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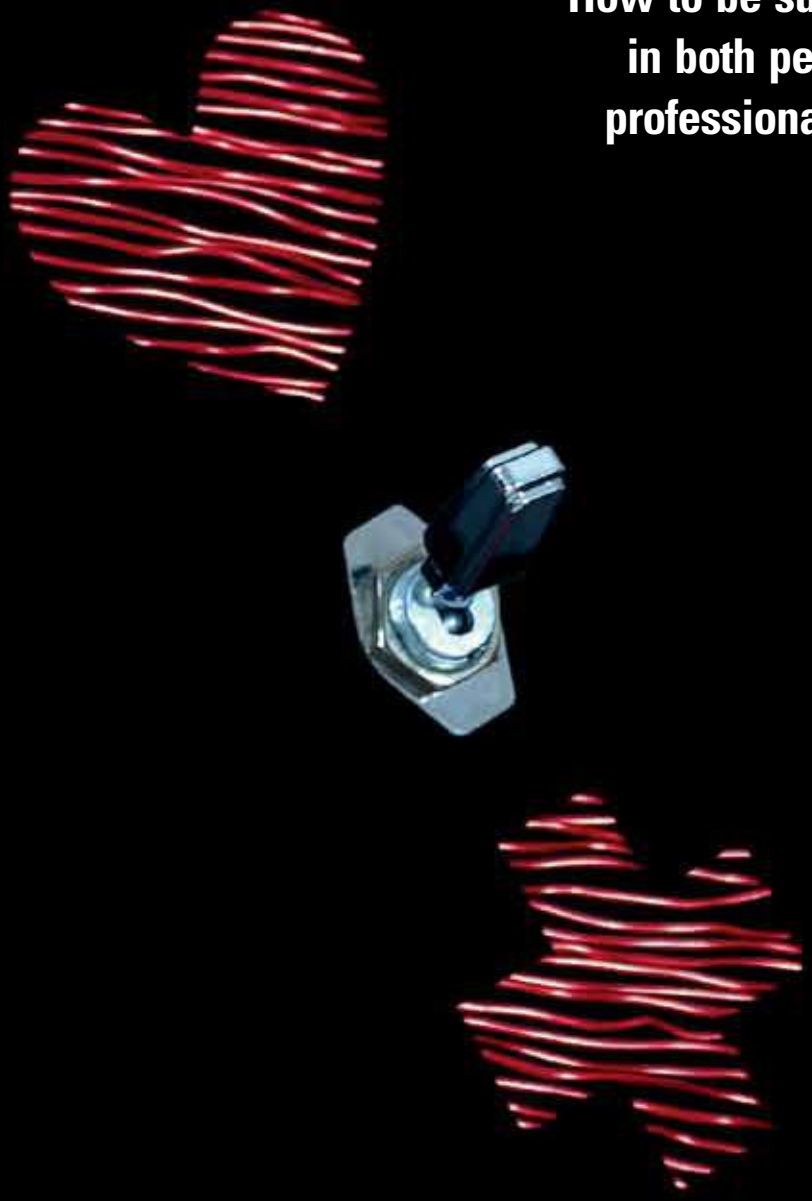
Physicians & their primary relationships:

How to be successful in both personal & professional realms



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ON THE COVER

The first challenge for doctors who want success in both work and their primary relationships is to be an effective physician while at work and a loving partner when not at work. Article begins on page 208.

The *BCMJ* is published by Doctors of BC. The journal provides peer-reviewed clinical and review articles written primarily by BC physicians, for BC physicians, along with debate on medicine and medical politics in editorials, letters, and essays; BC medical news; career and CME listings; physician profiles; and regular columns.

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Shifting toward health

Surely there are primary care physicians who enjoy dealing with the Insurance Corporation of British Columbia (ICBC)—I just haven't met any of them. I am pretty confident that the family physicians in my community don't look forward to this part of their practice. Listening to patients' complaints and recording soft tissue tenderness with painful reduced spinal range of motion isn't that onerous, so why do we all hate it? It has something to do with the looming shadow of secondary gain involved in these visits, as they become more about compensation than health and wellness. Even the best-intentioned patients can get caught up in the whole claim process. Compounding this is involvement by lawyers and other health professionals. Patients painstakingly list all their symptoms and disabilities while relating what their physiotherapist, chiropractor, and massage therapist are telling them. They often relay requests from their lawyer about investigations, treatment, and required frequency of visits. Redirecting them to focusing on health by getting active is an uphill battle.

As of 1 April 2019, new ICBC regulations have come in to effect for treating patients who have been in motor vehicle accidents. This new model aims to reduce ICBC's litigation costs while increasing patient care. A cap of $5500 has been put on payouts for pain and suffering for minor injuries. More choices in types of treatment will be available, including kinesiology, acupuncture, massage therapy, and counseling. In addition, the overall allowance for medical care and recovery expenses has doubled to $300 000. Doctors of BC was significantly involved as a key stakeholder to help raise issues and inform the new process and I appreciate all of the work that went in to this process.

Previously, when a patient was seen post-accident, a history and physical were recorded and a treatment program was designed. The patient was then seen in follow-up as needed. ICBC would send a request for records along with a patient consent at their discretion. If a patient had legal representation, ICBC was only entitled to a CL-19 form summarizing the patient's history, findings, treatment, and disability.

Under the new care-based model, physicians are asked to collect consent from patients to proactively send either a standard medical report if there is no work loss or an extended medical report if the patient is unable to work, study, or train. Based on this report, ICBC will decide whether the patient has suffered a minor or major injury. An independent dispute resolution process will take place through the Civil Resolution Tribunal if patients are unhappy with their injury designation. If a patient refuses to give consent, physicians are expected to collect their information but not send in the initial medical report. However, ICBC believes they are entitled to the patient's information and expect to receive it once requested; in their opinion, the Insurance Vehicle Act overrides the Personal Information Protection Act. If a minor injury lasts more than 12 months or if concussion symptoms and accident-related mental health issues are present after 4 months, it becomes a major injury, no longer subject to a financial cap.

Through my experience in dealing with ICBC patients for over 20 years, I would agree that ICBC costs are excessive, mostly due to the litigation process. Retaining legal counsel leads to more investigations, treatments, and consultations—all of which cost money. In addition, one-third of settlements go directly to the lawyers. I hope that the new regulations will lead to a reduction in costs and improved patient outcomes, but I remain a little skeptical. I am suspicious that after seeking legal counsel a significant number of patients will surprisingly have concussion symptoms and mental health issues after 4 months or remain symptomatic from their soft tissue injury a year later.

I'm interested to see how all of this plays out, but in the meantime I will continue to do my best to shift patients' focus away from financial compensation and toward health, where it belongs.

—DRR

Listen up, Doc

"Good morning, Ms S. What brings you in today?"

As I ask the question I see that she is clutching a tax credit disability form and there is a vitamin B12 vial sitting on the counter. Before she can answer, I say, "I see you have a form for me to fill out," and I gesture for her to hand it to me.

"Yes, I've been wanting to bring it in for some time but wasn't sure if I was eligible," she says. I'm signing on to my EMR as she speaks. I start flipping through the form and agree that she is not eligible for the credit. I then proceed to address that she needs her vitamin B12 injection. After giving her the injection I am ready to wrap up the appointment. As is my routine, I ask, "Is there anything else I can do for you today?" and I get up to take her BP as she starts speaking. "Actually . . . I've been having trouble with my memory," she says and starts to cry. I ditch my efforts at the BP, sit down facing her, put my hand on her arm, and I wait. She looks at me and starts to talk. It is quite apparent that she is very worried about her forgetfulness. She is embarrassed, sad, and scared. I continue to listen and then we formulate a plan for how we can further investigate her symptoms. She is thankful, and through tears she gives me a hug as she leaves.

According to a recent study in the *Journal of Internal Medicine* by Naykky Singh Ospina and colleagues,[1] on average, physicians give patients 11 seconds to explain their reasons for a visit before interrupting. It was also determined that primary care physicians allowed more time for patients to list their concerns than specialists. The authors concluded that, "Failure to elicit the patient's agenda reduces the chance that clinicians will orient the priorities of a clinical encounter toward specific aspects that matter to each patient."

I reflected on my visit with Ms S and other patients and realized that my idea of a successful encounter was usually one during which I had completed my agenda for the visit, not always the patient's agenda. If Ms S hadn't broken down I may not have been able to help her with her real concerns that day.

Being present and *being mindful* are phrases that I relate to the act of being a good listener. But I find that these skills have to be practised regularly to be naturally occurring during a patient visit.

A paper by Mary Shannon, "Please hear what I'm not saying: The art of listening in the clinical encounter,"[2] summarizes that "the simple yet complex art of listening is, in and of itself, a clinical intervention, for the healing that comes from being listened to is often greater than any cure. Listening constitutes the very heart and soul of the clinical encounter."

William Osler, often called the father of modern medicine, advised students: "Just listen to your patient, he is telling you the diagnosis."

A review of reports by the Joint Commission, a not-for-profit organization that performs accreditation of health care organizations, found that communication failure rather than physicians' knowledge or technical skills was the root of more than 70% of serious adverse health outcomes in hospitals.[3]

Why are physicians being touted as being poor listeners? I remember receiving what I thought was adequate training on how to communicate with the patient during my family medicine residency at the University of Saskatchewan. We were also taught how to direct the communication so that the encounter could be efficient and productive for both the patient and the physician. I believe that we

try to do the best in the time we have. The waiting room full of patients, the EMR waiting to receive its data, the tasks waiting to be reviewed at the end of the day, the patients expecting to be called back about their urgent concerns, our partners with supper on the table, our kids waiting for us to show up at their soccer game, and the financial burdens that we have created for ourselves are just some of the reasons we may feel the need to encourage the patient's visit to run along faster than is considered adequate.

I did a small-scale trial of better listening in my clinic a few weeks ago. What I discovered was that if I let the patient speak uninterrupted after my initial inquisition of what brought them in, it took most patients less than 10 seconds to relay their concerns. Of course there was further discussion after that, but being present and really listening to the patient at the onset of the visit sets the tone for the rest of the discussion. I know that most patients are mindful and respectful of my time and I think they deserve the same.

"Most people do not listen with the intent to understand; they listen with the intent to reply" – Stephen R. Covey. The message is clear; we need to start listening with the intent to listen—to our patients, our peers, our families, our friends, and ourselves. Physician burnout is starting to be more recognized and health authorities and physician groups are starting to take real steps to address this important topic. I'll save that discussion for another day. For now, in the words of TV psychiatrist Dr Frasier Crane, "I'm listening. . . ." **—JC**

I discovered that if I let the patient speak uninterrupted after my initial inquisition of what brought them in, it took most patients less than 10 seconds to relay their concerns.

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president's
comment

How's your week so far?

