BCMJ
BC Medical Journal

Letters for Personal View are welcomed. They should be double-spaced and fewer than 300 words. The *BCMJ* reserves the right to edit letters for clarity and length. Letters may be e-mailed (journal@bcma.bc.ca), faxed (604 638-2917), or sent through the post.

Warning: “safety” scalpels are dangerous

WorkSafeBC recently introduced regulations that “safety engineered scalpels” have to replace conventional scalpels—though there is no evidence that they reduce injuries. This regulation was recently implemented across the Interior Health Authority and will soon be coming to the other health authorities.

Contrary to their name, these devices are actually more dangerous. First, the protective plastic sheath is very difficult to manipulate back and forth, especially with greasy gloves on, risking injury to physicians and nurses. Second, the sheath has to be advanced and retracted multiple times during an operation, distracting the surgeon from the patient’s operation. Last, and most importantly, visualization of the blade is unacceptably obscured by the plastic sheath. This is illustrated in the accompanying pictures. The picture on the left is the visualization of the carpal ligament with a standard scalpel; and on the right with the so-called safety scalpel. Both scalpels are placed with the blade at the same level on the tissue and at the same angle of inclination.

WorkSafeBC has indicated that these scalpels do not have to be used if they are deemed “not clinically appropriate.” These will soon be coming to your health authority. For the sake of your patients and colleagues, be sure to be proactive in the process of establishing “clinical appropriateness” (or lack thereof) of these dangerous devices.

—Hamish Hwang, MD
Vernon Jubilee Hospital, Deputy Chief of Surgery

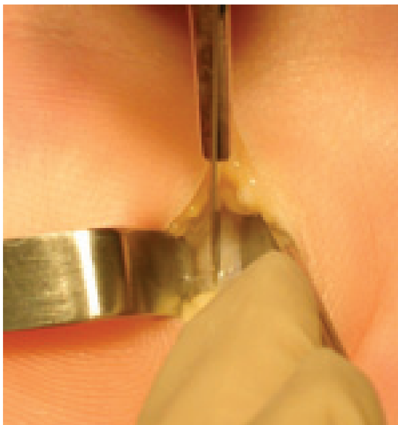
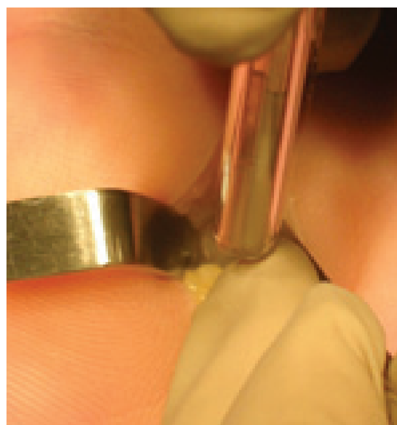

Figure. The carpal ligament with a standard scalpel (left) and a safety scalpel (right).

Re: Solving the primary care crisis

I read with interest the article by Nicholson and Levy (“Solving the primary care crisis,” *BCMJ* 2009; 51[1]:12-13). As an FMG who has practised in the distant reaches of rural Canada, I have always been struck by the lack of any real incentive system to attract physicians to those underserviced areas. The system proposed by the authors has merit, except in the suggestion that medical education should be “free.” In my opinion, creating one category of university students who enjoy so-called free education, whilst all other students and their tax-paying parents subsidize them, will never fly. A simpler solution, already utilized in many other countries, is for any interested community or health region to create a bursary system for eligible candidates. I myself was the recipient of such a system in South Africa, with partial coverage of my education costs in return for a service contract with the provincial government. Such a system would create an internal market for graduating students and allow the health regions to plan appropriately and to budget for future needs. A year’s worth of education bursary would translate into a year’s worth of service—the service would be according to the needs of the health region, but obviously would allow for some measure of choice for the newly graduated MD. In addition, should the MD wish to, breaking the contract would always be an option, with repayment of the bursary. This option encourages bursary-offering regions to offer competitive salaries and other incentives to discourage their bursary recipients from locating elsewhere.

—Alister Frayne, MD
Langley

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A recent article suggested that there is a good way to help medical students alleviate their crushing debt and at the same time assist outlying communities to solve their chronic shortage of doctors. The two eager students feel this is a classic "win-win," and on the surface of it they seem to be right, but they need to look a bit further back than their references went to see that this has been tried and failed.

When I was a house surgeon in New Zealand in 1976, it came to my attention that just such a scheme was being employed by the Australian government to entice students to make a commitment to the Flying Doctor Service (FDS)—2 years and your education is free. To start with this was fairly successful, until a few students found that their enchantment with the FDS was very limited. Some started to go to banks with their degree as collateral and arrange loans to pay off the government, get out into private practice, and repay the bank loan in less than a year.

Any system set up here would have to plug such a loophole (human rights?) or be so advantageous to the student that it would be a bad financial deal for the province. I think the principle of the proposed scheme is good, but it is a good deal more complicated to implement than it seems at first blush. Human nature and the real world always seem to get in the way.

—Mike Marshall, MD
North Vancouver

Teaching, research, and clinical practitioners

It is no secret that the university Faculty of Medicine and clinical practitioners who are currently clinical faculty teachers/mentors do not always see eye to eye.

What is the problem? Most of us enjoy and benefit from the company of learners, and since we remain short of doctors it is vital that we train more.

Who are clinical faculty and who "owns" them? Clinical faculty provide two-thirds of the teaching/mentoring needed to produce competent general practitioners and specialists; without them the medical school could not function. They owe primary allegiance to their patients; if anyone owns them it is society at large. They are certainly not owned by the Faculty of Medicine.

