Monday Message: January 9, 2024

Happy Monday- looks like winter has arrived!

I have been the Department Head for 2 years. I look back to see what I have accomplished. So much remains to be done! Please email me directly with your feedback -good and bad, what needs to be done, what I have missed.

We continue to have overwhelming pressures in our Emergency Department which affect us mostly indirectly in that we are asked to take patients who may or may not have surgical issues. We are asked to be MRP for ALC patients or even medicine patients because medicine services are capped. An MRP document was revised last year but was never actually accepted and operationalized, so we continue to be asked to take patients who are not appropriate to our scope of practice. This is an ethical and medicolegal issue. I have raised this with our leadership team. They acknowledge this. However, the crisis in our ED is driving this bus. Our ED is not even close to meeting targets in terms of time from arrival to patients being seen or time to offload ambulances. They are seeing patients in hallways, closets, in the waiting room. Why? Because consulting services haven't seen the patient in a timely manner, or consulting services haven't made a decision regarding disposition, or patient has been admitted but either there is no inpatient bed or they haven't yet been moved to a bed. I can tell you that Surgery is not the major offender on these issues but we still contribute. So I am requesting that faculty-- you - support your teams by going to the ED to help either by seeing a consult yourself, or help the resident make the decision re disposition. We no longer have the luxury of leaving these things until we get out of the OR or after clinic. We can no longer justify leaving the resident alone as education. at the expense of other patients not getting access to care. A patient died in our waiting room recently.

Later this month I will be sending you a draft of our strategic plan. Approximately half the department responded to our survey last spring and almost half of the department attended our retreat.

I am really happy with the level of engagement from Department members. Afterall - this is a plan for you!. The Department of Surgery Executive have reviewed the plan and are providing feedback but I want to hear from you too.

In my experience, when I have read strategic plans they often don't resonate with me. Some plans are very aspirational, some are apple pie and motherhood.
My goal for our plan is to have aspirational goals but also practical goals to address the concerns of our surgeons and to provide an action plan to achieve these. This plan needs to resonate with you, reflect yours concerns, your goals.

So, I will be sending you a draft document within the next couple of weeks. I want your feedback.

Thanks for your support over the past two years.

Well I asked for it! And I got it-- feedback.

Last week I participated in the survey for the Department of Emergency Medicine. I learned some very important things.
The first thing I learned was related to communication. I have been trying to communicate with DOS regularly but on reflection I acknowledge that I have not delivered to the degree that is required. I am going to try to provide information of which you may or may not be aware and will endeavor to keep you informed going forward.
This relates to the Emergency Department and overcrowding of the ED and the entire hospital.

1. This problem did not arise just due to COVID. It is not unique to NS. It is related to years of governments trying to keep spending under control and resulting under investment in health care infrastructure such as long-term care homes.
2. This problem has been exacerbated by COVID as senior staff-nurses and physicians and allied health decided to say "enough" and retire. Family doctors also retired.
3. The rest of us ---all of us--- are weary and many suffer burn out and to protect ourselves are saying " no more".
4. I want to be clear that I support the position of the members of DOS who state surgeons should not be MRP for ALC patients
5. I want to be clear that I support the position of the members of DOS who state that surgeons should not be MRP for nonsurgical patients – not just for medicolegal reasons but because these patients are outside our scope of practice and therefore we cannot deliver appropriate care.
6. I have tried to focus on the difference between an available bed and MRP.
7. There is a risk if we do not accept being MRP that all surgical beds will be filled with medicine patients.

8. I too question the "caps" on the number of patients "allowed " on medical services
9. However, I also question surgeons not be willing to accept patients who have problems that can be easily and appropriately looked after by surgeons – just because they don't need an operation.
10. I think all of us-- surgery, medicine, everyone needs to re-evaluate how we practice. In surgery we have ERAS pathways. DGH surgery developed a short stay unit with care pathways that allow the nurse to discharge the patient when they meet required milestones. They don't have to wait for the surgeon to round in the morning. Orthopedics developed same day joint replacement programs. We can always do more. Be innovative.

Just to ensure that you are aware, leadership has identified that we need inpatient beds for acute care patients so long term care beds are being developed, Hogan Court will come online within months-- ALC patients will go there; another long term care facility is under construction.
Leadership has identified that admitted patients in the ED are preventing physicians from being able to assess patients in appropriate spaces - so leadership at QE II opened a space for admitted patients to go pending bed availability elsewhere in the HI or VG (the bunker). There are still issues with respect to who care for these patients- GIM, hospitalists or ED physicians but that is not my problem to solve but I can assure you that leadership is actively engaged in solutions.

The bunker has not solved the problem but is one step.

Which brings me to feedback. Perhaps you didn't realize that I do agree with a lot of the issues you have raised as noted above. But I do not agree with the "us versus them" culture.

We are in this together. We must be in this together. It wasn't so long ago that surgery was cancelled daily because beds were needed for medicine patients admitted through the ED. Through Eileen MacGibbon's leadership that stopped. Did I advocate for surgery? Yes. My daily comment at C3 meetings was "surgery cannot be the relief valve for the ED". But it was through being engaged in the conversations, attending the meetings, participating, ensuring our voices were heard, that this happened. I also built relationships with others in the institution so they know they can call me with a problem and vice versa.

We are in this together. We must stop the finger pointing, the isolationist attitudes, the public berating of others, the lack of civility.

I am sure I will get feedback on this and I welcome it even if you don't agree with me.

Thanks for being engaged and participating

Monday Message: January 22, 2024

Attached to this message is the new strategic plan for the Dalhousie Department of Surgery 2024-2029.

I invite your feedback on this document.

It written as a roadmap to guide our efforts in the department over the next 5 years.
Our divisions heads have reviewed it.

It is very important that this document resonates with the members of the department, not just division heads.

If we have missed something please let me know.
I would appreciate any feedback by Jan 31st .
Thanks very much for taking the time to read the document

strategic.plan.Jan2024.docx

Monday Message: January 29, 2024

Last week I sent you a copy of our new strategic plan (a penultimate version). Not unexpectedly I have had very little response. Does that mean you liked it? I suspect that most of you were not particularly interested and either didn't read it or skimmed it. Does a strategic plan matter? Is it of any significance to surgeons? Will it affect your day to day work? I suspect for most of you think of a strategic plan as something that has no practical relevance to the front line. I myself have had those thoughts. I have tried to make this plan very practical with clearly articulated actions and timelines. Your leadership team in the Department of Surgery will be evaluating our progress quarterly and we will report to you semi- annually on our progress. I am hopeful that when you see some output from this plan, you will feel more engaged and will be willing to provide feedback.

One of the initiatives of the strategic plan is to advance our quality agenda. I am not speaking of an audit of our scrub practices. Rather our goal is for each division to examine the quality of care they are delivering whether it relates to wound infections, return to the ED, or lymph node harvest for cancer surgery. This work will occur at the Divisional level. Our Quality Lead Dr Greg Hirsch will be initiating meetings of the divisional quality representatives to share approaches and learnings that can be taken back to the divisions for implementation. Central to this goal is robust quality improvement rounds (M&M). These rounds should include some statistics that include the denominator (ie how many of these procedures were completed in a month or year), complications graded according to the Clavien Dindo classification, a case analysis looking at phases of care and action items for improvement. The content of these rounds should be kept in a secure database to enable a yearly review to identify trends. Only by measuring our outcomes will we know if we are providing the best case to our patients.