Yesterday was a typical office day in my community family practice. Periodic health/preventive exams, and geriatric and counseling visits had been allotted their usual 20- to 30-minute time frames on my day sheet, and shorter visits were booked in between. I always strive to start on time, arriving early even, to ensure the computer starts, urgent diagnostic reports from the previous office day are addressed, and messages are reviewed. I feel ready. At 8:30 a.m. patients arrive seeking advice from the trusted health care professional that has looked after them for 26 years. I know them and they know me. Despite this long-standing relationship, consultations often run longer than anticipated—sometimes by just a few minutes, but other times by much longer. I don't believe the one-problem-one-visit rule applies in my patient cohort, as patients are rarely just one problem in isolation. A follow-up blood pressure check may end with a discussion about their loss of independence. A diabetes management discussion may end with a lengthy discussion about the deteriorating health of a family member preventing their self-care. A sore throat can turn into a discussion about contraception, HPV vaccination, and safe sex. The clichéd hand-on-the-door complaints, "I've got blood in my urine" or "I have chest pain with activity," that don't make the top of the complaint list still need to be urgently addressed. By 11:00 a.m. I'm already starting most visits with, "Hello. Thank you for your patience." I adopted this phrase years ago when I stopped apologizing for the waits generated by the necessary care of other patients. Most people are very understanding, some less so. The 90-year-old patient giving me heck for running late as she was going to miss a bowling game is an excellent example, "My time is precious too." I am not in a position to dispute this argument from a 90-year-old. So, after 4.5 hours of clinic time, I am meant to have an hour for lunch, except many visits ran over and a sick immunosuppressed patient was fit in at lunch when the waiting room would be virtually empty of potentially infectious folks. There was no time for lunch as my morning finished 10 minutes into my afternoon. I quickly glanced at the diagnostic tests and messages to ensure nothing needed urgent attention before the afternoon clinic started. My afternoon was derailed by similar processes, and I saw my last patient to the door at 6:00 p.m.

I don't believe the one-problem-one-visit rule applies in my patient cohort, as patients are rarely just one problem in isolation.

It was a rewarding day full of a variety of complex and challenging diagnostic and treatment dilemmas. I know I made a significant impact. However, it is difficult not to feel beaten down and mentally fatigued—not to mention pretty darn hungry. Next, the document and diagnostic test reviews begin. I call several patients to alter their care or deliver the good news, or often bad news, that they have been waiting on since their test was completed. My spouse is texting by 7:00 p.m. about a delicious plate of real food waiting for me at home. I pack up my computer and more papers than I think a paperless office should hold and head home. After calling to touch base with our elderly parents living on their own, the computer is back on. It is 8:00 p.m. I spend the next hour returning patients' calls and notifying patients of results needing more urgent attention. I am always greeted with the same phrase, "Whoa, working late tonight," followed by expressions of gratitude and appreciation that I am calling at this hour to secure their care. I am "the best doctor ever." Several chart notes, care planning reviews, diagnostic forms, referrals, a nursing home admission, and one Persons with Disability form later, I look up. It is 11:50 p.m. My spouse headed to bed at some point, and as I collapse into bed myself a solution to a patient problem rushes to the forefront of my brain and I jot it down on the note pad by my pillow. I will remember to deal with this tomorrow.

To be a physician is to live a life of sacrifice of any number of aspects of our lives—missed time with family and friends, lack of adequate sleep, exercise, or meal preparation. Yet these often unrecognized sacrifices allow our health care system to function. The time spent on clinical care is what our patients and administrators see and understand. The time spent completing the relentless stream of forms, referrals, requisitions, and various other documents required to manage patients is more obscure. And the time spent considering patient care and researching difficult diagnostic dilemmas or new treatments available is primarily internal and not

obvious to an outsider. Clinicians offering longitudinal care will certainly find that a great deal of time is spent on this latter piece of work, sometimes waking us in the night with the solution.

Sir William Osler said, "The practice of medicine will be very much as you make it—to one a worry, a care, a perpetual annoyance; to another, a daily job and a life of as much happiness and usefulness as can well fall to the lot of man, because it is a life of self-sacrifice and of countless opportunities to comfort and help the weak-hearted, and to raise up those that fall." I most closely identify with the latter, and I believe that Canadian physicians work tirelessly 24/7 to live up to this ideal. We look in the eyes of patients seeking our advice and treatment every day. This is both an honor and a privilege. Unfortunately, in our current environment, multiple barriers routinely get in the way, such as limited access to investigations and treatments or limited clinic time to fully address all of our patients' concerns because of a lack of resources.

Working in this situation is causing a crisis in physician wellness and our ability to deliver the care we want in a timely manner. We feel the weight of this increasingly difficult burden compressing our profession. Doctors recognize that we need support more than ever to do our work. We cannot continue to work alone into the wee hours of the night. It simply isn't sustainable. We need support to tackle the leading health care delivery issues that are preventing access and causing barriers to care.

Over the course of my year as president I hope we will continue to engage all partners within physician groups, health authorities, communities, and of course our patients, families, and caregivers who ultimately receive our care to collaborate effectively to eliminate these barriers. The secret to success now and in the future is to listen to all voices and perspectives. This approach is essential to lead meaningful change and to ensure our profession continues to be a profession of influence both individually for our patients, and generally in the assembly of a sustainable health care system.

—Kathleen Ross, MD
Doctors of BC President

letters to the editor

Infection control in BC operating rooms

There is little difference between the practice of infection control in an operating room and religious dogma. Here are three examples that are patently ridiculous. Sinus surgery done by an ENT surgeon in the operating room is basically through snot but we make sure that the patient is prepped and draped. Hemorrhoidectomies are done by general surgery on a patient's anus but we prep and drape the patient. Maxillofacial surgeons do mandibular osteotomies where the oral mucosa is cut into, the mandible is sawed in two, then plated with screws and closed, but we prep and drape this patient also. "Antibiotics for the lawyers" are sometimes given in the first example, never given in the second example, and always given in the third example.

In the big picture, the infection control practices in operating rooms have a very bad effect on the planet as most waste winds up either in the ocean or the atmosphere.

Even though much has been written about this, very little has been done about it, basically because the power structures in place in hospitals are just fine with the status quo. And the prime purpose of these power structures is to employ people, not to decrease infections.

A small first step in British Columbia would be to stop the surgical prep and draping for the three aforementioned examples.

The same can be said (i.e., that it is patently ridiculous) about the strict enforcement of dress codes in operating rooms in British Columbia. There is no evidence for this, but signaling who is in charge is very important to the power structures in hospitals, usually under the rubric of standards.

—Mark Elliott, MD
Vancouver

Re: myoActivation for the treatment of pain and disability

Dr Suzanne Montemuro's letter to the editor (*BCMJ* 2019;61:111) states that "[myoActivation] has been shown to be effective in treating chronic pain originating in the soft tissues in the elderly as well as children." However, my searches of PubMed and Google Scholar yielded no studies to support this. In fact, the only publication I could find was the descriptive paper cited in Dr Montemuro's letter, containing only hypotheses and a few

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case studies. This scarcely qualifies as evidence of efficacy, let alone effectiveness, of this intervention. While Dr Montemuro has had pain relief in association with this intervention, personal experience is simply that. As Hippocrates is quoted, "experience [is] fallacious, and judgment difficult."

Chronic pain is poorly understood and interventions are challenging to evaluate. Nonetheless, while good study design can be difficult and certainly should have biostatistical advice in the planning, the scientific method remains public domain software. Isolated case reports are no substitute.

—Barry Koehler, MD, FRCPC
Delta

Author replies

My experience with myoActivation was the stimulus for writing the letter to the editor. As a skeptical physician I was impressed that it worked well and I wanted to learn more about the technique. I believe that myoActivation is an innovative methodology that can significantly benefit people living with chronic pain.

In your December 2018 letter to the editor in the *BCMJ* (regarding Dr Cadesky's article) [*BCMJ* 2018; 60:480] you stated "It's all about the patient . . . If change starts with what will benefit the patient and not what is perceived to benefit the system, better health care will ensue. We need flexibility and readiness to change as we try out any system. Indeed, that's how we practise patient care." I wholeheartedly agree!

Certainly more studies need to be completed to truly demonstrate myoActivation's effectiveness; myoActivation does, however, have similarities with other commonly practised myofascial release and needling techniques. One difference with myoActivation is that MSP covers it and it is carried out by physicians trained in the technique. I have included references to studies on myofascial release and other needling techniques below.

A number of studies are ongoing in BC. I felt that including them in my previous letter would turn a letter to the editor into a full article. Studies are being carried out in Prince George (Dr Cameron Grose), at BC Children's Hospital (Dr Gillian Lauder), and at Vancouver Coastal Health (Barb Eddy, NP). Vancouver Community Pain Service has started a 1-year pilot program for chronic pain patients using myoActivation and other therapies in marginalized populations with mental health and addictions.

In your profile in *UBC Medicine* (Vol. 2, No. 1, Fall 2005) you say, "It's all about seeing the patient and making observations." Making careful clinical observation of abnormal anatomy and dysfunctional movement in chronic pain patients is the focus of myoActivation.

I encourage you to take a closer look at the myoActivation methodology.

—Suzanne Montemuro, MD, CCFP
Victoria

Disclosure

Dr Koehler and I worked together at the Port Arthur Clinic in Thunder Bay, Ontario, in the 1970s.

Suggested reading

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We welcome original letters of less than 300 words; they may be edited for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. All letter writers will be required to disclose any competing interests.

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A revolution in medical imaging is coming

MRIs can cost millions to buy, hundreds of thousands yearly to maintain, and have a resolution of a few millimetres. Compare this to a machine that is a thousandfold cheaper to buy that provides images that are a million times cheaper to produce with a billion times the resolution. That is like buying a cellphone to take a picture at the resolution of an individual neuron.

And this technology is closer than you may think. The technology I am referring to is based on near-infrared light. Biological tissue scatters red light and silicon chips manufactured by the billions for cellphone cameras are very sensitive to it.

Remember when you were a kid in a tent in the backyard shining a flashlight onto the palm of your hand to make your hand light up? For illustration, take a laser pointer and shine it onto your finger. Your finger becomes translucent red because the laser's red light is scattered by the tissue. The scattering is random, so no information can be obtained about the tissue that it went through. But what if you could accurately measure both the angle of each ray of light and how faded in intensity it was by the finger it just went through? You could then reconstruct a holographic picture of the tissue that the beam of infrared light passed through.

In April 2018, Mary Lou Jepsen gave a TED Talk in Vancouver in which she described a prototype machine developed by her start-up, Open Water, which does exactly this. Basically that 30-ton MRI machine with its large magnet and liquid helium cooling system can be replaced with a wearable sensor weighing a few pounds.

When you shine red light onto a beaker of blood no light passes through. The blood totally absorbs the light. When going through tissue, light is scattered, which is why your finger is translucent red. Your body is 3% blood but a cancer over 1 millimetre or so develops a strange leaky vasculature that increases that amount to 15% in the tumor. This machine will be able to detect this at pretty much the cellular level of resolution.

This will profoundly alter the business model of screening for breast cancer. In my field of anesthesiology the potential is breathtaking because this imaging can now visualize and also alter the firing of neurons. Why use a pharmaceutical that has to be given in whopping big doses to cross the blood-brain barrier, poisoning the entire brain, to obtain adequate anesthesia in one part of the patient's body, when you can use a photon to pinpoint the anesthesia effect?

