

Swine flu questions

As a retired physician, I no longer read the *Journal* as fully as I used to, but I was attracted to the article on swine flu (*BCMJ* 2009;51[6]:257). I wanted to know how long I have to wait after contacting someone who is sick in order to know that I have not caught swine flu. In other words, what is the incubation period of this particular virus? I expected an article entitled “What the physician needs to know” to give me that information. Unfortunately, despite reading the “definitive article” twice, I am still in the dark!

—Ben Wilkinson, FRCS
Cedar

BCCDC responds

A cardinal feature of influenza illness is its short incubation and sudden onset. For seasonal influenza viruses, the incubation period is generally estimated to be 1- to 4-days.¹ The 2009 swine-origin pandemic A/H1N1 (pH1N1) virus is considered a novel pathogen, but it is nevertheless an influenza virus and anticipated to share consistent epidemiologic characteristics. Published data estimating the specific incubation period for pH1N1 are limited but nevertheless consistent with this typical 1- to 4-day range, with some series suggesting an upper limit of 7 days.²⁻⁴

In light of these observations, the US Centers for Disease Control and Prevention,⁵ European Centre for Disease Control,⁶ and the World Health Organization⁷ each currently cite an incubation period of 1 to 7 days for pH1N1, acknowledging up to 4 days is a more likely range. The Public Health Agency of Canada also initially advised of a 1- to-7 day incubation period but has recently revised its guidelines to specify 1 to 4 days as most likely.⁸ Thus, even doubling the likely incubation period as a margin of error, most people may consider

themselves “out of the woods” if still asymptomatic at 1 week following specific pH1N1 exposure.

—Danuta M. Skowronski, MD
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Re: *UBCMJ*

It was quite exciting to read about the new *UBCMJ* (*BCMJ* 2009;51 [6]:245).

Many years ago, we started a journal: student run, peer-reviewed, which was published for several years around 1963–1966 or so (I do not know the exact dates).

The issues of the 1960s *UBC Med J* may be in the UBC Library archives—

it might be worth a look. Congratulations on the rebirth of the *Journal*, and every wish for its continued success.


—Lawrence Burr, MD
Vancouver

Glass houses


I practised over 20 years along conventional lines with primary obstetrics care, hospital care including serving orphaned patients on rota for what was then called “doctor of the day,” and so forth. I now serve my patients out of a reputable walk-in organization and see more intimately what happens here. Front-line medicine is clearly going through much upheaval despite the attempts of the usual organizations trying to revive primary family practice, with government incentives and multilevel calls for action. This fragmenting is not only here but across the globe, and disparaging an evolving segment, walk-in medicine, only reveals to me true ignorance.

I have now brought my patients and practice to merge into an established walk-in clinic. New graduates are so much disinclined to consider the onerous responsibilities of a full conventional practice with all the management responsibilities, overhead, etc. My previous attempts to “hire” new graduates speak to this difficulty. Teaching first-year medical students revealed that most of them readily brought up the notion of lifestyle in contemplating selection of practice venues when looking to the future. From my present vantage, I do not begrudge them such thoughts. Where I am now, I focus more of my energy in good clinical practice, and pay a little more to have the nonclinical aspects of practice governed by the corporation of the clinic. I am much involved in the walk-in component aspect as well, a blended system that more primary care physicians are developing, evolving, and accepting. Indeed, they are being forced to do so

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- 42% of Nephrologists

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due to the sheer number of orphaned patients. These numbers will continue to balloon unless we get a healthier balance to our own practices to limit burnout.

I am astounded at the numbers of patients who show up who have good primary clinicians in the community! This has to do with the convenience of longer operating hours at our clinic and the advantage of seeing a physician quicker, despite the wait in hours here vs the wait of a week or two to see their regular practitioners. Much of what I do now is like a subacute emergency department; we must be helping decrease the numbers showing up in the local hospital emergency. We triage cases that may require more urgent assistance. I admit my earlier wrong (and naive) assumption that walk-in clinics only had the “easy” cream of money-making problems, such as simple prescription renewals. No, there truly is a spectrum of acute conditions (including H1N1 influenza A). My colleagues here are excellent clinicians making good decisions, and we work in a system with good follow-up.

Be careful when throwing stones! Walk-in clinics are here to stay, like so many other initiatives that add to the complex and varied styles of practices and opportunities that are clearly healthy for a viable society.

—**John de Couto, MD**
New Westminster

Sexual Assault Service

I was pleased to note Vancouver Rape Relief’s information in the *BCMJ* (*BCMJ* 2009;51[6]:263). If you can supplement that information, we would like to add that for female, male, and transgendered patients (aged 13 and above) sexually assaulted within the previous 7 days, expert and supportive health care and the

option of forensic evidence collection is offered by the BC Women’s Sexual Assault Service at VGH emergency, no referral required.

We also offer support and resources to health care providers. For non-urgent information, including other services for sexual assault patients throughout BC, call 604 875-2183 during office hours. In urgent cases, we can be reached through paging.