An important part of our governance is work that is already underway identifying what a 1.0 FTE surgeon delivers., and what each division delivers. This is why I have emphasized our DOS deliverables website We need accurate data to share with government. Marc Butler, our IT consultant, has been working diligently over the past year to ensure our clinical volumes are accurate (including OR cases and hours, new consults and visits, endoscopies and minor procedures). Dr Gerard Corsten has led work to standardize education and administrative deliverables. Lastly, we are prepopulating the website as much as possible from administrative data to reduce the work required by each surgeon. We are currently having discussions with government with regard to deliverables in terms of the new contract. I have indicated that we are back to pre-pandemic volumes of work, and we cannot deliver more with the same number of surgeons. I have requested additional FTE for surgery and am awaiting decisions from the business cases submitted in the fall. We are already working on business cases for this upcoming round of applications.

Finally, our NSH leadership has been listening. We have had approval for physician extenders in cardiac surgery, vascular surgery, thoracic surgery, ENT and neurosurgery. Significant efforts are underway to cohort patients together. Work is underway to help with the volume of patients coming to medicine from the ED. Unfortunately, last week we had to cancel surgery because of beds for the first time in almost a year. Fortunately, it wasn't worse. As more nurses, MDR

techs and anesthesiologists are recruited we will be able to open more ORs. We have already increased our OR capacity some-- and it shows with increased volumes.
Things are looking up!

have a great week

Monday Message: February 5, 2024

Wow, that was quite a storm. I hope everyone is safe.

I think it was a very sensible and responsible decision to cancel elective surgery as much as possible. Of course, now all those people have to be rescheduled. Just over a week ago, I had a "congratulations" from Karen Oldfield that our surgery volumes were up, wait lists are down.

This data demonstrates that when we are provided with resources, we do the work. We are essentially back to pre-pandemic volumes which is really all anyone can ask of us.

I hear your angst-
C3, OCEAN, OPOR, centralized booking – it is overwhelming.

After COVID why can't we be left alone to do our work operating?

Last week I realized that many of you may not have a clear understanding of what all of these programs do and why we have them.

More importantly how do these programs help you?

OPOR—an electronic medical record system—one source for everything to do with the patient: history, tests, procedures, orders, etc

I know the process is painful and implementation will also be painful but it will make practicing surgery easier- you will have all the info about your patients with a few keystrokes

We are desperately behind in this domain and the lack of a reliable EMR is hurting us and contributes to adverse events for patients.

This will improve our ability to provide good care to our patients.

C3- is a patient flow tool--- why did we need it? We had no accurate real time data on which beds were vacant; bed rounds were a game of broken telephone.

How does this help you? It has allowed us to go ahead with surgery everyday with minimal cancellations due to lack of beds. In fact until last week we have had virtually none.(And of course the storm this past weekend).

It is the one source of truth re occupancy.

Centralized booking: first I want to remind you that this is all about booking procedures in the OR and ultimately in endoscopy and nothing to do with patient referrals.

Monday Message: February 5, 2024

Why do we need it? Because we have so many patients waiting for surgery. It can be difficult to keep track of all of them- Centralized booking puts all patients in an electronic waiting list- it takes them off a folder on your desk.

Some surgeons and admin assistants have commented that they feel they are being punished- that we are in effect telling them that they are not doing a good job—this is not the case—but we can do better.

How will this help you? It will make it easier to identify patients who have been waiting and to prioritize them in terms of all the others who are waiting. It will make it easier for admin assistants to put together an OR list.

In response to your questions about control of your list—you will have final approval, you will have the option to change the list at short notice if you have a more urgent patient—you will still have ultimate control

OCEAN : OCEAN is really a tool for our referring physicians. The goal of OCEAN is a single entry point into the system to make it easier for family docs and other referring physicians to send a patient to a surgeon.

Does it help the surgeon—maybe it will but at this point there are still growing pains. I have no doubt it will improve.

In the end it is really all about the patient: trying to get them into the system in a timely manner, get them to the right surgeon, and get them into the OR in a timely manner.

It is unfortunate that the one tool that would help surgeons the most—OPOR is not on line yet but it is coming soon.

It is also unfortunate that all of these tools have rolled out one on top of the other with no time for us to get used to one before the next is upon us.

I know these have all been imposed on you and that is never welcome no matter how good these things may be.

But it will be fine. Take a deep breath, be calm and carry on.

Keep doing what you do best—taking care of patients.

Afterall that is why we are all here

Monday Message: February 12, 2024

Happy Monday- Sunshine today and snow on the way!

On Saturday I attended an in person meeting of the Canadian Association of Surgical Chairs. We had 3 attendees who were virtual and 3 Department heads who did not attend. It was actually a very useful meeting (to my surprise). Being in person is such an improvement on virtual. It really was worth the trip. One issue that was discussed was "surgicentres". Many provinces are paying large sums of money to a private group for joint replacements. These private facilities are drawing nurses, anesthesioloigst and surgeons out of the public system with lucrative pay and Mon-Friday daytime operating schedules. Of course, they only offer services to the "best" patients- low comorbidities, etc. And of course day surgery only. So, the comorbid, complex patients who require overnight stays continue to have surgery in the public system. Not surprisingly the cost per case at the private facility is less than the cost per case in the public hospital. These private companies then go to government and announce how cost effective they are. In London ON, Western has developed a public surgicentre. It follows all the same rules as the private clinic: healthy, non complex, day surgery patients. The facility is governed by the same standards as the hospital. And guess what? The cost per case is similar to the private clinic but it doesn't bleed human resources from the public system. Here in NS we are trying to do the same with the purchase of Scotia Surgery. I applaud our CEO for not buying into the private clinic marketing. Currently we are having discussions about how to optimize utilization of Scotia Surgery. At this point in time, we do not have full access to the operating rooms there but ultimately, we will. Our vision is to have our own NSH surgicentre: to offer high throughput cost effective surgery to the appropriate patients. This will provide more OR time for complex surgery, and comorbid patients who need to be done in a full-service hospital. For surgeons this is a win. For some surgeons this may disrupt the way you have always done things, but this is the way forward. We all need to be on the train.

A number of surgeons have questioned why they haven't been paid for their "extra OR day".

When this was first operationalized, I sent a message to DOS explaining how this would work. To remind you: you submit your billing for the extra days using the new BA code. MSI will match your billing with the patient lists submitted by your hospital. If the lists match, they will pay. They pay out quarterly. DOS has just received the first payment for work that was done last year under this new agreement.

“Medavie has to allow for the standard 90-day billing window to pass before claims are paid out. Post 90 days, Medavie will review claims for application and payment of base + premiums (for AFP Departments) based on the list of eligible surgeries provided by NSH.”

