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the pixilation of a small image, use the option that allows you to reduce image size. All of us with limited storage would be very appreciative if you could keep attachments and photos small, and use them only when necessary. Please don't embed photos or fancy logo attachments in ways that I can't un-embed or that aren't really necessary. Don't forward attachments I don't need, and take every opportunity to reduce the size of attachments when you do forward.

I will continue to do my best to archive and delete, keep printing to a minimum to save trees, and avoid jail.

Emptying the trash, thanks.

—CV

letters to the editor

When MDs treat other MDs: Sometimes less is more

In medicine, the opportunity to care for a colleague is a unique and rewarding one. However, it can be difficult to balance the desire to provide prompt care with the risks of overinvestigation and treatment. Here we present the case of a retired surgeon turned patient that exemplified some of these challenges and provided us with a learning opportunity that we'd like to share with readers.

An 81-year-old male surgeon was evaluated for chest pain, palpitations, and a troponin elevation. Acute coronary syndrome (ACS) was promptly diagnosed and standard therapies, including a coronary angiogram, were requested. Subsequently, laboratory tests revealed an acute kidney injury (serum creatine 404 umol/L), supported by the presence of hyperkalemia (K^+ 5.8 mmol/L). The on-call nephrologist was consulted; the patient's K^+ was pharmacologically treated, a Foley catheter was placed, a renal ultrasound was requested, and the angiogram was canceled. Several hours later, follow-up laboratory investigations were entirely normal. It was then determined that the original tests were reported in error, and likely no acute kidney injury was ever present. Unfortunately, our patient sustained trauma from the Foley, and the angiogram needed to be delayed owing to bleeding concerns on his ACS medications.

Medical errors are not uncommon occurrences,[1] and most relate to human factors.[2] A variety of decision support systems and quality improvement protocols exist to reduce mistakes.[3] Errors made by analytical equipment are less common and are on the decline.[4] In this case, the error related here not only resulted in patient harm but also led to needless investigations, prolonged hospitalization, and specialist referral. (In 2005, the average cost of hospitalization for ACS in Canada was $80 000.[5]) Thankfully, our patient recovered quickly and experienced no long-term morbidity. He graciously accepted our apology. As a retired surgeon, he wisely reminded the cardiology trainees to interpret laboratory results in the appropriate clinical context! It was a teachable moment in many respects.

—Thomas M. Roston, MD, FRCPC
—Pol Darras, MD, MSc, FRCPC
—Morris Pudek, PhD
—David A. Wood, MD, FRCPC

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Re: Residential care disparities

I recently came across a report while on a public health elective in my fourth year of medical school. Admittedly, I am new to medicine, but I was truly shocked by the data presented by the Office of the Seniors Advocate BC. These provincial data were powerful, concluding, "if you are a resident living in a licensed care facility operated by a *contracted* provider versus one operated by a health authority, you are 32% more likely to be sent to the emergency department, 34% more likely to be hospitalized, have a 32% longer length of stay, have a 47% greater likelihood that you will become an 'Alternate Level

of Care' (ALC) patient, and be 54% more likely to die in hospital."[1]

I went looking for these data because of a trend I had been seeing throughout my hospital-based electives. In my short career in medicine to date, I have encountered a number of patients with preventable admissions and have seen many negative consequences of the designated ALC label, something I'm sure more experienced physicians could relate to. Preventable transfers from contracted care facilities to hospital not only increase the demand on hospital physician and health authority resources ($17 million and over 16 000 beds annually),[1] but also result in poor outcomes for BC's vulnerable senior population. Contracted care facilities are not performing at the level of health authority facilities, and the Seniors Advocate report provides an excellent analysis attempting to get to the root cause. This is an important issue with hospital costs and congestion increasing. Reducing unnecessary hospitalization for seniors by decreasing the disparity between health authority and contracted care facilities is a worthy goal both for the taxpayer and for improving the lives of seniors.