—Mark Elliott, MD
Vancouver

Re: Falling through the cracks

My thanks to Ms Ono, Dr Friedlander, and Dr Salih for their article, "Falling through the cracks: How service gaps leave children with neurodevelopmental disorders and mental health difficulties without the care they need" [*BCMJ* 2019;61:114-124]. It is a powerful reminder that children grow up and develop into adults, with the spectrum of neurodevelopmental disorders continuing into adulthood.

I would like to advocate for the substantial number of adult individuals with neurodevelopmental disabilities presenting with mental health distress. These individuals do not have major neurodevelopmental disorders, but one or more specific neurodevelopmental disorders (e.g., speech, language, or communication disorders; ADHD; learning disorders; motor disorders; and others

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as described in the *DSM*-5). They, however, were either not diagnosed as children, or were diagnosed but the support and understanding of the impact of these disorders on their later functioning (personal, social, and employment) did not continue into adulthood. Often very capable individuals start to decompensate when their coping mechanisms (to deal with the neurodevelopmental disorder) are overwhelmed. This can have disastrous consequences for the individual and their families (e.g., unemployment, relationship difficulties, social/financial problems). Comorbid mental health disorders can be present or evolve over time. This can often create a vicious cycle of disadvantage and suffering for all involved.

A multiprofessional team should be available to manage the care of the patient and their family. This team should consist of at least a clinical psychologist, a social worker/MCFD social worker, a case manager, an occupational therapist, a therapist/counselor, a pharmacist to advise on complex polypharmacy, and a psychiatrist.

Thank you for creating the platform to participate in discussions.

—Cobus McCallaghan, MBChB
South Surrey

Ultrasound in undergraduate medical education

Bedside ultrasound, a term that comes up repeatedly in medical school, is becoming increasingly valuable in almost all fields of medicine.[1] This tool is being integrated into preclinical training, yet it seems that medical students are not using it on the ward. Why is this? Lack of resources? Lack of teaching? It certainly isn't lack of student interest.

Students are beginning to recognize the relevance of bedside ultrasound to their future careers and have begun to question why it isn't a higher priority in undergraduate medical education. Many of our peers are even seeking ultrasound training outside of curricular time. Interestingly, it seems as though students think bedside teaching would improve their skills the most, yet a lack of clinical time and opportunity may be the biggest barrier to their learning. Despite infrastructure being available (ultrasound machines and trained faculty), many students have described limited hands-on opportunities and preceptors who were hesitant to share the probes. Admittedly, there are exponentially increasing demands on curricular time[2] and some faculty believe that teaching ultrasound is not appropriate at the undergraduate level as it could lead to misdiagnosis or to distraction from learning important physical examination skills.[3] This raises questions of how high a priority undergraduate ultrasound education should be and who should shoulder the burden of that education. Should students be taking more initiative in their learning, or should we expand the curriculum?

We acknowledge the potential bias our perspective brings and are interested in hearing our preceptors' opinions. Do they feel it is a priority, and are they comfortable enough with techniques to be teaching? One thing is certain: bedside ultrasound is improving patient outcomes and decreasing costs to the system.[1] If students are not receiving the hands-on teaching they need to learn it, who will use it in the future?

—Ali Silver, BSc
—Sarah Fraser, BSc
—Megan Shurey
Kelowna

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Interactions between primary care management systems, IT, and patient care

Dr Piver replied to an opportunity from his local division of family practice to provide bottom-up feedback about primary care intervention programs and incentives. His original response, along with expanded information, is published here in order to share the content with physicians province-wide.

Andre C. Piver, MD, FCFP

My feedback about primary care intervention programs and incentives, originally provided to my local division of family practice, is included below. It reflects the evolution of our system's requirement to be seen to address evidence and to provide measurables attesting thereto.

"In response to your lovely questions about what divisions can do regarding our needs, I will offer my feedback/opinion regarding the system-wide evident focus on proxy measurables and the documentation of management, which is predictable given the intended health authority corporate culture. While appreciating the well-intended and worthwhile clinical goals, how do these silos improve on what a rostered primary care team model could provide? I have come to conclude that rostered primary care with payments per patient/year, modified for likely complexity, rather than per service, with access to a team, is the best natural model to allow us to practise primary care medicine for the complex individuals that are humans. The constant stream of apparent innovations aimed at specific disease/comorbidities/determinants-of-health management generally require ever more time spent on administrative/clerical tasks (i.e., constantly learning and applying complicated new specialized documentation and billing add-ons, with our attention focused on screens instead of patients' faces). A practical option like the RACE program is a different and useful process providing more timely and travel-conserving access to specialist support, particularly helpful in rural areas.

I would contrast this with the natural evolution of bottom-up human team-based care, with each regulated profession contributing and innovating in responding to changing local conditions and emerging evidence (as they fulfill their existing continuing education requirements). Examining local epidemiological data and emerging evidence would certainly be valuable, with periodic team participation in making meaning of such data and responding, where appropriate. Naturally occurring innovations could be shared and adopted laterally where chosen, rather than via top-down algorithms, which impose ponderous measurables built into documentation, as the principle, although flow sheets are indeed useful. Ideally all would be based on local discretion and motivation, intrinsic to existing professional standards of care and documentation and satisfaction. Where our proxy measurables cross these lines they are in fact duplicating other existing regulatory

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Dr Piver has, at different times, practised full-service family medicine and worked as a contract GP psychiatrist in Ontario and British Columbia. He currently works part-time at the Eastshore Community Health Centre in Crawford Bay, and occasionally as teaching faculty for UBC Family Medicine. He has been an examiner and exam coordinator for the CCFP (simulated office oral), published academic articles (primarily on the subject of mental health), led workshops at scientific assemblies, and was a member of the first national Shared Care Committee (Psychiatry).

This article has been peer reviewed.

Continued from page 205
institutions and their role, while justifying the salaries and bonuses of ever-more information management ensuring the appearance of accountability. The most common frustrations I experience with our EMRs are the idiosyncratic rigid choices in nomenclature, limited options and categories in dropdown menus, fixed smart options, etc. These clearly reflect convenience in harvesting these arbitrary proxy measurables, rather than reality on the ground. Furthermore, the IT platforms are designed with little understanding of their clinical application and variability; thus, they are constantly being patched and 'improved.'"

Further considerations

When I started family practice in 1982, I recall that a GP visit paid approximately $16 to $20 across Canada, and the price of an average house was between $45 000 and $75 000. As we know, office overhead has increased greatly and the cost of housing has multiplied close to tenfold since that time.

Today, patients are often asked to prefill questionnaires in writing, in the name of being more efficient with their primary caregiver's time in our fee-for-service structure. This activity removes the opportunity for the physician to experience the nonverbal cues that a patient provides while delivering their concerns, and to demonstrate their interest in the patient's concerns directly. This may have consequences, as may the one-problem-per-visit policy. A 10- or even 15-minute visit may be perfectly suited for a routine prescription refill or blood-pressure monitoring, or not. Suitability may depend on the need to detect everything from white coat syndrome to noncompliance to new symptoms that a patient may be ambivalent about sharing.

When I was trained in family medicine, I learned that patients bring 1 in 40 symptoms to their family physician's attention and that what they choose to share will likely fall into one or more of the following categories:

I have come to conclude that rostered primary care with payments per patient/year, modified for likely complexity, rather than per service, with access to a team, is the best natural model to allow us to practise primary care medicine for the complex individuals that are humans.

A. The symptom is intolerable with respect to discomfort or interference with functioning.
B. The symptom is causing worry as a possible indicator of a serious as yet unknown disease.
C. The symptom has been around for a while and represents neither A nor B but the patient is now unconsciously at a time when they may need to connect and share with a caregiver and receive reassurance.

Category C may occur more often than ever in a society experiencing an unprecedented prevalence of isolation, loneliness, and alienation. The primary caregiver cannot accurately assess what is the appropriate action with respect to investigation or treatment without being aware of the considerations outlined in categories A, B, and C.

The University of North Carolina has an excellent evidence-based summary outlining guidelines for improving communication skills and the patient-doctor relationship on their website, including easy-to-read tables. The overview states: "There is growing evidence that the key to success in patient care is a good patient-doctor relationship. In this era it doesn't bring in more money but it may help reduce costs for care. The value of good communication skills and the building of an effective relationship with the patient is supported by several medical studies that show that these skills can lead to improved patient and physician satisfaction, better disclosure of important information, greater adherence to treatment, reduced emotional distress, improved physiological parameters and overall better clinical outcomes."[1]

Fundamental research into human communication long ago recognized the important difference between verbal (digital) information and the much more powerful analogic communication (nonverbal messages). Consciously or not, we constantly transmit, read, and are powerfully affected by these analogic messages, especially when in the vulnerable role of a patient. One important example of analogic messages being understood is the caregiver mirroring the patient.[2] When our eyes are necessarily glued to an EMR screen, with the patient facing our backs, it interferes with the kind of presence required for effective care. Our attention is not merely an instrumental resource but critical to being present with our patients. The article "Attention is not a resource but a way of being alive to the world,"[3] which is about emerging research on the failure of instrumental attention, reflects as one example the loss in empathy that is occurring.

The ongoing well-intended evolution in assuring and incentivizing the piecemeal application of evidence-based care makes for ever higher management costs, both to our system and to the physician's administration. The quality-improvement measurables used to gauge if specifications are be-

ing met work for engineered systems such as assembly lines, but there are unintended consequences when they are applied to the very different complexities of natural systems such as primary care, where we only have proxy measures. They cannot capture all of the variables relevant to each unique patient; nor can they measure the interrelationships and consequences with a given patient (e.g., unusual risk or protective factors, personality, culture, trust, compliance, stress). Our humanity and personal connection makes a difference.

A relevant article of value is "Learning narrative-based medicine skills," published in the *Canadian Family Physician*.[4] I also strongly recommend listening to the episode of CBC's *The Sunday Edition* titled "Too long, didn't read – how reading online is hurting our brains."[5] The research findings of Professor Maryanne Wolf, an author and a researcher at Tufts University, explain part of the frustration often felt when trying to talk to someone who is stuck on ticking boxes. Neuroimaging shows how few service providers at the interface between IT systems and the front lines in any domain seem to *get* the meaning of information. We become busy going through the motions as quickly as possible, leaving little room for thinking/feeling about the details or their meaning and implications. I would submit that, at the most basic level, this is how IT impacts our management systems as well as our practices and lives.

Competing interests

None declared.

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Gordon J.D. Cochrane, Ed. D., R. Psych.

Physicians and their primary relationships: How to be successful in both personal and professional realms

Protecting a life-enhancing primary relationship requires knowing that career pressures can stress a relationship and exacerbate any potentially problematic perceptions, especially those concerning trust.

ABSTRACT: People in many professions have to deal with time pressures, interpersonal challenges, and fatigue, all of which can affect their primary relationships. Additional concerns affecting physicians are the science-based communication approach and the emotional self-protectiveness required by their work, which when used at home can contribute to stress and conflict. Ongoing awareness of which realm a physician is communicating in and which personal perceptions of trust may interfere with intimacy communication is needed for a primary relationship to succeed. A large study of couples in long-term satisfying marriages has provided valuable information on the key factors contributing to life-enhancing relationships. These factors include commitment, love, trust, and effective communication. For physicians, protecting their primary relationships can involve a number of strategies, including active listening that focuses on the communication of perceptions rather than science.