I know it is not in surgeons nature to be patient-- but you will get paid- Be patient.

have a good week

Monday Message: February 26, 2024

A few updates!

Centralized OR booking has rolled out to urology and gyn oncology. Both services are happy and have not found this program to be onerous in terms of work for their admin assistants. Plastics and OMF are next up!

It will come as no surprise that our ED continues to be challenged.
The volume of patients coming through the doors coupled with the volume of patients who are admitted but are still in the ED because of lack of beds on inpatient units has led to a number of problems.

The ED staff do not have appropriate spaces to assess patients. Perhaps some of you have had a similar experience? Seeing patients in closets, in hallways, in the waiting room etc? This is the daily experience of our ED staff.

This also interferes with the ability of ambulances to off load patients, causing delays in responding to other emergencies.

Starting today, Monday, ED staff will be empowered to send patients to the inpatient units, to hallways or wherever, if the ambulance offload time exceeds a given target. The target for this month is 10% less than our highest wait time of 355 min (that is almost 6 hours!!). This directive comes from NSH executive leadership. It is unlikely that this initiative will have much impact on surgery but it may lead to some OR cancellations, or patients awaiting surgery being transferred to PACU instead of waiting in the ED.

Additionally, we will be held accountable for time to consult and time to disposition. Please get your residents down to the ED promptly to assess patients and make sure the resident discusses the patient with you promptly – not at the end of the case or whatever. I appreciate that having the resident assess and make a decision is a key part of their education, but you need to ensure it happens in a timely manner. The decision as to admission or not, operating room or not needs to happen as soon as you are able. If the resident is not available, you will have to go to the ED yourself.

The organization is working on other initiatives to reduce bed block, including renovating 4A at the VG, improving discharge planning support and reducing LOS and sometime we will have more LTC/ transitional care beds for ALC patients. There is also work happening with respect to hospitalists and medicine.

Our system is in crisis. We need all hands on deck. We are in this together

Monday Message: March 4, 2024

It is March. The sun is shining. Many of us are looking forward to a holiday over the March break period. I think we all need a break. I think many of us are overwhelmed by things at work, feeling we don't have the resources to do our jobs, to look after patients the way we know we should We are always triaging, always making do with what we have.

If you follow the world news, we are so much better off than so many. But it doesn't necessarily make us feel better. The news is full of stories of terrible things, things we can't control or influence. So even though we are better off than many, the overall result is that we feel even more burdened.
I don't have a solution. But I suggest we all try to do our best in our circle of influence even if it seems too small to make a difference.

When we have our DOS executive meetings we talk about issues affecting the department. Somehow it always circles back to the system and then the conversation stops because we can't fix the system.
I suggest that we need to approach this by addressing things within our control, becoming engaged with system leadership through committee work, bring our best listening skills and offer perspectives and solutions instead of complaints.

Somethings that do make a difference are kindness and respect. Bring your best self to work every day, act to improve things within your circle of influence, be kind and respectful.
Have a great holiday and come back refreshed and reinvigorated!

Monday Message: April 8, 2024

Happy Sunny Monday-
A very exciting day with the total Eclipse happening!
I haven't written messages for the past many Mondays—March break, Easter, etc.
I have to admit I have been overwhelmed by the news- Gaza, Ukraine, Sudan, and the American government.

Here at home we have been working on our deliverables document in preparation for our full day meetings with DHW and DNS. As I mentioned previously last year's contract, we signed recognizing that there would have to be in-depth discussions about deliverables this year.

Members will be represented by their division heads as well as myself at all day meetings on April 26th and another in June. I have attached the deliverables document to this email. I appreciate it is not the most straightforward thing to read but I urge you to do so and provide feedback to your division head or to me.

Other work includes working with leadership and KPMG to identify how we can improve efficiency in our operating rooms. They want us to do 2500 more cases this year. I have told them that we cannot do this without more surgeons but we have not heard about the business cases submitted last year so I don't know if we have been approved for any additional surgeons. In the meantime, attention has been directed to increasing our day-to-day efficiency looking at on time starts, reduced turnover times, reduced end of day cancellations ("run out of time") and same day cancellations related to anesthesia concerns not identified in preadmission. Surgeons often point their fingers at anesthesia or nursing but I can tell you they point their fingers right back! The truth is we all contribute to inefficiency—with the notable exception of Mike Gross who helps turn the room over. We could all take a lesion!
Surgery is a team sport. We all have roles to play including supporting the other members of team in their role.

Have a good week

Monday Message: April 15, 2024

Another drizzly Monday !
But we have a lot to celebrate: our research day award winners!

Dr Mark Maclean (neurosurgery): Dr Robert Stone Travelling Fellowship
Dr Ashley Robinson (general surgery) : Best Resident Presentation
Kavita Krueger (pharmacology): Best Basic Science Presentation
John Gobran (plastic surgery): Best Medical Student Presentation

Honorable Mention
Dr Jenna Smith- Forrester (neurosurgery) : Resident presentation
Neha Katote (general surgery): medical student presentation

Our judges Dr Emily Krauss, Dr Lutz Weiss, and Dr David Wilson had a very challenging task! There were 54 outstanding presentations!

Our Bethune speaker, Dr John Marshall gave a terrific address entitled " How COVID 19 is changing clinical research". This talk outlined a new paradigm in clinical research called a platform trial which is nimble and responsive. The current paradigm of RCT by its nature of strict entry criteria and rigid protocols does not allow for change in response to new evidence and may lead to out of date and irrelevant results by the time the trial is completed. As an investigator in several such RCTs it is discouraging after untold dollars and many years to present the results of a trial that is no longer relevant.

Dr Marshall also made the important point that clinical trials should address important clinical questions and should be led by clinicians. An excellent example is the Canadian Critical Care Clinical Trials Group. These investigators have asked important clinical questions and have multiple NEJM publications as a result.

It is important that clinicians lead and participate in research.
That is the take home message of research day

Monday Message: April 22, 2024

Did anyone catch the Earth Day parade? It was quite a sight!
I had forgotten it was Earth Day-- so it was a good reminder.
With everything happening at work and at home, it is easy to forget about the impact we humans have on our home planet.
It seems so overwhelming-- what difference can one individual make?

But like in so many situations, little things add up.
Years ago, the messages were " turn off the lights" or "use cold water" for your laundry. Most people did these things probably more because it saved them money on their utility bills.

I read an interesting article about microplastics and clothing. When I think about microplastics, I think about plastic containers, water bottles, and packaging. But think about the synthetics in your clothing--- all from oil. In fact the fashion industry is competing with transportation as the biggest user of oil! Look at your clothing labels. I would wager that very few are 100% cotton, or 100% linen or 100% wool.

What can we do? The article I read suggested that we buy fewer clothes, less fast fashion, buy better quality that last longer and consider going to all natural fibres. Yup that costs more- but you will save money by not buying as many items.

The article also talked about how we do our laundry- yes cold water, but also gentle cycle and line dry instead of using the dryer.

