# Letters to the editor

**We welcome original letters of less than 300 words; we may edit them 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. Please disclose any competing interests.

## Avoid the routine use of ultrasound in evaluating clinically apparent inguinal and umbilical hernias

Inguinal and umbilical hernias are two of the most common reasons a primary care patient may need referral to a general surgeon. History and physical examination are usually sufficient to make the diagnosis. Patient symptoms include pain, burning, heaviness, or aching in the groin or umbilical region. It may be worse at the end of the day or after prolonged activity. The patient may also report a bulge that often disappears in the prone position.

It is best to examine the patient standing and then lying prone. Usually, with the patient standing, a visible asymmetry is seen. This can disappear when the patient is lying flat. Physicians can also feel the bulge or impulse when the patient coughs or strains.

The surgeon's diagnosis and subsequent treatment decisions are reliably made by the patient history and physical examination alone. The routine use of imaging, including ultrasound, in the setting of a clinically palpable inguinal or umbilical hernia is not required. This only adds unnecessary costs and treatment delay with no useful contribution to management decisions.

Choosing Wisely is a global movement for reducing unnecessary tests and treatments in health care. It tries to inspire and engage health care professionals to take the lead in reducing unnecessary tests, treatments, and procedures, and enables them with simple tools and resources that make it easier to choose wisely.

### Recommendation

The Fraser Health Authority Division of General Surgeons, with the support of the Section of General Surgeons of BC, recommends avoiding the routine use of ultrasound in the evaluation of clinically apparent inguinal and umbilical hernias. We are happy to accept elective referrals without an ultrasound. If the referring physician is not confident in the diagnosis, it is okay to order an ultrasound. Also, if the physician feels an ultrasound is necessary, it can be ordered at the time of initial consultation.

**—David E. Konkin, MD, FRCSC, FACS**
**Regional Division Head, General Surgery, FHA**
**Department of Surgery Head (Local), Eagle Ridge Hospital**
**Division Head, General Surgery, Royal Columbian Hospital & Eagle Ridge Hospital**
**Clinical Associate Professor, UBC**

### Suggested reading

Bohnen J.M.A Inguinal hernia in a 55-year-old man. CMAJ 2014;186:1010-1011. Accessed 25 June 2019. www.cmaj.ca/content/cmaj/186/13/1010.full.pdf.

Choosing Wisely. Society of American Gastrointestinal and Endoscopic Surgeons: Five things physicians and patients should question. 9 January 2019. Accessed 25 June 2019. www.choosingwisely.org/societies/society-of-american-gastrointestinal-and-endoscopic-surgeons.

Choosing Wisely Australia. Royal Australasian College of Surgeons: Tests, treatments and procedures clinicians and consumers should question. 10 May 2017. Accessed 25 June 2019. www.choosingwisely.org.au/recommendations/racs#collapse-2.

## Physicians have no right to complain

Physicians, as a rule, don't bother to vote in elections for organizations that deal with the practice of medicine, so we shouldn't complain about the results of those elections.

Organizations suffer two common diseases: regulatory capture and mission creep. In the former, the organization that is supposed to look out for all looks out for only a few. In the latter, the organization takes on more and more work outside its original mandate, which costs more and more. The institutions concerned with the practice of medicine (the College, CMPA, Doctors of BC, etc.) are no different.

One assumes there is rule of the majority in these institutions, but this is a fallacy.[1] Consider any Western liberal democracy. In these countries about half the population is under the voting age, bringing the number of eligible voters who decide the winners down to 50%. Usually about 50% of eligible voters bother to vote, meaning that 25% of the population does the deciding. Then, if you consider that two parties usually split the vote (say 51% to 49%), you realize that 12.5% of the population decides who rules 100% of the population.

For medicine-related organizations, voter turnout is even more pathetic, rarely topping 10%, and leading to an even more obvious example of minority rule.

The regulation of medicine is not a prescriptive thing. It is very much a give-and-take thing. In other words, there are rules, but these rules require interpretation. That is why unintended (unfair) consequences are unavoidable.

So if you don't vote, then don't criticize.

