafontaine (AB), Dr. Renee Fernandez, (BC), Dr. Dennis Kendel (SK), Dr. Sarah Hanafi, (QC), and Dr. Lesley Barron (ON). Our grant is for one year and we chose to focus on gender equity, while acknowledging that other related issues of inequity are important and also need to be addressed. Our actions are aligned with Dr. Cheri Bethune's comment, "Women are a marginalized group (despite their proportional numbers) and so can bring focus to the whole culture of medicine and its dominant values and hidden curriculum, which marginalize many others,".[3]

Networking groups are another way to address career barriers that women encounter. This spring I created YEG WiHN — the Edmonton Women in Health Networking group — to fill an existing gap.

During our first live chat, I spoke about our COI and explained, "The Equity COI will address gender inequity in medicine, which results in issues like gender pay gap, few women physicians in senior leadership positions, and harassment. The COI will examine why gender inequity continues, for example, due to hierarchy, power imbalance, and privilege. We also want to do something about it through education, support, empowering our community members, and leveraging action! We want to hear our community members' priorities and what we can do together to positively affect change."

Our Community of Interest has hosted three national live chats in 2019, and a fourth is scheduled for Tuesday, November 5th at 6 p.m. (MDT) with Ivy Bourgeault, PhD, Chair in Gender, Diversity and the Professions at the University of Ottawa. Participants are asked to submit a case which they would like to discuss during the chat. You can join the COI at this link: Registration for #EquityCOI

This past May, our guests were resident physician Dr. Jenna Webber, and Research Director for Queen's University Center for Studies in Primary Care, Dr. Susan Phillips. Both are authors of the 2019 research paper, 'Sexual Harassment of Canadian Medical Students: A National Survey',[4] which was the topic of this important live discussion. The conversation was co-hosted by University of Alberta's resident physician, Dr. Kaylynn Purdy and myself, and is posted on the Equity in Medicine COI platform (link: Sexual Harassment COI Live Chat)

During our live discussion, Dr. Phillips commented, "We need to blow this open into the public, make it okay for students to talk about this. This is not an individual problem but a systemic problem that needs a systemic solution." Dr. Webber responded, "We need to decrease the stigma and increase the safety." Dr. Phillips credited Dr. Margaret Steele, the first woman Dean of the Faculty of Medicine at Memorial University of Newfoundland, for her courage to disclose sexual harassment at Memorial University and call for an investigation.

Networking groups are another way to address career barriers that women encounter. This spring I created YEG WiHN — the Edmonton Women in Health Networking group — to fill an existing gap. My mission is to provide networking opportunities for women, build community, and foster mentorship and sponsorship, guided by the vision of gender parity in healthcare leadership at all levels. Thus far, 90 women have joined. The inaugural YEG WiHN event occurred this past April with guest Dr. John Bradley, President of the CPSA. We discussed the barriers to women in running for council positions and applying for CPSA committees — afterwards, one woman decided to put her name forward to run for council!

What my work so far with this COI has shown me is that physicians are ready, willing, and excited to have these important conversations about gender bias in medicine. Over the past year, the question has changed from whether that gender bias exists at all, to what can and should be done about it. The Equity COI and networking groups are concrete ways to affect positive change by adding your voice to the discussion and learning together.

An initial version of this article originally appeared in the Alberta Doctors' Digest in July 2019.

Kim Kelly, MD, CCFP(AM), FCFP
Edmonton, Alberta

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EMPOWERING PATIENTS TO MANAGE LONG-TERM CONDITIONS

An update on home infusion programs

Dr. Davinder Sidhu

Dr. Davinder Sidhu

In medical ethics, the concept of autonomy informs a significant public health goal: to encourage patients to actively participate in their own disease management. Encouraging patient self-care is a long-term, financially viable solution to dealing with chronic disease, and more importantly, it's a provincial government mandate.