Of course, we can do more than change our fashion choices. In the hospital there is much we can do especially in the OR. Dr Christie has spoken about this previously. We will have a DOS grand rounds on this topic in the upcoming academic year.

Have a good week. Spring is here!

Monday Message: May 6, 2024

It is Nurses Week: a time to thank our partners in care.
Nurses are essential partners in healthcare. Please thank those with whom you work for everything they do.

We are all grateful.

Spring appears to have arrived. The cruise ships have started to arrive. The end of the academic year is approaching.

We are looking forward to Golf Day and the start of summer.
It appears that we are really starting construction on the HI expansion which is very welcome news.
In the Department of Surgery, we are recruiting.
We have recruited Dr Alexandra Quimby in the Division of Otolaryngology - Head Neck Surgery and Dr Alexa Mordhurst in the Division of Vascular Surgery.
We will provide a proper introduction when they start.
Dr David Clarke is completing his term as Head of the Division of Neurosurgery and a new Head will be announced soon.

Meanwhile Neurosurgery is recruiting a Skull Base surgeon to replace Dr Steve Lownie who retired at the end of March.

Neurosurgery is also recruiting for a Spine Surgeon as Dr Jacob Alant has taken a position in the US.
Plastic Surgery is recruiting to replace Dr John Stein who has accepted a position at Western. Plastics is also recruiting via the TIP TOP process to replace Dr George Davis.
General Surgery at DGH is recruiting to replace Dr Les Waslewski via the TIP TOP process.
There is an additional position in Vascular Surgery and one in General Surgery.

We are still awaiting the results of the business cases we submitted last fall.
Meanwhile we have been asked to submit a brief form for any business case requests for fiscal 25-26.
These will be reviewed by QE II leadership to determine if a full business case should be submitted.
The deadline for the brief form is June 14th.

Lastly, we had our first AFP deliverables meeting on April 26th and I have just received the revised document. All DOS divisions were represented at the meeting on April 26th and we had a fulsome discussion with DHW, NSH, DNS and Physician Services representatives. Fortunately, DOS is well prepared, and we already have all necessary data on our DOS Deliverables Website. Many thanks to Marc Butler who has worked with NSH and IWK analytics to populate our deliverables website so that it is up to date. There were some bumps in the road on this project but mostly it will be smooth sailing from here on.

Have a good week

Monday Message: May 14, 2024

Sunshine Finally!
Apologies that my Monday message was delayed
Lots of things going on!

We are in the midst of discussions with DHW, NSH, IWK and Dal regarding deliverables. The clinical deliverables are relatively straightforward. We have all the data.
There is an expectation regarding increased OR volumes. I have stood fast on this. Even though funding was provided to open more OR rooms, and hire more anesthesiologists, the same number of surgeons cannot do more work.

We put in the business cases last fall asking for more surgeons but we are still waiting for decisions.

We have started our first TIP TOP process and have approval for 2 more. So far it seems to be a relatively straight forward process.

WE are working with KPMG on OR efficiency.
Our first priority is on time starts for the first case. This is multifactorial including the preop process, porters, nursing, anesthesia and surgeons.
Every time I hear that the room had to wait for a surgeon to show up, I feel nauseous.
We have to clean up our own house. I don't want to hear complaints about other groups when we are not doing our part.
I know there are a zillion things you need to do every day but at $100/ min- we can't afford to waste any OR time.

I don't believe that the other things you are doing instead of sticking around the OR are of more importance than the patient in the operating room.
You can answer emails on your phone or bring you laptop. Going back to your office is not acceptable.

As we move ahead with centralized booking, a reminder to have your bookings with complete packages in 2 weeks in advance. If you don't get your bookings in- you will lose your OR day and it will be reassigned.

It is totally fine if you switch a patient out to put in a more urgent case. The point is that we (the system) know you are going to use your time.

You may argue that you always use your time but not everyone does—and it is hard to reassign a day given up with only 1 or 2 days notice.

We can't afford to waste OR time.

Who ever said that I should make my messages more newsy and less philosophical might be regretting that comment!

So back to philosophy: there is so much bad stuff happening in the world, I can't bear to read the news. But it reminds me that we have a pretty good life here in Nova Scotia and much for which to be grateful.
Have a good week

Monday Message: June 3, 2024

June is here! A month to celebrate our graduating residents.

We have the annual A.S. MacDonald lecture on Wednesday morning 7:30 in the RBC theatre at HI. Sorry, there is no virtual option. This year's speaker is Dr Caitlin Hicks, a vascular surgeon who spoke up about atherectomy - an innovative technique that may have contributed to subsequent limb ischemia but was very lucrative to providers.

Dr Hicks spoke out despite the negative impact on herself from other providers.

This will be followed by our annual golf tournament at Chester Golf Club. Hopefully the weather will be more hospitable than it was on the weekend for Sail GP- which was exciting and amazing despite the weather especially for a land lubber like me.

Wednesday will be capped off with our traditional lobster dinner at the Shore Club. See you there!

Monday Message: June 10, 2024

Updates from DOS

WE had a fantastic day for Golf last Wednesday—the weather was amazing and everything was just perfect! Thanks to Sheila Reid for making all the arrangements and especially for the good weather!

The Dr A.S. Macdonald speaker Dr Caitlin Hicks gave a terrific talk on value-based care, and she joined us for golf and lobster! For those of you who missed her talk, it was recorded – and I highly recommend that you watch it—Charlene will send the link separately.

Congratulations to Dr Sean Christie who was selected as the new head of the division of Neurosurgery. My deepest gratitude to Dr David Clarke who was the head of the division for more than 10 years having been the interim head prior to his official appointment.

Dr Clarke built a great division that is incredibly productive and collegial. My understanding is that Dr Clarke is going to take a few months (coincidentally the summer months) to figure out what is next!!!

Congratulations to Dr Carman Giacomantionio who was selected to be the new Gibran and Jamile Ramia Chair in Surgical Oncology. This is a 5-year appointment once renewable.
We had very strong candidates for the chair and I want to thank all who applied. It demonstrates the strength and depth of the researchers in our department.
Thanks to Dr Geoff Porter who held the chair for many years and got our department on strong footing in oncology research. Dr Porter has retired from his clinical practice at QE II but will continue with his global surgery activities.

It is wonderful that others will benefit from his wisdom and experience.

Congratulations to Dr Michael Bezuhly who is taking over as our DOS research chair. Dr Bezuhly brings a wealth of research experience and success in grant capture. He has some terrific ideas and will be an excellent mentor to our researchers.

A big thank you to Dr Mike Dunbar who led the research team for many years and brought great success in gaining access to administrative data and utilizing this to identify system problems that affect all of us. The ED bounce back project caught the interest of our leaders at the zone level as well as in government.
I think this speaks to the importance of us being at the table in system improvement. Some might argue that this is quality improvement more than research but I would push back and emphasize that good research comes from good clinical questions. The ED bounce back project is just the beginning!

Tomorrow Tues June 11th we have a departmental business meeting at 5 pm. Please be sure to attend.