—Sarah Fraser, BSc
Kelowna

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Re: Pseudoscience, anti-science, and woo

Dr Cadesky wrote a powerful editorial on the importance of stories in patient education [*BCMJ* 2018;60:343]. While I wholeheartedly agree on the effectiveness of using personal narrative to drive social change, I wish to also point out the importance of physicians' language in engaging patients. Dr Cadesky encourages "[mentioning] our wheelchair-bound patients who have polio to vaccine-hesitant parents."

As a physiatrist, I regularly work with patients who use wheelchairs. Many will tell you that these devices are not binding, but rather opening. Wheelchairs may help our patients do things many able-bodied individuals take for granted—move about on our sidewalks and in our parks instead of being stuck at home, conserve the energy it takes to walk with a disability so that it can be better spent on time with family, and participate in sports like wheelchair basketball for social and health benefits.

The language we as physicians use has a powerful influence on how patients see themselves, how families see patients, how our colleagues and medical learners see patients, and how patients feel their physicians see them. Thus, language can help empower our patients, or it can alienate them. I encourage my fellow physicians to consider their own unconscious biases toward their patients who are differently abled, and to reflect how this plays out in the words they use in clinical settings. Maybe we need to change the language we use in our stories, too.

—Ranita Manocha, MD, FRCPC
Calgary, AB

Re: Diabetes in BC

Dr Ur, in his editorial for the November 2018 diabetes theme issue [*BCMJ* 2018;60:436-438], suggests we are grossly undertreating diabetes in BC, and that British Columbians deserve better.

Epidemiological evidence does not support this assertion. Data from the Canadian Institute of Health Information[1] found that Alberta and BC have the lowest rates of diabetes

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the viability of community medicine in peril. As we stand together in a changing climate there may be some projects we can quickly act on. The divisions of family practice and medical staff associations are acting locally, along with pilot projects through the Joint Collaborative Committees. And while negotiations on the next Physician Master Agreement will address these issues, such change will not be quick.

As an organization, Doctors of BC is working hard to achieve a more positive future. In return for your trust, there is accountability. I personally promise to continue to inform you whenever there is an agreement or announcement that affects you. This also means that between announcements there will be periods of relative silence; please do not mistake these for inactivity.

These are some of my thoughts, and I encourage you to share yours with me. No one person has the answers, but by listening to each other and working better together I am confident we will find the solutions to save our species.

—Eric Cadesky, MDCM, CCFP, FCFP
Doctors of BC President

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in Canada. Diabetes Canada also confirmed this incidence rate[2] and even proposed that by 2020, BC, at 25.4%, will have the second lowest prevalence of diabetes and prediabetes in Canada, after Alberta (23.6%) and will remain below the Canadian average (26%).

BC has the lowest rates of obesity, the highest rates of physical activity, and the highest per-capita consumption of fruits and vegetables in Canada. Perhaps we're already doing well compared to other provinces? Some might wonder, maybe we are not sufficiently screening for diabetes in BC? Not if what Diabetes Canada says is reliable, when they report that among all Canadian provinces, BC has the highest rate of screening for diabetes in Canada.[3] Canada has great variability, across provinces, how many diseases impact the population. In terms of diabetes hospital admissions, Quebec and BC have the lowest rates in the country, below the Canadian and OECD averages.[1]

Dr Ur's article, "Challenges to managing type 2 diabetes in British Columbia: Discordant guidelines and limited treatment options" not surprisingly, is highly critical of the Therapeutics Initiative.

Diabetes is a major cause of morbidity in British Columbia, but there are also myriad other health care issues. It is only reasonable that scarce funds are not wasted on very expensive new patented medications when generic ones may suffice.

—John Sehmer, MD, MSc
Vancouver

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Author replies

In his letter, Dr Sehmer disputes our assertions regarding the limited treatment options for diabetes in BC, yet he cites epidemiological data on incidence rates, obesity, and physical activity, none of which are relevant to our argument, and none of which we dispute.