The healthcare system, for example, routinely invites patients to participate in the treatment of hypertension with home blood pressure kits, and in diabetes, with home glucose monitoring. Indeed, self-administration of medications on a regular basis is the cornerstone of good chronic disease care. By redirecting some aspects of healthcare responsibility to patients, we can empower them and can simultaneously reduce the burden on an already over-burdened healthcare system.

One relatively recent achievement in the delivery of autonomous patient care — and one deserving of advertisement — is the Calgary subcutaneous immunoglobulin (SCIg) home-infusion program. This initiative was the brainchild of the Transfusion Medicine division of Calgary Lab Services (now Alberta Public Laboratories). The program is meant to address the need for more patient-involved care in association with the myriad chronic illness requiring immunoglobulin replacement.

Pooled immunoglobulin is an essential blood-derived product for many patients, including those with both primary and secondary immunodeficiencies. Higher dose immunoglobulin is also employed as a therapeutic option for a cadre of hematologic (e.g. ITP), neurological (e.g. Guillain-Barre syndrome), rheumatologic (e.g. Kawasaki disease) and others (e.g. toxic shock syndrome). In acute hospital settings, immunoglobulin replacement and/or therapy can be administered intravenously (IVIg). For those patients requiring prolonged dosing, SCIg can be offered as an alternative, with training provided by Transfusion Medicine personnel to permit home or self-directed administration.

Aside from the motivations relating to patient autonomy, the economics of patient self-directed SCIg therapy are compelling. Owing in part to complex production workflows, and also because much of the Canadian supply is sole-sourced, the costs associated with immunoglobulin replacement are very high. As an example, for patients with primary or secondary immunodeficiencies requiring immunoglobulin replacement, the in-patient costs of therapy are estimated at $30,000-$40,000 per patient, per year. Immunoglobulin products are provided to the provinces (except Quebec) by Canadian Blood Services, and therefore bear a fixed-cost per patient. By contrast, the remainder of in-patient expenses often relate to bi-monthly admissions required if patients opt for IVIg, and the attendant 4-5 hours per visit of nursing care. If patients opt to participate in the SCIg home infusion programme, the latter costs are largely nullified.

Since its inception in 2015, the SCIg home-infusion programme has demonstrated consistent year-over-year patient accrual (Figure 1). There's a notable relative drop in the current year, owing to a substantial shortage in available subcutaneous immunoglobulin product, that has led to a Canadian Blood Services amber phase product restriction (see these articles in Globe & Mail & CBS Notice). Most participant patients have a primary or secondary immunodeficiency requiring replacement immunoglobulin; figure 2 provides a breakdown of the primary indication for SCIg replacement for the 112 currently active patient participants. As demonstrated in Figure 3, the SCIg home-infusion programme participants come from a broad spectrum of age groups, with most patients in middle to older age ranges. Unfortunately, the current SCIg programme does not extend to pediatric age ranges, given a lack of dedicated funding and clinic space.

The SCIg home-infusion program, as a laboratory initiative, was originally supported with temporary grant funding that has now mostly expired. In order to maintain support for the SCIg home-infusion programme, the Transfusion Medicine division of Calgary Lab Services recently approached Alberta Health for pilot-dedicated clinic funding. We proposed a very unique clinic structure, in which patients are trained in autonomous care, and to which all specialties could consult (an opportunity afforded to patients and their caregivers whenever they are prescribed immunoglobulin products). Such a clinic, by virtue of the unique insights that Transfusion Medicine has in relation to blood product utilization, could help to drive usage standardization of a very expensive but potentially life-saving product. Similar ideas are being considered for centralized iron infusion clinics and centralized IVIG transfusion clinics to help shift patients from inpatient or day medicine spots and drive system costs down across the province.

As most Albertans already know, in late 2018, the Alberta government set out to amalgamate all clinical laboratory services under a single provider, Alberta Public Laboratories (APL). We also set out on an amalgamation of the medical IT infrastructure in the province with the Connect Care project. Both of these moves have been massive and costly undertakings.

