BCMJ BC Medical Journal

Letters of less than 300 words are welcomed; they may be edited for clarity and length. Letters may be e-mailed (journal@doctorsofbc.ca), faxed (604 638-2917), or sent through the post.

Re: Order up!

I was happy to read [Dr Richardson's] March editorial (*BCMJ* 2014;56:73) last week—I am seriously behind on my reading. I was beginning to think I was the only one in Fraser Health who wasn't convinced that computerization is the solution to all our problems. Of interest to you might be an article published in the May 2009 issue of the *Journal of the American College of Surgeons*.[1] It is the only article I have found that looked at what happened to a physician's time and workload when a physician order-entry system was introduced. Because hospitals and health regions don't pay for a physician's time, there is no incentive for them to develop or introduce a system that saves us time and work. The prevailing attitude is that technology in action is always better than any current system—a system that has evolved and adapted over the years and works very well. Even in the US, where they are pretty brutal about firing and laying off excess workers, there were no cost savings or safety improvements with the introduction of the system.

I am only a semi-Luddite, but like you I can't see how the one or two computer terminals are going to accommodate the 10 or 12 physicians doing rounds at any one time between 7 a.m. and 9 a.m. Maybe they are going to introduce a reservation system. I have never seen a business plan for EHR implementation and, as you have rightly pointed out, no one is going to have their job eliminated to fund the system. As far as I can see, it is simply a huge amount of money being spent on administrative matters while clinical funds dry up.

On a related subject, you might find an article in the 13 March 2014 issue of the *New England Journal of Medicine*[2] also of interest. Checklists have been the—and I mean *the*—linchpin of the culture of safety that administrators have been pushing on us. In short, there was no difference before or after the checklist, despite the significant amount of money and time invested in the introduction and use. Do you want to bet that the science will be ignored because the safety industry would be out of business?

—Norman Causton, MD
Chilliwack

References

1. Stone WM, Smith BE, Shaft JD, et al. Impact of a computerized physician order-entry system. J Am Coll Surg 2009;208:960-967; discussion 967-969.
2. Urbach DR, Govindarajan A, Saskin R, et al. Introduction of surgical safety checklists in Ontario, Canada. N Engl J Med 2014;370:1029-1038.

Re: Assisted suicide vs end-of-life care

In his letter published in the April issue (*BCMJ* 2014;56:124-125), Dr John Dale claims there are errors of fact and logic in my letter on assisted suicide (*BCMJ* 2014;56:6) but fails to show what they are. It seems that Dr Dale failed to read my letter correctly. I had stated that the slippery slope argument was not what I was discussing. However, commenting on that topic, Dr Dale provides evidence that the slippery slope is an active concern by claiming that many articles show how to avoid it through legal checks and balances. The wishful thinking in such articles fits the general principles so well described by Brian L. Mishara and David N. Weisstub:

> In debates about euthanasia and assisted suicide, it is rare to find an article that begins with an expression of neutral interest and then proceeds to examine the various arguments and data before drawing conclusions based upon the results of a scholarly investigation. Although authors frequently give the impression of being impartial in their introduction, they invariably reach their prior conclusions.[1]

Dr Dale further describes that I made an error of logic in predicting the influence that assisted suicide would have on people who consider themselves a burden on others. In an attempt to prove that assisted suicide would have no influence, he compared it to termination of pregnancy. It is *his* comparison that is illogical, and it is an attempt to play on the loyalties of people who feel strongly about a different issue in order to gain support for assisted suicide, rather than to shine light on the subject with an accurate comparison. What is unique about terminal illness is that people frequently find themselves increasingly dependent and consider them-

selves a burden on those around them.

Most strikingly, Dr Dale ends his letter by suggesting his motive for writing it, revealing he would like the opportunity to make use of assisted suicide. It is continuously a temptation for us as physicians to use our substantial professional influence to further our own priorities rather than to consider the good of our community.

—Allan Donkin, MD
Powell River

Reference

1. Mishara BL, Weisstub DN. Premises and evidence in the rhetoric of assisted suicide and euthanasia. Int J Law Psychiatry 2013;36:427-435.

Re: Changes to medical staff privileging in British Columbia

I am writing in response to the article "Changes to medical staff privileging in British Columbia" (*BCMJ* 2014;56:23-27). As the professional organization that represents more than half of all physicians in British Columbia, the British Columbia College of Family Physicians (BCCFP) welcomes the opportunity to participate in the provincial privileging standards project as it relates to family physicians.

Due to the unique nature of full-scope family practice, the development of the privileging dictionary for family physicians and the criteria for currency of family medicine responsibilities must be considered with a different lens: from the perspective of the longitudinal generalist. As the provincial voice of family physicians with this perspective, we wish to highlight some specific considerations for the privileging process for family physicians:

- The definition of currency as it relates to family physicians. The College of Family Physicians sets the standards for training and ongoing maintenance of certification for family physicians in Canada. The College defines and assesses the validated educational standards, which maintain competency. We would be pleased to share the criteria used by the College of Family Physicians of Canada in developing a competency-based approach, which we hope will be useful to the privileging process.
- Currency is but part of competence. In consideration of the breadth and scope of family practice, currency based on numbers of exposures or procedures does not adequately measure competence.
- The unintended consequences of applying such a narrow definition of competence. Applying a currency-based-on-numbers approach to privileging for family practice, a discipline with such a broad scope, may discourage family physicians from entering full-scope family practice and negatively impact recruitment and retention of family physicians for remote and rural areas.
- Evidence for the process of determining the privileging standards (currency or competence) specific to full-scope family practice must be considered.

The BCCFP has worked closely with the Society of General Practitioners and the Rural Coordination Centre of BC to identify a diverse cross-section of family physicians to populate the family medicine expert panel. We believe that their direct involvement in the project is important to ensure that privileging standards are developed to best meet the needs of our valued family doctors, patients, and the health care system.

—Patricia Mirwaldt, MD, CCFP
President, British Columbia College of Family Physicians