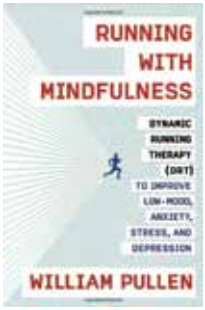
Book review: *Running with Mindfulness: Dynamic Running Therapy (DRT) to Improve Low-Mood, Anxiety, Stress, and Depression*



By William Pullen. New York: Penguin Life, 2017. ISBN-10: 0735219796. Paperback, 224 pages.

For as long as I can remember, running has been a part of my life. I chose to review this book, *Running with Mindfulness,* thinking it would improve my running—in particular, getting into "the zone" and being surprised when reaching my destination without recollection of pain, exhaustion, or the environment. However, that would be *mindless* running. Mindful running is just the opposite and focuses on the immediate present. In order to review this book I solicited the opinions of a few of my colleagues who are more conversant with mindfulness therapy.

The author is a psychotherapist who, based on his own life struggles, developed a program to improve low-mood, anxiety, stress, and depression. It is aimed at anyone who is feeling stuck and is interested in exploring self-awareness through exercise, either alone or preferably with a partner.

The first part of the book includes a useful review and description of mindfulness. The start of one's session (or run) begins with a four-stage grounding exercise. The reader is directed to focus on a question to explore during the physical activity: "moving with intention." Finally, the reader is to make notes.

Although this book is labeled *running* with mindfulness, I think it might better be labeled *exercising* with mindfulness. The techniques in the book can readily be applied to any exercise that leads to the achievement of "flow," a state of complete absorption in the activity.

The author encourages the reader to find a suitable partner willing to undertake the journey and to be a nonjudgmental listener. This would not work for everyone, but could be useful for some.

After the first three chapters on the basics, the book is divided into chapters on anxiety, depression, anger, relationships, and decision making. Each chapter has several questions to explore while exercising, along with space to record one's thoughts and conclusions. The author encourages note-making as being therapeutic.

I particularly enjoyed the chapter on parents and kids. It gave me some conversation ideas to explore when running with my grandchildren.

I enjoyed this book, which reinforced what I already know about the benefits of running. It also gave me ideas to focus on during runs, rather than being mindless.

Given the beneficial effect of exercise on the mind, the incorporation of mindfulness therapy makes this an even better resource to recommend to patients who are struggling with anxiety, depression, and relationship issues, and it may eliminate the need for medication.

—WRV

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Facility Engagement in Interior Health

I have been actively involved with the Facility Engagement Initiative within Interior Health (IH) since it began. My involvement has been as both the IH Facility Engagement physician liaison and chair of the Kelowna General Hospital Facility Engagement working group. As of 2018, 20 facilities across IH have initiated more than 200 Facility Engagement activities. In short, the initiative at Interior Health is flourishing.

When I think about where we started only a few years ago, I'm very excited to see that our sites are brimming with enthusiasm, particularly since there are a wide variety of projects underway, and the physician engagement among the groups continue to be excellent and growing.

Facility Engagement (www.facilityengagement.ca) is a provincial initiative that originates from the 2014–19 Physician Master Agreement. It aims to strengthen relationships, communication, and collaboration between health authorities and facility-based physicians to improve the physician work environment and the delivery of patient care.

To me, one of the positive impacts of this project has been the interdivisional and interdepartmental opportunities to regularly collaborate, such as pediatrics meeting with emergency or radiology meeting with surgery; these cross-collaborations are new. Getting physicians together to discuss common issues is very positive step.

Interior Health has committed to supporting Facility Engagement, both with my liaison position and with Dr Harsh Hundal as an executive medical director who has this initiative as an important part of his portfolio.

Last December, physician representatives from each IH facility, health administrators and executives, and representatives from HEABC and the Specialist Services Committee (SSC) met for the Interior Health Facility Engagement Symposium. The event was an excellent opportunity for learning and dialogue, to exchange ideas, to build relationships, and for everyone to get a feel for the initiatives underway at other IH sites.

While all Facility Engagement projects are unique and vary in length, they share a common theme, which is to give physicians a meaningful voice to address issues that affect them. For example, the Lillooet hospital physician group has increased mental health care access for children and youth with mental health issues. Initiated by Dr Nancy Humber, the project has physicians working together with local and regional Interior Health representatives, along with schools, Indigenous counselors, and other community members. Two child and youth psychiatrists provide outreach clinics to Lillooet and surrounding area.

At Vernon Jubilee Hospital, Dr Jason Doyle expressed concerns about redundant laboratory testing. In collaboration with the Vernon Jubilee Hospital Physician Society, they examined laboratory utilization and developed recurrent laboratory testing guidelines for inpatients. As a result of the changes, we hope that patients will experience less anxiety and discomfort and avoid unnecessary tests, and that cost savings will be realized.

These are just some of the many impressive projects happening across the health authority and I am ecstatic that IH is using the Facility Engagement Initiative to improve areas in need .

—John Falconer MD, FRCPC
Interior Health Facility Engagement Physician Liaison
Chair, Kelowna General Hospital Facility Engagement Working Group

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.

BCMJ
BC Medical Journal

Daily ibuprofen may prevent Alzheimer disease

Studies carried out by Vancouver-based researchers led by Dr Patrick McGeer suggest that if started early enough, a daily regimen of the nonprescription NSAID ibuprofen could prevent the onset of Alzheimer disease (AD).

As of 2016, an estimated 564 000 Canadians live with dementia (expected to rise to 937 000 by 2031). The combined health care system and out-of-pocket costs of dementia is estimated at $10.4 billion—estimated to increase by 60% to $16.6 billion by 2031.

