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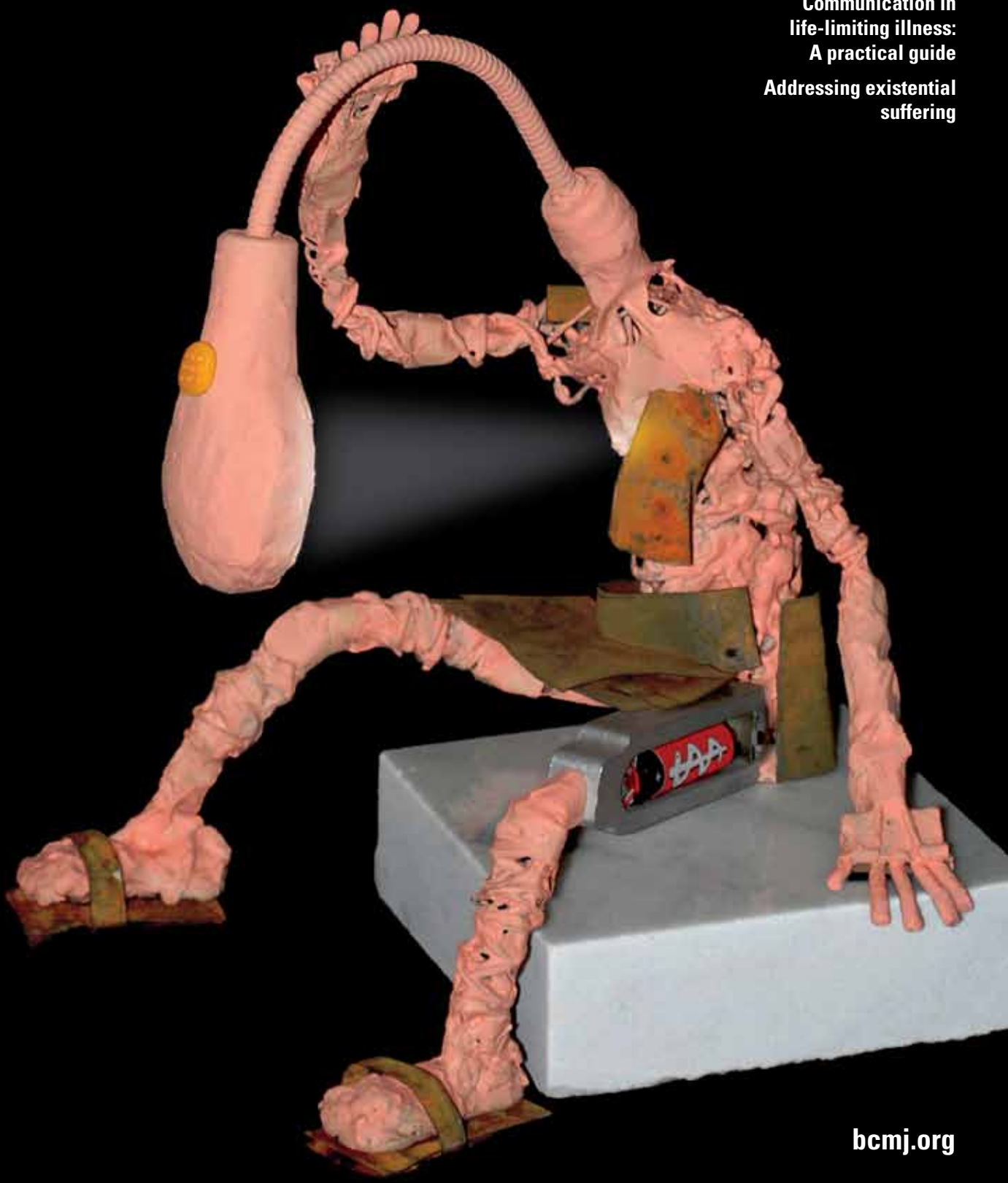

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ON THE COVER: The final days of life can be a time of self reflection, peace, and healing in the face of disease, and the palliative care that physicians provide can assist patients in this important journey. Our theme issue on palliative care begins on page 254.

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Ah, the good ol' days. Nary an orphan in sight.

Many hospitals in BC are looking for ways to deal with unattached, or *orphan,* patients. These admitted patients fall into three categories: those who have a family physician who has privileges at another facility, those who have a family physician in the local community who doesn't have any hospital affiliation, and those who just don't have a family doctor. Years ago orphans were quite rare and fell almost exclusively into the first category. However, as walk-in clinics proliferated and general practitioners gave up their hospital privileges for a number of reasons—round/call obligations, committee work, etc.—the number of orphans in the other two categories blossomed.

Initially most hospitals relied on the good nature of those who remained by adopting some form of Doctor of the Day strategy where orphans were assigned to a privileged hospital family physician. I remember administrators in our hospital being very reluctant to remunerate those family physicians for their extra workload. It seemed expected that we would pony up and take all comers regardless of time and expense. I believe that family physicians should take care of our own, but should not take care of Dr X's hospital patients while he works away in his clinic just down the road. Many overtures were made toward increasing payments for this added service but little was done. Therefore, the system eventually imploded due to the sheer numbers of unattached patients. This might have been avoided if more was offered to the gradually shrinking hospital-based GP workforce.

At this point well-funded hospitalist programs became the norm. Nothing against my hardworking hospitalist colleagues, but as time progressed the metrics (no idea what this is but always wanted to use the word) began to show that patients who were cared for by their own GP had shorter hospital stays. I guess there is value in knowing your patients' intimate details and intricacies. I would like to congratulate you GPs for a job well done over the years.

There is a current move in our health region away from hospitalists, and the GPs have been approached to take over hospital care for orphan patients. I guess we proved our worth. A lot of resources have been offered to fund this initiative, such as money for nurse practitioners, administrative help, and even paid call. I think it is unlikely that busy GPs will leap at this chance even with the extra resources. We have enough of a challenge managing our own hospital and office patients; there is no capacity to do more. Another troubling issue is that with all these resources being directed toward caring for orphan patients, those patients who are cared for by their capable GPs are relegated to being second-class citizens.

I'm not sure what solution will be found to this challenging problem, but I can't help but long for the good ol' days. If every family physician worked in a solo or group practice, took care of their own patients, and had an affiliation with their community hospital, most of the population would have a GP, and orphans would again be a rarity.

—DRR

The lies we tell

I lied. I lied to my wife.

It's out in the open now, so I can talk about it. She celebrated a special birthday this year and, because she is the Queen of Surprise Parties, I felt the need to throw her a surprise party in return for all the good surprises she has given me. Planning her party involved secrets, lies, subterfuge, conspiracy, deception, dishonesty, evasion, and misrepresentation. I was hiding my phone so she couldn't see texts from her friends and family members who were in on the surprise. I made up cover stories to explain my behavior. In the weeks leading up to the surprise I found myself waking up frequently in the night worried that I would inadvertently let the secret out. In the end, the party was a huge success and my wife enjoyed spending an evening surrounded by many of her close friends and family. All was forgiven.

All of this got me thinking about the lies we may tell our patients and about the lies they tell us. Physicians may lie, deceive, and misrepresent, for example, in order to get a patient to comply with treatment. This very paternalistic approach will invariably backfire on the physician. Doctors may also withhold information, for example, to avoid giving the patient bad news. Hopefully, those attitudes are long gone.

Recently, I tried to tell a frail, elderly patient that I believed that her life was nearing its end. She had end-stage chronic disease. As she lay in her hospital bed, becoming weaker and more drowsy, I started to tell her gently what I thought was happening. She politely disagreed with me, as if to say that she didn't want to know what was to come. I didn't push it, and she passed away peacefully 2 days later. Hopefully she heard what I was trying to tell her. I don't like giving patients bad news, but I know that honesty is appreciated more than any attempt to protect them from harm. If we, as physicians, want to continue to be seen by the public as some of the most trusted professionals, then we need to live up to that.

Physicians may lie, deceive, and misrepresent, for example, in order to get a patient to comply with treatment.

I also remember two patients I fired many years ago over lies they told me. I didn't like being manipulated and, after discovering their lies, I felt that they had damaged the doctor-patient relationship irreparably. Both patients lied to cover their misuse of opioids. I think that this is a common situation in which patients lie to doctors. Both patients' lies put them, me, and the public at risk, and I did not feel comfortable in continuing as their doctor. On that topic, all I will say is that there is a right way and a wrong way to fire a patient. As I found out more recently, if you don't do it correctly you may receive a pale yellow envelope in the mail containing an unpleasant letter of complaint and, ultimately, reprimand.

What I learned from the recent subterfuge surrounding my wife's birthday celebration is that lying is tiring. It took work to build the lies and keep them from being discovered. It disrupted my normal sleep pattern and made me worry about being found out. Except for the obvious case of a surprise birthday party for a loved one, I don't think it is worth all that energy. **—DBC**

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International medical graduates: The hurdles to practising in Canada

International medical graduates (IMGs) come to Canada with hope for a better life. However, for the majority of them, the life they start in Canada is far from what they'd imagined. For most of them, their professional lives come to an end.

Most IMGs know there will be hoops to jump through in the licensure process, but what surprises them are the unexpected hurdles. In short, we are suffering from the Canadian government's lack of transparency, consistency, and fair execution of recruitment management plans regarding IMGs.

My current professional situation in Canada exemplifies this mismanagement. I have fulfilled most of the requirements suggested by IMG advisors. Using Canadian resources and supports, I passed the Medical Council of Canada's exams with honors, scored high in my language exam, finished preceptorship in anesthesiology and family medicine, and was temporarily licensed for almost 3 years. Nonetheless, I could neither enroll in a residency program, due to the huge competition among IMGs, nor be successful in one of the practice-ready assessment programs. As a result, I've become a professional nobody, and I'm currently working in retail. After the project that I was licensed for was terminated in 2013, no program existed to bridge my qualifications to the next level. Instead, additional hurdles—a new language exam and a requirement to practise in my home country—were put in front of me.

The enrollment requirements for practice-ready programs in Canada, such as the requirement to be in a current practice as a fully licensed physician, mostly benefit newcomers. New IMGs who were practising in their home countries become superior to the IMGs who have been practising in Canada with a special licence and who have become familiar with electronic medical record systems, patient-centred practice models, and Canadian culture. The government of Canada is hiring physicians from outside Canada who have only obtained working visas, passed the MCCEE, and passed the language exams. This is happening while hundreds of sophisticated IMGs are living in Canada. If they were given the chance to use their expertise beyond

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Thoughts on professionalism

Historically, three recognized professional careers existed: medicine, law, and the clergy. The people whom each of these professions served looked for guidance, legitimate leadership, and a strong sense of hope. The people expected outstanding service, the safety of trusted relationships, and the leaders of these professions to practise and conduct themselves in an ethical manner.

Since I didn't choose a career in law and I'm not a member of the clergy, I can only speak to the valued profession of medicine. And in medicine today, those long-established tenets continue to be held in high esteem. Physicians take great pride in our profession's longstanding traditions of altruism, the use of scientific evidence, and the value and merits of the social contract. As doctors of medicine we strive for professionalism in every aspect of our working lives. It is the cornerstone of our relationships with patients, with one another, with other health care providers, and most certainly with society. As of late it has become increasingly difficult to live up to those standards.

What does it mean to be a doctor within the landscape of BC today? Our College feels that the social order has changed. And I sense feelings of angst and discomfort among our colleagues in the many areas of the province that I travel to. Over the last decade I have witnessed, and our peers are experiencing, the de-professionalization of medicine—a sense that the foundation of our professionalism is being eroded.

Medicine is changing faster than ever before and we are at a crossroads. Advancements in medical treatments and therapies, combined with societal changes and changes within the health care system itself, are impacting the way physicians practise medicine. Many of these changes have us feeling burned out and, yes, skeptical of the future of health care. We struggle with a fragmented system in which our patients are said to fall through the cracks, yet it is our patients and society who are looking to us as the medical profession for meaningful solutions. This is a great burden to carry, yet, at this time when the corporatization of medicine is the single biggest challenge to our professionalism, we have significant and determined obstacles ahead that require us to unite and rally strongly as a profession.

In choosing to uphold the virtues of professionalism and by holding one another accountable, we can enhance our professional satisfaction and the patient experience, and provide the highest standard of health care.

Health care is delivered through a network of relationships that encompasses many different health care professionals, administrators, and government, and of course our patients are central to this. These relationships, which are at times challenging, are influenced by individual behavior, constantly changing societal norms, and a political environment that has trouble planning and visioning for anything longer than a single election cycle or government. As a result, when changes occur in any of these areas, our core professionalism can be challenged.

In medicine, professionalism is very much about building and maintaining these relationships as we strive to provide quality patient care. And, as an association of doctors, we must deepen and expand our leadership in quality of care to and for our patients, and this can't be accomplished without professionalism. Professionalism encompasses the attitudes, skills, behaviors, attributes, and values that are expected from those to whom society has extended the most notable privilege of being considered a professional.

We doctors are extremely fortunate. Years ago we chose, and today we get to experience, a humbling and meaningful professional career. We are highly educated; indeed, we are the experts in modern-day medicine, and we simply must not take that for granted. We get to be who we want to be in the context of the responsibility of being a doctor. We are a profession that is entrusted with serving our patients to the best of our abilities and expertise. And that, dear colleagues, is a great honor. In choosing to uphold the virtues of professionalism and by holding one another accountable, we can enhance our professional satisfaction and the patient experience, and provide the highest standard of health care. And isn't that what being a doctor is all about?

—Alan Ruddiman, MBChB
Doctors of BC President

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bureaucratic work, they would also be able to fill the gaps in Canada's health care system.

To sum up, there are many qualified IMGs living in Canada who have passed exams such as the MCCEE, MCCQE1, MCCQE2, and NAC-OSCE, fulfilled various levels of training, and built good professional reputations. On top of that, both the IMGs and the government of Canada have spent thousands of dollars on exams and training. Despite this, the regulations and requirements for practice-ready assessment programs like the Saskatchewan International Physician Practice Assessment or the Practice Ready Assessment–British Columbia provide newcomers and foreign doctors a better chance to enroll.

Ultimately, I am left with one question for the authorities: Why don't you give IMGs a better chance to practise in Canada by recognizing their Canadian experience, and protect your own investment?

—Shirin Rostamkalaee, MD
Whistler

College replies

British Columbia has a long history of relying on international medical graduates (IMGs) to deliver competent medical care to patients. In fact, 20% of all physicians practising in the province are IMGs. As Dr Rostamkalaee points out, many organizations play a role in ensuring pathways for IMGs to help them establish themselves and set up practice in BC. The College's role in the recruitment process is to ensure IMGs meet educational competency and general requirements before they are granted registration and licensure. While the College will continue to work toward positive solutions for recruiting IMGs, it is not willing to compromise on the standards for registration and licensure. The College Bylaws ensure that IMGs, like Canadian-trained physicians, meet the required high standards expected of all physicians. The College looks to the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) to determine substantial equivalency in training requirements.

Family physicians who have completed their CFPC-recognized postgraduate medical training in family medicine from the United States, United Kingdom, Ireland, and Australia can be eligible for registration and licensure in the provisional class (a registration status under the Health Professions Act) under sponsorship and supervision. Similarly, there are 29 jurisdictions where specialist training is recognized by the RCPSC. To advance to the full unrestricted class of registration, an IMG must satisfy a number of requirements, including completing Canadian qualifying exams—just like Canadian medical graduates.

Family physicians and specialists who have completed their postgraduate training in a jurisdiction not recognized as being equal to Canadian training programs by one of the two national colleges may be eligible to participate in a practice-ready assessment (PRA) program, which involves a competency assessment. British Columbia launched its PRA-BC program for eligible family physicians last year, which requires candidates to complete a rigorous and comprehensive 12-week clinical field assessment following their successful completion of a number of examinations conducted as part of the orientation process.

The UBC family medicine program is one of four postgraduate residency training programs that accepts IMGs in the first iteration of CaRMS. The UBC Faculty of Medicine offers services and evaluations to allow physicians who have trained outside Canada to compete for and obtain medical residency positions that will lead to registration and licensure with the College. These positions and resources are generously funded by the government of BC.

The College is proud of its robust standards and requirements for IMGs to help ensure they can safely enter the practice of medicine. This high level of scrutiny is yet another example of what British Columbians have come to expect from the regulator of the medical profession so that they can receive the best possible care.

—Heidi M. Oetter, MD
Registrar and CEO, College of Physicians and Surgeons of British Columbia

Hurrah! Application complete

I finally finished my application for reappointment.

Initially, after hours spent scanning documents and attaching them to the electronic application, I was informed by the department head that the application was incomplete. After three more phone calls (in the end I had to e-mail the documents in order for them to be attached to the application) it was finally accepted.

I am sure that the BC Medical Quality Initiative has the best interests of patients at heart, but I think their agenda has been overtaken by bureaucrats, risk managers, and lawyers when the result is one more hoop for physicians to jump through before obtaining privileges. It is starting to feel like privileges are not such a privilege!

—T.W. Barnett, MD, FRCPC
North Vancouver

The resident experience in Cape Town, South Africa

Two residents from the UBC Rural Family Medicine program traveled to Cape Town, South Africa, for elective rotations in trauma and emergency medicine. Here they provide an overview of the steps to being accepted as a supernumerary resident, how to obtain temporary licensure with South African authorities, and their experiences in a foreign health care system.

A.W. Battison, MD, K.S. Wade, MD

Primary care physicians in British Columbia often work in rural and remote areas. Their scope of practice is broad and includes emergency medicine. In cases of critical injury and illness, there is often no immediate access to specialist care, and patients must be stabilized prior to transfer. However, opportunities for training in trauma and resuscitation are limited in Canada.

Residents in family medicine are rarely expected to manage severe traumatic injuries or critical illness because training largely takes place in tertiary hospitals. There, understandably, specialty residents take precedence in managing these patients. However, the vast majority of physicians in rural British Columbia are general practitioners and family physicians.[1] Recent studies have shown that only 3% of rural emergency departments in BC have access to CT and only 12% have 24-hour access to an on-call general surgeon.[2] Therefore, it is vital for rural physicians to have the skills and training to identify, resuscitate, and stabilize critically injured and ill patients, as they will inevitably require transfer to a higher level of care.

Cape Town is a city of 3.75 million people located near the southernmost point of South Africa and is a popular tourist destination. It is also one of the most violent cities in the world. Inequality, poverty, and substance abuse fuel a high occurrence of violence.[3] Predominantly black and colored townships were established during apartheid to segregate the residents from their white rulers. Although apartheid has officially ended, the socioeconomic conditions in South Africa have essentially preserved this legacy and much of the violence associated with it. Public hospitals receive most of the related fallout.