A heads up to all—we will be having a social event “Celebrating our People” on November 15th at Ashburn Golf Club. Instead of all the announcements I made at September Grand rounds I will be making an abbreviated version celebrating retirements, new hires, awards and promotions.
It will be a sit-down dinner with dancing to Big Fish.
Please mark your calendars!

Have a great week

Monday Message: July 8, 2024

Lots going on this summer.

We are in the process of recruiting! Some of the recruitments are replacements for retirements or departures, some are related to TIP TOP and some are net new positions recently approved through the business cases submitted last September. Looking at the applicants for these positions I can say that the future of Dal Surgery is very bright indeed! Our recruitment strategies follow best hiring practices used in business, academia and health care. Best practices include posting the position nationally (in some cases internationally) through specialty websites and journals as well as on the NSH website. Our selection committees include the division head, members of the division but also the relevant director, other relevant stakeholders and myself. We ensure that there is a mix of gender and ethnicity when possible. The committee may also include members from other departments or divisions for positions where there is a lot of collaboration. Our research director also will be involved for those positions wherein there is a major research commitment. We follow Dalhousie EDIRA policies.

Surgery applicants are required to have done extra training beyond their residency and also to bring "added value" in terms of education, research or leadership capabilities. It is through this approach that we grow Dalhousie Surgery, bringing new techniques and ideas. Henry Ford said, "if you always do what you always did, you will always get what you always got".

I have faced some pushback on this approach. Many of our Dalhousie surgery graduates are stellar, we know them, we know we can work with them, they will fit into our divisions. Indeed "fit" is very important. We spend more time with our work families than our biological ones so it is important that we can get along with the new recruit, they fit into our culture, and we know we can trust them. At the end of the day, we want to recruit the best candidate for the position and in many cases the recruit is a Dal graduate. Then everyone knows, we know, the chosen candidate knows – they really were the best person for the job.

We are planning to rejuvenate our quarterly DOS newsletter which will allow everyone to keep up to date with what is going on in Dal Surgery, including all our new recruits.

Don't forget our annual social event November 15 at the Ashburn Golf Club: "Celebrating our People". We will introduce our new recruits, celebrate our alumni and have fun! Mark your calendars

Monday Message: July 16, 2024

I guess everything is slower in the summer- myself included!
Two weeks in a row I have been late sending out my Monday message.

Recently I was reviewing our DOS code of conduct document.
As per the DOS executive we have changed the process for dealing with issues/ complaints such that the department head (me) will address complaints initially.
If required we will pass this on to our code of conduct committee.
A revised document is attached for your reference.

It was good to review the document and refresh my memory.
Of course, I remembered big things, but it was little things that had escaped my memory.
Things like avoidance of negative or non-constructive comments---- how often do we make these kinds of comments as an off-hand remark? I am guilty
Abstaining from derogatory criticism of the performance of colleagues or other health professionals **at any time,** both inside and outside of the health care setting—can I say I have never done this? Nope, guilty.

Following these “rules” are basic tenets of professionalism.

Thank you all for upping your game

The first of our new recruits started last week. Big welcome to Dr Ally Quimby who joined the division of Otolaryngology, Head and Neck Surgery!

DOS has a lot of great teachers!
Join me in congratulating Top 10% tutors
Med 1 tutors: Chris Blackmore, Stephanie Hiebert, Min Lee, Elaine Fung and Duncan Smith
Med 2 Skilled Clinician tutors: Emily Krauss, Ben Orlik, Cathy Coady, Jacob Alant and Andrew Caddell (whom we share with cardiology).

Teaching medical students is so important. Not only do surgeons have good teaching skills and important information to share, but early exposure to surgeons contributes to increased interest in surgical careers.
Students learn about what we do, how we save lives, cure cancer and improve quality of life. Early exposure to surgeons breaks down the stereotypes that students may have of us. We are a good bunch !

Have a great week

gail

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This week we welcome Dr Bernard Burgeson who is joining our division of Orthopedic Surgery. Welcome Bernard!

I am off on vacation for 2 weeks.
I hope everyone is getting some time off to relax and refresh!

Lots of things happening starting in September!
We will be welcoming several new recruits over the fall.
We will be following up on our strategic plan. A major thrust this year will be looking at quality: outcomes, enhance recovery and establishing benchmarks for wait times.
We are submitting a business case again asking for more surgeons but also supports for beginning our enhanced recovery programs.
I have received some guidance on governance for the Department of Surgery and Maureen Reid will present to our DOS executive in the fall to enable this work.
My theme for the upcoming year is for us to have a growth mindset, be innovative, be willing to try new ways of doing things.

We have worked on our deliverables template for the negotiations with DHW, NSH, IWK and Dal. It is in good shape. Our meeting will take place in September.
We have provided baseline data. I have emphasized that we cannot do more unless we get more resources—OR time, endoscopy time and surgeons.
We identified that our surgeons are working just as hard as before the pandemic but our target waitlist is still too long. Surprisingly, the same number of surgeons do the same volume of work. The additional ORs have not been fully utilized because we don't have additional surgeons to provide surgical care.
Can we be more efficient and get more done? Yes and we all need to do our share. So please help with our efficiency efforts.

And don't forget our annual social event Nov 15th at the Ashbourn Golf Club "Celebrating our People".

Have a good week!

gail

It appears that we have dodged the hurricane bullet this week,
but Fire and Floods elsewhere!
It seems like Mother Nature is angry with us and now we have payback for abusing our earth for so many years.
Summer is not over yet but already the school year is looming with back to school advertising.
Do we think about whether or not our children need all new stuff? Can we reuse that pencil case? That backpack? Do they really need the latest smartphone?
The peer pressure is enormous on our kids. If they don't have the latest whatever, will they be teased? Or worse?

Can we normalize and celebrate reuse? We should be role models. As adults and consumers, can we "make do" with what we have? Recycle? Reuse?
Do we really need a new pair of shoes?
In the operating room, we have the opportunity to reduce waste by only opening the disposables we actually use. We have the opportunity to recycle. Do we need to let the water run the whole time we are scrubbing?
These things seem so small but they add up. It is a start.
We all need to do our part to help.

Enjoy the remaining weeks of summer. It is a special time.

Gail

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Hope everyone had a good summer!
Although summer officially continues for a few more weeks, the Labour Day weekend marks the end of summer culturally.

In the 6 month report card for our strategic plan we identified that we had accomplished a number of goals specifically related to governance. However we really hadn't accomplished much in the domain of Quality.
So our focus for this upcoming year will be on Quality.
We have already started this work by Dr Greg Hirsch our DOS chair for our quality committee reaching out to all divisions to start working on Enhanced Recovery After Surgery pathways for 2 or 3 common procedures. Some divisions have made progress, others haven't started.
To kick start our Quality work, our first Grand Rounds on Sept 11th will be given by Dr Gregg Nelson who is the lead of Enhanced Recovery Canada. This will be a joint round with Urology, Gyn-Oncology and Anesthesia.
There will be an opportunity for divisional quality leads to meet with Dr Nelson after the rounds. We will then be asking divisions to send in their proposed pathways. This is just a start. My plan for next year's business case is to request the support needed for a departmental roll out of these initiatives.