This article has been peer reviewed.

Success as a physician requires stamina, highly refined cognitive abilities, and the ability to be emotionally self-protective. Emotional self-protection is unquestionably valuable in a professional context but can make it difficult to experience the easily accessible intimacy central to life-enhancing primary relationships. This does not mean, however, that the demands of a successful medical practice make it impossible to be a full partner in a life-enhancing relationship as well. What people in loving primary relationships have in common is an unequivocal understanding that while their professional life is important, their primary relationship comes first.

High-performing people in many fields have to deal with the demands, time pressures, interpersonal challenges, and fatigue that accompany their work and can affect their primary relationships, and these stressors are certainly present in the medical profession. In addition, the science-based approach used by physicians at work to discuss diagnoses and treatment may contribute to stress and conflict when used at home. The first challenge for physicians who want to be successful in both professional and personal realms is to retain the ability to be an effective physician when at work and a loving partner when not at work. Difficulties arise when the first challenge is not seen as a real challenge.

Challenge of intimacy communication

Most of the "medical couples" I have worked with over the years have expressed frustration with their differing expectations of intimacy. Whereas professional communication clearly requires a diagnosis and treatment approach, successful intimacy communication requires both partners to know from experience that they can

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be open and authentic in their interactions, that they will be heard by the other, and that their unique perspectives will be respected though not always endorsed. When a physician's professional communication style is used at home it can shut down intimacy communication, which leads to growing mutual resentment, distancing, and loneliness.

A recent study[1] confirms that effective communication in personal relationships occurs when both partners appreciate that their individual perspectives are unique and evolving and these perspectives are effectively expressed and heard. Ongoing awareness of which realm a physician is communicating in at any moment is needed to make success possible in both realms.

Challenge of perceptions

While career pressures can stress a relationship, they can also exacerbate any potentially problematic perceptions, especially those concerning trust and unguarded openness. Individuals who have experienced or observed dire consequences arising from misplaced trust are often wary of the openness state that makes intimacy possible. Unlike "intimacy compatible" individuals in long-term relationships, individuals who are "intimacy wary" respond to anticipated enhanced intimacy in creatively defensive ways. They change the subject, bring up past errors, become angry, or use whatever distraction works. These types of wariness-generated strategies need to be addressed by each couple independent of their professions.

A loving relationship requires that both partners readily feel and express empathy for the other. This can challenge physicians, who are expected to be constantly empathic at work, even though nobody can be empathic all of the time. Consequently, at home they may become somewhat guarded, skeptical, and demanding without realizing the degree to which they have become so. This understandable self-protectiveness may not be noticed by colleagues but will be noticed by a partner if brought home.

Three in four people in a loving primary relationship say their partner is their best friend and if they could go back in time they would choose the same person. As well, the more equal the domestic workload, the greater the happiness of both partners.

A loving relationship requires that both partners readily feel and express empathy for the other. This can challenge physicians, who are expected to be constantly empathic at work.

Loving, life-enhancing primary relationships are created by two self-aware, emotionally healthy people. Successful physicians who want such a relationship must be aware of their own potentially problematic perspectives and idiosyncrasies so they can respond to a partner in a manner that makes it possible to succeed in the relationship realm.

Benefits of primary relationships

In the past decades a number of studies have looked at the correlation between primary relationships and individual well-being.[2,3] Researchers have found that most people are happiest when in a loving, life-enhancing relationship, and that the rate of depression is significantly lower for people in successful primary relationships compared with people in problematic relationships.

Factors common to life-enhancing relationships

Pursuing a life-enhancing primary relationship can present challenges similar to those faced when pursuing a demanding career. For example, students beginning a program of professional studies may start out with an optimistic intellectual appreciation of what it takes to succeed and then find the endeavor to be much more difficult than expected. They may adjust their approach to the realities of their program requirements or they may withdraw and choose a different career path. As with career choices, relationship choices exist. Rather than pursuing a primary relationship, individuals may choose a relationship known in the literature as a complementary relationship. Complementary relationships are, to varying degrees, functional. Some are also long-lasting, but they are not primary

and they are rarely emotionally satisfying and life-enhancing.

A large study of long-term satisfying marriages[4] provides valuable information on the key factors contributing to life-enhancing primary relationships. After being interviewed separately to minimize self- and partner-protective reporting, study participants endorsed the following factors most frequently:

Commitment. Both partners reported being committed to one another and to their relationship. For both of them, their relationship is primary. Whereas other personal and professional relationships are important, their relationship with one another comes first. Both partners value and are committed to protecting their relationship.

Love and trust. Couples reported feelings of love for one another. They also reported trusting one another to be honest in a relationship free of secrets and to demonstrate their trustworthiness by being reliable. That is, to do what they say they are going to do. Because they are honest, reliable, and supported in their relationship, they can be unguarded, open, and authentic with one another.

Effective communication. Partners reported respectful and effective communication occurred regularly and included expressions of praise, acknowledgment, and affection. Each respects that the other's perception of reality is unique and the only reliable way to know the other's reality is to ask and then to actively listen. This fundamentally sound form of communication facilitates accurate self-expression rather than the mutual and often inaccurate mindreading that is common in problematic relationships. Couples reported disagreeing sometimes but not fighting because they have a line that they simply do not cross.

Effective problem solving. Couples reported openly acknowledging and responding to their problems as a team before proceeding in a cooperative, flexible, and adaptive manner. They identified joint decision making as most effective and satisfying.

Similar views and values. Most partners reported having similar views about politics, economics, religion, and spiritual beliefs and sharing similar values. When couples are "values compatible" they spend a lot of time together because they enjoy being together and like doing many of the same things (travel, family activities, recreation, socializing, etc.).

Sexual intimacy. Couples in the study reported finding each other attractive and enjoying mutual sexual fulfillment and expressions of affection. They generally agree on what they find pleasurable sexually and they are sensitive to the needs of one another.

Enthusiasm for life and a sense of humor. Partners reported being generally optimistic and positive about life and having a good sense of humor. They have fun together yet remain individuals who can encourage and support one another's uniqueness within the context of their committed primary relationship.

Attainability of a positive primary relationship

A skeptic will say that a positive primary relationship is unrealistic and unattainable. As studies have shown,[3,4] the skeptic is wrong. If, however, the skeptic says such a relationship is unrealistic and unattainable *for me*, the skeptic is correct. People in unfulfilling relationships are often those who have been hurt in the past and have drawn an understandable but fulfillment-limiting conclusion such as "the people closest to you hurt you the most," "better safe than sorry," "you can't trust men," and "you can't trust women." These emotion-laden conclusions do not resolve themselves. When a person does not address such conclusions and adheres to the ineffective principle of "put it behind you and get on with life," this creates a must-but-cannot dilemma. The person longs for a loving relationship[3] but fears the unguarded state that is essential for that type of relationship. Sadly, this fear is reinforced through selective attending and meaning attribution. We tend to notice only those relationship situations that confirm our experience-based bias and we confidently attribute meaning and causation to that which we perceive.

Protecting a primary relationship

Current research[5] shows that when highly stressed couples seek out various forms of couple therapy or education programs they tend to benefit for a while before gradually reverting to their old and problematic behaviors. These include looking for immediate alleviation of their stress, not grasping the importance of a relationship being primary, and blaming each other for their problems rather than giving sufficient attention to the personal and interpersonal factors that are at play in their relationship.[2]

Protecting a primary relationship requires refining the skill of quickly and fully transitioning from the professional world to the personal world of the relationship and not being like the absent-present pedestrian who is fully absorbed in looking at a cellphone while drifting across the street on a Don't Walk signal.

For many years the literature has portrayed struggling couples as poor communicators. Current research indicates otherwise and shows that people in struggling relationships are usually effective communicators in their career and social interactions but are less effective when communicating within their relationships.[2] The most common reason for poor communication in struggling relationships is a form of carelessness. The personal relationship is taken for granted and being preoccupied with professional concerns while with a partner is seen as acceptable, sending a message of priority that if sent too often will diminish the quality of the relationship.[6]

Physicians seeking success in both their personal and professional relationships can benefit from the following strategies:

- Be the best you can be. When you are working as a physician, be the best physician you can be. When you are with a partner in your primary relationship, be the best partner you can be.
- Accept that primary means first. If you are in a primary relationship and want to remain there, you will be at peace with this principle.
- Embrace the prime directive: Nobody gets hurt. In spite of periodic disagreements and frustrations, partners in a loving, life-enhancing relationship know that there is a line that does not get crossed. A primary relationship is founded on trust that makes it possible for partners to be unguarded and open with one another, and the prime directive is part of this foundation.
- Listen actively. As a physician, you rely on science-based tools and strategies for the diagnosis and treatment of health problems. As a partner in a primary relationship, you must focus on the communication of perceptions rather than science. Effective listening is important in both professional and personal settings, but in a primary relationship intimacy can only be achieved by actively listening to a partner's unique perception of the situation being discussed.[2]

As a partner in a primary relationship, you must focus on the communication of perceptions rather than science.

Many physicians have the best of both worlds. What such physicians share is a love for both their profession and their partner, and a reliable awareness of how to consciously and consistently protect and nurture both. BCMJ

Competing interests

None declared.

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Measles: Laboratory diagnostics and immunization of older adults

British Columbia had an outbreak of measles in early 2019 resulting in transmission to 10 people, and there continue to be sporadic measles importations. These imported cases have been unvaccinated or undervaccinated individuals returning from travel to countries in Asia. Three common issues with which clinicians should be familiar are outlined below.

What are the recommended diagnostic specimens to collect for measles confirmation?

If you have a patient in whom you suspect measles, the best specimens to collect are for virus detection. Collect a nasopharyngeal or throat swab at the time of clinical presentation and up to 8 days after rash onset using a BCCDC Public Health Laboratory flocked swab (COPAN, red top with universal transport media). If the 8 days have elapsed, a urine specimen can be collected up to 14 days after rash onset in a sterile container. Specimens should be placed on ice and shipped immediately to the BCCDC laboratory for testing. Testing is performed daily with results available by end of day; the medical health officer is notified if the test is positive. Diagnosis by serology is less helpful and is generally discouraged when virologic specimens can be collected. IgM may not be reactive in 20% of cases within 3 days of rash onset or in those who have been previously immunized. Diagnosis by IgG requires both acute and convalescent sera collected 10 to 30 days apart, which therefore delays diagnosis unnecessarily.

Should those who receive MMR vaccine and experience fever and rash be tested for measles?

The measles-mumps-rubella (MMR) vaccine is safe and effective, and most people have no adverse reaction following receipt of this vaccine apart from redness, pain, and swelling at the injection site. A small portion experience events such as malaise, fever, parotitis, rash, lymphadenopathy, or arthralgia around 7 to 10 days (range 5 to 30 days) following the MMR vaccine. These events are more common following the first dose of the vaccine in a nonimmune individual and are self-limited, lasting up to 3 days. These symptoms and signs can resemble those associated with wild type measles, mumps, or rubella infection, and are related to the live attenuated measles, mumps, and rubella vaccine strain viruses that replicate in the human host. About 1% to 10% of vaccine recipients may experience a measles-like rash and/or fever of more than 39 °C, and less than 1% may experience cough and/or conjunctivitis. If a patient presents with measles-like symptoms within 5 to 30 days of receiving an MMR vaccine and does not have a known measles exposure or recent travel history, do not test for measles.

