Acronyms 2: The return

I'm overdue for a good rant. Synonyms for the word *rant* include *shout*, *wild*, *impassioned*, *fulminate, vociferate, diatribe, sound off, spout, pontificate, bluster, tirade, yell*, and *bellow*. Who wouldn't feel better after all of that is said and done?

At the *BCMJ* we review all sorts of submissions for publication. I remain in awe of authors who put themselves out there and take the time to craft a scientific paper, letter, or opinion piece. Risking rejection, the creative individuals writing scientific papers design and complete studies, analyze the data, organize it into a paper with a discussion and conclusion, and support it all with references. I appreciate the time, effort, and energy this process requires. However, there are certain things that drive us crazy at the *BCMJ* Editorial Board, and I hope that by ranting about one of them, change will follow.

I think I have night terrors about acronyms. For some reason many authors feel they must use acronyms wherever possible. I addressed this issue in a previous tongue-in-cheek editorial (www.bcmj.org/editorials/do-abbrs-bother-u) in the hope of eradicating this trend. Alas, little changed after my editorial's publication (cementing my conviction that readership of my editorials consists more of family members than *BCMJ* authors). I am asking, pleading, and begging on behalf of the Editorial Board for authors to cease and desist.

Numerous acronyms in a manuscript make it difficult to read and detract from its message. I'm not talking about commonly used acronyms we all understand like DM for diabetes mellitus or CAD for coronary artery disease. I am talking about the obscure ones that not even the most scholarly readers understand. On brief perusal of last month's manuscript submissions I found RB, ICC, LIC, CAS, APSF, ELC, DLC, DALY, YLL, YLD, DAD, ERAT, SBIRT, HDSA, and CMHA. Perhaps I'm not up to speed, but I don't think this list contains any generally accepted frequent flyers. It is much better to use the actual words than an acronym because surely the objective is to convey meaning, not save space in the *BCMJ* or avoid the nuisance of typing? Also, for the love of everything holy, please don't use an acronym for a two-word phrase such as FD for family doctor or ED for emergency department (most of us middle-aged men think ED stands for something else anyway). Finally, to prevent me from having a hypertensive stroke, don't create an acronym for a phrase if is only used once in a manuscript.

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I'm not trying to deter prospective authors, but I am striving to reduce the total number of Editorial Board member facial tics that develop each time another unnecessary acronym is used. Remember that at the *BCMJ* we really do appreciate and look forward to the submissions that we receive, so keep up the good work.

For my next rant perhaps I will focus on low response rate survey studies?

—DRR, FD, ED

Time's up, Doc

If you have ever ordered a pneumoencephalogram, administered an aminophylline drip, cross-eyed stereo-viewed a cerebral angiogram, or used Tensilon to convert paroxysmal atrial tachycardia, then you are likely retired or in the retirement-contemplative stage. So it is with me. After 40 years in medicine it's time to retire and also step down from my 10-year membership on the *BCMJ* Editorial Board, which of all the committees I've served on has been my favorite.

The membership of the Editorial Board is composed of a diverse group of talented physicians and staff who, while not always like-minded, have always been able to achieve consensus on which articles would be of value and interest to BC physicians. The fact that the *BCMJ* is celebrating its 60th anniversary is a testament to its continued popularity.

It is always interesting to reflect on one's past view of the future, versus today's reality. For instance, I never saw the coming of plastic water bottles, Starbucks coffee, yoga, or that being tattoo-positive did not equate with being MSP-negative. I've always believed that patient autonomy and self-determination would extend to the end of life, and am relieved that medical assistance in dying has finally been decriminalized. I never saw the value of medical marijuana, but never saw the harm in decriminalizing marijuana, even if I don't like the smell of a skunk. For many decades my dream was to have a fully functional integrated EMR complete with lab and diagnostic imaging results, patient scheduling, data tracking, and prescribing software. Many years and dollars later I came to sympathize with the builders of the Tower of Babel. I'm hopeful for the day that all physicians can truly say that their EMR has resulted in delivery of safer and more efficient care.

If I may also reflect on the future of medicine, I see it as promising, exciting, and somewhat daunting, particularly with regard to technological changes that will challenge most physicians' ability to remain current. Advances in laboratory medicine, genetics, diagnostic imaging, and informatics are staggering, but in all its marvels we must remember that technology is our servant, not our master. We serve our patients, not our computers. No technology will ever replace our care.

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There are also political, economic, and societal pressures that will change the way we practise medicine. For instance, our role in being accountable to only our own patients is increasingly being challenged. We must be cognizant of the provincial government's frustration that despite huge financial expenditures there is a perception that collectively we sit on the sidelines while patients are unable to access timely medical care. In Quebec this has resulted in draconian incursions into physician autonomy by the introduction of Bill 130, which includes physicians having to guarantee availability of service. While in BC we may feel that we are doing enough by collaborating with government on initiatives such as the General Practice Services and Specialist Services committees, there are many poorly accessible services. We must vigorously promote and publicize our collaborative engagements, and barriers when they exist, "in matters relating to public health, health education, environmental protection, legislation, function, and improvement of health services."[1]

Just as I never envisioned retiring from medicine, someday, if you are lucky, that day will arrive for you. It might seem far away for some, but it's not. Plan for it just as diligently as you planned your career. Ask yourself, aside from medicine, what gives you the joy, excitement, and purpose that will fuel your retirement years.

I have been very privileged to have been part of this Editorial Board. Thank you.

—WRV

1. Canadian Medical Association. CMA code of ethics (2004): 42. Responsibilities to society. Accessed 19 March 2018. www.cma.ca/En/Pages/code-of-ethics.aspx.