The laboratory of Drs Patrick and Edith McGeer is renowned for 30 years of work in neuroinflammation and neurodegenerative diseases, particularly AD. A paper detailing the McGeer's most recent discoveries ("Alzheimer's Disease Can Be Spared by Nonsteroidal Anti-Inflammatory Drugs") was published in the *Journal of Alzheimer's Disease*.

In 2016, Dr McGeer and his team announced that they had developed a simple saliva test that can diagnose AD, as well as predict its future onset. The test is based on measuring the concentration of the peptide amyloid beta protein 42 (Abeta42) secreted in saliva. In most individuals, the rate of Abeta42 production is almost exactly the same regardless of sex or age. However, if that rate of production is 2 to 3 times higher, those individuals are destined to develop AD. Abeta42 is a relatively insoluble material made everywhere in the body but deposits of it occur only in the brain, causing neuroinflammation, which destroys neurons in the brains of people with AD.

Dr McGeer's team demonstrated that the peptide is made in all organs of the body and is secreted in saliva from the submandibular gland. As a result, with one teaspoon of saliva it is possible to predict whether an individual is destined to develop AD. This allows the opportunity to begin taking early preventive measures such as consuming nonprescription nonsteroidal drugs such as ibuprofen.

Knowing that the prevalence of clinical Alzheimer disease commences at age 65, Dr McGeer recommends that people get tested 10 years prior, at age 55, when the onset of AD would typically begin. If they exhibit elevated Abeta42 levels then, that is the time to begin taking daily ibuprofen to ward off the disease.

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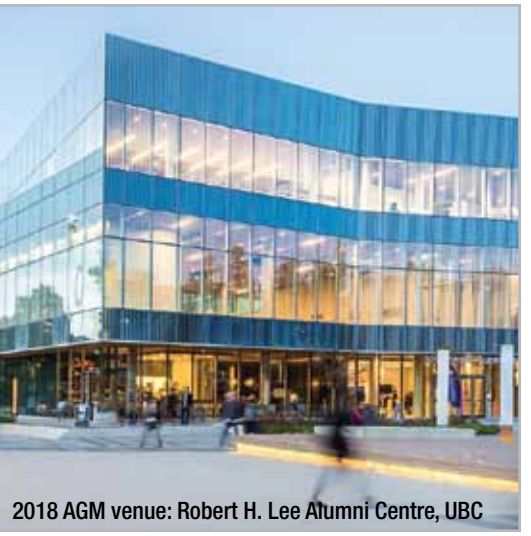
Doctors of BC 2018 annual general meeting

Doctors of BC members are invited to attend the 2018 annual general meeting (AGM) on 2 June 2018 at the Robert H. Lee Alumni Centre (UBC Campus, 6163 University Blvd., Vancouver). Onsite registration opens at 8:15 a.m. and the AGM will begin at 9:30 a.m. in Jack Poole Hall.

The evening events will be held at the Sheraton Vancouver Wall Centre, commencing at 5:15 p.m. with a reception, followed by the Doctors of BC annual awards ceremony at 6:00 p.m., including installation of officers. Register to attend the three-course President's Dinner, with an address given by the new president, Dr Eric Cadesky.

To register, or for more information, go to www.doctorsofbc.ca/news-events/event/2018-doctors-bc-annual-general-meeting.



2018 AGM venue: Robert H. Lee Alumni Centre, UBC

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The importance of expediency in writing the APS

An attending physician's statement (APS) is a common requirement for insurance underwriting. Insurers will order an APS as part of standard age and coverage amount requirements or to explore information received from an applicant's telephone interview or paramedical testing. The insurer's underwriting vendor will generally contact a physician's office to verify that the applicant is a patient, then send a request for file information. The vendor will follow up regularly by email, fax, or phone, as long as the APS remains outstanding. After several follow-ups, the insurer will contact the insurance advisor, and perhaps the applicant, to request their intervention with the physician. If an APS remains outstanding, the insurance application may be closed.

Underwriters can usually expect to wait a minimum of 2 to 3 weeks to receive an APS. Wait times can be influenced by factors such as a physician's patient volume or absence from the office.

A delay in receiving the APS can significantly lengthen insurance underwriting time. It is not uncommon for a motivated applicant to complete the underwriting requirements within 2 to 3 weeks and then spend an additional 6 weeks waiting for the physician to provide the APS. The underwriter must then review the APS and may need to request further information from the original physician or another source, adding another wait period to the process.

Longer underwriting can increase expense to the insurance applicant. For instance, if applicants are obtaining term life insurance to replace an existing policy that has renewed at higher rates, they must continue paying to maintain that coverage until they are approved for a less-expensive replacement policy. Even a month of delay may mean thousands of dollars in renewal premiums for insurance that could otherwise have been canceled sooner.

Further, a delay in underwriting may impact an applicant's ability to qualify for insurance. When signing for an approved individual insurance policy, the applicant must disclose any personal health changes since the date of the application. Even a seemingly benign event may cause the underwriter to postpone settlement of coverage and conduct a review. If the applicant has had a routine physical or visited her family doctor with flu symptoms, the underwriter will seek details on any recommended follow-up. Our administrators see multiple cases each year where a member applies for insurance, submits underwriting requirements and is approved for coverage, then advises during policy delivery that the applicant sought treatment for indigestion, chest pain, or a minor injury. Each additional week of underwriting is another week in which the applicant may slip on icy pavement or suffer a heart attack, and the consequences for an insurance application can range from further delay in settling coverage to withdrawal of the insurer's offer. If the member does obtain coverage, it may then be more expensive or have significant restrictions. In a worst-case scenario the member may be declined for coverage altogether and will remain uninsured. Efficient underwriting, with all requirements including the APS promptly supplied, reduces the member's risk of becoming uninsurable while waiting for insurance to be approved.

—Laura McLean
Client Services Administrator,
Doctors of BC