Do people born before 1970 need to be immunized against measles?

Among those born prior to 1970, the older a person is, the less likely they are to be susceptible to measles. Killed measles vaccine came into use in the late 1960s, and live vaccine in 1969. Older individuals are more likely to have immunity due to prior measles infection, while younger individuals born after live measles vaccine came into routine use will need to rely on vaccine-derived immunity.

People born before 1970 are generally considered immune to measles (unless they are health care workers). However, should an individual born prior to 1970 self-identify as susceptible (i.e., "I've never had measles or been vaccinated"), they can be offered 1 dose of MMR vaccine. There is no need for a provider to proactively ask their older patients whether they have had measles infection or otherwise promote measles vaccination for this age group.

BC measles sero-immunity studies using prenatal blood specimens conducted in 1999 indicated that 99% of those born from 1944 to 1956 were immune to measles, and a study conducted in 2010 indicated that 97% of those born from 1960 to 1964 were immune. At a population level, 99% immunity is on par with that achieved from two doses of measles-containing vaccine.

For more information, please refer to www.bccdc.ca and the following pages:

- Communicable Diseases (www.bccdc.ca/health-professionals/data-reports/communicable-diseases)
- *Communicable Disease Control Manual* (www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual), Chapter 1, Communicable Disease Control, Measles; Chapter 2, Immunization
- Global measles activity reported by the World Health Organization (www.who.int/immunization/monitoring_surveillance/burden/vpd/surveillance_type/active/measles_monthlydata/en).

—Monika Naus, MD, MHSc, FRCPC, FACPM
Medical Director, Communicable Diseases and Immunization Service, BCCDC

This article is the opinion of the BC Centre for Disease Control and has not been peer reviewed by the BCMJ *Editorial Board.*

Addiction and psychiatry services for workers with coexisting conditions

Workers with accepted physical injury or mental health claims who present with concurrent substance use may be eligible for a range of psychiatric and addiction services through WorkSafeBC. Family doctors whose patients will benefit from mental health or addiction assessment and treatment can provide this recommendation by contacting their patient's WorkSafeBC case manager or providing a medical history summary and recommendation in your Physician's Report (Form 8/11).

WorkSafeBC's contracted providers deliver a variety of community-based and residential addiction services.

Community services

Community Pain and Addiction Services

These services are provided by physicians who are certified by the American Society of Addiction Medicine, the Canadian Society of Addiction Medicine, or the American Board of Addiction Medicine, or are fellows in addiction medicine. These specialists provide assessments for diagnosing substance-use disorders and may also assess patients with coexisting pain and addiction, complex medication regimes, or those who are demonstrating aberrant behavior. Treatment services are designed to manage and monitor a patient's medication plan and can include tapering and weaning strategies for opioids and sedatives, as well as adjunct medication use. Opioid agonist initiation and maintenance therapy could include methadone or buprenorphine substitution and management. Urine drug screens may be used to monitor the effectiveness of the medication plan, and progress reports will be provided to the patient's attending physician.

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

WorkSafeBC's contracted providers deliver a variety of community-based and residential addiction services.

Intensive Outpatient Program

Counselors in the Intensive Outpatient Program provide one-on-one supportive counseling or group treatments over a 12-week period for patients with a mild to moderate substance-use disorder who would benefit from staying at work or who have recently completed an inpatient residential addiction program. For 2 hours per day, 4 days per week, the program includes group meetings, random drug and alcohol screening, and aftercare.

Concurrent Care Program

For patients with concurrent mental health and addiction issues, addiction psychiatrists, psychologists, and clinical counselors in the Concurrent Care Program address the patient's complex needs with an interdisciplinary approach. This approach includes individual and group sessions, education classes, cognitive behavioral therapy, dialectical behavioral therapy, mindfulness-based relapse prevention, motivational enhancement therapy, and family support. The treatment goal is to stabilize the patient's mental health and substance use with biopsychosocial treatment.

Residential services

Residential Addiction Services

The interdisciplinary team in Residential Addiction Services employs a biopsychosocial model to treat patients with alcohol and drug addictions on an inpatient basis, providing medically supervised abstinence-based interdisciplinary programs. Where clinically appropriate, residential programs provide supportive medication-assisted treatment to promote recovery from opioid addiction, which can include the use of naltrexone or buprenorphine. Services include detox, behavioral therapy, individual and group sessions, anger management, and individualized care.

Residential Trauma and Addiction Services

Where posttraumatic stress disorder (PTSD) is an accepted condition, or is determined to be a result of the patient's work-related physical or mental trauma, the interdisciplinary team in Residential Trauma and Addiction Services provides intensive integrated treatment for concurrent PTSD and addiction. This residential service provides a medically supervised abstinence-based interdisciplinary program using a biopsychosocial model. Trauma-specific components (in addition to substance-abuse treatment) include stabilization grounding techniques and self-regulation, specialized trauma-focused groups including psycho-education, coping strategies, and cognitive processing therapy, and in vivo exposure and behavioral activation.

WorkSafeBC will soon be contracting with a provider to deliver an intensive residential mental health program for patients with primary

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mood and anxiety disorders, PTSD, or substance use.

Support recovery services and relapse prevention

Support Recovery Services

To facilitate recovery and allow for community reintegration, Support Recovery Services provides a safe, supportive, and stable temporary environment to facilitate recovery. This service solidifies relapse-prevention skills while recovering patients are living in a safe setting.

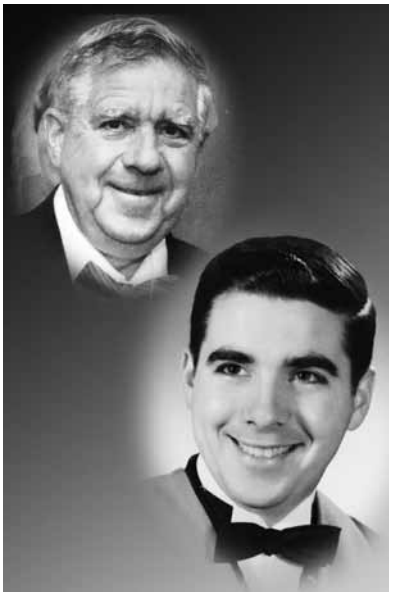
Relapse Prevention Medical Monitoring Services

Coming soon, WorkSafeBC will be contracting with a provider for Relapse Prevention Medical Monitoring Services. These services are designed to ensure compliance with a patient's customized relapse-prevention agreement while under clinical supervision. Medical monitoring will include random biological testing, regular PharmaNet reviews, and ongoing accountability sessions to ensure engagement in recovery activities.

For further information or assistance regarding a worker's mental health condition or substance-use issues, contact either a medical advisor in your local WorkSafeBC office, or the claim manager for your patient, or make the request on your Form 8/11. You can also call the new WorkSafeBC physician hotline (1 855 476-3049), which is available to external prescribers who have patients with active WorkSafeBC claims. The hotline is staffed by in-house and external medical experts in addiction who can provide counseling in management of opioids, tapering, nonpharmaceutical strategies, harm reduction programs, community resources, and referrals. It is open weekdays from 8:30 a.m. to 4:30 p.m.

—Michelle Tan, MD, CCFP
Medical Advisor, Health Care Programs, WorkSafeBC

obituaries



Dr Addie Charles McGregor Ennals 1937–2019

It is with sadness that we announce the passing of Dr Addie Charles McGregor Ennals (Charles). Born in the King's Daughters' Hospital in Duncan on 13 June 1937, he passed away from postoperative complications following emergency surgery in Nanaimo.

After graduating from Cowichan Secondary School, Charles entered Victoria College and was then admitted to the UBC Faculty of Medicine, graduating in 1962. The inaugural issue of the *UBC Medical Journal* was printed in that year, highlighted by a comprehensive eight-page article written by this fourth-year student, titled "Trends in BC medical care." How prophetic was his vision! This was an evolving but tumultuous time in Canadian medicine, and Charles indeed contributed to its successful transition. He practised family medicine for 40 years, predominantly in Cowichan, where he quickly gained respect from his colleagues and was elected to the position of president of the medical staff at Cowichan District Hospital from 1974 to 1977. During that time a gradual transformation to a regional referral centre took place under his diplomatic and able hand.

When medical care insurance was established in BC, the BCMA was very much involved in setting up the honor system of billings that is the mainstay of our system today. Charles was astutely appointed to the Patterns of Practice Committee, which he chaired from 1971 to 1987. He then represented the BCMA on the Medical Advisory Committee and Audit Inspection Committees of MSP until 2005. For his many contributions, he was deservedly awarded an honorary membership in the CMA in 2006.

Charles was active in politics as well, first as vice president and treasurer of the BC Social Credit Party from 1969 to 1970, and as a candidate for the provincial legislature in four elections. He was also a member of the Malaspina University-College Board, and chair from 1990–92. For 33 years Charles was also a member of the Zenith Gyro Club of Duncan.

Retirement for Charles and Jill (his bride for 48 years) led them back to Jill's family homestead farm at Craig Bay in Parksville where they became active at growing produce, selling vegetables and eggs, and interacting with their market clients. Charles dreamed of playing the bagpipes again, but his wind was just not sufficient. Perhaps there will be a skirl of the pipes heard where this fine man now rests.

—Jill Ennals, RN
Nanoose Bay
—Donald R. Hilton, MD, FRCPC
Chemainus

CME listings rates and details

Rates: $75 for up to 1000 characters (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.

Place your ad at www.bcmj.org/cme-advertising. You will be invoiced upon publication. Payment is accepted by Visa or MasterCard on our secure online payment site.

Planning your CME listing: Planning to advertise your CME event several months in advance can help improve attendance. Members need several weeks to plan to attend; we suggest that your ad be posted 2 to 4 months prior to the event.

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GP IN ONCOLOGY TRAINING
Vancouver, 9–20 Sep and 3–14 Feb 2020 (Mon–Fri)
The BC Cancer'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 30 days 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.

ST. PAUL'S EMERGENCY MEDICINE UPDATE
Whistler, 26–29 Sep (Thu–Sun)
Join us for the 17th Annual St. Paul's Conference. Four exciting days of learning, networking, and, of course, recreation! We had over 300 attendees last year. Don't miss out! Preconference workshops: CASTED, HOUSE EM, CAEP AIME. Target audience: Any physician providing emergency care, emergency nurses, paramedics. Keynotes: Best Literature of the Past Year (Dr Grant Innes, Dept. of Emergency Medicine, University of Calgary); Sub-Arachnoid Hemorrhage—What the ED Doc of 2019 Needs to Know (Dr Jeff Perry, Dept. of Emergency Medicine The Ottawa Hospital); Gender and Medicine in 2019—Where Are We? Where Can We Go? How Can We Get There? (Dr Carolyn Snider, St. Michael's Hospital, Toronto); Managing Stress in a High Risk Environment (Mr Will Gadd, gold medalist, X-Games). Conference details and registration: https://ubccpd.ca/course/sphemerg-2019. Phone: 604 675-3777; fax: 604 675-3778; e-mail: cpd.info@ubc.ca. Accommodation: http://bit.ly/sph2019reservations.