Out of the research work led by Dr Mike Dunbar on ED bounceback which was presented at our annual research day, it was identified that ED visits by postop patients accounted for 2% of all ED visits. That may sound like a small number but the direct cost for those visits exceeds $4 million. Furthermore, the majority of visits were for relatively minor things like wound assessments, and analgesia. Totally avoidable. With this in mind Dr Jenna Forster and Dr Sean Christie have proposed a postop clinic at Bayer's Lake open Monday to Friday- 9-4. We have included a request for this in our current business case. This would also include an early postop telephone call to patients which would serve to identify problems needing early attention but also to answer questions and reassure patients. Of course significant problems would be escalated to the staff surgeon.

Our other quality initiative that will start this fall relates to opioid prescriptions. As surgeons we contribute to the opioid problem by overprescribing which can lead to addiction and diversion. We need to be part of the solution. More to come on this work soon.

Have a good week
gail

Welcome to our 4 new DOS recruits who started over this past week!
Dr Chris Chin ENT
Dr Ayham Al Afif ENT
Dr Rhys Kavanagh General Surgery DGH
Dr Nadim Joukhadar Plastic Surgery

I am so pleased that we have been able to recruit outstanding surgeons to our Department of Surgery. They bring new ideas, techniques and perspectives to our Department. It is so easy for us to get set in our ways.
All of our new recruits have worked or trained in other centres. They can push us out of our comfort zone—out of our rut!
As an academic Department of Surgery it is our mandate to advance our specialty. This is why it is important that we travel to other centres to see new things, attend conferences to gain new knowledge, read the literature to keep up to date.
It is not good enough for us to just to keep doing things the way we were taught during our training. We need to measure and constantly evaluate our results. We need by open to new things and compare the new technique with our standard of care.
This is how we will advance.
I would also encourage our department members to attend international conferences- in the USA and elsewhere. So many advances are happening outside of our borders, it is important that we keep abreast of what is happening. Again, it is important to get out of our comfort zone!
Lastly adopting new ways of doing things applies to our health care system too!
I know that many new things were foisted upon this past year or so—OCEAN, centralized booking and in the upcoming year OPOR. These things challenge us, push us out of our comfort zone, and make us change our routines.
The launch of new systems is never completely smooth but based on feedback (or lack thereof) things seem to be going better that I anticipated.
Thank you all for your cooperation as we improve our health care system.
Our health care system exists for our patients and our job is to do everything we can to improve health care delivery for them whether is it a new way to book ORs or a new technique.

Have a good week
gail

Sticks and stones may break your bones but words will never hurt you.

Not true!
Our words are very powerful.
Consider online bullying—so powerful that people have committed suicide.
Our words are powerful. We often don't realize how offhand comments can be very damaging.
We often don't realize how our words or tone may be offensive to others.
As surgeons, we are in a high stress, high stakes environment. We get frustrated, we lose our temper, we swear, drop a few F-bombs.
We don't mean anything by these words, they are not directed to anyone except maybe ourselves. In the past, these incivilities would be overlooked as people understood we were stressed.
We got a "by" in the civility category.

Civility and respect in the workplace is no longer optional.
We are all held to high standard.
I appreciate that all of you are aware of this and achieve this standard every day. Thank you.

Even so we may say things in casual conversation that are offensive to others. Some people decry this "woke" culture, that we have to watch every word we say lest we offend someone.
I would say that we need to be respectful of others, we need to be aware who is in the room, who might overhear our words.

I can't tell you how many truly offensive jokes I heard as a trainee and I am happy that I know longer hear them. We have come a long way in terms of civility.
Let's take it to the next level.

Thank you for considering your words

Have a great week
gail

On call.
What does this mean?
I think it means being available to look after patients after hours, whether by providing guidance over the phone to housestaff or other staff physicians, or coming into the hospital to assess a patient or take them to the operating room.

When I was a senior resident at Western, I was on call for my surgeons everyday, every week for the six months I was on that rotation. Then I switched teams and was on call everyday, every week for six months for a different group of surgeons.
The only time I was not oncall was during the two weeks I took vacation. I was in the hospital every evening until 10 or 11 and often overnight. I started sleeping in the lounge after I nearly drove my car off the road. I was sleep deprived and exhausted.
We now know this was not really a good idea.

Residents now have limits to their oncall schedule and they have their post call day off. If residents take call from home, they are allowed to be on call more frequently but if they have to spend time in the hospital it is considered to be in hospital call and call frequency must be adjusted.
This is a good thing. It is hard to learn when you are exhausted. Patient care may be compromised by exhausted sleep deprived physicians. I am not going to argue for or against the literature on this.

So what about staff surgeons? We are pretty fortunate at Dal that we have sufficient surgeons on most teams, that our call burden is not onerous. There are exceptions to this for some subspecialties eg pediatric neurosurgery and cerebrovascular neurosurgery wherein the surgeons are on 1:2 call.

What about post call day off? If you have been up all night should you work the next day? Generally, we work the next day because we are not up all night every night we are on call. How many of you have cancelled your next day activities because you were up all night? But does the knowledge that you have to work the next day, influence your decision to take someone to the OR at 2 am? When you are tucked into bed in a deep sleep and your resident calls about an emergency case that needs to go to the OR, do you jump out of bed? Or do you think hmmm- I wonder if it can wait until the am? Maybe we should repeat the bloodwork? Get a CT scan?

Should surgeons consider having a night shift like Critical Care? Those who cover the night shift would have the next day off. How would this work with the AFP? Would the surgeon have to stay in house? Critical care night shift doesn't stay in if things are quiet. But if the surgeon is not in house - will they be as likely to take a patient to the OR at 2 am? Or 3 am? or 4 am?

Oncall is part of our obligation as surgeons. But being on call means working when on call. It doesn't mean leaving work for the day-time team. Whether it is an extra waitlist case or a 2 am case, we need to step up. If we want to be shift workers, we can join the others who have already made this change.

Maybe we should start a converstion?

gail

Today September 30th is a National Day for Truth and Reconciliation.
Establishment of a statutory holiday to" honour Survivors, their families, and communities and ensure that public commemoration of the history and legacy of residential schools" was # 80 of the calls to action from the Truth and Reconciliation Commission.
This call to action was passed unanimously by the House of Commons and the Senate.
September 30th was the day chosen for this holiday because this was Orange Shirt Day. Orange Shirt Day was established in 2013 initially in BC to promote awareness of the horrors of the residential school system. The symbol Orange shirt comes from a survivor Phyllis Jack Webstad, whose grandmother bought her a new outfit for school—just like all of us. Ms Webstad wore an orange shirt on her first day of school which was taken from her on arrival at the school and never returned. Of course September is when the RCMP came to take the children from their families.
The initial proposal for a statutory holiday was tabled in the House of Commons on September 29, 2020. But it was after the discovery of the 215 unmarked graves at the site of the former Kamloops residential school that spurred the government to move forward and fasttrack the bill.
I have read that In Indigenous culture, the colour orange represents sunshine, truth-telling, health, regeneration, strength and power. How appropriate for the National Day for Truth and Reconciliation .