With the change in government, we face new challenges and economic uncertainty when it comes to how AHS funding may shift in the years to come. The proposed SCIg clinic not only encourages the important goal of patient autonomy, but might serve as a model for clinical care and cost-savings as we move forward in Alberta.

Davinder Sidhu, LLB/JD, MD FRCPC
Division Head/Clinical Section Chief Transfusion Medicine and Cellular Therapy, Alberta South Sector, APL, Calgary

FIGURE 1: Annual Number of SCIg Patients Enrolled In SCIg Home Infusion Program
*2019 Cuvitru Amber Phase

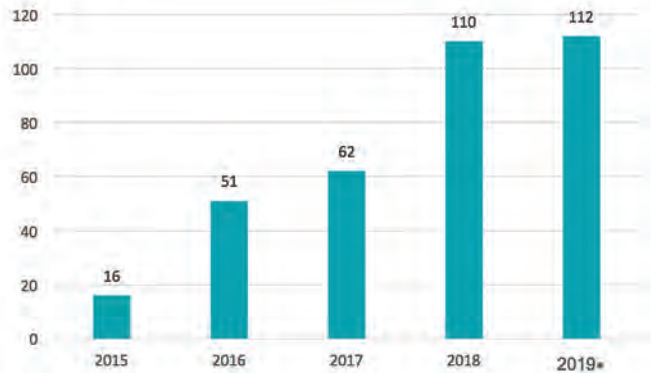


FIGURE 2: SCIg Patient Indication Categories
Blue = Primary Immunodeficiency; Brown = Secondary Immunodeficiency; Gray = Neurological Disease; Yellow = "Other"

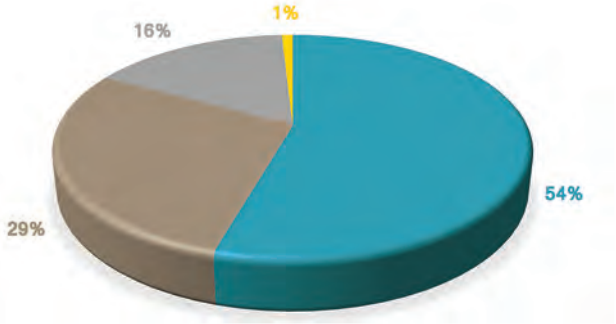
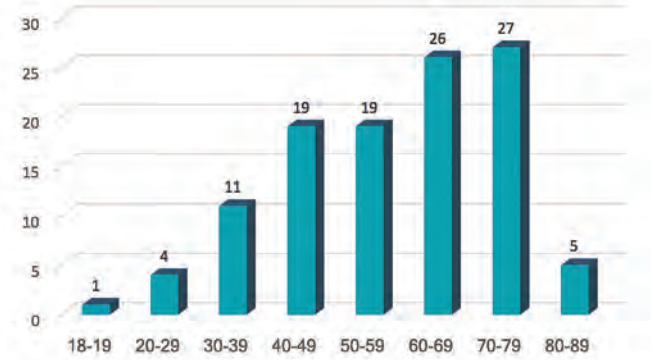


FIGURE 3: SCIg Patient Age Distribution



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What do we mean by diversity and inclusivity?

Dr. Richard Bergstrom

In our current climate, the words 'diversity' and 'inclusivity' can sometimes be on par with corporate jargon like 'engagement', 'value', and 'respect'. It's not that these are bad words, but rather that sometimes, they are just surface-level.

Dr. Richard Bergstrom

As an older white male, I can easily be dismissed when talking about diversity and inclusivity by those who might immediately consider me to have had a life of privilege. But like everyone, there is more to my story that might make someone think twice about using the word 'privilege' to describe my life experience. I am concerned that the idea behind diversity and inclusivity is not about meritocracy, but rather about photoshopping the picture, so that it appears right on the surface.