It is extraordinary therefore that the Faculty of Medicine, without first discussing the contents with them, sent a contract to clinical faculty accompanied by a letter asking them to either agree or resign. The meaning of this terse request remains unknown.

Would this be tolerated in other professions? We are in dire need of doctors; why frighten willing teachers away?

Equally worrying to many are rumors that clinical privileges in several regional hospitals will become contingent on agreeing to teach and even research. Given the university's insatiable quest for research publications to increase its international ranking, if clinicians are required to contribute in order to keep their clinical position, the danger is obvious.

Although with a mutually agreed working arrangement most clinical faculty would be enthusiastic teachers/mentors, the pressure to research is ominous. As reported on 17 February 2009 in the *CMAJ,* "The potential for patients to be coerced into participating in trials or be subject to undue influence is considerable…"

The CMA, concerned at this pressure on clinical faculty, passed Resolution 21 at their meeting in August, 2008 stating they "… will work with provincial/territorial medical associations to inform faculties of medicine, provincial/territorial ministries of health and regional health authorities that the linking of hospital privileges of attending physicians to the requirement to teach and conduct research is unacceptable…"

The UCFA/SCF (www.bcdoctorswhoteach.ca) is the only group trying to get justice and respect for clinical faculty, but we need much more support if we are to prevail. With an agreed, not an imposed, contract most would happily enroll and get on with expanding our medical school in harmony with our colleagues in the university.

Other countries have settled this problem; why can't we?

—Angus Rae MB, FRCPC
Clinical Professor
Emeritus of Medicine
BCMA Section of Clinical Faculty

The Dean responds

The Faculty of Medicine, now numbering 3600 people across the province, includes those who are appointed as clinical faculty members and who contribute significantly to the academic strength of UBC's reputation nationally and internationally. The value of this contribution is extraordinary and is an integral part of the teaching and research programs that are conducted within the Faculty.

I believe that all of us are engaged in the health system with a primary view of improving the health of our population and our patients. The suggestion that the Faculty "owns" any of our colleagues I find both most disrespectful and inaccurate.

When it comes to contracts regarding clinical faculty appointments, although it is not yet a perfect process, I am very pleased with the progress that has been made in the development of the recent contract letter provided to those with clinical faculty appointments. This positive impression has been reflected in earlier correspondence in this *Journal* from myself and Dr William Mackie, President, BCMA. The contract was developed after much active discussion with the Clinical Faculty Affairs Committee within the Faculty of Medicine, comprised of our clinical faculty colleagues, together with the Clinical Teaching Subcommittee of the BCMA, UBC Liaison Committee. Also key to these discussions was the extensive input of the office of legal affairs for both BCMA and USC. A significant majority of our colleagues have seen the positive advance in this contract and have signed this, allowing all of us to move forward with positive energy to address other matters facing the health care system and our patients in our province.

It is regrettable that uninformed opinions continue to propagate rumors that suggest that UBC is coercing practitioners to engage in the academic enterprise by limiting hospital privileges. This is plainly inaccurate. Indeed, the Faculty of Medicine does not require that hospital privileges are linked to a faculty appointment. It is fully appreciated that some of our colleagues in the province will choose not to engage directly and others will welcome the opportunity. As long as misinformed opinions are being expressed, rumors will continue, which surely does not serve students or potential teachers.

We are all most grateful for the continued contribution of teaching and research by clinical faculty members. Their commitments of time and energy are a critical component of improving the health of our population by increasing the number of practitioners and generating knowledge. We look forward to their continued collective success.

—Gavin C.E. Stuart, MD
Dean, UBC Faculty of Medicine

Re: Scope of practice

One has to admire Bill Mackie's measured tones when announcing yet another nail in the coffin of scientific, Hippocratic medicine in BC [*BCMJ* 2009;51(1):6]. It is obvious that the government is trying to placate the public's demand for greater access to medical care, but this is not the way. It might well be quite popular as the ability of the average layperson to evaluate diagnostic and therapeutic interventions critically is limited, yet at the same time many individuals see themselves as well informed after having consulted various Internet sites, many of them misleading and substituting plausibility for evidence. It goes without saying that in the process of allowing naturopaths, optometrists, and chiropractors to prescribe such powerful prescription drugs as antibiotics, antidepressants, and painkillers, the status of physicians in the community will be reduced even further and the quality of medical treatment in BC will be watered down and patients put at risk. As a profession we owe it to the public to prevent this from happening, and we have the tools to do so.

The physicians of British Columbia, as represented by the BCMA, should start a publicity campaign focused on explaining the meaning of evidence-based medicine, contrasting it with unconventional approaches. Throughout, we should remain objective, acknowledging that any intervention may have a non-specific effect. The placebo effect has been proven to make some people feel better, decreasing their anxiety, pain, and frustration. What it does not do is to fight diseases, a distinction rarely understood by the public.

At the same time we should dissuade the government from going ahead with its plans by making contingency plans for the profession as a whole to opt out of the provincial insurance plan and demand payment directly from the patients (which are then to be reimbursed by MSP). One suspects that the resulting uproar from the public, and the costs of setting up the additional bureaucracy, might well bring the government to its senses. The time has come for all good men and women to stand up for our profession and the future of quality health care in British Columbia. I look forward to the BCMA providing the leadership.

—Gerald J.M. Tevaarwerk, MD
President, Victoria Medical Society