—**Blanka Jurenka, MD**
Medical Director, Sexual Assault Service BC Women’s Health Centre

Re: GI endoscopy

I would like to respond to the article “GI endoscopy in rural communities: Experience of a rural family physician in British Columbia” (*BCMJ* 2009;50[6]:300-303).

I am a family physician and the author of the cited 1997 articles describing my initial experience in esophago-duodenoscopy and colonoscopy. Since then I have successfully performed many thousands more procedures as well as newer procedures such as pill endoscopy and ambulatory esophageal pH monitoring capsule (Bravo) placement. Though I practise in Georgia, I was trained in Edmonton, Alberta.

I would just say that I applaud the practice of endoscopy by well-trained family physicians in Canada and hope that Canadian doctors continue to encourage this kind of practice.

—**Richard Pierzchajlo, MD**
Tifton, Georgia

Hope

I lost a good friend recently. She was too young, too vibrant, too involved, too full of life to go so soon—just 51. But she died of metastatic disease. She died with hope and dignity and fighting to the end.

This story to those of us in medicine isn’t unique. But why I am writing this letter is to describe some of the good and bad interventions related to her care.

She was diagnosed after her initial presentation by her family doctor who explained to her and her husband what he had found. He made an immediate referral to the BC Cancer Agency where her initial oncologist asked her what she wanted and expected from oncology. She was told on this initial visit she could not be cured.

She wasn’t asking for a cure—just someone knowledgeable who would help her fight her illness—someone on her side fighting for and with her. Someone who gave the impression they cared!

She changed cancer treatment centres and oncologists. Her new oncologist was informative and told her he would do everything he could for her, but gave her and her husband realistic expectations.

When the initial chemo failed he went to bat for her, applying through a board of three other oncologists to get approval for another chemo costing \$15 000 per month. He kept both her and her husband informed and his door open for any concerns either of them had. He listened. He didn’t presume he knew better than they did what they needed, other than with specific regard to medical treatment.

Right up to the end she was hopeful—she had a cause—to fight, with the help of her oncologist, her family doctor, her husband, her family, her friends—and hopefully to conquer her disease. She had a reason to live, right up to the end.

She was an intelligent woman. She knew the gravity of her situation. But she wanted and needed allies in her fight and hope to go on. To take that from her would leave her without any hope—something we as physicians

have no right or reason to do.

The first oncologist was medically correct—there was no cure. But what the patient hears in these circumstances is, “There is no hope, no chance, no reason to try or go on.”

That may have been factual, but it was also cruel. We can have the discussion about getting one’s affairs in order, DNR orders, and so on, pragmatically, as part of the patient’s visits. We can do this without removing all hope.

Is being less than factual in these circumstances giving false hope? Is it wrong to not say in so many words, “No matter what we do you’re going to die?” I don’t think so.

I think hope, any hope, is something we can and should give the patient while we do our best to care, comfort, and, if possible, cure. We’re not gods. In case we haven’t noticed, miracles do happen. Sometimes we’re even wrong. Why not give the patient the benefit of our expertise and some hope so he or she can go on—right up to the end?

—Stephen Shore, MD
Langley

Book reviews



The Wrong Side of an Illness. By Owen Stanley Surman, MD. Online: iUniverse, 2007. ISBN: 978-0595477524. Paperback, 216 pages. \$20.90.

The secondary title of this book is *A Doctor’s Love Story*; it follows the life and death (from ovarian cancer) of the wife of a transplant psychiatrist in New England. Theirs is a happy and successful family, with a past and future familiar to many *BCM/J* readers. A dire diagnosis out of the blue changes the perspectives and observations from the other “wrong” side of the medical team. Although the deeper philosophies are only touched upon, and the story is told in a voice that somehow seems a bit more detached than it could be, the book is well written and overall a good read. Through the illness, the characters change their relationships with colleagues who become caregivers, patients who become partners in shared grief, and knowledge of prognosis and expectation that become damning. Some conflicts and disagreements with caregivers, mostly related to ego and fear, surface throughout the story, and fam-

ily relationships predictably are both tested and appreciated. There are several British Columbia connections that brought this story closer to home, and the medical and surgical descriptions would not be overwhelming to non-medical readers.

—CV



Still Alice. By Lisa Genova. Toronto: Pocket Books (Simon and Schuster Inc.), 2007. ISBN: 978-1439102817. Paperback, 320 pages. \$17.50.

This book haunts me. It is the realistic fictional account of a brilliant cognitive psychologist and Harvard researcher who has an international reputation in her study of the acquisition and mechanisms of language. At the age of 50, after episodes of forgetfulness (some uncomfortably familiar to me), she is diagnosed with early-onset Alzheimer disease. The story is written mainly from her perspective as she descends into her dementia from a life dependent on the superiority of her brain function. Its effect on her career, her spouse, her children, and her own perception of who she really is are beautifully and

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