**—Mark Elliott, MD**
**Vancouver**

### Reference

1. Taleb NN. Skin in the game. New York: Penguin Random House; 2018.

## Success in personal and professional realms

It was with some weariness that I read the article by Gordon J.D. Cochrane, "Physicians and their primary relationships: How to be successful in both personal and professional realms" [*BCMJ* 2019;61:208-211]. I understood the author's concern that physicians may drag their doctor-patient communication methods home, causing stress and conflict and thus interfering with the intimate level of communication needed in primary relationships. My first problem with the article was the implication that the physician should be living in two spheres: be the best when at work as a doctor and be the best when in his (or presumably in her) primary relationship. Easier said than done, and besides, perhaps the partner enjoys

being a doctor's husband or a doctor's wife, with all the imperfections. Reading on, my second problem was that the article was based on the results of a study of long-term relationships of only 57 supposedly happy nonphysician couples. In that study the factors cited to achieve success at home included commitment, love and trust, good communication, effective problem solving, similar views and values, enthusiasm for life with a sense of humor, and sexual intimacy. All I could say was, amen. Actually, I rather liked the helpful suggestions relating to the last item, but think of the performance anxiety trying to excel in all the recommended factors. My third problem with the article was more personal: I am not a fan of generalized behavioral advice. This article had all the good intentions of providing specific assistance in the home relationships of busy doctors, but I couldn't help but imagine Clark Kent changing out of his Superman costume (or Superwoman changing out of her costume) when arriving home after a day's work.

**—George Szasz, CM, MD**
**Vancouver**

## Author replies

Thank you for this opportunity to respond to Dr Szasz's letter. He is simply offering an opinion about my article and I have no problem with his comments. In many ways he is right. Maintaining a demanding profession and a fulfilling relationship can be challenging for anyone and his Superman/Superwoman metaphor is often fitting. This is why I wrote the article.

**—Gordon J.D. Cochrane, Ed. D., R. Psych.**
**Vancouver**

## Reducing disability paperwork and family practice visits

I am inundated with requests from my patients to refill medications and assess conditions outside my scope. Many of them have disabilities and are unable to wait for hours at a walk-in clinic. There is a lack of resources to treat poverty, mental health, and addictions. The money should go there.

The paperwork and number of patient visits related to an injury is overwhelming. The bulk of these patients have soft-tissue injuries that are not quantifiable. A huge number of unnecessary imaging and consults are ordered to prove the diagnosis. I am an experienced physiatrist who teaches and lectures at home and abroad, but have absolutely no idea how to answer the generic questions found on those forms. Most doctors fill out what the patient tells them or face conflict, strains to the treating relationship, and letters of complaint. When I do a legal review it is alarming to see the number of times some patients see their family physician—three to four times per month, then twice per month, then monthly for years, with essentially no change. Serial visits to family doctors do not improve outcomes in litigation or open claims.[1] Visits should be every 2 to 3 months for a chronic condition.[2] "My lawyer/insurer says I must," is not a medical necessity.

We need strict limits on visits for injury. After the initial assessments, insurers should be responsible. Even for significant pathology, there is no need to be assessed at frequent intervals. ICBC, WorkSafeBC, and insurers should stop feeding off the public trough and treat their own patients. We should just write that "The patient has limitations with their right arm. Please modify their job to accommodate or find them another position; if not, get a vocational and functional assessment and follow that plan."

**—Paul Winston, MD, FRCPC**
**Medical Director Rehabilitation and Transitions, Island Health**
**President, Canadian Association of Physical Medicine and Rehabilitation**

### References

1. Felhaber T. The risks of worklessness. Accessed 6 August 2019. https://thischangedmypractice.com/the-risks-of-worklessness.
2. Verhulst L. Am I overservicing my patients? BCMJ 2017;59:402.

## Plastic-bag concerns

Numerous readers have written to the *BCMJ* recently expressing concerns about the plastic bags that print issues of the journal are occasionally wrapped in. We wholeheartedly agree with readers' concerns about plastics, which is why we don't use them. The bags we use are plant-based and compostable. Furthermore, we rarely use these compostable bags. We discourage advertisers from this type of enclosure and try to steer them to print inside the journal. Over time, we've successfully moved away from this type of advertising. However, we are also not in a position to refuse revenue from this source as we are a membership-funded publication and all advertising helps us defray publishing costs.

The *BCMJ* seeks to minimize its negative impact on the environment by:

- Supporting members who wish to read online with an e-subscription to www.bcmj.org.
- Avoiding bag use, and using certified-compostable plant-based bags when needed.
- Working with Mitchell Press, ranked third in North America for sustainability by canopy.org.
- Printing with vegetable-based inks.
- Using FSC-certified paper.
- Printing locally in British Columbia.

What else we're doing, thanks to your feedback:

- We're looking into printing "compostable" on the bags we use.
- We have added a note to our masthead page about the bags, and about our other environmental practices.

Thank you to everyone who took the time to write to us. It's a good reminder that we need to be more explicit about our environmentally aware practices—and that we should always strive to do more.

**—Ed**