British Columbia is indeed fortunate to have a somewhat lower (though still alarming) incidence of diabetes, and complex social, economic, and demographic factors are at play here. The problem is what happens to British Columbians after they are diagnosed with diabetes, and it is simply a matter of public record that therapeutic options for diabetes in our province are limited in comparison to the rest of the country. Of course, even in BC, they are not limited for fortunate individuals like government and university employees who have extended employment insurance benefits that provide them with access to modern evidence-based medications that other provinces offer to their less-wealthy residents.

Those who are excluded in BC are the poor and the old, and I do not believe that offering them additional therapeutic options would constitute wasting scarce funds.

Multiple recent trials have demonstrated outcome benefits (CVD, total mortality) for these newer, more expensive medications. Benefits that have never been demonstrated

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for older cheaper drugs (as concerns for their harms grow).[1,2]

—Ehud Ur, MBBS, FRCPC
Vancouver

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Impact of donor origin on survival after orthotopic heart transplantation

Heart transplantation is the definitive management for select patients with end-stage heart failure in BC. Due to an ongoing organ donor shortage, organs are sometimes allocated from distant locales. These organs may be perceived as less desirable due to donor risk factors and ischemic times. We compared survival after heart transplantation in BC between 1 December 1988 and 21 October 2014 stratified by donors originating from BC, other Canadian provinces, and the US.

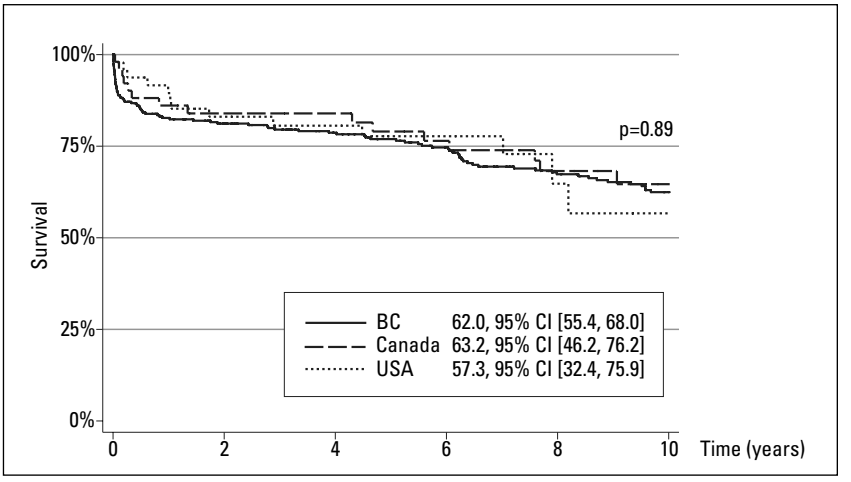

Figure. Survival following orthotopic heart transplantation stratified by donor geographic origin.

Among 382 patients, 297 (77.7%) recipients and 238 (62.3%) donors were male. The median recipient age was 55 years and the median donor age was 33 years. Median ischemic time was lower in BC donors (168 IQR [107.5, 228.0] min) compared with Canada (243 IQR [204.5, 291.0] min) and the US (244 IQR [217.3, 278.8] min) ($P < 0.01$). Overall 10-year survival was 62.1%, 95% CI [56.3, 67.4]. There was no difference in 10-year survival when comparing donors from BC, Canada, and the US (**Figure**) despite significantly different ischemic times. Multivariate Cox regression analysis found no relationship between origin and mortality after controlling for recipient age, donor age, and cold ischemic time.

Among patients undergoing orthotopic heart transplantation in BC, carefully selected distant-donor organs result in similar long-term outcomes despite increased ischemic times. Incorporating these findings into organ allocation protocols may extend criteria for donor selection, thereby increasing the donor pool and organ availability.

—Omid Kiamanesh, MD
—Annemarie Kaan, MCN, RN
—Mustafa Toma, MD
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