A good example of this can be seen in the Vienna Philharmonic Orchestra, which was once exclusively male. When they eventually decided that ability, not sex, was the most important thing, they introduced "the screen" where the applicant was only heard, not seen during an audition. When the first woman was chosen, a shudder must have gone through the orchestra, and it was probably a healthy shudder in that it broke the unspoken code that 'Only males need apply'.

Medicine was a male dominated profession for a very long time — in many ways, it still is. I will totally agree that many professions have been dominated by men, and with men at the helm driving the system. Men from all walks of life have abilities and redeeming qualities, but I

Humility is a good attribute: it forces you to think about who you are, who others are, and how others think.

agree that we have, on average, better chances and will have experienced far less discrimination, especially if we are white.

I sometimes make the comment that women (white women especially) in North America have it good — not equal, but good — when compared to so many women in the developing world. As a man, or maybe just as a human, I feel great sorrow for so many women in the world who have opportunity not just snatched from their hands, but deliberately and violently taken from them. This is simply wrong.

Ideally, we should become humble at the idea of diversity and inclusivity. Humility is a good attribute: it forces you to think about who you are, who others are, and how others think. Everyone should take the time to try and put themselves in the mindset of someone different from them, and that's how we'll begin to build meaning behind these important words.

It's about what makes a hand — we cannot have a hand will all thumbs; it will not work, and neither will a hand with only a forefinger for pointing. I posit that we can be wiser, better and, more importantly, do better when we do not obscure or omit information from the agenda.

When we marginalize people, we are the losers, and in medicine, our patients are the losers. When we have, both out loud and covertly, told women and other marginalized groups that they are not welcome, the profession and our patients suffer. We have for too long sent the message that women and minorities need not apply. That is wrong, and we as a profession need to drive the change. Diversity and inclusivity don't mean we need to photoshop the picture — it's about making sure we put up a curtain to not judge by sight, but rather, by the ability, one we surely need to add to the conversation.

With this, we should also think of the problem of power. If you have power, it's presumed that you have strength and leadership. But if you have leadership without followership, you really have no leadership at all. Commanding an army, steering a course for excellence, creating the best care for patients — all of these are laudable goals. They will not occur without finding the best people, and not excluding anyone with ability to contribute.

Diversity and inclusivity are not about making the picture right. These words are about creating a better product by finding the best people, including them, listening to them, and not discounting what they have to bring to the table.

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

Keeping up the momentum

Let's continue the conversation about female physician leadership

Dr. Charlene Lyndon

Recently in Alberta, concerns have been raised regarding both the lack of female leadership throughout our healthcare ranks, and the sub-optimal support for existing female physician leaders. This is no surprise; it's a national issue, and like many industries, women and people of colour have too often been the minority in medicine.

Luckily, that's starting to change. Alberta Health Services conducted a survey of female leaders and released a report in December 2018, titled: 'Female Physician Leaders in Alberta Health Services,' which stated that the atmosphere for female leaders in AHS requires improvement.

There has been a strong reaction and a lot of discussion around this report, but it's important to note that it's a starting point: AHS acknowledged that this is a problem, and are open to listening and learning about how best to move forward and begin solving it. I saw evidence of this in May, when three of the Calgary Medical Staff Associations (MSAs) hosted an information session with Dr. Francois Belanger, Vice President, Quality and Chief Medical Officer, AHS. The session was well attended by both female and male physicians, and lasted for more than two hours — locally, it tells me that our conversation has begun in a meaningful way. During the session, some of the following themes were discussed:

- The need to develop healthy work environments, where concerns regarding abuse and mistreatment can be discussed without fear of reprisal.
- The issue of female physicians continuing to overall earn less than their male counterparts, while often providing care with superior outcomes.
- The lack of understanding about how to provide feedback about significant negative events with colleagues, and how to formalize the process.
- Concerns about the dissemination plan for the report.

