

# BCM J

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@bcmj.bc.ca](mailto:journal@bcmj.bc.ca)), faxed (604 638-2917), or sent through the post.

## Flu protection for physicians

I have recently moved from Ontario to BC in rural family practice. I work in the clinic and hospital full-time in Invermere, BC.

In Ontario every doctor's office was supplied with a stock of protective masks, gowns, etc., after the deaths of doctors, nurses, and paramedics in the SARS outbreak in Ontario.

What are the BCMA and the Ministry of Health doing to protect front-line health care workers from the next pandemic outbreak?

Will we be supplied with protective equipment since we are asked to deal with these patients in our offices? Will we be supplied with prophylactic antivirals for exposed health care workers?

—Stephen Arif, MD  
Invermere

## The Provincial Health Officer replies

In response to Dr Arif's enquiry, I would refer all BC physicians to the recently posted documents on the Public Health Agency of Canada web site, "Interim Guidance—Infection Prevention and Control Measures for Health Care Workers in Ambulatory Care Facilities for Human cases of Swine Influenza A H1N1," [www.phac-aspc.gc.ca/alert-alerte/swine-porcine/hp-ps-info\\_amb-eng.php](http://www.phac-aspc.gc.ca/alert-alerte/swine-porcine/hp-ps-info_amb-eng.php) and

the accompanying document for "Infection Control Guidelines in Acute Care Facilities," [www.phac-aspc.gc.ca/alert-alerte/swine-porcine/guidance-orientation-ipc-eng.php](http://www.phac-aspc.gc.ca/alert-alerte/swine-porcine/guidance-orientation-ipc-eng.php).

The BC Ministry of Health Services is not planning at this time to follow the Ontario decision to supply physicians' private offices with protective equipment as the ministry believes it is properly the responsibility of the physician to ensure that infection control practices are in place in these offices.

At the request of Canada's ministers of health, a national advisory group reviewed the issue of providing antivirals as prophylaxis during a pandemic and recommended that governments not do this. Rather, they emphasized that government's antiviral stockpiles, with few exceptions, should be reserved for early treatment of infection during a pandemic. This report and its annexes can also be accessed at the Public Health Agency of Canada web site.

—Perry Kendall, MD  
Provincial Health Officer

## Why differences in tuna limits?

With respect to canned tuna in Canada, HealthLink BC Files recommend that British Columbians limit consumption of all types of canned tuna<sup>1</sup> whereas Health Canada currently recommends

limiting consumption of albacore tuna.<sup>2</sup> HealthLink BC and Health Canada have set different serving limits and age categories in their fish consumption recommendations. The recommendations also differ somewhat from those of the State of Washington and the US FDA/EPA.<sup>3</sup>

One of my associates, Dr Laurie Chan, chair of Aboriginal environmental health at UNBC, has told me that cheaper light tuna tends to have an Hg level 5 times lower than that found in albacore tuna.<sup>4</sup>

I would sincerely like to know the background, rationale, and references used by the Ministry of Health and the CDC to make this recommendation. I remember listening to Ray Copes in a meeting one day, and he mentioned

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that he had come across a case of Hg poisoning in a boy that was related to some higher-than-normal Hg levels in some canned tuna. Is the recommendation based on this incident? I would also like to know which government agency should be looked to for contaminant consumption advice.

—Karen Fediuk, RD

References

1. HealthLink BC Health Files. Healthy Eating: Choose Fish Low in Mercury. www.healthlinkbc.ca/healthfiles/hfile68m.stm (accessed 19 February 2009).
2. Health Canada. Mercury in Fish. Consumption Advice: Making Informed Choices about Fish. www.hc-sc.gc.ca/fn-an/securit/chem-chim/envIRON/mercur/cons-adv-etud-eng.php (accessed 19 February 2009).
3. Washington State Department of Health. Fish Facts for Healthy Nutrition. www.doh.wa.gov/ehp/oehas/fish/fishadvisories.htm (accessed 19 February 2009).