BLENDED LEARNING COURSE IN OCCUPATIONAL MEDICINE
videoconferences & workshops, Sep–Jun
The Foundation Course in Occupational Medicine, developed by the University of Alberta's Division of Preventive Medicine, is a blended learning course designed to provide knowledge and skills in the areas of occupational medicine encountered in family medicine and other community-based clinical practice. The program is presented as eight modules, each supplemented by monthly tutorials via videoconference. Two face-to-face workshops are planned to be held at Vancouver General Hospital. To be eligible to participate in the course, you must be a physician licensed to practise in Canada. This group learning program has been certified by the College of Family Physicians of Canada for up to 111 Mainpro+ credits. Registration is now open. For more information please visit our website at www.foundationcourse.ualberta.ca, or email us at omcourse@ualberta.ca.

Improving care for patients with obesity by recognizing weight bias

Ask yourself what you think when you see a person with obesity: healthy, active, motivated? For many people these are not the words that come to mind.

Despite societal progress toward reducing discrimination on the basis of race, gender, disability, and sexual preference, bias related to weight remains common, unchecked, and in many cases, institutionalized. Many people continue to hold feelings of disapproval toward people with obesity, leading to unfair judgment and discrimination. Weight bias is largely based on inaccurate assumptions. The most common and important assumption is that obesity is a completely modifiable condition that an individual can voluntarily control by exercising more and eating less. Despite the lack of any evidence, this belief is prevalent even within the medical profession.

Obesity is an extremely complex condition resulting from many factors. Genetics, epigenetics, adverse childhood experiences, and cultural, environmental, emotional, and physiological determinants all contribute to weight. Attempting to alter only diet and exercise rarely results in sustainable weight reduction.[1]

As physicians, our biases can negatively influence the treatment of patients with obesity.[2] It is important to recognize that although obesity can be associated with a number of medical conditions, many people with obesity are physically fit and metabolically healthy.[3]

We often assume that a person with obesity is inactive, eats poorly, or does not care about their health. Many also assume that all people with obesity want to lose weight and need to be encouraged to do so regularly. Further, physicians often incorrectly attribute patients' health concerns to their weight, implying that their problems would be resolved if they lost weight, despite many weight-associated conditions also being common in normal-weight individuals.

"I have avoided going to a doctor at all. That is very common with fat people. No matter what the problem is, the doctor will blame it on fat and will tell you to lose weight. . . Do you think I don't know I am fat?"

When we default to weight-loss advice and label patients as noncompliant, we neglect to offer alternative, more realistic recommendations. This leads to patients feeling frustrated, can perpetuate feelings of failure and low self-esteem, and can exacerbate mental health problems.

Some patients may actually stop seeking care entirely. The author of the novel *Dietland*, Sarai Walker, says, "I have avoided going to a doctor at all. That is very common with fat people. No matter what the problem is, the doctor will blame it on fat and will tell you to lose weight. . . Do you think I don't know I am fat?"[4]

As physicians who pride ourselves on professionalism and evidence-based practice, we need to become more aware of our assumptions and their consequences.[5] Before discussing the topic of weight, we should request permission and agree on a plan based on the patient's values and goals, which may not involve weight loss. An individual's best weight may not align with the traditionally accepted ideal BMI. Focusing on a healthy lifestyle rather than weight is often just as effective in addressing health problems such as hypertension, osteoarthritis, and diabetes. It also avoids adding the credible voice of physicians to the powerful societal pressures leading patients to desperate and sometimes dangerous attempts at weight loss.

Physicians should provide a supportive and sensitive environment to prevent patients with obesity from feeling humiliated or unwelcome. The practice of routinely weighing all patients should be re-examined. Chairs, scales, gowns, and blood-pressure cuffs should be available for patients of all sizes. We must believe our patients when they say they have tried to lose weight. We can remind them that obesity, like most medical conditions, is not their fault, and they should not be blamed any more than those with other diseases like Alzheimer disease or cancer. Obesity is not a choice; if it were, most people would probably not choose it.

Obesity Canada has many excellent resources to assist physicians in learning more about weight bias and providing high-quality health care for patients with obesity.[6]

—Ilona Hale, MD

This article is the opinion of the Nutrition Committee, a subcommittee of Doctors of BC's Council on Health Promotion, and is not necessarily the opinion of Doctors of BC. This article has not been peer reviewed by the BCMJ *Editorial Board.*

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Supporting team-based care in family practice: Incentive fees, education, and resources

The GPSC is working with its partners—including family doctors, local divisions, and health authorities—to transform primary care in BC by creating patient medical homes and primary care networks. The goal is to enable access to quality primary health care that effectively meets the needs of patients and populations in BC.

Patient medical homes (with family physicians at the centre) form the foundation for primary care networks, which bring together services and organizations to better coordinate care for patients. Team-based care is the overarching principle of this work. When GPs work in teams—whether those teams are located in their family practice or in the community and linked to the practice—this care model can broaden the availability of clinical supports for patients.

Working in teams benefits family physicians in a number of ways. Teams enable doctors to:

- Distribute responsibilities.
- Focus on chronic and preventive patient care needs.
- Streamline patient referral and patient care processes.
- Ensure patients have timely access to a primary care provider.
- Decrease the burden of caring for patients alone.
- Attract locums and new GPs to their practice and community.

When doctors share responsibility for patient care with a team of care providers, patients benefit as well through timely access to a primary care provider and continuous, coordinated care.

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

Table 1. Team-based care incentive fees.

Fee name	Fee code	Value
GP Patient Telephone Management Fee	G14076	$20
GP Email/Text/Telephone Medical Advice Relay Fee	G14078	$7
GP Complex Care Planning & Management Fee	G14033	$315
GP Frailty Complex Care Planning & Management Fee	G14075	$315
GP Mental Health Planning Fee	G14043	$100
GP Palliative Care Planning Fee	G14063	$100
GP Allied Care Provider Conferencing Fee	G14077	$40
Allied Care Provider Practice Code	G14029	$0

Table 2. The PSP's seven-part team-based care learning series.

1. Foundations: Introducing team-based care and interprofessional competencies, role clarification, and medico-legal liability.
2. Patient-Centred Care: Developing a team that enhances quality patient care.
3. Interprofessional Communication: Understanding individual styles and building effective interprofessional communication.
4. Team Functioning: Developing strategies and mechanisms to work together.
5. Interprofessional Conflict Management: Understanding and resolving interprofessional conflict.
6. Collaborative Leadership: Understanding characteristics, mechanisms, and benefits of collaborative leadership.
7. TBC Practice Approach: Integrating content to support the development of a TBC approach for a practice team.

The GPSC supports GPs to work in teams in their practices through incentive fees, education and training, and the GPSC Team-Based Care Reference Guide.

Incentive fees

The GPSC offers family doctors eight incentives (**Table 1**) that enable them to delegate certain tasks to team members in their practice. To qualify, the team members can be employed in the practice or work in the practice with their salary paid directly or indirectly by a third party. For more information on team-based care incentive fees, doctors can visit www.gpscbc.ca or email gpsc.billing@doctorsofbc.ca.

Education and training

To help doctors enhance patient care by working in primary care teams, the Practice Support Program (PSP) offers a seven-part learning series (**Table 2**), supported by in-practice facilitation.

No matter the type or size of team, these sessions can help develop key competencies for building successful team-based care in practice.

Practice teams are encouraged to participate in sessions together. The Foundations session is open to all interested doctors and team members and is a prerequisite for the next six sessions. Subsequent sessions are available to practices currently working in teams

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gpsc

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or those in the process of implementing a team into the practice.

This three-credit-per-hour group learning program has been certified by the College of Family Physicians of Canada for up to 48 Mainpro+ credits. The program consists of in-person learning sessions, action planning, and integrated learning packages.

The program is designed to be adaptable, flexible, and streamlined. Sessions are 2.5 hours long and can be tailored to reflect physicians' practice needs. Physicians are encouraged to include all members of their practice team, and sessions are kept focused and interactive by including a maximum of 20 participants.

Once doctors and their team members complete the program, in-practice coaching and support is provided to help them implement what they have learned.

For more information, doctors are encouraged to contact their PSP Regional Support Team, or email psp@doctorsofbc.ca.

GPSC Team-Based Care Reference Guide

The GPSC has curated a list of links to tools and resources that support doctors to develop and lead practice teams, including templates, sample documents, and planning guides. These resources are made available by the GPSC (Practice Support Program and Divisions of Family Practice), the Ministry of Health, and stakeholder organizations.

Resources are categorized as follows:

- Practice management (compensation, job descriptions samples, practice tools, privacy and legal, and patient medical record).
- In-practice coaching and education.
- Frameworks.
- Patient engagement.

For more information about these team-based care supports, email gpsc@doctorsofbc.ca.

—Alana Godin, Director, Community Practice and Quality, Community Practice, Quality and Integration

cohp

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—Paula Osachoff, Librarian

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The *British Columbia Medical Journal* is a general medical journal that seeks to continue the education of physicians through review articles, scientific research, and updates on contemporary clinical practices while providing a forum for medical debate. Several times a year, the *BCMJ* presents a theme issue devoted to a particular discipline or disease entity.

We welcome letters, blog posts, articles, and scientific papers from physicians in British Columbia and elsewhere. Manuscripts should not have been submitted to any other publication. Articles are subject to copyediting and editorial revisions, but authors remain responsible for statements in the work, including editorial changes; for accuracy of references; and for obtaining permissions. The corresponding author of scientific articles will be asked to check page proofs for accuracy.

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Letters to the editor, articles, and scientific papers must be reviewed and accepted by the *BCMJ's* eight-member Editorial Board prior to publication. The Board normally meets the last Friday of every month, at which time submissions are distributed for review the following month. We do not acknowledge receipt of submissions; the editor will contact authors of articles by e-mail once the submission has been reviewed by the Board (usually within 8 to 10 weeks of submission). The general criteria for acceptance include accuracy, relevance to practising BC physicians, validity, originality, and clarity. The editor contacts authors to inform them whether the paper has been rejected, conditionally accepted (that is, accepted with revisions), or accepted as submitted. Authors of letters are contacted only if the letter is accepted and editorial staff need further information. Scientific papers and other articles typically take 5 to 10 months from the date of receipt to publication, depending on how quickly authors provide revisions and on the backlog of papers scheduled for publication. Manuscripts are returned only on request. The *BCMJ* is posted for free access on our web site.

FOR ALL SUBMISSIONS

- ☐ Avoid unnecessary formatting, as we strip all formatting from manuscripts.
- ☐ Double-space all parts of all submissions.
- ☐ Include your name, relevant degrees, e-mail address, and phone number.
- ☐ Number all pages consecutively.

Opinions

BCMD2B (medical student page). An article on any medicine-related topic by a BC physician-in-training. Less than 2000 words. The *BCMJ* also welcomes student submissions of letters and scientific/clinical articles. BCMD2B and student-written clinical articles are eligible for an annual $1000 medical student writing prize.

Blog. A short, timely piece for online publication on bcmj.org. Less than 500 words. Submissions on any health-related topic will be considered. Should be current, contain links to related and source content, and be written in a conversational tone.