To build upon this discussion, the **Calgary MSAs are hosting an event on November 18th, titled: 'Women in Medical Leadership: Building Solutions', to begin addressing the issues raised and build upon the existing momentum.** Our goal is that following this event, we will have formulated suggestions on how to improve the working environment for female physician leaders. To do so, we hope to see a strong attendance of physicians who would like to have their voices heard, and join in on this important conversation.

From the discussions and actions that have taken place this year, it is clear the majority of physicians support inclusion and diversity in medical leadership. Alberta physicians can be proud to know that AHS leadership and clinical leaders — both male and female — are coming together to address these identified concerns. Ultimately, change will take place when we have physicians from all walks of life committed to finding and implementing solutions.

The November 18th event will be held at Fort Calgary, and RSVP is required. The schedule is as follows:

- ***5:00-5:30 pm: Meet & greet, refreshments available***
- ***5:30-7:30 pm: facilitated discussion with fellow colleagues and expert moderators***

For more information or if you are interested in attending, please visit: http://albertazmsa.com/camss-and-msa-events, or contact zmsaadmin@albertadoctors.org.

Charlene Lyndon, MD
President, Rockyview General Hospital MSA, Calgary, Alberta

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Shauna McGinn

Dr. Rachel Grimminck

WE CLAIM TO VALUE MENTAL HEALTH. So why don't the numbers add up?

Shauna McGinn, in partnership with Dr. Rachel Grimminck

Calls for increased and better access to mental health services have reached an all-time high, but the public dollars to support this outcry are still too low to address needs here in Alberta, and throughout the rest of Canada. This funding discrepancy, or spending disparity, represents a persistent issue in our healthcare system: mental health is not afforded nearly as many resources as physical health.

What does this funding discrepancy look like?

This is a national issue, and here in Alberta, advocates have indicated that funding discrepancies for mental health is a recurring feature in the province's health spending. In advance of the most recent election, the Alberta chapter of the Canadian Mental Health Association (CMHA) released a call for increased funding for mental health services in the provincial budget. The organization suggested an increase from 6 per cent to 12-13 per cent of the health budget, which would put the province on par with other jurisdictions in Canada for mental health spending. The Alberta government acknowledged this spending disparity in the 2015 report, 'Valuing Mental Health', stating that based on the best available research, 9 per cent of an overall budget should be the minimum allocation for mental health. Whatever the ideal number, it's clear that current spending is falling short.

In September, the UCP government committed $140 million over four years to add more than 4,000 beds for substance use treatment and other addiction services. While this is important, it's addressing just one facet of the myriad mental health concerns and treatment needs in Alberta. Both hospital and community-based mental health care remain severely underserved, in some cases leading to wait times of up to three years for specialty programs like the gender clinic, or up to two years for Dielectical Behavior therapy for Borderline Personality.

Due to factors like stigma and poor understanding of the complex intersection of physical and mental health, lack of funding is a global issue when it comes to treating mental health concerns. Though awareness efforts have grown tremendously in the

past few years, the dollar signs to accompany this emerging culture of openness has lagged. Wait times for mental health beds in hospitals remain high, reaching up to two weeks in the emergency rooms in Calgary alone this past year. Even when family physicians refer patients to a psychiatrist, the wait can sometimes be months to years long — even though, as the CMHA reports, more than one million Albertans made an appointment to discuss mental health concerns with their primary care provider in 2017.

The Alberta government directly spent over $80,000 on mental health-specific programs in 2018 (that figure excludes front-line and/or acute delivery of mental health care). While that's a more than 50 per cent jump from the year prior, it's still significantly less than other spending areas, like primary healthcare at $231,511, and population and public health at $114,302.

There's also a discrepancy when comparing mental health beds available in Edmonton and Calgary, the province's two largest zones. In 2017, Liberal MLA David Swann lead and compiled a report for the NDP government which found that Edmonton had 97 beds per 100,000 people, while Calgary had just 67. Then-premier Rachel Notley noted that AHS had opened 30 beds in Calgary over the previous two years for various mental health treatment — but only three of those were for acute adult care. To achieve parity at that time, Calgary would've needed an additional 200 beds, which has yet to come to fruition.