The UBC Rural Family Medicine Residency program based in Kelowna includes a mandatory 1-month rotation in trauma, which may be completed in Canada or abroad. We had both completed rotations in South Africa as medical students and were compelled to return. Beyond our educational goals of learning about trauma and emergency medicine, we also wanted to offer assistance to those in desperate need and experience life as residents in a foreign health care system. We spent our time at Tygerberg Hospital (TBH) and Khayelitsha District Hospital (KDH), where we worked as supernumerary residents.

Participating university and hospitals

Our rotations were overseen by Stellenbosch University, which is one of two medical faculties in the Western Cape. The faculty has an international office that assists students and residents with elective applications. Note that applications should be submitted a minimum of 1 year prior to planned commencement of a rotation.

The campus of the Stellenbosch University Faculty of Medicine is located at TBH, an 1800-bed public teaching hospital located approximately 20 km east of Cape Town. It serves as the referral centre for many

This article has been peer reviewed.

Dr Battison is a resident in the UBC Rural Family Medicine program based out of Kelowna. He graduated from UBC medical school in 2014 and is pursuing further emergency medicine training at the University of Calgary beginning this summer. Dr Wade is also a resident in the UBC Rural Family Medicine program based out of Kelowna. He completed UBC medical school in 2014 and continues to work as a medical officer in the Canadian Forces, 12 Field Ambulance.

of the community hospitals located in the Cape Flats region, which is one of the most violent areas in South Africa.[4]

KDH is one such public community hospital. It is located in the largest township in the Western Cape and sees a high volume of severe trauma and late-stage medical illness. Alcohol and extreme poverty fuel much of the violence. KDH has X-ray, ultrasound, and basic laboratory services, but it does not have a CT scanner, intensive care unit, or access to surgical subspecialists. Patients must be stabilized prior to ambulance transfer to TBH for definitive treatment.

Both TBH and KDH have resource issues. Both hospitals are severely overcrowded. It is sometimes difficult to find proper working equipment, and improvisation is the norm, not the exception. However, the medical staff are excellent and provide evidence-based, timely care to sick patients.

The provincial government heavily subsidizes the cost of health care. The tariffs are income based and set out in the Uniform Patient Fee Schedule.[5] Those who cannot afford to pay receive services at no cost. The patient's economic circumstances do not factor into any diagnostic or therapeutic decision making in public hospitals.

Obtaining a licence

A significant amount of time, paperwork, and phone calls is required to become licensed as a supernumerary resident in South Africa. Fortunately, the international office at Stellenbosch University helps guide students and residents through this process.

The Health Professions Council of South Africa (HPCSA) regulates medical practice. The organization requires university sponsorship and document verification through the Educational Commission for Foreign Medical Graduates (ECFMG) and ECFMG International Credentials Services (EICS). Notarized copies of an applicant's medical degree and current licence must be sent to the EICS for verification. From personal experience and based on conversations we had with other residents, we can confirm that this process takes a minimum of 6 months.

Once the EICS verifies the required documents, they send them to the HPCSA in Pretoria. Upon also receiving a current Certificate of Professional Conduct from the College of Physicians and Surgeons of British Columbia, the HPCSA then grants a temporary postgraduate medical licence. This licence allows a resident to prescribe medications and order tests.

Our experience

The emergency and trauma units in Tygerberg and Khayelitsha District Hospitals are some of the busiest in South Africa due to the high levels of violence in the surrounding townships. At KDH, postgraduate interns, medical officers, and emergency medicine registrars (equivalent to senior residents) staff the emergency centre. A consultant staff physician is on-call 24 hours a day, but is not necessarily in house. On one overnight shift at KDH, we counted nearly 40 patients who arrived with penetrating stab wounds to the chest. The majority of these patients were diagnosed with pneumo- or hemothoraces, necessitating thoracostomy tube insertion. Resuscitations, from obtaining peripheral intravenous access to rapid sequence intubations, are performed by the medical officers and registrars on duty. We discovered that having training in advanced trauma and life support and extended focused assessment of sonography in trauma were vital skills. Day shifts at KDH tended to be more medical in nature, with patients commonly presenting with severe illness such as bacterial meningitis, diabetic ketoacidosis, septic shock, and complications of HIV and tuberculosis.

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Examples of medical cases we saw:

Status epilepticus
Status asthmaticus
Pulmonary and extrapulmonary tuberculosis
HIV/AIDS
Immune reconstitution inflammatory syndrome (IRIS)
Malaria
Diabetic ketoacidosis
Septic shock
Tetanus
Severe hypoglycemia
Organophosphate poisoning
Massive postpartum hemorrhage
Bacterial meningitis
Cryptococcal meningitis

Examples of trauma cases we saw:

Hemothorax
Pneumothorax
Stab wounds
Gunshot wounds
Globe rupture
Open skull fracture
Basal skull fracture
Increased ICP/brain herniation
Traumatic brain injury
Hypovolemic shock
Cardiac tamponade
Traumatic amputation
Fracture-dislocations
Splenic laceration
Liver laceration
Perforated viscus
Abdominal evisceration

Procedures we performed:

Thoracostomy tube insertion
Central lines
Peripheral IVs
Arterial blood gases
CPR
Endotracheal intubation
Pericardiocentesis
Emergency thoracotomy
Phlebotomy
Closed reductions and casting

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At TBH, the tertiary referral centre, patients are received in a trauma front room managed by medical officers with trauma surgeons available as consultants. Most patients are transferred from other community facilities such as KDH where initial stabilization was completed, and management is focused around secondary surveys, advanced imaging, and referral of patients to the various specialty surgical services. Other polytrauma patients are brought directly from motor vehicle and pedestrian accidents. These patients frequently require reduction and casting of joint and long-bone injuries. Trauma and medical emergencies are separated at TBH, so the medical management of traumatized patients is focused on comorbidities such as tuberculosis, HIV, and sepsis that may complicate an injury.

Interactions with nursing and allied health care staff are different in the South African medical environment from what they are in Canada. Physicians and house staff are responsible for all procedures performed on patients, such as intravenous access, phlebotomy, blood gases, and ECGs. Health professions often work independently of each other, and communication is limited. While this system improved our knowledge and capabilities with these important procedures, it also renewed our appreciation for the allied health care workers and open communication we enjoy in British Columbia.

Working in Cape Town hospitals was a taxing experience emotionally. The volume of patients can be overwhelming and, as such, utilitarian policies are necessary and patients who are deemed terminally ill are removed from the resuscitation area promptly. Tragic cases of untreated AIDS in young people are a daily occurrence. As well, we were in disbelief of the sheer number of patients who came in due to stabbings. It became frustrating to try to clear a hallway of patients, who were injured due to seemingly senseless violence, awaiting thoracostomy tube insertion. Remarkably, the house staff seemed to take it all in stride, working tirelessly to attend to those in need.

Conclusion

Cape Town is a vibrant, fascinating, and often shocking place to train. The time we spent in South Africa better prepared us to manage life-threatening injuries and illness, and made us grateful for the health care system we have in BC. We highly recommend a rotation in South Africa to residents who are seeking a unique trauma experience.

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Simple Wealth Strategies for Physicians

By Don Murdoch

Incorporation May Still Be Right for You

This is the third instalment of our 'Simple Wealth Strategies for B.C. Physicians' article series.

As expected, the new Federal Government does intend to implement changes to the use of corporations by professionals. What may be a surprise to some, is that the changes may not impact many BC Physicians.

You will recall from our earlier article, a key advantage of the use of a professional corporation lies in the ability to earn income from your medical practice at a preferred low corporate income tax rate, creating earnings from the higher savings within the corporation and paying the remainder of the income tax that has been deferred when the funds are withdrawn for personal use.

This remains unchanged for many incorporated B.C. physicians. In fact, the low B.C. corporate income tax rate has been reduced further from 13.5% to 13% for 2016. The proposed rules are complicated and have not yet been confirmed. The proposed rules may reduce the ability for certain corporate structures to access several annual $500,000 taxable income limits at this new 13% tax rate. If you are a B.C. physician practicing in a large group, you should be talking with a knowledgeable advisor in order to understand how the changes may impact you and your partners / associates.

For those who have been cautious about moving forward with incorporation, the three key factors to consider remain unchanged.

1. If you are able to earn more income than you currently need to take to live on, consider incorporation for the growth of your wealth / investing.
2. If your family circumstances provide income splitting opportunities, consider incorporation for income tax savings.
3. If your Medical Practice requires you to borrow funds to invest in the assets / operations of your practice, consider incorporation to increase your debt repayment power.

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Palliative care: Learning to fall

Dr Romayne Gallagher

As I walked to his bedside I was struck by the calmness in his eyes despite the gaunt cheeks, the emaciated body, and the struggle of accessory breathing muscles to draw in enough air for the failing lungs. He told me, "I am totally at peace with what is happening and ready to die anytime." After I acknowledged the wisdom of this he asked, "Are you ready to die, doctor?" My nonverbal response gave me away: I stepped back. Realizing my body had answered for me, I admitted "No, I guess not."

All humans struggle with the certainty that our lives will end. Society has developed many defences to avoid confronting this fact. In medicine we have changed death from a natural completion of the life cycle to a medical failure and have developed a technical armamentarium to thwart death as long as possible. We live longer—a great advance—but we take longer to die. This has changed the event of dying from a few days of fevered delirium and sepsis to a process that can take many months. Depending on how someone copes, these months can be a time of intense living, of growing both emotionally and spiritually as the body declines. Or they can be months of suffering induced by poor symptom control, lack of support to cope with increasing dependence, and the loss of oneself and one's dignity. Palliative care is a treatment approach that begins at the diagnosis of serious life-limiting illness that continues throughout the disease process, that improves symptoms and quality of life, and that provides the right environment for personal growth and meaning-making.

Patients expect physicians to care for the whole person, not just the body. A study of patients with COPD, AIDS, and cancer identified emotional support, communication, accessibility, and continuity as more important than competency.[1] Yet physician-author Abraham Verghese probably speaks for many physicians when he describes his unease in the presence of a dying patient:

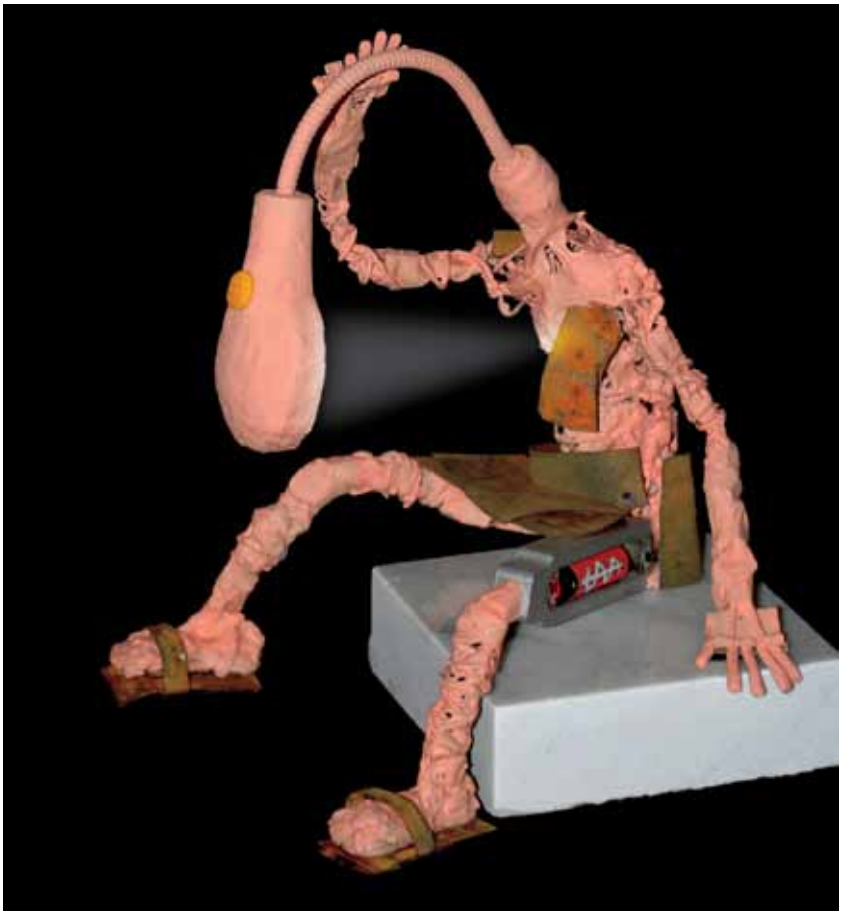
I had always felt inexpert when a patient was near death . . . Give me a patient with massive gastric bleeding or ventricular fibrillation and I am a model of efficiency and purpose. Put me at a deathbed, a slow dying, and purpose is what I lack. I, who till then have been supportive, involved, can find myself mute, making my visits briefer, putting on an aura of great enterprise—false enterprise. I finger my printed patient list, study the lab results on the chart, which at this point have no meaning. For someone dealing so often with death, my ignorance felt shameful.[2]

What Dr Verghese expresses here is the helplessness a physician feels in the face of a patient's inevitable death. As physicians we encounter death more frequently than the average person, and one of our defences against the death anxiety present in all humans is a medical culture that

focuses on a collection of organs rather than on a person who is dying from an illness. We use this organ-focused care as emotional armor against the sharp terror of our own death. The technology of medicine, as wielded by the doctor, bravely fights against disease on the battlefield of the patient's body.[3] With the language of fighting there is usually a winner and a loser, and thus death becomes a failure of medicine. For some patients, fighting to the death is the way they wish to end their life, but for most patients, accepting the inevitable brings peace and healing in the face of disease.

Physicians have found that they can use self-awareness to stop themselves from putting on the emotional armor that protects them from admitting their own mortality, which in turn allows the physician to discuss fears and concerns with the dying patient, to experience being completely present with the patient, and to feel greater compassion.[4] This openness leads to exploring which approach to the illness best matches the patient's preferences and reduces care that is futile or does not feel right to the patient. Many wise traditions from ancient times to the present maintain that facing our own mortality leads to a deepening of appreciation for our lives. Facing death with patients can bring humility, compassion, and connection and give greater meaning to the work we do.

In this theme issue we focus on palliative care, knowing that even in the wake of the Supreme Court decision to no longer prohibit physician-assisted death the vast majority of Canadians will still choose to die naturally and will look to physicians to assist them in living as well as they can and for as long as they can before they die. To help physicians do this, the first article outlines what palliative care has to offer patients and families and when to implement it. The second article describes how to communicate effectively throughout the illness trajectory. The third and final article provides background on existential suffering and spiritual distress—often the reason a patient wants death hastened—and describes therapeutic communication techniques that physicians can use to help individuals cope with their illness and achieve healing.



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Palliative care: Therapy for the living

Studies have confirmed that suffering can be relieved and patients can live well until they die when palliative care is introduced early and integrated into the management of serious illness.

ABSTRACT: Palliative care arose as a movement from outside academic medicine in the middle of last century as a response to "bad dying." Today, palliative care improves quality of life, patient and family satisfaction, length of hospital stay, and health care costs near the end of life. Newer studies have demonstrated a survival advantage when palliative care is introduced early in the illness trajectory. In BC, physicians wishing to acquire more palliative care knowledge and skills can use practice supports provided by the General Practice Services Committee, including a useful algorithm and other clinical tools. In future, the integration of palliative care into the management of all serious illness and greater involvement of the wider community can be expected to help more patients live their remaining life to the fullest and experience a natural, comfortable death.

This article has been peer reviewed.

In the middle of last century, British psychiatrist John Hinton documented the medical deficiencies in end-of-life care: "We emerge deserving of little credit, we who are capable of ignoring the conditions which make muted people suffer. The dissatisfied dead cannot noise abroad the negligence they have experienced."[1] At the time he wrote this, patients were treated until they died uncomfortably in hospital, surrounded by machines, rather than in a place of comfort, surrounded by family and friends. Shared decision making was unheard of. Palliative care arose from a movement outside of medicine as a response to what was recognized by some as "bad dying."

Both medicine and palliative care have changed much since then. We live longer and age with less disability than ever before. Our system is well designed to treat and modify acute diseases that used to result in death. But medicine's ability to rescue people from the cliff of sudden fatal illness has led to the accumulation of morbidities and a longer period of disability and dying. Perhaps the most challenging clinical skill these days is finding a balance between prolonging living and prolonging dying.

Palliative care is no longer trying to gain acceptance as a medical discipline—experience and research have now established palliative care as an evidenced-based field of medicine with a defined set of principles, body of knowledge, and skill set. Palliative care has expanded from serving patients with cancer to serving those with any life-limiting diagnosis, including multimorbidity and frailty. Much more than passive care is needed to ensure a comfortable death, and today palliative care strives to help patients live well until they die. What living well entails is unique to each patient and family.

Helping patients with terminal illness live their remaining life to the fullest by communicating well and balancing interventions to achieve a natural, comfortable death requires that all physicians embrace essen-

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tial palliative care knowledge and skills. Expecting physicians to diagnose, initiate, and maintain treatments without knowing how to deliver palliative care is akin to expecting a pilot to take off and transport passengers safely without knowing how to land the plane. Having essential palliative skills and being aware of what specialized palliative care can do for people with advanced illness is the standard of care today.

Definition of palliative care

Palliative care supports patients, their loved ones, and treating clinicians by addressing physical, social, psychological, and spiritual suffering. This is done using advanced communication techniques to establish goals of care and then matching treatments to these individualized goals and providing sophisticated care coordination.[2] Palliative care is no longer reserved for a time when all disease-modifying therapies have failed, and can be introduced early in the illness trajectory to prevent psychological and spiritual suffering through multidisciplinary care. An early definition states that palliative care "affirms life and regards dying as a normal process" and that it "intends neither to hasten or postpone death" (World Health Organization, 1990, www.who.int/cancer/palliative/definition/en/). Current definitions continue this theme of respecting the process of natural dying. Although involved in dying, palliative care aims to help people live as fully as possible until natural death. There are many myths about palliative care (see **Table**)[3-11] and one of the newest is that physician-assisted death is an extension of palliative care. Physician-assisted death is not in keeping with palliative care principles, and there is a realistic concern that patients who are already reluctant to self-identify as requiring palliative care may become even more reluctant if the range of services is perceived to include physician-assisted death.