4. Burger J, Gochfeld M. Mercury in canned tuna: white versus light and temporal variation. Environmental Research 96 2004:239-249.


COHP replies

The recommendations in the HealthLink BC files have been developed based on BC and Canadian evidence and data indicating safe and at-risk human body mercury levels and consumption levels. The BC Centre for Disease Control (BCCDC) and the Ministry of Health Services (MOHS) agree with Health Canada’s review of mercury toxicity levels and the guidelines limiting mercury to below 1.0 ppm and 0.5 ppm for most fish and shellfish species sold in Canada. But because BC fish consumption patterns are unique in Canada and there is regional variation in mercury levels in the fish available to consumers across Canada, Health Canada’s fish consumption guidelines

regarding mercury risk do not apply well in the BC context. For British Columbians, information on local patterns of fish consumption, local levels of mercury in different fish species, and local risk factors for elevated blood mercury were carefully considered.


In addition, the BCCDC and the MOHS categorized the mercury level in different fish species into low (<0.1 ppm), moderate (between 0.1 ppm and 0.5 ppm), and high (>0.5 ppm) making them easier to understand. Health Canada has one regulatory cut point of 0.5 ppm of mercury and has recommended consumption limits for fresh and frozen tuna and canned albacore. Health Canada states that canned albacore tuna has higher mercury levels than other types of canned tuna and therefore does not recommend limits for consuming other types of tuna. The BCCDC and MOHS support grouping all canned tuna, including albacore, into the moderate category.

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to ensure that the rural clerkship remains a sustainable program, we encourage you to find out more about the initiative and get involved in any way you can.

The rural medicine clerkship is a valuable program that will help to increase the number of physicians choosing to practise in rural and northern BC. Nevertheless, in order for this important initiative to succeed, the students need the support of the medical community. With this support, we can work together to ensure that the future of presently underserved communities is improved.

#### References

1. Stewart MA, Bass MJ. Recruiting and retaining physicians in northern Canada. *Can Fam Physician* 1982; 28:1313-1318.
2. Rourke J. Strategies to increase the enrolment of students of rural origin in medical school: Recommendations from the Society of Rural Physicians of Canada. *CMAJ* 2005;172:62-65.
3. Wilson G, Kelly A, Thommasen HV. Training physicians for rural and northern British Columbia. *BCMJ* 2005;47:373-376.

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The types of recommendations can be confusing, especially between the different canned tuna, and fresh and frozen. Since the BCCDC and the MOHS have focused on local fish and local risk factors, their recommendations may be more appropriate.

—**Shefali Raja, BSc, RD**  
**Nutrition Committee,**  
**Council on Health Promotion**

## Re: BC needs another medical school

**W**hile I agree with Dr Murray's basic assertion that BC could be graduating more MDs ("BC needs another medical school," *BCMJ* 2009;51[4]:150), I would first suggest a recheck of the statistics. UBC will graduate approximately 256 medical students in 2010. With a population of roughly 4 400 000, that makes for a ratio of 5.8 MDs per 100 000 (not 2.8 MDs). Furthermore, Dr Murray speaks in broad strokes about Fraser Health having the courage to move ahead with a second "innovative" program. Is he talking about some odd notion to "fast track" a medical school *de novo* at SFU?

I would put it to you that patching together something resembling a med-

ical school with no reference back to existing resources (i.e., UBC) makes little sense from a time or resource point of view. Our peak need for physicians will hit between 2010 and 2030 as the baby boom makes a transition from age 65 to 85. After that, the load on the health care system decreases. UBC is currently on track to local and distant expansion across the province. It is accredited and offers programs both through a traditional model and an apprenticeship-type model at sites in the Lower Mainland, Vancouver Island, Prince George, Chilliwack, and, coming very soon, Terrace, Kelowna, Kamloops, and Fort St. John.