In light of the recent MacKinnon report, in which a panel of experts provided health spending recommendations for the UCP, there is reason to expect cuts to various healthcare services in the coming years. The report discussed a troubling pattern in which the provincial government tends to spend more during economic upturns in the energy industry, only to have that cause a problem during an inevitable downturn later on. The report indicates that cutting back on frontline healthcare may be one of the only ways to salvage this over-spending, which could further damage underfunded mental health services.

The cost of neglect

Some areas of healthcare — like physician compensation or infrastructure — will likely always require a larger share of public dollars. But mental health is directly tied to physical health, and if not treated, it results in a need for care that is urgent, ongoing, and costly in more than one sense. One section of the aforementioned 'Valuing Mental Health' report discusses what "maintaining the status quo" will mean to Albertans:

"If nothing changes, we need to be prepared for the consequences:

- Those with mental illness will continue to have shorter lives — mental illness can cut 10 to 20 years from a person's life expectancy.
- Those with addiction and mental illness will continue to struggle with housing and homelessness, and be at higher risk of entering the criminal justice system.
- There will be more cases of addiction and mental illness, with increased pressures on health, social and justice systems."

These consequences are widespread, and affect even those who are not personally experiencing mental health challenges, including patient families and those in the legal system. Moreover, Albertans have already been sacrificing more than their mental wellbeing as a result of this issue. The CMHA report summarizes why:

"Counselling services are out of reach for many Albertans; few publicly-funded counselling services exist. Most people who receive counselling are relying on their private insurance or pay directly. This is not the case in other provinces... Consequently, Canadians spend $950 million on counselling services each year — 30% of it out of pocket."

This shows not only that individuals are already paying steep fees for mental health care, but that those who can't afford it privately are left to rely on an environment of limited, constrained resources.

The current situation with rising methamphetamine use in Alberta also serves as a good example of what the cost of neglecting mental health services can be. In 2018, Edmonton police reported seizing over 30,000 grams of the drug compared to less than ten thousand in 2013, and Calgary police dealt with more than 412 meth-related incidents by the end of last November, a staggering 536 per cent jump from five years prior.

Along with the harmful physical effects of the drug, up to 40 per cent of meth users experience transient psychotic symptoms, and chronic users are at high risk of developing ongoing difficulties with psychosis that can have devastating long-term consequences.[1] Often times, users experiencing psychotic symptoms end up in the emergency room: Calgary ERs sometimes saw up to six of these patients per shift in 2018, with the average length of stay at 10 hours.[2] This puts additional pressure on frontline health services, and is also a driver of burnout, as staff come up against the erratic and sometimes violent behaviour of these patients.[2] The issue is compounded when patients may need longer term mental health care: if there aren't enough resources for others in need to begin with, how will hospitals and treatment centres accommodate this fallout?

While the $140 million commitment from the UCP for treatment beds may address some of this need, those funds are targeted at detox and rehabilitation, not necessarily comorbid mental health conditions that may drive substance use, such as depression and anxiety. Comorbidity is the rule rather than the

— continued on page 16

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exception, and a focus on substance treatment alone neglects the complexity of mental illness. The recent methamphetamine situation exposes how the mental health funding discrepancy can leave us playing catch-up, and treating just one portion of a complex presentation in need of ongoing care.

An underlying cause

As physicians and as a society, we can say we care about mental health, but the numbers tell a different story; one where the system we operate within still doesn't value mental health as much as physical health. The funding discrepancy demonstrates that we still don't have an understanding of mental illness that includes the awareness of a need for a biopsychosocial approach for each patient, and early intervention. It shows that stigma remains pervasive, and has concrete, ongoing consequences.