Outcomes of palliative care

Palliative care services (inpatient, outpatient, and community) have repeatedly been found to improve patient and family satisfaction with care, to improve symptom control and quality of life, and to reduce health care utilization in the last months of life.[1,12,13] These benefits are seen in patients with cancer, neurological disease, multimorbidity and frailty, and organ failure.

Research in acute care shows that earlier referral leads to a greater positive impact on length of stay and health care costs.[14] Research has also revealed that patients and families received significantly less benefit when they felt they had been referred "too late."[15] Late implementation of palliative care can result from poor communication, health care provider lack of awareness of palliative care therapies, physician reluctance to discuss end-of-life issues due to prognostic uncertainty, and patient or family reluctance to consider palliation due to persistent myths about palliative care.

Table. Palliative care myths and realities.

Myth	Reality
Opioids shorten life.	There is no evidence that opioids shorten life when dosed appropriately and titrated to control symptoms. In fact, multiple large studies have shown no relationship between opioid dose or dose escalation and time to death. Also, research confirms that appropriate doses of opioids do not cause respiratory depression in patients with dyspnea due to advanced disease.
Patients with a history of addiction should not be prescribed opioids in the palliative care setting.	Physicians have a moral obligation to treat pain in all patients, including those with addiction. Opioids are often necessary and should not be withheld, even though management may be more complex and involve closer monitoring, interdisciplinary involvement, and tighter control of drug dispensing.
Palliative care is only for patients who are at the end of life and have not responded to disease-modifying therapy.	It is appropriate to pursue a palliative approach to care whenever disease or its treatment begins to have a significant impact on quality of life, quantity of life, or both. Physicians with palliative care skills can help patients from the time an incurable illness is diagnosed (e.g., by communicating to increase prognostic awareness) and continuing through the illness trajectory (e.g., by discussing advance care planning).
Palliative care should be provided only when patients meet the criteria for palliative care billing incentives or qualify for the BC Palliative Care Benefits program (< 6 months prognosis).	Palliative care skills and knowledge can benefit patients early in the illness trajectory, as described above.
Choosing palliative care means giving up hope.	Even when hope for a cure is no longer possible, palliative care allows patients to hope to live as well as they can and for as long as they can.
When symptoms are difficult to manage, sedation until end of life is the only option.	Specialist palliative care opinion should be sought in this situation. Experts are available in all health authorities and can be contacted by physicians located outside major centres. Also, physicians can call the toll-free BC Physician Palliative Care Consultation Line.

The integration of palliative care into chronic disease management and oncology care has been recommended now for over 10 years,[16] but referrals are still coming far too late for this model to be considered effective. Advocacy for earlier referral has led to related streams of research designed to answer two important questions: What is the best model for providing palliative care in chronic illness? Does early palliative care have benefits beyond relief of symptoms?

Benefits of early palliative care

In the last 10 years there have been a number of high-quality randomized controlled trials (RCTs) of early palliative care versus usual care in the study of outcomes such as symptoms, mood, quality of life, and survival. The best known RCT is a study of 151 patients newly diagnosed with metastatic lung cancer.[17] Patients were randomly assigned to receive either usual oncology care or early palliative care integrated with oncology care. Quality of life, mood, and survival were tracked. Patients receiving early palliative care had significantly better quality-of-life and mood scores. They also survived 2.7 months longer than those who received usual care, despite undergoing fewer chemotherapy treatments than their counterparts receiving usual care. A qualitative analysis of the difference in the character of the visits is revealing.[18] Patients who received usual oncology care discussed symptoms, the state of their cancer, as well as potential chemotherapy treatment and complications. Patients who received palliative care discussed symptoms and their management as well, but they also had the opportunity to increase their prognostic awareness and strengthen their coping skills during palliative care clinic visits. Because of this study and other similar RCTs, the American Society of Oncology released a provisional clinical opinion in 2012 recommending combined palliative care with oncologic care for any patient with metastatic disease or high symptom burden.[19] This recommendation has yet to be implemented in Canada.

A further systematic review of 28 randomized clinical trials of early palliative care integrated with usual chronic disease management found benefits to the early inclusion of palliative care,[20] but there are serious methodological differences between all these studies and further research is needed to answer two key questions: When is the optimal time to integrate palliative care into chronic disease management? What is the best model for the provision of this care?[20] There are many challenges involved in end-of-life care research, but there will eventually be evidence to support a model that allows us to care for patients and families seamlessly from diagnosis through to death and bereavement, helping patients deal with the impact of the disease on function and quality of life, and supporting survivors.

Incorporating palliative care into your practice

Research is improving our understanding of symptom management and the prevention and relief of suffering, but the challenge lies in applying this new knowledge and changing the care provided to patients. Essential competencies in palliative care are being incorporated into Canadian education programs at both the Royal College of Physicians and Surgeons and the College of Family Physicians. The competencies include basic management of pain and other physical symptoms, management of anxiety and depression, and specific communication skills. All physicians must be skilled in discussing prognosis, CPR status, goals of care, and suffering.[21] The symptom management and communication competencies apply for all physicians who provide serious illness care: primary care physicians, general and subspecialty internists, general and subspecialty surgeons, and pediatric physicians and surgeons.

Many patients receive end-of-life care through their family physician in collaboration with community or hospital nursing services. Knowing from study results that early palliative care can improve quality and quantity of life, it is important for family physicians to continue incorporating these new skills and knowledge into their practice.

Doctors of BC through the General Practice Services Committee has developed a number of learning modules to improve care for patients with chronic conditions (see **Box** describing palliative care resources for both health care providers and patients). One of these, the End-of-Life module, can help physicians identify patients who could benefit from a palliative approach to care, increase physician confidence and communication skills, and improve collaboration with specialist services, patients, families, and caregivers. The module encourages physicians to keep a database of patients requiring a palliative approach to care to ensure timely discussion of advance care planning and recommends seeing patients regularly to maintain optimum symptom control and prevent suffering. A number of physicians have found the resources in the End-of-Life module useful for building palliative care processes into the care of their patients with chronic illness (www.gpscbc.ca/content/end-of-life-module-helps-family-doctors-discuss-planning-death-patients).

The module includes an excel-

lent algorithm with links to symptom management guidelines, communication tips, and the necessary forms to ensure that patients receive all the benefits and resources they are entitled to. Keeping this active document on the office computer gives the physician access to end-of-life tools for use throughout the illness trajectory.

In BC, all patients who are estimated to be in the final 6 months of life are entitled to support under the Palliative Care Benefits program (www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/prescribers/plan-p-bc-palliative-care-benefits-program), which provides free access to symptom management prescriptions and over-the-counter medications for constipation and other concerns. This same program allows health authorities to provide equipment in the home when appropriate. While such benefits support patients in the 6 months immediately prior to death, the use of palliative skills and knowledge can start much earlier in the illness trajectory.

When to introduce palliative care

In past centuries when no disease-modifying therapy was available, the doctor would spend time discussing prognosis after making the diagnosis. Being able to predict the course of the illness and its eventual outcome was dependent on knowing the disease and its natural history and likely complications, and knowing the patient with the disease. A good physician was a good judge of prognosis. Because we now have multiple therapies to offer patients diagnosed with life-limiting disease, we often skip over the fact that organ failure, neurodegenerative disease, and cancer will eventually lead to death. However, prognosis has always been important for the patient and family, and even early in the illness trajectory there is an opportunity to speak in general terms about the disease and the involvement of palliative care at some point along the way. Palliative care can be characterized as "a way to add an extra layer of support and to allow you to live as well as you can for as long as you can." It is also a way to raise the topic of advance care planning and help patients understand some of the decisions they may need to make down the road and identify people they wish to involve in this process. Patients have repeatedly said they expect physicians to initiate this conversation as part of their care.[22]

Estimating prognosis is a devil we all wrestle with. Prognostic estimation tools are inherently faulty because they only consider physical symptoms, signs, and disease indices and cannot factor in the desire to live to see a grandchild born or readiness to "let go." Nevertheless, patients who are aware of their prognosis

Box. Palliative care resources

Resources for care providers

General Practice Services Committee (GPSC) End-of-Life Tools and Resources:
www.gpscbc.ca/what-we-do/professional-development/psp/modules/end-of-life/tools-resources
Source for useful forms (e.g., Application for Death Certificate, No CPR form), assessment tools (e.g., Palliative Performance Scale, Edmonton Symptom Assessment System), clinical tools (e.g., Joint Protocol for Expected/Planned Home Deaths in BC, Fraser Health's Hospice Palliative Care Symptom Guidelines), and an algorithm (www.gpscbc.ca/sites/default/files/Algorithm_v7%206%20Mar%202015.pdf) that contains links to many of these resources.

BC Physician Palliative Care Consultation Line: 1 877 711-5757
Provides toll-free 24/7 access to a palliative care physician able to offer symptom management information and other advice.

iPal: www.ipalapp.com
Free website-based app that works on all mobile devices and desktops to provide essential information about assessing need for palliative care, managing symptoms, and communicating.

Canadian Virtual Hospice: www.virtualhospice.ca
Source for articles, videos, and online courses on palliative care for health care providers.

Resources for patients and families

Compassionate Care Benefits:
www.esdc.gc.ca/en/ei/compassionate/index.page
Source of information about benefits available to eligible individuals who must be away from work temporarily to provide care or support to a family member who is seriously ill and at risk of dying.

Speak Up: www.advancecareplanning.ca
Source of information about advance care planning and end-of-life care, as well as about issues related to an aging population and a strained health care system.

Canadian Hospice Palliative Care Association:
www.chpca.net
Provides access to an excellent handbook for caregivers (www.chpca.net/family-caregivers.aspx) and other information about achieving quality hospice palliative care for all Canadians and increasing awareness of end-of-life care issues in Canada.

Canadian Virtual Hospice: www.virtualhospice.ca
Best overall website for patients and families looking for information about palliative care, end-of-life care, and grief.

and its inherent uncertainty are able to participate more fully in decision making about further investigations and therapy. Informed consent is only truly informed when this issue has been discussed openly.

A palliative approach is certain to be of benefit to patients who are in their final 6 months of life, and criteria to aid in identifying these patients have been developed. Providence Health Care has adapted criteria from a consensus report about how to identify those in need of a palliative care assessment in a hospital setting.[23] The method begins with the validated question "Would you be surprised if this patient died in the next 6 to 12 months?"[24] General criteria for serious illness and disease-specific criteria from the literature are combined to identify patients likely to have a prognosis of 6 months or less. While there is no way to calculate how multiple diseases change the prognosis, it is known from several large studies of multimorbidity that the number of medical conditions can accelerate progress through the illness trajectory, likely indirectly though the effect of increasing disability, which has a direct adverse effect on mortality.[25]

When to consider specialist palliative care

When to refer a patient to a palliative care specialty team depends on the knowledge and skills of the primary care physician and a number of other factors. If the primary care physician has up-to-date palliative care knowledge and skills, specialist palliative care may not be needed. Specialist palliative care can be helpful when:

- Physical and psychological symptoms and spiritual distress are not responding to the usual therapies.
- The patient or family members or health care providers are uncertain about or disagree over goals of care.
- The patient or family members are distressed despite explanations.

A team approach to care is always better for the patient and family because it is near-impossible for one person, the physician, to meet the complex needs of a patient and family struggling with a life-limiting illness. Having access to a team depends on the size and resources of the local area. In a smaller community, the team may consist of the family physician, home care nurse, pharmacist, and neighbors. Other centres may have local hospice societies or physicians with added training in palliative care. Tertiary palliative care programs are only found in large cities, but should always be considered a resource for smaller communities.

Specialist (nonpalliative) physicians also should ensure they have essential symptom management skills as well as the ability to communicate about diagnosis, prognosis, and advance care planning. Specialists can assist the primary care physician in providing appropriate care for the patient by estimating prognosis or indicating the patient's place in the trajectory of the illness. For example, if a patient with COPD and shortness of breath at rest visits the respirologist and is deemed to be on maximal therapies (home oxygen and medications), the respirologist may indicate that the patient has advanced disease and at this stage would benefit from small doses of opioids to manage dyspnea. Informing the patient of this supports a shared-care approach and allows the primary care physician to provide the needed symptom management and communicate further about planning because now everyone is aware of the prognosis.

All the health authorities in British Columbia have palliative care programs with experts who can be contacted by physicians working outside the large centres. In addition, physicians in British Columbia and Yukon have access to a toll-free phone line for palliative care consultations. This line connects the physician with a palliative care physician in Vancouver who can advise on symptom management and other issues. This service is billable for the calling physician who is seeking assistance.

The future of palliative care

Despite decades of effort to make palliative care an integral part of medical care, there is ample evidence that people are still dying without access to adequate symptom management and while receiving care that does not reflect their preferences.[26,27]

A public health approach to palliative care may be the way to reorient care in advanced serious illness and move forward. This approach acknowledges that serious illness involves the whole community and that a few specialized health care providers cannot meet all the needs of a patient and family affected by serious illness. It is everyone's obligation to influence and contribute to the system of care for someone with advanced illness. The underlying principles for approaching care in this way are from the Ottawa Charter for Health Promotion (World Health Organization, 1986, www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html), which affirms the need to:

- Build public policies that support health.
- Create supportive environments.
- Strengthen community action.
- Develop personal skills.
- Reorient health services.

A public health approach attempts to involve the whole community in care of patients with serious illness. It looks to establish health and social policy that contribute to identifying and supporting those affected by seri-

ous illness, death, and bereavement. A number of cities in Australia, Ireland, and England have mobilized under the name Public Health Palliative Care International: Developing Compassionate Communities (www.phpci.info) to engage people from various sectors to develop public policy, community action groups, and volunteers to support people living with advanced illness.

Now that the Supreme Court of Canada has overturned the prohibition against physician-assisted death, all physicians will be faced with requests from people fearful of suffering who know they now have an alternative. As other jurisdictions have shown, the vast majority of people wish to die a natural death after living as well as and for as long as they can. Palliative care, delivered as an integrated therapy by skilled practitioners, can help prevent and relieve suffering for most people.

Physicians: Please be motivated to learn about palliative care—for your patients, for your loved ones, and for yourself.

Competing interests

None declared.

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Communication in life-limiting illness: A practical guide for physicians

Challenging but essential patient-physician conversations about advance care planning, goals of care, and final days of life can help dying patients receive the best care possible.

ABSTRACT: Communicating with patients and families affected by life-limiting illness is challenging. Evidence supports using thoughtful and deliberate communication approaches that balance hope and reality in a caring and honest way. Clinical resources for everyday practice are available and include information about advance care planning, goals-of-care discussions, and support for patients and families in the final days of life. Physician-patient conversations will vary with the cultural, personal, and disease diversity encountered across clinical practice. What matters most is that these conversations occur and are not avoided.

This article has been peer reviewed.

Communication, an essential part of all clinical practice, involves particular challenges and rewards when patients are facing life-limiting illness. These interactions are not usually restricted to the doctor-patient relationship but occur in the context of family relationships and diverse cultural and spiritual perspectives.[1] There is well-established evidence that effective communication can result in positive clinical outcomes. Patients with advanced cancer who had end-of-life discussions with their physician were less likely to receive chemotherapy in the last 2 weeks of life, had lower rates of ventilation, resuscitation, and intensive care use, and overall improved quality of life.[2,3] Importantly, such discussions were not associated with higher rates of depression or anxiety in patients.[3] Early discussion of end-of-life wishes and values of hospitalized older adults led to improvements in anxiety and depression scores of bereaved family members following the patient's death when compared with the scores of relatives who did not have such discussions.[4] Furthermore, lack of discussion related to end-of-life care has been shown to result in higher health care costs in the final week of life and a worse quality of death associated with such expenditures.[5]

Communication clearly has value for the care of the patient and family as well as for the stewardship of medical resources. All clinicians must develop an informed approach to communication with patients with life-limiting illness and consider this skill as essential as taking a history, performing a procedure, or prescribing a drug. Three of the most challenging conversations involve advance care planning (ACP), goals of care, and the final days of life.

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Advance care planning

Advance care planning began as the process of documenting patient treatment preferences and designating a substitute decision-maker to act should the patient become incapable. While these are still integral components of advance care planning, a broader understanding of ACP has emerged as a process of engaging in conversations related to wishes, values, goals, fears, and hopes of the patient and family.[6] The intent is to begin such discourse well before acute illness occurs so that care appropriate to the individual's preferences can be discerned throughout the illness trajectory.

Many clinicians have expressed concern that initiating conversations too early in the illness trajectory might lead to increased patient distress and a sense of impending discontinuation of life-prolonging therapies.[7] In opposition to this view, a study found that avoiding end-of-life conversations in an effort to maintain hope was actually viewed as unacceptable by patients[8] and substitute decision-makers.[9] Patients and caregivers have identified physician discomfort with such conversations as being a barrier to having them,[6] and patients generally expect their physician to initiate ACP discussions.[10]

First implemented in the care of patients with incurable malignant disease, advance care planning is applicable to all patients regardless of diagnosis or prognosis. While the general goals of ACP discussions remain similar across diagnoses, the specificity of conversation will vary with the disease and its severity. Training programs for ACP discussions recognize that for healthy individuals, ACP may be limited to designating a substitute decision-maker and a general discussion of life values.[11] It can be challenging to make decisions for possible medical situations ahead of the actual event. For example, a patient may consider artificial nutrition acceptable as an intervention to facilitate recovery from acute illness but not for indefinite use, especially if the patient is in a dependent, noncommunicative state. The most effective information for future decision making outlines what brings value and meaning to living for the patient rather than what might be wanted in a range of hypothetical clinical scenarios. If specific complications and interventions become more likely as the disease progresses, then the advance care plan can be changed to give appropriate directions.

It is important for the physician to initiate an advance care planning discussion by introducing the topic and normalizing the conversation as one necessary to have with all patients. It is also important to determine what the patient understands about his or her individual health currently, as this will affect how the conversation unfolds and establish whether the patient has discussed this understanding or hopes for future care with anyone. In some cases, the initial doctor-patient ACP conversation will be the first time a patient has considered the need for a substitute decision-maker, and it is most helpful for the substitute decision-maker to be present for subsequent conversations. Even when the initial ACP discussion addresses only a few introductory questions, it provides an opportunity to offer further resources for the patient to review before a follow-up meeting. ACP conversations ideally occur early in the illness trajectory in the outpatient setting, but may be initiated in a hospital or care facility. Sample questions for initiating and continuing ACP discussions[12,13] are outlined in **Table 1**.

Avoiding end-of-life conversations in an effort to maintain hope was actually viewed as unacceptable by patients and substitute decision-makers.