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- ☐ All authors' professional/institutional affiliations, sufficient to provide the basis for an author note such as: "Dr Smith is an associate professor in the Department of Obstetrics and Gynaecology at the University of British Columbia and a staff gynecologist at Vancouver Hospital."
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Survey studies must have a response rate of at least 50% in order for the paper to be reviewed for publication consideration. Papers with less than this response rate will not be reviewed by the *BCMJ* Editorial Board. We recognize that it is not always possible to achieve this rate, so you may ask the Editor in advance to waive this rule, and if the circumstances warrant it, the Editor may agree to have the paper reviewed.

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- ☐ Drafted the article or revised it critically for important intellectual content, and
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Try to keep references to fewer than 30. Authors are responsible for reference accuracy. References must be numbered consecutively in the order in which they appear in the text. Avoid using auto-numbering as this can cause problems during production.

Include all relevant details regarding publication, including correct abbreviation of journal titles, as in *Index Medicus;* year, volume number, and inclusive page numbers; full names and locations of book publishers; inclusive page numbers of relevant source material; full web address of the document, not just to host page, and date the page was accessed. Examples:

1. Gilsanz V, Gibbons DT, Roe TF, et al. Vertebral bone density in children: Effect of puberty. Radiology 2007;166:847-850.

(NB: List up to four authors or editors; for five and more, list first three and use et al.)

2. Mollison PL. Blood Transfusion in Clinical Medicine. Oxford, UK: Blackwell Scientific Publications; 2004. p. 78-80.
3. O'Reilly RA. Vitamin K antagonists. In: Colman RW, Hirsh J, Marder VJ, et al. (eds). Hemostasis and Thrombosis. Philadelphia, PA: JB Lippincott Co; 2005. p. 1367-1372.
4. Health Canada. Canadian STD Guidelines, 2007. Accessed 15 July 2008. www.hc-sc.gc.ca/hpb/lcdc/publicat/std98/index.html.

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A book cited in full, without page number citations, should be listed separately under Additional or Suggested reading. Such a list should contain no more than five items.

References to unpublished material

These may include articles that have been read at a meeting or symposium but have not been published, or material accepted for publication but not yet published (in press). Examples:

1. Maurice WL, Sheps SB, Schechter MT. Sexual activity with patients: A survey of BC physicians. Presented at the 52nd Annual Meeting of the Canadian Psychiatric Association, Winnipeg, MB, 5 October 2008.
2. Kim-Sing C, Kutynec C, Harris S, et al. Breast cancer and risk reduction: Diet, physical activity, and chemoprevention. CMAJ. In press.

Personal communications are not included in the reference list, but may be cited in the text, with type of communication (oral or written) communicant's full name, affiliation, and date (e.g., oral communication with H.E. Marmon, director, BC Centre for Disease Control, 12 November 2007).

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Should possible scientific misconduct or dishonesty in research submitted for review by the *BCMJ* be suspected or alleged, we reserve the right to forward any submitted manuscript to the sponsoring or funding institution or other appropriate authority for investigation. We recognize our responsibility to ensure that the question is appropriately pursued, but do not undertake the actual investigation or make determinations of misconduct.

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Tables and figures should supplement the text, not duplicate it. Keep length and number of tables and figures to a minimum. Include a descriptive title and units of measure for each table and figure. Obtain permission and acknowledge the source fully if you use data or figures from another published or unpublished source.

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- ☐ Place explanatory matter in footnotes, not in the heading.
- ☐ Explain all nonstandard abbreviations in footnotes.
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- ☐ Ensure each figure is cited in the text.
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Units

Report measurements of length, height, weight, and volume in metric units. Give temperatures in degrees Celsius and blood pressures in millimetres of mercury. Report hematologic and clinical chemistry measurements in the metric system according to the International System of Units (SI).

Abbreviations

Except for units of measure, we discourage abbreviations. However, if a small number are necessary, use standard abbreviations only, preceded by the full name at first mention, e.g., in vitro fertilization (IVF). Avoid abbreviations in the title and abstract.

Drug names

Use generic drug names. Use lowercase for generic names, uppercase for brand names, e.g., venlafaxine hydrochloride (Effexor). Drugs not yet available in Canada should be so noted.

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2018 J.H. MacDermot writing award winner

The *BCMJ* is pleased to present Dr Heather E. Cadenhead with the J.H. MacDermot Prize for Excellence in Medical Journalism (2018) and the associated $1000 award. Dr Cadenhead's article, "Sport-related ocular trauma in Vancouver, British Columbia: Not the usual suspects," was selected as the winner for this prize from all 2018 published medical-student articles. Dr Cadenhead graduated from UBC Medical School and has started her residency in anesthesia at UBC. Though her winning article is in the area of ophthalmology, she had a last-minute change of career choice and was drawn to anesthesia. She is looking forward to submitting anesthesia-related articles in the future.

BC medical students are encouraged to submit full-length scientific articles and essays for publication consideration. Each year the *BCMJ* awards a prize of $1000 for the best article or essay written by a medical student in the province of British Columbia.

Erratum: Hall of Honour

In the news item, "Vancouver Medical Staff Hall of Honour 2019 Inductees," published in the May 2019 issue, Drs Allison Harris, Silvia Chang, and Brenda Kosaka were incorrectly given the title "Ms." Dr Maria Chung was incorrectly listed as "Marie."

Improving accuracy, sensitivity, and localization of radiation

Researchers have developed a system they say may improve the ability to maximize radiation doses to cancer tissues while minimizing exposure to healthy ones. This new system, described in a study from UBC Okanagan and Duke University, may lead to improvements in dose accuracy, sensitivity, and localization during therapy.

Andrew Jirasek, UBC Okanagan physics professor and senior author of the study, explains that the solution is to make it easier to see exactly which tissues are getting a radiation dose and how much. The new system uses a specialized polymer gel to assess both the 3D location and the treatment dose. The team's first step was to validate the spatial accuracy of the gel, known as a dosimeter. They compared the dosimeter readings with traditional radiation treatment–planning algorithms and found that the gel dosimeter was accurate in mapping the spatial location of the delivered radiation. Measurements of the radiation dose were also validated and visualized with the dosimeter. The new system also allows for direct visualization of the radiation dose immediately after therapy, which results in efficient and accurate testing.

Jirasek worked with colleagues from Duke University to take advantage of positioning systems already in place on most linear accelerators that deliver a radiation beam to the patient, which allowed for a new adjustment to be implemented without significant changes to the equipment. Next steps are to improve the process so it can move into the clinic setting.

The research was published in the *International Journal of Radiation Oncology, Biology, and Physics*. The article, "Delivered dose distribution visualized directly with onboard kV-CBCT: Proof of principle," is available at www.redjournal.org/article/S0360-3016(18)34189-0/fulltext.

Promise of novel radiation treatment for metastatic cancer patients

A study co-led by BC Cancer researchers has found that the use of stereotactic ablative radiotherapy (SABR) technology may improve survival rates for patients with limited metastatic cancer. The findings are the result of the world's first randomized clinical trial of SABR as it relates to cancer that has already spread to other parts of the body. SABR technology is a highly precise form of radiotherapy where much higher doses of radiation can be safely delivered to tumors over a shorter time period. The technology features advanced machines with built-in CT scans that can sculpt the dose of radiation to tumors from multiple angles while reducing the dose to healthy nearby tissue.

Until now, there was not much evidence to support the claim that patients with a small number of additional tumors could be cured of the disease once all growths are killed with radiation. The SABR-COMET trial aimed to assess the effect of SABR on survival, outcomes, toxicity, and quality of life in patients with a controlled primary tumor and one to five additional tumors.

During the randomized trial, which took place over 4 years at 10 centres worldwide (including all six BC Cancer centres), the patient group who was treated with SABR technology saw an overall improvement in survival. However, there is a possibility of serious side effects, so future research is needed to confirm its efficacy.

Phase III trials are needed to conclusively show an overall survival benefit and to determine the number of metastatic tumors that could benefit from SABR treatment.

The study was led at BC Cancer

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by Dr Robert Olson, radiation oncologist, along with an international team of researchers. The results will open the door for patients in the upcoming trial, titled SABR-COMET-3, a Phase III randomized controlled trial for patients across the province with one to three metastatic tumors; that trial is being led by Dr Olson from BC Cancer, Prince George.

The article, "Stereotactic ablative radiotherapy versus standard of care palliative treatment in patients with oligometastatic cancers (SABR-COMET): A randomised, phase 2, open-label trial," was published in *The Lancet*. It is available at www.thelancet.com/journals/lancet/article/PIIS0140-6736%2818%2932487-5/fulltext.

Are Canadians in the dark about potential drug safety risks?

Government warnings about potential drug safety risks vary significantly across countries, according to a new international study coauthored by researchers at the University of British Columbia.

In a study published in *JAMA Internal Medicine*, researchers analyzed how often drug regulators in Canada, the US, the UK, and Australia issued safety advisories about the potential health risks of medications. After analyzing 1441 advisories over a 10-year period, covering 680 drug-safety concerns, researchers found that regulators in the four countries were only consistent in the decision to warn the public in their own country 10% of the time. Between 2007 and 2016, Health Canada issued safety warnings for only 50% of the drug safety issues identified by regulators in Australia, the US, and UK.

The study's primary investigator, Barbara Mintzes, affiliate associate professor at UBC's School of Population and Public Health and associate professor at the University of Sydney in Australia, finds it concerning that there is so little consistency between countries regarding how they communicated emerging health risks of medicines.

Before new medicines hit the market, each country's regulator approves them for use often based on limited safety evidence collected during clinical development. However, once a drug enters general use, other safety issues can become apparent including rarer or longer-term effects—prompting regulators to issue safety advisories on how to avoid these risks. For example, in January 2013, Health Canada issued a warning that statins were associated with a "risk of increased blood sugar levels and a small increased risk of diabetes among patients already at risk for the disease." Regulatory warnings about this risk appeared almost a year earlier in the US and Australia.

Adverse drug reactions are estimated to account for up to two-thirds of drug-related emergency department visits and hospital admissions, according to the Canadian Institute for Health Information. More information is available at www.med.ubc.ca/news/are-canadians-kept-in-the-dark-about-potential-drug-safety-risks.

Emergency room patients' acuity levels not always considered when within wait time targets

New research from the UBC Sauder School of Business reveals that Metro Vancouver emergency patient acuity levels sometimes come second to wait time targets, largely due to doctors being unclear on existing emergency room prioritization guidelines. The study found that patient acuity levels are considered more seriously once wait time targets have passed.

The study is the first of its kind to statistically analyze doctor decision making in the emergency room and the impacts it can potentially have. Through an analysis of more than 186 000 emergency department admissions between April 2013 and November 2014 in the four largest emergency departments in Metro Vancouver, the researchers modeled how decision-makers chose which patient was seen by the next available physician.

Metro Vancouver emergency departments currently use the Canadian Triage and Acuity Scale (CTAS) to classify patients into priority levels. While each level, ranging from one to five (most acute/serious to least acute/serious) has a suggested wait time for patients, it can still be difficult for ED physicians to decide who should be seen next.