You would have to build a massive infrastructure, both in terms of physical buildings and people, become accredited, get students through the system, and then have them qualified and licensed. The most optimistic forecast would have your first MDs operational in 10 years. That would give your medical school 10 more years of useful lifespan until the population bust removes the demand. It seems like a great waste of resources and money when UBC is able to quickly expand and contract its medical school offering with an infra-

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—Ari Giligson, MD  
Delta

### Competing interests

Dr Giligson earns a stipend as undergraduate program director for the Department of Ophthalmology at UBC.

**T**he popular cry these days from politicians and some bureaucrats is that there is a need for more doctors. As a retired MD who practised and taught in BC from 1954 until retirement in 1988, I am concerned about the under-utilization of our existing hospitals. They generally operate from 8 a.m. to 4 p.m., Monday through Friday, handling emergencies whenever they occur. Even with our newer and more efficient technologies the waiting lists continue.

In most industries, when needs increase, plants operate longer, producing more results at reduced per-unit costs—as well as providing more employment in a particular field.

Surely this approach could apply to our hospitals. Why not operate from 8 a.m. to midnight, two shifts per day, Monday through Saturday? More patients could be treated and more laboratory and investigative procedures (e.g., CAT scans) could be carried out. This would benefit patients and their attending physicians.

All too often we hear stories of newly trained MDs having to leave BC (and Canada) to practise their specialties because of time restrictions in our current hospital management. This has become more apparent recently with ill-timed and inappropriate hospital closures throughout BC.

The change I propose would require creation of a new payment formula for hospitals that rewards them for work done (the more the better) as

compared to the archaic and old system of block payments per bed. So, while a new medical school might sound like a solution to our ever-changing needs, perhaps in the interim we could better utilize our facilities to enjoy the full potential of our present graduates.

—Al Boggie, MD  
Delta

## Re: Let's support naturopathy

**M**y esteemed colleague Dr Marshall Dahl has concluded that the “almost complete disappearance of formerly serious and prevalent problems such as chronic hypoglycaemia, chronic candidiasis, chronic Epstein-Barr infection, sero-negative Lyme disease, and toxicity related to dental amalgam” must have been due to “the efforts of the naturopaths and other alternative practitioners” (“Let's support naturopathy,” *BCMJ* 2009;51[4]:150).

I am sorry to have to disabuse him of that notion—they have all moved to Victoria! Since arriving here in “God's waiting room” they have increased their demands by asking to be tested for, among other things, Wilson's low temperature syndrome and adrenal exhaustion, and asking to be treated with ThyroSense, AdrenaSense, and bioidentical hormone replacement in addition to the black cohosh, ginseng, and dong quai they are already taking.

Vancouver's loss is our gain!

—Gerald Tevaarwerk, MD  
Victoria

**I**would like to thank Dr Dahl for pointing out a number of formerly serious and prevalent problems that have almost completely disappeared from his practice (“Let's support naturopathy,” *BCMJ* 2009;51[4]:150).

In this discussion I elect to comment on one entity, chronic candidia-

sis, candida hypersensitivity syndrome, also known as *Candida albicans* overgrowth syndrome. It is not to be confused with chronic mucocutaneous candidiasis.

The existence of this presumed disorder is based on clinical pictures and dubious diagnostic questionnaires. There is no specific diagnostic laboratory test. In addition, “no clear definition of the disease has ever been advanced.”<sup>1</sup>

The proponents postulated that the “sensitivity” to candida present in the gastrointestinal tract was responsible for various systemic symptoms. They managed this presumed disorder by dietary manipulation and use of anti-fungal medications. It received much attention in the media and health magazines in the past.

A position paper of the American Academy of Allergy Asthma and Immunology in 1986 stated that the concept was “speculative and unproven.”<sup>2</sup>

There is no scientifically valid evidence that cell-mediated sensitivity to candida antigens, present in about 50% to 70% of normal adults, is responsible for this condition.