Not respected in life and not respected in death.
How could this happen?
Government approved the residential school system. Our government. Our elected representatives.
How could they approve such a system? Perhaps our elected representatives didn't read the fine print, assumed that the true intent of the residential schools was actually to provide indigenous children with education.
Afterall education is a good thing.
We now know that the real intent was to "take the Indian out of the Indian children", assimilate them into White man's culture, ie cultural genocide.

Education is a good thing. We now know the truth about the residential school system. Our children now learn about this dark side of Canada's history.
Just like in Germany and South Africa, we must remember the horrible things we did as a nation, and be reminded of this part of our history, lest we repeat it.

So I ask you, as you relax on your day off, to remember why you have the day off. Our Indigenous people suffered and continue to suffer because of actions of our government, our elected representatives. We as individuals didn't create the residential school system but consider how our attitudes continue to contribute to inequity for our Indigenous people. All people deserve to be heard and respected. All people.

gail

Why did you go to medical school?
I think that we all wanted to contribute, to make a difference, to help people.
At least this was supposed to be our motivation.
Money of course is a great incentive. Work more, get paid more. This is fee for service.
But FSS doesn't always work. Especially in a small province like Nova Scotia, we cannot provide the breadth of services the province needs and still make a reasonable living.
We also are not workers in factory turning out widgets.
So we have an AFP. This allows us to provide the care Nova Scotians need and deserve, allows us to contribute academically by teaching future physicians and surgeons and contribute to new knowledge through research.
AFP allows us to do these things without taking a hit in our income. It also allows us to go to conferences or go on vacation without financial penalty.
For someone who worked in a FSS environment for my whole career in Ontario, I think we are very fortunate here in Nova Scotia.
Ok so the orthopedic surgeons and the neurosurgeons don't make as much in Nova Scotia as they do in Saskatoon. The plastic surgeons are making at least double what those at the University of Toronto bring home.
You may disagree but I think we have a pretty good set up here.

All this is contingent on us providing the care Nova Scotians need and deserve.
We recently engaged with DHW, NSH, IWK and Dal re our deliverables.
In the document we reported our current volumes. Some of you might say – well that's all we get paid for—that's all we are going to do.
That is not correct. We are paid to look after Nova Scotians, to provide the care they need and deserve. For this, we get paid vacations amongst other things.

In my Monday message of Sept 23rd, I asked a question about our work. Do we want to be shift workers? Paid a sessional fee like Anesthesia, Critical care and Emergency Medicine?
This would be a radical change from our current payment model wherein we are paid for comprehensive, holistic care.
If you do not want to change the payment model, then we need to step up.

Senior leadership recently identified that we in CZ gave back over 500 days due to slow downs:
DGH site 25% reduction for 6 weeks in summer= 60 rooms –and 50% for 3 weeks -54 rooms –total 114 rooms
VG site 25% reduction for 6 weeks in summer= 90 rooms ,and 50% x 3 weeks- 75 rooms for total 165 rooms
HI site 25% for 6 weeks in summer= 120 rooms ,and 50% x 3 weeks -111 rooms for total 231 rooms
My rough math and estimate has 510 rooms during this time .

The reason for the slowdown is that this allows our nurses to all have vacation time during the summer. Anesthesia has always supported this.
For surgeons it has been different in that we can take vacation whenever we want as long as our service is covered.
We all want our vacations, and we need them. But our patients need care. We must work with NSH to deliver care.

I don't believe any of you want to be shift workers. So I am counting on you to step up.
Thanks

Sunshine to start a new week!
I hope everyone had a wonderful Thanksgiving weekend.
We have so much for which to be grateful!

gail

What a fabulous weekend! The weather was - and is amazing.
I personally am overwhelmed with all the badness in the world- I actually can't read the news these days.
We celebrated Thanksgiving last week- and truly we here in Nova Scotia have so much for which to be grateful.

I am sharing the lyrics to a song that a dear friend shared with me--
In case you missed it-- or didn't bother to open it- the punch line is:
" and no one seems to know this is heaven".

Have a great week.

Last week Karen Oldfield announced the appointment of a new NS Health Administrator and the plan to create a Health System Performance and Accountability Council. Interestingly, our DOS executive had a presentation by Maureen Reid last week about governance. Our DOS executive functions partly like a board of directors and is responsible for our performance and accountability.

One of the areas of work for the organization is OR efficiency. Initial efforts have focussed on:
1) first case on time starts,
2)first case goes ahead whether or not a bed is available unless an ICU bed is required,
3) submitting the order of the next day's waitlist by 6 pm.
The first two initiatives are working well.
The waitlist initiative is supposed to facilitate starting the waitlist on time but I am not certain this is working as well as it might.
4)Centralized booking
5) The booking deadline of 14 days (30 days at DGH and Hants).
All divisions are now using the centralized booking system. The key to this is that all consented patients must be in Novari. This allows us to truly know how many patients are waiting for surgery. The 14 day booking rule is working fairly well overall but some services have some issues which we are addressing. Importantly cancellations have been reduced and we have increased our utilization of OR time especially at the QE II.

The next areas of focus are:

1. Right cases, right site: we are underutilizing Hants but do we have the right case mix/ patient population? We are looking at our data.

2. Optimizing the block schedule: this may require revising the master schedule to balance periop flow and resources

Just as the overall health system has to optimize performance and be accountable, we in surgery have to do the same within our sphere of influence.

I know that all these changes have been challenging for you and your assistants.
I am grateful for your efforts to optimize our surgical programs to improve access for our patients.

Thank you all
Have a good week

gail

Tomorrow is the US election.
Although the pundits discuss differences in policy and various other issues, to me the most important issue is the character of the two candidates. The Oxford dictionary defines character as
"the mental and moral qualities distinctive to an individual".

As surgeons, the matter of character is important. We take this one step further and refer to professionalism. What does it mean to be a professional? Inherent in the definition is a commitment to excellence. A professional is honest and trustworthy. A professional puts the patient first and has the courage to advocate them and the ability to put themselves in the patient's shoes.

I think we sometimes forget that it isn't about us- the surgeon. It is about the patient. What is best for the patient in front of us? What is best for all patients? As health care providers we need to understand this. The health care system has to prioritize what is best for patients. Sometimes that means that we to change the way we work. That doesn't mean that we need to compromise in delivering high quality care.

Henry Ford said - " if you always do what you always did, you always get what you always got".
Change is hard and uncomfortable. We need to be open to change. We need to be engaged in discussions and decisions. We need to consider what is best for the patient (not ourselves) and advocate for them.