In British Columbia, the *My Voice* workbook provides a framework for approaching ACP discussions.[14] The workbook begins by asking the patient to think about beliefs, values, and wishes for future health care and then proceeds to help the patient document these in the form of a representation agreement, an advance directive, and an enduring power-of-attorney agreement. It is important to record ACP conversations in the patient chart and to obtain a copy of any documents completed by the patient for future reference. Many patients, and occasionally some legal professionals and physicians, are not aware of the difference between appointing someone

Table 1. Questions for advance care planning conversations with patients.[12,13]

Introduce the topic	"One thing I like to do with all my patients is to discuss advance care planning. Do you know what this means?" "Is this something you would feel comfortable discussing today?" "Is there someone you would like to be present with you for these conversations?" "What do you understand about your illness or what's happening to you?"
Assess prior knowledge	"Do you have an advance care plan? Do you know what I mean by this?" "Have you done any of the following: written a living will, appointed a health care representative, completed an advance directive?"
Identify substitute decision-maker (if no plan prior to review)	"If decisions about your care needed to be made in the future and you were unable to speak for yourself, whom would you want me to ask about your care?"
Explore prior conversations	"Have you talked to your substitute decision-maker, family, or other health care providers about your wishes or preferences for health care that may come up (e.g., resuscitation)? May I ask what you discussed?" "Could a loved one correctly describe how you would like to be treated in the case of a terminal illness?"
Understand values	"What is important to you as you think about this topic?" "Where do you fall on a scale with the following endpoints?" 1 = Let me die without medical intervention, except for control of pain and symptoms. 5 = Do not give up on me no matter what; try any proven or unproven intervention possible.
Determine end-of-life care preferences	"If you could choose, would you prefer to die at home, in hospice, in residential care, or in hospital?"

in a power-of-attorney agreement to make financial decisions and naming a substitute decision-maker in a representation agreement to make medical decisions. It is important to clarify this distinction.

In addition to the *My Voice* workbook designed for use in British Columbia, other resources and interactive tools for patients are available through the Speak Up program.[12]An additional resource for patients is the Engage with Grace tool, which poses five questions to encourage further conversation.[13]

Goals of care

For patients with advanced illness, whether their primary diagnosis is progressive organ dysfunction, motor neuron disease, cancer, or some other life-limiting disorder, there comes a time in the illness trajectory when a discussion of goals of care becomes essential to providing patient-focused care. Goals of care is a vague term that should not be considered synonymous with code status, although this is anecdotally often the case. While advance care planning is intended to be done well ahead of any need for medical decision making, goals-of-care discussions occur during the course of illness. Many goals-of-care discussions will include considering whether it is time to shift from a disease-modifying therapy to a palliative care approach that minimizes or rationalizes medical interventions to focus on therapies likely to increase patient comfort and improve quality of life.

There are significant barriers to goals-of-care discussions, including patient and family factors, physician discomfort in initiating the conversation, and systemic pressures and dynamics. This last barrier can involve ambiguity or uncertainty regarding who is the most responsible clinician.[10,15] Evidence can guide when and how these discussions occur. With respect to timing, it can help to answer the so-called surprise question: "Would you be surprised if this patient died in the next 6 to 12 months?" A response of "no" indicates the time is likely right for a goals-of-care discussion.[16] In general, patients with a progressive disease, decreasing function, or an acute episode necessitating hospital admission or changes in treatment are those who would benefit from a focused goals-of-care discussion.

Goals of care may be established between a clinician and patient at the bedside, on admission to hospital, iteratively over multiple outpatient visits, or at a more structured family meeting after hospital admission. Family meetings are common and are thought to improve communication, bereavement outcomes, length of stay, and resource utilization.[17]

In a goals-of-care discussion physicians will often explain the medical context of the treatments being offered, what the risks and benefits are, and guide patients and families to explore patient expectations in terms of prognosis and level of function.

The following outlines one approach to a goals-of-care discussion.

1. Find out how much information the patient and family wish to have. Give the patient and family permission to ask questions and explore their understanding of the patient's disease and future.

- "Please ask for clarification or more detail if you like, or let me know if you're hearing more detail than you feel you need."
- "Before we talk in detail, it would help me to know what you understand about your illness."
- "Can you tell me your understanding of your medical situation right now?"
- "What do you expect your health will look like in the future?"

2. Summarize the medical situation. Know the patient's medical history well enough to summarize it without reading off the chart and refer back to the chart only for details when needed (e.g., size of lesions, lab values, medication doses).

- Maintain eye contact with the patient and any family present to get a sense of understanding.
- Use simple language and define medical terms if used. For example, "Your creatinine is high, meaning that your kidneys aren't working well."
- Check understanding along the way. For example, "Does that make sense?"

3. Ask questions regarding values and preferences. Find out what is important to the patient at this time (e.g., place of care; burden of treatment that is acceptable; important upcoming milestones; tasks, hobbies, pastimes, and occupational, family, or social engagements that are important to maintain).[10]

- "If your health situation worsens, what are your most important goals?"
- "What are your biggest fears and worries about the future with your health?"
- "What abilities are so critical to your life that you can't imagine living without them?"
- "If you become sicker, how much are you willing to go through for the possibility of gaining more time?"

4. Incorporate values and preferences information into recommendations for a treatment plan and present possible options. This may include shifting the focus of care to symptom management rather than active treatment of the underlying disease. Use discretion when discussing plans that are not true options (e.g., patient might want to go home, but given your diagnosis and the patient's function this is not an option).

5. Discuss options and your recommendation. This may occur either after sitting in silence during the meeting or after allowing hours or days to pass so that the patient and family can digest the information and confirm a plan.

6. Check understanding. Summarize information heard from the patient and family and clarify what changes, if any, will be made directly after the meeting or when you will confirm a care plan.

Keep in mind that the process is a dynamic one and the order of steps outlined above can vary. Whatever the order, the steps in a goals-of-care discussion should focus on the patient rather than clinical values: the patient's quality of life, important upcoming milestones, and perception of wellness are more important than vital signs, laboratory values, or findings on imaging. Undoubtedly, the questions described above involve assessment that is not a standard part of medical history taking; physicians are not accustomed to asking about a patient's values, and these may take several conversations to elicit fully.

When a goals-of-care discussion is successful, a collaborative plan emerges, grounded in the clinician's medical knowledge and guided by the patient's priorities. Some conversations can evoke significant emotion and lead to conflict. A patient and family may request futile interventions, refuse to discuss unwanted outcomes, or become angry and blaming. In these situations, tools may be needed to help clinicians break bad news, display empathy, and conduct effective family meetings. Physicians should remind themselves to use open body language and appropriate eye contact,[18] respond to emotional cues,[19] and check understanding of patients and family members.[20] Many physicians are familiar with the SPIKES model,[20] which was designed to help deliver bad news to cancer patients and can be used in a variety of health contexts.[21] Another evidence-based approach used by experienced clinicians is the VALUE model,[22] which is more appropriate for goals-of-care discussions because it focuses on gathering information from the patient and family rather than on relaying information:

- **V**alue and appreciate what the family said.
- **A**cknowledge emotions.
- **L**isten.
- **U**nderstand: ask questions that allow one to know the patient as a person.
- **E**licit questions from the family.

While many goals-of-care discussions clarify the types of interventions to be initiated for patients, others address the possibility of withdrawing life-sustaining therapies. The perceived moral difference

between withholding and withdrawing therapies can vary among cultures, regions, and individuals. However, in the Canadian setting, the ethical and legal equivalence of withholding and withdrawing interventions is well established.[23] It is always important to help families differentiate between the decision to withhold or withdraw therapies from euthanasia/physician-assisted suicide as these are ethically distinct acts. For example, a physician might need to explain that withdrawing or not escalating use of a therapy does not hasten the dying process but instead avoids extending life artificially and allows for a natural death.

Overall, empathetic, direct, and honest responses to questions and exploration of questions, fears, and emotions will help find common ground. Goals-of-care discussions take time and effort, but are worthwhile because they lead to improved quality of care and clearer, shorter, and more collaborative discussions and decisions as the patient's condition and needs change further.[10]

Final days of life

Supporting a patient and family members through the final days of the patient's life can be daunting, particularly if this is not a common occurrence in your clinical practice. It can be difficult to diagnose dying because of ongoing hope that the patient will get better, because of mixed information about the overall status of the patient, and because of failure to recognize signs and symptoms of imminent death.[24] Even when clinicians accurately identify the dying process and families and patients are accepting of this, addressing questions and concerns from patients and family members can be difficult. Common questions relate to issues of hunger and thirst at end of life, prognosis, signs of imminent death, the ability of unresponsive patients to sense their surroundings, and how family members can support a minimally responsive or unresponsive patient. In general, it helps to encourage family members to be present as they are able, and to observe any end-of-life spiritual traditions important to the patient. As well, you can help by going over natural changes in breathing, intake, and alertness at the end of life as outlined in **Table 2**.

A handout about imminent death for family members is a useful resource available in many institutions (e.g., "As Death Approaches"[25] from the Vancouver Island Health Authority). Such resources can remind clinicians about important topics to discuss, and allow family members to review information later when they feel less overwhelmed.

Table 2. Common family concerns and information physicians can provide in final days of life.

Level of alertness	Alertness is less at the end of life, although brief periods of lucidity/energy can occur. Patients may be able to hear and feel touch when unresponsive, and informing family members of this can help them be present with the patient.
Oral intake	Patients usually do not feel hunger or thirst and oral intake is significantly reduced. Patient indication of hunger or thirst should guide intake.
Changes in breathing	Irregular breathing with apneic pauses may indicate a prognosis of hours rather than days. Wet breath sounds can occur and are unlikely to be uncomfortable, but may be reduced with repositioning or decreasing the production of saliva and phlegm with medication (e.g., scopolamine, glycopyrrolate).
Circulation	Peripheral pulses decrease and hands and feet may become mottled and cool.
Bowel and bladder function	Patients are often incontinent and insertion of an indwelling urinary catheter may be appropriate.
Agitation and confusion	Patients often settle with reassurance from family and care providers and in response to a calm environment. Ongoing agitation may be reduced with medication (e.g., methotrimeprazine, midazolam).

Conclusions

Communicating with patients and families facing life-limiting illness involves challenges. In conversations about advance care planning, goals of care, and final days of life, clinicians are faced with the delicate task of balancing hope and reality in a caring and honest way. These discussions also require us, as clinicians and individuals, to confront our own understanding and experience of death and dying, which can be inherently discomforting. How such conversations occur will vary with the cultural, personal, and disease diversity encountered across clinical practice. Of greatest importance is that these conversations do occur and are not avoided. In talking to our patients, we will come to know them better and help them receive care in a way that most respects who they are.

Competing interests
None declared.

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It is always important to help families differentiate between the decision to withhold or withdraw therapies from euthanasia/physician-assisted suicide as these are ethically distinct acts.

Alan T. Bates, MD, PhD, FRCPC

Addressing existential suffering

Physicians can feel better equipped to deal with a dying patient's emotional experience by considering some relevant contributions of existential philosophers and being aware of possible interventions, including manualized therapies.

ABSTRACT: Existential distress is often present in terminal illness and may be associated with syndromes such as depression, anxiety, and desire for hastened death. Physicians with expertise in managing physical pain may feel unequipped to address social, psychological, and spiritual aspects of pain. Through a brief exploration of the foundations of existentialism and existential psychotherapy, this article aims to demystify existentialism and provide practical tips for addressing existential suffering, even in parents and children with terminal illness. Formalized interventions that assist patients with existential issues are recommended. Physicians are encouraged to get support in exploring domains that they may feel are outside their scope of practice, such as spirituality, and encouraged to adjust boundaries in the doctor-patient relationship in palliative care settings. With the aid of a physician who addresses existential suffering, it is possible for patients to transition from feeling hopeless to feeling more alive than ever.

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"It feels as though I'm traveling further and further into a cave that's getting darker and narrower, and there's no way to go back."

Patients with terminal illness express existential suffering and spiritual distress in a number of different ways. Hearing a patient say the words above, a physician may feel paralyzed or poorly equipped to respond. What can you really say when a patient has a progressive terminal illness? There is no denying the illness, and no denying the patient's experience of it. However, the feelings of dread, powerlessness, and loss of control that a physician may experience on hearing these words can be used to help the patient. Experiencing these emotions shows our capacity to understand or perceive some of what our suffering patients are feeling. Though initially difficult for us to experience, these feelings can become a guide to what a patient needs help with.

Foundations of existentialism and existential psychotherapy

Existentialism is something we have usually heard of, but few of us know much about. And lots of us feel intimidated by the term because we do not really understand what it means. It sounds like something we might have studied at university if we had not been so busy taking all the medical school prerequisites. Fortunately, a physician does not need to be a philosophy major to understand the core concepts of existentialism and use that understanding in the care of patients.

Clearly, talking to patients about death is key to helping them cope with anxiety about it. By taking something as nebulous as death and discussing it in more concrete terms in regular conversation, we can make death less frightening and unpredictable for our patients. And in that same spirit, by considering some relevant contributions from a few existential philosophers and thinkers, we can feel better equipped to do this.

Kierkegaard

Søren Kierkegaard is widely regarded as the father of existential philoso-

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phy.[1] His work often focused on personal choice and commitment, and how everyone lives as a "single individual."[2] Kierkegaard also explored the emotions of people making significant life decisions, and certainly there can be often a number of these to make at the end of life in a modern medical system.

Martin Heidegger extended Kierkegaard's idea of living as a single individual to dying as a single individual, proposing that death is an entirely personal experience that must be taken on alone.[3] Patients do sometimes experience a new and distressing sense of aloneness at the end of life, knowing that nobody is going to share this specific experience with them. The feeling of being the only one who can make choices about how to live out final days can be overwhelming.

While some at the end of life take great comfort from their faith, others may find their unfortunate circumstance cause them to question it. Kierkegaard theorized that there is no faith without uncertainty or doubt.[4] He described how faith is not required to believe in something tangible like a chair, but is necessary to believe in something for which there is little or no evidence. In other words, faith is required when there is significant uncertainty or doubt, and without uncertainty or doubt there may be little role for faith. The concept of a "leap of faith" originates in Kierkegaard's writings, although he does not use this exact phrase. One can suggest to a patient that fear centred on uncertainty surrounding death is common and that the doubt they are feeling may actually be an opportunity to strengthen their faith rather than to abandon it. While not directly related to Kierkegaard's ideas, another potentially comforting aspect of uncertainty is that it means you have wiggle room or flexibility and that nothing is set in stone.

Nietzsche

Friedrich Nietzsche is intimately associated with the concept of nihilism, which in turn is related to existential nihilism—the idea that life has no meaning or purpose. Patients at the end of life may experience a kind of existential nihilism and say that their existence has been meaningless or that there is no longer any point in being alive. Nietzsche argued that our primary driving force is not meaning or happiness, but rather the "will to power" or pursuit of high achievement and reaching the best possible position in life.[5] If this is our primary driving force, it is understandable that patients who have had great success in their careers or other pursuits may feel there is no longer any purpose to their existence once they are seriously ill.

Although it may be a manifestation of depression or some other modifiable condition, existential nihilism is a concept that great minds have either supported or struggled with, and one that is not easy to dismiss out of hand. However, there are certainly alternate views that may facilitate a patient's leap of faith to a more comfortable opinion.

Sartre

Jean-Paul Sartre argued that "existence precedes essence"[6] and that it is not until we have engaged with life and done things that we can look back and see our "essence" reflected in what we have done. At the end of life, patients may feel they are returning to mere existence. Sartre even suggested that death results in us existing only to the outside world, leaving evidence of a uniquely individual experience of existence that is no longer present. The thought of retreating from essence to existence only to others could certainly be a frightening one. In contrast, Sartre also wrote about needing to experience "death consciousness"[7] in order to discover what is really important in life, and patients sometimes describe this as a kind of "silver lining" to being terminally ill. Unfortunately, this can also be experienced as a terrible realization that much of life was not spent on what the patient now views as most important.

Frankl

Viktor Frankl was an Austrian psychiatrist who spent 3 years in Nazi concentration camps. In contrast to Nietzsche's "will to power," Frankl maintained that "will to meaning" is the primary driving force of human behavior. His experiences in the concentration camps are described in his book *Man's Search for Meaning,*[8] which confirms his belief that meaning can be found in any situation, even in great suffering. He theorized that finding meaning in difficult situations gives us the will to continue living through the worst of circumstances. Frankl's ideas are now being applied in modern evidence-based psychiatric interventions for patients with advanced cancer as meaning-centred psychotherapy.[9,10]

Yalom

Irvin Yalom has written extensively on existential psychotherapy,[11] where psychiatric symptoms or inner conflicts are viewed as the result of difficulties in facing what he describes as the four "givens" of human existence: mortality, meaninglessness, isolation, and freedom. Existential psychotherapy focuses on identifying which of these existential givens patients are struggling with and helping them to respond in positive ways. Certainly, acute appreciation of one's mortality, disconnection from meaning, feelings of isolation, and uncomfortable freedom in making difficult choices can all play a significant role in existential suffering at the end of life.

What is existential suffering?

If you are still not sure how to define existential suffering, you are not alone. In a review of existential suffering in the palliative care setting, Boston and colleagues[12] reviewed 64 papers and found 56 different definitions. Themes common to the descriptions of existential suffering included lack of meaning or purpose, loss of connectedness to others, thoughts about the dying process, struggles around the state of being, difficulty in finding a sense of self, loss of hope, loss of autonomy, and loss of temporality.

Cicely Saunders introduced the concept of total pain, which encompasses physical, social, psychological, and spiritual suffering.[13] Spiritual factors (e.g., belief in life after death), psychological factors (e.g., sense of self), and social factors (e.g., connectedness to others) can easily be seen in the descriptions of existential issues listed above, so perhaps existential suffering is best thought of as distress within these three spheres of total pain. However, it is important to note that the divisions between these different sources of pain are artificial as all three spheres are connected. For instance, we have all had the experience of physical pain being exacerbated by emotional context (e.g., hitting your head on something in the middle of a frustrating day). It is also wrong to imagine we can treat any of these spheres in isolation. Opiate medications for physical suffering, for example, have significant psychological effects. An important corollary to this is that addressing social, psychological, and spiritual pain is likely to affect a patient's experience of physical pain as well.

What is the physician's role in the face of spiritual distress?