While the recent past suggests that stigma against mental health will continue to decrease, there are current examples in our country of how this progress can and is being regressed. The Ontario government recently proposed limiting psychotherapy to 24 hours per patient, per year, as a way to offset the cost of mental health treatment. Psychiatrist Dr. Wei-Yi Song wrote in the Toronto Star that while this might filter out the "worried well" (i.e. patients who need less intensive mental health care) it will harm those facing severe mental disorders.

"Patients in hospital with refractory psychosis, severe depression or thoughts or plans to take their own life may see a psychiatrist on a daily basis for three to six months. Once stable enough to leave hospital, these patients often need up to an hour a week of intensive support for an additional six to 12 months," Dr. Song wrote. "Do these proposed arbitrary limits perhaps reflect the burden of stigma affecting those with mental disorders?"

Knowing how widespread and persistent the underfunding of mental health is, it's difficult to see how such policies are underpinned by anything other than stigma. The 2015 'Valuing Mental Health' report echoes this sentiment: "People with addiction and mental illness often face attitudes of disrespect, fearfulness and, within the healthcare system itself, judgment." And an environment of constrained resources takes a toll on care providers: "A lack of focused funding, inpatient beds, coordination, and accountability leaves service providers demoralized and exhausted, yet knowing that more could be done."

Why this problem impacts all physicians

According to the Mental Health Commission of Canada and the College of Family Physicians of Canada, family physicians deliver up to two thirds of mental health care in our country.[3] This is reinforced by the above CMHA statistic that over 1 million Albertans reached out to their primary care provider to discuss mental health in 2017. The link between cardiovascular disease — which accounts for the largest burden of disease in Canada — and poor mental health has been well established,[4] and many common conditions with no clear anatomic cause have significant overlap with poor mental health.[5]

What this demonstrates is that regardless of your specialization, with few exceptions, physicians of all disciplines are either directly treating mental health conditions, or are treating conditions influenced by a patient's mental health, or lack thereof. Furthermore, it can be challenging for non-psychiatric specialties to manage mental illness in acute care settings, and the presence of a mental illness can impact a patient's adherence with treatment.

If, as physicians, we don't have a nuanced understanding of mental health, it will impede our ability to provide quality care in any setting, and will make it difficult to advocate in the right ways. Just like resources for treating mental illness are in short supply, there is a shortage of mental health professionals in our hospitals and communities available to support the practitioners from other health disciplines and their patients. As the saying goes: "There is no health without mental health."[5]

In order to demand the proper value for mental health, we need advocates across all disciplines: from family medicine, to ER, to surgical specialities. Given the demand and intersectionality with physical illness, mental illness requires a broad approach to strengthen resources in all settings, and at all stages. This issue cannot be siloed, and we all stand to benefit from equal funding and a more widespread, consistent commitment to support mental health services in Alberta.

Shauna McGinn, Vital Signs Staff Editor/Writer
Rachel Grimminck, MD, FRCPC, DABPN
Clinical Medical Director, Psychiatric Emergency Services, Foothills Medical Center; Clinical Assistant Professor, University of Calgary