Thank you for all that you do every day.
Have a good week

gail

Today is Remembrance Day.
We pause to remember at the 11th hour of the 11th day of the 11th month. We pause to remember the dead. The thousands of young men who never came home from the Great War: The war to end all wars. Except it didn't. We have had a long period of "peace", at least for us here in Canada but our Canadian Armed Forces have continued to serve in conflict zones- most recently Afghanistan even though our nation was not "at war". Some of those who served did not come home, but even amongst those who did return to Canada many were damaged. The physical wounds were obvious but the PTSD with which some are afflicted is not. It was called "shell shock" in the Great War. In a way it is surprising that some soldiers escape this. They all have witnessed, experienced the horrors of war.
Today while we remember the dead, we should also remember those who live but continue to suffer as a result or war. We must also remember to be grateful to all those who serve.

In Flanders Fields *by John Macrae*

In Flanders fields the poppies blow
Between the crosses row on row,
  That mark our place; and in the sky
  The larks, still bravely singing, fly
Scarce heard among the guns below.

We are the Dead. Short days ago
We lived, felt dawn, saw sunset glow,
  Loved and were loved now we lie
    In Flanders fields.

Take up our quarrel with the foe:
  To you from failing hands we throw

The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.

We had a terrific party on Friday night
Big shout out to Charlene for organizing the event! Thank you Charlene!
We had a great turnout including many of our alumni: Dr A.S. Macdonald, Dr Chris Jamieson, Dr Michael Johnston and our recently retired: Dr Dave Kirkpatrick, Dr Geoff Porter and Dr Steve Lownie.
Several of our new recruits were able to attend: Dr Bernard Burgeson, Dr Ayham Al Afif and Dr Phil Tremblay.

Big Fish provided excellent dancing music. Who knew that Dr Dave Johnston was so light on his feet? I think he and his wife Atula win the prize for longest on the dance floor!

I was absolutely delighted by the noise level in the room-- so many conversations and laughter.

On Friday I attended the Dean's retreat. The focus was on the pillar of the strategic plan entitled valuing our people. One of the sessions was on wellness. I think that wellness initiatives are best delivered locally ie within departments or divisions or just between individuals: getting together, having face time, sharing stories good and bad, and small daily acts of kindness and respect.

Thank you for all you do!

Have a great week

A couple of weeks ago I attended the annual Dean's retreat.
One of the pillars of the FOM new strategic plan is "valuing our people" and this was the focus for this year's Dean's retreat. We had an excellent discussion on wellness. We also discussed about all the resources that have been implemented to help our faculty. I have to admit I had not clicked on the emails that provided details of these things. I had no idea of the breadth of resources. You might check them out!

At the same time, I had a bit of the same reaction as I do to "wellness event" — you know the yoga class?
I actually think yoga is great-- the whole "zen" nature of it, mindfulness, physical focus and clearing your mind of all the nasty things going on.
Do I do yoga? No but I would like to. So why don't I do it? These sort of things that I know are good for me, and that I might even enjoy, have just never been part of my life as a surgeon. I just didn't seem to have time for these activities, there were so many other things that were more important- including my children.
Many of you figured this out and make time for things outside of surgery. I applaud you. It is not only the physical activity that is a benefit, it is spending time, interacting with people.
This is important for your wellness.

When we look at what makes people feel valued, it isn't all the great resources provided by FOM although they are useful. What make people feel valued is respect. They are listened to, they have a voice, they are acknowledged.

In a health care bureaucracy, we often feel like no one is listening to us. They don't even ask our opinions about things that are of great concern to us. Oh yes, we are asked to be on committees and this is interpreted as us being involved and part of the decision making.

To be fair, we don't always step up and get fully engaged with things that are going on in our organization. Why not? Because we are busy!! Also many meetings are scheduled during our clinical day. But we need to speak up and share our opinions and knowledge. We may have to do it in an email if we can't attend the meeting. The road goes both ways.

We may think we deserve respect for the work we do, our education and accomplishments. And I think we do, but not if we behave like jerks. Every member of our team is essential to the success of what we do. And they each deserve our respect. They deserve to be listened to, to be heard, to be acknowledged.

Treating our team members with civility and respect every day demonstrates that we value our people.

Have a good week
gail

On Friday December 6th, we remembered 14 young women who were murdered at Ecole Polytechnique in Montreal just because they were women. The gunman called them feminists whom he blamed for everything wrong in his life.
The largest massacre in Canada in modern times took place in Portapique in April 2020. The killer Gabriel Wortzman began this massacre with an assault and subsequent attempted murder of his partner Lisa Banfield.

We would like to think these are isolated events of people suffering from mental illness. Does this explain the epidemic of femicide? I suspect that this epidemic is nothing new- it just has a name now. Intimate partner violence is often at the root of femicide. Women have been dying at the hands of their partners forever. Perhaps there is more awareness so that it is identified for what it is. Reporting of Intimate partner violence increased from 2014 to 2022 when it apparently stabilized.

In Nova Scotia, the rate of IPV is 344 per 100,000, which is about the same as the Canadian average. 78% of victims of IPV are female. Lest you think that the men who perpetrate these attacks are different, less educated, less affluent etc, there are many instances of well educated, affluent men who attack and murder their partners including a brilliant talented young neurosurgeon in Toronto named Dr Mohammed Shamji.

So what is the common thread? Why do men perpetrate violence against women? I certainly don't have the answers.
But until we address the root causes, this epidemic will continue. A recent opinion piece in the Globe and Mail queried why we are teaching women joggers how to protect themselves and not teaching men not to attack them?

I worry about our boys. We need to ensure that they grow up with their self esteem intact, understanding their emotions, acknowledging their vulnerability and providing them with the tools to succeed as caring human beings.

I love the phrase " we are all treaty people". It really says it all. We all belong, we are all on the same level playing field, we are all respected.

All respected.

Have a good week

gail

The countdown is on! 9 days until Christmas.
There is a flurry of meetings this week as the organization tries to get things done before the holidays.
We have asked surgeons to get their bookings in for the new year as much as possible with the thought that offices will not be open. Please do your best. I realize this is may be a problem for some of you. I have asked for some leeway on this.

The world around us continues to be in turmoil. Here is Canada we are blessed to live in peace. We have our problems of course but in comparison with people in other parts of the world, we are very fortunate. Of course the people receiving this Monday message are generally well off and not worrying about food or shelter. Not all Nova Scotians are this fortunate, I ask that you do what you can to support our fellow citizens here at home. I am not sure what if anything we can do to help those elsewhere. It seems that human beings have been fighting with each other forever. It is traditional to pray for peace at this time of year. It seems a bit trite to say this but I will anyway.

Have a good week and remember those less fortunate

gail

Merry Christmas to all!!
The tree is up and decorated. The shopping is done (mainly) and the food is organized.
I am making my gravy base today, preparing the filling for my Christmas Eve toutiere, and letting my bread for stuffing get dry. I made the Christmas pudding on the weekend- should have
Made it earlier but hey - you do what you can do!

We are having 14 people to dinner on Christmas Day- seated at a table that comfortably seats 10!
It will be cozy! And raucous! The grandchildren-3 and 8 will be pumped !

In days gone by I used to invite people who were alone - sometimes neighbours, sometimes residents or fellows. If you have room at your table- consider adding one more- the best gift of Christmas is sharing a meal together.

Very best wishes for the holidays and the New Year ahead!

Gail