Looking at social, psychological, and spiritual suffering, spiritual distress is likely to be viewed as the most remote from a physician's core training. Many equate spirituality with religion and, understandably, physicians are reluctant to discuss religions they may know little about. Physicians are about half as likely as patients to hold a particular spiritual belief.[14] Even if a physician follows a religion, he or she might be concerned about being intrusive,[15] and some guidelines for communicating with patients about spiritual issues caution against discussing your own religious beliefs, stating they are generally not relevant.[16] However, it is possible to bring wisdom from the world's major religions into therapeutic discussions about illness and death without intrusively promoting a particular faith. It is always helpful to know what a patient's spiritual beliefs are, and questions based on the FICA spiritual history tool[17,18] can help you do this (see the **Table**).

Although one could argue it is a religious leader's role, and not a physician's, to discuss spiritual or religious matters with a patient at the end of life, an equally strong argument could be made in support of a role for the physician by posing questions about training: What exactly is the training religious leaders receive to provide this kind of care? Is their training accredited in some way or based on evidence of effectiveness? Do religious leaders know more than palliative care specialists? These questions are posed here not to diminish the important role of religious leaders (some of whom do have specialized training in working with dying patients) in caring for patients at the end of life, but rather to suggest that physicians' knowledge and training should make them confident that they, too, have something to offer. In Boston and colleagues'[12] summary of how existential suffering is defined in the literature, many of the definitions focus on meaning and purpose, and these are concepts for which modern evidence-based medical interventions have been developed.[9,10]

Central to whatever role physicians play when helping patients deal with spiritual distress is the need for adequate support. Feelings such as sadness, isolation, inadequacy, or hopelessness can be experienced by physicians caring for seriously ill patients, and it is important for physicians to seek help for themselves. A concept discussed in psychotherapy supervision is parallel process, whereby issues that arise between a patient and a therapist are mirrored in the interactions of the therapist and the therapist's supervisor. This and other evidence shows that phy-

Table. Questions based on the FICA spiritual history tool to help physicians address issues of faith and belief with patients.

Faith and belief	"Do you consider yourself spiritual or religious?" "Do you have spiritual beliefs that help you cope with stress/difficult times?" "What gives your life meaning?"
Importance	"What importance does spirituality have in your life?" "How has your spirituality affected your experience of this illness?"
Community	"Are you part of a spiritual community?" "Does this community provide you with support?" "Can you reach out for help?"
Address in care	"How would you like me to address spiritual issues in your health care?"

sicians need connectedness and support to cope with their own existential distress.[19] In addition, providing the best possible care to dying patients generally involves recruiting assistance from others when that luxury is available. Just as with other kinds of clinical challenges, it is always a good idea to seek advice from peers who have likely had similar experiences. In larger centres, palliative medicine, psychiatry, social work, and spiritual care are all services to consider involving in a dying patient's care. In Canadian hospitals, most spiritual care providers are associated with the Canadian Association for Spiritual Care and are experts in supporting an individual patient's spiritual beliefs without promoting any of their own. Some hospitals also have a professional ethicist or ethics team to help with ethical dilemmas.

How can physicians address existential suffering?

As summarized by LeMay and Wilson,[20] existential suffering is associated with a number of clinical issues, including reduced quality of life, increased anxiety and depression, suicidal ideation, and desire for hastened death. Recognizing existential suffering can therefore alert us to the likely presence of symptoms we can address. Anxiety, depression, suicidal ideation, and desire for hastened death are addressed regularly by physicians (particularly psychiatrists) in other settings, and there is good evidence that our interventions work in the palliative care setting as well. For example, Holland and colleagues[21] showed that both fluoxetine and desipramine were effective in treating depression and improving quality of life in women with advanced cancer. Psychotherapeutic interventions such as cognitive-behavioral therapy (CBT), which is used routinely to treat depression and anxiety, can also be effective in treating terminally ill patients. For example, patients with serious illness sometimes describe a complete loss of identity, a problem that can be addressed using CBT to help patients identify this generalization or "all-or-nothing" thinking and aid them in recognizing core parts of themselves that remain unchanged. Depression and hopelessness have been found to be the strongest independent predictors of desire for hastened death in terminally ill patients[22] (stronger than poor physical function), and these are also both symptoms physicians can address.

As well as alerting us to the possible presence of clinical issues, existential suffering sometimes presents as another symptom. For example, if a patient with serious illness begins complaining of new-onset insomnia, a clarifying statement and question can elicit further information: "Sometimes people are afraid they're not going to wake up. Is that something you worry about?" Answers will often provide evidence of anxiety and existential suffering that require a broader approach and more than an order for zopiclone.

Assisting with patient loss of identity

Loss of identity or a defining role in life is a common part of existential suffering. Assisting patients to see that many things (possibly core values, relationships, interests, skills) have not been changed by their diagnosis can be very therapeutic. For example, a father who feels he is no longer fulfilling his role as a parent because his illness prevents him from playing catch with his son can benefit from being educated about how he is fulfilling another role: modeling for his son how to get through an extremely difficult experience. By demonstrating how to maintain relationships and recruit support, a parent provides an invaluable lesson for a child. Some parents also like to create legacy projects for their children, such as writing cards for each birthday up to a particular age. Older parents are often concerned about burdening adult children with having to care for them. They are used to giving rather than receiving care and the role reversal can be quite upsetting. In these cases an older parent can benefit from knowing that allowing adult children to pay back just a small

Existential suffering is associated with a number of clinical issues, including reduced quality of life, increased anxiety and depression, suicidal ideation, and desire for hastened death. Recognizing existential suffering can therefore alert us to the likely presence of symptoms we can address.

fraction of the care they have received over many years helps them with their own feelings and ability to cope. There are clearly exceptions, but in general parents tend to speak highly of their children and enjoy telling clinicians about their children's positive attributes. "Where did they get that from?" is a simple, yet often very effective question for helping parents reflect on positive things they have passed on to their kids.

Children with terminal illness are another unique population. Adults' praise of children frequently involves telling them about what they are capable of achieving. Children may lose their sense of self-worth if they know there is nothing they can become as an adult.[23] How to best address existential concerns in children depends strongly on developmental stages.[24]

Supporting family members

Family members experience distress and require support as well. We all internalize aspects of our parents, and when a parent is dying both young and adult children may feel a core part of themselves or their life is dying. Related to children feeling that their purpose or worth is in "becoming" something to please encouraging adults, children may feel a loss of identity or purpose with a parent's death. Similarly, family members often grieve not only the loss of their loved one, but also the loss of their caregiving role, especially if the person has been ill for a long time. Educating family members about how common these feelings are and letting them know that these feelings will generally become less painful over time can reduce distress. In expressing condolences to family members, we commonly say something like "I'm sorry for your loss" or "This must be very difficult" to convey empathy. Following up such statements by asking "Who's supporting you right now?" communicates a greater impression that you care about how they are going to cope with their grief.

Adjusting boundaries

Holding a patient's hand for any length of time would be a boundary violation in many medical settings, particularly for psychiatrists who tend to avoid touching patients at all. Yet given that loss of connectedness to others is such a common theme in definitions of existential suffering, few things are more therapeutic than holding the hand of a dying patient who is otherwise alone. Similarly, placing a gentle hand on a patient's shoulder as you arrive or as you leave the bedside can communicate a connectedness or caring that might be difficult to convey appropriately in words. Best practice is always to observe appropriate boundaries in the doctor-patient relationship, but there is good reason to shift these boundaries in some palliative care settings.

Using formalized interventions

Formalized interventions include meaning-centred psychotherapy, an intervention developed at Memorial Sloan Kettering Cancer Center and aimed at helping patients with advanced cancer reconnect with experiential, creative, attitudinal, and historical sources of meaning;[9,10] Dignity therapy, created by Harvey Chochinov and colleagues in Winnipeg;[25] and Managing Cancer and Living Meaningfully (CALM) psychotherapy, developed by Gary Rodin and colleagues in Toronto.[26,27] LeMay and Wilson present a review of other manualized therapies for existential distress.[20]

Helping patients find a silver lining

Many dying patients see their newfound realization about being alive and knowing how they want to spend their time as a silver lining to a diagnosis of terminal illness. Unfortunately, this is sometimes paired with guilt or remorse related to a sense of not having spent their time well up to that point. Some patients may also feel there is now no opportunity for anything other than dying because of the large amount of time they "wasted." Helping patients with existential suffering realize they are still alive is often key. Some argue that hope is an act rather than a feeling. Children generally have a remarkable way of achieving hopefulness on their own. Youth in hospice generally have the same desires and interests as other young people, such as wanting to make friends and being interested in sex.[28]

As children, we develop an understanding of death-related concepts, including universality (all living things die), irreversibility (once dead, dead forever), nonfunctionality (all functions of the body stop), and causality (what causes death). Perhaps a new application of these concepts to the patient's own situation is what can lead to a sense of opportunity—that silver lining—rather than existential suffering. Patients with terminal illness know they are not a unique exception to universality, and they often know what is going to kill them (a personalized causality). They are also likely experiencing irreversible physical deterioration (nonfunctionality). They have fallen into the same cave as everyone else, it is getting darker and narrower as time goes by, and they even know what unfortunate companion is pushing them along. Hopefully, they can also realize they are still free to explore some of the cave's more beautiful features, to draw or write on the walls, to show courage in exploring some of the uncharted alcoves, and

to map out some of the more treacherous terrain for others who will follow.

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Competing interests

None declared.

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Changing epidemiology of *Clostridium difficile*–associated infections

Clostridium difficile infection continues to be a common cause of health care–associated diarrhea in North America, contributing to patient morbidity and mortality. *C. difficile* is a gram-positive, spore-forming, anaerobic bacteria that spreads via the fecal-oral route from person to person. Its pathogenicity is based on the production of toxins and, in some strains (e.g., NAP-1 strain), an overproduction of toxins. Manifestation of *C. difficile* is characterized by diarrhea, fever, nausea, and abdominal pain, and in severe cases progresses to toxic megacolon, sepsis, and death. As well, reduced susceptibility to metronidazole is emerging, and this complicates treatment. Those who are immunosuppressed and those over 65 years of age have increased risk of complications and death. Children were traditionally thought to be asymptomatic carriers of the organism; however, children between the ages of 1 and 18 years are affected by *C. difficile*.[1]

It is important to understand the changing epidemiology of *C. difficile* to understand diagnosis and guide infection prevention and control practices. According to the Provincial Infection Control Network of British Columbia (PICNet), the provincial rate of *C. difficile* has decreased by more than 50%, from 8.6 per 10 000 inpatient days in 2009–10 to 4.2 per 10 000 inpatient days in 2014–15. Among the 2014–15 cases, however, close to 30% were community-associated, which is double the number of those cases in 2009–10.[2] This increase in incidence of community-associated *C. difficile* has been reported across Europe and North America and is occurring in patients who are younger, healthier, and with fewer risk factors. A recent report showed a shift in strain types in a region in BC from a highly virulent strain associated with health care–associated *C. difficile* in 2008 to novel strain types in 2013.[3] These novel strain types identified in the health care setting in 2013 were seen in the community setting within this region in 2008, suggesting that *C. difficile* strains from the community setting were likely introduced into health care facilities where they contributed to circulating health care–associated strains. Using whole genome sequencing, a group in the UK demonstrated that there are numerous sources for *C. difficile* acquisition, including colonization in the community prior to admission to hospital.

C. difficile is a gram-positive, spore-forming, anaerobic bacteria that spreads via the fecal-oral route from person to person. Manifestation of _C. difficile_ is characterized by diarrhea, fever, nausea, and abdominal pain, and in severe cases progresses to toxic megacolon, sepsis, and death.

Currently, there is very limited information on potential environmental sources of *C. difficile*. However, *C. difficile* can be recovered from retail meats and vegetables. Colonization by household pets has also been reported.[4]

Although little is known of where and how *C. difficile* is acquired, it is well known that alteration of the normal enteric flora, especially from unnecessary use of antibiotics, is an important risk factor. Two of the main challenges in *C. difficile* are relapse and recurrence of disease. Predisposing factors for relapse include insufficient length of treatment, inadequate doses of oral agents (commonly metronidazole), or both. It is important to note that almost 30% of cases were reported as recurrent in 2012.[1] In many of these cases, conventional antibiotic treatments have had limited success and patients suffer repeated episodes. Proper choice and dosing of antibiotics according to recommended guidelines are important stewardship practices. Patients should be counseled to adhere to treatment regimens and to complete the prescribed course. Recently, stool transplantation has provided a safe and effective alternative to antibiotic treatment for patients with recurrent CDI. A guide for best practice management is available at www.picnet.ca/wp-content/uploads/Toolkit-for-Management-of-CDI-in-Acute-Care-Settings-2013.pdf.

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Available at bcmj.org.

New inorganic lead-monitoring guidelines

Lead (Pb) is the quintessential heavy metal with toxic properties that have been recognized for centuries. It's a naturally occurring, nonessential element with well-defined dose-toxic effect relationships. Adverse health effects may start with blood lead levels (BLL) as low as 0.48 µmol/L (10 µg/dL)* in adults. The 95th percentile for BLL for Canadian adults is approximately 0.2 to 0.3 µmol/L. Adverse health effects associated with elevated lead exposure include hypertension and anemia, as well as renal, gastrointestinal, reproductive, and central and peripheral nervous system dysfunction. The International Agency for Research on Cancer has deemed lead a probable carcinogen.

Inorganic lead is absorbed by inhalation or ingestion. Signs and symptoms of lead exposure vary with the dose and duration of exposure. They are typically nonspecific and can include fatigue, myalgia, arthralgia, irritability, lethargy, abdominal discomfort or pain, tremors, headaches, constipation, and difficulty concentrating. More extreme exposures can result in encephalopathy with seizures, altered consciousness, coma, and death. Enquiring about workplace activity and exposure can identify lead exposure as a possible contributing factor. For additional information on lead toxicity and management, see the suggested reading.

Adverse health effects associated with elevated lead exposure include hypertension and anemia, as well as renal, gastrointestinal, reproductive, and central and peripheral nervous system dysfunction.

Lead exposure in the workplace

Lead exposure still occurs in many workplaces in BC, and every year WorkSafeBC adjudicates claims for exposure and toxicity. Exposure situations vary from law enforcement officers doing target practice, to workers at battery recycling facilities or radiator repair shops, welders dismantling lead painted bridges, metal refinery workers, grinders of fishing lead lures, and others. WorkSafeBC requires that employers have an exposure control program for lead-exposed workers.

Exposure control programs typically include biological monitoring for lead by measuring BLL. WorkSafeBC guidelines for BLL monitoring were summarized in a prior article in the *BCMJ* (2009;51:388). The guidelines were based on the American Occupational Safety and Health Administration standards first enacted into law in 1978 for general industry. Many clinicians and researchers in the field of occupational medicine have advocated for a review of the older standards of practice because they are not considered to be sufficiently protective for workers with occupational lead exposure. Newer recommendations have been proposed to rectify this situation and better protect the health of workers. In response to these changes, WorkSafeBC is also updating its guidelines. These newer guidelines are summarized in the **Table**.

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Table. Recommended actions for measured BLL.

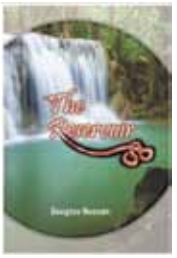
Blood lead level	Retest recommendation	Recommended action
< 0.48 µmol/L (< 10 µg/dL)	None to annually.	No specific actions necessary.
0.48–0.96 µmol/L (10–19 µg/dL)	Every 6 months.	ALERT Minimize exposure by reviewing all sources of exposure and improving protective measures.
0.97–1.44 µmol/L (20–29 µg/dL)	Every 1 month.	REMOVAL 1. Remove worker from further lead exposure if a repeat test is greater than 0.97 µmol/L (20 µg/dL). 2. Return worker to previous duties when: - Blood lead level is acceptable to a physician, and - Exposure is minimized by reviewing all sources of exposure and improving protective measures.
≥ 1.45 µmol/L (≥ 30 µg/dL)	Monthly until the level is acceptable to a physician.	REMOVAL 1. Remove worker from further lead exposure. 2. Return worker to previous duties when: - Blood lead level is acceptable to a physician, and - Exposure is minimized by reviewing all sources of exposure and improving protective measures.

Note: Pregnant or breastfeeding women should be reassigned to tasks that do not involve lead exposure.

*In the past, BLL was reported in µg/dL, but now it is reported in µmol/L (1 µmol/L is approximately 20 µg/dL).

This article is the opinion of WorkSafeBC and has not been peer reviewed by the BCMJ *Editorial Board.*

Book review: *The Reservoir*



By Douglas Hassan, MD. New York, NY: Page Publishing, 2015. ISBN 978-1-68139-655-2. Paperback.

Dr Hassan was in several of my classes while working toward his medical degree at UBC in 1987, and then went on to study orthopaedics and hand surgery. He currently works with Puget Sound Orthopaedics. I have also known his father, Dr Leslie Hassan, a retired North Vancouver physician for many years, so it was a very pleasant surprise to read Dr Hassan's thriller, *The Reservoir*, the first volume of a planned trilogy.

Several stories are intertwined in this fiction with bioterrorism as the underlying theme. A report of an Ebola-like virus that is devastating the populations of small villages in the Virunga area of the Congo, and the suspicion that an unidentified species of highly evolved apes might be the reservoir of the virus, prompts a scientific expedition. A small team sets out from Seattle—an anthropologist expert in apes, his friend, an orthopaedic surgeon, an adventurer familiar with the area, and a security person. In Paris they are joined by a virologist from the Pasteur Institute. After an arduous journey down the Congo River the group encounters the new species of ape and obtains blood samples for further study, but unknown to them a Pakistani doctor turned terrorist hoping to create a biological weapon is also on his way to find a sample of the same virus. When the CIA becomes aware of the potential bioterrorism threat, agents joint the race to intercept the plan.

It would be unfair to readers to reveal the dangers and conflicts that the group runs into, and the CIA's wild pursuit of the terrorist across several continents. As for more about the viral sample held in the Pasteur Institute in Paris, you'll have to wait for the second installment of this trilogy. I am looking forward to it.

—George Szasz, CM, MD
West Vancouver

GPAC guideline: Asthma in Children—Diagnosis and Management

A new BC Guideline developed by Child Health BC in collaboration with the Guidelines and Protocols Advisory Committee provides recommendations for diagnosis and management of asthma in patients aged 1 to 18 years presenting in a primary care setting. The guideline is available to physicians across British Columbia at www.BCGuidelines.ca and includes new action plans and flow sheets.