Researchers found that once triage level-2 patients waited beyond 13.3 minutes and triage level-3 patients waited beyond 18.9 minutes, physicians put more consideration on other attributes, such as acuity level, chief complaint system, age, and so on, rather than waiting time.

The study's authors suggest future policy revision should call for detailed guidelines on how wait times can be weighed against the patient's acuity level, rather than simple targets based on wait times.

The article, "Patient prioritization in emergency department triage systems: An empirical study of Canadian Triage and Acuity Scale (CTAS)," was published in the journal *Manufacturing & Service Operations Management*.

Ketamine alleviates acute pain during ambulance rides

In December 2015 Dr Gary Andolfatto had a biking accident, broke his femur, and dragged himself for almost 4 hours until he found a park ranger who called an ambulance. In a great deal of pain, the emergency physician was shocked to find that nitrous oxide was the only option. The attending primary care paramedic was frustrated too, explaining that it was par-

Dr Gary Andolfatto believes that primary care paramedics in BC should be permitted to administer ketamine.

ticularly difficult during hours-long transports in rural areas.

Dr Andolfatto, a clinical assistant professor in the Department of Emergency Medicine in the UBC Faculty of Medicine and researcher with the Vancouver Coastal Health Research Institute, embarked on a research study to find a solution. His findings were published recently in the *Annals of Emergency Medicine*. In the study, Dr Andolfatto and his colleagues found that when ketamine is added to nitrous oxide and administered as a nose spray, it provides clinically significant pain reduction and improved comfort.

Between November 2017 and May 2018, 120 patients suffering with acute pain were given nitrous oxide, per existing paramedic protocols. Half of the 120 patients also randomly received intranasal ketamine and half received the placebo, a saline solution. Neither the paramedic nor the patient was told which had been administered. Individuals who received ketamine along with the nitrous oxide experienced a clinically significant reduction in pain at 15 minutes and 30 minutes after administration. Comfort was most pronounced at 15 minutes. While the majority of patients reported mild dizziness and a feeling of unreality, their levels of satisfaction were higher than those who received the placebo.

Dr Andolfatto wants to see primary care paramedics throughout the province permitted to use ketamine, a controlled substance. Advanced and critical care paramedics have more training and therefore more pain-alleviating options, including the use of ketamine, but of the more than 4000 paramedics in BC, 70% are primary care paramedics.

Ketamine is the most commonly used anesthetic worldwide because it doesn't hamper breathing. It has previously gained notoriety for being an animal tranquilizer popular with ravers. "With low-dose ketamine, says Dr Andolfatto, "there is no risk of serious harm, the technology is simple and cheap, and the level of training is negligible. There are many reasons why it makes sense for this to be used more widely in an ambulance setting."

No benefits to eating placenta

Eating the placenta provides no mental health benefits for new mothers, suggests new research from the BC Mental Health and Substance Use Services Research Institute and the University of British Columbia. The study, published in the *Journal of Obstetrics and Gynaecology Canada*, is the largest so far to look at the effects of eating one's placenta—a practice known as placentophagy. Researchers used data from a 10-year genetic study involving 138 women with a history of mood disorders, and compared outcomes of those who had eaten their placenta to those who had not.

Eating one's placenta following childbirth is a growing trend, with celebrities claiming that the practice provided them with health benefits, including preventing postpartum depression. However, previous studies have shown that consuming the human placenta poses risks for mothers and their babies, including viral and bacterial infections.

The study also showed that women who consumed their placentas did not have more energy, had no increase in their vitamin B12 levels, and required no less lactation assistance than women who did not consume their placentas. More information is available at https://news.ubc.ca/2019/05/02/new-research-suggests-no-mental-health-benefits-to-eating-your-placenta.

New method of HIV transmission and effective prevention technique

New studies from Lawson Health Research Institute and Western University have found for the first time that HIV can be transmitted through the sharing of equipment used to prepare drugs before injection and that a simple intervention—heating the equipment with a cigarette lighter for 10 seconds—can destroy the virus, preventing that transmission. The findings, used to inform a public health campaign called Cook Your Wash, have helped reduce rates of HIV transmission in London, Ontario.

The two studies published in the Journal of Acquired *Immune Deficiency Syndromes* were initiated in 2016 to address a public health emergency in London, Ontario, when HIV rates among injection drug users more than doubled. The outbreak occurred despite London having Canada's largest per capita sterile needle and syringe distribution program, a strong opiate substitution therapy program, and a multidisciplinary HIV clinic, so researchers knew there must be a novel method of HIV transmission at play.

From August 2016 to June 2017, the research team interviewed 119 injection drug users to understand their injection behaviors and risk for HIV. They discovered that those who shared equipment used to prepare drugs for injection were 22 times more likely to contract HIV than

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those who did not, despite not sharing needles or syringes.

The equipment includes a metal cooker used to dissolve drugs in water and a filter used to draw the mixture, known as the wash, into the syringe. Injection drug users reported reusing the equipment when consuming controlled-release hydromorphone, one of the most commonly injected opioids.

Controlled-release hydromorphone is expensive and difficult to dissolve. After the first wash, large amounts of the drug remain in the equipment which is then saved, shared, or sold for future use. While people know not to share needles, some use their own needle multiple times, allowing for contamination of the equipment.

The team took their findings back to the research laboratory and confirmed that, on average, 45% of the drug remains in the equipment after the first wash and that HIV can be transmitted between needles, cookers, and filters. They also discovered that controlled-release hydromorphone has properties that promote survival of the virus. However, when the cooker is heated with a cigarette lighter for approximately 10 seconds, or until the wash bubbles, the virus is destroyed. Heating the cooker did not impact drug concentration. They termed the technique "cook your wash."

After running a Cook Your Wash public health campaign with local community groups, local rates of new HIV cases fell dramatically. While the researchers acknowledge that the campaign wasn't the sole reason for the reduction in HIV rates as other interventions were also introduced, the timing suggests it was part of the solution.

The studies build on previous research that shows sharing equipment can lead to the transmission of hepatitis C, and controlled-release hydromorphone can promote the survival of bacteria that can cause endocarditis.

Celebrating the work of BC's family doctors

This year, BC Family Doctor Day is 19 May, a day when the BC College of Family Physicians recognizes and celebrates the important work of the more than 6000 family doctors who practise in communities across the province. Whether in hospitals, other health care facilities, patients' homes, or community-based doctors' offices or clinics, family doctors are experts in diagnosing and treating the whole person, and are often a patient's first point of contact with the health care system. In recognition, the BCCFP's annual awards include five patient-nominated My Family Doctor awards, honoring recipients from each of BC's health regions, as well as peer-nominated awards for family doctors and family medicine residents. The BCCFP award recipients for 2019 are:

BC Family Physician of the Year: Dr Catherine Textor, Prince George

First Five Years of Practice Award: Dr Aryn Khan, Vanderhoof

Small Changes, Big Difference Award: Opioid Agonist Treatment (OAT) Force—an initiative of the Surrey–North Delta Division of Family Practice

My Family Doctor Award:
- Dr Elizabeth Payne, Port Coquitlam
- Dr Steven Broadbent, Kamloops
- Dr Christopher Collins, Nanaimo
- Dr Marlowe Haskins, Smithers
- Dr Margo Sweeny, Vancouver

Resident Leadership Award: Dr Saima Ali

Dr Manoo and Jean Gurjar Award, BCCFP Family Medicine Resident Scholarship:
- Dr Natalie Chan
- Dr Vincent Wong

For more information about the award recipients, visit https://bccfp.bc.ca/bccfp-awards/2019-award-recipients. To learn more about BC Family Doctor Day, visit https://bccfp.bc.ca/news/bc-family-doctor-day.

Lab offers e-check-in for patients

LifeLabs has introduced an electronic service that lets patients skip the line by virtually checking into a queue at a LifeLabs patient service centre. Available for BC, Ontario, and Saskatchewan, the service can be accessed on the LifeLabs website or through an app downloaded from the App Store or Google Play website. To learn more, visit www.lifelabs.com/save-my-spot.

Rural citizens: What are your care planning priorities?

The Rural Evidence Review project's goal is to work with rural citizens and communities to provide high-quality, useful evidence for rural care planning in BC. The project team at UBC is conducting a survey that is voluntary and anonymous. In most cases it will take 10 minutes to complete. To learn more or to take the survey, go to https://ubc.ca1.qualtrics.com/jfe/form/SV_77zOjfWWBNV3wax.

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employment

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KELOWNA—FLEXIBLE S/L-TERM LOCUM
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NANAIMO—GP
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NEW WEST—ROYAL CITY MEDICAL CLINIC: LOCUM, WALK-IN, FT FAMILY PRACTICE
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cian. Relocation incentives, insurance benefits available for the right candidate. Locums and walk-in shifts also available at a competitive overhead. Please contact Richard at rw@bc-drug.com or visit www.elicare.ca.

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SICAMOUS—SPACE AVAIL PRIVATE MEDICAL CLINIC/PHARMACY
Private medical clinic/pharmacy in a family-orientated community. Community seeking general physicians. Currently available: 1500 sq. ft. in a shopping plaza next to Interior Health Community Services. Recently used as a dental practice, would make an ideal family medical practice. Check our website for current updates: www.parklandsicamous.com.

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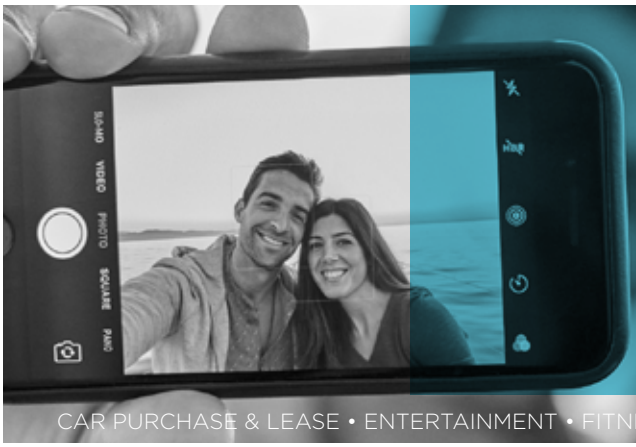

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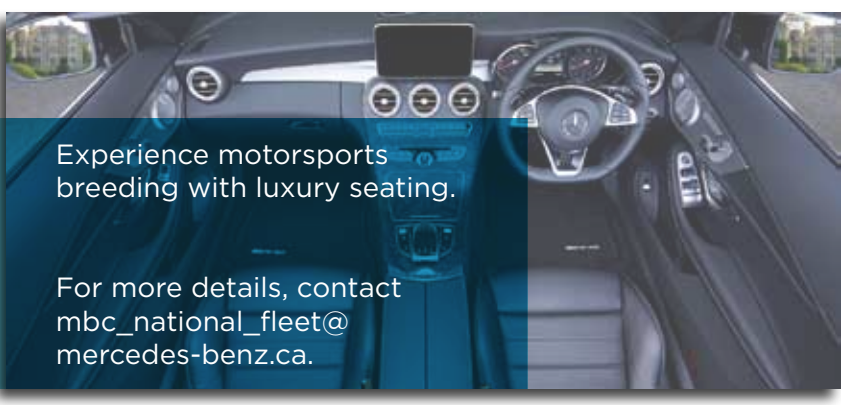

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