A randomized, double-blind, placebo-controlled study in 42 premenopausal women with the presumed diagnosis of chronic candidiasis was reported.<sup>3</sup> It compared oral and vaginal nystatin with placebo. It was found that nystatin did not “reduce systemic or psychological symptoms more than placebo did.”

In 1990 the New Jersey attorney general secured consent agreements barring two physicians from diagnosing and treating *Candida albicans* overgrowth syndrome. Both were assessed \$3000 for investigative costs and had their medical licence on probation for 1 year.<sup>4</sup>

It is not surprising that this presumed disorder and others are presently with “reduced incidence and prevalence.” It is interesting that the naturopaths and other alternative practitioners had been spending so

much energy diagnosing and treating this presumed entity and others in the past, which are currently being barred in some jurisdictions.

I am not aware of any report of evidence-based studies published in peer-reviewed, reputable journals supporting the validity of the various diagnostic techniques mentioned. I have come across some patients spending hundreds of dollars for blood tests ordered by and sent away to US laboratories by some of these practitioners. Many reports show numerous positive results not validated by patients or physicians.

With regard to colonic irrigation, there is an interesting article on colon therapy and related quackery on [www.quackwatch.com](http://www.quackwatch.com).

We should always have an open mind to any complementary and alternative medicine. However, we should never lose sight of evidence-based approaches in the diagnosis and management of our patients.

—H.C. George Wong, MD  
Vancouver

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## Another unwanted plastic bag

**T**he plastic bag covering the May 2009 *BCMJ* has just sent me over the edge. We cannot

recycle plastic bags in Salmon Arm and your bag is just one more useless item to go in our landfill.

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—W. Peter Barton, MD  
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## Prenatal genetic screening

**T**he BC Perinatal Health Program has unveiled its new Prenatal Genetic Screening Program, with mailings of an algorithm and pamphlets to be handed out to patients.

The program is very good, with an algorithm that is clear and easy to follow. The recommendation with nuchal translucency (NT), however, I believe, puts us practitioners in a very awkward medicolegal position. The protocol directs that NT be recommended for pregnant women aged 35 to 39 "if available." However, when a requisition is submitted under such circumstances to either the BC Women's Hospital or Surrey Memorial Hospital (I have not canvassed other hospitals), the requisition is rejected citing "clinical situation does not meet criteria." I understand that NT need not be offered if the test is *not* available. However, in such instances, the aforementioned hospitals should issue statements that NT is not available. Otherwise, the implication is that it is available. In such a case, for us to not recommend it would expose us to medicolegal difficulties in the unfortunate (albeit maybe rare) circumstance that a positive case is not picked up by a Serum Integrated Prenatal Screen. On the other hand, if we

choose to protect our own behinds by submitting requisitions, fully expecting rejections, the patients would get confused and worried that they are missing out on a test that is recommended by the powers that be!

—Peter Yeung, MD  
Surrey

## Med student journal launched

**I**t is with great excitement that we announce the first edition of the *UBCMJ*! The *University of British Columbia Medical Journal* is a student-run, peer-reviewed academic journal. Currently, over 100 students at UBC from all levels and training and three distributed sites are involved in as writers, artists, reviewers, editors, layout designers, and executive directors. The *UBCMJ* accepts articles in all areas of medicine, including research, reviews, case reports, medical history, ethics, medical anthropology, epidemiology, public health, and international health. The *UBCMJ* also features original artwork and photography created by medical students as its cover art. With financial support from the CME, the BCMA, the UBC Faculty of Medicine, and the UBC Medical Undergraduate Society, the *UBCMJ* is available in print and online.

Please join us in celebration of our launch on 8 September 2009 at the Life Sciences Centre, UBC. E-mail [med.journal@ubc.ca](mailto:med.journal@ubc.ca) if you are interested in submitting student writing or placing an advertisement. Check out our web page at [www.ubcmj.com](http://www.ubcmj.com) for information on how to get involved with our second edition, and to download our first edition (available September 2009).

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