Key recommendations

- Send children aged 6 years and older for spirometry when they are symptomatic to improve accuracy.
- Send patients for spirometry regularly as part of the assessment of asthma control.
- Prescribe controller medication daily and not intermittently.
- Controller medication does not need to be increased with an acute loss of asthma control in children.
- At each visit, assess for proper use of asthma medication devices and medication compliance as these are common reasons for poor asthma control.
- Prescribe an age-appropriate spacer device for patients using metred dose inhalers (MDI).
- Send all patients and families to an asthma education centre to learn self-management (where available).
- Given that many children less than 6 years of age outgrow their asthma symptoms, reassess the persistence of symptoms every 6 months in this age group.
- There is insufficient evidence to recommend one inhaled corticosteroids molecule over another with respect to efficacy or safety.
- Ensure children have normal activity levels and do not limit physical activity to control asthma symptoms.
- Complete a written asthma action plan with each patient and reassess this plan with the patient on a regular basis.

Resident Doctors of BC: 2015 award winners

The annual Awards of Excellence recognize members of the health care community for their contributions to creating an optimal training environment for residents in BC. Congratulations to this year's winners.

Award of Merit: Dr Meghan Ho

The Award of Merit recognizes a resident who has shown outstanding initiative in resident health and well-being, promotion of the role of residents in the health care system, or advocacy and representation of residents that leads to improved work or learning environments.

Dr Meghan Ho, an internal medicine resident, advocated for a program to improve the training that junior residents receive so that the transition to senior resident is smoother. The resulting transition program has become a formal part of the internal medicine residency program with the full support of program administration.

Dr Patricia Clugston Memorial Award for Excellence in Teaching: Dr Jagdeep Ubhi

The Dr Patricia Clugston Memorial Award for Excellence in Teaching recognizes a physician clinical educator for his or her contributions to residents' medical education. The recipient will have created a safe learning environment that encourages self-inquiry, supports adult learning, and fosters within learners a desire to achieve their highest potential.

Dr Jagdeep Ubhi is program director of the UBC Obstetrics and Gynaecology Residency Program and the resident site director at Royal Columbian Hospital. His nominators noted that he is an excellent teacher who is calm and encouraging when teaching integral skills, and is always looking for innovative and effective ways to help residents learn. Additionally, he is timely and effective in his feedback, offering residents semi-annual "fireside chats" to highlight their strengths and suggest improvements.

Residents' Advocate Award: Dr Andrew Campbell

The Residents' Advocate Award recognizes an individual who advocates for the personal, professional, or educational advancement of residents.

Dr Andrew Campbell is the program director of cardiac surgery and a staff congenital cardiac surgeon at BC Childen's Hospital and St. Paul's Hospital. He has advocated for simulation training for residents since becoming program director 5 years ago, and the simulations he developed have provided residents with invaluable experience to practise emergency scenarios and complex situations in a low-risk environment. He is a

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staunch ally of resident well-being and provides support on a personal level by sharing meals with residents, accommodating illness and family needs, and adding physical health into academic sessions to promoting personal well-being.

Each award winner receives $1000 to donate to a charity of their choice and a personalized memento to recognize the achievement.

Correction: Abusive head trauma

The author of the article "Abusive head trauma: Evolution of a diagnosis" *(BCMJ* 2015;57:331-335) has corrected an error that appeared on pages 331, 332, and 334. The sentence that read "… the leading cause of traumatic death in children under 2 years of age …" should have read "… a leading cause. …" The corrected article is available at www.bcmj.org/articles/abusive-head-trauma-evolution-diagnosis.

Partners For Life
Canadian Blood Services
it's in you to give
Rallying together to save lives

CFMS national blood drive: The need is constant

One in ten Canadian patients admitted to hospital receives blood products and, in most cases, from more than one donor. That's one reason why the Canadian Federation of Medical Students (CFMS) entered into a partnership with the Canadian Blood Services 39 years ago.

The CFMS represents over 8400 medical students across Canada who are committed to helping others in every way possible. The CFMS is a Canadian Blood Services Partners for Life organization and pledges an annual goal for blood donations because the need is ongoing. Less than 4% of eligible Canadians give blood, yet half of Canadians have either needed blood or know someone who has. In 2015 we collected 1326 units of blood, surpassing our goal of 1225 units. Therefore, our 2016 goal is to reach 1350 units.

Annual Phlebotomy Bowl

To encourage blood donations and to raise awareness, the CFMS runs a friendly 6-month-long (September through February) competition between medical schools to track which school accumulates the most donations and first-time blood donors. This competition, appropriately named the Phlebotomy Bowl, pits medical schools against one another. Students register as donors through their school's Partners for Life number, and donations are tracked by Canadian Blood Services at local blood clinics. Results are then converted from absolute numbers into a per capita rate, and the winning schools receive engraved plaques from Canadian Blood Services at the end of the competition.

Our 2015–16 Phlebotomy Bowl was a great success, resulting in 754 lifesaving donations and 98 new blood donors. McMaster University placed first in the Most Donations Per Capita category, followed by Queen's University and the University of Saskatchewan. McMaster University took first again in Most New Donors, followed by the University of Ottawa and Queen's University. The next Phlebotomy Bowl will start in September 2016. That being said, don't wait to donate. The need is constant.

The CFMS sincerely thanks the junior and senior blood champions at each medical school across Canada for their volunteered time and dedication to this important cause. Blood champions are medical students who work hand in hand with their local territory managers to plan blood drives at their schools year round. They go above and beyond in encouraging their peers to donate blood, while helping at blood-typing events (called What's Your Type?) and stem-cell cheek swabbing events held on campus.

CFMS is also looking into actively participating in stem-cell registration events. The national stem-cell network matches donors to patients who need stem-cell transplants. Stem cells are used to treat more than 80 blood-related diseases and disorders, and less than 25% of patients who need transplants will find a match in their family. If you are between 17 and 35 years old, you can contribute to the Give Life campaign by donating stem cells. Please register today at www.blood.ca/stem-cells.

To find out how you can help your medical school win the coveted Phlebotomy Bowl while Giving Life, contact me at salima.abdulla89@gmail.com.

—Salima Abdulla, BSc
CFMS National Blood Drive Officer
UBC Medicine, Class of 2017

Doctors of BC annual report: This is leadership

The 2015–16 annual report celebrates a few of your colleagues who are pioneers in their respective fields—BC physicians offering forward-thinking innovation and medical leadership in a diversity of practice areas.

- Dr Arun Jagdeo: Shaping and improving residents' experiences and residency education, and expanding the scope of Resident Doctors of BC.
- Dr Davidicus Wong: Inspiring patients to embrace health education, and bringing evidence-based health information to the public.
- Dr Ahmer Karimuddin: Fostering a collaborative, comprehensive approach to Enhanced Recovery programs for patients undergoing surgery.
- Dr Fiona Duncan: Supporting local, regional, and provincial initiatives to lead primary care.
- Dr Sandy Whitehouse: Transforming care for youth growing up with complex health conditions.

The core elements, which scan the association's work in supporting members, are also represented: the message from the CEO, reports from the president and the chair of the Board, financial highlights, and reports from all Doctors of BC committees in the *White Report*.

Explore this year's report at www.doctorsofbc.ca/who-we-are/annual-report.

Disability insurance: Your financial safety net

In the pursuit of practising medicine, you have made many sacrifices. Following your perseverance throughout medical school and residency, your most valuable asset is the ability to work. If your circumstances changed due to a disability and you found yourself unable to practise medicine, would your family be financially secure?

Data from Statistics Canada indicate that 18.3% of working Canadians in the 45 to 64 age bracket identify as having a physical, mental, or other health-related limitation to their daily activities. The top five reasons for claims among phyisicians are accidents, musculoskeletal disorders, psychological disorders, cancer, and circulatory disorders.

These categories span a broad range of potential disabilities. A physician would likely recommend that a patient with one of these conditions take time away from work, as needed, to further their recovery and increase their quality of life. If you were to find yourself with a limitation, would you have the freedom to follow your own advice?

The provincial government funds the Physician's Disability Insurance (PDI), but coverage is not automatic: you must apply and provide proof of good health.

Your health circumstances may change when you least expect it. While you decrease your workload due to illness or injury, you may find your savings diminishing or your line of credit ballooning as you care for personal and professional expenses out of pocket.

Many assume that there are government-funded programs in place to assist you in the event that you become disabled. The Canada Pension Plan Disability Benefits may be available to you if you have paid into CPP for 4 of the last 6 years. However, the maximum monthly disability benefit is $1264.59. This amounts to only $15 175.08 annually, well below both the minimum wage and the living wage in British Columbia. To ensure your financial well-being, supplemental disability insurance is a necessity.

Physicians' Disability Insurance and Disability Income Insurance

Disability insurance helps you plan for your family's needs in the event that you are no longer able to work or your workload is significantly decreased due to a disability. The provincial government funds the Physician's Disability Insurance (PDI), but coverage is not automatic: you must apply and provide proof of good health. The PDI plan provides a maximum $6100 monthly benefit, based on your income. Additional disability insurance is also available to increase your benefit amount and fill any gaps in coverage.

Residents' Disability Insurance

BC's medical residents are provided with health coverage through Resident Doctors of BC. Due to recent collective bargaining outcomes, Resident Doctors of BC is no longer able to provide disability insurance for residents, and has, instead, instated a requirement for residents to hold disability insurance independently.

In order to fill this need in the resident community, Doctors of BC has enhanced the Resident Disability Insurance plan. Residents transitioning into practice have 90 days from the end of residency to convert their resident coverage to the Member Disability Insurance plan without having to provide proof of good health.

Newly practising physicians are also eligible to enroll in the provincially funded Physicians Disability Insurance plan without proof of good health provided that, as residents, they held a minimum $2000 monthly benefit in the Doctors of BC Resident Disability plan for at least 12 months.

Planning for the unplannable

If you were faced with a disability, with an appropriate disability insurance plan in place, you would be able to take time off work and focus on your health and well-being while ensuring that your hard-earned savings and your family were protected.

Doctors of BC has noncommissioned insurance advisors available to help you find the best plan for your career stage and financial situation. To arrange a complimentary insurance review, contact insurance@doctorsofbc.ca or 604 638-7914.

—Caleb Bernabe
Insurance Administrator

Water recycling: A step to better water stewardship and public health

My children were angry at me. It was another scorching summer day and the "waterpark" Dad built in the backyard was not operational due to water restrictions. Incredibly, in rainy Vancouver, a poor winter snowfall combined with the record sunny summer we experienced last year resulted in a moratorium on running the hose over the playhouse slide. The kids were dying to cool off, which is better than how the garden tomatoes felt; they were just dying.

As my children and tomatoes continued to wilt I chatted with my neighbor and learned that Vancouver restricts the outdoor use of only treated drinking water.[1] My neighbor has a rainwater tank. Now I do too, and I am ready for another summer.

Water restrictions are not always headline news, but they do point to a growing issue in BC and throughout the world. To be sure, drought has been part of the earth's climate repertoire for millennia, but current projections call for increased frequency of and more widespread occurrence of water shortages as global temperatures rise.[2]

The human health implications of water scarcity are already upon us and are likely to be further exacerbated as water supplies become more precarious. Water scarcity directly threatens agricultural production, food security, and the effectiveness of sanitation systems. Also troubling are the geopolitical implications of diminishing access to water. The World Bank warns of the prospects for economic decline, increased poverty, and international conflict.[3]

This article is the opinion of the Council on Health Promotion and has not been peer reviewed by the BCMJ *Editorial Board.*

Though there are many facets to prudent water management, one option is to recycle greywater and rainwater. Greywater is the household wastewater from bathtubs, showers, sinks, dishwashers, and washing machines. Water from toilets and urinals is considered blackwater and is not suitable to be recycled. Water from kitchen sinks and dishwashers, which contains food waste, may be considered grey or black depending on the jurisdiction.[3] Rainwater can be harvested from roofs or through other collection methods.[3]

At home, my rainwater barrel is standing ready and my garden is looking good.

It is estimated that reusing greywater can save up to 60% of household water,[4] and there are many ways to reuse water (e.g., watering gardens and lawns, or flushing toilets and urinals), but regulations around reusing water vary across jurisdictions.

In BC regulations have included provisions for the use of reclaimed water since 1999. Wastewater in BC is already being reused in toilet/urinal flushing, landscape watering, playground use, green-roof irrigation, golf course irrigation, and forage crop irrigation. The BC government has also updated the Building Code to allow water utility providers to distribute nonpotable water and to allow nonpotable distribution systems to be installed in buildings.[3] Currently, the BC Ministry of Health is drafting a manual for greywater use in composting toilets.[5]

Using recycled water to flush our toilets and to water our lawns and gardens can benefit the environment by reducing the draw on drinking water, improving plant growth and soil maintenance, recharging local groundwater, and decreasing the load on sewage and treatment infrastructure. To go a step further, some systems can even extract the heat from washing machine and bath effluent for use elsewhere in the home.

On the other hand, the use of reclaimed water may carry human health risks, although the danger is thought to be low.[6] For example, water from bathing may carry potentially pathogenic microorganisms, and water from kitchen sinks or dishwashers may contain food waste and chemicals.[7] Moreover, some chemicals contained in greywater can adversely affect plants.[7] To mitigate risks to human health and agriculture, systems are typically used to prevent direct human exposure or to divert unwanted waste and chemicals.

In BC there are still opportunities to enhance existing regulations to balance water stewardship with public health, including more comprehensive Ministry of Health policies and regulations for reusing different types of water, and municipal bylaws on plumbing code reuse provisions.[3] More broadly, greater alignment between environmental, health, and municipal policies and regulations can minimize human health risks associated with reusing water.

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The person first

This essay is based on the winning entry from the UBC Faculty of Medicine Book Club's 2016 writing competition.

Trish Caddy, MD

"The Family Room," the triage nurse said, nodding me in and handing me a crumpled scrap of something.

A receipt. Weird. I yawned and stuffed the paper in my pocket as I stepped into the windowless space. Stopping short, I saw her. Elise was young, deaf, and mute. She sat erect, clutching a cardboard tray in shaking hands. Waves of nausea were racking her, and her smooth, dark skin had a greenish cast. Her translator shook my hand. I had met many women by that time in those rooms with their faded couches, Kleenex boxes and dusty plants on dated sideboards. Rooms that were beepless and halogen-lit, trying to soften the blow of loss. I introduced myself, explained my role, and sat down. She looked at the ground, at the door.

I said, "I know you've told your story a hundred times tonight. It's okay. You don't have to tell me."

She started to tell me. Slowly at first, but soon, the ideas tumbled out and over each other as fast as her hands could form them. Pausing only once or twice, she would lift the tray to wretch uselessly at the cardboard before setting it into her lap again.

"Nothing left," she signed, and sighed. She shifted her weight in her seat, and I noticed something odd about the way her movements translated themselves down her limbs.

Her insteps were slightly different shades, and I wondered at first if she had a rash.

Maybe a burn? Then, all at once, I realized that Elise's left leg was prosthetic.

The translator's voice became hers. I was an on-call support worker for survivors of sexualized violence. I was also 20 years old, a med school hopeful, technically prepared, and yet, not ready at all for what she would tell me.

That very morning, same as me, she had gotten out of bed, changed her clothes, and brushed her teeth. She stopped by a friend's house for coffee. Once inside, he barred the door. She plunged into a nightmare. This person she had trusted threatened murder, then assaulted her. Try as she might, she found she couldn't overpower him, or even shout for help. Faced with no alternatives, she prayed he wouldn't kill her, and waited.

Afterwards, he cried and said he didn't know what to do; now it was over. She swore she'd never tell. She even told him she loved him. It was fine. She'd keep it quiet. He let her go, and she got herself to an Esso around the block. On the back of a receipt, she wrote to the cashier: "Call me an ambulance. Tell them no sirens." As she waited for paramedics, she wrote down the rest of her story for the nurse at triage.

In that job I had heard many nightmare stories, but hers hit me the hardest. Her courage was monolithic, butting up next to the giants of grief and fear, filling the room completely.

I felt useless, tiny, foolish. I thought, "Why am I here, in this stranger's nightmare, at 11:30 p.m. on a Friday? I shouldn't know these terrible things. Who am I to her?" She might have wondered all this, too. Her story told, I played my part, discussing prophylactic medication, hospital policy, police procedures. After all that, we still had time to kill before seeing the doctor. Maybe to lend the encounter some semblance of normalcy, we began to chat. She asked me about myself, and I answered.

Ms Caddy recently received her MD from the University of British Columbia and is excited to start her residency training in family medicine. Having forgone a creative writing degree to pursue biology, she attended Malaspina University-College (now Vancouver Island University) before earning her BSc in biology at the University of Victoria.

UBC Medicine's writing competition aims to encourage writing as a way to reflect and communicate, just as adjuvants boost the immune system in vaccines. The competition was open to all UBC medical students. The winning submission was selected by a panel of judges with literary experience and an interest in fostering the relationship between the written arts and medicine.

Three older brothers, yes. Coffee with extra cream, no sugar. A job teaching med students pelvic exams. Surprised, she asked why anyone would ever sign up for a job like that. Smiling, I told her I loved to teach, but what I really wanted was to be a doctor, like my students would be. She frowned and wrinkled her nose. "I hate doctors," she signed. "I've dealt with them all my life, and I hate them. I hate them."

". . . But why?"

She looked at me, incredulous.

"Because they don't care. They don't look at you and see a person, they see a problem. Especially me."

She consented to a special, extensive pelvic exam that collects evidence in cases like hers. It was optional. I explained that pelvic exams don't usually hurt, but that, in light of her injuries. . . . She nodded in haste that she understood as she signed her consent, determined. But she had turned from green to grey, frightened, despite herself.

Slamming down the pen, she turned briskly and asked if I would hold her hand. I felt myself pale. I had always waited down the hall as women were examined.

"Of course," I said. Inside, my heart hammered. The blood in my ears was torrentially loud. Down the hall where I usually sat, the story she told me was safely sequestered by all my professional boundaries. But in the exam room. . . .

The nurse was ready for us. The curtain swung around, sealing us in. The day-surgery wing abandoned, we helped Elise to lay supine on the table and guided her foot and prosthetic to the footrests. Stupidly, I told her that I had two hands and could afford to have one broken. Her face blank and stony, she watched the translator as I spoke, but signed nothing. A knot in me tightened, somewhere.

It was a difficult exam. Elise crushed my fingers together, and whipped her head around to seek my eyes. Nobody, before that moment, had ever fixed me with that look. Years later, I'd see it again and again in the eyes of soon-to-be mothers in labor, close to the end. That fear of death, the pain, and dread of pain, mingled with tears and a coarse resolve. Elise grit her teeth and stared through me, inside of me, holding on in desperation, a drowning woman adrift. Staring, clenching her jaw, refusing to stop the exam, it was clear she was taking me with her. I followed her down as far as a person who had never lived her life, who would never truly understand, could go. Her desperate grasp was counterpoint to everything her face beheld: gratitude, shades of dignity and pride in the corners of her mouth, and a deep, enduring sorrow ringing the sockets of her bloodshot eyes. Looking back at her, I was flooded with certainty.