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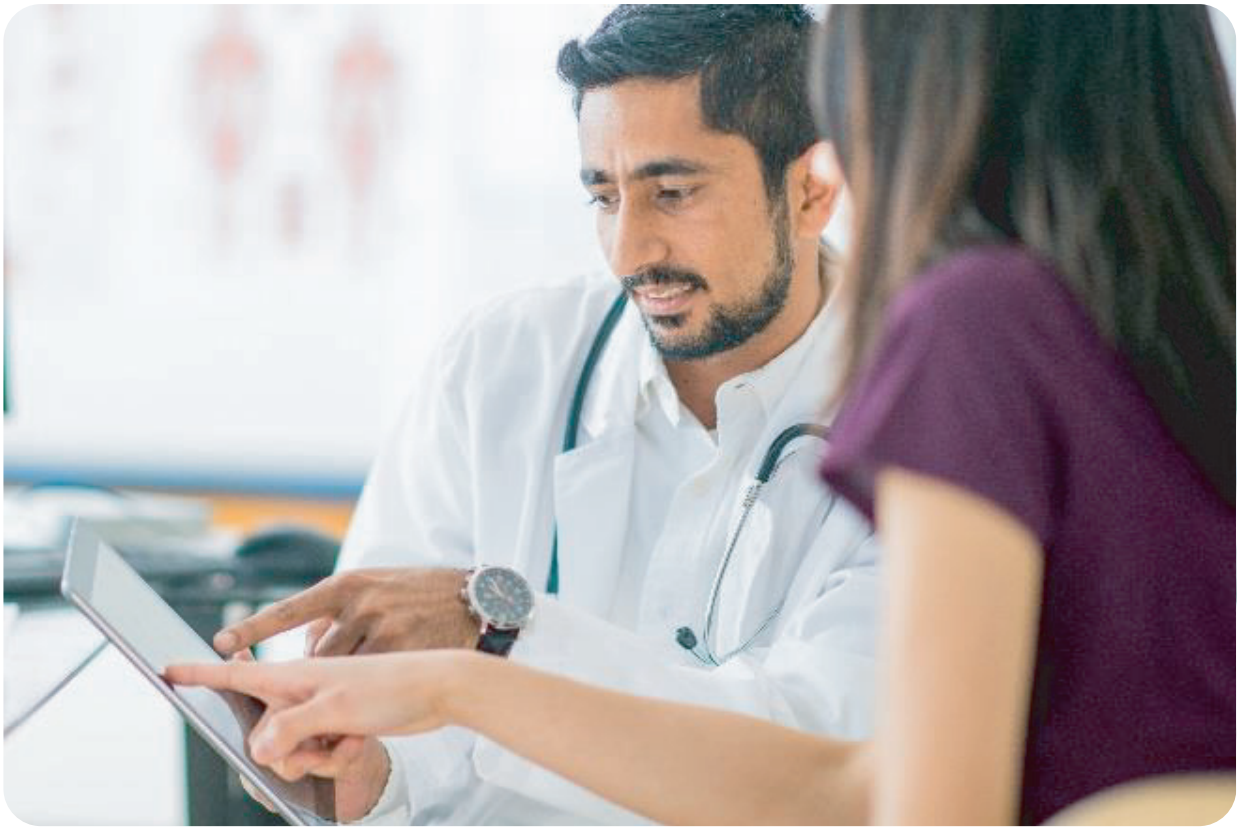

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Your Voice Needs to be Heard

Please take the opportunity to share your voice with us. Vital Signs exists to inform, inspire, and advocate for physicians in Alberta by sharing issues and ideas pertinent to the profession. We do this by publishing articles written by physicians that have something to say, and are looking for a place to translate and discuss their ideas. The Vital Signs team can help see your ideas to fruition, so that your story is told in the strongest way possible.

Whether you have contributed countless articles or you merely enjoy reading Vital Signs, thank you for your time and attention.

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Content submitted to Vital Signs should be of interest to and advocate on matters pertinent physicians in Alberta, such as:

- Patient care: quality, safety, and interdisciplinary aspects
- Service planning and delivery
- Medical and workplace culture, and wellness — Specific issues within your field that other physicians should be aware of
- Medical Staff bylaws and rules

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. It's also important to remember that this is not an academic paper: this is a chance to use a more casual tone — Vital Signs is an ongoing conversation, physician to physician.

FORMATTING:
Articles submitted should be approximately 800-1,000 words in length (sometimes longer depending on the subject matter) and in MS Word format with sources cited and trademarks and copyrights honoured.

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.

***Note:** *With the addition of a Staff Editor/Writer to the Vital Signs team, there is now the option to have an article produced via interview or a writing framework, should you prefer that. Please get in touch with the Staff Editor/Writer (e-mail given below) for more details.*

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