This. This mattered. This was why, at 3:00 a.m., I was not fast asleep in my comfortable bed. This moment was why I wore that pager, and later, this one. Without any warning, a total stranger mattered in a way that deeply affirmed something shared, and resilient, between us. Its relation to bruises and bloodwork was only tangential. My eyes pricked with tears as I held that hand, that stare, that moment of deep and honest human, humane connection. This was the heart and soul that would drive the years of sleepless nights, on-call disasters, and overtime hours. The live, electric brilliance of that unguarded, understood moment had lit the way through an evening of hell.

I looked at Elise, surrounded by people she barely knew, on the very worst day of her very young life. Her hand in my hand, I said nothing. But then, and forevermore, I would see the person.

The person first, Elise. I promise.

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At home, my rainwater barrel is standing ready and my garden is looking good.

But my kids are still angry at me. They hate tomatoes.

—Lloyd Oppel, MD

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calendar

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OCCUPATIONAL MEDICINE COURSES
Self-learning course, Sep–May
The Foundation Course in Occupational Medicine, developed at the University of Alberta, is now being presented across Canada in two parts. Our British Columbia Part A course is facilitated by three BC occupational physicians and runs from September to May by monthly teleconferences and two full-day face-to-face Vancouver-based workshops (21 Jan and 27–28 May). This practical, case-based, group learning curriculum enhances the effectiveness of primary care and community-based physicians in dealing with occupational medicine cases including fitness-to-work determinations and disability prevention and management. Course enrollment is limited to 15 participants to enhance the small-group experience. This course (Part A) has been accredited by the CFPC for up to 111 M1-MainPro

BCMJ's CME listings

Rates: $75 for up to 150 words (maximum), plus GST per month; there is no partial rate. If the course or event is over before an issue of the *BCMJ* comes out, there is no discount. VISA and MasterCard accepted.

Deadlines:
Online: Every Thursday (listings are posted every Friday).
Print: The first of the month 1 month prior to the issue in which you want your notice to appear, e.g., 1 February for the March issue. The *BCMJ* is distributed by second-class mail in the second week of each month except January and August.

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credits. Those completing Part A can progress to the Part B course. Participants who pass written exams on both parts are eligible for accreditation from the Canadian Board of Occupational Medicine. Further information visit the Foundation's website at www.foundationcourse.ualberta.ca.

PRACTICE SURVIVAL SKILLS
Vancouver, 11 Jun (Sat)
This 9th annual conference will be held at UBC Robson Square. PSS 2016 will emphasize practical, non-clinical knowledge crucial for your career, with topics such as billing, navigating through the medical organizations, accreditation, practice audits, medicolegal advice and report writing, job finding, office skills and management, physician resources, practice management, and mindfulness. Target audience for "What I Wish I Knew in My First Years of Practice" conference are family physicians, specialty physicians, locums, IMGs, physicians new to BC, family practice and specialty residents, and physicians working in episodic care settings. Conference format: Interactive, didactic lectures, interactive small-group workshops, plenty of networking opportunities, practice-based exhibits, end-of-day job fair, and reception. Meet with colleagues and make career connections! Conference registration and information at www.ubccpd.ca, call 604 875-5101, fax 604 875-5078, or e-mail cpd.info@ubc.ca.

ST. PAUL'S EMERG MED UPDATE
Whistler, 22–25 Sep (Thu–Sun)
Join us at the Whistler Conference Centre for the 14th annual St. Paul's conference—four exciting days of learning, networking, and of course, recreation! Last year more than 300 people attended this meeting, so don't miss out this year. Preconference workshops: AIME, CASTED, EDE, EDE2, ACLS, CARE. Target audience: Any physician providing emergency care—from rural to urban, part-time to full-time, residents to seasoned veterans, and emergency nurses and paramedics. Special guests, the Hair Farmers will be featured at our Friday night reception at the newly renovated GLC. Keynote speakers: Dr Grant Innes (University of Alberta), Dr Stuart Swadron, (Keck School of Medicine, USC), Dr Judith Tintinalli, (UNC School of Medicine), and Sam Sullivan (CM, MLA, Vancouver-False Creek). Conference registration, information, program details, and online registration is available at http://ubccpd.ca/course/sphemerg-2016. Phone 604 875-5101, fax 604 875-5078, e-mail cpd.info@ubc.ca, web ubccpd.ca.

MINDFULNESS IN MEDICINE
Tofino, 28 Sep–2 Oct (Wed–Sun)
Mindfulness in Medicine—Foundations of Theory and Practice is a 4-day

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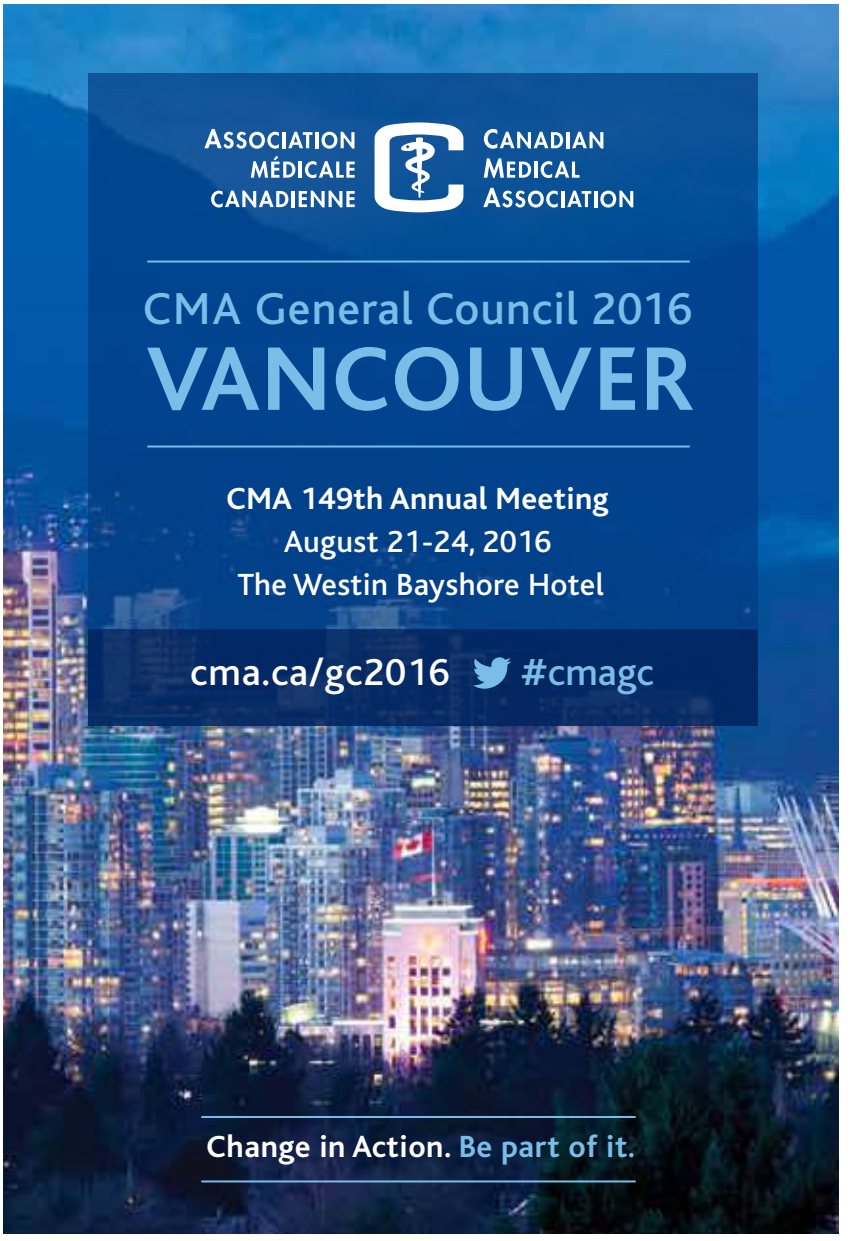

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experiential workshop approved for 16 Mainpro C credits. The workshop's focus will be mindfulness and meditation as it relates to the unique challenges and blessings of our work as physicians. As chronic stress and its associated mental and physical health challenges continue to rise in epidemic proportions, the application of mindfulness in clinical practice settings has gained prominence both in terms of evidence-based research and in the popularity of its use. Learn about the latest clinical evidence and neuroscience on mindfulness in medicine, find out about programs offered throughout BC and Canada, and explore practical meditation tools for yourself and for your patients. Visit www.drmarksherman.ca for more information, or register at info@drmarksherman.ca.

LIVE WELL WITH DIABETES
Richmond, 4–6 Nov (Thu–Sun)
Come check out the conference for health care professionals at the Radisson Hotel, our new venue in Richmond, close to the Canada Line station! Building on the success of our new 3-day format, this year's agenda includes presentations designed for family physicians, allied health professionals, podiatrists, and other health care professionals who have an interest in recent advances in diabetes. Featured topics: Diabetes and the elderly; Ambulatory glucose monitoring/CGMS; Combination therapy: Does 1 + 1 equal 3; Economics of diabetic foot complications: Importance of risk reduction; How to discuss obesity – A family physician's perspective. A public health fair has been scheduled for Sunday, 6 Nov at the same venue. Conference registration, information, program details, and online registration are available at www.ubccpd.ca. Tel 604 875-5101; fax 604 875-5078; e-mail cpd.info@ubc.ca.

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HAWAIIAN CME: MAUI AND/OR KAUAI
Maui, 27–29 Mar 2017 (Mon–Wed), and Kauai, 10–12 Apr 2017 (Mon–Wed)
Aloha! Please join us in the happiest American state next spring for award-winning CME in medical cognitive behavior therapy—Medical CBT: Ultra-brief Techniques for Real Doctors. The Maui workshop (CBT for Depression/Happiness) will be held at the idyllic Sheraton Maui on Ka'anapali Beach. With 23 acres of lush Hawaiian grounds, you'll never feel crowded! Maui has been voted best island by the readers of Condé Nast Traveler for more than a dozen years. Attractions include 10 000 foot Hale'akala (Hawaiian for house of the sun), 14 golf courses (including some of the world's top-rated), the scenic road to Hana, the Seven Sacred Pools of Oheo, and over 500 restaurants. The Kauai workshop—CBT Tools, will be held at the spectacular Grand Hyatt on sunny Poipu Beach. The Grand Hyatt Kauai is ranked among the world's top resorts by both the *Condé Nast Traveler* and *Travel+Leisure*. Kauai is the most tranquil and pristine of the main Hawaiian Islands, with beaches fringing nearly 50% of its tropical coastline. Attractions include the world-famous Kalaulua Trail on the Napali Coast, red-rocked Waimea Canyon, 17-mile Polihale Beach (Hawaii's longest), crescent-shaped Hanalei Bay, and Hawaii's only navigable river, the Wailua. See www.cbt.ca for details about both the Maui and Kauai workshops. Warning: Our significantly discounted guest rooms for these two workshops will sell out far in advance.

GP IN ONCOLOGY TRAINING
Vancouver, 12–23 Sep (Mon–Fri), and 20 Feb–3 Mar 2017 (Mon–Fri)
The BC Cancer Agency's Family Practice Oncology Network offers an 8-week General Practitioner in Oncology training program beginning with a 2-week introductory session every spring and fall at the Vancouver Centre. This program provides an opportunity for rural family physicians, with the support of their community, to strengthen their oncology skills so that they may provide enhanced care for local cancer patients and their families. Following the introductory session, participants complete a further 6 weeks of customized clinic experience at the cancer centre where their patients are referred. These can be scheduled flexibly over 6 months. Participants who complete the program are eligible for credits from the College of Family Physicians of Canada. Those who are REAP-eligible receive a stipend and expense coverage through UBC's Enhanced Skills Program. For more information or to apply, visit www.fpon.ca, or contact Jennifer Wolfe at 604 219-9579.

SOUTH PACIFIC CRUISE
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The world's most romantic destinations, from French Polynesia to Fiji. Join us for a 13-night cruise exploring exotic Tahiti (where Captain Bligh's men mutinied to stay put), Mo'orea (Arthur Frommer's vote for "the most beautiful island on earth"), Taha'a (French Polynesia's vanilla-scented isle), Bora Bora (the celebrities' exclusive hideaway), the Cook Islands (New Zealand's private paradise), the Kingdom of Tonga (proudly never colonized), and three idyllic islands of Fiji (Viti Levu, Vanua Levu, and postcard-perfect Beqa). You'll be enchanted by the South Pacific's craggy volcanic peaks, sugary beaches, warm lagoons teaming with fish, glistening black pearls, and tamure dancing suggestive enough to make you blush. The CME provides a rock-solid foundation in medical CBT for depression, reviewing a plethora of ultra-brief office techniques to defeat depression and be happy. CBT Canada is a national winner of the CFPC's CME Program Award, and is celebrating its 20th anniversary this year. Lead instructor Greg Dubord, MD, is a University of Toronto CME Teacher of the Year. Assistant faculty includes the inimitable Fijian psychiatrist Benjamin Prasad, MD, FRCPC, from the University of Manitoba. Super early bird rates for ocean-view staterooms aboard the spectacular m/s *Paul Gauguin* start at $12 850 (which includes all beverages, all taxes, all gratuities, return airfares, and companion cruises free). Book with Canada's largest cruise agency, CruiseShipCenters. See CBT Canada at www.cbt.ca or call 888 739-3117.

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Further information

If you are concerned about the evaluation of a worker's exposure or BLL results, please contact a medical advisor in your nearest WorkSafeBC office.

—Sami Youakim, MDCM, MSc, FRCP
WorkSafeBC Medical Advisor

Suggested reading

Agency for Toxic Substances and Disease Registry. Case studies in environmental medicine, lead toxicity. Accessed 19 April 2016. www.atsdr.cdc.gov/csem/lead/docs/lead.pdf.

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The Laboratory Services Act: Recovery of lab-test costs

In the May issue of the *BCMJ* we described how physicians may be affected by the Laboratory Services Act (LSA). The Act reinforces the provision of recovering lab-test costs from the referring practitioner (Section 54). This means that the Ministry of Health is able to recover funds from doctors who order tests that are not associated with a benefit but are billed to the Medical Services Plan. The ministry can recover these funds by withholding amounts from future remittances. This month we're providing examples of circumstances under which recovery for lab-test costs may be sought by the ministry.

While most physicians will not be impacted, those practising wellness or lifestyle medicine may want to be sure that they are ordering and billing lab tests in keeping with the Act.

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*

Preamble C.1 of the *Doctors of BC Guide to Fees* states:

> "Benefits" under the Act are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them in accordance with the Commission's policies on delegated services.
>
> Services requested or required by a "third party" for other than medical requirements are not insured under MSP. Services such as consultations, laboratory investigations, anesthesiology, surgical assistance, etc., rendered solely in association with other services which are not benefits also are not considered benefits under MSP, except in special circumstances as approved by the Medical Services Commission (e.g. Dental Anaesthesia Policy).

The following examples describe situations in which the laboratory service would *not* be considered a benefit:

- A physician performs a pre-employment examination for a new recruit from the local fire department. A CBC, lipid profile, and liver function tests are required as part of the employer's pre-employment package.
- Ms Jones brings a list of tests that her naturopath requested of her physician and asks the physician to order the tests.
- A physician is performing a cosmetic procedure on a patient who is on anticoagulants and orders a CBC and INR.
- Mr Smith, age 35, goes to see his physician for an annual physical with no medical indication. The physician bills MSP for the complete exam and orders a CBC, BUN, creatinine, TSH, calcium, and liver function tests. In this case, the costs of both the visit and the lab tests could be recovered from the ordering physician.
- A physician in a wellness clinic (i.e., a facility devoted to the promotion of healthy living and the prevention of illness and disease) faxes a lab requisition to the lab prior to seeing a patient. The following tests are ordered:
  - Male patient: CBC, ferritin, Macro +/- micro urine, fbs, A1C, lipid profile, TSH +/- T4, Na, K, ALT, GGT, eGFR, PSA (the PSA is patient pay), LH, FSH, estradiol, total testosterone, DHEAS, hs-CRP, anti-TPO, homocysteine, IGF-1.
  - Female patient: CBC, ferritin, Macro +/- micro urine, fbs, A1C, lipid profile, TSH +/- T4, Na, K, ALT, GGT, eGFR, LH, FSH, prolactin, estrogen, progesterone, testosterone, DHEAS, hs-CRP, anti-TPO, homocysteine, IGF-1.

Previously, in order to recover funds from the ordering physician, the Medical Services Commission would have to prove that the tests ordered were not medically necessary. Under the LSA, it may be up to the physician to prove the tests ordered *were* medically necessary.

—Keith J. White, MD
Chair, Patterns of Practice Committee

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employment

ABBOTSFORD—LOCUMS
Full-service East Abbotsford walk-in clinic requires locum physicians for a variety of shifts including weekends and evenings. Generous split; pleasant office staff and patient population. Please contact Cindy at 604 504-7145 if you are interested in obtaining more info.

CHILLIWACK—MEDI-SPA
We are a medi-spa in Chilliwack that is currently expanding and looking to hire a GP or naturopath. The position involves administering Botox Cosmetic and dermal fillers. Ideally, the candidate would have experience in the field but we are also willing to train and help with the costs of education. The position is flexible regarding days and hours worked, so it can be worked around another position. Approximately 12–18 hours per week. Please forward resume and cover letter to terri@beautyrenewed.ca (www.beautyrenewed.ca).

KAMLOOPS—HOSPITALISTS
Royal Inland Hospital, a 246-bed tertiary hospital and referral centre, is seeking permanent full-time physicians to join our collegial hospitalist service. You will provide general medical care of hospitalized adult patients and co-management of surgical and psychiatric patients. The hospitalist service is supported by a complement of specialty services including anesthesia, general internal medicine, general surgery, orthopedics, psychiatry, radiology, and urology. Opportunity to teach. Income of $244 200 supported through a service contract with on-call stipend and no overhead. For more information e-mail physicianrecruitment@interiorhealth.ca or visit www.betterhere.ca.

KELOWNA—FP/WALK-IN
Busy family practice/walk-in clinic. Looking for PT or FT doctors. Open 7 days per week. Great staff. Shared weekend work. No call, no OB, hospital privileges optional. Possibility of future partnership. Contact Dr Alden Lange at awlange@shaw.ca.

KELOWNA—HOSPITALISTS
Kelowna General Hospital, a tertiary hospital and referral centre with 400 beds, is seeking permanent full-time and part-time physicians to join our progressive hospitalist service. You will provide general medical care of hospitalized adult patients, and co-management of surgical and psychiatric patients. The hospitalist service is supported by a complement of specialty services including anesthesia, general internal medicine, general surgery, orthopedics, psychiatry, radiology, urology, and oncology. Income of $244 200 supported through a service contract with on-call stipend and no overhead costs. For more information e-mail physicianrecruitment@interiorhealth.ca or visit www.betterhere.ca.

LANGLEY—PT/FT FP
Enjoying an excellent reputation, Glover Medical Centre (GMC) offers a great opportunity to practise in a multidisciplinary primary care environment offering a variety of services: family practice, walk-in, urgent care, occupational medicine, clinical research. Spacious, fully equipped (suture room, slit lamp, plaster room), and recently renovated. Rica Pizzinato, Office Manager: rica@glovermedical.com.

LILLOOET—FP
Five-physician, unopposed fee-for-service practice seeks sixth family physician with ER skills. Clinic group focus is on balancing work and lifestyle. Easy access to Lower Mainland, Whistler, and Interior of the province. Call is currently 1 in 5. Regular schedule includes 1 week off every fifth week. Full rural physician recruitment and retention benefit eligibility, including 38 days of rural locum coverage for holidays. World-class wilderness at your doorstep for skiing, hiking, fishing, white-water kayaking, and mountain biking. Full-service rural hospital with GP surgeon and anesthetist on staff. For more information e-mail physicianrecruitment@interiorhealth.ca or visit www.betterhere.ca.

MERRITT—FP
Rolling hills, sparkling lakes, and over 2030 hours of sunshine every year make Merritt a haven for four-season outdoor recreation. We have a need for family physicians in their choice of clinic. Nicola Valley Hospital and Health Centre is a 24-hour level-1 community hospital with a 24-hour emergency room. Royal Inland Hospital in Kamloops is a tertiary-level hospital located only 86 km away. Remuneration is fee-for-service ($250 000 to $450 000-plus per year), rural retention incentives and on-call availability payment. For more information e-mail physicianrecruitment@interiorhealth.ca or view online at www.betterhere.ca.

NANAIMO—GP
General practitioner required for locum or permanent positions. The Caledonian Clinic

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is located in Nanaimo on beautiful Vancouver Island. Well-established, very busy clinic with 26 general practitioners and 2 specialists. Two locations in Nanaimo; after-hours walk-in clinic in the evening and on weekends. Computerized medical records, lab, and pharmacy on site. Contact Ammy Pitt at 250 390-5228 or e-mail ammy.pitt@caledonianclinic.ca. Visit our website at www.caledonianclinic.ca.

NEW WEST—FAMILY PHYSICIAN

New Westminster: Columbia Square Medical Clinic is looking for a family physician for a full- or part-time position. Partnership and options to buy are available. Flexible hours, competitive split. The clinic is newly renovated with bright rooms, Oscar EMR, excellent friendly and efficient staff, 20 minutes from downtown Vancouver. We have 800 families waiting for a family doctor who wants to establish a permanent practice or work part-time. Considering a change of location or practice style? Call Irina at 778 886-6511 or e-mail irinapaynemd@gmail.com.

POWELL RIVER—PERMANENT FPs & LOCUMs

Powell River is a rural community of 20 000 people on the Sunshine Coast of British Columbia, a 25-minute flight from Vancouver. It's known for its waterfront location, outdoor beauty, urban culture, and international music festivals. Supported by a 33-bed general hospital, the close-knit medical community consists of 26 general practitioners, 4 ER and anesthesia physicians, 2 NPs, and 7 specialists. We are looking for permanent general practitioners and locums. Please visit divisionsbc.ca/powell river/opportunities for details.

RICHMOND—FP

Opportunity to practise in a busy family practice in Richmond, BC. Great location. Excellent staff. Please call Lesily at 604 270-1998 or e-mail lesily@shaw.ca.

RICHMOND—FP & LOCUMS

Opportunities for physicians looking to do walk-in shifts, build a practice, or relocate in our busy modern clinic. EMR OSCAR. Great location next to a 24 hr Shoppers Drug Mart. No hospital work, no call, 70/30 split—walk-in shifts at $100 per hour minimum—and bonus available. Contact us at healthvuemedical@gmail.com, 604 270-9833/604 285-9888.

RICHMOND—FT/PT FP/WALK-IN

Busy, modern clinic looking for more physicians to join Dr Tse's practice! Oval Village Clinic is fully furnished and spacious: seven exam rooms, staff lounge, large waiting area, MedAccess EMR. Perfect for physicians to establish a practice or work part-time. Located in Oval Village with 6000 residential units in need of family doctors. Already a long patient wait list. Flexible hours, 30/70 to 25/75 split, hourly minimum negotiable. All administrative work will be taken care of. Training and billing support provided. A platform for you to build your own patient-centred career. Join our passionate team by contacting us at 604 285-2555 or e-mail inayu@crcdrugs.ca.

SURREY/DELTA/ABBOTSFORD—GPs/SPECIALISTS

Considering a change of practice style or location? Or selling your practice? Group of seven locations has opportunities for family, walk-in, or specialists. Full-time, part-time, or locum doctors guaranteed to be busy. We provide administrative support. Paul Foster, 604 572-4558 or pfoster@denninghealth.ca.

SURREY—LOCUM/ASSOC

Full- or part-time locum or associate needed. Clinic well staffed; busy, diverse patient panel. Hours flexible from Monday to Saturday. Split is 25/75. Locum needed from 4–15 Mar, 8–19 Aug, 21 Nov–7 Dec. Staff friendly and experienced. Wolf EMR in office (training available). Please call Dr Pawan K. Ram at 778 998-9445 or e-mail drpramcic@gmail.com.

THROUGHOUT BC—CORRECTIONS MED

Curious about prison medicine? Interested in a blend of general medicine, psychiatry, addictions, infectious diseases, HCV, and HIV? Opportunities exist in centres throughout BC—Prince George, Interior, Lower Mainland, Vancouver Island. Mostly part-time. Fee-for-service. No overhead. EMR. No call. Full nursing support. Shirley.halliday@gov.bc.ca.

VAN/RICHMOND—FP/SPECIALIST

Walk-in or full-service family medicine positions available. Split or fixed-cost options for specialists as well, especially a pediatrician, at the South Vancouver and Richmond Superstore medical clinics. Modern and clean facilities with many unassigned patients. Efficient and customizable EMR. Please contact Lisa at medicalclinicbc@gmail.com.

VANCOUVER—FP

Mainland Medical Clinic is seeking a family doctor for our modern, multidisciplinary street-level clinic in Yaletown, downtown Vancouver. We have been operating for over 13 years in a comfortable setting shared with a chiropractor, massage therapists, and a nutritionist to complement our three family doctors. Ideally seeking someone with an existing practice—perhaps relocating or cutting back. We serve a broad spectrum of patients, both walk-ins and appointments. Excellent revenue split. The clinic offers a pleasant work environment in an upbeat, fun neighborhood. Contact Dr Brian Montgomery at brian@mainlandclinic.com or 604 240-1462, or just drop by.

VANCOUVER—FT/PT DERM

Dermatologist wanted to join busy Aesthetic Medical Clinic in Vancouver. Full- or part-time. Please reply by e-mail to kt.crawford03@gmail.com.

VANCOUVER—LOCUM

Busy walk-in shifts in Kitsilano at Khatsahlano Medical Clinic, three-time winner of Georgia Straight reader's poll for Best Independent Medical Clinic in Vancouver. Split is 65%; 70% on evenings/weekends. Contact Dr Chris Watt at drchriswatt@gmail.com.

VANCOUVER—PRIVATE BILLING

Associate/locum wanted for lucrative non-MSP practice. Initially 1 to 2 days per week

with a view to taking over eventually. Recent graduate with a business inclination and strong computer skills would be ideal. Reply by e-mail to dr.ciszak@immigrationmedical.ca. No phone calls please.

VANCOUVER—PT/FT PHYSICIAN
South Granville Medical Centre, conveniently located on the west side of Vancouver (3195 Granville St.), is seeking a physician (FP or specialty) to join full-time or part-time. OSCAR EMR. Attractive split. Collegial group and experienced staff. Please contact Dr Paula Iriarte at paulairiarte@shaw.ca.

VERNON—AESTHETICS/VEIN/LASER
Outstanding opportunity to join a well-established and thriving GP derm/aesthetics/vein/laser practice in one of the best places to live in Canada. We are looking for an associate/equity partner(s). The office has all the latest technology and an excellent, congenial staff. Training provided but a special interest in dermatology a definite asset. The Okanagan has some of the best weather, lakes, wineries, golf courses, ski hills, and overall lifestyle anywhere in Canada, if not the world. Contact Dr William Sanders: 250 558-9606, w.sanders@shaw.ca.

VERNON—HOSPITALISTS, PERMANENT
Vernon Jubilee Hospital is a 180-bed regional referral hospital in the Okanagan Valley. Clinical and communication skills and ability to work with the health care team is required. Admission, MRP, and discharge of unattached medical and surgical patients are primary responsibilities. Daily census of 60 to 70 inpatients and 6 to 10 admissions is managed by a team of 3 to 4 hospitalists supported by a nurse practitioner. Hours are 7:00 a.m. to 5:00 p.m. Average 20 inpatients/physician; mean length of stay is 3 to 5 days. Estimated salary $245 299 plus MOCAP Level 2. Contact Interior Health Physician Recruitment at 1 877 522-9722 for further information.

VICTORIA—GP/WALK-IN
Shifts available at three beautiful, busy clinics: Burnside (www.burnsideclinic.ca), Tillicum (www.tillicummedicalclinic.ca), and Uptown (www.uptownmedicalclinic.ca). Regular and occasional walk-in shifts available. FT/PT GP post also available. Contact drianbridger@gmail.com.

VICTORIA—LOCUM OPPORTUNITY
Curious about practising in beautiful Victoria, BC? If you are wondering if practising family medicine in Victoria could be your future, here is an ideal opportunity to try it out. Busy family practice/walk-in clinic looking for someone to provide locum coverage for a 3- to 6-month period starting March 2017. Ideal for husband-wife team. The clinic currently runs Monday to Friday, fully functions using EMR, and is supported by superb long-time staff. This opportunity could develop into a long-term position should there be an interest. No obstetrics or hospital privileges are necessary. Please send inquiries to pcrawford@omniwest.com.

VICTORIA—WALK-IN
Walk-in clinic shifts available in the heart of lovely Cook St. Village in Victoria, steps from the ocean, Beacon Hill Park, and Starbucks. For more information contact Dr Chris Watt at watt1@telus.net.

WEST VAN—FAMILY PHYSICIANS
West Vancouver, FP/walk-in. Continuum Medical Care is a large multidisciplinary clinic located in the heart of West Vancouver. We are again expanding and are looking for primary care physicians to join our team of 12 FPs, 7 specialists, and a variety of allied health professionals. With over 17 000 patients, we are seeking primary care physicians to work in our recently opened walk-in clinic and in our newly renovated main clinic, offering full-service family practice care. Specialty training or diploma in sport medicine, geriatrics, lifestyle medicine, concierge medicine, or executive health would be an asset. Please contact Dr Bryce Kelpin at 604 928-8187, or e-mail bkelpin@telus.net.

WILLIAMS LAKE—FP EMERGENCY
Seeking CCFP-EM or CCFP with ER experience. Cariboo Memorial Hospital services a population of approximately 26 000 with 20 000 visits to the ER annually. ER is staffed by six full-time ER physicians and a variety of part-time ER physicians (staffed 24/7). We have a 28-bed hospital with 3-bed ICU. Excellent collegial specialist support including general surgery, OB/GYN, pediatrics, internal med, radiology, anesthesia, and psychiatry. Further specialist support available at our referral centre in Kamloops. Williams Lake is known for its outdoor opportunities and full range of amenities (including local college and airport). Contact 1 877 522-9722 or physician recruitment@interiorhealth.ca.

medical office space

ABBOTSFORD—OFFICE SPACE
Fully furnished, ready-to-go medical office available for lease in heart of Abbotsford. Rent-free for 6 months! Clinic includes four large exam rooms, reception area, large waiting room with TV, two washrooms, large private office, on-site free parking. Located in a professional building at a busy intersection with lots of walk-in traffic. Great opportunity for someone looking for an existing space with the flexibility to design their own practice and hours of operation. Please contact Frank Dykstra at 604 835-6300 or fdykstra@hotmail.com.

DELTA—PRIME SPACE, MED BLDG
High-profile, professionally designed building with ample natural light from large windows. Well situated in one of Surrey's fastest growing areas close to Hwy 91 and Scottsdale Mall. Other tenants include family medical practices, a dental clinic, a chiropractic clinic, and a pharmacy. Phone Alfred Marchi at 604 576-3868 (www.paragonrealty.ca).

KELOWNA—PRIME AREA, GROUND FLR
3295 Lakeshore Rd. Professional bldg. Bright, well-lit with large windows; 710 sq. ft.; four treatment rooms, two plumbed. Ground floor in lovely part of Kelowna just off the lake. Private entrance to outdoors. Bathroom. Small waiting area. Wheelchair access. Option to share reception. Modern finish with tile, hardwood, and rounded walls. E-mail duane@veinskin.com or call 250 469-1416.

N DELTA & SURREY—1700 SQ. FT. (7 ROOMS)
Located at 84th Ave and 120th Street. Renovated space available from recently departed, high-volume walk-in clinic (1700 sq. ft., seven rooms). Six examination rooms, one treatment room, office, kitchen, three bathrooms, two large reception areas (one could be converted to make two more rooms), and large waiting area. Ample parking. Compensation for breaking your lease available. Contact harjsamra@rghs.ca.

PRINCE GEORGE—BUILD-TO-SUIT OPPORTUNITY
Office space for lease: Up to 3500 sq. ft. Build-to-suit opportunity at 6760 Madill Rd, Prince George. Location has easy access on/off the Hart Highway and is also tenanted by Shoppers Drug Mart. Great opportunity to open a clinic in a new space with convenient access to amenities. Contact Michael Spaull at mike@hallpacific.com or 778 960-4878.

RICHMOND—MED OFFICE SPACE
New modern EMR clinic in Steveston Village looking for physicians to join our team. Opportunities to start a practice or relocate existing practice without worrying about administrative headaches. We offer base 70/30 split and higher for complex care and forms. Visit www.HealthVue.ca or contact healthvuemedical@gmail.com, 604 285-9888.

SURREY HLTH & TECH DISTRICT—SPACE
Locate your practice within the growing Health & Technology District of Innovation Boulevard in Surrey's Central City. A LEED Gold–certified building with over 600 parking stalls and an on-site gym and spa boasts significant space for health professionals, clinical spaces, professional technology companies, as well as multiple restaurants and retail outlets. Currently provides space for over 90 medical professionals. Immediately adjacent to Surrey Memorial Hospital and Health Sciences Campus, City Centre 2 (of the rapidly growing Health & Technology District) is set to be completed in early 2017. Sales and leasing options available in this strata build. Visit us at www.larkgroup.com.

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Recently deceased physicians

If a BC physician you knew well is recently deceased, consider submitting a piece for our "In Memoriam" section in the *BCMJ*. Include the deceased's dates of birth and death, full name and the name the deceased was best known by, key hospital and professional affiliations, relevant biographical data, and a high-resolution photo. Please limit your submission to a maximum of 500 words. Send the content and photo by e-mail to journal@doctorsofbc.ca.

classifieds

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SURREY/DELTA—MED OFFICE SPACE
Newly renovated Specialist Medical Clinic: private offices with either one or two exam rooms. Full-time, part-time, or satellite office. Flexible terms. Ideal for specialists. New furniture and medical equipment. Fully EMR. Large waiting room. Near Scott Rd. and Nordel Way. Contact a.kanani@ubc.ca.

VAN (VGH AREA)—MED OFFICE SUBLEASE
Office space for psychiatrists, psychologists, or any other specialist MD. No secretary or other additional overhead expenses. Top floor. Great view. Two offices for sublease. One office is bigger and has a sink and space for an examination table. E-mail alevin@drlevin.ca.

VANCOUVER—CLINIC SPACE AVAILABLE
Medical office space for rent on Main and 50th. The clinic has five exam rooms, ideal setup for walk-in clinic, high-volume walk-through traffic area, attached to existing pharmacy, available 1 October 2016. Very attractive and negotiable terms. Contact vanmedicalclinic@gmail.com.

WHISTLER—VISITING SPECIALISTS
New office space for rent for visiting specialists in Whistler. Day rate, reception and booking, wheelchair accessible, free parking, available now. For more information please call 604 905-1500 or e-mail katduval53@gmail.com.

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miscellaneous

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RICHMOND—MED OFFICE EQUIPMENT FOR SALE
Closing medical office 1 July. Two Ritter examination tables, two wall units, autoclave, numerous small surgical instruments for minor procedures, large refillable liquid nitrogen canister, large computer/office desk, office and waiting room chairs, storage unit, etc. Phone 604 220-9197 or e-mail docmgfrey@gmail.com.

VANCOUVER—TAX & ACCOUNTING SVCS
Rod McNeil, CPA, CGA: Tax, accounting, and business solutions for medical and health professionals (corporate and personal). Specializing in health professionals for the past 11 years, and the tax and financial issues facing them at various career and professional stages. The tax area is complex and practitioners are often not aware of solutions available to them and which avenues to take. My goal is to help you navigate and keep more of what you earn by minimizing overall tax burdens where possible, while at the same time providing you with personalized service. Website: www.rwmcga.com, e-mail: rodney@rwmcga.com, phone: 778 552-0229.

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Locum Opportunities

Northwest British Columbia is one of the most scenic places on earth. Rich in First Nations culture, the region boasts spectacular mountain views, clear rivers, lush forests and unspoiled coastlines. Year-round adventure awaits with fishing, hunting, biking, hiking and backcountry, downhill or cross-country skiing all in your backyard.

The Pacific Northwest has many amazing locum opportunities. Eleven diverse communities are served by over 85 family physicians with regional specialist support available. Practice opportunities include:

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- **Solo or group family practices**
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For more information on the locum opportunities available, check out
https://www.divisionsbc.ca/pacificnorthwest/locumnetwork
or contact Zach Davies, PNW Locum Network Coordinator
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—Skye Raffard, MD, Williams Lake, BC, Canada

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